STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235482	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fenton Healthcare	512 Beach St Fenton, MI 48430

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 - Minimal harm or potential for 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** 22348 REFER TO INTAKE NUMBER: MI00147356 Based on observation, interview, and record review, the facility failed to provide the appropriate skin care interventions to prevent the development of pressure ulcers and promote healing consistent with professional standards for three residents (R301, R302, and R304) of four sampled residents reviewed for pressure ulcers resulting in delay in treatment and healing and potential for worsening of wound, infection and further complications. Findings include: Resident 301(R301): R301 was [AGE] years old and admitted to the facility on [DATE] with a diagnosis of Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Major Depressive Disorder, and Pressure Ulcer of the Sacral Region in addition to other diagnoses. On 9/12/2024, R301 was discharged to the nearby acute care hospital to evaluate and treat the wounds. R301 did not return to the facility after discharge to the urgent care on 9/12/2024. A review of R301's Treatment Administration Record (TAR) dated in July, August, and September of 2024, there were missing signatures in the treatment record. On the TAR for July 2024, the treatment order: Cleanse sacrum area and apply Chamosyn with Manuka honey cream every shift. There were missing nurse signatures on 7/2/2024, 7/6/2024, 7/9/2024, 7/18/2024, 7/23/2024, and 7/26/2024. The August 2024 TAR had a one-time order: Cleanse the sacrum area with normal saline and pat dry. Apply Medihoney and Optifoam dressing every day shift dated 8/23/24. The box for 8/23 was not signed and was left blank. Another order: Cleanse sacrum area and apply chamosyn with manuka honey cream every shift. It was noted to have blanks without a signature on the following dates: 8/1/2024, 8/3/2024, 8/4/2024, and 8/16/2024. The September 2024 TAR was reviewed. Another treatment order to apply skin prep to the discolored red area on the right buttock/hip every shift for skin care revealed that on 9/10/2024, the box was left unsigned or blank R Treatment order for the left heel was noted: Apply skin prep to left heel every shift for preventative heel care. Every shift for preventative skin care. It was noted that the treatment box was not signed on 9/2/2024 and 9/10/2024. R301's wound measurement dated 9/12/24 per Wound Consultation by a Nurse Practitioner noted the following: (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: 235482	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/23/2024
NAME OF PROVIDER OR SUPPLIER: Fenton Healthcare		STREET ADDRESS, CITY, STATE, ZIP CODE: 512 Beach St Fenton, MI 48430	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Date of Service: 9/12/24 Visit Type: Wound Care Consult Wound Assessment: .L89.150- Pressure Ulcer of Sacral region, unstageable: Patient will be sent to hospital for further evaluation of deteriorating sacral wound. Location: Sacrum Stage: Unstageable Measurements: Length: 9.50centimeters (cm) Width: 1.40 cm Depth: 0.10 cm Drainage Type: serosanguineous Drainage Amount: Moderate Granulation: 50 Sough 50 Date recorded: September 12, 2024 Status: Deteriorating . The EMR was reviewed on October 23, 2024, at 1:30 PM. The nurse notes for R301 dated 9/12/2024 at 11:00 AM noted that during wound rounds, wound care Nurse Practitioners (NP) (two names mentioned, #1 NP and #2 NP) evaluated her sacral wound and recommended she go to the hospital for further evaluation of deteriorating sacral wound and recommended she go to the hospital for further evaluation of deteriorating wound . On 9/12/24 at 12:27 PM, Wound care doctor in to see the resident. Order received to send the resident to (name of Hospital mentioned) nearby hospital for eval and treatment of deteriorating sacral wound. A review of R301's care plan for at risk for impaired skin integrity date initiated on 11/7/2023 revealed: > Cue to reposition self as needed. Initiated 11/7/2023 . > Follow the facility policies /protocols for the prevention/treatment of the impaired skin integrity . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 302 (R302): A wound treatment performed by the Wound Nurse A for R302 was observed on 10/23/24 at. A review of R302's clinical record EMR conducted on 10/22/24 at 2:30 PM revealed R302 was admitted to the facility on [DATE] with the diagnosis of Parkinsonism, bipolar disorder, difficulty in walking, and limitation of activities in addition to other diagnoses. R302's Braden Scale score was=16, which puts R302 at risk for pressure sore. A stage 3 pressure ulcer at R302's sacral area was noted during admission assessment on 10/11/24. The treatment order specified, dated 10/12/24, was: Cleanse wound on sacrum with NS. Pack area with normal packing strip and apply calmoseptine to reddened area around wound. Cover with Optifoam every day and evening shift. R302's Treatment Administration Record (TAR) was reviewed on 10/22/24 at 2:30 PM, revealed that treatment boxes on 10/16/24 and 10/18/24 were unsigned, and no notes were indicating why the box was left empty by nurses. The Nurses Notes from 10/11/2024 up to 10/22/24 were reviewed 10/22/24 at 2:30 PM. There was no mention in the nurses' notes indicating any treatments performed or missed treatments mentioned. However, on 10/22/24 at 17:19 (5:19 PM), a late entry on 10/22/24 at 17:19 (5:19 PM) as noted stated, Late entry-10/18/24 treatment complete. An interview with Nurse B was conducted on 10/22/24 at 3:10 PM. She confirmed working that day but did not know why the treatment was left blank on 10/16/24. She stated that according to nursing protocol,if not signed, that means it did not happen. Nurse C was interviewed on 10/22/24 at 3:15 PM. She confirmed that she was working on 10/18/2024 and remembered that she had been given all medications and treatments. She stated, I must have missed signing it off that day. Resident 304 (R304): R304 was observed for treatment on 10/23/24 at 2:00 PM. The area was red, and the incontinence pad was soaked and saturated with urine. An open area was noted on the left coccyx area, described by the Wound Nurse A as a part of the skin came off. Wound Nurse A confirmed it, and measurements of the observed open area were noted. On 10/23/24 at 2:15 PM, R304 was observed for wound treatment. R304 was not one of the facility's identified in the list of residents with pressure sore submitted by the facility administrator. Wound treatment and measurement observation revealed an open area on the right sacrum, observed on 10/23/24 during the wound and incontinence care for R304. The top layer of the skin is off on the right sacrum, measured 0.2 centimeters (cm) length x 0.2 cm width and depth of 0.1 cm wound. The Wound Nurse A cleansed the area with Normal Saline and applied calmoseptine cream. The Wound Nurse A explained that this is the standard treatment until the wound nurse practitioner evaluates the area. Wound Nurse A denied receiving a report or knowledge of the open area found in the sacral area. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R304 was admitted to the facility on [DATE] with the diagnosis of metabolic Encephalopathy, Type 2 Diabetes Mellitus, and Limitation of Activities due to disability. R304 was observed with Status/Post-Bilateral Above the Knee Amputation (AKA). R304's Care Plan for at-risk for impaired skin integrity was initiated on 5/20/24, with the last updated interventions dated 8/27/24. The treatment Administration Record TAR for October 2024 was reviewed. A treatment to cleanse the area on the coccyx/sacrum area with Normal Saline and apply calmoseptin every shift for wound care was ordered on 9/25/2024. An empty box with no signed-off signature was noted on 10/20/24. An interview with Wound Nurse A on 10/22/24 at 3:00 PM was conducted. She indicated that it is our protocol to make sure we sign off all treatments that were done. If it is not signed, it didn't happen. During the interview with the Director of Nursing on 10/23/24 at 2:45 PM, she stated that nurses are to provide the treatment as ordered and to document by signing off treatments when done. The facility wound care protocol, dated effective 9/19/24, was reviewed on 10/23/24 at 1:00 PM. The policy's practice guideline noted: . #3. Appropriate preventative measures will be implemented on residents identified at risk, and the interventions are documented in the care plan .#5. The licensed nurse will initiate documentation in the electronic health record, which includes a description of the skin impairment as follows: In Electronic Health Record (EHR) facilities, the licensed nurse will document the skin and wound evaluation for pressure injury and vascular ulcers. Document weekly until the area is resolved .