STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235296	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MEDILODGE OF SOUTHFIELD	**26715 GREENFIELD RD SOUTHFIELD, MI 48076**

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 -** Minimal harm or potential for 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 434 Based on observation, interview, and record review, the facility failed to ensure pressure ulcer dressings were performed per physician's orders [REDACTED]. Findings include: On 8/4/20 at 8:35 AM, R603 was observed in bed. R603 was not able to speak clear words when verbal conversation was attempted. R603 was observed to have a tube feeding pump at the bedside and was lying on a low air loss mattress. R603's feet were uncovered and an occlusive, adhesive, bordered foam dressing that had come partly unstuck (and was stuck to the sheet) was observed on the lateral aspect of their right foot. On 8/4/20 at 9:35 AM, a request was made from R603's assigned nurse, Licensed Practical Nurse (LPN) 'B' to observe the wound. LPN 'B' partially removed the already unstuck bordered foam dressing from the wound on the lateral aspect of the right foot and a circular wound measuring approximately 2 centimeters (cm) in length and 2 centimeters in width was observed. The date on the dressing was 8/4/20. After the observation LPN 'B' re-applied the foam dressing. At that time, R603 was only observed to have the occlusive foam dressing in place. On 8/4/20 a review of R603's clinical record was conducted and revealed an admission date of [DATE] with [DIAGNOSES REDACTED]. R603's most recent Minimum Data Set assessment dated [DATE] indicated R603 had severe cognitive impairments, was non-ambulatory and required extensive to total assistance from one to two staff members for activities of daily living. A review of R603's Wound Care notes from Nurse Practitioner (NP) 'C' was conducted and revealed that on 5/28/20 R603 had been evaluated for stage III (full thickness loss of skin in which adipose (fat) tissue is visible and granulation tissue and rolled wound edges are often present) pressure ulcer on the lateral aspect of their right foot. NP 'C' ordered a treatment for [REDACTED]. An order on 7/23/20 indicated the wound was to have collagen wound treatment applied and then be covered with a bordered (adhesive and occlusive) foam dressing. On 7/30/20, NP 'C' placed a new order for the right foot treatment that read, Cleanse with wound cleanser. Pat dry. Apply silver alginate (a natural fiber wound dressing that when absorbs wound exudate forms a gel like covering to maintain a moist wound bed) as directed to the wound base of the right lateral foot. Skin barrier wipe to per wound. Cover with non-bordered foam (foam that is not occlusive or adhesive) and roll gauze (bulky gauze to cover the wound and provide padding to the foot) every day shift. On 8/4/20, an interview with the facility's Wound Care Nurse was conducted and they were queried regarding the differences between bordered foam dressings, non-bordered foam dressings, and roll gauze. The Wound care nurse indicated that a bordered foam dressing was adhesive and occlusive, a non-bordered foam dressing was only a piece of foam that was not adhesive or occlusive, and roll gauze was a bulky dressing used to wrap a wound. At that time, the Wound Care nurse was made aware that the current order for the treatment to the wound on the right lateral foot was for non-bordered foam and roll gauze, but what was observed on the resident at 9:35 AM, had been an occlusive, adhesive, bordered foam dressing. The Wound Care Nurse was made aware no bulky roll gauze had been observed on R603's right foot. The Wound Care Nurse indicated that the nursing staff changing the dressings should follow the orders and indicated they would look into it. On 8/4/20 a review of a facility provided policy titled, Pressure Ulcers/Pressure Injury Prevention and Treatment-Clinical Protocol was reviewed and read, Based on the comprehensive assessment of a resident, a resident received 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 a resident with pressure ulcers received necessary treatment and services, consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing . The facility was asked if they had any additional documentation to provide regarding the concern; none was received by the end of the survey.

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