STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235294	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Cedar Springs	400 Jeffrey Cedar Springs, MI 49319

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 47955 This citation pertains to intake #MI00148287 Based on interview andrecord review, the facility failed to protect the residents right to be free from resident to resident sexual abuse in 1 of 1 residents (Resident #30) by Resident #58 Findings include: Review of Incident Report dated 11/3/24 revealed Reported resident (Resident #30) was outside the south cafe door when another male resident (Resident #58) was seen with his hand in her pants. It is reported by witness resident (Former Resident (FR) VV) that resident (Resident #30) tried to roll away and male resident (Resident #58) grabbed her (Resident #30) hair and pulled her back. Resident #30 Review of an Admission Record revealed Resident #30 had pertinent diagnoses which included: dementia and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #30, with a reference date of 11/19/24 revealed a Brief Interview for Mental Status (BIMS) score of 2/15 which indicated Resident #30 was severely cognitively impaired. Review of Care Plan for Resident #30 revealed Focus, Goals, and Interventions: I have severe impaired cognitive function r/t (related to) dementia; I have difficulty understanding situations: please encourage me to stay on East/West unit. I have communication problem r/t sometimes not understanding verbal communication r/t advance dementia. I will attempt to sit away from male residents at meal times and group activities, I do propel myself around the room. monitor behavior symptoms that include wandering. No noted care plan related to trauma informed care. Review of Kardex (a document that instructs workers how to care for the resident) for Resident #30 dated 12/10/24 revealed safety - wandering; please remove me from stressful situations. Resident #58 (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #58 had pertinent diagnoses which included: dementia and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #58, with a reference date of 10/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #58 was cognitively intact. Review of Care Plan for Resident #58 revealed Focus, goal and interventions: I have the potential to exhibit behaviors that sound or appear sexual in nature. I have a hx (history) of requesting others give me oral pleasure (10/8/2024) I also have a history of touching myself and others inappropriately: I will not engage in behaviors that sound or appear sexual in nature in a public place. I make statements or ask staff/other residents to join me in sexual acts. Interventions: two staff with all personal care, I may make sexual statements or ask staff/other residents to join me in sexual acts. Please inform me this in inappropriate: initiated 9/13/2024 Review of Progress Note for Resident #58 dated 9/12/24 revealed was reported to this nurse that resident exposed himself and started to masturbate in front of a minor staff who was delivering dinner trays . Review of Progress Note for Resident #58 dated 9/14/24 revealed .cna went in to help resident and he said, 'would $20 make you get freaky with me? Review of Progress Note for Resident #58 dated 9/29/24 revealed resident asked CNA 2 times if she would take $200 in exchange for sexual favors with resident. Review of Progress Note for Resident #58 dated 10/8/24 revealed A resident .was passing out crafts to other resident. When she entered this resident's room, he asked her to suck my cock for $5 . Review of Progress Note for Resident #58 dated 10/16/24 revealed .resident's sexual behaviors are not stopping even after medication adjustments . Review of Progress Note for Resident #58 dated 11/3/24 revealed resident was witnessed by another resident putting his hands in a female residents pants. In an interview on 12/9/24 at 5:32 PM., Resident #58 stated I did an inappropriate to her and they called the police on me. Resident #58 stated she made me feel good, and a guy saw us and told on us. This surveyor asked Resident #58 how she (Resident #30) made him feel good and Resident #58 stated She let me touch her and that made me feel good. Resident #58 stated I did not rape her, I just touched her. In an attempted interview on 12/8/24 at 9:41 AM., Resident #30 was in bed in her room, eating breakfast, and did not engage in any meaningful conversation with this surveyor. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In a telephone interview on 12/9/24 at 12:07 PM., Former Resident (FR) VV reported he observed Resident #58 blocking Resident #30 in the hallway near the cafe on the south unit and Resident #58 had his hand down Resident #30's pants. FR VV reported he pulled Resident #58 away from Resident #30 and Resident #58 went right back to Resident #30 and put his hand up her shorts along her leg, grabbed her hair, and was pulling her in her wheelchair to him. FR VV reported he then yelled for help. FR VV reported Resident #30's face was grim, she was crying, and she appeared to be completely helpless. In an interview on 12/8/24 at 11:52 AM., Certified Nurse Assistant (CNA) D reported Resident #58 was alert and oriented and aware of what he was doing. CNA D reported Resident #58 did grab Resident #30, pull her to him, and put his hand down her pants. CNA D reported she heard Resident #58 state he was giving her (Resident #30) what she was asking for. CNA D reported Resident #30 was mostly non-verbal, did not speak much, if at all, was confused and unaware of what was going on around her. In an interview on 12/8/24 at 2:56 PM., Unit Manager (UM) C reported Resident #58 has had many behaviors during his stay, he had a resident-to-resident incident, and he had asked staff for oral sex in exchange for money. UM C reported Resident #58 had been observed by staff exposing his genitalia and masturbating in the open doorway of his room. UM C reported when the incident on 11/3/2024 between Resident #30 and Resident #58 occurred Resident #58 was touching Resident #30 inappropriately (Resident #58 had his hand in Resident #30's pants), Resident #30 tried to escape, and Resident #58 grabbed Resident #30 by the hair and pulled her back to him. In an interview on 12/9/24 at 9:11 AM., CNA QQ reported Resident #30 did wander around the facility while sitting in her wheelchair and she was very confused. CNA QQ reported Resident #58 had offered her (CNA QQ) 200 dollars cash to get freaky with him while she was assisting him with personal care. In an interview on 12/9/24 at 9:25 AM CNA QQ reported staffing on the south unit during meals was one CNA and one nurse. The second assigned CNA to the unit was required to assist with the dining room. In an interview on 12/9/24 at 12:22 PM., Licensed Practical Nurse (LPN) DD reported Resident #58 had escalating behaviors prior to the incident with Resident #30 and Resident #58 continues to display inappropriate behaviors including exposing himself to others. LPN DD reported on 11/3/24 FR VV yelled out for her and when she rounded the corner near the cafe on the south unit, she saw Resident #58 aggressively trying to get ahold of Resident #30. LPN DD reported she made herself a barrier between the two residents as Resident #58 aggressively continued to grab Resident #30. LPN DD reported she separated Resident #30 and Resident #58. LPN DD reported Resident #58 was taken to his room and Resident #30 was taken to her room. In an interview on 12/9/24 at 12:35 PM., LPN DD reported staffing on the south unit during meals was one CNA and one nurse. The second assigned CNA to the unit was required to assist with the dining room. LPN DD reported the incident that occurred on 11/3/24 between Resident #30 and Resident #58 occurred during breakfast and staffing was only one nurse and one CNA, who was assisting a resident in a room, on the unit at that time. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 12/9/24 at 1:29 PM., Scheduler (S) T reported Resident #30 would wander around the facility in her wheelchair. S T reported Resident #58 would fixate on sex and his behavior would escalate. S T stated we are doing our best to keep the environment safe. S T reported staffing on the south unit during meals was one CNA and one nurse. The second assigned CNA to the unit was required to assist with the dining room. During an interview on 12/9/2024 at 2:34 PM., Director of Nursing (DON) B reported her expectations were that one of the two CNAs scheduled on the South unit assisted with the main dining room during meals. DON B reported the staffing on south unit during meals was one CNA and one nurse. In an interview on 12/9/24 at 2:48 PM., Physician Assistant (PA) XX reported she recognized when Resident #58 admitted that something was off with him, he would talk to himself, he would hallucinate, and it progressed to behaviors sexual in nature. PA XX reported medications have been adjusted for Resident #58 and the sexual behaviors have lessened but were not eliminated. In an interview on 12/10/24 at 10:26 AM., Social Services Manager (SSM) X reported Resident #58 was observed by another resident with his hand down Resident #30's pants. SSM X reported Resident #30 did not verbalized anything during follow up sessions with her. SSM 'X reported Resident #58 did not recall the incident on the first of three follow up sessions, but did recall the incident on the second and third follow up session. SSM X reported Resident #58 appeared unphased by the incident. SSM X reported Resident #58 was aware of his actions. In an interview on 12/10/24 at 12:56 PM., CNA Z reported Resident #30 was touched inappropriately by Resident #58, and that incident was the second time Resident #30 had been touched inappropriately by a male resident. CNA Z reported Resident #58 had put his hand in Resident #30's pants and when it happened Resident #30 was crying. CNA Z reported staffing on the south unit during meals was one CNA and one nurse. The second assigned CNA to the unit was required to assist with the dining room. Using the reasonable person concept, though Resident #30 had decreased ability to verbally express her own thoughts due to mental diagnosis, witness accounts of Resident #30 crying during the incident with Resident #58 on 11/3/24 clearly indicated she was upset. This emotional response has the potential to continue well past the date of the incident based on the reasonable person concept. During a telephone conversation on 12/9/24 at 4:45 PM., Family Member (FM) WW (a family member of Resident #30) reported Resident #30 would have been upset, angry, and wound have tried to slap Resident #58 during the altercation.

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 47955 Based on interview and record review the facility failed to ensure that an effective training program for abuse prevention for all staff was maintained and monitored for completion, resulting in the potential for decreased resident safety. Findings include: In an interview on 12/9/24 at 2:30 PM., Director of Nursing (DON) B reported the facility does not have a staff development role. DON B reported she was responsible for monitoring completion of assigned online trainings. DON B reported the facility no longer had an employee in the role of human resources present in the facility. DON B reported employee training records were maintained by human resource at the corporate level. In a telephone interview on 12/9/24 at 4:45 PM., Former Nursing Home Administrator (FNHA) UU reported abuse education was completed online annually, and the facility had completed the topic of abuse sometime during the summer. Review of Course Completion History for Module - Abuse, Neglect, and Exploitation provided by the facility on 12/9/24 and dated 12/9/24 revealed Abuse, Neglect, and Exploitation course was due on 7/31/2024. 66 total employees from all departments were listed, and 11 had not yet started the module. Also, Unit Manager (UM) C and DON B status for assigned module, Abuse, Neglect, and Exploitation with a due date of 7/31/24 was noted to be listed as in progress. The facility did not provide documentation for the completion of abuse training by all employees by the time of exit.