STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235552	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents a notice of rights, rules, services and charges. 35103 Based on interview and record review, the facility failed to provide information regarding facility rules and regulations, including denture loss, prior to or upon admission to the facility for one Resident (R2) of three residents reviewed for notice of rights and rules. Findings include: This deficiency pertains to Intake MI00147954. Review of the Complaint Intake MI00147954 on 12/3/24 revealed the following, in part: .During the late afternoon on 9/29/2024 [Complainant F] cleaned the residents top and bottom dentures per his request and put them back in their case on his bedside table. The complainant states on 9/30/24 [they] received a call from the facility staff asking if [they] took the residents (R2's) dentures home . because they were missing. The complainant states [they] went to the facility at 5:00 p.m., and an aide [Certified Nurse Aide E] told [Complainant F] that [CNA E] saw the dentures on the nightstand the following evening and when he went into the room in the morning, they were missing . the residents' dentures still haven't been found . During a telephone interview on 12/2/24 at 4:19 p.m., when asked about R2's denture loss, Complainant F stated, [R2] entered the facility on September 27th . the CNA said they (dentures) were there on 9/29/24, on the night stand. When [CNA E] went in the room on 9/30/24 they (dentures) were gone . They never reimbursed me for the missing dentures. They should have taken my father to be fitted for new dentures . Upon [R2's] admission I should have been given a packet, and there would have been a pamphlet with her (Ombudsman) information on it. Complainant F said R2 did not receive any documentation of facility rules upon admission, and neither did the Resident Representative when it was determined [R2] was not able to make their own medical decisions. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/3/24 at 11:37 a.m., when asked about R2's missing dentures, the Nursing Home Administrator (NHA) stated, [R2] was admitted with upper and lower dentures on September 27th. [R2's Family Member (FM I)] took them out of [R2's] mouth and cleaned them and put them in a denture case after his lunch on the 29th . Then before supper [CNA E] said they took them out of the case and put them back in the resident's mouth for supper, and after supper [CNA E] removed them, cleaned them and put them back in the denture case and put them on top of the residents' dresser. Then the next morning the dentures were missing. The were discovered missing on September 30th. What I said to [FM I] was, 'This is our Dental Policy, and these are the steps we need to take before we can even get to that point (of replacing or reimbursing for the lost dentures) .So the first thing is several of us will search, and I gave her a copy of the Dental Policy . The Dental Policy is not in the admission packet .but the admission packet does have verbiage (wording) on dentures . On 12/3/24 at 11:49 a.m., a copy of the Admission Packet, and the Dental Policy were reviewed by the NHA and this Surveyor. During an interview on 12/3/24 at 1:52 p.m., when asked about R2's dentures, CNA E stated, I took them (dentures) out and brushed them and put them in a clear bowl on the bedside table on Sunday Night (12/29/24). The next morning, I came to work at 2:00 p.m. They asked me if I knew what happened to the teeth (R2's Dentures). I said 'Yes, I had put them in a clear bowl. There was no top on the bowl. There were not really close to the edge of the bedside table. They (facility staff) said they were not present at 7:00 a.m. that morning. CNA E said he had no idea what had happened to R2's dentures after that. During an interview on 12/5/24 at 3:03 p.m., the NHA provided R2's Receipt Acknowledgement of Admission Documents that was observed to be a list of items reviewed and/or provided to R2 following admission to the facility. The Receipt Acknowledgement of Admission Documents including all facility rights, rules, and responsibilities was dated 10/2/24. This was two days following the loss of R2's dentures. The NHA confirmed all Admission paperwork, including the admission contract, were completed by the facility for R2, dated 10/2/24. Review of the Admission Packet, Page 9 provided by the facility on 12/4/24 at 10:03 a.m., revealed the following, in part: Missing Items: The facility trains the staff to safeguard resident's personal property. Please report any lost or missing item to the charge nurse. All efforts will be made to investigate and locate the item. Review of the facility policy entitled Lost of Damage of Personal Property, dated 3/2024, revealed the following, in part: Policy: Loss or damage of personal property belonging to a resident will be promptly investigated and reported . 1. It is the responsibility of the facility to offer safeguard options for resident property to the extent possible to assure there is no misappropriation of resident property. 2. When an item is reported as missing a proper investigation is completed, regardless of the item's value. 3. Immediately search the facility to attempt to locate the missing item(s). 4. Talk with residents and staff to determine if anyone had seen or heard any unusual happenings. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Search the resident's room and other locations visited by the resident within the last 24 hours to determine if the item was misplaced. 6. If the item is not recovered after the initial search complete a Resident Assistance Form and notify the Administrator. 7. Notify law enforcement and complete state reportable 24-hour report and 5-day investigation for any suspicion of a crime. 8. Facility will investigate all complaints within 15 days following receipt of the complaint by the facility and within 30 days shall offer to the complainant a written report of the results of the investigation or a written status report indicating when the report may be expected. 9. Residents are offered the trust account to deposit money for safe keeping upon admissions. 10. Residents are encouraged to send home valuable items if able/desired. 11. The facility will not be responsible for lost or broken items unless it is determined that it was fault of facility. 12. Missing items should be reviewed by the QAPI for trends and patterns. No evidence was presented during the survey to show this policy was provided to Resident R2 prior to 10/2/24. Review of the Dental Policy, updated 6/2023, revealed the following, in part: . 4. The facility will not be responsible for lost or broken dentures unless it is determined that it was the fault of the facility. a. The facility shall determine responsibility for the loss or damage of dentures on a case-by-case basis, considering the circumstances surrounding the loss/damage, resident characteristics, and the residents' plan of care. 5. For residents with lost or damaged dentures, the facility will refer the resident for dental services within three days . No evidence was presented to show this policy was provided to R2 before or upon admission. During an interview on 12/6/24 at 11:28 a.m., the NHA acknowledged that upon review of R2's Admission Contract and Receipt Acknowledgement of Admission Documents there was no additional information to show why the documentation was not completed until five days following admission, and two days after R2's dentures had been lost in the facility. An attempt was made to contact form Admission Director D via telephone by the NHA on 12/6/24 at 11:36 a.m. No answer was obtained, and no return phone call was received prior to the end of the survey. The NHA did not provide any additional information from Admission Director D following the survey Exit on 12/6/24 at approximately 2:00 p.m. (continued on next page)

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Admission Process for Contracts and Agreements facility procedure revealed the following, in part: 1. Day of Admission: Admission Director is responsible with BOM (Business Office Manager)/HIC (Health Information Coordinator/other as a back-up. a. Update Profile tab to ensure that all contacts are updated and the Primary Contact-Financial is correct. b. Generate Packet (if weekend-Generate Monday) (Wound have been September 30th). c. Complete Signatures within 24 hrs. (hours) for packet within Document Manager. i. Create Administrative Progress note if packet is unable to be signed with the 24-hour period from within the Residents Chart. Progress notes cannot be deleted or updated - make notes simple. 1. Example: Resident unable to sign packet due to being incapacitated. 2. Example: DPOA is refusing to sign. 3. Example: Working with DPOA to schedule time to complete packet in person. 4. Example: Patient left AMA or prior to being able to complete contract and reason why. Review of the Resident Rights policy, reviewed/revised 2/2024, revealed the following, in part: Policy: The facility will inform the resident both orally and in writing, in a language that the resident understands, of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility . Receipt of any such information must be acknowledged in writing. Policy Explanation and Compliance Guidelines: 1. Prior to or upon admission, the social service designee, or another designated staff member, will inform the resident and/or the resident's representative of the resident's right and responsibilities .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to respond timely to a change in condition for one Resident (R2) of three Residents reviewed for a change in condition. This deficient practice resulted in delayed transfer and treatment of an identified changed in condition. Findings include: This deficiency pertains to Intake MI00147954. Review of the Complaint Intake MI00147954 revealed the following, in part: .Complainant (F) . on 10/11/24 visited the resident (R2) and noticed his eyes were closed, but [R2] was flailing their arms and legs and appeared to be in pain . [Complainant F] alerted nursing staff and was told it was part of [R2's] decline and nothing to worry about . [Complainant F] visited the resident again on 10/12/24 and [R2] was in worse condition . [Complainant F] found [Registered Nurse (RN) B] and told [RN B] that they wanted the resident sent to the hospital. The Complainant states [RN B] said they needed to finish what they was doing and then they'd call the doctor. The complainant states . hours later the resident was sent to the [Hospital] . was told [R2] was extremely dehydrated, had a collapsed lung, and [R2's] bladder was extremely full which was causing [their] pain . During a telephone interview on 12/2/24 at 4:19 p.m., when asked about R2's change in condition and transfer to the emergency room (ER), FM I stated, .When [R2] went to the ER, October 12th, I am ringing the bell (call light) and [R2] was worse than . the night before. I said you get [R2] to the hospital right now. The nurse said I have to finish morning medications (medication pass), and [RN B] probably waited two more hours. ER doctor said R2 was severely dehydrated, collapsed lung, bladder so full he would have been in so much pain . Review of R2's Minimum Data Set (MDS) assessment, dated 10/3/24, revealed R2 was admitted to the facility on [DATE] with active diagnoses that included the following, in part: cancer, heart failure, urinary tract infection, acute pyelonephritis, and metabolic encephalopathy. R2 scored 4 of 15 on the Brief Interview for Mental Status (BIMS) reflective of severe cognitive impairment. Review of R2's Admission Record, dated 9/27/24, revealed the Resident was identified as being responsible for themselves, with a family member (FM I) noted as Emergency Contact #1. Review of a Medical Determination detailing that R2 was no longer capable of participating in the medical treatment decision making process affecting his/her own health was signed by two physicians, completed on 10/9/24, when FM I was identified as R2's Responsible Party. Review of the following Secure Conversations found in R2's Progress Notes detailed the decline in R2's condition: Effective Date: 10/13/24 11:36 Type: Secure Conversations: Message: Subject: not able to swallow. [10/10/24 0034 AM (12:34 a.m.)](from RN J): Hello, [R2] needs to be seen by speech therapy. [R2] has been unable to swallow any crushed pulls or pudding. Take any sips of liquids. No yogurts. It goes to the back of [their] throat and comes right back up. Thank you. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[10/10/24 09:08 AM] [R2's] on ST (speech therapy). [R2] was unable to be seen yesterday evening due to being too lethargic . [10/10/2024 09:15 AM] Physician K: Noted. [10/12/2024 08:14 AM] RN B: Resident still having issues this morning. Was [R2] ever seen? [10/12/24 09:57 AM] RN B: [R2] has been doing some confused reaching and grasping with his hands too, [R2's FM I] is concerned and here. I know [FM I] would like an update when possible. [10/12/24 11:08 AM]: RN B; [R2] had a UA (urinary analysis) on 10/9 . [10/12/24 11:12 AM]: Physician K: Oh ok. Do you think [R2] is ill? Or do you think [R2] is just declining? [10/12/24 11:14 AM] RN B: I think [R2] is dehydrated and declining. [R2] is having a hard time keeping anything down, trouble swallowing still. [10/12/24 11:16 AM] RN B: I will talk to [FM I] after noon med pass. His vitals are okay, but I feel [FM I] probably will want him sent (to the hospital) . [10/12/24 12:28 PM] RN B; I just spoke with [FM I] . okay with [R2] being sent to [Hospital] for Eval [evaluation] and hopefully some fluids. Order to send okay? [10/12/24 12:19 PM] Physician K: Yes. [10/12/24 13:45 PM] RN B; [Ambulance Service] left with resident to bring to [Hospital] at 1340 (1:40 p.m.) for eval (evaluation) per dr (doctor). instruction. Review of R2's Change of condition Evaluation - 5.1, dated Effective Date of 10/12/24 at 12:48 p.m., revealed R2 was identified with altered mental status, food and/or fluid intake (decrease or unable to eat and/or drink adequate amounts), other change in condition (the resident has been not keeping his trunk control as much. Head bobbing and reaching with hands more. Communicating less . not been eating or drinking well for the last couple of days. 2. This started on 10/10/24 (two days previous) . 6. Most Recent Weight: Weight 108.6, Date: 10/4/24 11:08 AM, Standing .8. [FM I] would like [R2] evaluated. [They] are concerned. Unsure if . presentation is being sick, or if it is decline we are seeing . Summarize your observations, evaluation and recommendations: The resident should be evaluated by ER (emergency room) for extra fluids and labs . Date and time of family/resident representative notification: 10/12/24 13:09 (1:09 p. m.) .signed by RN B . Review of R2's Skilled Documentation assessment completed 10/12/24 at 13:22 (1:22 p.m.) by RN B revealed the following documentation: . LOC (level of consciousness) Alert, Orientation: boxes for Person, Place, Time, and Situation were all checked, with Impaired Decision Making identified. Notable changes in LOC/Orientation/Cognition None, Changes to mood or behavior? No', Lung sounds WNL (within normal limits) remained unchecked for yes or not. Nutrition: Appetite poor, Resident is being sent to ED for Eval. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempt was made to contact RN B on 12/6/24 at 10:25 a.m., with the number provided by the facility staff listing. The number was unable to be called. On 12/6/24 at 10:45 a.m., a new number was provided by the facility. There was no answer to the call at that time, but a voicemail was left to return the call to this Surveyor. No return call was received from RN B. Review of R2's 10/12/24 ER visit and subsequent inpatient treatment documentation revealed the following, in part: [R2] does show (urinary) retention and given his symptoms have been worsened since his Foley catheter was removed, Foley was placed. Given significant pleural effusions previously and shortage of IV fluids, patient was given 500 cc bolus of normal saline . Patient is much improved in terms of agitation after Foley catheter was placed . patient to inpatient service . Resident did not return to the facility. R2 was discharged to home on 10/16/24. Review of the Residents at Risk Meeting policy, revised 5/2024, revealed the following, in part: Policy: A weekly focused Residents at Risk meeting is held to monitor progress residents with acute conditions or situations posing a risk to their health or well being as part of the facility's systemic approach to risk prevention and management. Policy Explanation and Compliance Guidelines: 1. Clinical leaders from the interdisciplinary team and the Medical Director/designee meet weekly to discuss the care, and response to care, of residents identified as at risk. Residents deemed at risk may have one or more of the following conditions or situations: pressure injury or significant risk for pressure injury, existing wounds of other etiology, significant change in condition, nutritionally at risk, behavioral concerns/behavior management, pain control issues, end of life, elopement/wandering, risk for contractures, fall with significant injury, or multiple falls . 6. The facility will utilize the Residents at Risk Meeting Log to track resident to be monitored by the interdisciplinary team and discussed at the Residents at Risk Meeting. 7. The facility will utilize the Weekly At-Risk Meeting Attendance Sheet to track meeting attendance and policy adherence. Review of the At-Risk Meeting Logs for September and October 2024 revealed there were no Logs completed prior to R2's discharge/transfer from the facility on 10/12/24, showing R2 was being tracked by the IDT committee. During an interview on 12/3/24 at 2:01 p.m., when asked about the delay in transfer to the ER for an identified change in condition for R2, the DON stated, I did tell [RN B] that we don't have to wait for a physician order to send a resident out to the ER, and from the sounds of the Secure Communication (between RN B and Physician K) it sounded like [RN B] thought [R2] needed to be sent out (to the ER). The DON was asked to review R2's Change of Condition and Skilled Documentation both completed on 10/12/24 by RN B. The DON agreed that the Skilled Documentation dated 10/12/24 should match the Change of Condition dated 10/12/24; not contradicted each other. The DON acknowledged the Change of Condition assessment said the change in R2's condition started on 10/10/24. The DON also stated, No, it is not acceptable to delay from 9:57 a.m. (when FM I was present and concerned in the building) to 1:40 p.m. (the actual time of transfer to the ED). The noon med pass does not take priority over transfer to the hospital . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 12/5/24 at 10:10 a.m., when asked about the timing of emergency transfers to the ER and any additional Change of Condition policy, Regional Clinical Director L stated, We just have the Change of Condition policy (already provided to this Surveyor). If the nurse feels there is a decline in and the DPOA wants them sent I would send them to the hospital. We don't have a policy for that .I would expect that the nurse would have sent the resident to the hospital right away, if they were failing .A daily Skilled Assessment should be done daily for this resident (R2). Regional Clinical Director L agreed the daily Skilled Assessment should match the Change in Condition form.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on interview and record review, the facility failed to appropriately assess weights to assist in identification and prevention of significant weight loss for three Residents (R2 , R4, & R8), of six residents reviewed for weight management. This deficient practice resulted in inadequate weight documentation/tracking and the development of a significant weight loss for R2. Findings include: This deficiency pertains to Intake MI00147954. Review of R2's Minimum Data Set (MDS) assessment, dated 10/3/24, revealed R2 was admitted to the facility on [DATE] with active diagnoses that included the following, in part: heart failure, urinary tract infection, acute pyelonephritis, and metabolic encephalopathy. R2 scored 4 of 15 on the Brief Interview for Mental Status (BIMS) reflective of severe cognitive impairment. Review of the 10/13/24 Hospital Progress Note , revealed the following, in part: . Assessment/Plan: Malnutrition/Cachexia (wasting away appearance): Documented 30-pound weight loss (significant weight loss) from when patient was here 3 weeks ago until admission (10/12/24). BMI (Body Mass Index) 13.3. Likely multifactorial in the setting of progressive chronic illness and decreased oral intake as patient (in facility) as dentures have been lost . Review of R2's Electronic Medical Record (EMR) on 12/3/24 at 10:22 a.m., revealed R2 was 67 inches in height (5'7), with an IBW (ideal body weight) range of 153-185 pounds, and the following documented weight measurements: 9/30/24 10:26 (a.m.) ,115 lbs. (pounds) in wheelchair. 10/1/24 17:10 (p.m.) ,117 lbs. in Wheelchair. 10/4/24 11:08 (a.m.), 108.6 lbs. Standing. During an interview on 12/3/24 at 11:37 a.m., the Nursing Home Administrator (NHA) was asked about R2's weight assessments while in the facility. The NHA stated, We failed to get an admission weight on this Resident . The NHA acknowledged no other weight measurements, other than the above listed, were found in R2's EMR. Review of the Weight Monitoring policy, reviewed 1/2024, revealed the following, in part: .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. Assessments should include the following information: a. General appearance, b. Height, c. Weight .5. Weight will be obtained upon admission, readmission, and weekly for the first four weeks after admission and at least monthly unless ordered by the physician. If a resident declines to be weighed this should be noted in the resident's record . Resident R4 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's Admission/Readmission Assessment upon admission on 11/12/24, revealed R4 was admitted at 1608 (4:08 p.m.) on 11/12/24 with a Most Recent Weight of 262.8 lbs. (measured) on 8/13/2020 at 9:18 a.m. (weight from prior to admission). Review of R4's Weights and Vitals Summary, retrieved 12/5/24 at 17:27 (5:27 p.m.) revealed and admission weight for the 11/12/24 admission to the facility was not assessed upon admission, but first documented on 11/15/24 at 13:59 (1:59 p.m.) with a weight of 226.6 lbs. Resident R8 Review of R8's Weight and Vitals Summary retrieved 12/5/24 at 17:27 p.m. (5:27 p.m.) revealed weekly weights were documented as follows: 11/8/2024 - 152 lbs. (Standing) 11/8/2024 - 152.4 lbs. (Wheelchair) 11/8/2024 - 152.4 lbs. (Wheelchair) 11/29/2024 - 151.2 lbs. (Standing) Weekly weights were not performed and/or not documented in R8's Electronic Medical Record (EMR) for the weeks of 11/15/2024 and 11/22/2024. During an interview on 12/6/24 at 10:47 p.m., the Director of Nursing (DON) acknowledged R4 did not have an admission weight performed, R8 had two weeks following admission that their weight was not measured/documented, and R2 had a significant weight loss while in the facility. During an interview on 12/6/2 at 11:44 a.m., when asked about documentation of new admission resident weight monitoring, including R2, R4, and R8, the Nursing Home Administrator stated, More than one person was missing weights (either admission weight or weekly weights).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235552	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103 Based on observation, interview, and record review, the facility failed to ensure the call light communication system was fully operational for 6 Residents (#1, #2, #6, #9, #10, & #11), out of the total population of 46 residents residing in the facility. This deficient practice resulted in residents' inability to utilize the call light system for emergency care needs, delayed provision of care and resident dissatisfaction. Findings include: This deficiency pertains to Intakes MI00146426 & MI00147954 which both alleged the facility call lights were not operational. Resident #2 (R2) Review of Intake MI00147954 revealed; Complainant (F) states the resident call light also wasn't working (on 10/1/24) . between 10/7/24 and 10/11/24 the resident's (R2's) call light still wasn't working . during a visit with the resident [Complainant F] pressed [R2's] call button because they needed to have a bowel movement and needed help getting to the bathroom. The complainant states no one was responding so [Complainant F] went into the hallway and found the light wasn't coming on. The complainant states the resident ended up having their bowel movement in their brief . During an interview on 12/2/24 at 4:19 p.m., Complainant F stated, The call light was not operational [for Resident #2 (R2)] the same night the DON (Director of Nursing) came into the building. [The DON] went and got another cable (that plugged into the wall/call light)and plugged it in and (then) it was working. Later . that week the call light was not working again . During an interview on 12/3/24 at approximately 2:30 p.m., when asked if R2's call light had been found not working on 10/1/24 the DON acknowledged they had been in the building and tested the call light and found that it was not working. The DON stated, I pushed the call light (for R2), and it did not go on. I got a replacement cord and then verified that it worked before I left. Resident #1 (R1) During an interview on 12/3/24 at 1:35 p.m., when asked about call lights, R1 stated, At one time if the call light in the bathroom was on, then the main call light in the room (by the bed) wouldn't work. One time the call light itself burnt out . During an interview on 12/3/24 at 1:52 p.m., Certified Nurse Aide (CNA) E stated there were, .Occasionally problems with call light functionality (working properly). During an interview on 12/5/24 at 11:10 a.m., Registered Nurse (RN) H was asked about functionality of the call light system. RN H stated, Resident's complain, and I am aware that there have been times that call lights don't work. I tried them (call lights), and they don't work and then they have to be changed. The cords get frayed, or the [NAME] are messed up or the bulbs on the outside of the door are messed up. Resident #6 (R6), Resident #9 (R9), Resident #10 R10), Resident #11 (R11) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235552	A. Building B. Wing	12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Hancock	1400 Poplar St Hancock, MI 49930

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observations of call lights on 12/5/24 between 12:05 p.m. and 1:28 p.m., revealed the following call lights for four beds were not functioning for the following Residents: R6, Bed B, not working. R9, Bed A, not working. R10, Bed B, not working. R11, Bed A, not working. During an interview on 12/5/24 at approximately 1:05 p.m., when in the process of room observation of call light functionality, the Nursing Home Administrator (NHA) stated, It is almost like the whole system needs to be replaced. [Resident R9] did have his call light replaced not long ago . The NHA said they completed call light audits, and everything seems to be working, or they will replace the non-functional call light cords, and then randomly the call lights will continue to be non-functional with no apparent pattern.