STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235511	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Of	1290 East Michigan Highway Roscommon, MI 48653

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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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review the facility failed to maintain general cleanliness and repair of the premises. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living affecting all residents in the facility. Findings include:On 3/9/2026 at 4:17 PM there was an observed lack of hot water at the two hand sinks in the kitchen. The hand sink closest to the maintenance hallway was observed to have hot water at 81 degrees, and the hand sink on the other end of the kitchen closest to the dish machine room was observed at 80 degrees, as registered on a probe thermometer. On 3/9/2026 at 11:35 AM the dish machine room hand sink temperature was recorded at 82 degrees and the sink closest to the maintenance hall at 80 degrees, using a probe thermometer. During this observation, Maintenance Director G stated that the water heater was recently replaced and the mixing valve was turned down too low. According to the 2022 FDA Food Code section 5-202.12 Handwashing Sink, Installation. (A) A HANDWASHING SINK shall be equipped to provide water at a temperature of at least 29.4 C (85 F) through a mixing valve or combination faucet. On 03/10/2026 at 8:13 AM an observation in the Dietary Managers office just off of the hall to the kitchen revealed a ceiling vent cover and the ceiling around it with a buildup of dust and debris.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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** Based on observation, interview and record review, the facility failed to identify a change in bowel health for one Resident (#20) of one resident reviewed. This deficient practice resulted in the potential for constipation, intestinal blockage and discomfort.Findings include:Resident #20 (R20)Review of the quarterly Minimum Data Set (MDS) assessment, dated 12/24/2025, revealed R20 was admitted to the facility on [DATE] and had diagnoses including end-stage renal disease, heart failure, right side hemiplegia, bilateral foot amputation, and diabetes. Further review of the MDS assessment revealed R20 received hemodialysis treatment, required supervision/touching assistance with transfers and scored 13 out of 15 on the Brief Interview for Mental Status (BIMS), indicating the Resident was cognitively intact.On 3/10/2026 at 8:47 a.m., R20 was observed seated on the edge of his bed eating breakfast. R20 was not wearing a shirt and a dialysis access line was observed to be in place in his upper arm right. R20's meal tray contained one eight-ounce (240 milliliter) mug of coffee. No other fluids/drinks were visible on the meal tray or anywhere in R20's room. During an interview at the time of the observation, R20 was queried about his bowel habits and reported his last bowel movement was the other day. R20 could give no further information related to the frequency of his bowel movements.Review of R20's electronic medical record (EMR) revealed the following active order, dated 12/26/25, 1000 cc [cubic centimeter or milliliter] fluid restriction daily . four times a day every Mon [Monday], Wed [Wednesday}, Fri [Friday]. An additional active order, dated 12/27/2026, included a 1000 cc fluid restriction on Tuesday, Thursday, Saturday and Sunday. It was noted in review, R20 was on a daily 1000 cc fluid restriction.Review of R20's point of care documentation titled, Bowel Movements, revealed the Resident's last documented bowel movement was 3/5/2026 at 8:06 p.m. R20's bowel movements were documented as None, on the follow dates/times:3/06/2026 at 2:22 p.m. and 8:06 p.m.3/07/2026 at 11:29 p.m.3/08/2026 at 4:30 a.m. and 5:11 p.m.3/09/2026 at 4:14 a.m., 3:22 p.m. and 8:07 p.m.R20 had no documented bowel movement from 3/6/2025 at 8:06 p.m. to the time of review on 3/10/2026 at 10:46 a.m., which was determined to be more than four days without a bowel movement.Review of R20's March 2026 Medication Administration Record (MAR), revealed the following orders: MiraLax Oral Powder [laxative medication used to aid in passing stool)] 17 GM [gram] Scoop . Give 17 gram by mouth every 24 hours as needed for no BM [bowel movement] x 2 days/constipation. Start Dated: 11/15/2024 . No doses were documented as administered. Dulcolax Suppository [laxative medication used to stimulate bowel movements] 10 MG . Insert 1 suppository rectally every 24 hours as needed for if no bowel movement in 72 hours. Start Dated: 11/01/2022 . No doses were documented as administered.The March 2026 MAR for R20 documented oxycodone-acetaminophen (an opioid pain medication with a known side-effect of constipation) 5-325 MG four times daily was consistently administered.During an interview on 3/10/2026 at 12:18 p.m., Licensed Practical Nurse (LPN) A reported she was unaware R20 had no documented bowel movement since 3/05/2026 at 8:06 p.m. LPN A reported the night shift nurse usually passed along a list of residents requiring evaluation for bowel movements and the need to administer laxative medications per standing orders. LPN A reported she did not receive a list that morning indicating any residents were in need of intervention for bowel care. LPN H, present during the interview, reported she checked the lists from the previous shift and R20 was not listed.Further review of R20's EMR for March 5, 2026, through March 10, 2026, to include progress notes, evaluations and dialysis communication records, revealed no documentation of bowel movements, staff evaluation or resident assessment related to the Resident's bowel health or constipation. During an interview on 3/10/2026 at 1:47 p.m., the Director of Nursing (DON) confirmed there was no documented bowel movement for R20 since 3/5/2026 at 8:06 p.m. The DON reported LPN A alerted her about the situation following this Surveyor's inquiry. The DON reported she had just finished speaking with R20 who reported he had daily bowel movements, although not documented. The DON (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed there was no documentation of staff inquiry regarding R20's documentation of the lack of bowel movements for more than four days and no initiation of standing orders for constipation. The DON said she was unsure how nursing overlooked the issue and any reported bowel movements by R20 should be documented.Review of facility, Standing Orders, provided by the Nursing Home Administrator (NHA) revealed the following: Bowel Protocol: If no BM after 2 days give 30 ml of MOM (non-dialysis patients only-Do not order MOM if dialysis patient). If no BM after 3 days give Dulcolax suppository. If no BM after 4 days five Fleets enema.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure:(1) the correct dosage of medication was administered and(2) medication administration according to manufacturer recommendations for two Residents (R28 and R38) of three residents reviewed for medication administration. This deficient practice resulted in a medication error rate of 6.4% from 2 of 31 opportunities for error.Findings include:Resident #28 (R28) On 3/10/26 at 8:08 AM, Licensed Practical Nurse (LPN) A was observed administering medications to R28 who required medication administration through a gastrostomy tube (G-tube - a tube in the abdominal wall to provide direct access to the stomach for nutrition, fluids, and medication).LPN A added water to a 30 ml (milliliter) plastic medication cup containing a crushed medication tablet. The medication did not dissolve in the water and LPN A used a plastic spoon to stir the medication in the cup. When the medication was stirred in the 30 ml cup, the medication began spilling over the sides of the cup onto the bedside table. LPN A continued to stir the content of the cup with the medication spilling over the cup onto R28's bedside table until the medication tablet was dissolved. LPN A administered the remaining medication in the cup to R28. LPN A signed the medication on the Medication Administration Record (MAR) of R28 as administered despite R28 not receiving the prescribed amount of medication due to spillage of approximately 25% of the cup's content.During an interview with the Director of Nursing (DON) on 3/11/26 at 10:46 AM, the DON said if a nurse spilled medication, the nurse should dispose of the remainder of the medication and obtain new medication to ensure residents receive the correct dosage of medication.Resident #38 (R38)Registered Nurse (RN) B was observed preparing and administering medications to R38 on 3/11/26 at 7:19 AM. RN B removed a Toujeo Max SoloStar Subcutaneous Solution Pen (an insulin injection device) from the medication cart. RN B dialed the insulin pen to the prescribed 80 units of insulin without first priming the pen. The surveyor asked RN B about priming the pen with insulin before administering the 80 units of insulin. RN B said the insulin pen did not require priming. When RN B administered the insulin to R38, RN B injected the 80 units of insulin and immediately removed the pen without holding the injection button and maintaining the pen against the skin for a period of time to ensure the full dose of insulin was administered.During an interview with the DON on 3/11/26 at 10:46 AM, the DON said insulin pens need to be primed before adjusting to the prescribed amount of insulin. The DON said the injection button on an insulin pen should be held against a resident's skin after delivery of insulin but said she did not know how long to hold the pen against the skin.The manufacturer administration guidelines of the Toujeo Max SoloStar Subcutaneous Solution Pen (https://products.sanofi.us/Toujeo/Toujeo.pdf) provided the following instructions, in part: . Step 3: Do a safety test. Always do a safety test before each injection to: ˆ check your pen and the needle to make sure they are working properly. ˆ make sure that you get the correct insulin dose.3A Select 3 units by turning the dose selector until the dose pointer is at the mark between 2 and 4. 3B Press the injection button all the way in. ˆ When the insulin comes out of the needle tip, your pen is working correctly. Step 5: Inject dose.5D Keep the injection button held in and when you see 0 in the dose window, slowly count to 5. ˆThis will make sure you get your full dose. 5E After holding and slowly counting to 5, release the injection button. Then remove the needle from your skin.The policy General Dose Preparation and Medication Administration dated as revised 11/15/24 read, in part: .Verify each time a medication is administered that it is the correct medication, at the correct dose.Follow manufacturer medication administration guidelines.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to properly store medications in one medication cart of two medications carts reviewed for medication storage. Findings include:On 3/10/26 at 7:58 AM, Licensed Practical Nurse (LPN) A prepared 11 medications in a medication cup for Resident #15 (R15). LPN A placed the cup of medications on the overbed table in R15's room while she replaced a medication patch on R15's left upper posterior arm. After placing the medication patch, LPN A picked up the cup of medications from the overbed table to administer the medications. R15 told LPN A he didn't want the medications at that time. LPN A took the cup of medications back to the medication cart and placed the cup of medications in the top drawer of the medication cart.On 3/10/26 at 8:08 AM, Licensed Practical Nurse (LPN) A then proceeded to prepare seven medications for Resident #28 (R28), including a losartan tablet (medication to treat high blood pressure) obtained from a blister pack (a medication packaging system that holds individual doses of medication in separate compartments). LPN A left the medication cart and entered R28's room with the blister pack of losartan still atop the medication cart, unsecured and unattended. After administering the medications to R28, LPN A returned to the medication cart. The surveyor picked up the blister pack that contained 14 tablets of losartan and asked LPN A why the medication was left on the cart. LPN A said she forgot to secure the blister pack of medication back into the medication cart with the rest of R28's medications.The Director of Nursing (DON) was interviewed on 3/11/26 at 10:46 AM. The DON said nurses are expected to place blister packs of medication back into the medication cart when walking away from the cart. The DON agree it was unsafe to leave medications unsupervised and unattended atop the medication cart. The DON said if a nurse prepares medications and a resident does not want the medication after preparation the nurse should dispose of the medications and get a new supply of medications if the resident later decides to take the medication.The policy General Dose Preparation and Medication Administration dated as revised 11/15/24 read, in part: .Facility staff should not leave medications or chemicals unattended.Dispose of unused medication portions.The policy Storage and Expiration Dating of Medications and Biologicals dated as revised 6/30/25 read, in part: . Facility should ensure medications and biologicals that .have been contaminated .are stored separate from other medications util destroyed . Facility should ensure the medications and biologicals for each resident are stored in the containers in which they were originally received .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 to provide barriers for resident care equipment and maintain infection control practices during medication administration for four Residents (#10, #15, #28, & #38) of seven residents reviewed for infection prevention and control.Findings include:Resident #10 (R10)R10 was admitted to the facility on [DATE]. A quarterly MDS (Minimum Data Set) assessment dated [DATE] documented R10 had chronic respiratory failure with hypoxia and required supplemental oxygen and a non-invasive ventilator (respiratory support device). On 3/9/26 at 2:05 PM, R10 was observed wearing a nasal cannula (an oxygen delivery device that provides supplemental oxygen through the nostrils) connected to an oxygen concentrator. An additional nasal cannula was connected to a portable oxygen tank on the back of R10's wheelchair. The nasal cannula on the portable oxygen tank was unbagged and lying across the back of R10's wheelchair without a barrier (a barrier is an item intended to prevent contamination of items and reduce the potential for transmission of infectious organisms).A BiPAP (a type of non-invasive ventilator used to support breathing) was observed unbagged and atop the nightstand next to the bed of R10 with the face portion of the mask resting directly against the nightstand without a barrier beneath it on the following dates and times:3/9/26 at 2:05 PM3/10/26 at 9:29 AM3/10/26 at 10:31 AM3/10/26 at 2:04 PM On 3/10/26 at 10:31 AM, R10 was asked about the cleaning of the BiPAP and tubing, and storage of the BiPAP mask and nasal cannula tubing. R10 said the nurses do not clean or change the BiPAP or mask and do not change or bag the nasal cannula when not in use. R10 said he was not supplied with a bag to put the BiPAP mask in when he is done using it.The Director of Nursing (DON), who also served as the facility's Infection Preventionist, was interviewed on 3/11/26 at 10:46 AM. The DON said BiPAP masks and nasal cannulas should be in a bag when not in use.Resident #15 (R15)R15 was admitted to the facility on [DATE] for aftercare following a surgical amputation.During an interview on 3/9/26 at 2:14 PM, R15 said he had finished his antibiotics and was scheduled to discharge from the facility the following day.Licensed Practical Nurse (LPN) A was observed administering medications on 3/10/26 at 7:58 AM. LPN A prepared 11 medications in a medication cup for R15. LPN A placed the cup containing the medications on R15's overbed table without a barrier beneath it while she replaced a medication patch. R15 said he did not want his medications at that time. LPN A took the medication cup from the overbed table and exited the room. LPN A placed the cup of medications on top of the medication cart without a barrier beneath it while she unlocked the medication cart. LPN A placed the cup of medications in the top drawer of the medication cart without a barrier beneath it. LPN A commenced preparing medications for other residents without cleaning or sanitizing the top of the medication cart where the cup of medications had been placed after being on the overbed table without a barrier in the room of R15.Resident #28 (R28) R28 was admitted to the facility on [DATE]. A quarterly MDS dated [DATE] documented R28 required a feeding tube for administration of nutrition, fluids, and medications.During medication administration with LPN A on 3/10/25 at 8:08 AM, LPN A entered R28's room with six clear plastic medication cups of crushed medication. LPN A placed the cups on the overbed table without a barrier beneath them. LPN A announced she did not have a measuring device in which to measure the feeding tube for placement prior to medication administration. LPN A picked up the medication cups from the overbed table, exited the room, and placed the medication cups on top of the medication cart without a barrier beneath them. LPN A unlocked the top drawer of the med cart and placed the medication cups in the cart without a barrier. LPN A obtained a measuring tape from another area of the facility and returned to the medication cart to obtain the six cups of medication for R28. LPN A did not clean or sanitize the top of the med cart or the drawer where she had stored the medication cups after the cups were on R28's overbed table without a barrier. When LPN A re-entered R28's room, she placed the six cups of medications back on top of the overbed table without a barrier beneath them.While in (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R28's room, a pen fell from the pocket of LPN A onto the floor. LPN A picked up the pen and placed it on R28's overbed table without a barrier beneath it. After administering medications to R28, LPN A picked up the pen and placed it back into her pocket without cleaning or sanitizing it.Resident #38 (R38)R38 was admitted to the facility on [DATE]. R38 had a diagnosis of diabetes and received insulin daily.Registered Nurse (RN) B was observed preparing and administering medications to R38 on 3/11/26 at 7:19 AM. RN B removed a Toujeo Max SoloStar Subcutaneous Solution Pen (an injection device to deliver insulin) from the medication cart. RN B placed a needle on the end of the pen without first cleansing the end of the injection pen.During the interview with the DON on 3/11/26 at 10:46 AM, the DON said nurses are expected to clean the ends of insulin pens with alcohol before applying needles to the pens. When asked the expectations regarding the use of barriers, the DON said, If something is set down and needs to leave the room or go back to the medication cart, nurses should use barriers. The DON agreed nurses should clean and sanitize medication carts when potentially infectious items are placed atop or within the cart. The manufacturer administration guidelines of the Toujeo Max SoloStar Subcutaneous Solution Pen (https://products.sanofi.us/Toujeo/Toujeo.pdf) provided the following instructions, in part: .Pull off the pen cap.Wipe the rubber seal with an alcohol swab. Step 2: Attach a new needle.The policy Medication Administered through Certain Routes of Administration dated as revised 11/15/24 read, in part: . Subcutaneous Injections [an injection between the skin and muscle - insulin is a subcutaneous injection] . swab vial with alcohol, let dry.The policy titled BIPAP-CPAP dated as last reviewed/revised June 2023 read, in part: .Store mask or nasal pillows [soft inserts that fit directly into the nostrils] in mesh bag or other approved storage container approved by the facility when not in use .The policy Oxygen Administration and Concentrator Policy dated as revised 6/23 read, in part: .keep delivery devices stored in a sanitary manner.The policy Storage and Expiration Dating of Medications and Biologicals dated as revised 6/30/25 read, in part: .Facility should ensure medications and biologicals that .have been contaminated .are stored separate from other medications until destroyed .Facility should ensure the medications and biologicals for each resident are stored in the containers in which they were originally received .