STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235722	A. BUILDING _____ B. WING _____	07/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MISSION POINT NURSING AND REHAB CENTER OF HOLLY	313 SHERWOOD ST 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 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** This citation pertains to intake #MI 813. Based on interview and record review, the facility failed to provide skin/wound treatments per physician orders for one (R701) of two residents reviewed for surgical incisions, resulting in the potential for delayed surgical healing, worsening of skin conditions, and infection. Findings include: On 7/20/20 at 4:05 PM, a phone interview was conducted with the complainant who reported concerns that the facility had not provided skin/wound treatments to R701 as ordered by the physician. A review of the clinical record revealed R701 was admitted into the facility on [DATE] and had been discharged home per family request on 11/13/19. According to the face sheet [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) assessment dated [DATE] documented R701 had intact cognition, had no pressure ulcers but was at risk for developing one, and had a surgical wound with surgical wound care during this assessment period. There was no care plan initiated which addressed the resident's specific surgical wound care needs. A review of R701's admission skin assessment completed on 10/30/19 documented the resident was admitted with a stage II pressure ulcer to the upper-mid vertebrae area measuring 1.0 cm length by 1.0 cm width. There was no documentation included on this assessment regarding the resident's surgical incision. A review of the admission progress note dated 10/30/19 at 9:52 PM documented, .left chest surgical tx (treatment) over pace maker site, do not change for 72 hours, orders noted to change on 11/2/19. Surgical scar midline chest . A review of skilled charting documentation included an assessment on 11/5/19 at 5:38 PM which read, .Resident has treatable wounds .Pacemaker insertion site left shoulder/chest is open to air with no redness, swelling or drainage noted . There was no physician order to leave the surgical wound open to air at that time. A review of R701's skin/wound treatments ordered by the physician, and the Treatment Administration Records (TARs) revealed the following missing/incomplete (blank) documentation to indicate if treatments had been provided as ordered for: Start date of 11/1/19 at 7:00 AM, Cleanse incision site with NS, pat dry and cover with dry dressing every day shift. Review of the TAR documentation revealed blank entries for: 11/1, 11/2, 11/3, 11/5, 11/6, 11/12, and 11/13/19. This order conflicted with the other order written on 10/30/19 which indicated the treatment for [REDACTED]. On 7/21/20 at 12:45 PM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for completing physician ordered skin/wound treatments, the DON reported they should be done as ordered. When asked about the times the treatments should be completed, such as if ordered for day, or for night, the DON indicated the nurses worked 12 hours shifts, so if due on day shift, should be completed on day shift and if on night, should be on night. The DON was asked to review the aforementioned TAR documentation and confirmed the multiple blank entries. When asked if there would be any other documentation available to verify if these treatments had been completed, the DON reported as a past wound nurse, the documentation should be filled in on the TAR when treatment was completed. The DON further indicated it could be under the skilled charting assessments. The DON was unable to offer any further explanation as to the missing/blank skin/wound treatment documentation for R701, but indicated this same concern had just been discussed during the June agenda nursing meeting. On 7/21/20 at 12:50 PM, the DON requested to have Unit Manager/Wound Care Nurse A review R701's documentation and Nurse A was unable to offer any further explanation as to the lack of documentation in regards to the resident's skin/wound treatments. Nurse A reported R701 may have been seen by the contracted wound physician, however upon review of the clinical record, there were no consultations available for review. On 7/21/20 at 1:45 PM, a review of R701's skilled charting for the aforementioned blank skin/wound treatments revealed there was no documentation that the treatments had been completed. The section of the skilled charting which prompted Dressing changed as per treatment orders was left unchecked (if completed, would have been marked) for these assessments. A review of the facility's Nursing Services Policy and Procedure Manual for Long-Term Care Skin and Wound Management dated Revised April 2015 documented, in part: .Review the resident's care plan, current orders and [DIAGNOSES REDACTED].The following information should be recorded in the resident's medical record, treatment sheet or designated wound form: 1. The date and time the dressing was changed .the name and title (or initials) of the individual changing the dressing .The type of dressing used and wound care given .

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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.