STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235355	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehab Center of L	13030 Commerical Street Lamont, MI 49430

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement its Infection Control and Prevention policies and procedures during resident care and medication administration and have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), resulting in the potential for increased risk of respiratory infection among all residents in the facility. Findings include: During an observation of medication administration beginning at 8:15 AM on 12/15/2025, Registered Nurse (RN) D was met at the medication cart on the east hall of the facility. An uncovered plastic cup of yellow carbonated liquid was observed to the right of the computer. An uncovered cup of clear liquid was observed to the left of the computer screen. When asked, RN D said the yellow liquid was their personal drink and that the other uncovered cup of clear liquid was water she had poured for another resident who was not yet ready for their medications. During an observation of medication administration on 12/15/2025 at 8:30 AM, RN D entered Resident #8's (R8), who required Enhanced Barrier Precautions (EBP), room and proceeded to remove a lidocaine patch from R8's back, apply a new lidocaine patch and administer medications without donning gloves or a gown for the high contact (patch removal and application) resident interaction. RN D then discarded the uncovered plastic cup containing yellow liquid in the adjacent shower room. RN D did not discard the uncovered cup of clear liquid intended for another resident. During an observation of medication administration for on 12/15/2025 at 8:40 AM, RN D gathered prescribed medications for Resident #27 (R27). As RN D was pushing a capsule of pantoprazole 40 milligram (MG) from a blister pack, the medication dropped onto the medication cart rather than into a plastic medication cup and RN D picked up the medication with bare hands and placed it in the medication cup. After administering the morning doses of medication to R27, RN D went back to the medication cart to obtain a piece of 2 MG Nicotine gum as requested by R27. Again, RN D pressed the prescribed dose of medication from a blister package, the piece of nicotine gum landed on the medication cart rather than in the medication cup and RN D used her bare hands to pick up the dose and place it in the medication cup. During an observation of incontinence care on 12/15/2025 at 2:22 PM, Resident #16 (R16) was lying in bed and required a brief change and perineal cleansing. Certified Nurse Aides (CNAs) I and J donned appropriate PPE and provided appropriate perineal care for R27. Throughout the process, both CNA's were observed changing gloves but did not implement hand hygiene between glove changes (the use of alcohol-based hand sanitizer or soap and water). Once the CNA's completed cares for R16, they proceeded to adjust the linens, utilize bed controls, open dresser drawers to replace supplies and recap supplies with soiled gloves. Review of the facility policy and procedure for Enhanced Barrier Precautions, dated 3/2024 reflects It (continued on next page)

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 - Many	is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (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. Review of the facility policy and procedure for Hand Hygiene dated 3/2024 reflected All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. Hand hygiene is a general term for cleaning your hands by handwashing with soap and water or the use of an antiseptic hand rub, also known as alcohol-based hand rub (ABHR). The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. On 12/14/2025 at 11:01AM, observed in the Soiled Utility room on East Hall, hopper in the soiled utility rooms, has a cold-water line that cannot be turned on at the faucet by hand. On 12/15/2025 at 8:35AM, Environmental Manager (EM) L says the lines for the hopper are not on the schedule for routine flushing and he is unsure if hopper is used routinely. The facility's Water Management Plan states water lines not in use are flushed weekly. On 12/14/2025 at 11:10AM, the East Hall Housekeeping Closet has a spigot with hot and cold-water lines, at the time the hot water handle was turned on, brown water came out of the spigot. 12/15/2025 at 8:40AM, interview with EM L indicates the spigot in the Housekeeping Closet is not in use and the water lines are not flushed weekly.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain general cleanliness and repair of staff access only areas and residents living areas. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living, among all the residents in the facility.Findings include: On 12/14/2025 at 10:58 AM, observed, in the Resident Care Supply room, the condenser cover of ice machine had a buildup of debris on the surface. On 12/15/2025 at 8:25AM, walkthrough of building with Environmental Manager (EM) L, during discussion regarding cleaning schedule EM L stated that their TELLs system automatically reminds his department of continuous cleaning and maintenance schedules, ice machine is scheduled to be wiped down monthly by housekeeping personnel. On 12/14/2025 at 11:01AM, observation of hopper in the Soiled Utility room on East Hall, the hopper had a buildup of brown film on the interior, the film was partially dislodged when sprayed with water. On 12/15/2025 EM L indicated cleaning of the hopper was a responsibility of the Housekeeping Department. On 12/15/2025 at 12:45PM, observed ventilation cover for the vent in the shared restroom, for rooms [ROOM NUMBERS], was not flush with ceiling, allowing an opening of over a half inch between the ceiling and vent cover. At that time, it was also noticed that the fan was operating and creating loud noise and could be heard in room [ROOM NUMBER] with the door to the restroom closed. EM L when asked, was unaware of the issue with the vent cover or the noise level of the fan when operating.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for one (Resident #10) of seven resident's reviewed for call light placement. Findings:Resident #10 (R10)Review of an admission Record revealed R10 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses of anoxic (lack of oxygen) brain damage, unsteadiness on feet, muscle weakness, and adjustment disorder with anxiety. R10 required assistance from 1 staff person for most ADL's (activities of daily living).During an observation on 12/14/25 at 9:36 AM, R10 sat up in bed awake and stated that he did not know where his call light was. The call light laid on top of the heat vent, almost to the floor, between the wall and the resident's bed out of sight and out of reach. During an observation on 12/14/25 at 11:40 AM, the floor nurse went into R10's room and brought in his medications. After the nurse finished and exited R10's room, the call light remained on the vent between the bed and the wall, out of sight and out of reach of R10. During an observation on 12/14/25 at 1:41PM R10 laid in bed resting with his eyes closed. The call light remained on the vent between the bed and the wall out of sight and out of reach of the resident. During an observation on 12/15/25 at 8:30 AM, R10 laid in bed with his eyes open. The call light laid on the vent, near the floor, between the bed and wall out of sight and out of reach of R10. R10 stated no he had not had access to his call light throughout the night. R10 then stated that if he had needed something he would have had to yell for staff. When asked if R10 felt sure that staff would hear him yelling, he reported that he was not sure because his room was at the end of hall.Review of a safety Care Plan for R10 reflected the following intervention .be sure my call light is within reach.During an interview on 12/16/25 at 10:23 AM, Certified Nurse Aide (CNA) C indicated that staff check call light placement in each room with every 2 hour check.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure licensed nurses followed The Five Rights (Right Resident, Right Drug, Right Dose, Right Route, and Right Time) of medication administration in accordance with professional standards for 2 residents (R8 and R27) out of 3 residents observed during medication administration. Findings Include: During an observation on 12/15/2025 at 8:20 AM, Registered Nurse (RN) D prepared medications for R8 including Lidocaine External Patch 4% (Lidocaine) and Cranberry Oral Tablet 500 MG (milligram) (Cranberry (Vaccinium macrocarpon)) Give 2 tablets by mouth in the morning for UTI (urinary tract infection) prevention. RN D discovered the only dosage form of the Cranberry supplement prescribed for R8 available in the facility was a 450 MG tablet, not the 500 MG dosage ordered. RN D reported she would obtain a clarification order from the prescriber before administering a dose lower than prescribed. During the same medication administration observation on 12/15/2025 at 8:30 AM, RN D discovered a Lidocaine patch was already present on R8's back. The Lidocaine patch did not have a date or nurse initials indicating when the patch was applied or by whom. RN D said she did not believe the resident was to wear the patch overnight and reported the concern to the Assistant Director of Nursing (ADON) K. During an interview on 12/15/2025 at approximately 8:35 AM, ADON K reported that she had contacted the physician who confirmed R8 was to wear the lidocaine patch during the day and remove it at night. During an observation on 12/15/2025 at 8:40 AM, RN D prepared medications for R27 which included Sertraline HCl (Hydrochloride) Tablet 100 MG, Give 200 MG by mouth in the morning for depression. RN D discovered the prescription medication was not available in the medication cart. ADON K was nearby and said it was available in the backup supply of medications in the medication room. As RN D was walking toward R27's room to administer the other medications ordered for R27, ADON K handed RN D a medication cup that allegedly contained 4 (four) 50 MG tablets of Sertraline HCl. RN D did not witness ADON K obtain the medication from the backup supply and did not verify the tablets were indeed the right dose of the right drug for the right patient. RN D proceeded to administer medications to R27, including the unverified antidepressant.On 12/15/2025 at 10:30 AM, Central Supply Clerk N reported she was in charge of ordering supplies for the facility, reviewed the supplier's ordering details online, and confirmed the facility had never stocked the cranberry supplement in a 500 MG dose. Review of R8's Medication Administration Record (MAR) for the month of December 2025 reflected that a licensed nurse documented the Lidocaine patch had been removed on 12/14/2025, despite the discovery of a lidocaine patch in place the morning of 12/15/2025. The MAR also reflected licensed nurses had been documenting the administration of Cranberry Oral Tablet 500 MG (milligram) (Cranberry (Vaccinium macrocarpon)) Give 2 tablets by mouth in the morning for UTI (urinary tract infection) prevention, every day in December 2025, despite the Right dose was never available in the facility. Review of R27's MAR for the month of December 2025 reflected RN D documented she administered Sertraline HCl (Hydrochloride) Tablet 100 MG, give 200 MG by mouth in the morning for depression, despite not conducting the Five Rights of medication administration. During an interview on 12/15/2025 at 2:44 PM, the Director of Nursing (DON) reported that licensed nurses are expected to adhere to professional standards during medication administration. The DON reported that an audit of residents who were prescribed Cranberry Oral Tablet 500 MG revealed that 5 (five) residents had been receiving doses lower than prescribed. The DON also reported that the ADON K and RN D did not adhere to professional standards of medication administration related to R27's prescription antidepressant. Review of the facility policy Medication Administration - General Guidelines dated June 2019 reflected Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. The policy also specified 3) The Five Rights (Right Resident, Right Drug, Right Dose, Right Route, and Right Time) are applied for each medication being administered. A triple check of these Five Rights is recommended at three steps in the process of preparation of a medication for administration:a. When the medication (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is selected, the label, container, and contents are checked for integrity and compared against the Medication Administration Record (MAR) by reviewing the Five Rights.b. When the dose is removed from the container, it is verified against the label and the MAR by reviewing the Five Rights.c. Immediately after the dose is prepared and the medication is put away, the label is reverified against the MAR by reviewing the Five Rights.4) If the medication and/or dosage schedule on the label and the MAR are different, and the container has not already been flagged indicating a change in directions, or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule. When a medication order is changed, and the current supply may continue to be used, the container should be flagged, and the order change must be communicated to (name of pharmacy) so that the next supply of the medication is labeled with the current directions.The Medication Administration - General Guidelines policy also specified The person who prepares the dose for administration is the person who administers the dose. The nurse who administers the medication records the administration on the resident's MAR immediately after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. In no case should the nurse who administered the medications report off-duty without first recording the administration of all medications.