

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 4/17/2025
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 & Physical Rehab Center Of Warren was surveyed for an Abbreviated survey 04/17/25. Intakes: M100152014, M100152174, M100152184, and M100152308. Census: 122	F0000		
F0600 SS= J	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: This citation has two deficient practice statements. Deficient practice number one. This citation pertains to Intake MI00059836. Based on observation, interview, and record review, the facility failed to protect one resident from physical abuse from staff (R800) out of three reviewed for abuse, this deficient practice resulted in an Immediate Jeopardy (IJ) and the	F0600	F600 – Freedom from Abuse, Neglect, and Exploitation Deficient Practice #1: Failure to Protect Resident (R800) from Staff Abuse Element #1 ¿Resident R800 received immediate emotional support from Social Services on 4/16/2025. Resident was assessed by nursing for physical injury and psychosocial trauma. Ongoing counseling and support have been arranged as requested by resident. Resident's care plan was updated to include Element #2¿ On 4/16/2025, all residents with a BIMS of 8+ were interviewed for abuse concerns. Residents with BIMS <8 were assessed for known history of behavioral 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.¿ Element #3¿ LPN "E" was immediately suspended on 4/3/2025 and has not returned to the facility. CNA "C" and LPN "D" received 1:1 education	5/2/2025

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

TITLE

(X6) DATE

Electronically Signed

05/04/2025

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>likelihood for serious physical and /or psychosocial harm, injury, impairment, or death. Findings include:</p> <p>R800</p> <p>A review of Facility Reported Incident (FRI) noted the following, "On April 3, 2025, Abuse coordinator made aware of an abuse allegation by DON [Director of Nursing] ...around 10AM. [DON] stated, while rounding the A-wing unit, [R800] stated [they] was slapped by [their] midnight nurse. [R800] BIM [Brief Interview for Mental Status] score of 15, who also locomotes freely within the facility with a wheelchair. Around ten am, [R800] reported to the DON that a midnight nurse slapped [their] arm during care. The employee was immediately suspended, pending investigation ..."</p> <p>On 4/16/2025 at 10:12 AM, an interview was completed with R800 regarding the incident with Licensed Practical Nurse (LPN) "E" on 4/3/2025. R800 reported they were having a bowel movement and LPN "E" took their wheelchair so they could not go to the bathroom. R800 reported LPN "E" was "very mean" to them and would not let them use the bathroom. R800 reported LPN "E" told them to "shut the f*** up" and was calling them names. R800 reported LPN "E" then slapped them in the arm twice. R800 reported another person (Certified Nurse Assistant (CNA) "C", was in the room with them and tried to tell LPN "E" to stop, but they did not listen. R800 reported the other person in the room left, and they were in there with LPN "E" until their assigned nurse came back, and subsequently went to the hospital. R800 indicated nothing like that ever happened to them in the facility before and they felt "embarrassed" about the whole situation. R800 reported they do not feel safe in the facility at this time.</p>		<p>on mandatory reporting. All staff, including nursing, activities, and ancillary services, were re-educated on, the "Abuse, Neglect, and Exploitation" policy by 4/17/2025. No staff are permitted to work without re-education. Abuse training emphasized staff must ensure immediate removal of alleged abusers from said areas and make immediate notification to Abuse coordinator. The Medical Director was notified of the event and involved in QAPI review. The policy for abuse and neglect was reviewed by the IDT Team and deemed appropriate.¿</p> <p>Element #4</p> <p>The Administrator 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 issues are corrected. The Facility Administrator will be responsible for maintaining compliance.¿</p> <p>Deficient Practice #2: Failure to Protect Resident (R801) from Resident-to-Resident Abuse</p> <p>Element #1</p>	

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	<p>A review of the medical record revealed R800 was admitted into the facility on 12/15/2023 with the following medical diagnoses, Dysphagia and Weakness. A review of the Minimum Data Set (MDS) assessment revealed Brief Interview for Mental status (BIMS) score of 15/15 indicating an intact cognition. R800 also required staff assistance with bed mobility and transfers.</p> <p>On 4/16/2025 at 3:06 PM, a phone interview was conducted with LPN "D". LPN "D" reported R800 was having diarrhea, throwing up, and sweating profusely. LPN "D" reported LPN "E" came to sit with R800 along with CNA "C", while they prepared the paperwork to send them out to the hospital. LPN "D" reported while they were at the nurses' desk when CNA "C" walked by and said they were not going to be involved with what LPN "E" had going on. LPN "D" reported CNA "C" did not report anything else to them and they were focused on getting everything together for R800's transfer to the hospital. LPN "D" reported after they were done getting R800's transfer together, they went back in the room with LPN "E" and R800. LPN "D" indicated the whole event started approximately around 2:00 AM until 3:00 AM when R800 left the facility. LPN "D" reported that after R800 left the facility, LPN "E" went back to their set and continued working their assigned residents until the end of their shift.</p> <p>Further review of CNA "C" witness statement dated 4/11/2025 noted the following, "On the morning of 4/3/2025 ...R800 threw himself to the floor. We placed him back on the toilet. That's when LPN "E" started yelling and told R800 if you have to s*** then take a s***. [LPN "E"] was speaking loudly, very loud. R800 yelled saying [they] were sick, after that [LPN "E"] took [their] right hand and slapped [R800] on [their] left arm two times. I told [LPN "E"] to stop and [LPN "E"] yelled at me, got in my face, and was very</p>		<p>R801 was physically assessed and found to have no visible injuries. Resident was offered and received psychosocial support by Social Services. Resident's safety plan and care plan were updated.</p> <p>Element #2 Review conducted of all residents residing in common areas with history of aggressive behaviors. Resident R802 was identified and sent for psychiatric evaluation and inpatient treatment on 4/16/2025. All interactions between cognitively impaired residents are being monitored.</p> <p>Element #3 Lobby/common area supervision increased during peak resident usage hours. Behavioral Care Plans reviewed for all residents with cognitive impairment and aggression history. Staff re-educated All staff, including nursing, activities, and ancillary services, were re-educated on, the "Abuse, Neglect, and Exploitation" policy by 4/17/2025 and monitoring of resident interactions. No staff are permitted to work without re-education. Abuse training emphasized staff must ensure immediate removal of alleged abusers from said areas and make immediate notification to Abuse coordinator. Reception staff received 1:1 education on mandatory reporting The Medical Director was notified of the event and involved in QAPI review. The policy for abuse and neglect was reviewed by the IDT Team and deemed appropriate. ;</p> <p>Element #4 The Administrator 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</p>	

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	<p>aggressive. I ran out the room and told [LPN "D"] that [LPN "E"] was 'tripping' ...I called the Administrator immediately and I texted the DON at 7:00 AM when I got off work."</p> <p>On 4/16/2025 at 12:35PM, an interview was conducted with the DON. The DON reported that they were informed about the incident around 7:30AM-8:00AM on April 3rd, when they came in the facility. The DON reported when they came in the facility R800 was also coming back in from their hospital visit.</p> <p>At 12:55, an interview was conducted with the Nursing Home Administrator (NHA). The NHA reported they were informed about the incident around 10:00 AM from the DON when they were completing room rounds. The NHA reported they informed Human Resources, and they called and suspended LPN "E". The NHA reported they called the police, reported the incident to the State Agency (SA) and began their full investigation. The NHA reported that LPN "E" did continue to work their entire shift following the incident and was suspended the following morning.</p> <p>Further review of incident submitted to State Agency on 4/3/2025 at 11:49 AM, the abuse was substantiated.</p> <p>The Immediate Jeopardy (IJ) started on 4/3/2025 and was identified on 4/16/2025.</p> <p>The Nursing Home Administrator (NHA) was notified of the IJ on 4/16/2025 at 3:35 PM and was asked to submit a plan to remove the immediacy.</p> <p>The IJ was removed on 4/17/2025, based on the facility's implementation of the removal plan as verified onsite.</p>		<p>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 issues are corrected. The Facility Administrator will be responsible for maintaining compliance. 2</p>	

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	<p>Although the immediacy was removed on 4/17/2025, the facility's deficient practice was not corrected and remained isolated with actual harm.</p> <p>Removal Plan:</p> <p>1. Identification of Residents Affected or Likely to be Affected:</p> <ul style="list-style-type: none"> o On 4/16/25 the DON and designee(s) interviewed/assessed residents with BIMS scores of 8 and above for potential abuse. Residents with BIMS below 8 were assessed by a license nurse for an acute change in condition. Concerns were/were not identified. o On 4/16/25 Social Services completed a supportive visit with R800. <p>2. Actions to Prevent Occurrence/Recurrence:</p> <p>The facility took the following actions to prevent an adverse outcome from reoccurring.</p> <ul style="list-style-type: none"> o LPN E was suspended pending investigation on 4/3/25 and has not returned to the facility. o On 4/4/25, the Abuse, Neglect and Exploitation policy was reviewed by the Administrator and deemed appropriate. o Beginning on 4/16/25, the Administrator/designee re-educated all staff on the Abuse, Neglect and Exploitation policy, highlighting the requirement to notify the Abuse Coordinator (Administrator) immediately with all abuse allegations. No staff member will be permitted to work until re-education is received. o The facility Medical Director was notified of this event on 4/16/25. 			

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	<ul style="list-style-type: none"> o Facility IDT Team held an ADHOC QAPI meeting on 4/16/25. o From the abuse policy all staff were educated all on: VI. Protection of Resident o The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to: <ul style="list-style-type: none"> o A. Responding immediately to protect the alleged victim and integrity of the investigation; o B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; o C. Increased supervision of the alleged victim and residents; o D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; o E. Protection from retaliation; o F. Providing emotional support and counseling o CENA that left the room, was provided 1:1 education regarding not to leave resident alone with abuser and the LPN assigned to the resident was provided 1:1 education to immediately report allegations of abuse and remove abuser as well and the educations received will be added to both their employee files. o Facility IDT Team conducted an audit on all 			

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	<p>residents for their Safety/ Abuse on 4/16/25. Any negative findings will be Immediately corrected.</p> <p>o All findings will be taken to QAPI on 5/8/25 to follow up/ track for any systematic changes that may be needed.</p> <p>Deficient practice number two.</p> <p>This citation pertains to Intake MI00152184.</p> <p>Based on observation, interview and record review, the facility failed to protect one resident (R801) from physical abuse by another resident (R802) out of three reviewed for abuse. Findings include:</p> <p>A review of Facility Reported Incident (FRI) noted the following, " ...Around 10 AM, [Receptionist "A"] communicated that while both residents were in the lobby, [R802] walked up to [R801] and slapped [them] in the face ..."</p> <p>A review of the medical record revealed R801 was admitted into the facility on 7/14/2023 with the following medical diagnoses, Cerebral Infarction and Anxiety Disorder. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 12/15, indicating an impaired cognition. R801 also required assistance with bed mobility and transfers.</p> <p>A review of the medical record revealed R802 was readmitted into the facility on 11/14/2024 with the following medical diagnoses, Schizoaffective Disorder and Bipolar Disorder. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 10/15 indicating an impaired cognition. R802 also required staff assistance with bed mobility and transfers.</p>			

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	<p>On 4/16/2025 at 11:14 AM, an interview was conducted with R801. R801 did not recall the incident and stated they did not have a problem with anyone in the facility.</p> <p>On 4/16/2025 at 11:52 AM, an interview was conducted with Receptionist "A". Receptionist "A" reported the incident occurred at approximately 9:05 AM and R802 was already in the lobby. Receptionist "A" reported R801 was sitting on one couch and R802 was sitting opposite of them on another couch. Receptionist "A" reported R802 got off the couch, walked towards R801 and slapped them in the face. Receptionist "A" reported they went over to R802 and informed them they could not put their hands on anybody to which R802 stated they will do it again. Receptionist "A" reported R802 then walked away and they (the receptionist) went and told the Nursing Home Administrator (NHA) what they witnessed.</p> <p>On 4/16/2025 at 12:04 PM, an interview was conducted with the Social Service Director (SSD) "B". SSD "B" stated Receptionist "A" came in morning meeting and told the NHA about the incident. The SSD reported they asked R802 did they slap R801?, and the resident confirmed they did and will do it again.</p> <p>At 1:04 PM, an interview was conducted with the NHA. The NHA reported R802 was sent to in patient psychiatric and has not returned since the incident.</p> <p>A review of a facility policy titled, "Abuse, Neglect, and Exploitation" Policy: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of</p>			

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	resident property."				