

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235290	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/09/2026
NAME OF PROVIDER OR SUPPLIER Mission Point Nursing & Physical Rehabilitation Ce		STREET ADDRESS, CITY, STATE, ZIP CODE 828 East Washington Street Greenville, MI 48838	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility, failed to ensure food stored in the kitchen coolers and a pantry refrigerator were labeled and dated in accordance with the facility food safety policy. Findings include: On 06/7/2026 at 8:20 AM an initial tour of the kitchen was conducted with Dietary Manager (DM) U. During the tour, a review was conducted of the reach-in cooler to the left of the microwave oven. A large, opened container of cottage cheese that was undated when opened was observed. Review of the reach-in cooler to the right of the microwave revealed: a metal container of chopped vegetables that was undated, a bag of shelled raw eggs that was undated, and a 2-quart pitcher, approximately one third full, of a red liquid that was unlabeled or dated. DM U reported the red liquid was a dietary supplement for a resident that had discharged. DM U later reported that the resident was still in the facility but was no longer consuming the supplement. The policy provided by the facility titled Food Safety Requirements last revised 11/1/2025 was reviewed. The policy reflected, .It is the policy of this facility.(that) Food will also be stored.in accordance with professional standards for food safety. The policy further reflected 3.c, iv. Labeling, dating, and monitoring refrigerated food, including but not limited to leftovers, so it is used by it's used-by date, or frozen/discarded. This indicated that stored food was to be labeled with a known opened date so a discard date could be calculated. On 6/7/2026 at 8:45 AM, a review of the North /South pantry refrigerator revealed a plastic bag of ham dated 6/2 with a first name of a resident on it. The policy provided by the facility titled Use and Storage of Food Brought in by Family or Visitors , implemented 4/1/2026, was reviewed. The policy reflected Policy: It is the right of the residents of this facility to have food brought in by family or other visitors, however, the food must be handled in a way to ensure the safety of the resident. The policy further reflected 2.a. The facility may refrigerate labeled and dated prepared items in the nourishment refrigerator . c. If not consumed within 3 days, food will be thrown away by facility staff. This indicated that facility staff had not monitored the North/South pantry refrigerator for food safety where resident food was stored past the 3 days as directed by policy.		

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed 1) ensure proper usage of enhanced barrier precautions (EBP), 2) ensure proper infection control practice during wound treatment, and 3) ensure proper hygiene during medication administration. Findings include: Enhanced Barrier Precautions R11 Review of a Face Sheet revealed R11 admitted to the facility on [DATE] with pertinent diagnoses which included obstructive uropathy (a blockage in your urinary system that prevents urine from flowing normally) and pressure ulcer of right buttock. Review of a current Care Plan focus for R11, initiated 12/24/2025, revealed .I require enhanced barrier precautions d/t (due to) increased risk of MDRO (multidrug-resistant organism) acquisition due (to) Foley catheter. Further review revealed the following intervention initiated 12/24/2025, .Gown/Gloves should be worn during high-contact resident care activities (Dressing, Bathing, Transferring, Hygiene, Linen changes, Toileting/Brief changes, device or wound care) . In an observation on 6/7/2026 at 11:32 AM in R11's room, R11 had a Foley catheter in place with no signage on his door directing staff that he required the use of EBP. In an observation and interview on 6/8/2026 at 11:30 AM in R11's room, Licensed Practical Nurse (LPN) A donned gloves but no gown prior to pulling down his brief to observe the skin on his buttocks. After she was finished, LPN A reported she should have used a gown as R11 was in EBP and by handling his brief she was providing personal care. Review of facility policy/procedure Enhanced Barrier Precautions, revised in March of 2024, revealed .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities. Wound Treatment Review of a Face Sheet revealed R7 originally admitted to the facility on [DATE] and currently has a pertinent diagnosis of a stage III pressure ulcer. During an observation and an interview on 6/7/26, Licensed Practical Nurse (LPN) S provided wound care for R7 while the fan was blowing in the room at the resident. LPN S was observed not performing hand hygiene after doffing gloves and donning new gloves a few times during the dressing change. When questioned about the fan and the hand hygiene after the dressing change was completed, LPN S reported she should have had the fan off and performed hand hygiene between glove changes. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication Administration During a medication administration observation on 6/8/26 at 7:16 AM at the East Hall med cart, Registered Nurse (RN) K was observed pouring R81's morning medication pack into a medication cup. Two of the 3 medications spilled out onto the medication cart. RN K picked up the spilled medications with her fingers and placed them in the medication cup. RN K provided these medications to R81. After RN K provided the medications, she was asked what she should do when she spills medication on the cart and she responded she should have picked them up with a spoon. When asked if the papers and part of cart the pills landed on were a clean surface, she responded no, I should have wasted them and provided new medications. During an interview with the facility Infection Preventionist (IP) R on 6/9/26 at 10:30 AM, the surveyor reported the infection control concern with the medication pass on 6/8/26. The IP R confirmed it is an infection control issue, and she is working on a root cause and will be doing staff education. In a medication observation on 6/8/2026 at 7:29 AM in room [ROOM NUMBER]-2, Registered Nurse (RN) T was observed removing a fluticasone nasal spray (prescribed to relieve allergy symptoms) and a Flonase inhaler (used to prevent asthma) from the medication cart. RN T proceeded to enter the R67's room and place both medication boxes onto the overbed stand. RN T did not sanitize the overbed stand or use a barrier prior to placing the medication boxes. RN T administered R67's medications and proceeded to place both boxes of medications back into the medication cart. In an interview on 6/8/2026 at 7:34 AM, RN T stated he does not normally use a barrier when administering those medications. In an interview on 6/8/2026 at 12:07 PM, the Director of Nursing (DON) was informed of the medication observation regarding RN T not utilizing a barrier for the two boxes of medications in a R67's room. The DON reported a barrier should have been used. Review of facility policy/procedure Medication Administration, reviewed 1/17/2023, revealed . Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to document rationale for two residents (R4 and R9) of five residents reviewed for unnecessary medications to extend as needed (PRN) psychotropic medication beyond 14 days. Findings include: R4 Review of R4's Face Sheet dated 6/9/26 revealed he was admitted to the facility on [DATE] and had diagnoses that included: schizoaffective disorder, major depressive disorder, and generalized anxiety disorder. R4 was not his own responsible party. Review of R4's, Note to Attending Physician/Prescriber dated 1/13/26 revealed, PRN Lorazepam, Per federal LTC (Long Term Care) regulations, if the above PRN anxiolytic order is to continue for longer than 14 days, intended duration and rationale to support use should be documented. The physician/prescriber Response was marked Agree and noted, note placed on 1/20/26. Review of R4's current medication orders dated 6/9/26 revealed, Lorazepam Oral Tablet 0.5 mg *Controlled Drug* Give 1 tablet by mouth every 8 hours as needed for agitation, anxiety, restlessness. Start date 11/14/25 and no stop date. Review of R4's Practitioner Progress Notes dated 1/20/26 at 13:33 (1:33 PM) revealed, Patient follows with (name of psychiatric services) who is helping with psychiatric medication management. He continues on Buspar TID (3 times a day) and has PRN (as needed) Ativan (brand name for Lorazepam) available without end date. (No medical documentation of duration of use or necessity for ongoing use was provided). Review of R4's Order Audit Report dated 6/9/26 revealed, Lorazepam Oral Tablet 0.5 MG was last ordered on 11/14/25. (Requires reordering every 14 days or assessment of ongoing need every 14 days). During an interview with the Director of Nursing (DON) on 6/9/26 at 12:14 PM, she was made aware of the documentation that revealed R4's Practitioner was ordering Lorazepam ongoing past 14 days. The DON confirmed the documentation and provided no additional documentation. R9 Review of a Face Sheet revealed R9 admitted to the facility on [DATE] with pertinent diagnoses which included alcoholic cirrhosis of the liver, dementia, and adult failure to thrive. Review of R9's Physician Orders revealed an active order dated 4/3/2026 for ativan (used to treat anxiety) 0.5 milligrams (mg) one tablet every six hours as needed for anxiety and agitation with no stop date. Upon further review of R9's Physician Orders revealed and active order dated 4/27/26 for a (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	gel that contained Ativan 1 mg, Benadryl (used to treat allergies) 50 mg, and haldol (used to treat acute agitation and behaviors) 2 mg every 6 hours as needed for agitation with no stop date. In an interview and record review on 6/9/2026 at 10:31 AM, the Director of Nursing (DON) was unable to find documentation that the medical provider had documented rationale and risk versus benefit to extend the order beyond 14 days for R9. In an interview on 6/9/2026 at 10:40 AM, the Nurse Practitioner (NP) Q reported that she was unaware that she was required to document rationale and duration for PRN psychotropic medication orders beyond 14 days. Review of facility policy/procedure Behavior Management Program revised 12/20, revealed . PRN (as needed) orders for psychotropic medications are limited to 14 days. If the prescribing practitioner believes it is appropriate for the order to be extended beyond 14 days, then he/she should document their rationale in the medical record and indicate the duration for the order.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to pass medications per physician orders for 1 Resident (R4) of 5 residents reviewed for pharmacy review. Findings included: Review of R4's Face Sheet dated 6/9/26 revealed he was admitted to the facility on [DATE] and had diagnoses that included: schizoaffective disorder, major depressive disorder, and generalized anxiety disorder. R4 was not his own responsible party. Review of R4's active order start date 11/14/25 for Midodrine HCL (powerful medication that constricts blood vessels, which rapidly elevates blood pressure) revealed, Midodrine HCL Oral Tablet 5 MG, Give 1 tablet by mouth two times a day for orthostatic hypotension Hold if SBP (systolic blood pressure), (sign for greater than) 130. Review of R4's blood pressure log for the last 90 days, run date 6/9/26 around noon, revealed R4 only had 23 recorded blood pressures taken in the last 90 days. R4 had 4 blood pressures that had a SBP above 130. The blood pressures with SBP above 130 were dated 6/7/26 at 20:12 (9:12 PM), 6/6/26 at 15:10 (3:10 PM), 6/6/26 at 7:01 AM, 6/5/26 at 15:11 (3:11 PM). See June 2026 Medication Administration Record, R4 was provided Midodrine on these dates. Review of R4's, Medication Administration Record (MAR) dated 6/1/26 - 6/30/26 revealed, Midodrine HCL oral Tablet 5 mg give 1 tablet by mouth two times a day for orthostatic hypotension Hold if SBP (sign for greater than) 130. The boxes were completed to show R4 had been given this medication two times a day from June 1 to June 8 and one dose was provided on June 9. The MAR did not indicate the time of day this medication was provided and did not show R4's blood pressure was taken prior to giving this medication. During an interview with the Director of Nursing (DON) on 6/9/26 at 12:14 PM, the DON reviewed R4's physician orders and documentation related Midodrine and confirmed staff were not documenting taking R4's blood pressure prior to administration of Midodrine.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to supply clean oxygen tubing for one resident (R58) of 4 residents reviewed for oxygen therapy. Findings include: Review of a Face Sheet revealed R58 was initially admitted to the facility on [DATE] with pertinent diagnoses which included chronic obstructive pulmonary disease (progressive lung condition that restricts airflow), chronic respiratory failure, and Alzheimer's disease. During an observation on 6/7/2026 at 8:30 AM in R58's room, R58's oxygen tubing (tubing that connects an oxygen source to a person) was brown in color and appeared dirty. Further review of R58's oxygen tubing revealed white tape wrapped around the tubing dated 3/30/2026. Review of an Order Summary on 6/7/2026 at 8:45 AM for R58 revealed no active order for oxygen tubing to be changed. During an interview and record review on 6/9/2026 at 8:38 AM, Registered Nurse Unit Manager (RN/UM) F reported that R58's oxygen tubing should have been changed every week on Sundays. RN/UM F reported there was not an active order for R58's oxygen tubing to be changed until 6/8/2026. Review of facility policy/procedure Oxygen Administration and Concentrator Policy, reviewed 6/2023, revealed .change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated and document in the electronic health record.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely follow up for the monthly drug regimen review recommendations for 2 residents (R4 and R9) of 5 residents reviewed for unnecessary medication. Findings include: R4 Review of R4's face sheet dated 6/9/26, revealed he was admitted to the facility on [DATE] and had diagnoses that included: schizoaffective disorder, major depressive disorder, and generalized anxiety disorder. R4 was not his own responsible party. Review of R4's monthly pharmacy progress notes revealed that the pharmacy identified potential irregularities on 3/8/26, 1/13/26, 12/2/26, 11/11/25, and 10/8/25. Review of R4's Electronic Medical Record (EMR) reviewed no documentation related to the details of the irregularities, the physician being aware of what the irregularities were or had addressed the pharmacy concerns. During an interview with the Director of Nursing (DON) on 6/9/26 at 12:14 PM, R4's pharmacy progress notes were reviewed with the DON. A request was made for the irregularity notes for 12/2/26, 11/11/25 and 10/8/25. The DON said the facility had identified they had a problem with Pharmacy Irregularity documentation in December 2025 and she would not have any additional information for pharmacy irregularities for those dates. R9 Review of a Face Sheet revealed R9 admitted to the facility on [DATE] with pertinent diagnoses which included alcoholic cirrhosis of the liver, dementia, and adult failure to thrive. Review of R9's Note to Attending Physician/Prescriber dated 3/6/2026 revealed .PRN (as needed) Lorazepam (used to treat anxiety), per federal LTC (Long Term Care) regulations, if the PRN anxiolytic (used to treat anxiety) order is to continue for longer than 14 days, intended duration and rationale to support use should be documented. Upon further review a second Note to Attending Physician/Prescriber dated 3/5/2026 revealed if the as needed anxiolytic/antipsychotic (used to treat acute agitation and behaviors) order is to continue for longer than 14 days, intended duration and rationale to support use should be documented. Both recommendations had no response from the physician documented. Review of R9's Physician Orders revealed an active order dated 4/3/2026 for lorazepam 0.5 milligrams (mg) one tablet every six hours as needed for anxiety and agitation with no discontinuation date. Upon further review of R9's Physician Orders revealed an active order dated 4/27/26 for a gel that contained Ativan 1 mg, Benadryl (used to treat allergies) 50 mg, and haldol (used to treat acute agitation and behaviors) 2 mg every 6 hours as needed for agitation with no discontinuation date. (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/9/2026 at 10:31 AM, the Director of Nursing (DON) reported R9's two Note to Attending Physician/Prescriber recommendations dated 3/5/2026 had not been reviewed by the physician. The DON reported that the recommendations were not addressed. Review of facility policy/procedure Medication Regimen Review, reviewed 1/24, revealed .Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication.the MRR includes: Review of the medical record in order to prevent, identify, report, and resolve medication- related problems, medication errors, or other irregularities. Collaboration with other members of the interdisciplinary team, including the resident, their family, and/or resident representative. facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure complete and accurate medical record documentation of a change of condition that resulted in a transfer to a hospital for one resident (R1) of two residents reviewed for hospitalization. Findings include: Review of the Electronic Medical Record (EMR) revealed R1 was admitted to the facility 2/25/2025 with pertinent diagnoses that included chronic respiratory failure and dependence on a ventilator. Review of the EMR for R1 reflected a Progress Note entry dated 2/2/2026 at 11:15 PM that Resident was transferred. Sent To: (Name of hospital) 2/2/2026 at 21:37 (9:37 PM) Sent From: (name of facility) Reason(s) for Transfer: Abnormal Pulse Oximetry (low oxygen concentration) . The Progress Notes did not reveal documentation of an assessment or findings that described a change of condition that required an emergency transfer to the hospital. Review of the EMR for R1 reflected a Doctor's Order, Oxygen.maintain SPO2 (pulse oximetry) greater than 92%. This indicated that a pulse oximetry result greater than 92% was considered normal. Review of the EMR historical O2 Sat Summary (oxygen saturation) for R1 revealed: 2/2/2026 at 3:59 PM 99% oxygen saturation. On 2/2/2026 at 6:00 PM 93% oxygen saturation, 2/2/2026 at 7:00 PM 93% oxygen saturation. No further oxygen concentration results were documented until 2/10/2026. Review of the EMR historical Assessment section for R1 did not reveal a nursing assessment has been documented on 2/2/2026. The Assessment section did reflect a Transfer to Hospital form dated 2/2/2026. Review of the EMR Transfer Form-V5.1 for R1 dated 2/2/2026 at 11:15 PM reflected Description: Transfer to Hospital. The Reason for Transfer is documented as Abnormal Pulse Oximetry. No other documentation was identified on this form or elsewhere in the EMR that described the signs, symptoms, findings, or other assessments that indicated a change of condition warranted an acute care evaluation. During an interview on 6/8/2026 at 11:46 AM, Unit Manager Registered Nurse (UM RN) G was informed that documented change-of-condition findings resulting in a transfer to the hospital were not identified in the EMR of R1. UM RN G reported a review of the EMR of R1 and a follow up would be conducted. During an interview on 6/9/2026 at 2:09 PM, the Nursing Home Administrator (NHA) was informed additional information was anticipated from UM RN G regarding the transfer of R1 to the hospital on 2/2/2026. The NHA reported that this had been deferred to the Director of Nursing (DON). During an interview conducted 6/9/2026 at 2:12 PM, the DON reported no additional information was found regarding the reason R1 was sent to the hospital on 2/2/2026. The DON reported she had contacted the transferring nurse, and no additional information had been obtained.		