

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 504100	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 4/8/2025
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NAME OF PROVIDER OR SUPPLIER MISSION POINT NSG & PHY REHAB CTR OF WARREN	STREET ADDRESS, CITY, STATE, ZIP CODE 11525 E TEN MILE RD WARREN, MI 48089
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F0000 SS=	INITIAL COMMENTS Mission Point Nursing and Physical Rehab Center of Warren was surveyed for an Abbreviated survey on 4/8/25. Intakes: MI00150899, MI00151133, MI00151378, and MI00151681. Census=127	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The	F0550	Element #1 Although R504 is no longer a resident, the facility made post-discharge contact with the legally designated DPOA (Stepson) & the resident is at home with no ill effects related to this occurrence. Re-education was immediately provided to all Social Services and Nursing leadership on interpreting and honoring DPOA and Patient Advocate documentation. Element #2 The facility conducted a comprehensive review of all current residents with a designated Durable Power of Attorney (DPOA) or Patient Advocate. This audit was completed by the Social Services Director and the Interdisciplinary Team. No additional instances of failure to honor a resident's DPOA or Patient Advocate authority were identified. Element #3 Policies regarding resident rights, discharge procedures, and DPOA/legal representative documentation have been reviewed and deemed appropriate. The Social Services Director completed a facility-wide audit of all residents with a listed	4/25/2025

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

TITLE

(X6) DATE

Electronically Signed

04/25/2025

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.

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	<p>resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to Intake MI00151378.</p> <p>Based on interview and record review, the facility failed to honor the rights, notify, or obtain consent from a Durable Power of Attorney (DPOA) regarding a resident discharge for one resident (R504) of three sampled residents reviewed, resulting in the released to an unauthorized family member. Findings include:</p> <p>R504</p> <p>R504's Electronic Medical Record EMR was reviewed on 4/8/25 at 11:30 AM. R504 was admitted to the facility on 1/6/25 with the diagnosis of Cervical Disc Disorder, Type 2 Diabetes Mellitus, and Carcinoma of the Prostate, in addition to other diagnoses. R504's Brief Interview for Mental Status (BIMS) Score dated 1/15/25, assessed by the facility, was 6/15. A BIMS score of 6 indicates severe cognitive impairment. R504 Minimum Data Set (MDS) Assessment dated 1/20/25 revealed they are frequently incontinent with both bowel and bladder elimination patterns and requires substantial/maximal assistance</p>		<p>DPOA or Patient Advocate to ensure documentation is accurate, activated properly, and reflected in the medical record. The IDT was re-educated on the role and authority of a DPOA/Patient Advocate. Legal definitions and proper activation (based on cognitive assessment and advance directive terms). Proper documentation and communication procedures. Audits will be repeated monthly for the next three months, then quarterly thereafter.</p> <p>Element #4 Ongoing Monitoring and QAPI Review: The DON and Administrator will review all discharges weekly during clinical stand-up to verify compliance with discharge and legal representative requirements. The QAPI committee will review audit results monthly and ensure any issues are corrected with retraining and process reinforcement. The Facility Administrator will be responsible for maintaining compliance.</p>		

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	<p>with Activities of Daily Living (ADLs).</p> <p>A review of R504's electronic record revealed on 3/4/25, the facility discharged R504 with another family member not listed in the contact list of R504's Face Sheet to another state (Indiana). No home care, Rehab Therapy, Pharmacy, or Physician were arranged for follow-up care after R504 was discharged.</p> <p>According to Adult Protective Services staff member "A," on 4/8/25 at 9:15 AM, during an interview by phone, the facility did not honor the resident's Durable Power of Attorney and Designated Patient's Advocate despite legal documents submitted to show evidence that R504's stepson was the legally appointed Durable Power of Attorney. As a result, R504 was released and discharged to an estranged family (birth son), who did not notify nor obtain permission from the DPOA.</p> <p>An interview with the Social Services Director (SSD) "B" was conducted on 4/8/25 at 12:15 PM. R504 was admitted in January 2025, and was their own responsible party. However, the stepson was making decisions for them. SSD "B" revealed she called the stepson on March 4, 2025, to update him on the plan. Because the stepson did not call back, the facility released R504 to the estranged family member (son) who showed up and presented his birth certificate as proof that he was R504's son.</p>			

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	<p>R504's family came to visit and decided to bring R504 home with them in Indiana; SSD "B" added that the facility called R504's estranged ex-wife, who was the mother of the estranged son, and confirmed that he was the birth son of R504. The SSD "B" indicated it was the DON and her who decided to release R504 to the birth son. SSD" B" confirmed not arranging home care, no physician order, no pharmacy, no DME (Durable Medical Equipment), or hospice arrangement when R504 was discharged. When asked why, SSD" B" explained that they took the resident to Indiana, where the son and his family live. SS"B" was questioned why the signed Patient Advocacy form or the DPOA documents were not honored and replied R504 was their own responsible party and did not have a change in cognition.</p> <p>The Social Services Notes were reviewed. A late entry: written by SSD "B" dated 2/14/25 was noted. It revealed that: "SW (Social Worker) informed APS (name mentioned) that the staff had tried to inform DPOA (name mentioned) of resident's medical health decline and that it would be in the resident's (R504) best interest to remain in LTC (Long Term Care) placement ..."</p> <p>R504's Designation of Advocate Form was reviewed on 4/8/25 at 1:35 PM. It specified the name and address of residence of the appointed Patient Advocate with the instructions:</p>			

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	<p>"My Patient Advocate may only act if I am unable to participate in making decisions regarding my medical treatment. My Patient Advocate shall have the authority to make all decisions and to take all actions regarding my care, custody, and medical treatment ... This document is to be treated as a Durable Power of Attorney for Health Care and shall survive my disability or incapacity ... If I am unable to participate in making decisions for my care and there is no Patient Advocate able to act for me, I request that the instructions I have given in this document be followed and that this document be treated as conclusive evidence of my wishes ... I am providing these instructions of my free will. I have not been required to give them in order to receive or have care withheld or withdrawn ..." Signed by R504 on October 17, 2024, with two witnesses and acknowledged by the designated by the appointed Patient Advocate on 10/18/2024.</p> <p>An interview with the Director of Nursing (DON) was conducted on 4/8/25 at 2:59 PM. The DON revealed that on 3/8/25, R504's family (birth son and granddaughters) came to visit R504. They have been estranged for over 5 years. The son came in and presented a Birth Certificate, and the estranged son's mom (R504's ex-wife) confirmed the family in possession of the birth certificate was their son together over the phone. When the DON was asked how she verified the ex-wife's identity, she said she did not. When the DON</p>			

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F0600 SS= D	<p>was asked if R504's son or ex-wife was on R504's contact list, She stated, "No."</p> <p>The Administrator was interviewed on 4/8/25 at 3:16 PM. He stated that R504 had not changed from their baseline since admission, so there was no indication to change anything. The Power of Attorney papers were for Financial POA, not medical decisions.</p> <p>Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to Intake MI00151133.</p> <p>Based on interview and record review, the facility failed to protect and prevent abuse from occurring for one resident (R504) who was inappropriately touched by another resident (R505) of three residents reviewed for abuse. Findings include:</p> <p>A review of the facility investigation revealed</p>	F0600	<p>Element #1 On March 3, 2025, immediately following the incident, the Activities Director separated residents R504 and R505 and reported the incident to the facility's Abuse Coordinator and Administrator in accordance with the facility's abuse policy.</p> <p>A full investigation was initiated within the required timeframe, including interviews with involved staff and residents, and findings were documented per regulation. Resident R504 was assessed for physical and emotional well-being by nursing and social services and monitored closely for psychosocial distress.</p> <p>Resident R505's care plan was immediately updated to reflect the behavior, with interventions including 1:1 supervision during group activities, increased monitoring, and review of the need for behavioral health support. R505 was moved to a different unit with staff trained to supervise higher-risk behaviors and reduce the risk of future interactions with R504.</p> <p>Element #2 The facility conducted a full audit of all residents with a known history of behavioral</p>	4/25/2025	

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	<p>that on 3/3/25 at 3:30 PM. The Activities Director reported witnessing R505 inappropriately touching R504 to the Social Service Director. The incident occurred in the dining room with no staff present. The Activities Director happened to step out of her office door and saw R505 touching R504's breast. The Activities Director called out R505's name. She said that the behavior was unacceptable and immediately separated both residents (R504 and R505). The Social Services Director reported the incident to the Abuse Coordinator.</p> <p>R504</p> <p>Record review revealed F504 was admitted to the facility on 1/6/25 with diagnosis of cervical disc disorder with myelopathy, carcinoma of the prostate, repeated falls, and adult failure to thrive. R504's Brief Interview for Mental Status (BIMS) Score dated 1/15/2025 assessment was 6/15. A score of 6 indicates severe cognitive impairment. A care plan for mood difficulties and adjustment concerns related to psychotropic medication use was created on 1/10/25. R504 had been identified with Activities of Daily Living (ADL) Care deficit and initiated a plan of care, which included a Bowel and Bladder incontinence on 1/7/25.</p> <p>R505</p> <p>Record review revealed R505 was admitted to the facility on 6/27/2024 with a diagnosis of</p>		<p>challenges, cognitive impairments, or psychiatric diagnoses to determine if any similar incidents or risks were present. No further noncompliance or similar incidents were identified during this audit.</p> <p>Element #3 Revised supervision in the dining room from the Activities department was implemented requiring an increased presence in dining/activity rooms when residents are present. No additional cases of resident-to-resident inappropriate behavior were identified during the audit. All staff, including nursing, activities, and ancillary services, were re-educated on, the Abuse Policy and procedures, how to identify and document inappropriate behaviors, immediate response steps to peer-to-peer abuse enhanced, supervision strategies. The policy for abuse and neglect was reviewed by the IDT Team and deemed appropriate.</p> <p>Element #4 The Director of Nursing or designee will conduct weekly rounds for four weeks then 1 x a month for 3 months until QAPI determines sustained compliance in communal areas to verify active supervision and implementation of care plan interventions. IDT Team will hold weekly At-Risk Meetings to monitor residents with high-risk behaviors and review behavior logs. All reported incidents involving potential abuse, elopement risk, or behavioral triggers will be reviewed monthly in QAPI meetings to identify trends and provide ongoing solutions. A monthly audit of care plans for residents with behavioral or cognitive concerns will be conducted to ensure individualized supervision strategies are in place and staff are aware of them. The QAPI committee will review audit results monthly and ensure any</p>		

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	<p>Hemiplegia and Hemiparesis following Cerebral Infarction affecting Left non-dominant side, unsteadiness on feet, reduced mobility, and dysphagia in addition to other diagnoses. R505's ADL Self Care Performance requiring extensive assistance was created on 6/27/24 with Bowel and Bladder Incontinence Care.</p> <p>An interview with the Activities Director was conducted on 4/8/25 at 12:15 PM. The Activities Director confirmed witnessing R505 touching another resident's chest in the dining room. The Activities Director described, "There were 3 to 4 residents in the dining room, but no staff was there to supervise them. I just stepped out of my office when I saw the incident."</p> <p>Social Services Director SSD "B" was interviewed on 4/8/25 and confirmed R504 was right next to R505 when R505 inappropriately touched R504.</p> <p>Certified Nurse Aide CNA "J" was interviewed on 4/8/25 at 3:30 PM. CNA "J" was assigned to R505 and revealed that R505 was heard exhibiting sexual behaviors before the incident occurred. R505</p> <p>was at the B-wing. CNA "J" stated, "I did not see it for myself but heard staff talk about it. R505 looks at you in an "inappropriate way" and was warned by other staff to be careful when providing care for R505."</p>		<p>issues are corrected. The Facility Administrator will be responsible for maintaining compliance.</p>	

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	<p>The Director of Nursing (DON) on 4/8/25 at 4:20 PM stated no staff reported any inappropriate or sexual behavior observed for R505. We separated both and updated their care plan. There are many activities staff, and they should not have been left unsupervised.</p> <p>The facility's Policy for Abuse and Neglect was reviewed on 4/8/25 at noon.</p>				