STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235632	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANTAGE LIVING CENTER - SAMARITAN	5555 CONNER AVENUE, SUITE 4000 DETROIT, MI 48213

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 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 717 Based on observation, interview, and record review the facility failed to 1. Administer wound treatments consistently. 2. Assess, document, and revise wound care plan interventions. 3. Prevent new potential pressure ulcers 4. Notify Attending Physician and family of change in condition, Affecting One Resident (R#701) out of three residents investigated for wound care treatment, resulting in the prevention of worsening wounds and failure to notify Physician and family of changes in R#701's condition. Findings include: On 8/19/20, review of document provided by facility Facility Past Non-Compliance dated 1/9/20 documented the following: In depth analysis of how the deficiency occurred: Lack of documentation of assessments/progress notes pertaining to weekly wound healing with holes in the TAR (Treatment Administration Record), resulting in current treatment in progress for a resident being ineffective and wound worsening. On 8/19/20, record review of R#701 revealed admission into facility on 3/22/19 and readmission on 10/21/19 with [DIAGNOSES REDACTED]. According to the Minimum Data Set ((MDS) dated [DATE], R#701 has severe impaired cognition and was extensive assist with all Activities of Daily Living (ADLS). On 8/19/20, record review revealed last documentation of R#701's wounds in facility. Review of Visit Report for R#701 on 12/17/19 documentation was provided wound care consultant and documents the following: Wound #1 Left Great Toe Tip is a Vasculitic Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 0.4 cm length x 0.4 cm width, with an area of 0.16 sq. cm. There was no drainage noted. Wound bed has Dry Base [MEDICATION NAME]. This was last documentation of wounds in facility until admission to hospital. Wound #2 Left, Plantar Foot is a Vasculitic Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 2 cm length x 3 cm width x 0.3 cm depth, with an area of 6 sq. cm and a volume of 1.8 cubic cm. There is a small amount of serous drainage noted which has no odor. Wound bed has Necrotic Base [MEDICATION NAME]. The peri wound skin texture is normal. The peri wound skin moisture is normal. The peri wound skin color Is normal. Peri wound skin does not exhibit signs or symptoms of infection. General Notes: Minimal pink tissue exposed, Irregular edges Wound #3 Left, Distal Buttock is a Stage 3 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 0.3 cm length x 0.3 cm width x 1 cm depth, with an area of 0.09 sq. cm and a volume of 0.09 cubic cm. There is a small amount of serous drainage noted. Wound bed has Yellow Base [MEDICATION NAME]. The peri wound skin texture is normal. The peri wound skin moisture Is normal. The peri wound skin color is normal. General Notes: Irregular edges Wound #4 Left, Anterior Ankle is a Vasculitic Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 0.5 cm length x 0.5 cm width, with an area of 0.25 sq. cm. There was no drainage noted. Wound bed has Dry Base [MEDICATION NAME]. The peri wound skin texture is normal. The peri wound skin moisture is normal. The peri wound skin color Is normal. General Notes: Irregular edges On 8/19/20, review of Final Report admission wound care notes at hospital documented on 1/2/20 the following: 1. Left plantar great toe/foot with a full thickness venous wound that measures 2cmx3cmx0 3 cm, 50% of the wound base with a dry intact dark black/brown necrotic tissue and 50% with red wound base a scant amount cf a serosang drainage noted Peri wound skin intact with no [DIAGNOSES REDACTED] noted Recommend to cover with an allevyn foam to protect 2. Left great toe with a dry necrotic wound that measures 0.7cmx0.7cm, intact with black tissue, no drainage no [DIAGNOSES REDACTED]. Keep open to air and monitor. 3. Left lateral heel with a deep tissue injury that measures 3cmx3cm, skin intact with a dark purple non-blanchable coloration, no drainage. Monitor and reduce pressure. 4. Left lateral mid foot with a deep tissue injury that measures 2cmx1cm, skin intact with a dark purple coloration, no drainage, [DIAGNOSES REDACTED]. Monitor and reduce pressure 5. Left lateral distal foot with a deep tissue injury that measures 1 cm x 0.5 cm, skin intact with a dark purple coloration, no drainage, monitor and reduce pressure. 6. left ischium with a full thickness opening that measures 0.5 cm x 0.5 cm x 1.5 cm, with undermining circumferentially that measures 3 cm. Wound draining a brown stringy drainage, mild odor. Peri wound skin intact with a light purple/red coloration. Recommend surgery to evaluate. Loosely pack with [MEDICATION NAME] Ag rope and allevyn foam 7. Scrotum with moisture associated [MEDICAL CONDITION], skin with [DIAGNOSES REDACTED] and partial thickness wound that measures 1cmx1cm. Recommend applying barrier cream to protect. On 8/19/20, record review of Weekly Wound Healing Records (an assessment done weekly to document residents wounds measurements and notify Physician and family of any changes) revealed the last completed assessment was performed on 10/8/19. Review of Skin/wound note provided no documentation of Physician or family notification of change in wounds or documentation of assessment of wounds. Review of wound care plan revealed no revision to update interventions of wounds in December 2019. Review of Treatment Administration Record (TAR) revealed multiple treatments not provided in the month of December 2019. On 8/19/20 at 12:30 pm, during interview with Director of Nursing (DON), when asked if Wound Care Nurse (WCN) G failed to Assess wounds weekly, document, revise wound care plans and provide consistent wound care for R#701, DON stated, Yes. When asked if it was the responsibility of WCN G to notify the Physician and the family when there is a change in the condition of a residents wounds, DON stated, Yes, WCN G did not share this information at meetings either. When asked if this resulted in the worsening of R#701's wounds, DON stated, Yes. On 8/19/20, record review of Facility Acquired Pressure Ulcers documented the following: PROCESS 1. All residents will be screened on admission, quarterly, annually, and with a significant change of status, for their risk for development of pressure ulcers. 41 1. Residents identified as at risk for development of pressure ulcers will have a care plan developed and interventions included in the care plan to reduce the risk. 2. All residents will be assessed from head to toe weekly by a licensed nurse to identify any new pressure ulcers or other types of skin alterations. Results of weekly assessment will be documented by the licensed nurse on the weekly head to toe skin check form. 3. When a pressure ulcer is identified, the licensed nurse will document in the progress notes and on the Weekly Wound/Skin Healing Record, to include size, stage, location, drainage, and odor; obtain treatment order, initiate a care plan, and notify the interdisciplinary team, including the dietitian. 4. The licensed nurse will communicate all identified pressure ulcers to the attending physician and resident's family or responsible party. The licensed nurse will document notifications in the resident's medical record and the 24-hour report. 5. A Risk Management Meeting will be conducted weekly by the Interdisciplinary Team. Residents reviewed for skin alterations are as follows: Newly developed vascular/pressure ulcers Any pressure or non-pressure area that has shown no signs of healing during a two-week timeframe New admissions & readmissions with skin conditions (pressure, non-pressure, surgical sites, rashes, etc.) 6. The physician will review all cases of pressure ulcer development, modify treatment, as indicated, and document accordingly.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain proper infection control practices by ensuring staff properly used Personal Protection Equipment (PPE), affecting sixteen of seventeen residents observed on Blue Unit for infection control, resulting in the potential for the spread of disease to a vulnerable population. Findings include: On 8/18/20 at 11:15 a.m., during tour of Blue Unit, it was observed rooms designated for isolation for 14 days (Rooms 320-327) and were occupied by residents did not have signs posted on doors. Observed CNA A (Certified Nursing

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235632	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANTAGE LIVING CENTER - SAMARITAN	**5555 CONNER AVENUE, SUITE 4000 DETROIT, MI 48213**

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Assistant) Providing care to a resident in room [ROOM NUMBER], CNA was observed only wearing a mask and gloves and no gown. PPE carts were observed in area. On 8/18/20 at 11:20 a.m., during interview with Unit Manager B, when asked if these rooms were designated as 14-day isolation rooms, Unit Manager B stated Yes. When asked if staff should be wearing gowns when entering the room, Unit Manager B stated, No, we are wearing mask and gloves only. When asked if the same nurse is providing care of all 16 residents that are in isolation and not in isolation, Unit Manager B said Yes. When asked if the nurse wears a gown into isolation rooms, Unit Manager B said, No. On 8/18/20 at 11:30 a.m., during interview with Director of Nursing (DON), when asked if staff should be wearing mask, gowns and gloves when entering the isolation rooms, DON replied, Yes, the supplies are over there. When asked if signs should be posted on these doors, DON stated, Yes. When asked what protocols are being followed for residents that are in a 14- day isolation, DON said, We are following the CDC guidelines. On 8/19/20, record review of guideline provided by facility Development of isolation vs Transition Units documented the following: The facility should designate a section of the facility to monitor and care for residents who develop symptoms of COVID 19 or who test positive. A separate section of the facility should be established to transition residents admitted from the hospital or other setting. Transition/Surveillance Unit - staff should follow as close to normal isolation procedures as possible. Face masks may be worn throughout the shift per optimizing guidance from the CDC. Cross-Staffing (staff will be allowed to work in-between units) surveillance unit and general population unit. Proper PPE and infection control processes must be followed. Residents should be cared for as individuals as they are each being monitored for COVID signs and symptoms. Residents remain under surveillance for at least 14 days. Gowns should be changed between residents. Ideally, washable gowns should be used in the surveillance area to extend the use of the gown. Goggles and face shields only need to be used if aerosol treatments are being administered. If the resident develops symptoms of COVID, the resident should be moved to the isolation unit and be tested . Residents should be tested weekly for COVID 19 per direction of State of Michigan.