STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824075	A. BUILDING _____ B. WING _____	2/22/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NSG & REHAB GROSSE POINTE WOODS	21401 MACK AVE GROSSE POINTE WOODS, MI 48236

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0000 SS=	Initial Comments The Promedica Skilled-Grosse Pointe Woods Nursing Home was surveyed on 2/22/23 for the purpose of the COVID 19-Focused Infection Control Survey. They were found to be in compliance with 42 CFR Part 483.80 Requirements for Long Term Care Facilities. Census: 52	E0000		
F0000 SS=	INITIAL COMMENTS The Promedica Skilled Nursing Home was surveyed for an Abbreviated Survey on 2/22/23. Intake Numbers: MI00130153, MI00130664, MI00131593, MI00131797, MI00132161, MI00132399, MI00132406, MI00132702, MI00132819, MI00132826, MI00132998, MI00133086, MI00133173, MI00133175, MI00133454, MI00133573, and MI00133793. Census: 52	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity	F0550	F 550 Element 1 Resident #117 no longer resides in facility. The facility failed to have her call light within reach for use as needed. Element 2 All residents in the facility have the potential to be affected. A facility wide audit was conducted to ensure that all residents had a call light within reach. Any non-compliance was addressed immediately with nursing staff. Element 3 “Call Light Policy” was reviewed by the QAPI and deemed appropriate. Staff was re-	3/20/2023

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

Electronically Signed | 03/17/2023

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	of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00133573. Based on observation, interview, and record review, the facility failed to ensure that a call light was within reach for on resident (R714) out of one reviewed for call lights, resulting in the potential for unmet care needs. Findings include: On 2/21/2023 at 12:27 PM, an interview was conducted with R714 regarding their stay in the facility. R714 stated that their wound was causing them pain in the bed and they wanted to get up in a chair. R714 stated that they also could not reach the doughnut given to them by activities. R714 was queried as to if they had activated their call light for assistance. R714 stated that they did not know where their call light was located. Upon observation R714's call light was located on the floor under the bed. R714 was not able to reach		educated on the “call light” policy, the expectations of meeting the resident’s needs. Element 4 Director of nursing or designee will randomly audit 10% of residents weekly x4 then monthly x3 to ensure call lights are within reach. Results to be shared in QAPI for further guidance. Administrator is responsible for achieving and maintaining compliance. Element 5 Date of compliance March 20, 2023.	

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	the call light. On 2/21/2023 at 12:27 PM, the Director of Nursing (DON) was asked to observe where R714's call light was located. The DON observed it on the floor and under the bed and picked it up and clipped it to R714. The DON stated that residents should be able to always reach the call light. A review of the medical record revealed that R714 admitted into the facility on 12/15/2023 with the following diagnoses, Pressure Ulcer of Sacral Region, and Muscle Weakness. A review of the most recent Minimum Data Set (MDS) assessment dated 12/22/2022 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating an intact cognition. R714 also required extensive two-person assistance with bed mobility. A review of a facility policy titled, "Call Light" noted the following, "Procedure: 6. Position call light conveniently for use and within reach."			
F0551 SS= D	Rights Exercised by Representative §483.10(b)(3) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with State law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated. (i) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative. (ii) The resident retains the right to exercise those rights not	F0551	F 551 Element 1 Resident #712 no longer resides in the facility. The facility failed to contact the emergency contact for the resident when they transferred to the hospital. Element 2 All residents have the potential to be affected by this citation. An audit of all residents sent to hospital from 2/22/2023 was completed to ensure emergency contacts were notified. Any non-compliance was corrected immediately. Element 3 The policy on “Change of Condition” was reviewed by the QAPI team deemed appropriate. The license nurses were	3/20/2023

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	delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by State law. §483.10(b)(4) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(5) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law. §483.10(b)(6) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and in the manner required under State law. §483.10(b)(7) In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under State law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with State law. (i) In the case of a resident representative whose decision-making authority is limited by State law or court appointment, the resident retains the right to make those decisions outside the representative's authority. (ii) The resident's wishes and preferences must be considered in the exercise of rights by the representative. (iii) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process. This REQUIREMENT is not met as		reeducated on contacting the responsible party when sent to hospital. The director of nursing or designee will verify this has occurred at morning meeting M-F when reviewing hospital returns. Element 4 Director of nursing or designee will conduct audits weekly x4 and monthly x3 to ensure that the responsible party is notified if transferred to hospital. Results to be shared in QAPI for further guidance. Administrator is responsible for achieving and maintaining compliance. Element 5 Date of compliance March 20, 2023.	

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	evidenced by: This citation pertains to Intake MI00133454. Based on interview and record review the facility failed to inform an emergency contact of a hospital transfer for one resident (R712) out of one reviewed for resident representatives, resulting in the potential for delay in notification and treatment. Findings include: A review of Intake called into the State Agency (SA) noted the following, "[R712] was found unresponsive in [their] room. [They] were transferred to [Hospital Name] in [City]. I was never contacted by the rehab center. A doctor at [Hospital Name] contacted me for information on [R712]." A review of the medical record revealed R712 was admitted into the facility on 11/19/2022 with the following diagnoses, Muscle Weakness and Difficulty in Walking. A review of the most recent Minimum Data Assessment (MDS) set dated 11/21/2022 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating an intact cognition. R712 also required extensive one-person assistance with bed mobility and transfers. The face sheet had one emergency contact listed for R712. A review of the progress notes revealed the following, "Effective Date: 12/7/2022 at 4:42 AM. Note Text: Writer summoned to pt. (patient) room per CNA (Certified Nursing Assistant) pt. unresponsive but breathing, have a pulse ...pt. sent to [Hospital Name] via EMS ...both physician and DON(Director of Nursing) notified." On 2/22/2023 at 10:43 AM, an interview was			

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	conducted with the DON regarding emergency contacts. The DON stated that they would expect for the emergency contact to be notified upon transfer to the hospital. A review of a facility policy titled, "Change in Condition" noted the following, "3. Intervention Phase: Notify the responsible party."			
F0656 SS= D	Develop/Implement Comprehensive Care Pla §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must	F0656	F656 Element 1 Resident #710 no longer resides in the facility. The facility failed to ensure that the residents care plan was updated with bed mobility status listed. Element 2 All residents in the facility have the potential to be affected. A facility wide audit was conducted of all resident's care plans to ensure that bed mobility status was addressed and updated where needed for those residents requiring additional assistance. Element 3 The policy "Care Plan Preparation Long Term Care" was reviewed by the QAPI Committee and deemed appropriate. The licensed nurses were reeducated on the importance of placing transfer status and bed mobility into the plan of care. The director of nursing or designee will ensure that this is entered into the care plan with admission when reviewing in the morning meeting. Any resident with changes that result in a change in transfer status will be addressed with the interdisciplinary team and revised in the care plan within the morning IDT meeting as well. Element 4 Director of nursing or designee will conduct audits weekly x4 then monthly x3 on all new	3/20/2023

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	document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00133173. Based on interview and record review, the facility failed to implement a care plan intervention of, two persons assist for bed mobility" for one resident (R710) out of one reviewed for care plan interventions, resulting in the increased risk for injury and dissatisfaction with care. Finding include: A review of a Facility Reported Incident (FRI) noted the following, "CNA (Certified Nursing Assistant) stated, I went into the patient's room to change [them]. I informed the patient that I was going to clean the front of [them] first. Once I was done, I told [them] I was about to turn [them] and told [them] to give [themselves] a hug. Once I began to use the draw sheet to turn the patient, [they] grabbed the TV and it dropped down to the dresser. The patient then yelled stop and said [they] wanted someone else to finish. I replied, 'I didn't mean to startle you and I won't let you fall.' I rolled the patient back, left out the room to find another CNA to change [R710]". A review of the medical record revealed that		admits ensuring all care plans has transfer status and bed mobility. Results to be shared in QAPI for further guidance. Administrator is responsible for achieving and maintaining compliance. Element 5 Date of compliance March 20, 2023.	

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	R710 admitted into the facility on 10/18/2022 with the following diagnoses, Obesity, Heart Failure, and Fibromyalgia. A review of the most recent Minimum Data Set (MDS) assessment dated 11/17/2022 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 indicating intact cognition. R710 also required extensive two person with bed mobility, toilet use, and transfers. Further review of the Care Plan revealed the following, "Focus: Requires assistance/potential to restore function for TRANSFERRING from one position to another as evidenced by need for 2-person extensive assistance related to stroke, weakness. Date Initiated: 10/19/2022." "Goal: Will be able to transfer with assistance of 2 people." On 2/22/2023 at 10:43 AM, an interview was conducted with the Director of Nursing (DON) regarding the FRI. The DON stated that they were new to the position and was not familiar with the resident. The DON stated that they were waiting for therapy to provide notes regarding R710's required assistance levels. No therapy notes were provided prior to survey exit. A review of a facility policy titled, "Care Plan Preparation, long-term care" noted the following, " Elements of a Care Plan ...Include information regarding ways to address causes and risks associated with issues and conditions to allow for resident's highest level of well-being."			
F0684	Quality of Care § 483.25 Quality of care	F0684	F684	3/20/2023

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SS= D	Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake: MI00131797, MI00132819, MI00132826 and MI00133573. Based on observation, interview and record review, the facility failed to respond timely to a resident experiencing a change of condition for one sampled resident (R707) of one resident reviewed, resulting in unmet care needs. Findings include: A review of Intake called into the State Agency revealed the following, "On 11/10, [R707] was experiencing chest pain and difficulty breathing starting at around 6:45p. [They] turned on [their] call light, but staff did not respond to help [them]. [They] called [their family member] and begged [them] for help. [Family member] repeatedly called the facility for over one hour, but staff never answered the phone. [Family Member] drove to the facility (approximately 17 miles) and called 911... [R707] was transported to [local hospital]..." A review of R707's medical record revealed that they were admitted into the facility on 2/10/18 with diagnoses that included Chronic Kidney Disease, Diabetes, Coronary Artery Disease, Muscle Weakness and Polyneuropathy. A review of their Annual Minimum Data Set (MDS)		Element 1 Resident #707 still resides in the facility. The facility failed to ensure that the resident needs were met by recognition of quantitative data to show a change in condition. The facility failed to respond to this need in a timely manner. Element 2 Any resident who experiences a change of condition has potential of being affected. The resident chart was reviewed to include labs and any other pertinent findings. The primary physician was consulted on any findings that were out of the normal for the resident. No changes in orders or plan of care were noted by the physician upon review. A facility wide audit was conducted to assess for potential changes in condition. This was done by reviewing a vital sign report of all in house residents with a focus on anything that was not WNL, or out of the normal for that resident. Any variations were assessed for potential a potential change in condition. Lab values/x-rays were also reviewed for the same parameters. Element 3 The policy “Change of condition” and “call lights” was reviewed by the QAPI committee and deemed appropriate. All licensed nurses were reeducated on the importance of responding to a change of condition immediately. Nurse managers will continue to discuss abnormal lab values, tests and vital signs when discussing changes of condition within the morning IDT meeting. Element 4 Director of nursing or designee will audit weekly x4 then monthly x3 on change of condition and call lights. Results will be shared in QAPI meeting for further guidance. Administrator is responsible for achieving and maintaining.	

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	assessment dated 1/17/23 revealed that R707 had a Brief Interview for Mental Status (BIMS) score of 12/15 indicating a moderately impaired cognition, and required extensive assistance of 2 persons for bed mobility, transfers and bathing. On 2/21/23 at 12:26 PM, R707 was observed sitting up in their wheelchair. They were asked about the incident in November (2022) with their call light not being answered. R707 explained that when they didn't receive assistance, police officers and their family member came into their room, and then they were sent to the hospital. A review of R707's progress notes revealed the following written by Licensed Practical Nurse (LPN) "L", "11/10/2022 20:45 (8:45pm) Skilled Nursing Note Text: Writer had just came from down stairs and got some ice water for the patients. When standing at my cart, I heard a moaning noise that was coming from room [707's room] I went in room and it was [R707], I asked [them] what was wrong, and [they] stated, Its too tight, I stated what? your brief, so I took a look at [their] brief and loosen it, but it wasn't tight, then [they] pointed to [their] stomach and stated that it hurts. Looking at pt (patient) [they] didn't look or sound [themselves], [R707] had small amounts of mucus coming from [their] mouth and wheezing sounds noted.I went out the room and called 911 immediately, printed face sheets, medication sheets and transfer/discharge sheets and went back in room with vital sign machine to take [their] vitals...While in room with patient a policeman walked in. I told him I had just called 911 for pt (patient) to be transferred to hospital, a few minutes later EMTs x 2 (2 emergency medical technicians) was here and was asking what was going on with the pt, about that time [R707's family member] came in room yelling and cursing, Writer trying to tell [them] what's going on and talking to the EMTs, pts' [family member] rushed over in my face cursing, I told		Element 5 Date of compliance March 20, 2023.	

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[family member] I'm not going to go back and forth with [them], and continued to talk to the EMTs. The Police told [family member] to exit rm (room) where [they were] in the hallway cursing at the cnas (certified nursing assistants). EMTs got paperwork and took pt to the hospital. Police in hallway talking to [family member] then [they left] with EMTs. Police stayed and asked what happened to patient and my name then [they] left..."

On 2/21/23 at 11:26 AM, a phone interview was completed with Police Officer "M" about their response to 911 calls made regarding the facility. Police Officer "M" explained that when he is often dispatched to the facility, it is a result of the residents indicating that they are unable to obtain help or assistance from facility staff, and reports that the call regarding R707 was the second 911 call in a 7-day period, in which residents were indicating that they weren't being assisted. Police Officer "M" explained that the family of R707 called 911 because they kept calling the facility for over an hour and no one was responding to their calls. Police Officer "M" explained that he arrived at the facility 5 minutes prior to Family Member "P" arriving, as they had driven a distance to arrive at the facility. Officer "M" explained that the facility did eventually called 911, and the resident was sent to the hospital.

A review of R707's preliminary report, dated 11/11/22 from their admission into the hospital revealed the following, "History of Present Illness: The patient is [identifying information] transferred from the nursing home because of shortness of breath and fluid retention ....I spoke to [family members "N" and "P"]. Family Member "P" said that [they] were apparently talking to [R707] and [they] suddenly stopped talked and [they] could hear in the background [R707] calling for help. [They] called [nursing facility] but there was no answer, so [they] called

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PROMEDICA SKILLED NSG & REHAB GROSSE POINTE WOODS	**21401 MACK AVE GROSSE POINTE WOODS, MI 48236**

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	[family member] who in turn called 911 and brought [R707] here ..." A review of R707's census report revealed that they were transferred from the facility to the hospital on 11/10/22, and returned to the facility on 11/15/22. On 2/22/23 at 8:06 AM, a second request for incident and accident reports (I/As) for R707 were requested from the facility. The Director of Nursing (DON) explained that due to a new corporation taking over the facility, they don't have access to some I/A's however, they are looking for them. They were not received by the end of the survey. On 2/22/23 at 8:48 AM, Family Member "N" was interviewed via phone regarding the November (2022) incident involving R707. Family Member "N" explained that every day they along with three other family members contact R707 and converse with them. Family Member "N" explained that during the phone call which occurred between 7-9pm, R707 began to complain of shortness of breath, in which R707 was advised by family members to push their call light however, no one responded. As a result, another family member (Family Member "O") called the front desk, but no one answered. Family Member "N" explained that they remained on the phone with R707 for an hour with calls continuously being made to the facility to no avail. Family Member "N" explained that 911 was contacted by Family Member "Q" resulting in the police being dispatched to the facility, and R707 being transported to the hospital for "fluid around their heart". On 2/22/23 at 9:01 AM, Family Member "O" was interviewed via phone regarding the November (2022) incident involving R707. Family Member			

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	"O" explained that the incident occurred at approximately 7 PM while on a phone with R707 and 3 other family members. Family Member "O" explained that they noticed R707 was short of breath and sounded as if they were vomiting. Family Member "O" explained that R707 had pressed their call light, and kept saying, "help me, help me". Family Member "O" referred to their call log and explained that they contacted the facility eight times with the phone ringing up to 30 times without anyone answering. As a result, Family Member "Q" contacted 911 while Family Member "P" drove to the facility where they were met by the police. Family Member "O" explained that after the receptionist leaves for the day, no one ever answers the front desk phone, and when their concern was brought to the attention to facility leadership, they were advised that they were working on getting nurses phones. On 2/22/23 at 9:20 AM, Family Member "P" was interviewed via phone regarding the November incident involving R707. Family Member "P" explained that while on the phone with R707 and 3 other family members, R707 began to cough and could barely talk. Family Member "P" explained that R707 was advised to put on their call light which they did, however, no one was responding. As a result, Family Member "O" began to call the facility back-to-back without receiving a response, while Family Member "Q" called 911. Family Member "P" explained that they left their home to drive to the facility while remaining on the phone with R707 who kept stating, "help me." Family Member "P" explained that the drive from their home to the facility is approximately a 25-minute drive, and when they arrived at the facility, the call light was still on and the police and EMTs had arrived as well. Family Member "P" explained that R707 was sent to the hospital for complications related to Heart Failure and when the facility was confronted on why it took so long for someone to respond, they			

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	indicated that they were short-staffed. Family Member "P" explained that they spoke to the responding officer who explained to them that they had received two calls regarding R707, the first one from their family member, and second call being from the facility. On 2/22/23 at 11:07 AM, LPN "N" was contacted via phone to no avail. A review of the police report dated for 11/10/22 revealed the following, "On 11/10/2022 around 2027 (8:27pm) responded to [facility]...[family member] called our dispatch about [R707]. [Family member] stated that [R707] needed help, but staff was not helping [them]. I arrived at the location and an unknown nurse let me in. I then went to room [removed] where R707 was located. I observed a nurse assisting [them]. The nurse [LPN "N"] said that R707 is saying [their] stomach was hurting and she said they called an ambulance. I asked [R707] what was wrong [they] said that [their] chest was tight. Medics did make the location and transported [R707] to [local hospital]....[R707's family member] did show up to the facility. [Family Member "P"] stated that [they] called [R707], and [they] did not sound good. [R707] said to [Family member "P"] that [they] needed help and that [they] put [their] call light on, but the nurses were not coming. [Family Member "P"] said that [Family Member "O"] started calling the facility around 1843 (6:43pm) but received no answer. The family did call around six more times after that and let it ring for 20 times each call, but no staff ever answered. That's when [Family Member "P"] finally came to the facility to check on [R707]. [Family Member "P"] did call our dispatch at 2027 (8:27pm) and requested us to respond to do a welfare check. The facility did call for an ambulance at 2037 (8:37pm)..."			

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	On 2/22/23 at 10:52 AM, the Director of Nursing (DON) was asked if she was aware of the incident regarding R707 and the lack of response from staff. The DON explained that she was not aware of the incident as she was new to the facility. She was asked her expectation for call lights to be answered, and she stated, "15 minutes". The DON was asked about phone calls made to the facility after hours, and she indicated that she would get back to surveyor. On 2/22/23 at 11:28 AM, the DON explained that after hours, phone calls are transferred to the nurses' station however, she is working on getting the nurses assigned phones. Regarding prompt care she explained that they are striving to provide excellent care, and that also includes hiring additional staff, specifically CNAs. A review of the facility's "Call Lights" policy revealed the following, "Purpose: To use a call light and/or sound system to alert staff to patient needs...Procedure: 1. Answer call lights in a prompt, calm, courteous manner. Staff, regardless of assignment, answer call lights..."			
F0686 SS= G	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of	F0686	F686 Element 1 Resident #714 no longer resides in facility. The facility failed to ensure wound care orders were in place for a resident on admission and ongoing for other residents when orders were changed by the physician. Element 2 All residents with wounds have the potential to be affected. A facility wide audit of all residents with wounds was completed to ensure all orders and intervention are in	3/20/2023

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	practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00133793, MI00131797, MI00132161, and MI00132399. Based on observation, interview, and record review, the facility failed to implement wound care interventions per physician orders for two residents (R714 and R702) and enter wound care orders upon admission for one resident (R713) out of four reviewed for wounds, resulting in worsening of wounds, surgical intervention, and hospitalization. Findings include: Resident R714 On 2/21/2023 at 12:27 PM, R714 was observed in their room laying on their right side. R714 stated that they were in pain. R714 stated that the pain was on their bottom and that they had a wound on their bottom. R714 was not noted to be on any pressure relieving air mattress. A review of the medical record revealed that R714 admitted into the facility on 12/15/2023 with the following diagnoses, Pressure Ulcer of Sacral Region, and Muscle Weakness. A review of the most recent Minimum Data Set (MDS) assessment dated 12/22/2022 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 indicating an intact cognition. R714 also required extensive two-person assistance with bed mobility. A review of the most recent skin assessment dated 2/17/2023 revealed that R714 had a Stage Four pressure ulcer (deep wound reaching the		place. Element 3 The policy “skin management guidelines” was reviewed by the QAPI team and deemed appropriate. All licensed nurses were reeducated on implementing wound care orders and interventions on both admission as well as PRN. The director of nursing or designee, during the morning IDT discussion, will review new admissions M-F. Those with identified wounds will be checked for orders. When discussing skin, all new skin concerns will be reviewed for treatments and orders as needed. Element 4 Director of nursing or designee will audit weekly x4 and then monthly x3 of all new admits with wounds. Results will be shared in QAPI meeting for further guidance. Administrator is responsible for achieving and maintaining compliance. Element 5 Date of compliance March 20, 2023.	

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muscles, ligaments or bones) on the Sacrum (buttocks region)

A review of the physician orders revealed the following, "Order: APM (Alternating Pressure Mattress) to bed. Status: Active. Revision Date: 12/16/2022."

On 2/21/2023 at 12:39 PM, the Director of Nursing (DON) was asked to observe R714 and their mattress. The DON stated that R714 should have an air mattress, especially because R714 has a wound.

Resident 713

A review of Intake called inot the State Agency (SA) noted the following, "[R713] had a bedsore on coccyx and inner buttocks that progress from being managed with ointment to a Stage 4 (deep wound reaching the muscles, ligaments or bones) status."

A review of the medical record revealed that R713 admitted into the facility on 12/9/2022 with the following diagnoses, Peripheral Vascular Disease and Pressure Ulcer of Right Buttocks. A review of the most recent Minimum Data Assessment (MDS) set dated 12/19/2022 revealed a Brief Interview for Mental Status (BIMS) score of 6/15 indicating impaired cognition. R713 also required extensive two-person assist with bed mobility and transfers.

A review of the Nursing Admission Assessment dated 12/10/2022 noted the following skin impairment, "Site: 23) Coccyx. Description: dark red, no open areas, no discharge."

A review of the progress notes revealed the following, "Date:12/16/2022 at 11:21 AM. MP Wound Progress Note: HPI: This is a 56 year

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	...today at [facility] for present on admission unstageable coccyx wound, unstageable left buttock wound, left hip Stage 2 (outer surface of skin damaged), left and right diabetic heels, and venous PVD (Peripheral Vascular Disease) of BLE (Bilateral Lower Extremities) ... Discussed with Administration that the wound team was not made aware of present on admission unstageable wounds, Stage 2 hip wound, venous wound, or diabetic heel wounds until 12/16/2022. Consult was placed per nursing on admission, however unit manager or wound team was not alerted per protocol, picture was not captures on admission, and a wound care order was not obtained from the wound team or the primary team from nursing during the admission assessment ...Discussed coccyx wound appearance with primary team, Keflex (antibiotic) 500 mg (milligram) Q8 (every eight hours) by mouth for seven days ...Primary team will arrange possible surgical debridement." A review of the physician orders noted the following; "Order: Cleanse coccyx with normal saline, pat dry, apply therahoney sheet, and cover with foam dressing every shift and PRN (as needed). Start: 12/10/2022." "Order: Cleanse right and left hip wounds with NS (Normal Saline), dry, apply large foam dressing to each side. Start:12/16/2022." "Order: Cleanse back of left hip with NS. Dry. Apply calazime to area and cover with foam. Start: 12/16/2022." "Order: Cleanse Coccyx wound with NS. Dry. Apply Dakins ¼ wet to dry on coccyx. Cover with large foam. Active:12/16/2022." On 2/22/2023 at 7:25 AM, an interview was			

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	conducted with Wound Care Nurse (WCN) "K" regarding R713. WCN "K" stated that they were not employed as the wound care nurse at that time. WCN "K" stated that if an admission comes in on the weekend, then the floor nurse should complete a full skin assessment, enter a wound consult, and put in an order until they can be seen. WCN "K" stated that they now go see every new admission, even if it's not documented that they have a wound, so nothing gets missed. R702 A review of Intake called inot the State Agency (SA) revealed the following, "Complainant states the facility neglected to properly treat the resident when they were transferred. Complainant states the facility failed to put the resident's wound vac (vacuum assisted closure of wound) on for 3 days and when [they] visited today the wound vac was put on incorrectly..." A review of R702's medical record revealed that they were admitted into the facility on 10/6/22 with diagnoses that included Diabetes, Unspecified Open Wound to Right Foot, and Chronic Kidney Disease. Further review revealed that the resident was alert and oriented x 3 (person, place and time), and required extensive assistance for bed mobility, toileting and personal hygiene. Further review of R702's medical record revealed a hospital record dated from R702's admission to the hospital on 9/28/22, prior to admission onto the facility, " ...Patient with history of right heel ulcer treated with 4 separate courses of abx (antibiotics) since January 2022 without improvement. Pt. (patient) with history of diabetes and peripheral neuropathy, PAD (Peripheral Arterial Disease), nonhealing ulcer. MRI showed underlying osteomyelitis ...Plan			

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	consult podiatry: s/p (status post) right foot debridement..." Further review of the medical record revealed a podiatry note dated for 10/4/22, "CC (chief complaint): Right heel wound. Patient was seen and examined today, in bed with wound vac in place functioning properly. [Family member] is present at bedside. [They were] updated. Patient is stable for discharge per podiatry. [R702] will need to be discharged with the wound vac and it will need to be changed every other day with adaptic placed over the graft site, then black foam, then wound vac adhesive ...." Further review of R702's medical record revealed one progress note indicating the use of a wound vac,"10/10/2022 06:35 (6:35 AM) Type: General Progress Note, The pt (patient) is alert and oriented x3. Although the pt has a language barrier pt is able to make needs know. Writer applied wound vac to the pt's right heel at 125 (1:25 PM). The pt denies any pan/discomfort. No concerns at this time." Further review of R702's medical record did not reveal physician orders for a wound vac, additional progress notes, or a care plan indicating the use of a wound vac. Further review of R702's 10/7/22 physician orders indicated the following for the care of R702's wound, "Cleanse right heel w/ NS (normal saline). Pat dry. use packing gauze one time a day for wound care AND as needed for wound care...bilateral soft protective boots to be applied when patient in bed." On 2/22/23 at 7:26 AM, the Wound Care Nurse "K" was asked about their process for ensuring recommendations from the hospital are followed upon residents arrival to the facility. She			

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	explained that the goal is to review documentation, communicate with their physician internally, and the resident's outside physician to ensure that recommendations are being followed. On 2/22/23 at 10:48 AM, the Director of Nursing (DON) explained that her expectation is for the wound care nurse to ensure that recommendations are being followed for the care of residents' wounds. A review of the facility's "Skin Management Guidelines" did not address following recommendations/orders for wound care of residents being admitted from the hospital to the facility.			