

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 06/11/2025
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent the development of a pressure ulcer, ensure the facility accurately assessed/identified the wound timely and accurately implemented treatment for one (R27) of two residents reviewed for pressure ulcers, resulting in the development of a Stage IV (full-thickness skin and tissue loss) pressure ulcer to the bilateral buttocks that required an extensive hospital stay and a diagnosis of osteomyelitis (bone infection). Findings include:</p> <p>On 6/10/25 at approximately 10:12 AM, R27 was observed lying in bed. The resident was resting and did not answer questions asked. Prior to the observation, the facility provided information that noted R27 was the only Hospice resident at the facility.</p> <p>A review of R27's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Cerebral Infarction, Dysphasia, Adjustment Disorder and Moderate Protein-Calorie Malnutrition. A review of R27's Minimum Data Set (MDS) noted that the resident had a Brief Interview for Mental Status (BIMS) score of 4/15 (severely cognitively impaired) and required extensive one to two person assist for most Activities of Daily Living (ADL). A contract to begin Hospice services was signed by R27's representative on 5/10/25.</p> <p>Continued review of R27's record documented, in part, the following:</p> <p>10/25/24: Practitioner Progress Note: .admitted from another facility .patient does not respond appropriately . HAD a PEG (percutaneous endoscopic gastrostomy) tube .he is eating orally .SKIN .generally intact .Patient was seen by video .</p> <p>10/26/24: Order: .Clean coccyx (area just above center buttocks) area with soap and water, apply triad paste every shift for excoriation .Start date 10/26/24 .D/C (discontinue) date 11/12/24 .</p> <p>10/30/24: Nutrition Summary Note: .My appetite is fair to good. Eating 50-100% of meals .</p> <p>11/1/24: Braden Scale for Determining Pressure Ulcer Risk: .R27 .Category: Moderate Risk .Score 13 . Moisture .Occasionally Moist Activity:Bedfast .Nutrition: Probably Inadequate .Friction and Shear .Potential Problem .</p> <p>(continued on next page)</p>

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Care Plan: Focus: I am at risk for impaired skin integrity (10/26/24) .Interventions: .Assist me to moisturize my skin as needed (initiated 11/7/24) .Assist me to turn &/or reposition routinely .while in bed and redistribute .when I am up in my chair (11/7/24) .Cleanse area and apply zinc oxide cream barrier to buttock/peri area after incontinence episodes .(Initiated 10/26/24) .Standard pressure relieving mattress to bed (Initiated 11/7/24) .Focus: I have history of skin impairment d/t (due to) excoriation and healed old scar on buttocks Intervention: Keep skin clean and dry .apply triad paste to buttocks area .</p> <p>11/4/24: Weekly Skin Sweep: R27 .Please choose the skin condition that was observed: Discoloration .Site: Right buttock (excoriation-wearing off or abrading the skin resulting in a possible lesion or sore) .Left buttock (excoriation) .</p> <p>11/11/24: : Weekly Skin Sweep: R27 .Please choose the skin condition that was observed: Non-skin intact . Site: old healed red area . *On 11/11/24, R27 stopped receiving any treatments to his buttocks.</p> <p>11/21/24: Weekly Skin Sweep: R27 . Please choose the skin condition that was observed: Discoloration . Site: Right buttock (excoriation-wearing off or abrading the skin resulting in a possible lesion or sore) .Left buttock (excoriation) .</p> <p>11/22/24: Order: .Provide skin barrier ointment after each incontinent episode and PRN (as needed) . *It should be noted that this order was not transferred to the Medication/Treatment Administration Record (MAR/TAR) and there was no documentation in R27's record that they received the treatment.</p> <p>A review of R27's MAR/TAR from 10/26/24-11/30/24 noted that the only treatments provided to the coccyx area were as follows: Clean coccyx area with soap and water, apply triad paste every shift for excoriation. This treatment was provided starting 10/26/24 and ended on 11/11/24. No additional treatments, including skin barrier ointment, were provided to the coccyx area through November 2024.</p> <p>11/28/24: Weekly Skin Sweep: .R27 .Discoloration .Right buttock (excoriation) . Left buttock (excoriation) .</p> <p>12/5/24: Progress Note Details: .R27 .12/5/24 .Established pt New Wound Resident .is being seen by wound care for assessment of skin breakdown bilateral buttock .Wound #1 Bilateral Buttock is a Partial Thickness MASD (Moisture Associated Skin Damage) and has received a status of Not Healed. There is a small amount of Sero-sanguineous drainage (a type of wound drainage that is a combination of fluid and blood) noted .Area appears to as multiple superficial open areas .Wound Orders: Wound Cleansing: Normal Saline or Wound Cleanser .Primary Dressing .Stock Calmoseptine or Chamosyn paste .Change frequently 2x per day and as needed . (Authored by Nurse Practitioner (NP) B).</p> <p>12/11/24: Practitioner Progress Note: Late Entry .Seen for eval sacral ulcer .Opening per staff .sacral area open/excoriation .</p> <p>12/12/24: Progress Note Details: .R27 .12/12/24 .Wound Assessment: .Bilateral Buttock is a Full Thickness MASD .status of not Healed .Small amount of sanguineous drainage .The wound is worsening .Orders . Primary dressing Medi honey .Apply Medi honey to slough following triad paste to perimeter of wounds . Secondary - apply Medi honey to abd pad, in center of pad, apply triad paste on to ABD pad surrounding Medi honey and place on area of skin break down BID and as needed . (Authored by NP B).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>12/19/24: Progress Note Details: .R27 .12/19/24 . is being seen by wound care for reassessment of bilateral buttock skin breakdown .Wound #1 Bilateral Buttock is a Full Thickness MASD and has received a status of Not healed. Subsequent .measurements are 6cm (centimeters) length x 5.5cm width, with an area of 33 . Small amount of Sero-sanguineous drainage .wound margin is undefined wound bed has 76-100% granulation, 1-25% slough .Pressure Ulcer Unavoidable Evaluation . (Authored by NP B).</p> <p>12/27/24: Weekly Skin Sweep: .Open area .Coccyx .</p> <p>12/28/24: Progress Note Details: .R27 .12/28/24 (resident is being seen today instead of 12/26) .Wound #1 Bilateral Buttock Coccyx is an unstageable Pressure Injury Apply Medi honey to slough followed by &frac12; strength moist Dankins gauze, lightly fill to depth of wound Imaging Radiology .x-ray of Sacrum/coccyx to r/o (rule out) osteomyelitis (a bone infection that develops from a wound) .Pressure ulcer: Unavoidable . (Authored by NP B). *It should be noted there was no order for the x-ray of sacrum/coccyx until 1/1/25. However, the X-ray order was never completed. In addition, the treatment Dankins was not ordered for R27 and thus the resident did not receive the treatment recommended by NP B starting on 12/28/24.</p> <p>1/1/25: Nursing Progress Note: .resident wife and daughter came to check on their loved one .Wife stated that resident did not look right, and she would like to speak to doctor .PA (physician assistant) spoke with wife at length and agreed for resident to be sent to the Hospital .</p> <p>1/1/25 (5:25 PM) Ambulance Service: .R27 .Incident Location: Facility .Destination: Hospital .Bed Confined (yes) .Last known well : 4 days ago .Primary Complaint: Sacral Wound .</p> <p>Hospital Records: 1/1/25 Emergency Department (ED): .ED notes Stage IV pressure injury to coccyx . malodorous .concerning for sepsis secondary to sacral osteomyelitis from a Stage IV decubitus ulcer .There is minimal history provided but it was reported the symptoms have been going on for 3-4 days .current medication information was not provided by the nursing facility at the time of transfer to the hospital .CT . Order Date (1/1/25) Reason for Exam: Sepsis, Sacral decubitus ulcer .Routine axial images .Impression: . Large sacral decubitus ulcer extending into the dorsal perineum to the anal verge .Focal examination of wounds: Sacrum to bilateral buttock- stage 4 pressure injury .Measurements 7.5 x 9.5x 3.6 cm .Base: Moist, tan necrotic tissue open would base with palpable bone, with open pink and tan necrotic tissue at wound edge. Full thickness tissue loss with depth to bone .Plan: Moisten Kerlix with Dankin's solution (ring out excess) and loosely pack into open wound on the sacrum q12 hours .Specialty Mattress- Striiker .Antibiotics per Infectious Disease .maintain vancomycin .</p> <p>1/10/25: Admisison Note: Resident arrived at facility .Skin assessment done with large wound at sacrum area .</p> <p>1/10/25: Practitioner Progress Note: late entry .R27 .sacral wound was sent to the hospital for worsening sacral wound concerning for infection .started on Dakins dressing changes daily and broad-spectrum ABX (antibiotics) .continue IV (intavenous) Vancomycin and Zosyn for 30 days .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/25 at approximately 9:55 AM, an interview and record review were conducted with Wound Nurse (WN) C. WN C reported that they had worked for the facility in the past, took a break from July 2024 and started again as the wound nurse in February 2025. They indicated that they are not yet wound certified but work along with NP B and Wound Physician N. WN C noted that prior to their employment as the wound nurse, Nurse A served as the facility wound nurse. WN C was queried as to R27's wounds. WN C noted that R27's wounds are currently healing and noted the resident is on Hospice and receives tube feeding. WN C was further asked if they were aware that R27 developed a facility acquired Stage IV pressure ulcer while at the facility. WN C again reported that they were not employed at the time the resident developed the pressure ulcer(s). While WN C was not able to specifically answer questions about R27's wound development they were able to confirm that orders, including treatments and radiology should be followed by staff.</p> <p>On 6/11/25 at approximately 12:01 PM, a phone interview was conducted with NP B. NP 'B reported that they started working at the facility in December 2024 and work generally on Thursdays. NP B reported that they do not work with all the facility residents, just those brought to their attention by nursing staff. NP B was specifically asked about R27, and they noted that the resident required total care, was a two person assist and recalled that he was admitted to the hospital for wounds in early 2025. NP B was asked if prior to seeing R27 on or about 12/5/24 where they aware that the resident's skin sweeps frequently noted they had excoriation to both the left and right buttock. NP B noted they could not recall as it was prior to their initial visit. However, NP B reported that residents with excoriated skin, are bedridden/chairbound and are incontinent must be turned and repositioned frequently. In addition, they require that the area at risk is cleaned, remains dry and barrier creams like triad paste should be applied as ordered. NP 'B was not aware R27's record indicated they received no treatment to their buttocks from 11/22/24-12/1/24. When asked if the recalled whether the resident had a low air loss mattress on or about 12/5/24, as an order could not be found, NP B reported they believed the resident did have one, but noted it was on the wrong setting and was too firm.</p> <p>During the continued interview with NP 'B they were asked as to their first visit (12/5/24) with R27 and what made them determine R27's bilateral buttocks as MASD as it was noted in their documents that there was superficial open areas and sanguineous drainage. NP 'B reported that they waived between calling it a Stage II or MASD and went with MASD. NP B was asked about their note from 12/28/24 that indicated the resident's wound was noted as unstageable and whether they were aware that the required Dakins treatment was never ordered and never administered to R27's wound. NP B stated that they were not aware. When asked if they were aware that the recommendation for an X-ray to determine osteomyelitis dated 12/28/24 was never completed, NP B noted that it should have been completed. NP B was asked as to the current state of R27's wound and they reported it was showing signs of improvement. NP B was asked as to why they noted the wound was unavoidable as it was noted as improving. NP B reported that R27 in late December 2025 was showing quick deterioration of their skin that could have been prevented.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation related to Intake #: MI00150321.</p> <p>This citation has two deficient practice statements.</p> <p>Deficient Practice Statement #1</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent two physical resident-to-resident incidents for three Residents (R7, R13, R23) of three residents reviewed for incidents. Findings include:</p> <p>Review of a Facility Report Investigation (FRI) report, dated 2/11/25 through 2/13/25, revealed there was a resident-to-resident incident which occurred on 2/10/25. The incident began as a verbal altercation when R7 removed a chair from the hallway for their guest to be seated, which R13 believed was their own personal chair. There was a subsequent disagreement between R7 and R13, with an exchange of words, which resulted in R13 kicking R7 in the left ankle. The report conveyed R7 initially reported pain and was later found not injured.</p> <p>Review of R7's Minimum Data Set (MDS) assessment, dated 1/14/25, revealed R7 was admitted to the facility on [DATE] with diagnoses including stroke, anxiety, and depression. The assessment showed R7 required supervision for transfers and toileting. The Brief Interview for Mental Status (BIMS) assessment showed a score of 14/15, which showed R7 was cognitively intact.</p> <p>Review of R13's MDS assessment, dated 12/27/24, revealed R13 was admitted to the facility on [DATE], with diagnoses including atrial fibrillation (heart rhythm irregularity), bipolar (mood) disorder, and schizophrenia (a chronic mental health disorder which may affect one's perceptions). The assessment revealed R13 toileted themselves and transferred and walked short distances with set-up. The sensory assessment showed R13 was able to make themselves understood and could understand others, with clear speech.</p> <p>Review of R7's Accident and Incident report, dated 2/10/25 at 9:02 (a.m.), revealed, Writer (Licensed Practical Nurse) LPN D was called to hallway by a resident saying, They (R7 and R13) are about to fight. Writer along with medical records (staff) noticed residents (R7 and R13) arguing in hallway. Both residents were separated and asked to go to their rooms. At that time, (R7) said that resident (R13) kicked (them) in the ankle. Resident (R7) was assessed for injury. No injury found .(R7) says, I went and got a chair from the hallway because I was having company. I got the chair and took it to my room. At that time (R13) tried to enter my room to get the chair; (R13) said the chair was (theirs). I explained that the chair was in the hallway and not (theirs). (R13) has a chair in (their) room. (R13) began to swear at me and (R7) swore back . This incident was brought to staff attention by a resident, not by a staff member.</p> <p>Review of R7's progress note, by Physician L, dated 2/11/25 at 19:03 (6:03 p.m.), revealed R7 was kicked in the ankle by another resident and had developed some mild pain/swelling in the left ankle. The note further revealed an x-ray was taken of the left ankle, which was negative for a fracture or soft tissue swelling.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R7's nursing assessment narrative, dated 2/11/25 at 18:03 (6:03 p.m.), revealed, (R7) was kicked by (R13) because (R13) would not allow (R7) to remove a chair from (their) room that (R7) had put there for a visiting guest. (R13) felt that the chair that was sitting outside (their) door was (their) chair .</p> <p>Review of R13's Accident and Incident report, dated 2/10/25 at 16:35 (4:35 p.m.), by LPN D, revealed, Writer (LPN D) was called to hallway by a resident (not discovered by staff). Writer and medical records clerk witnessed two resident's fussing (sic) in hallway and making threats. Both residents were stopped and asked to go to their rooms. (R7) informed writer (LPN D) that (they were) kicked by (R13) in the Lt. (left) ankle . (R13) informed writer that (they were) in (their) room when (they) noticed (R7) taking (their) chair from the hallway. (R13) went to get (their) chair back and (R7) would not let (them) get the chair. They started yelling at each other and (R13) kicked (R7) because (they were) mad .Immediate action taken .(R13) was educated on not putting (their) hand or feet on (R7) and to let staff handle things of that nature .</p> <p>On 6/12/25 at 12:20 p.m., LPN D was asked about the verbal and physical altercation between R7 and R13 on 2/10/25. LPN D confirmed they were the nurse working and discovered the incident. LPN D clarified the incident occurred on the East Hall, and they understood R13 kicked R7, because R7 took a chair outside R13's room, which R13 believed was their own personal chair. LPN D was asked if they believed this was a deliberate act by R13. LPN D reported they believed when R13 kicked R7 there was some deliberateness, since R13 kicked R7 in anger because R13 took a chair which they believed was theirs.</p> <p>Review of R13's Care Plan, accessed 6/13/25, revealed an intervention after the incident occurred, which showed they have behaviors of physical aggression when I get upset or provoked by others. The intervention, dated initiated 2/12/25, revealed, Please give me time and the ability to talk thru my aggression or when I'm upset. There was no mention of R13 believing the chair in the hallway was their own personal chair, or a follow-up intervention.</p> <p>Review of R13's progress note, dated 2/18/25 at 16:57 (4:37 p.m.), revealed a second resident-to-resident incident, when R13 was walking to their room and a second resident (R23) attempted to make physical contact with them. R13 responded by making physical contact with the left arm of R23 and apologized to staff for their actions after staff education.</p> <p>Review of R13's behavioral care provider psychiatry note, dated 1/28/25, revealed R13 had been living in several nursing homes for the past several years, and they had been in an ALF (Assisted Living Facility) immediately prior to the last hospitalization, but the ALF homeowner said they would not take R13 back due to their aggression. The visit note confirmed R13 had schizophrenia and bipolar disorder, and a history of alcoholism and symptoms of alcohol induced dementia.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/25 at 12:30 p.m., LPN D continued to describe the second resident-to-resident incident about a week later, between R13 and R23, when asked. LPN D reported on 2/18/25 after 3:00 p.m., they observed R23 walking down the East Hall and R13 was walking on the hall also, and they saw R23's hand touch R13 on their shoulder, which they believed was a caring touch. LPN D described R13 did not like R23's hand on their shoulder, and moved their hand, and they said, Don't do that; don't touch me, and R13 made contact with R23's arm with their hand. LPN D reported they were able to separate the residents and there were no injuries. LPN D reported R13 was upset with R23 about an hour prior, when R23 sat in a chair outside R13's room which staff used for charting, which R13 believed was their own personal chair. LPN D clarified R13 liked their own space and their room a certain way, and they were particular about their personal items. LPN D confirmed the chair outside R13's room door was related to both resident-to-resident physical incidents by R13, and remained outside R13's room for staff use. LPN D confirmed they called the Nursing Home Administrator (NHA) when the incident occurred.</p> <p>Review of R23's progress note, dated 2/18/25 at 16:06 (4:06 p.m.), revealed, (R23) was trying to touch another .resident (R13) in hallway and that resident (R13) reached (their) right hand and hit this .resident (R23) on (their) left arm. not hard, per witness . It was later clarified by the NHA the witness was a resident who no longer resided in the facility. No injury was described for R23 or R13.</p> <p>Review of R23's Accident and Incident report, dated 2/18/25 at 15:30 (3:30 p.m.) revealed, When (R23) was walking in the hallway and trying to touch (R13), (R13) reached back using (their) right hand and hit (R23) on (their) left arm. A third resident witnessed what happened . No pain, injuries, or distress was found per the report.</p> <p>Review of R23's MDS assessment, dated 1/28/25, revealed R23 was admitted to the facility on [DATE], with diagnoses including dementia, anxiety, and PTSD (Post Traumatic Stress Disorder). R23 was dependent for toileting, and independent with transfers and walking. The BIMS assessment showed a score of 0/15, showing severe cognitive impairment.</p> <p>Review of R23's behavioral management program review note, dated 2/07/25, revealed, .Behavior assessment. Behavior #1. 1a. Type of Behavior: I will invade other resident personal space .</p> <p>Review of R23's behavioral care psychiatry note, dated 11/04/24, revealed, ,(R23) is well-known to have significant behavioral and emotional disturbances associated with (their) dementia. (R23) displayed wandering, emotional lability, and frequently gets close in other resident's personal space which puts (R23) at high risk for physical conflict .</p> <p>Review of R23's Care Plan, accessed 6/11/25, showed no mention of R23 invading other residents' personal space, or a related intervention.</p> <p>On 6/11/25 at approximately 1:30 p.m., this Surveyor observed R23 walking by R13 in a facility hallway. R13 agreed to be interviewed and headed towards their room.</p> <p>On 6/11/25 at approximately 1:34 p.m., R23 was observed walking by R13's open door of their room to the end of their hallway and standing there talking to themselves. There were no staff present observed on the hall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/25 at 1:35 p.m., R13 stated they observed R23 walked by and stated, (R23) is a headache; (they) get on my nerves .I slapped (them) a little bit, as (they were) just driving me crazy and everything, but I am not doing it anymore . When asked why, R13 said they felt frustrated with R23. R13 confirmed R23 did not go in their room but walked on their hallway. R13 was asked about any incidences or concerns with other facility residents and denied any, including with R7. When asked about the black padded chair outside their room, R13 reported this was their own personal chair, and the staff could sit there. When asked about residents sitting in the chair, R13 stated the residents could not sit in their personal chair outside their room in the hallway, as it was their chair. It was observed there was a similar chair in R13's room, so it was unclear why R13 identified the chair staff used in the hallway for charting as their own personal chair. R13 was alert and oriented to themselves, their room (which they easily found), and to their surroundings.</p> <p>On 6/11/25 at 1:42 p.m., a black padded chair was observed outside R13's room, approximately five feet away from their room outer door. It was observed R7's room was on the same hall, a few doors down from R13's room. The chair was not labeled in any way, for staff or resident use.</p> <p>On 6/11/25 at 1:46 p.m., R23 approached this Surveyor on the hallway outside R7's room, walking ad lib, wearing casual sweat clothes. R23 began speaking non-sensically and attempted to follow this Surveyor into R7's room. No staff were observed on the hall or intervened. This Surveyor softly verbally redirected R23 out of R7's doorway, and they walked down the hall. R23 was oriented to their name only.</p> <p>On 6/11/25 at 1:48 p.m., R7 agreed to be interviewed in their room. R7 was in their bed, dressed, and a power wheelchair was observed next to their bed. R7 was alert and oriented x 4 spheres (to person, situation, time, and place). R7 was asked about any concerns with facility residents. R7 reported there was one concern, when they (R7) took a chair from their facility hall, and said R13 did not like it. R7 reported they (and R13) were doing fine now and declined to discuss it further. R7 stated, (R13) is my friend. this Surveyor asked if R23 or any residents were coming into their room. R7 responded, No.</p> <p>On 6/11/25 at approximately 1:53 p.m., this Surveyor was exiting R7's room, standing in the doorway, when R23 approached this Surveyor a second time, walking rapidly up to this Surveyor. Despite a computer table being in front of the Surveyor, R23 quickly leaned forward and grasped this Surveyor by both upper arms, just below the shoulders. R23 was pleasant and conversational however was in the Surveyor's personal space. No staff were observed to intervene, or in line of sight, R23 was verbally redirected to release their grasp by this Surveyor, with R23 complying and letting go. R23 followed Surveyor up to the nurse's station, where a nurse was seen around the corner coming out of a room, not in line of sight of R23, and was asked to redirect R23.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/25 at approximately 1:55 p.m., this Surveyor was standing in view of the facility elevator near the first-floor resident dining room. R13 was observed standing nearby. R23 walked from around the corner quickly and approached R13, who was near/across from the elevator, invading their personal space. R23 was heard to call R13 fat @ss loudly from a few feet away. R13 was observed to appear frustrated. The Activity Director, Staff F, walked up to R13 after and removed them from the situation by escorting them into the dining room. R23 next walked rapidly towards this Surveyor and again grasped this Surveyor's upper arms tightly, just below the shoulders, invading Surveyor's personal space, and took three loud grunting breaths, sounding unsettled and appearing angry. No staff came to intervene during this occurrence. This Surveyor softly verbally asked R23 to let go, which they did, and this Surveyor removed themselves from the situation.</p> <p>On 06/11/25 at approximately 1:57 p.m., this Surveyor asked to speak with R13 if they agreed. R13 agreed to a brief interview. This Surveyor asked R13 how they were doing, and they said, I'm ok. Everything's going to be ok.</p> <p>On 06/11/25 at 1:58 p.m., Staff F was asked about their observations of the verbal altercation. Staff F acknowledged R23 called R13 a fat @ss, a few minutes earlier, as observed by this Surveyor as well, and said R23 says this all day. Staff F stated they tried to redirect the other residents when this occurred, and said staff tried to keep R13 and R23 apart. Staff F explained R23 liked to touch people, but it was in a caring way typically. Staff F was asked if R23 attempted to go into other resident rooms or was targeting R13 in any way. Staff F denied both and reported this was R23's typical presentation, saying swear words under their breath.</p> <p>Review of R23's Care Plan, accessed on 6/11/25, revealed R23's PTSD/trauma diagnoses with triggers unknown, given their pronounced cognitive impairment. One intervention was to respect their personal space, and another was to provide soft redirection, structured routines, and a low stimulation environment. There was no targeted behavior or intervention for swearing under their breath or at facility residents or staff.</p> <p>Review of R23's behavioral tracking logs, accessed on 6/11/25, under tasks in the Electronic Medical Record (EMR), showed no targeted behavior tracking. The logs were blank without documentation during the 30-day look back period.</p> <p>Review of R13's behavioral tracking logs, accessed on 6/11/25, under tasks in the EMR, also showed no targeted behavior tracking. The logs were blank without documentation during the 30-day look back period.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/11/25 at 2:53 p.m., the NHA, with Regional Consultant K present, was notified of the verbal altercation observed by the elevator between R23 and R13, which was described. This Surveyor shared that Staff F corroborated the incident occurred when the NHA asked if the incident was witnessed. The NHA was asked if they had camera footage this Surveyor could review with them and their team, and the NHA responded, No. This Surveyor shared an unnamed staff member had earlier reported R23's typical behavior was saying fat b@ or fat @ss to residents and staff under their breath frequently. The NHA planned to review the incident further with their staff and denied being aware of this behavior for R23. This Surveyor shared concerns related to the two resident-to-resident incidences both involving R13's belief the black chair outside their room was their own personal chair. This Surveyor explained R13 said (on 6/11/25) facility residents could not sit in the black chair outside their room in the hallway, as it was their own personal chair. This Surveyor shared this appeared to be a contributing cause of both physical incidents perpetrated by R13, as this had not been addressed, and remained a potential risk factor. The NHA acknowledged they had not been made aware. The NHA reported they understood this concern and planned to follow up.</p> <p>On 6/11/25 at approximately 4:42 p.m., this Surveyor shared with the NHA, with Regional Consultant K present, supervision concerns for the involved residents related to the incidents, including direct observations on this date of a verbal altercation between R13 and R23, with R23 not being adequately supervised, given unwarranted physical contact with this Surveyor twice. This Surveyor shared R13 reporting they hit R23 out of frustration with the NHA, as well as staff reporting R13 seemed to deliberately kick R7 in anger when the black chair in the hallway outside their room was taken by R7. This Surveyor explained how the chair being related to both incidents was corroborated in facility documentation and by staff. The NHA reported they had done follow-up, and R13 had denied hitting R23 to them, and they interviewed staff involved in the concern today, and understood R23 was yelling into the air, not at R13. The NHA reported they had not been made aware or heard R23 saying swear words under their breath to residents. The NHA was asked if there was any camera footage anywhere in the building to review the observations of R23 with this Surveyor (and R13) and responded No. The NHA made further clarification their investigation into the incident today (on 6/11/25) with R13 and R23 was continuing, as they reported the verbal incident to the State Agency, and the State Manager.</p> <p>The NHA further clarified they had just discussed the black chair in the hallway with R13, and corroborated R13 said they believed the black chair was their own personal chair, and R13 did not want any residents sitting in the chair, including R23. The NHA explained they labeled the chair as R13's chair and moved this same black chair into R13's resident room, per R13's wishes. The NHA was asked if they understood the concerns regarding physical aggression (behaviors) which R13 perpetrated towards two facility residents (R7 and R23) during two verbal/physical incidents in February 2025, on 2/10/25 and 2/18/25, which may have been avoidable, given appropriate supervision and the chair perception concerns being addressed. The NHA indicated with any resident-to-resident incidences, their staff would immediately intervene and follow-up, which had occurred. The NHA respectfully disagreed with the supervision concerns, as they believed they had more than adequate staffing, and they respectfully declined to comment further.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Policy, Incident Reporting: Accidents and Supervision, revised 8/2024, revealed, Policy: The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents. This includes: 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring effectiveness and modifying interventions when necessary. Policy Explanation and Compliance Guidelines: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents. 1. Identification of Hazards and Risks .2. Evaluation and Analysis . 3. Implementation of Interventions .4. Monitoring and Modification . 5. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency, b. Based on the individual resident's assessed needs and identified hazards in the resident environment. 6. Documentation- The purpose of the Incident/Accident report is to provide a standardized, systematic process to ensure that all accidents and incidents are promptly identified, reported and investigated, and that measures addressing causes are implemented to reduce recurrence. An Incident/Accident is any situation that involves harm or potential harm, which is outside of the usual and expected. These include but are not limited to: d. Resident altercation with staff/family/visitor/other . i. Resident to resident altercations (including inappropriate and or unwanted touching) . References: Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities .</p> <p>Deficient Practice Statement #2</p> <p>Based on observation, interview, and record review facility failed to consistently implement fall prevention interventions as ordered/recommended for one (R29) of two (with history of multiple falls) Residents reviewed for falls. This deficient practice has the potential to result in further falls with/without injuries. Findings include:</p> <p>R29</p> <p>Record review revealed R29 was a long-term resident of the facility admitted on [DATE]. R29's admitting diagnoses included dementia, muscle weakness, high blood pressure, narrowing of carotid artery (blood vessel to brain) with history of falls. Based on the Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12/15, indicative of moderate cognitive impairment.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An initial observation was completed on 6/10/25 at approximately 9:40 AM. R29 was observed sitting in their wheelchair and moving around in the hallway. The wheelchair had an antiroll back mechanism (a device that prevents the wheelchair from rolling back during transfers) attached to the wheelchair when a resident is not compliant or forgetful with locking the wheelchair brakes. The left arm/lever for the antiroll back device was turned inward and not in alignment to lock the left wheel/function appropriately. At approximately 10:15 AM, R29 rolled down the hallway and went into their room. The left lever for anti-roll back mechanism was in the same nonfunctional position. A brief interview was completed with R29. R29 reported that they wanted to walk like their roommate and added that they were not allowed to stand because of their falls. Later that day at approximately 3:20 PM, R29 was observed in their bed with their eyes closed. The wheelchair was parked next to the bed and the brakes were not locked. The left lever for the anti-roll back device was turned inward, in the same position. When this surveyor checked the wheelchair it moved freely and the anti-roll back mechanism was not functional.</p> <p>At approximately 4:30 PM, R29 was on their bed and the wheelchair was parked next bed and with left lever in the same position. Throughout the day, on multiple occasions, staff members including the nurse, Certified Nursing Assistants (CNAs) and leaders were observed going in and out of the room and speaking with the R29 in the hallway.</p> <p>On 6/11/25, at approximately 8 AM, R29 was sitting up in their wheelchair, in their room, facing the window and back of the wheelchair was visible from the hallway. The left arm of the anti-roll back device was in the same position. R29 stated that they were waiting to see someone from therapy. At approximately 8:10 AM, this Surveyor was speaking with Unit Manager (UM) E in the hallway, outside R29's room and R29 was observed self-transferring back to bed from their wheelchair.</p> <p>Review of R29's Electronic Medical Records (EMR) revealed that R29 had falls during their stay in the facility. Review of R29's fall risk assessment dated [DATE] revealed a score of 18, indicative of high risk for falls. Review of R29's nursing progress notes revealed a note dated 2/12/25 at 14:33 that read in part, Resident was observed sitting on his butt next to bed .missed the bed and slipped down to the floor . An interdisciplinary progress notes dated 12/13/25 titled anti-gravity team note read, Root cause of fall: Resident forgot to lock his wheelchair prior to attempting to get in to bed. New interventions: Anti-wheel back to be placed on wheelchair. Progress notes dated 2/27/25 revealed that R29 was observed sitting on the floor next to their bed. There were no follow-up interdisciplinary progress notes or root cause analysis and interventions in the EMR. Review of the care plan did not reveal any additional/change in interventions.</p> <p>A progress note dated 3/16/25 revealed that R29 had fall while they were attempting to self-transfer from wheelchair to bed. An anti-gravity team note dated 3/17/25 at 10:34 read, Root cause of fall: Resident attempted to self-transfer from chair to bed and did not lock the wheelchair. New interventions: Adjustment to anti-roll backs.</p> <p>A request for incident and accident reports/investigations for R29 from admission to current date was requested via e-mail to the facility administrator on 6/10/24 at 10:49 AM via e-mail, however were not received prior to survey exit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with UM E was completed on 6/11/25 at approximately 8:20 AM. During the interview UM E reported that they were familiar with R29 and agreed that they were a high fall risk. They reviewed the EMR and confirmed the interventions that were in place. When queried about the fall on 3/16/25 and the intervention that read adjustment to anti-roll back (dated 3/17/25), UM E reported that the therapy team had checked after the fall and it had to be adjusted. When queried about the expectation for their team to ensure appropriate interventions are in place and functioning they reported that it was the responsibility of their team. They were shared the observation from 6/10/25 and 6/11/25.</p> <p>At approximately 8:30 AM, UM E went to R29's (with this surveyor) and R29 was in bed. The wheelchair was parked next to bed and the lever was in the same position as before and they checked the wheelchair and confirmed that the device was not working. They reported that it needed to be fixed and asked a staff member to take the wheelchair to therapy.</p> <p>An interview with the Director of Nursing (DON) was completed on 6/11/25 at approximately 9:30 AM. The DON was queried about the facility process to ensure that the ordered/recommended interventions were in place consistently and they reported that they had a running list of all the safety devices and they expected all staff and leaders to make sure that they were in place and functioning during their rounds. the DON was shared observations for R29 and they reported that they did not have the anti-roll back device on their list and they were going to add them for future. They agreed on the concern and reported that they were addressing it with their staff.</p> <p>A facility provided document titled Incident Reporting - Accident and Supervision with revision date of 8/24 read in part, Policy: The resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistive devices to prevent accidents.</p> <p>This includes:</p> <ol style="list-style-type: none"> 1. Identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). 3. Implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring effectiveness and modifying interventions when necessary. <p>Policy Explanation and Compliance Guidelines: The facility shall establish and utilize a systematic approach to address resident risk and environmental hazards to minimize the likelihood of accidents.</p> <ol style="list-style-type: none"> 1. Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. <ol style="list-style-type: none"> a. All staff (e.g., professional, administrative, maintenance, etc.) are to be involved in observing and identifying potential hazards in the environment, while taking into consideration the unique characteristics and abilities of each resident. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>b. The facility should make a reasonable effort to identify the hazards and risk factors for each resident.</p> <p>c. Various sources provide information about hazards and risks in the resident environment.</p> <p>d. These sources may include, but are not limited to:</p> <ul style="list-style-type: none"> i. quality assessment and assurance (QAA) activities ii. environmental rounds iii. MDS/CAA (care area assessment) data medical history iv. physical exam v. facility assessment vi. individual observation <p>e. This information is to be documented and communicated across all disciplines.</p> <p>2. Evaluation and Analysis- the process of examining data to identify specific hazards and risks and to develop targeted interventions to reduce the potential for accidents. Interdisciplinary involvement is a critical component of this process. a. Analysis may include, for example, considering the severity of hazards, the immediacy of risk, and trends such as time of day, location, etc. b. Both the facility-centered and resident-directed approaches include evaluating hazard and accident risk data, which includes prior accidents/incidents, analyzing potential causes for each hazard and accident risk, and identifying or developing interventions based on the severity of the hazards and immediacy of risk. c. Evaluations also look at trends such as time of day, location, etc.</p> <p>3. Implementation of Interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment.</p> <p>4. Monitoring and Modification- Monitoring is the process of evaluating the effectiveness of care plan interventions and making modifications as needed.</p> <p>5. Supervision- Supervision is an intervention and a means of mitigating accident risk. The facility will provide adequate supervision to prevent accidents. Adequacy of supervision: a. Defined by type and frequency, b. Based on the individual resident's assessed needs and identified hazards in the resident environment .</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that one (R25) of one resident reviewed for nutrition received nutritional supplements as ordered, resulting in the potential for weight loss and overall decline in their condition. Findings include:</p> <p>Record review revealed R25 was a long-term resident of the facility admitted to the facility on [DATE]. R25 was most recently re-admitted to the facility after hospitalization on 6/7/25. Review of R25's admission history revealed that R25 had multiple hospitalizations between 1/12/25 and 6/10/25. R25's admitting diagnoses included stroke, bladder cancer, difficulty swallowing, left ankle pressure ulcer and malnutrition. Based on the Minimum Data Set (MDS) assessment dated [DATE], R25 had a Brief Interview for Mental Status (BIMS) score of 4/15, indicative of significant cognitive impairment.</p> <p>An initial observation was completed on 6/10/25 at approximately 9:30 AM. R25 was observed laying on their bed. R25's bed on the right side was close to the wall and they had low air loss mattress. R25 was able to answer simple questions. When questioned if they had breakfast they stated yes when asked how they were doing, they stated OK. A follow up observation was completed during dinner time at approximately 4:20 PM. At approximately 4:30 PM, the dinner cart for the front end of the hall (where R25 was residing) arrived on the unit and staff started serving the trays. Approximately 10 minutes later this surveyor checked from the hallway, R25 was in their bed, the bedside table was on the left side of the bed. There was no dinner tray in their room.</p> <p>At approximately 4:45 PM the dinner cart for the back hall arrived and staff were serving the dinner trays. Staff members who finished serving the meal tray on the front end of the hall and were observed walking down the halls and engaged with other tasks. An unknown resident from the front end of hall brought out their finished dinner tray to the doorway to hand it to staff.</p> <p>At approximately 4:55 PM, Registered Nurse (RN) A, who assigned to care for R25 was observed in the hallway. This surveyor asked RN A about the tray arrival and serving process. They reported that the trays arrived in two carts, one cart for the front end and one cart for the back end and reported that the tray pass for the front hall was done. This surveyor asked if R25 had received their dinner tray. RN A reported that they would go and check in the back cart. This surveyor accompanied RN A to the back hall. When arrived at the back hall, a staff member was pushing the cart past the nurses' station towards the north end of the hall. RN A asked the staff member who was a Certified Nursing Assistant (CNA), if R25's tray was on the cart. The CNA reported that R25 did not get their tray and staff went to kitchen to get their tray. RN A asked the CNA to check the cart. The CNA started to check the cart and pulled R25's tray. RN A walked back to the room and started assisting R25. R25 received a regular diet with a dessert and a glass of pink drink. RN A started to assist R25 with their dinner. The ticket read regular diet, large portions, and health shakes. There was no health shake on R25's meal tray. When RN A was queried about the health shake, they reported that it should come with the dinner tray. They were not sure why it did not come with dinner tray and stated that they would get one. RN A left the room and returned after a few minutes with a health shake and started assisting R25. When queried on the process on who/how they ensured resident received appropriate supplements as ordered, RN A reported that kitchen should have checked and added that floor staff also should double check. They agreed R25 was high risk resident and understood the concern.</p> <p>(continued on next page)</p>		

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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	
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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R25's Electronic Medical Record (EMR) revealed that R25 had a guardian (brother) and was a 'full code (wished to receive all life sustaining measures as needed). R25 also had significant weight loss during hospitalization. R25 was re-admitted with a pureed diet and they were changed to a regular diet on 6/9/25. Review of R25's physician orders revealed an order dated 6/7/25 that read House supplement - two times a day 4 OZ health shake with lunch and dinner-dietary to provide. Another order dated 6/7/25 read Patient requires 1:1 assist during meals. Review of R25's care plan read, I have a potential for nutritional/hydration problem. The care plan also revealed that R25 was receiving supplements (initiated on 5/20/25) prior to their recent hospitalization.</p> <p>A Registered Dietician (RD) note dated 6/10/25, read in part, My MNA (Mini Nutritional Assessment) score is 6. I am at nutritional risk due to dementia, hydronephrosis (urine backing up into kidneys) .SLP (Speech Language Pathologist) evaluated resident and upgraded to regular textures .upon return my supplements were put back into place .</p> <p>An interview with Unit Manager (UM) E was completed on 6/11/25 at approximately 8:50 AM. They were asked about R25 and they agreed they were a nutritional risk, had recent weight loss during hospitalization and they needed staff assistance with eating. They were queried about the tray pass process to ensure every resident received a meal tray with appropriate supplements as ordered. UM E reported that it was the responsibility of the kitchen team and floor staff to ensure that every resident their meal trays as ordered. This surveyor shared the observations and the concern and UM E reported that they agreed with the concern and they would follow up with their team.</p> <p>An interview with Dietary Manager (DM) M was completed on 6/11/25 at approximately 9 AM. They were asked about the tray assembly process and what their expectation for their staff to ensure that residents received the diets/supplements as ordered. DM M: reported that every resident had a ticket based on their order, staff followed the ticket and reached out to them if anyone had a question. When questioned about R25 and why they did not receive their supplement they reported R25's diet was recently changed and staff were in a rush when the nurse came and asked for the dinner tray on 6/10/25 and missed it. DM G was notified RN A picked up the dinner tray that was already assembled and was sent in the back hallway cart. They reported that they must have misunderstood and agreed on the concern. They stated that it was an oversight on their end.</p> <p>An interview with the Director of Nursing (DON) was completed on 6/11/25 at approximately 9:45 AM. The DON was queried about the tray pass process and how did the staff ensure that everyone received a meal tray with supplements as ordered. The DON reported that it was their team's responsibility to ensure that everyone received a meal tray as ordered. The observation and concerns for R25 were shared with the DON. The DON added that R25 would have received their tray and they added that staff should have made sure that R25 received their supplements as ordered. They added that they agreed with the concern and they had already followed up with their staff.</p> <p>A facility provided document titled Weight Monitoring with a revision date of 1/21 read in part,</p> <p>Policy: Based on the resident's comprehensive assessment, the facility will ensure that all residents maintain acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Compliance Guidelines: Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem.</p> <p>1. The facility will utilize a systemic approach to optimize a resident's nutritional status. This process includes:</p> <ul style="list-style-type: none"> a. Identifying and assessing each resident's nutritional status and risk factors b. Evaluating/analyzing the assessment information c. Developing and consistently implementing pertinent approaches d. Monitoring the effectiveness of interventions and revising them as necessary. <p>2. A comprehensive nutritional assessment will be completed upon admission on residents to identify those at risk for unplanned weight loss/gain or compromised nutritional status.</p> <p>Assessments should include the following information:</p> <ul style="list-style-type: none"> a. General appearance (e.g., robust, thin, obese or cachectic) b. Height c. Weight d. Food and fluid intake e. Fluid loss or retention f. Laboratory/Diagnostic Evaluation <p>3. Information gathered from the nutritional assessment and current dietary standards of practice are used to develop an individualized care plan to address the resident's specific nutritional concerns and preferences.</p> <p>4. Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status .</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than five percent. Two medication errors were observed for R10 from a total of 30 opportunities reviewed during medication administration, resulting in an error rate of 6.67%.</p> <p>Findings include:</p> <p>On 6/11/25 at 8:29 AM, record review of a medication reconciliation was conducted for R10 and two medications: Metoprolol (medication for lowering blood pressure and heart rate) 25 milligram (mg) and Thiamine (Vitamin B1, essential nutrient for brain, heart, and nervous system function) 100 mg were documented as administered at 9:00 AM and were not observed prepared or administered.</p> <p>On 6/11/25 at 8:37 AM, RN M was questioned if the two medications in question were administered after the survey observation, at which time they reviewed the Electronic Medical Record (EMR) for R10 and apologized I am sorry for that and acknowledged they documented the Thiamine was given but it was not and RN M was observed providing Thiamine to R10.</p> <p>RN M was questioned about the Metoprolol medication and RN M commented they administered it and probably forgot to show the medication card and the blister pack being opened during the survey observation.</p> <p>On 6/11/25 at 9:06 AM, the Director of Nursing (DON) and Licensed Practical Nurse (LPN) Manager C were informed of the concern with the Metoprolol not being observed as prepared and administered. Both acknowledged they would follow up and obtain vital signs for R10. The DON and LPN C were also informed the admission by RN M of documenting R10's Thiamine was administered, and it was not given.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure appropriate medication storage and labeling for medications in two of two medication carts reviewed and one residential room.</p> <p>Findings include:</p> <p>On 6/10/25 at 9:12 AM, while observing a medication administration in room [ROOM NUMBER], a white round pill was observed lying on the floor along the baseboard near the bathroom. Attention to the pill was brought to Unit Manager Licensed Practical Nurse (LPN) C at which time they were observed picking it off the floor with their bare hand. They were inquired if any identifiers were on the pill and LPN C confirmed there was nothing to identify the pill and it should not be on the floor.</p> <p>On 6/10/25 at 9:55 AM, a medication storage observation was conducted with Registered Nurse (RN) N for Medication Cart East and revealed in drawer one, one green colored oval shaped pill and one small peach colored pill both unidentifiable and not stored in containers and unidentified.</p> <p>Drawer two revealed one small green oval pill, one small white round pill, one partial white pill, one white oval pill, and one round yellow pill, not stored in containers and unidentified.</p> <p>On 6/10/25 at 10:13 AM, a medication storage observation was conducted with LPN C for Medication Cart Gold and revealed one white round pill, one capsule colored blue and pink, and two white round pills not stored in containers and unidentified.</p> <p>On 6/10/25 at 2:39 PM, the Director of Nursing (DON) and LPN C both acknowledged the concerns of loose medications observed within both medication carts not stored in containers and unidentified, and the concern of medication found on the floor of a resident's room.</p> <p>A request for the facility policy for medication storage was made via email on 6/11/25 at 9:27 AM and was not provided by end of the survey.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure laboratory services for a urine culture/sensitivity test were received timely resulting in administering a resistant antibiotic for a Urinary Tract Infection in one resident (R27) of one reviewed for laboratory services.</p> <p>Findings include:</p> <p>A clinical record review revealed R27 was admitted to the facility on [DATE] with a sacral (base of the spine) ulcer and osteomyelitis (infection in the bone) of the sacral region. As a result of a stroke, and intracerebral hemorrhage (brain bleed) R27 was incontinent of urine and stool, resulting in high risk for a Urinary Tract Infections (UTI). R27 had impaired mobility and was unable to communicate their needs and their Brief Interview for Mental Status (BIMS) score was 4/15 indicating severe cognitive impairment.</p> <p>On 2/21/25 at 11:10 AM, a Nursing progress note documented a Urinalysis and Urine Culture and Sensitivity (C/S) was obtained and sent to the lab.</p> <p>On 2/26/25 at 10:45 AM, Interdisciplinary Team (IDT) Review Note documented R27 had a large amount of WBC (White Blood Cells) in their urine based on the urinalysis and the MD (Medical Doctor) was going to start them on an antibiotic and was prescribed Nitrofurantoin Macro crystal (Macrobid) Capsule 100 milligram (mg) every eight hours for UTI for seven days.</p> <p>On 3/5/25 at 7:09 PM, record review of the Practitioner Progress notes documented R27 was seen for evaluation of urine culture (collected 2/21/25) and was resistant to present antibiotic (Macrobid) had to be changed to a different antibiotic (Levaquin).</p> <p>On 6/11/25 at 9:36 AM, Infection Control (IC) E was questioned why was R27's antibiotic changed from Macrobid to Levaquin and was the C/S reviewed prior to starting the Macrobid. IC E indicated the Urinalysis results were obtained from the outside lab as it is integrated into their Electronic Medical software, however, the C/S is obtained via another software portal, and the facility was unable to obtain the C/S results. When questioned if the lab was contacted for the results, IC E replied they did not call, but mentioned maybe the Director of Nursing (DON) followed up.</p> <p>On 6/11/25 at 10:13 AM, the DON acknowledged there have been concerns with the facility's current lab and not receiving timely results. The DON indicated they had been in contact with lab about the concern and recalled this situation but was unable to confirm details of the delay. The DON further acknowledged R27's C/S results collected on 2/21/25 should have been resulted within 2-3 days and had not resulted until 3/5/25, confirming the originally ordered antibiotic was resistant to the infection and required a change in antibiotic therapy to treat R27's UTI.</p> <p>Review of the policy titled; Laboratory, Radiology, and other Diagnostic Services dated 11/2016, documented:</p> <p>.The facility is responsible for the timeliness of the services .</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist and ensure timely dental services (to obtain replacement dentures) for an extended period (approximately 6 months) for one (R6) of one resident reviewed for dental services resulting in the potential for avoidable decline in nutrition, overall health and well-being. Findings include:</p> <p>Record review revealed R6 was admitted to the facility from another skilled nursing facility on 1/29/25. R6's admitting diagnoses included neck fracture (of unknown age), temporomandibular joint disorder (pain and tenderness in jaw joints and surrounding muscles and ligaments), anemia, vitamin deficiency, and protein calorie malnutrition.</p> <p>Based on the Minimum Data Set (MDS) assessment dated [DATE], R6 had a Brief Interview for Mental Status Score (BIMS) score 12/15, indicative of moderate cognitive impairment. R6 had a Durable Power of Attorney (brother) who was making healthcare and financial decisions for R6.</p> <p>An initial observation was completed on 6/10/25 at approximately 9:20 AM. R6 was observed laying on their bed. The bed was placed in a low position. R6 was wearing a hard neck collar. Their mouth movements were restricted due to the use of their collar. When queried how they were doing they stated that they were okay. They stated that they fell. They had a pain patch on their left hand. R6 reported that patch helped with their pain. When asked if they received staff assistance they stated, not really. When asked to explain further they were unable to provide any further specifics.</p> <p>On 6/10/25, at approximately 11:50 AM, during a call with R6's representative, they had mentioned that the previous facility had lost R6's dentures prior to coming over. They had brought it up to the facility's attention. They further explained that R6 received a dental consult and they were notified by the facility's social worker that they were not eligible for new dentures until 2029. They added that it bothered them as they were not able to eat regular food and why they were not getting any assistance from the facility. They were asked to pay out of pocket if they needed the dentures sooner.</p> <p>Review of R6's hospital discharge orders revealed that R6 was ordered to use the hard neck collar at all times except for showering due to cervical (neck) fracture of indeterminate age.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R6's clinical records revealed a social work progress note dated 1/29/25 that revealed that R6 did not come with their dentures from the other facility and the social worker had followed up with R6's brother. A social work note dated 2/3/25 read received only upper denture from (facility name). No further note or evidence were noted in the record about what had happened with the upper dentures. There was no further follow up note from social worker on their denture situation until 6/11/25, after the concern was brought to the facility's attention by this surveyor. An initial dental visit was completed on 2/20/25 (27 days after admission) and the treatment notes revealed they had completed prior authorization for new dentures as R6 had lost their dentures. A follow-up dental visit note dated 5/1/25 noted that initial impressions for dentures were completed. The section that read Action required by nursing home staff read monitor mastication (chewing) and continue modified diet for optimal nutrition. A letter from the dental health provider that was uploaded after the interview with Social Worker (SW) J. The note from the dental service provider dated 5/2/25 revealed that R6 needed upper and lower dentures with cost of the dentures. The letter stated that Michigan Medicaid covered dentures every five 5 years and R6 will not be eligible for new dentures until 5/15/29. The letter also read to move forward we need your written approval and payment.</p> <p>A social worker note dated 6/11/25 at 13:36 read that they had reached to the Ombudsman regarding the denture situation after the concern was brought to the attention of the social worker and queried how they were assisting R6.</p> <p>Another social work note dated 6/11/25 at 12:30 PM read that the SW had called the other facility (one of their sister facilities) to follow up on the missing dentures. It must be noted that the call was placed after this surveyor had brought the concern to the facility.</p> <p>Review of R6's diet order revealed that R6 was on a mechanically altered diet with soft and bite size textures. A Registered Dietician assessment dated [DATE] read based on R6's Mini Nutritional Assessment (MNA) score of 8, the resident was considered at risk for malnutrition.</p> <p>Review of Speech Therapy evaluation dated 5/17/25 revealed under the section referral that R6 was referred for speech therapy due to an oral (mouth) functional problem with prolonged mastication (chewing) of solids foods with signs and symptoms of dysphagia (difficulty swallowing).</p> <p>After the concern was brought to facility's attention, the facility administrator provided a summary with timeline of events that read that there were no deficient practice and had outlined 6 bullet points and a conclusion. #4 titled private pay option offered (for a resident receiving services under Medicaid), #5 Outreach for financial advocacy reaching out to ombudsman (after the concern was brought to facility's attention on 6/11/25).</p> <p>An interview with Unit Manager (UM) E was completed on 6/11/25 at approximately 8:45 AM. They were queried about R6's dentures. They reported that R6 did not have their dentures and they were seen by the dentist and social worker would be able to provide additional information.</p> <p>(continued on next page)</p>		

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<p>F 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Social Worker (SW) J at approximately 11:05 AM, they were questioned about R6's dentures. They reported that R6 came from another facility (one of their sister facilities) and had lost their dentures at the other facility. They had followed up with R6's brother after admission. The other facility had sent a set of dentures that did belong to R6. They reviewed the clinical records and reported that R6 had a dental consult on 5/1/25 and per the dental provider, R6 was not eligible for new set of dentures until 2029 and a private pay letter was sent to R6's representative (brother). SW J was queried further if they had reached out to the other facility and how would they expect the R6's representative to make payment for lost dentures. When queried about the letter that was sent they added that it was not in the clinical record and uploaded it during the interview. They reported that they had not reached out to other facility and had looked into any other options. They called the other facility while this surveyor was in the office and reported that they had left a message for that facility's social worker. SW J did not provide any other explanation on how the facility expects the representative to private pay for a resident (under Medicaid) and why they had not attempted to assist R6's representative in obtaining the dentures. SW J added that they would inform their administrator (of the concerns).</p> <p>During an interview with the facility administrator on 6/11/25 at approximately 12:35 PM, the administrator reported that facility had made all reasonable efforts to assist R6 and added that the resident was eating well and had not lost any weight. When questioned further on what efforts were made to assist R6 to obtain replacement dentures after 5/1/25; if they were aware the private pay letter that was sent to the resident's representative and if they expected the representative to pay for the lost dentures. The administrator reported that they were unaware of a private pay letter that was sent and they would reach out for additional resources. The administrator did not provide any further explanation on why the facility was not assisting until the concern was brought to their attention and why the facility expected a representative (of a resident receiving services under Medicaid) to make payment out of their pocket for lost dentures. No explanation was provided on why the facility had not assisted to reach out to the other facility or assist in reaching out to other external resources prior to 6/11/25. During this interview a corporate support staff member came in and reported that they vaguely remembered about the same concern that was brought up during their last annual survey (completed on 12/18/24). They were notified that R6 was admitted to the facility on [DATE]. The administrator was notified of the concern.</p> <p>A facility provided document titled Dental Services with a most recent revision date of 6/23 revealed the policy was not revised after the most recent guidance from Centers for Medicare and Medicaid Services (CMS) with an issue/implementation date of 8/8/24. The facility policy had blanket statement that read in part, The facility will not be responsible for lost or broken dentures unless it is determined that it was the fault of the facility. The facility shall determine the responsibility for the lost or damage of dentures on a case-by-case basis considering the circumstances surrounding the loss or damage, resident characteristics and the resident's plan of care . The policy did not specifically address/identify the instances when it was facility's responsibility to cover for lost or missing dentures and or the process of how it would determine if facility was responsible or not.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices, hand hygiene, during medication administration observations for five (R4, R6, R10, R25, R27) of five residents resulting in the increased likelihood for the spread of infection.</p> <p>Findings include:</p> <p>On 6/10/25 at 9:12 AM, Registered Nurse (RN) A was observed for medication administration for R27 and was not observed performing hand hygiene prior to the preparation of the medications and prior to administering the medication. At 9:23 AM, Unit Manger Licensed Practical Nurse (LPN) C was observed whispering into RN A's ear at which time RNA made an audible comment to R27 that they need to do hand hygiene and proceeded into the residents restroom.</p> <p>On 6/10/25 at 9:25 AM, RN A provided a medication pass to R25 and was observed entering the room without performing hand hygiene. R25 placed a cup of medications on the side table, then proceeded to readjust the resident pressing the controls of the electronic control pad, call light, bedside table, and blankets with bare hands. RN A was observed placing the cup of medications into the resident's mouth and providing water without performing hand hygiene. RN A was observed exiting the room, and no hand hygiene performed. RN A commented R25 required another medication that was in the medication room and was observed removing a Band-Aid from their pointer finger and pressing onto the computer screen (biometric security), RN A retrieved the medication, exited the medication room, and proceeded to administer the medication to R25 without performing hand hygiene.</p> <p>On 6/10/25 at 3:46 PM RN A was observed providing a medication to R4 in the television activity room and was observed not performing hand hygiene before and after administering.</p> <p>On 6/10/25 at 3:49 PM, RN A was observed providing a medication to R6 and was observed not performing hand hygiene before and after administering.</p> <p>On 6/11/25 at 8:00 AM RN M was observed providing morning medications to R10 and was observed not performing hand hygiene before and after administering.</p> <p>On 6/11/25 at 8:37 AM RN M was observed providing an additional morning medication to R10 and was observed not performing hand hygiene before and after administering.</p> <p>On 6/11/25 at 9:06 AM, the Director of Nursing (DON), Licensed Practical Nurse (LPN) Manager C and Infection Control Nurse (ICN) E were informed of the concern that Nursing did not perform hand hygiene consistently with the Residents during medication administration and they said would follow up with Nursing staff.</p> <p>The facility acknowledged the concerns of not performing hand hygiene practices and reeducated staff while the survey was still in progress on 6/11/25.</p> <p>Review of the Policy titled; Medication Administration dated 2/2025, documented:</p> <p>(continued on next page)</p>		

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 06/11/2025
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.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medications are administered .in a manner to prevent contamination or infection .Wash or sanitize hands prior to administering medication .		