STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Flint	G 3201 Beecher Rd Flint, MI 48532

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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** 22348 This Citation pertains to Intake Numbers MI00151112 and MI00151113. Based on observation, interview, and record review, the facility failed to provide adequate and appropriate wound care: Percutaneous Endoscopic Gastrostomy (PEG) tube site, assess, monitor, document wound status, and provide interventions as care planned for three residents (R#501, R#502 and R#503) of 4 residents reviewed for wound care, treatments and interventions. Findings include: Resident #501 (R501): During wound observation on 3/18/25 at 1:45 PM, the Wound Nurse (RN A) was observed while providing R501's unstageable wound area, measured as 0.4 cm (in length) and 0.2 cm (in width). The wound depth was not measured. R501 was lying in bed, and her bare feet were cold and exposed, not in an elevated position, and she had no preventive protectors as care was planned to prevent pressure ulcers from developing. There were no pillows under her lower extremities to keep both heels off the pressure.R501's Percutaneous Endoscopic Gastrostomy (PEG)Tube site was the dressing was dated 3/14/25. Nurse Aide (CNA B) confirmed the date written on the PEG Tube dressing was 3/14/25. The Wound Nurse A (RN A) confirmed the PEG dressing was dated 3/14/25. When asked about their policy and procedure on PEG site dressing changes, RN A stated that it should be a daily dressing change for the PEG tube site. She further explained that the nurses on the floor do daily dressing changes, and the PEG tube site is a daily dressing change. A review of resident R501's Electronic Medical Record on 3/18/25 revealed that R501 was admitted with no wounds on 1/3/2019. R501 was [AGE] years old and admitted with a diagnosis of hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, adjustment disorder with mixed anxiety and depressive mood, with Percutaneous Endoscopic Gastrostomy (PEG), and dysphagia in addition to other diagnoses. R501 was non-verbal and dependent on staff for all Activities of daily Living (ADLs).R501 was dependent on Eating, mobility, bathing, oral and personal hygiene, dressing, transfers, and toileting. She is incontinent with bowel and bladder elimination patterns. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the wound nurse A in an interview on 3/18/25 at 1:45 PM, R501 developed a Facility Acquired Stage III pressure ulcer on the left ischial area on 9/24/2024. Wound Nurse RN A stated, Her wound is getting better. She verified that the PEG tube wound dressing on R501 was dated 3/14/25. RN A revealed that the facility's policy for the PEG tube site was a daily change. The floor nurses do the daily dressing changes. A review of R501's care plan for the PEG Tube site conducted on 3/18/25 at 3:00 PM, has the enhanced Barrier Precaution but no mention of the daily change of dressing as part of the care plan. R501's at risk for impaired skin integrity specified to: 1.) Assist in positioning the body with pillow/support devices and protecting bony prominences. 2.) Assist/encourage to elevate heels off the bed. 3.) Licensed Nurse skin assessment per protocol. A review of the PEG Tube order on 3/18/25 at 3:00 PM revealed a treatment order of: Change tube dressing daily at bedtime for enteral feeding start date at 3/13/25. Nurses signed off as checked, indicating that it was done on the dates 3/13/25, 3/14/25, 3/15/25, 3/16/25, and 3/17/25. But the dressing remained dated 3/14/25, validated by RNA and CNA B on 3/18/25 at 1:45 PM. There was no treatment order to apply measures to prevent pressure from developing for both feet and ankles specified in R501's plan of care. Resident #502 (R502): On 3/18/25, at 1:59 PM, R502 was observed in his room lying in bed. He indicated his preference for the surveyor to observe his wound care the next day because of his wound treatment for the day. R502 was noted with scabs scattered on both feet, but both legs had no socks, no protective device such as Prafo boots, and both feet were elevated. The order was verified on 3/18/25 at 3:00 PM; Prafo boots to bilateral lower extremities are to be on daily while in bed. The order was active with a start date of 11/9/2024. During wound care observation on 3/19/25 at 10:30 AM, the Wound Nurse (RN A) was observed cleansing and measuring the Unstageable wound to the coccyx. It measured 1.10 centimeters (length) by 0.4 centimeters (width); wound depth was not measured. RN A following the measurement of R502's coccyx wound, RN A did not change her gloves and did not was hands nor sanitize after using her gloved hand to take pictures of R502's wound on the coccyx area RNA then proceed to apply the treatment: Xeroform gauze and wound sponge dressing on top of the xeroform dressing. There were scabs on both feet, but no treatment was applied on R502. They were not elevated before and after wound care while R502 was in bed. The staff did not elevate, and no prafo boots were applied according to his plan of care. R502 was [AGE] years old, admitted to the facility on [DATE], with a diagnosis of a displaced fracture of the fourth cervical vertebra, quadriplegia, adjustment disorder with depressed mood, and Percutaneous Endoscopic Gastrostomy (PEG Tube) in addition to other diagnoses. R502 was interviewable and was his own responsible party. R502's plan of care required total assistance with Activities of daily living (ADLs), specifically for bathing, bed mobility, oral and personal hygiene, dressing, toileting, transferring, and eating due to quadriplegia and impaired visual function. R502 was incontinent for both bowel and bladder elimination patterns. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The wound physician was interviewed on 3/19/25 at 10:40 AM regarding multiple scabs found on both feet. The doctor did not comment on treating R502's on either foot. A review of R502's care plan on 3/18/25 at 3:00 PM revealed R502's Care Plan for At risk for skin integrity . was initiated on 11/04/2024, with revision date was 11/14/2024, R502's skin care plan initiated on 11/14/2024 and revised on 12/31/2024, specified, Prafo boots to bilateral lower extremities to be on daily while in bed. There were no progress notes nor indication of any refusal to PRAFO Boots on the daily treatments in the Treatment Administration Record (TAR). Resident #503 (R503): R503 was recently readmitted after hospital discharge on 3/18/25. A review of Electronic Medical Records on 3/19/25 at 10:30 AM revealed that R503 was diagnosed with Parapalegia, Hydronephrosis with nephrostomy, and Malignant Neoplasm of the Prostate in addition to other diagnoses. According to the 3/11/2025 Minimum Data Set assessment, R503 has a BIMS (Brief Interview of Mental Status) score of 15/15. This indicates that R503 is cognitively intact. Section GG of the MDS assessed on 3/17/2 indicated that R503 was dependent on staff with Toileting, showers, upper and lower body dressing, and personal hygiene activities. R503's Kardex indicated extensive two-person assistance with toileting and transferring. On 3/19/25 at 1:00 PM, R503 was in bed and stated he was comfortable and experiencing no pain. R503's Prafo boots were found on top of his wheelchair. When R503 was interviewed, he revealed, They did not put them on me. Sometimes they do, and sometimes they don't. I'm supposed to have them on me when I'm in bed. Treatment Administration Record dated 3/9/25 revealed a wound care order to cleanse the coccyx area and apply medihoney to the wound bed. The order was discontinued the following day on 3/10/25. According to the Electronic Medical Record review, R503 left the faciity on [DATE] and returned on 3/18/25. RNA stated on 3/19/25 at 1:25 PM and revealed that during rounds with the nurse practitioner on 3/7/2025, they discovered a stage III wound on the right lumbar area. It was facility-acquired. It was the first time it was observed because they wanted us to assess his nephrostomy tube site and drain. The drain had a greenish discharge from the tube and the drainage bag. R503 was sent to urgent care for evaluation and treatment. In R503's wound summary dated 3/7/25, the wound nurse noted that an active stage III note on 3/7/2025 was pink or red, non-granulating 100%. There was the presence of a scant serous exudate 9.0 cm)(length X 3.50 cm (width and 0.40 depth Facility Acquired Pressure ulcer. There was no treatment documented in progress notes nor on the resident's Treatment Administration Record dated 3/7/25. According to the Nurse Practitioner's progress notes draft initiated on 3/9/25 and signed by the nurse practitioner on 3/10/25, she noted: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	L89.133 Decubitus Ulcer of right lower back, Stage 3 secondary to nephrostomy tubing. The patient was educated on tubing positioning regarding his clothing positioning. The wound was cleansed with normal saline, xeroform, and gauze covering applied. The patient is being transferred to the ER (emergency room)and will reassess the wound upon return from the hospital for a dressing recommendation. This progress note referred to when R503 was sent to theER on [DATE]. The resident returns to the facility on [DATE]. When RNA was queried, she stated that she assessed, evaluated, and treated R503's R503's wound when it was first discovered on 3/07/25 but did not document it in the nursing progress notes. And did not document that there was treatment. When asked if she documented anywhere else, she stated that she documented the wound measurements but did not note that she gave any treatment. No treatment was recorded in the Treatment Administration Record (TAR), in the Progress notes, or in R503's Wound Summary dated 3/07/25. The Facility's Care and Treatment of Feeding Tubes Policy (date reviewed and revised 2/25) was reviewed on 3/19/25 at 12:15 PM. The policy specified: It is the policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible. The facility's policy on Wound Treatment Management and Documentation (Revised date: 2/2024) Policy: To promote wound healing of various types of wounds, it is the policy of the facility to provide evidence based treatments in accordance with current standards of practice and physician's orders. MPHS utilizes the [NAME] & [NAME] Clinical Nursing skills/Techniques and National Pressure Ulcer Advisory Panel. Policy Explanation and Compliance Guidelines: Wound treatments will be provided in accordance with physicians orders . 6. Treatments will be documented on the Treatment Administration Record . 8. Wound Assessments are documented upon admission, weekly, and as needed if the resident or wound condition deteriorates. Wound treatments are documented at the time of each treatment . 9. The following elements are documented as part of a complete wound assessment: a. Type of wound (pressure injury, surgical, etc.) and anatomical location. b. Stage of the wound if pressure injury (stage 1, 2, 3, 4, unstageable, deep tissue injury) c. Measurements: height, width, depth, undermining, tunneling d. Description of wound characteristics: i. Color of the wound bed ii. Type of tissue in the wound bed (i.e. granulation, slough, eschar, epithelium) (continued on next page)

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