STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nursing & Physical Rehabilitation Ce	313 Sherwood Street Holly, MI 48442

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 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** This citation relates to Intake 3020377. Based on interview and record review, the facility failed to transcribe a medication accurately per physician orders for one Resident (R102) of two residents reviewed for medication administration. Findings include:Review of an intake received by the State Agency on 5/21/26 revealed an allegation R102 was administrated medications inaccurately during their stay, resulting in medication errors. It was alleged R102 was administered the wrong dose type of Depakote, used as a mood stabilizer, which resulted in mood swings and atypical behaviors for R102. The complainant reported they did not find out until R102 was discharged that R102 was supposed have received Depakote extended release (medication dose released slowly and continuously over 24 hours) pills. The complainant alleged R102 was given delayed release (medication dose released quickly after two hours), which would have only lasted a couple of hours in R102's system per their reporting. Review of R102's profile revealed they were their own responsible party, with an inactivated Power of Attorney (POA). This was confirmed by the facility management. Review of R102's census revealed R102 was admitted to the facility on [DATE] and discharged on 3/23/26. Review of R102's Minimum Data Set (MDS) assessment, dated 2/03/26, revealed R102 had diagnoses including deep vein thrombosis (blood clot), heart failure, arthritis, wedge compression fracture (back), anxiety, depression, bipolar disorder, schizoaffective disorder, psychotic disorder, schizoaffective disorder, pseudobulbar affect (neurological condition causing sudden uncontrollable episodes of laughing or crying that do not match a person's emotions), spinal stenosis (narrowing of spine), and back pain. Review of R102's hospital discharge medication list, dated 1/30/26, retrieved from the documents section of the Electronic Medical Record (EMR), .Discharge Medication Instructions (continued). These are your home medications, divalproex (generic medication) 500 mg (milligrams) 24 hr (hour) tablet (in bold print), commonly known as: Depakote (mood stabilizer or anti-seizure medication) ER (Extended Release). Take 1,500 mg (milligrams) by mouth at bedtime. Review of R102's hospital discharge summary, by the hospitalist, revealed, .divalproex 500 mg 24 hr (hour) tablet.Commonly known as: Depakote ER. 1,500 mg, Oral. At bedtime. Review of R102's printable discharge hospital referral form, dated 1/26/26, showed R102 was prescribed Depakote Extended Release prior to their admission to the facility on 1/30/26, at the dose 1500 mg at bedtime. Review of R102's progress note, dated 3/25/26 at 9:45 a.m., by Licensed Practical Nurse (LPN) B, revealed, Resident (102's) Depakote was not transcribed into (Name of EMR) correctly from hospital discharge instructions. (R102) was receiving delayed release Depakote instead of extended-release Depakote. Facility made aware of error after discharge. Management, doctor and family notified of incident. This progress note showed R102 did not receive the correct dosing of their Depakote during the duration of their facility stay. Review of R102's February MAR (Medication Administration Record) showed Divalproex Sodium (Depakote) delayed release was administered 2/01/26 to 2/10/26 at the dose of 1500 mg once a day at night. The MAR continued to show from 2/11/26 to 2/28/26 three Divalproex Sodium 500 mg tablets were administered at night (all together) delayed release for a total dose of 1500 mg noted. This showed R102 continued to have delayed release medications verses extended release, with all their medication being given once a day, at night. Review of R102's January (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(2026) MAR showed Divalproex Sodium delayed release was given at night at 1500 mg on 1/30/26 and 1/31/26. Review of R102's March (2026) MAR showed they received 1500 mg total of Divalproex Sodium at night daily in the delayed release form, not extended release. Review of R102's Order Summary Report, dated 3/23/26 (Date of facility discharge), revealed Divalproex Sodium (name brand Depakote) Oral tablet delayed release 500 mg was dosed three tablets at bedtime, for a total of 1500 mg a day. This showed the medication was still not the extended-release version upon R102's facility discharge, and three shorter acting pills were given together at night, and not spread throughout the day for extended coverage, despite three pills being prescribed (500 mg) instead of the one pill (1500 mg) dosing. On 5/27/26 at 3:09 p.m., LPN B reported the facility did not discover the medication dosage type error regarding the inaccurate medication transcription of R102's Depakote from the hospital medication list until after R102 was discharged , when they were made aware by R102's family member via email along with the Director of Nursing (DON). LPN B explained they made Physician I aware of the situation after R102's discharge. LPN B reported while R102 had behaviors during their stay, they could not necessarily attribute them to the medication dose type transcription error. LPN B clarified R102 had verbal behaviors at times, such as yelling out however said they had no physical behaviors or resident-to-resident incidents. LPN B was asked to review R102's February MAR with Surveyor during the interview, and the change of dosing on 2/11/26. LPN B acknowledged there would be no difference in 3 - 500 mg pills (totaling 1500 mg) vs (verses) one 1500 mg pill (totaling 1500 mg), when each dose was given at night. LPN B clarified this was the same medication dose type, and amount of Depakote delayed release, and said the MAR showed R102 received the medications at night only, not staggered (like two to three times a day). LPN B reported they understood the transcription error concern and the potential for a mood or behavior outcome. Review of R102's Care Plan, accessed 5/27/26, revealed, (R102) at risk for changes in mood and behavior due to diagnosis of pseudobulbar affect, schizoaffective disorder, depression, bipolar, and anxiety disorder. (R102) admitted on two antipsychotics (medications to treat psychosis symptoms), antidepressant, antianxiety, and mood stabilizer medications. I (R102) have been on these medications for 10 - 20 years. I (R102) have a community psychiatrist. I (R102) have a history of hallucinations and hearing voices. I (R102) can be labile and religiously preoccupied. (R102) may make false accusations about staff mistreating her, has catastrophic responses. Date initiated 2/04/26. The Care Plan also revealed R102 had a history of traumatic experiences. On 5/27/26 at approximately 3:50 p.m., the Director of Nursing (DON) acknowledged being made aware R102 had not received the correct Depakote dose type during their stay and had received delayed release verses extended release. The DON said they had re-educated the nurse involved. The DON understood the concern for a potential outcome however could not ascertain this had occurred, as R102 reportedly had behaviors throughout their stay, and said they generally only saw behaviors when one family member was present. The DON explained there were times when R102 did not want their family member involved in their care, since they were their own responsible party. The DON said they had received complaints from R102's family member, but R102 did not have complaints themselves. On 5/27/26 at 4:01 p.m., and 5:04 p.m., attempts were made to contact R102, who was their own person, with no call returned. Review of the psychiatric practitioner's evaluation, by Nurse Practitioner (NP) H titled, Psychiatry Initial Evaluation, dated 2/04/26, dated 2/04/26, revealed, Chief complaint: Schizoaffective disorder (a mental health disorder with schizophrenia and mood symptoms), bipolar disorder (mood disorder), neurocognitive decline (significant decline in neurological function). History of present illness: (R102) is a [AGE] year-old female admitted [DATE] for skilled nursing and rehabilitation services following hospitalization related to recurrent falls, deconditioning, and functional decline. It was noted R102's medications were documented as reconciled by NP H during the visit, and Divalproex 1500 mg was prescribed to be administered at bedtime. It was noted their reconciliation did not designate extended release or delayed release in their medication review. On 5/27/26 at approximately 4:20 p.m Physician I was asked during a phone interview about the R102's (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication concerns with wrong dose type of Depakote administered during their stay. Physician I acknowledged being made aware after R102 was discharged and understood the concern. Physician I referred Surveyor to follow up with the outside behavioral care practitioner if needed, to ascertain if there was a potential outcome. On 5/27/26 at 5:11 p.m., NP H was asked during a phone interview about R102 being administered the wrong dose type of Depakote during their stay and any outcome. NP H said they were not made aware of the medication dosage concern with Depakote during their stay. NP H said there was a difference in the dosing and they would opt for Depakote DR with bipolar disorder and did not have a concern with them receiving the full amount at night. NP H said when they saw R102 on 2/04/26 and at that time R102 had no symptoms of (acute) mania or psychotic symptoms and had a consistent clinical representation per their review. NP H reported their records showed R102 was on Depakote 1500 mg at night per their documentation with no documentation of the dose type (ER vs delayed release). NP H denied an outcome per their awareness. NP H acknowledged while there may have been a difference in the conversion from a Depakote delayed release to Depakote extended release, they did not provide an answer as to whether more or less medication would be needed for a resident with bipolar disorder. Review of the policy, Medication Reconciliation, revised 9/2025, revealed, This facility reconciles medication frequently throughout a resident's stay to ensure that the resident is free of any significant medication errors. Definitions: 'Medication reconciliation' refers to the process of verifying that the resident's current medication list matches the physician's orders for the purposes of providing the correct medications to the resident at all points throughout his or her stay. Policy Explanation and Compliance Guidelines: Medication reconciliation involves collaboration with the resident/representative and multiple disciplines, including admission liaisons, licensed nurses, physicians, and pharmacy staff. Resident identifiers will be verified on all medication labels and documents containing medication information to verify the correct person and that the documents are placed in the correct resident's medical record. Pre-admission Processes: Obtain current medication list from referral source (i.e. hospital, home health, hospice, or primary care provider). Obtain current medication/admission orders. Verify resident identifiers. Forward to nursing unit accepting the resident. admission Processes: Verify resident identifiers on the information received. Compare orders to hospital records, etc. Obtain clarification orders as needed. Transcribe orders in accordance with procedures for admission orders. Order medications from pharmacy in accordance with facility procedures for ordering medications. Verify medications received match the medication orders. Obtain home list of medications from the receiving facility and/or resident/representative. Place in the EHR for physician review and revision of medication regimen, if warranted. Interim medication review completed on upon admission, if warranted. Daily Processes: Address any clinically significant medication irregularities reported by pharmacy consultant. Verify medication labels match physician orders and consider rights of medication administration each time a medication is given. Obtain and transcribe any new orders in accordance with facility procedures. Obtain clarification as needed. Order medications from pharmacy in accordance with facility procedures for ordering medications. Verify medications received match the medication orders. Monthly Processes: Provide pharmacy consultant access to all medication areas and records for completion of pharmacy services activities. Respond to any medication irregularities reported by pharmacy consultant within relevant time frames. Review of the manufacturer's recommendations for taking Depakote, titled, Taking Depakote(R) Products (divalproex sodium), accessed on 6/04/26, revealed, Depakote Tablets are delayed-release, which means they have a special coating that prevents the drug from dissolving too early in the digestive tract. Available in three strengths, Depakote Tablets must be taken twice a day, as prescribed by your doctor. Talk with your doctor about the most appropriate tablet strength for you. Depakote Extended-Release Tablets: The ER in Depakote ER stands for Extended Release. Available in two strengths, Depakote ER contains the same active ingredient as Depakote Tablets but it is designed to slowly deliver the medication over a 24-hour period. This means that Depakote ER has to be taken (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	only once a day. If you have been prescribed Depakote Tablets, ask your doctor if Depakote ER is right for you. What is DEPAKOTE used for? DEPAKOTE comes in different dosage forms for oral use. DEPAKOTE(R) (divalproex sodium) delayed-release tablets, DEPAKOTE(R) ER (divalproex sodium) extended-release tablets, and DEPAKOTE(R) Sprinkle Capsules (divalproex sodium delayed release capsules) are prescription medicines used:alone or with other medicines to treat:- complex partial seizures in adults and children [AGE] years of age and older- simple and complex absence seizureswith other medications to treat:- patients with multiple seizure types that include absence seizuresDEPAKOTE ER and DEPAKOTE are also used to prevent migraine headaches.DEPAKOTE ER is also used to treat acute manic or mixed episodes associated with bipolar disorder with or without psychotic features.DEPAKOTE is also used to treat manic episodes associated with bipolar disorder. Review of the article titled, Divalproex to Divalproex Extended-Release Conversion, accessed 6/04/26, from Medscape, revealed, Abstract and Introduction: Objective: Divalproex extended release (ER) tablets have lower bioavailability than conventional divalproex tablets. Objectives were to provide dose-increment justification for conversion of a patient from conventional enteric-coated divalproex to a once-daily enteric-coated divalproex to a once-daily divalproex ER regimen and to discuss the pharm kinetic factors affecting these unequal total daily dose conversions.Conclusions: An 8-20% higher divalproex ER daily dose should be used when converting from a total daily dose of divalproex. The lower fluctuations of valproic acid concentrations, consistent time to trough concentration, and lower dosing frequency of divalproex ER should offer benefit to the patient by providing convenient once-daily administration, and to the clinician by facilitating easier and reliable therapeutic drug monitoring and improving patient adherence. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: Each resident prescribed Depakote was identified and had their Depakote orders audited to ensure that the correct type of Depakote matched the physician orders. All were in compliance. Nurses were re-educated on the transcribing of medication. Each new admission who is prescribed Depakote will be audited to ensure that the correct order for Depakote is transcribed to the MAR. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.