STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235102	A. BUILDING _____ B. WING _____	09/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AMBASSADOR, A VILLA CENTER	**8045 E JEFFERSON AVE DETROIT, MI 48214**

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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes MI 398 and MI 632 Based on observation, interview and record review, the facility failed to provide proper incontinence care for one resident (Resident #607) of five sampled residents reviewed for activities of daily living, resulting in the potential for an infection and skin breakdown. Findings include: Resident #607 Review of a Admission Record revealed, Resident #607 admitted to the facility on [DATE] and readmitted on [DATE] with pertinent [DIAGNOSES REDACTED]. Review of an admission Minimum Data Set (MDS) assessment, with a reference date of 7/29/20, revealed Resident #607 had cognitive impairment. Resident #607 required total dependence of one staff with ADL care (Activities of Daily Living). In an observation on 9/16/20 at 2:21 p.m., Certified Nursing Assistant (CNA) A prepared to perform incontinent care on Resident #607. Resident #607's room had a strong urine and bowel movement odor. Resident #607 laid on a half folded fitted sheet and the brief was visibly soiled. A large yellow and brown circle was on Resident #607's fitted sheet. CNA A cleaned Resident #607's peri area with wet soapy wash cloth, rinsed and then patted dry. Resident #607's brief was tucked under the buttocks. CNA A dropped a washcloth on the floor. CNA A covered Resident #607 up, removed gloves, performed hand hygiene, and exited the room. In an interview on 9/16/20 at 2:35 p.m., CNA A reported the last she time changed Resident #607 was at 7:30 when she first got here. CNA A reported Resident #607 should be changed at least two to three times a shift. In an observation on 9/16/20 at 2:49 p.m., CNA's A and B prepared to complete care for Resident #607. CNA B rolled Resident #607 to the right side. A large amount of BM was in Resident #607's brief. CNA A washed Resident #607's buttocks from front to back with a soapy washcloth, rinsed and then patted dry. CNA A then put a new brief on Resident #607, removed gloves and performed hand hygiene. Review of a Physician order [REDACTED]. with a start date of 8/21/20 In an interview on 9/17/20 at 9:35 a.m., Nurse C reported peri care or check and change should be provided every two hours and as needed. In an interview on 9/17/20 at 2:10 p.m., Unit Manager E reported Resident #607 should be checked and changed every two hours. In an interview on 9/17/20 at 2:14 p.m., CNA D reported Resident #607 was changed earlier during first rounds by another CNA. CNA D reported Resident #607 should be changed every two to three hours. Review of a Care Plan for Resident #607 with a focus The resident has bowel and bladder incontinence r/t (related to) Impaired Cognition and Mobility with an initiated date of 8/3/20. Intervention included . Check change q (every) 2 hours and prn . with an initiated date of 9/18/20. In an interview on 9/18/20 at 10:19 a.m., the Director of Nursing (DON) reported the standard for checking and changing a resident is every 2 hours or as needed.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 967 Based on observation, interview and record review the facility failed to provide [MEDICAL CONDITION] care and tracheal suctioning according to physician orders [REDACTED].#607) of one resident reviewed for [MEDICAL CONDITION] care, resulting in the potential for ineffective removal of respiratory secretions, and increased risk of infection. Findings include: Resident #607 Review of a Admission Record revealed, Resident #607 admitted to the facility on [DATE] and readmitted on [DATE] with pertinent [DIAGNOSES REDACTED]. Review of an admission Minimum Data Set (MDS) assessment, with a reference date of 7/29/20, revealed Resident #607 had cognitive impairment. Resident #607 required a [MEDICAL CONDITION] (surgical airway created in trachea). In an observation on 9/16/20 at 2:33 p.m., Resident #607 coughed and thick pale sputum came out of [MEDICAL CONDITION]. Unit Manager (UM) F stood outside Resident #607's room door. UM F reported she will come in the room to suction Resident #607. In an observation on 9/16/20 at 2:35 p.m., Resident #607 continued to cough hard (body tight with each cough). Unit Manager F requested to immediately suction Resident #607. In an observation on 9/16/10 at 2:40 p.m., Resident #607 continued to cough, and the nurse was not in the room. In an observation and interview on 9/16/20 at 2:42 p.m., Unit Manager F entered Resident #607's room. UM F reported the last time Resident #607 was suctioned was this morning. UM F then reported Resident #607 is suctioned as needed and had heavy secretions. UM F prepared to suction Resident #607. UM F then placed suction tube in Resident #607'[MEDICAL CONDITION]. UM F stated, there is nothing coming out. UM F removed the suction tube from Resident #607'[MEDICAL CONDITION]. Resident #607 coughed, and a large amount of thick sputum was in [MEDICAL CONDITION]. UM F then suctioned Resident #607 again and thick sputum was in the suction tube. Review of a Physician order [REDACTED]. [MEDICATION NAME] HCl Capsule 300 MG Give 1 capsule via PE[DEVICE] every 6 hours for [MEDICAL CONDITION] for 10 Days with a start date of 9/9/20. In an interview on 9/17/20 at 9:35 a.m., Nurse C reported suctioning for Resident #607 is documented in the progress notes. Nurse C then reported Resident #607 was suctioned at 7:30 a.m. In an interview on 9/17/20 at 2:00 p.m., Unit Manager E reported suction documentation should be on the EMAR (electronic medication administration record). In an interview on 9/17/20 at 2:08 p.m., UM E then confirmed the suction documentation for Resident #607 is not on the EMAR. UM E stated, It should be on the EMAR but it's not, it's an order. Review of a Medication Administration Record (MAR) for July, August and September 2020 revealed, no documentation of suctioning for Resident #607. In an interview on 9/18/20 at 10:20 a.m., the Director of Nursing (DON) reported documentation for suctioning is included [MEDICAL CONDITION]. The DON stated, It is included [MEDICAL CONDITION], when asked if an order for [REDACTED].

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.