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	504210	A. BUILDING _____ B. WING _____	**3/28/2023**

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FATHER MURRAY, A VILLA CENTER	**8444 ENGLEMAN CENTER LINE, MI 48015**

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F0000 SS=	INITIAL COMMENTS Father Murray, A Villa Center was surveyed for an Abbreviated survey on 3/28/2023. Intakes: MI00132939, MI00133015, MI00133018, MI00133148, MI00134206, MI00134235, MI00134486, MI00134947, and MI00135089. Census: 211.	F0000		
F0686 SS= D	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 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 MI00135089. Based on interview and record review, the facility failed to initiate wound treatment orders upon admission for one resident (R702) of five reviewed for pressure ulcers/skin alterations, resulting in the potential for infection and worsening of an existing wound. Findings include:	F0686	Element #1: Resident #702 no longer resides in the facility. Element #2: Residents admitted with wound care needs are at risk. This deficiency occurred due to the admitting nurse failing to obtain and write the treatment order for wound care treatment. An audit of all new admissions for the past 14 days was conducted as well as a skin assessment audit (ensuring treatment orders in place) on all current residents was done to identify any further deficiencies. No further deficiencies identified. Element #3: The policy for wound care was reviewed and deemed appropriate. All licensed nurses were educated on skin assessment upon admission, obtaining and writing wound care treatment orders for resident presenting with wound care needs. A New Admission Worksheet (including guidance on wound care treatment orders) was developed and provided to nurses to use for all new admits. Clinical managers will complete this audit daily x 14 days, weekly x 4 and then quarterly as needed. Element #4: The Director of Nursing/designee will complete weekly random audits of new	4/6/2023

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

Electronically Signed | 04/05/2023

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.

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	A review of R702's record revealed that the resident was admitted into the facility on 1/27/23 and discharged on 2/8/23. R702's medical diagnoses included Acute Respiratory Failure with Hypoxia, Diabetes Mellitus Type 2, Pressure Ulcer of Buttocks, Muscle Weakness, Morbid Obesity, Ventricular Tachycardia, Hypokalemia, Constipation, Hypertension, Atrial Fibrillation, Acute on Chronic Heart Failure, and Retention of Urine. Further review of R702's record revealed that the resident was cognitively intact and required substantial/max assistance for bed mobility. A review of R702's admission progress note dated 1/27/23 at 19:50 (7:50 PM) revealed, "...[S]kin assessment showed pressure wounds on bilateral buttocks, open wound with drainage, unstageable...functional assessment documented extensive assist on toileting, bathing, transfers, ambulation..." A review of R702's medical record revealed two photos taken on 1/28/23 of a large wound located on R702's sacrococcyx/bilateral buttocks. The assessments accompanying the photos, also dated 1/28/23, indicated that the nurse who had taken the photos, Licensed Practical Nurse (LPN) "F", had cleansed the wound with normal saline and applied an antimicrobial treatment covered with a dry dressing. A review of a progress note dated 2/2/23 and written by the facility's visiting wound care practitioner revealed, "... Procedures: Wound #1 (Pressure Ulcer) is located on the sacrococcyx/bilateral buttocks. A non-selective mechanical debridement was performed by [practitioner]. Non-viable tissue was removed. The procedure was tolerated well. Post Debridement Measurements: 14.7 cm (centimeter) length x 10.5 cm width x 0.2 cm		residents admitted with wound care needs to ensure treatment orders in place per expectation. The results of audits will be reported during the scheduled QAPI meeting and used to provide additional training to staff falling short of this expectation. The Director of Nursing will be responsible for assuring compliance is maintained.	

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	depth;...post debridement Stage notes as Stage 4 Pressure Injury (skin damage into muscle and/or bone)... Plan: Wound Orders: Wound #1 Sacrococcyx/Bilateral Buttocks...Cleanse wound with Normal Saline...Apply Dakins moist gauze (1/4) strength) BID (twice a day) / PRN (as needed) x 7 days..." A review of R702's physician orders revealed that a treatment order for R702's sacrococcyx wound was not entered into the record until 2/6/23. The treatment initiated on 2/6/23 for R702's wound was the one recommended by the wound care practitioner on 2/2/23. Additional review of R702's progress notes, assessments, and record revealed no additional documentation that indicated regular and consistent wound treatments and dressing changes were being performed for R702's wound after admission and prior to entry of the 2/6/23 treatment order. On 3/27/23 at 2:05 PM, LPN "E" and LPN "F", two of the facility's wound care nurses, were interviewed regarding R702. LPN "F" indicated she does not work on Fridays (R702's day of admission was a Friday), and therefore ended up taking photos of R702's wound on Saturday 1/28/23. LPN "F" confirmed she changed the resident's wound dressing when she took the photos, and stated that she put the wound treatment orders in the record. LPN "F" added that she recalled that she could not get R702's wound to stop bleeding. When queried regarding where to find R702's admission wound treatment orders, the nurses indicated they would look in the record and report back. LPN "E" stated that residents typically, "Get wound care orders...as soon as they walk in the door," and the treatments			

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	are documented on the TAR (treatment administration record). A review of R702's TAR revealed only the wound treatment ordered on 2/6/23. On 3/27/23 at 2:42 PM, LPN "E" approached and stated she, "Looked everywhere, but couldn't find [R702's] wound care order," upon admission and thereafter. LPN "E" insisted that wound care treatments were performed for R702 prior to 2/6/23 but acknowledged the lack of documentation to support that statement. On 3/28/23 at 11:27 AM, the Director of Nursing (DON) was interviewed and queried regarding R702's wound treatment orders. The DON indicated that it is her expectation that wound care orders are entered into a resident's record upon admission. A review of the facility's policy/procedure titled, "Skin Management Guideline," dated 11/28/17 revealed, "...It is the practice of this facility to properly identify and evaluate residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care...When a pressure ulcer is present, daily wound monitoring should include: an evaluation of the ulcer, if no drainage is present; an evaluation of the status of the dressing, if present..."			
F0691 SS= G	Colostomy, Urostomy, or Ileostomy Care §483.25(f) Colostomy, urostomy,, or ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services, receive such care consistent with professional standards of practice, the comprehensive person-centered	F0691	Element #1: Resident #700 no longer resides in the facility. Element #2: Residents admitted with ostomy sites are at risk. This deficiency occurred due to the admitting nurse failing to obtain and write the	4/6/2023

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	care plan, and the resident's goals and preferences. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake MI00132939. Based on interview and record review, the facility failed to adequately assess, monitor and document provided care to an ileostomy (last part of small intestine has an opening through the abdominal wall to collect waste) and surrounding skin for one resident (R700) of one residents reviewed for ostomy care, resulting in unmet care needs, and inadequate assessment and treatment of skin breakdown resulting in hospitalization. Findings include: A complaint filed to the State Agency was reviewed and included the following: "[R700]...has a Colostomy (ileostomy) Bag... [and] was brought into the Emergency Room (ER) today via ambulance for Medical Device Malfunction. There was not a malfunction, [R700] has a colostomy (ileostomy) with no bag on it. [R700] has been sitting in [their] own feces for long enough to cause horrendous skin breakdowns throughout [their] abdominal area. [R700] will be kept in the hospital for at least a couple of days. Upon [their] discharge, [R700] will have a full colostomy device." A review of R700's record revealed that the resident was admitted into the facility on 11/10/22 and discharged to an acute care hospital on 11/16/22. R700's medical diagnoses included Ileostomy Status, Anxiety Disorder, Respiratory Failure, Protein-Calorie Malnutrition, and Metabolic Encephalopathy. Further review of R700's record revealed that the resident was		treatment order for ostomy care. An audit (including type/size of ostomy, treatment order in place) was done on all residents with ostomy sites and no further deficiencies identified. Element #3: The policy for ostomy care was reviewed and deemed appropriate. All licensed nurses were educated on obtaining and writing ostomy care orders upon admission of residents with ostomy sites. A New Admission Worksheet (including guidance ensuring ostomy care orders are in place) was developed and provided to nurses to use for all new admits. A new audit tool was developed and will be utilized to review all new admissions and to identify ostomy care needs. Clinical managers will complete this audit daily x 14 days, weekly x 4 and then quarterly as needed. Element #4: The Director of Nursing/designee will complete weekly random audits of new residents admitted with ostomy care needs to ensure treatment orders for ostomy care are in place per expectation. The results of audits will be reported during the scheduled QAPI meeting and used to provide additional training to staff falling short of this expectation. The Director of Nursing will be responsible for assuring compliance is maintained.	

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cognitively intact and required the assistance of one staff for most activities of daily living (ADLs). R700 was also noted to be receiving oral antibiotic treatment for Clostridium difficile (C. Diff) infection (gastrointestinal infection causing diarrhea) upon admission into the facility.

A review of R700's physician orders (typically generate to a medication (MAR)/treatment (TAR) administration record) did not include any related to ileostomy care or monitoring.

The following order was found:

-"Skin Checks Weekly - complete Skin Evaluation in (electronic medical record system) on admission and weekly on assigned day one time a day every Mon, Thu." This order was checked off in the MAR/TAR as being completed on 11/14/22, however, no corresponding assessment nor progress note related to it was found in the record.

A review of R700's care plan revealed:

-"Focus: The resident has actual impairment to skin integrity r/t (related to) colostomy (ileostomy) with loose stool coming in contact with surrounding skin. Date Initiated: 11/10/2022...

-Interventions: Evaluate and treat per physicians orders. Date Initiated: 11/10/2022...

Evaluate resident for S/SX (signs/symptoms) of possible infections. Date Initiated: 11/10/2022...

-Monitor skin surrounding site q/ (every) shift and complete dressing change as ordered. Date Initiated: 11/10/2022...

-Avoid scratching and keep hands and body parts

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	from excessive moisture. Keep fingernails short. Date Initiated: 11/15/2022... -Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Date Initiated: 11/15/2022... -Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx of infection, maceration (breaking down of skin) etc. to MD (physician). Date Initiated: 11/15/2022." A review of R700's progress notes revealed the following: -11/11/22 02:09 (AM)..."Skin Observation Note Text: Resident has new skin issue(s) observed. 1 Vertebrae (upper-mid) - wound to L (left) 8 or 9th rib, Sacrum - small opening to coccyx. Abdomen - RUQ (Right Upper Quadrant) iliosteomy (sic). Skin turgor with good elasticity...Skin condition is normal." -11/11/22 11:18 (AM)..."Comprehensive Nutrition Assessment...General appearance is: thin, Resident is not well nourished...Resident has severe fat loss...has severe muscle loss...There is presence of skin alteration/s...Stage 3 (full thickness skin loss) PU (pressure ulcer) spine...recent total colectomy with ileostomy..." -11/11/22 18:39 (6:39 PM)..."Physician/PA/NP - Progress Note (Narrative)...s/p (status post)...end ileostomy, abdominal closure 9/28(/22)...Physical Examination:...Skin: Intact. No visualized rash...s/p SBO (small bowel obstruction) ileostomy. Continue to monitor output..." (Written by Nurse Practitioner (NP) "I"). A review of R700's progress notes and assessments dated 11/12/22, 11/13/22, and			

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	11/14/22 did not indicate that staff assessed the resident's skin nor provided ileostomy care/monitoring. Continued review of R700's progress notes revealed: -11/15/22 15:25 (3:25 PM)..."Physician/PA/NP - Progress Note (Narrative)...Infectious Disease Initial Evaluation...Physical Exam: Skin: warm, dry, right upper quadrant ileostomy with surrounding erythema tenderness extending to lateral flanks no open areas or drainage..." -11/15/22 16:33 (4:33 PM)..."eMar - Medication Administration Note Text: Acetaminophen Capsule 500 MG (milligram) Give 2 tabled by mouth every 6 hours as needed for Mild pain c/o (complaints of) ab (abdominal) pain." -11/16/22 06:59 (AM)..."Health Status Note (nurses note)...Upon arrival of shift, resident was cleaned by this writer new brief applied, and colostomy bag changed as well, resident later stated that [they] did not want to wear colostomy bag due to red irritated skin and...was going (sic) to take the bag off...this writer removed bag and cleaned area and left towel over per residents request, upon end of shift bag was reapplied." -11/16/22 10:45 (AM)..."Health Status Note (nurses note)...Resident has history of refusing care to...ileostomy site. Risk vs benefits explained to resident in terms that [they] could understand. Resident was explained the benefits of allowing staff to apply barrier to peri-stoma site and what could potentially happen to skin if care is not rendered. Resident voiced understanding of receiving good skin care, will continue to monitor skin and encourage resident to allow staff to render care. Pain medication will be offered prior to care."			

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-11/16/2022 14:43 (2:43 PM)..."Physician/PA/NP (Nurse Practitioner) - Progress Note (Narrative)...SUBJECTIVE: Patient seen today as a follow up and request by staff due to ostomy not staying on and patients request to go to ER due to skin irritation...Continues to have watery diarrhea from stoma that is getting on...abdomen which is excoriated from flank to flank. Wound care and staff have been working...since admission on trying to keep the skin clean, dry and free of stool. It is reported by staff that [R700] has been picking at...dressing and loosening it causing more problems. Due the severity of the irritation requested patient be sent to ER for evaluation and wound care evaluation..."

-11/16/22 14:57 (PM)..."Health Status Note (nurses note)...Pt (patient) transferred to [hospital] at 2:50 PM...r/t (related to) complications w/ (with) ileostomy...Pt aware of ostomy site but continues to tamper w/ (with) bag at times stating that its uncomfortable...Ostomy changed multiple times throughout shift. Skin irritated d/t (due to) fecal matter causing breakdown and constant ostomy changes..."

A review of R700's care plan, progress notes, and administration records did not reveal documentation indicating R700 refused ostomy care or tampered with their ostomy bag until the day the resident was discharged from the facility with skin breakdown.

On 3/27/23 at 3:15 PM, wound care nurse, Licensed Practical Nurse (LPN) "E" was interviewed and queried regarding the expected process for caring for a resident with an ostomy in the facility. LPN "E" indicated that orders for ostomy care/monitoring are put into place by the floor nurses, and documentation of the provision of ostomy care would be on the MAR/TAR.

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	When queried regarding the lack of ostomy care documentation/orders for R700, LPN "E" was unable to provide any further information. On 3/28/23 at 10:22 AM, NP "I" was interviewed via phone regarding R700. NP "I" stated she was familiar with the resident and followed R700's care over the course of multiple facilities. When asked if R700 came into the facility with skin irritation and breakdown on their abdomen, NP "I" stated, "No. [R700] was having very liquid stools...makes it hard for the bag to stick...[the resident] was taking [the bag] off [themselves]...and staff was having to re-apply it almost daily." When queried regarding the lack of documentation in R700's record prior to the day of discharge to support that claim, NP "I" was unable to provide any further information. On 3/28/23 at 11:22 AM, the Director of Nursing (DON) was interviewed regarding R700. The DON indicated that there are normally orders put into place in the resident's record for ostomy care. The DON acknowledged the lack of documentation related to ostomy care and assessment/monitoring/treatment of R700's skin surrounding their ostomy and did not provide any further information. A review of the facility's policy/procedure titled, "Colostomy, Urostomy or Ileostomy Caret" dated 6/29/21, revealed, "Purpose: To ensure residents who require colostomy, urostomy, or ileostomy services receive care consistent with professional standards of practice and person-centered goals and preferences...It is essential that a pouch be placed over a stoma correctly so the output from the stoma is contained, the skin around the stoma is protected and a patient free from odor or leakage...Peritoneal skin: Presence of blisters, rash and excoriated skin is abnormal...Observe pouch for leakage and length of time in			

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	place...When pouch leaks, skin damage from effluent causes more skin trauma than early removal of the wafer..."			
F0755 SS= D	Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00134206. Based on interview and record review, the facility failed to accurately reconcile medications upon admission for one resident (R701) of four reviewed for medications, resulting in the	F0755	Element #1: Resident # 701 no longer resides in the facility. Element #2: All new admission residents are at risk. This deficiency occurred due to the admitting nurse failing to enter/reconcile medications from the hospital. An audit of all new admissions for the past 14 days was conducted, and no further deficiencies identified. Element #3: The policy for new admissions process (including the medication reconciliation) was reviewed and it was deemed appropriate. All licensed nurses were educated on the appropriate admission process to ensure that the attending physician is contacted, and medications are reconciled upon admission. A New Admission Worksheet (including guidance on medication reconciliation) was developed and provided to nurses to use for all new admits. Clinical managers will complete this audit daily x 14 days, weekly x 4 and then quarterly as needed. Element #4: The Director of Nursing/designee will conduct random weekly audits of newly admitted residents' medication reconciliation. Results will be reported to the scheduled QAPI meetings. The Director of Nursing will be responsible for assuring compliance is maintained.	4/6/2023

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	potential for the exacerbation of acute or chronic health conditions. Findings include: A review of R701's record revealed that the resident was admitted into the facility on 12/29/23 and discharged on 1/14/23. R701's medical diagnoses included Systolic Congestive Heart Failure, Hypertension, Anemia, Kidney Failure, and Muscle Weakness. Further review of R701's record revealed that the resident was cognitively impaired and required substantial/max assistance for most activities of daily living (ADLs). A review of R701's "Patient Discharge Summary," dated 12/29/22, included the following medications to be continued upon the resident's transfer to the facility: -"Carvedilol (Coreg oral tablet), 3.125 mg (milligram), by mouth, 2 times a day (with meals), hold for SBP (systolic blood pressure) < (less than)110, HR <55, prescription sent to (pharmacy)...Next dose due: 12/29/22 Evening." This medication is used to treat high blood pressure and heart failure. -"Esomeprazole (used to treat certain stomach and esophagus problems such as acid reflux and ulcers)....40 mg oral delayed release capsule, 40 mg, by mouth, once a day...Next dose due: 12/30/22 Morning." A review of R701's orders upon and after admission into the facility on 12/29/22 revealed that neither medication was ever ordered for this resident. The order, "Metoprolol Tartrate Tablet 25 MG Give 1 tablet by mouth one time a day for HTN (Hypertension)," was not entered in the resident's record until 1/4/23 with a start date of 1/5/23 for the medication.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	504210	A. BUILDING _____ B. WING _____	**3/28/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	Further review of R701's record reveal an EKG (electrocardiogram, also known as ECG) was ordered on 1/4/23 due to "increased pulse" but was not completed until 1/13/23. The EKG noted, "FINDINGS: sinus tachycardia NSTT (non-specific ST-T) wave abnormality. Abnormal ECG." On 3/28/23 at 10:32 AM, Licensed Practical Nurse (LPN) "H" was interviewed, as she was noted to have entered in R701's medication orders upon admission. LPN "H" confirmed that she was the one who transcribed R701's admission orders, and when queried regarding the expected process for doing so, LPN "H" explained that staff is to talk with the doctor, make sure the ordered medications are the same as what the hospital has written, and to copy the medication orders from the hospital paperwork. LPN "H" indicated she did not believe the doctor wanted any of R701's hospital medications to be different from what was on the paperwork. When queried as to why the Carvedilol and Esomeprazole were not ordered, LPN "H" was unable to provide an explanation. LPN "H" added that she may have been helping with the admission during shift change. On 3/28/23 at 11:29 AM, the Director of Nursing (DON) was interviewed and queried as to why R701's medications were not ordered as indicated by their hospital discharge paperwork. The DON explained that she can understand where the error was made, as the hospital paperwork had the medication orders split into two sections, but acknowledged that someone should've caught the missed medications after the initial transcription. A review of the facility's policy/procedure titled, "Medication Monitoring and Management" dated August 2019, did not reveal information regarding medication reconciliation on admission.			

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