STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235461	A. Building B. Wing	05/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mission Point Nsg & Phy Rehab Ctr of Clarkston	4800 Clintonville Rd Clarkston, MI 48346

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00152863. Based on interview and record review the facility failed to accurately assess a sacral/coccyx wound, implement adequate and appropriate interventions to prevent wound development, failed to timely identify the decline of a sacral/coccyx wound and notify the Physician for one (R202) of two residents reviewed for pressure wounds, which resulted in hospitalization for an infected wound, sepsis and a Stage 4 Pressure wound (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) to the sacral/coccyx. Findings include: Review of a complaint submitted to the State Agency (SA) documented concerns regarding R202's pressure wounds. A review of the medical record revealed R202 was admitted to the facility on [DATE], with diagnoses that included: dementia, gastrostomy (opening in the stomach for the insertion of a feeding tube), dysphagia (difficulty swallowing) and was dependent on staff for all Activities of Daily Living (ADLs). Review of a . Change in Condition Evaluation dated 12/18/24 at 6:53 AM, documented in part . Skin wound or ulcer . This started on 12/18/2024 . Triad (wound ointment) to open area . Coccyx - Open area to coccyx/TX (treatment) started . Review of a Wound consultation dated 12/18/24, documented in part . Established pt (patient) New wound . Bilateral Buttock Gluteal fold is a Full Thickness MASD (moisture associated skin damage) . The wound margin is undefined Wound bed has 26-50%, granulation, 26-50% slough (non-viable yellow, tan, gray, green or brown tissue . The description of the wound by the wound clinician is not the description of a MASD impairment. It is the description of a Stage 3 pressure wound (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present. Slough maybe visible). Review of the medical record and a weekly skin assessment dated [DATE], revealed no documentation of the facility to have identified the wound. (continued on next page)

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 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the care plans revealed no documentation of adequate and appropriate interventions to prevent the development of the wound. Review of progress note dated 12/26/24 at 2:00 AM, documented in part . Change in Condition . Abnormal vital signs . altered mental status, Fever, Tired, Weak, Confused or Drowsy . sending to hospital due to fever and increasing respirations . The medical record revealed R202 was readmitted to the facility on [DATE]. A medical provider note dated 1/8/25 at 9:04 PM, documented in part . Visit Type: F/U (follow up) ER (emergency room)/Hospital . Patient seen and examined for hospital follow-up . was admitted to (hospital name) for sacral decubitus ulcer 12/26/2024 to 1/7/2025. Wound was debrided while in the hospital. Foley catheter was placed for severe sacral wound. She was started on IV (intravenous) antibiotics for sepsis related to this . Review of a wound consult dated 1/8/25, documented in part . Sacral is a Stage 4 Pressure Injury Pressure Ulcer . This indicated the resident was hospitalized for an infected sacral wound and became septic. The wound required debridement which revealed a stage 4 sacral wound. Review of the medical record revealed no identification by the facility staff to have identified the sacral wound to have worsened from the 12/18/24 to 12/26/24, when the resident was transferred to the hospital. On 5/22/25 at 1:41 PM, an interview was conducted with the Administrator and Director of Nursing (DON) regarding the identified wound concerns for R202- inaccurate clinician/staff assessments, lack of appropriate interventions/treatments, the failure of the facility staff to identify the deteriorating wound and notify the physician. The Administrator stated they had identified the same concerns regarding R202's wound. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included facility wide education with the nursing staff, the termination of the wound practitioner and the hiring of the new wound clinician. Audits were provided and the documentation of Quality improvement measures implemented. The audits were still ongoing at the time of the survey. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.