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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235664 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 09/03/2025 |
| NAME OF PROVIDER OR SUPPLIER Mission Point Nursing & Physical Rehabilitation Ce | | STREET ADDRESS, CITY, STATE, ZIP CODE 18200 W 13 Mile Road Beverly Hills, MI 48025 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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| <p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake 1291048. Based on observation, interview, and record review, the facility failed to protect one Resident's (R204) right to be free from abuse mistreatment of two residents reviewed for abuse, when R204 was intimidated by a former staff member (witnessed by R203) with verbal aggression and a threatening gesture. Findings include: A facility-reported incident report was received by the State Agency on 6/27/25, which showed on 6/26/25 at approximately 3:30 p.m., R203 reported to the facility Social Worker, SW A, they witnessed an incident several days prior on the afternoon shift when R204 was observed swearing at Certified Nurse Aide (CNA) C. The report further revealed CNA C left the building and returned with a bat (baseball bat). The report described CNA C threatened R204 by approaching them and pursuing them with the bat. The staff member was suspended, and no physical contact was noted. It was reported that law enforcement was notified and stated R204 was not harmed. The staff member did not return to work and was terminated by the facility. The facility investigation determined the incident occurred on 6/22/25 between 3:00 p.m. to 4:00 p.m. The investigation showed R204 was unable to recall the incident, and denied any fear, pain, or distress. Review of the facility's investigation report revealed Maintenance Employee, Staff E observed they witnessed R204 tell CNA C to Shut the f* up and then saw CNA C retrieve a bat from their car and reenter the facility. The investigation conclusion revealed CNA C was separated from employment for failing to meet expectations regarding professional conduct and de-escalation practices. Review of R204's Accident and Incident report, dated 6/27/25, showed on 6/26/25 at 5:00 p.m., a resident (R203) made writer (nurse) aware of an incident which occurred on 6/22/25, when (R203) observed a worker (later identified as CNA C) making a threat towards another resident. (R203) stated they didn't like it and told some of the other residents about it. The writer asked the resident (R203) if they felt safe, who said yes. Writer interviewed R204 who said they were ok and did not recall any incident. The writer confirmed R204 had no injuries and no pain was found. The report showed the management and guardian were made aware an incident occurred. Review of R204's nursing assessment, dated 6/27/25 at 3:32 p.m. revealed a resident informed staff R204 was threatened by a worker on Sunday (6/22/25), the proper authorities were notified, and they assessed R204, and found no injuries. Review of Staff E's witness statement, dated 6/22/25, described on 6/22/25, The resident (R204) told the employee (CNA C) to, Shut the f* up. I witness (sic) employee (CNA C) went outside to her car and retrieved a bat out of the trunk of her car and entered the building on 6/22/25. There was no further description of what occurred when CNA C reentered the building with the bat, or if they followed up. Review of the Electronic Medical Record (EMR) showed R204 was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease, schizophrenia (mental disorder which may include psychosis), and an anxiety disorder. When the incident occurred, R204 was ambulatory and had moderate cognitive impairment. On 9/03/25 at 12:20 p.m., R204 was observed standing in the doorway of their room, dressed, and well groomed. On 9/03/25 at 12:22 p.m., R204 reported they had no concerns or recalled any incidents. R204 declined further interview. On 9/03/25 at 12:24 p.m., R203 was observed dressed and seated in a wheelchair in their room. On 9/03/25 at 12:25 p.m., R203 reported they recalled an incident between CNA C and R204, which occurred at the front door of the facility in front of the nurse's station, on the [NAME] end of the building. R203 stated CNA C got in (R204's) face and told (R204) 'I am not the person to mess with; I will f*** you up, intimidating (R204) and then stormed out to her car 'all heated' and came back with a big canvas bag. There was a Little League (smaller) aluminum bat and (CNA C) hit it on the ground, like intimidation. It just surprised me. Yes, I was upset. When asked how R204 responded, R203 said, (R204) didn't really respond. R203 denied R204 was harmed. R203 was alert and oriented x four spheres and could tell time. R203 reported they felt safe at the facility. On 9/03/25 at 1:37 p.m., SW A confirmed the incident occurred as described by R203 during a phone interview. SW A explained R203 shared with them an employee pursued R204 with an object, and it had happened a few days before they reported the incident and said they had not told their nurse or a manager the incident occurred. SW A reported they immediately reported the incident to the Nursing Home Administrator (NHA) and the Regional Director of Operation (RDO), NHA F. SW A stated R203 was alert and oriented fully and said they were an accurate reporter and said R203 was concerned about R204's well-being. SW A clarified they understood CNA C pursued R204 in the facility with an object per the investigation findings but R204 was not harmed. SW A reported they did psychosocial follow-up with R204 and no concerns were found. On 09/03/25 at 1:47 p.m. Staff F reported</p> | | |

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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>This citation relates to Intake 1291048. Based on interview and record review, the facility failed to report an abuse mistreatment incident for one Resident (R204) of two residents reviewed for abuse. Findings include: Review of the Facility Reported Investigation Summary/Actions Taken revealed, Reported Event: On 6/26/25, the Abuse Coordinator was informed by Social Worker (SW) A, of an alleged incident of staff-to-resident physical intimidation, involving R204 and Certified Nurse Assistant (CNA) C. The incident was reported to have occurred on 6/22/25, between 3:00 - 4:00 p.m. and allegedly involved the staff member retrieving an object from her car and reentering the building to confront the resident after a verbal altercation. Background: Upon notification, the facility suspended the staff member (CNA C) pending investigation, contacted the (Name of) Police Department, and initiated a full investigation. Further review of the report further revealed, (Staff E) submitted a statement dated 6/27/25, stating he witnessed (R204) tell (CNA C) to 'shut the f* up ** and then saw (CNA C) retrieve a bat from her car and reenter the facility. On 09/03/25 at 1:47 p.m., Staff E reported during a phone interview they saw incident between R204 and CNA C, when they observed CNA C go to their car, followed them out, and saw CNA C obtain a bat, and (Staff E) said, You can't come (in) here with that bat. And then they observed CNA C reenter the building, who showed R204 the baseball bat. Staff E said, Why are you showing them the bat? Staff E stated CNA C had a metal bat, and she hit it on the floor and then CNA C walked away and said, I am done. Staff E denied any reaction by R204 and confirmed no contact, or harm occurred to R204 and said they did not appear fearful. Staff E acknowledged they did not report the incident when it occurred to the facility. Review of the policy, Review of the policy, Abuse, Neglect, and Exploitation, revised 6/24, revealed, It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property. Definitions: Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse and certain resident to resident altercations. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Alleged Violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor or others but has not yet been investigated and, if verified, could be indication of noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. VII. Reporting/Response: A. The facility will implement the following: 1. Reporting/Response: A. The facility will implement the following: 1. Reporting of all alleged violations to the facility Administrator (Abuse Coordinator) immediately after ensuring resident safety. 2. Reporting of all alleged violations to the State Agency, Adult Protective Services, and to all other required agencies (e.g. law enforcement when applicable) withing specified timeframes. a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in bodily injury, or b. not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included immediate action, education, and monitoring prior to the onsite survey on 9/03/25. The facility was able to demonstrate monitoring of the correction action and sustained compliance by 7/03/25. -</p> | | |