STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235596	A. Building B. Wing	09/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	8380 Geddes Road Ypslianti, MI 48198

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 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. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer oral chemotherapy medication as ordered for one (Resident #200) of three reviewed. This citation pertains to intake 2582143.Review of the clinical record revealed R200 was admitted into the facility on 4/23/25 with diagnoses that included: aphasia following cerebral infarction (impaired ability to understand or produce speech following a stroke), malignant neoplasm of upper third of esophagus (throat cancer) and vascular dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R200 scored 8/15 on the Brief Interview for Mental Status exam (which indicated moderately impaired cognition).On 9/22/25 at 9:59 AM, during an interview with family member (FM) E, when asked to clarify which medication R200 was allegedly not being provided, they reported it was an oral chemotherapy medication and that when family had taken R200 to his oncologist appointment the oncologist could tell that he was not receiving the medication. FM E reported that the medication was not administered for approximately one month and R200's oncologist had not ordered for it to be stopped.Review of R200's Discharge Summary (from the hospital that R200 was at prior to admitting to the facility) documented in part capecitabine 500mg tablet, Take 2 tablets (1,500 mg total) by mouth 2 (two) times a day, Take on Days 1-14, followed by 7 days off, of every 21-day cycle.Review of R200's physician's orders for oral chemotherapy revealed:4/24/25-5/8/25 Capecitabine Oral Tablet 500mg, Give 3 tablet enterally two times a day for Esophageal cancer stage IV for 14 days, 1500mg given enterally. Do not crush, Handle with gloves, Disperse in water for 15 minutes prior to5/9/25-7/4/25 Capecitabine Oral Tablet 500mg, Give 3 tablet enterally two times a day for Esophageal cancer stage IV for 14 days, 1500 mg given enterally. Do not crush, Handle with gloves. Disperse in water for 15 minutes prior to enteral administration, 14 days on; 7 days off, then restart on 5/15/258/5/25-9/30/25 Capecitabine Oral Tablet 500mg, Give 3 tablet via PEG-Tube two times a day for Esophageal cancer for 14 days, dissolve in warm water. Use gloves. DO NOT CRUSH. Give 14 days then 7 days off and then repeat cycle.This review revealed that there was not an active order for R200's oral chemotherapy from 7/5/25 to 8/4/25.A review of R200's Medication Administration Record revealed:July 2025 Capecitabine 1500mg was documented as administered twice a day on the 1st through the 3rd and once on July 4th (no additional doses were documented in July)August 2025 Capecitabine 1500mg was documented as administered twice a day on the 5th through the 18th (medication resumed 7 days later on 8/26/25)This review revealed that the Capecitabine (R200's oral chemotherapy medication) was not administered for a 30-day timespan (spanning from the evening of July 4th through August 4th). Review of a progress note from Nurse Practitioner (NP) C dated 6/10/25 documented in part Principal diagnosis of Esophageal cancer. Pt (patient) is strictly NPO (nothing by mouth) with a peg tube in place.External specialists during regulatory period: Oncology specialist; no new order or papers seen.Medications:.Capecitabine Oral Tablet 500mg Give 3 tablets via PEG-Tube two times a day for Esophageal cancer for 14 days, dissolve in warm water prior to administration.Examined notes from oncology as no noted orders or papers came with pt to appointment. Pt was examined at appointment with no concerns.Follow up appointments with oncology an infusion were added to orders. Pt to continue with capecitabine tablet per peg tube twice daily per orders.Review of progress note from Licensed Practicing Nurse, LPN D, dated 8/4/25 documented in part Resident back from his appointment and continue with his chemo medicine as per NP from hospital- 14 days on and 7 days off and repeat the cycle and continue. On 9/15/25 at 2:44 PM, a request was made for any medication error reports for R200 and 2:51PM ADON reported they did not have any medication error reports for R200. The facility was asked to provide any documentation from R200's oncologist. The only notes that were provided were dated 8/21/25 and 8/25/25. No consult notes prior to the timeframe that R200 did not receive his oral chemotherapy medication were provided. No documentation found to support the medication should have been stopped. On 9/15/25 at 3:17 PM, during an interview with Director of Nursing (DON) and Assistant Director of Nursing (ADON), when asked what the facilities process is to review for any medication changes when a resident goes to an outside appointment, DON reported that paper work (consult report) is sent back to the facility with the resident or whomever accompanied the resident to the appointment. It is the responsibility of the receiving nurse to review for any medication changes. When asked why there was a 30-day period where the resident did not receive his oral chemotherapy medication, DON reported that the resident had went out to the hospital. It was determined by ADON and DON that a hospitalization did not occur around the time the medication was