

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235056	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/26/2024
NAME OF PROVIDER OR SUPPLIER Hoyt Nursing & Rehab Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 1202 Weiss St Saginaw, MI 48602	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944</p> <p>This citation pertains to Intake Number MI00148622.</p> <p>Based on interview and record review the facility failed to operationalize the facility policy for wound management for one resident (R4) of three residents reviewed for wounds, resulting in a missed weekly skin picture, a missed weekly assessment and the potential for the wound to worsen.</p> <p>Findings include:</p> <p>R4 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include age related physical debility, reduced mobility, cerebral infarction and hypertension. R4 has a brief interview for mental status (BIMS) score of 12, indicating moderately impaired cognition.</p> <p>Review of the electronic medical record (EMR) of R4, revealed R4 was admitted to the facility on [DATE] with a Stage 2 (partial thickness skin loss, appearing as a shallow open sore) pressure injury on the coccyx. R4 discharged to the hospital on 09/25/2024 and returned to the facility on [DATE].</p> <p>Review of the wound evaluation on 10/04/2024 (upon readmission to the facility) revealed the coccyx wound is now a Stage 3 (full thickness tissue loss, subcutaneous fat is visible in the wound) pressure injury. A wound picture and assessment were completed and revealed the wound measured 8.46cm long and 6.8cm wide.</p> <p>On 10/28/2024 a wound evaluation was completed on the Stage 3 coccyx wound.</p> <p>Review of the EMR revealed that a wound evaluation, including a picture and assessment was not completed for the week of 11/03/2024.</p> <p>On 11/11/2024 a wound evaluation was completed on the Stage 3 coccyx wound.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/26/2024 at 01:49pm, an interview was conducted with the Director of Nursing (DON). The DON was asked about the coccyx wound on R4. The DON stated that R4 was admitted to the facility with a Stage 2 pressure injury to the coccyx. R4 went to the hospital and returned to the facility in October with the coccyx wound now being a Stage 3. The DON stated that at one point the wound started to get worse, even with treatment, turning and repositioning and having an air mattress on the bed. The DON was asked about the missed weekly assessment and what the policy is for assessing pressure injuries. The DON stated that the facility is supposed to take pictures and assess the wounds weekly. The DON was asked about the missed assessment resulting in no picture or assessment being completed between the weeks of 10/28/2024 and 11/11/2024. The DON stated it was an oversight, I know my staff completed the treatment, but they must not have taken pictures to complete the assessment.</p> <p>Review of the policy titled, Wound Management Program revision date 08/17/2017, revealed:</p> <p>Process (management of pressure ulcers/non pressure wounds):</p> <p>4. Complete the following documentation weekly, as applicable to type of wound/skin condition:</p> <p>-Weekly pressure ulcer wound documentation and picture in wound rounds.</p>