STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235525	A. BUILDING _____ B. WING _____	08/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE NURSING AND REHABILITATION COMMUNITY	**320 E CENTRAL AVE ZEELAND, MI 49464**

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI 014. Based on interview and record review, the facility failed to notify the physician of a change in condition for 2 of 3 residents (Resident #1 and #2) reviewed for physician notification. This deficient practice resulted in Resident #1 and #2's pressure ulcer exhibiting signs of decline and the physician was not immediately notified of the change in condition to evaluate the interventions, treatment orders and plans to avoid worsening or developing pressuring sores. Findings include: The facility provided a copy of the policy/procedure for Notification of Change dated 7/2017 for review. The policy reflected, A complete wound assessment and documentation will be conducted on all skin conditions upon discovery and weekly thereafter until they are healed .The Residents physician and responsible party must be notified when an event involving the resident occurs or when the resident experiences a change in condition .Notification: 1. Call the physician and document using the SBAR (situation, background, assessment, recommendation) Communication Form and or Progress Note .7. Once the Physician calls back, describe residents condition (see Planning). Document physician's orders [REDACTED]. Resident #1 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS), reflected a score of 8 out of 15 which represents Resident #1 had moderate cognitive impairment. Resident #1 had a Resident Representative who made medical decisions. Resident #1 did not reside at the facility during the onsite survey. The facility provided the Pressure Ulcer Care Plan dated 2/5/20 for review. The care plan intervention included (but not limited to), Notify Dr. if wound exhibits decline in status, s/s (signs and symptoms) of infection or if pain is uncontrolled or increased. During an interview on 7/29/20 at approximately 11:00 AM, the Corporate Nurse Consultant (CNC) A stated that Resident #1 was admitted with an unstageable (unable to see the wound bed) pressure ulcer to the coccyx (tailbone area). CNC A read the following weekly wound measurements of the pressure ulcer as follows: 1/15/20 2.5 x 2.0 (unable to measure depth due to slough covering the wound bed) 1/17/20 2.5 x 2.0 with slough 1/24/20 2.5 x 1.8 with slough 1/31/20 5.4 x 5.3 (increase in size noted) 2/7/20 5.2 x 5.4 x 0.4 depth at 7 o'clock, no tunneling noted 2/14/20 5.1 x5.3 x 0.7, no tunneling noted 2/21/20 5.1 x 5.3 x 0.5, no tunneling noted When asked if the physician was notified of the decline in healing (increase in size) on 1/31/20, the CNC A stated, I remember talking with him but was unable to find an SBAR or a progress note regarding the notification and any changes in intervention the physician requested. According to the January and February Treatment Administration Record (TAR) the dressing order on 2/3/20 (3 days after the noted decline in the wound) was changed back from once every 3 days to once daily. The Medication Administration Record [REDACTED]. According to the physicians orders a urinary foley catheter was placed to reduce the irritation of urine to the wound on 2/5/20 (5 days after the noted decline in healing). CNC A stated the resident was sent out to the wound clinic on 2/11/20 for further evaluation and treatment recommendations. Resident #2 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #2 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS), reflected a score of 15 out of 15 which represents Resident #2 was cognitively intact. Record review of the Care Plan dated 11/01/18 reflected, Resident has a Stage 2 (pressure ulcer) to coccyx with potential for infection and discomfort to area. Associated factors: end stage disease, left sided weakness, dementia, impaired mobility, decline in health status, poor appetite, refusal of turning and repositioning and refusing to take nutritional supplements. The goal reflected, Ulcer will heal without complications and Resident will experience no further skin breakdown secondary to pressure. The approach reflected, Notify Dr. if wound exhibits decline in status, s/s (signs and symptoms) of infection or if pain is uncontrolled or increased. During an interview and record review on 7/30/20 at 2:30 PM, the DON stated that an unavoidable stage 2 (partial dermis loss) pressure ulcer had developed to the right lower buttock on 4/2/20 that measured 3.0 x 3.5 x 0.5. The wound was measured weekly and on 5/15/20 measured 2.4 x 0.5 x 03 which represented healing. On 5/22/20 the wound measured 3.0 x 2.0 x 1.0 with 4 cm of undermining at 10 o'clock. The DON stated that it evolved from a Stage 2 to a Stage 3 with dermis loss and undermining. When asked if the physician was notified of this change in condition and if there were any order or interventions changed as a result, the DON stated that she remembered speaking with the physician but could not provide an SBAR, progress note or intervention/order change to promote the healing of the wound. The April and May TAR reflected that the wound treatment from 4/13/20 until 5/27/20 was to cleanse with normal saline, pack with calcium alginate, and cover with dermafoam and change it daily. On 5/27/20 the order was changed (5 days after the wound declined) to cleanse with normal saline, pack with calcium alginate and cover with thin bordered [MEDICATION NAME] wound dressing and change every 3 days. When asked why the new order was not initiated after the noted decline on 5/22/20, the DON stated that she did not know that when a new order is obtained the old one must be discontinued, a new TAR must be printed and placed in the treatment book to be initiated.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate a baseline care plan for 1 of 3 residents (Resident #3) reviewed for baseline care plans. The deficient practice resulted in Resident #3 having no identified interventions care planned to promote the healing of a pressure ulcer. Findings include: Resident #3 Review of the Face Sheet and the admission assessment dated [DATE] revealed Resident #3 admitted to the facility on [DATE]. The admission assessment reflected that Resident #3 was cognitively intact. During an interview and record review on 7/30/20 at approximately 11:00 AM, the DON stated that Resident #3 had acquired a pressure ulcer at home (from an incident) before she was hospitalized , and later transferred to the facility on [DATE] with a wound to the right inner gluteal (buttock). Upon admission the wound measured 9.5 x 1.5 and was noted as a deep tissue injury (dark purple/maroon colored covering with intact skin). On 7/24/20 the wound measured 9.5 x 1.0 with eschar (scab like covering the wound bed) was forming with intact wound edges. The DON stated the treatment order was changed at that time. Record review of the baseline care plan for Resident #3 identified the problem of the pressure ulcer but had no interventions listed to promote the healing of the wound. The DON stated the staff should have identified some immediate interventions to put in place to promote the healing of the pressure ulcer and documented them on the care plan.
F 0686 **Level of harm** - 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** This citation pertains to intake MI 014. Based on interview and record review, the facility failed to promote the healing

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

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F 0686 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) of pressure ulcers by routinely assessing, monitoring, updating treatment changes timely and reporting changes to the physician for 3 of 3 residents (Resident #1, #2 and #3) reviewed for pressure ulcers. This deficient practice resulted in Resident #1's physician not being informed of a decline in healing, and treatment orders were not implemented timely, Resident #2's wound deteriorated from a stage 2 to a stage 3 pressure ulcer and the physician was not notified and the wound went unmonitored and measured for changes in condition for 14 days, and Resident #3 receiving the incorrect treatment and dressing to the pressure ulcer causing worsening or developing pressure sores. Findings include: The facility provided a copy of the Care Standard (for Pressure Ulcers) dated 4/2018 for review. The policy reflected, Weekly assessments of skin conditions will be documented in the residents electronic medical record using the following observation: Weekly Pressure Ulcer Progress Report .If the wound/skin condition does not show signs of improvement in fourteen (14) days, the physician will be notified for further recommendations and/or treatment changes .Notification of Change in Skin Condition will be made to the physician/NP/PA utilizing the INTERAT SBAR communication tool (an assessment tool). Resident #1 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #1 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS), reflected a score of 8 out of 15 which represents Resident #1 had moderate cognitive impairment. Resident #1 had a Resident Representative who made medical decisions. Resident #1 did not reside at the facility during the onsite survey. The facility provided the Pressure Ulcer Care Plan dated 2/5/20 for review. The care plan intervention included (but not limited to), Notify Dr. if wound exhibits decline in status, s/s (signs and symptoms) of infection or if pain is uncontrolled or increased. According to the hospital discharge orders dated 1/15/20 reflected the order for Santyl to the pressure ulcer once daily with the dressing change. According to the facility Treatment Administration Record (TAR) for January and February reflected the following orders and treatments provided: 1/15/20 apply Santyl to wound and cover with a derafilm, change daily. 1/17/20 apply Santyl to wound and cover with derafilm, change every 3 days. 2/3/20 apply Santyl to wound and cover with gauze and change daily. 2/11/20 clean wound with normal saline, apply Santyl and cover with gauze and secure with mepalex, change daily. This order came from the Wound Clinic visit and recommendation on 2/11/20. 2/17/20 clean wound with normal saline, apply Santyl to eschar (thick scab cover) area and pack tunneling at 7 o'clock with calcium alginate, change daily. This order was not signed out as done or initiated until 2/24/20 (7 days later). The February Medication Administration Record [REDACTED]. During an interview on 7/29/20 at approximately 11:00 AM, the Corporate Nurse Consultant (CNC) A stated that Resident #1 was admitted with an unstageable (unable to see the wound bed) pressure ulcer to the coccyx (tailbone area). CNC A read the following weekly wound measurements of the pressure ulcer as follows: 1/15/20 2.5 x 2.0 (unable to measure depth due to slough covering the wound bed) 1/17/20 2.5 x 2.0 with slough 1/24/20 2.5 x 1.8 with slough 1/31/20 5.4 x 5.3 (increase in size noted) 2/7/20 5.2 x 5.4 x 0.4 depth at 7 o'clock, no tunneling noted 2/14/20 5.1 x5.3 x 0.7, no tunneling noted 2/21/20 5.1 x 5.3 x 0.5, no tunneling noted (but had a treatment order to pack tunneling dated 2/17/20) When asked why the order from the hospital that recommended the dressing be changed daily was changed on 1/17/20 to change it every 3 days, CNC A reviewed the records and stated that must have been done in error. The TAR reflected that the dressing continued to be changed every 3 days from 1/17/20 until 2/3/20. When asked if the physician was notified of the decline in healing (increase in size) on 1/31/20, the CNC A stated, I remember talking with him but was unable to find an SBAR or a progress note regarding the notification and any changes in intervention the physician requested. According to the TAR the dressing order on 2/3/20 (3 days after the noted decline in the wound) was changed back from once every 3 days to once daily. The MAR indicated [REDACTED]. According to the physicians orders a urinary foley catheter was placed to reduce the irritation of urine to the wound on 2/5/20 (5 days after the noted decline in healing). CNC A stated the resident was sent out to the wound clinic on 2/11/20 for further evaluation and treatment recommendations. As a result of the wound clinic visit on 2/11/20 the order was changed to clean the wound with normal saline, apply Santyl and cover with gauze, secure with mepalex, and change daily. The dressing order was changed again on 2/17/20 to clean wound with normal saline, apply Santyl to eschar area, pack tunneling at 7 o'clock with calcium alginate, and change dressing daily. When asked why the dressing order dated 2/17/20 was not signed out as done or initiated until 2/24/20 (7 days later), CNC A stated upon receiving a change in order the old order must be discontinued and the new one printed and placed in the treatment book for the nursing staff to initiate the new order. The CNC A stated that the order must have been missed. The physician noted dated 2/13/20 reflected, Coccyx decub ulcer - Wound has deepened despite aggressive wound care by facility & wound clinic notes from hospital questioned deep tissue injury, suspect this is correct as wound has worsened. Now stage IV, about deep. Not sure if we have seen the full extent of Res. (resident's) wound yet. Resident #2 Review of the Face Sheet and Minimum Data Set ((MDS) dated [DATE] revealed Resident #2 admitted to the facility on [DATE]. Brief Interview for Mental Status (BIMS), reflected a score of 15 out of 15 which represents Resident #2 was cognitively intact. During an interview and record review on 7/30/20 at 2:30 PM, the DON stated that an unavoidable stage 2 (partial dermis loss) pressure ulcer had developed to the right lower buttock on 4/2/20 that measured 3.0 x 3.5 x 0.5. The wound was measured weekly and on 5/15/20 measured 2.4 x 0.5 x 03 which represented healing. On 5/22/20 the wound measured 3.0 x 2.0 x 1.0 with 4 cm of undermining at 10 o'clock. The DON stated that it evolved from a Stage 2 to a Stage 3 with dermis loss and undermining. When asked if the physician was notified of this change in condition and if there were any order or interventions changed as a result, the DON stated that she remembered speaking with the physician but could not provide an SBAR, progress note or intervention/order change to promote the healing of the wound. The April and May TAR reflected that the wound treatment from 4/13/20 until 5/27/20 was to cleanse with normal saline, pack with calcium alginate, and cover with dermafoam and change it daily. On 5/27/20 the order was changed (5 days after the wound declined) to cleanse with normal saline, pack with calcium alginate and cover with thin bordered [MEDICATION NAME] wound dressing and change every 3 days. When asked why the new order was not initiated after the noted decline on 5/22/20, the DON stated that she did not know that when a new order is obtained the old one must be discontinued, a new TAR must be printed and placed in the treatment book to be initiated. According to the Pressure Ulcer Policy all wounds will be assessed and measured weekly. The facility provided a copy of assessments dated 7/10/20 and 7/24/20. There was no assessment provided to review covering that 14-day period. When asked why the stage 3 pressure ulcer went unassessed and monitored for 14 days, the DON stated that she did not know why but it should be measured weekly. Resident #3 Review of the Face Sheet and the admission assessment dated [DATE] revealed Resident #3 admitted to the facility on [DATE]. The admission assessment reflected that Resident #3 was cognitively intact. During an interview and record review on 7/30/20 at approximately 11:00 AM, the DON stated that Resident #3 had acquired a pressure ulcer at home (from an incident) before she was hospitalized , and later transferred to the facility on [DATE] with a wound to the right inner gluteal (buttock). Upon admission the wound measured 9.5 x 1.5 and was noted as a deep tissue injury (dark purple/maroon colored covering with intact skin). On 7/24/20 the wound measured 9.5 x 1.0 with eschar (scab like covering the wound bed) was forming with intact wound edges. The DON stated the treatment order was changed at that time. The July TAR reflected 2 treatment orders for the same wound. The first order was to apply Venelex ointment to the wound bed three times daily. The second order started on 7/25/20 (and overlapped with the first) to apply Santyl to the eschar, cover with border dressing and change it twice daily. The TAR reflected the Venelex was to be applied 37 times from 7/17/20 - 7/30/20 and it was not signed out as done (left blank) 17 times. The DON stated the Venelex treatment order should have stopped on 7/25/20 when the new order was obtained. The DON stated that when she talked with the nurses they told her that they were indeed applying both treatments. The DON stated that practice was incorrect, and she would get the first order clarified and stopped. Record review of the baseline care plan for Resident #3 identified the problem of the pressure ulcer but had no interventions listed to promote the healing of the wound. The DON stated the staff should have identified some immediate interventions to put in place for the pressure ulcer.