STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235357	A. Building B. Wing	06/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	414 E State Street Belding, MI 48809

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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 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 interview and record review, the facility failed to adequately monitor laboratory values and ensure the resident representative was involved with treatment decisions for 3 residents (Residents #58, #90, and #16) out of 21 residents reviewed for unnecessary medication.Findings Include;Review of the FDA prescribing information for Clozaril revealed, Severe Neutropenia CLOZARIL treatment has caused severe neutropenia, defined as an absolute neutrophil count (ANC) less than 500/uL. Severe neutropenia can lead to serious infection and death.Recommended Frequency of ANC Testing During CLOZARIL Treatment-Day 1 to Month 6: WeeklyMonth 7 to Month 12: Every 2 weeksMonth 13 and thereafter: Every month (if ANC continues to remain in the normal range)Resident #58 (R58)Review of an admission Record revealed R58 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: schizoaffective disorder.Review of R58's Order Summary dated 3/16/24 revealed, Clozaril Oral Tablet 50 MG (Clozapine) Give 1 tablet by mouth two times a day for schizoaffective disorder Give with 200mg tab = 250mg AND cloZAPine Oral Tablet 200 MG (Clozapine) Give 1 tablet by mouth two times a day for schizoaffective disorder Give with 50mg tab = 250mg.Review of R58's Monthly Medication Review dated 11/20/24 revealed, Due to potential for severe adverse drug reaction, it is recommended to monitor ANC (absolute neutrophil count) every 4 weeks during maintenance therapy with clozapine. If not already being done, please obtain CBC (complete blood count) monthly.Review of R58's Monthly Medication Review dated 2/27/26 revealed, This resident has several standing order labs on record including.CBC.During review of his electronic health record, I was unable to locate recent results.Review of R58's Psychiatry Initial Evaluation dated 5/14/26 revealed, .Recommend monthly CBC with differential for clozapine monitoring.During an interview via email on 5/27/26 at 3:47 PM a request for the last 6 months of R58's laboratory testing results was requested. On 5/28/26 at 8:32 AM the Nursing Home Administrator (NHA) reported there were 2 lab reports dated 3/9/26 and 5/11/26.Resident #90 (R90)Review of an admission Record revealed R90 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: schizoaffective disorder.Review of R90's Order Summary dated 1/30/25 revealed, Clozaril Oral Tablet 200 MG (Clozapine) Give 1 tablet by mouth two times a day for Schizophrenia.Review of R90's Psychiatry Follow up dated 12/17/25 revealed, Recommend continue regular interval lab draws of CBC. Review of R90's Psychiatry Follow up dated 4/15/26 revealed, .Recommend updated CBC with differential for Clozaril. Patient would benefit from updated CMP.During an interview via email on 5/27/26 at 3:47 PM a request for the last 6 months of R90's laboratory testing results was requested. On 5/28/26 at 8:32 AM the NHA reported there were 3 lab reports. 2 were dated 12/2/25 and 1 was dated 5/11/26.During an interview on 6/1/26 at 12:43 PM, the Director of Nursing (DON) reported the behavioral management team follows the providers orders, the psychiatric providers recommendations, and the pharmacist recommendations regarding laboratory testing for residents on Clozaril and confirmed R58 and R90 did not have monthly laboratory testing ordered.During an interview on 6/1/26 at 1:12 PM, Social Services Advocate (SSA) I reported the unit manager would be responsible for obtaining labs for Clozaril if they were (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	required.Resident #16 (R16)Review of an admission Record revealed R16 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: psychotic disorder with hallucinations. Further review of the record revealed R16 had a guardian and was not his own decision maker.Review of R16's Order Summary dated 4/1/26 revealed, Abilify Oral Tablet 2 MG (Aripiprazole) Give 2 mg by mouth one time a day for psychotic disturbance GDR per (psychiatric consultant) recommendation.Review of R16's Psychiatry Follow up dated 2/24/26 revealed, .Patient is currently undergoing GDR of Abilify, currently tolerating 5 mg dose, will recommend trial of 2 mg dose.Review of R16's Progress Note dated 5/1/26 revealed, Abilify dose was reduced from 5 mg to 2 mg daily on 02/26/2026, after which behavioral symptoms increased.Review of R16's Electronic Medical Record (EMR) revealed no documentation that R16's guardian participated in the decision to continue with the GDR (gradual dose reduction) of abilify or that she was notified of the dose decrease in February 2026.During an interview on 6/1/26 at 1:12 PM, SSA I reported that the behavioral management team met monthly to review residents receiving psychotropic medications. If the psychiatric consultant recommended a GDR it was discussed as a team and did not automatically result in an attempted GDR if the behavior management team felt it was not safe and/or appropriate for the resident. SSA I reported the resident's guardian would be notified of the gradual dose reduction by the behavior management team.During an interview on 6/1/26 at 1:44 PM, Unit Manager (UM) H reported the resident's guardian is not notified of a dose change in medication further reporting that the guardian would be notified of the initiation of a medication and the discontinuation of the medication stating the facility staff don't have to get consent to change the dose of medications. UM H was asked if the residents guardian/representative was involved with the process to GDR a medication and if the decision to forego a dose decrease by the guardian/representative would be honored. UM H stated the facility (didn't) have a choice, CMS says we have to (complete a GDR on psychotropic medications). SSA I clarified that the behavior management team did not force dose reductions but would ask that they try (the GDR).During an interview via email on 6/1/26 at 2:09 PM, the DON stated, I do not see documentation of notification in the chart for the second GDR for (R16) in February.Review of the facility policy, Behavior Management Program last reviewed/revised June 2023 revealed, .d. As part of the least restrictive environment for each resident, gradual dose reductions will be attempted per the most current guidelines .Review of the State Operations Manual revealed In accordance with the requirements at S483.10(c), residents have the right to be informed of and participate in their treatment. Prior to initiating or increasing a medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, in advance of such initatiation or increase. The resident has the right to accept or decline the initiation or increase of a medication. To demonstrate compliance, the resident's medical record must include documentation that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options and was able to choose the option he or she preferred .Medication management is based in the care process and includes recognition or identification of the problem/need, assessment, diagnosis/cause identification, management/treatment, monitoring, and revising interventions, in accordance with S483.45(d)(3) and (d)(5), as well as documenting medication management steps. Monitoring and accurate documentation of the resident's response to any treatment (such as, lab results, vital signs, progress notes, behavior flow sheets, medication administration records and the consultant pharmacist's drug regimen review) is essential to evaluate the ongoing effectiveness, benefits as well as risks of non-pharmacological approaches and psychotropic medications .One of the existing mechanisms to warn prescribers about risks associated with medications is the Food and Drug Administration (FDA) requirement that manufacturers include warnings about adverse reactions and potential safety hazards identified both before and after approval of a medication, and what to do if they occur (Visit: https://www.fda.gov/safety/medwatch-fda-safety-information-and-adverse-event-reporting-program (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or search for FDA Safety Alerts for Human Medical Products. Manufacturers are required to place statements about serious problems or contraindications in a prominently displayed box (black box) in the medication labelling. The boxed warning is reserved for prescription drugs that pose a significant risk of serious or life-threatening adverse effects, based on medical studies.Review of the FDA Drug Safety Communication dated 8/27/25 revealed, Based on FDA's re-evaluation of the Clozapine REMS and on the November 19, 2024 Joint Meeting of the Drug Safety and Risk Management Advisory Committee and the Psychopharmacologic Drugs Advisory Committee, the Agency determined that the REMS was no longer necessary to ensure the benefits of clozapine outweigh the risk of severe neutropenia. Although there remains a risk of severe neutropenia with clozapine use, clozapine labeling (including a new Medication Guide) is sufficient to mitigate this risk and maintain a positive benefit/risk profile. ANC monitoring can help identify neutropenia early to allow for timely intervention. Therefore, prescribers should continue to monitor patients' ANC according to the monitoring frequencies described in the prescribing information. (https://www.fda.gov/drugs/drug-safety-communications/fda-removes-risk-evaluation-and-mitigation-strategy-r

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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 ensure medications were administered and assessments were completed in accordance with physician orders for 2 of 21 residents (Resident #15 and #16), reviewed for nursing professional standards of practice.Findings:Resident #15 (R15)Review of an admission Record revealed R15 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: chronic pain.Review of R15's Order Summary dated 3/26/26 revealed, traMADol HCl Oral Tablet 50 MG Give 1 tablet by mouth three times a day for pain. To be administered at 7:00 AM, 2:00 PM, and 9:00 PM.Review of R15's Controlled Substance Proof of Use Record revealed that on 5/25/26 a dose of tramadol was dispensed at 7:59 AM and at 8:10 PM. The 2:00 PM dose was not documented as dispensed.Review of R15's Medication Administration Record revealed documentation that all 3 doses of tramadol was documented as administered on 5/25/26.During an interview via email on 5/29/2026 at 2:50 PM, the Director of Nursing (DON) stated, On 5/25/26, the nurse did document Tramadol as administered in (electronic medication administration record) for the afternoon administration, but did not sign it out on the controlled substance record and did not administer the medication. Education is being provided to this nurse. Resident #16 (R16)Review of an admission Record revealed R16 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: congestive heart failure.Review of R16's Order Summary dated 4/1/26 revealed, Midodrine HCl Oral Tablet Give 2.5 mg by mouth three times a day for hold for SBP >100 (systolic blood pressure [top number] less than 100) give if diastolic (bottom number) below 50. Review of R16's Blood Pressure Summary and Medication Administration Record revealed:On 4/4/26 R16's blood pressure was 113/65 and the midodrine was administered.On 4/6/26 blood pressure was 111/76 and the midodrine was administered.On 4/22/26 blood pressure was 108/76 and 113/57 and the midodrine was administered.On 5/2/26 blood pressure was 135/69 and the midodrine was administered.On 5/16/26 blood pressure was 115/70 and the midodrine was administered.On 5/21/26 blood pressure was 113/53 and the midodrine was administered.On 5/22/26 blood pressure was 107/55 and the midodrine was administered.During an interview via email on 5/29/2026 at 2:50 PM, the DON stated, (R16's) Midodrine was administered outside of parameters. Discussed with some of the nurses that regularly care for (R16) and initiated education regarding following provider order including risks associated with administration of cardiac medications outside of ordered parameters.Review of the facility policy Medication Administration-General Guidelines dated 9/1/23 revealed, .4. Rights-Right resident, right drug, right dose, right route, right reason, right documentation and right time, are applied for each medication being administered.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure 3 residents (R57, R7 and R13) out of 4 residents reviewed for accidents, had appropriate interventions implemented to avoid accidents.Findings Include:Resident #57 (R57)Review of a Face Sheet reflected R57 admitted to the facility with diagnoses that included Parkinson's disease, dementia and spinal stenosis. During an observation on 5/26/26 at 11:00 AM, Certified Nurse Aide (CNA) F provided incontinent care for R57 without another staff member present to assist with positioning the resident. CNA F was observed rolling R57 away from their body without support at the edge of the bed, placing R57 at risk for rolling off the side of the bed. During an interview on 5/27/26 at 4:15 PM, Licensed Practical Nurse (LPN)/Unit Manager (UM) G reported CNAs are expected to review Kardex (a resident care guide) to identify what level of assistance a resident need. LPN G reported R57's ability to assist with bed mobility varies. It would be her expectation that the resident be pulled toward the staff member for cares and bed mobility, not away. Review of a Care Plan initiated on 4/10/2022 reflected R57 required assistance with Activities of Daily Living (ADLs). Interventions reflected the resident required 2 people for bed mobility, 2 people for transfers, and 1-2 people to assist with toileting needs (interventions initiated on 11/03/2024). If incontinent care is being provided in the bed, two people would be required to move R57 in the bed in order to render care. Resident #7 (R7)During an observation on 5/26/26 at 9:18 AM, R7 laid in bed resting with her eyes open. The call light laid on the floor, on the right side of the bed, out of sight and out of reach of R7.Resident #13 (R13)During an observation on 5/26/26 at 9:30 AM, R13 laid in bed with her eyes open. The call light hung from a plastic hook on the wall, behind and to the right of the resident. The button used to activate the call light laid on a bedside table behind some personal belongings, out of sight and out of reach of the resident. Review of a policy Call Light System revised 12/2020, reflected The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. The policy specified, 5. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed.