STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235480	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANTAGE LIVING CENTER - HARPER WOODS	**19840 HARPER AVE HARPER WOODS, MI 48225**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 4 and 6. Based on observation, interview, and record review, the facility failed to document and/or provide skin treatments given per physician's orders [REDACTED]. Findings include: On 7/8/20 at 9:24 AM, R801 was observed lying in bed. When queried regarding any wounds on their body, the resident stated they had wounds that caused them pain. When queried regarding if the staff take care of their wounds daily, the resident indicated that they did not. The resident indicated they felt they had wounds on their bottom and their feet. The resident was queried regarding when they developed the wounds, however, the timing of the wounds was not made clear by the resident. A review of R801's progress notes revealed the following: 4/22/2020 09:01 Skin/Wound Note: Per writer resident skin was assess and noted with Right Heel Diabetic Ulcer 2.0 x 1.5 x <0.01cm (centimeters) approximately Dry Discolored Base, Left Heel Diabetic Ulcer 0.5 x 2.5 x 0.01cm approximately 0.5 x 2.5 x 0.1 cm approximately Pink Base small serosanguinous drainage irregular edges peri wound dry discolored Possible tissue damage, right upper thigh fistula, Bilateral Buttock dry and intact. Treatment/Pressure relieving devices currently in place to aid in skin healing and prevent the likelihood of further skin breakdown. Resident has pain medication in place to aid in comfort. Resident will continue to be reposition and monitored for any changes in skin condition. 7/3/2020 08:16 Skin/Wound Note: Resident observed dime sized area to bilateral heels, moderate amount of serosanguineous drainage, no odor noted, resident c/o (complained of) discomfort. Bilateral feet elevated and resident stated the pillows under legs helped relieve the discomfort. Treatment put in place wound consult ordered . On 7/8/20 at 9:47 AM, Licensed Practical Nurse (LPN) A assisted the resident for a skin observation. LPN A stated, (R801) doesn't have an open wound on the bottom, just the heels, but they are resolved. The wound doctor was here yesterday and did walking rounds. They looked and said they were resolved. Last week there was some drainage on the right one (heel). The resident's skin was then observed. The resident's right and left heels appeared dry with scarring; no drainage was noted on the dressing removed from the resident's right heel/foot. The resident's bottom had protective cream in place and no open areas were observed. On 7/8/20 at 10:42 AM, the Nursing Home Administrator (NHA) was queried regarding the facility's wound care nurse. The NHA indicated the facility had a wound care doctor (from outside of the facility) do rounding weekly and had a couple nurses in the facility handling wound care rounds (LPN A being one of them) but that the facility did not have a designated wound care nurse currently. Review of R801's Treatment Administration Records (TARs) from April through July 2020 revealed the following orders: -TheraHoney Gel (Wound Dressings Apply to Lt (left) Heel topically every day shift for wound healing -D/C Date- 04/22/2020 0914. Documentation was blank (not present) as given for this order on 4/15, 4/16, 4/17, and 4/18. -Dry Dressing to Right Heel every day shift every other day for Skin Injury After cleaning with wound cleaner. -D/C (discontinue) Date- 05/16/2020 0923. Documentation was blank (not present) as given for this order on 4/22, 4/24, 4/28, 5/2, 5/4, 5/6, 5/8, and 5/14. -TheraHoney Gel (Wound Dressings) Apply to Left Heel topically every day shift for Skin Injury After cleaning with wound cleaner, cover with dry dressing. -D/C Date- 05/16/2020 0923. Documentation was blank (not present) as given for this order on 4/22, 4/23, 4/24, 4/27 4/28, 4/29, 5/1 through 5/4, 5/6, 5/8, 5/11, and 5/14. -Apply A&D ointment (skin protectant) to bilateral feet every day shift for dryness. Documentation was blank (not present) as given for this order on 5/19, 5/20, 5/22, 5/27 through 5/30, 6/4, 6/6, 6/7, 6/9, 6/13, 6/14, 6/19, and 6/26 through 6/29. -Cleanse Bilateral heels, pat dry, apply [MEDICATION NAME] with 4X4 gauze, ABD pad and wrap with Kerlix on time a day and PRN (as needed). one time a day for wound healing -D/C Date- 07/08/2020 0938. Documentation was blank (not present) as given for this order on 7/5. On 7/8/20 at 12:16 PM, the Director of Nursing (DON) was interviewed and queried regarding R801's wounds. The DON indicated she did not believe the resident had any active wounds anymore. She indicated she believed he did have some on his feet at one point. Then DON was then asked to review the TARs for R801 from April, May, June, and July. After reviewing the missing documentation on the orders, the DON stated, If (the resident) is in the facility and (a treatment is) ordered, I would expect them (TARs) to be filled out. I expect (staff to) document as ordered when treatment is given. On 7/8/20 at 1:35 PM, R803 was observed lying in bed. The resident was unable to answer interview questions appropriately. Prafo boots (protective foam boots put on heels to cushion pressure points on skin) were observed sitting on the resident's wheelchair and not on the resident. R803's nurse, Nurse B was queried regarding the resident's feet and if they were supposed to have on protective devices while the resident was in bed. Nurse B lifted the bed sheet and the resident's heels were observed to be wrapped with kerlix and lying on the bed with no heel protection present. Nurse B stated, Usually the Prafo boots are for when (R803) is in the wheelchair. There are smaller heel protectors for the bed, but they are down being washed. A review of R803's care plan revealed: I have actual impairment to skin integrity of the .Left MP Joint (joint in foot, where toes connect to rest of foot bones) Pressure Injury Stage III (full thickness tissue loss). Date Initiated: 10/23/2018, Revision on: 04/16/2020 .Follow your Skin Management Program Date Initiated: 04/10/2019; PROVIDE TX (treatment) AS ORDERED TO MY LEFT MP Joint. Date Initiated: 01/31/2019, Revision on: 04/16/2020; Soft heel lift boots Float heels Date Initiated: 04/10/2019; Revision on: 06/10/2019. A review of R803's TARs from April, May, and June 2020 revealed the following: -Dry Dressing to Left MP Joint every day shift every other day for Pressure Injury After cleaning with wound cleaner. -D/C Date- 06/18/2020 1515. Documentation was blank (not present) as given for this order on 4/16, 4/18, 4/20, 4/22, 4/24, 4/26, 4/28, 5/4, 5/12, 5/28, 6/9, and 6/15. -Cleanse right foot, pat dry and apply ABD pad and kerlix. one time a day for Protection - D/C Date- 06/18/2020. Documentation was blank (not present) as given for this order on 5/23, 5/28, 6/9, 6/10, 6/12, and 6/15. - Cleanse right outer knee, pat dry and apply [MEDICATION NAME] dressing for protection of bony area one time a day every other day for protection of bony area. Documentation was blank (not present) as given for this order on 5/23, 6/10, 6/12, 6/20, and 6/22. On 7/8/20 at 2:55 PM, the NHA was asked when treatments are given per physician order, if it is to be documented in the TAR. The NHA responded, Yes. A review of R801's medical record and Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was admitted into the facility on [DATE] and most recently re-admitted on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed a Brief Interview for Mental Status of 12/15 indicating mildly impaired cognition, and that the resident required extensive to total assistance from staff for bed mobility, transfers, dressing, toileting, and hygiene. A review of R803's medical record and MDS assessment dated [DATE] revealed that the resident was admitted into the facility on [DATE] and re-admitted on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was severely cognitively impaired and required extensive assistance from staff for bed mobility, transfers, dressing, toileting, and hygiene. A review of the facility's policy/procedure titled, Skin, undated, revealed the following, The nursing staff reviews the pressure ulcer prevention and treatment procedures with the resident's physician .the licensed nurse implements the wound care treatment procedures in accordance with current standards of practice .Document skin status in the resident record .use devices that relieve pressure on the heels, most commonly by raising the heels off the bed .document approached and interventions on the care plan .document in designated area .document in medical record .

F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 isolate a resident with new onset respiratory symptoms and place a newly admitted resident into observation for COVID-19 signs/symptoms, affecting two sampled residents (R801 and R804) of four reviewed, resulting in the potential spread of COVID-19 or other respiratory illness. Findings include: On 7/8/20 at 9:24 AM, R801 was observed lying in bed in their room. R804 was observed at this time occupying the second bed in the room. During the interview, R801 sneezed and cleared their throat multiple times. The resident had a droplet mask on however, it was positioned under their chin. R801 indicated they are a [MEDICAL TREATMENT] resident and leave the facility for [MEDICAL TREATMENT] multiple times per week. R804 indicated they were just admitted to the facility and that they would be leaving the facility to go to [MEDICAL TREATMENT] as well. The room did not appear to be under isolation precautions as there was no personal protective equipment (PPE) caddy or cart and no signage for the room. A separate unit in the facility was noted to be an observation/transitional care unit but did not include the room that housed R801 and R804. A review of R801's and R804's medical records at this time revealed: The last COVID-19 test for R801 was reported Not Detected on 6/22/20. R804's hospital admission documentation noted the resident's hospital stay was from 6/30/20 to 7/7/20 with a COVID-19 nasal swab done on 7/1/20 with a result of Not Detected. R804 was admitted into the facility on [DATE] as R801's roommate. Further review of R801's medical record revealed the following progress notes: 7/5/2020 13:37 (1:37 PM) Nurses Note Text: Resident observed having a wet cough. Writer assessed resident lung sounds. Rhonchi sounds auscultated to bilateral upper lobes. No s/s (signs/symptoms) of respiratory distress no SOB (shortness of breath) noted. VS (Vital Signs) 157/83 (blood pressure) hr (heart rate) 72 rr (respiratory rate) 18 temp 97.3 spo2 (oxygen saturation) 97% on room air. (Doctor) notified and new order for chest x-ray. Order faxed .awaiting tech arrival. Resident alert and verba (sic), with no s/s of acute distress. 7/5/2020 19:01 (7:01 PM) Nurses Note Text: Writer received chest x-ray results early pneumonia detected. (Doctor) notified and new order for [MEDICATION NAME] 1 gram Im (intramuscularly) daily for 3 days. Residents (family) notified of chest x-ray and treatment. Resident is alert with no s/s of respiratory distress and afebrile. No further progress notes addressing the respiratory symptoms were present. On 7/8/20 at 10:28 AM, the Director of Nursing (DON) who is also the facility's Infection Preventionist, was queried regarding R801's progress notes dated 7/5/20 which detailed new onset respiratory symptoms. The DON indicated she was not aware of a cough. When queried regarding whether the resident should be in isolation currently or not, the DON stated, If there has been a negative COVID-19 test they wouldn't be in isolation. If there was something to warrant isolation, we would have (the resident) on that side. When queried regarding a recent COVID-19 test, the DON was unable to provide a date of a recent test but indicated she would come back with that information. The DON added, I don't think that resident has ever tested positive. On 7/8/20 at 1:55 PM, the DON approached and indicated she had contacted the lab to see if there was a pending COVID-19 test for R801 after 6/22/20. The DON then stated, The nurse did not tell me about the respiratory symptoms (for R801). I don't know why. I talked with her. Then with (R804), our admission person with them thought that because they go out for [MEDICAL TREATMENT] that (they) would go into that room. But we are moving that new admission into the 14-day isolation area and are going to test (them). (R804) should have been there (on the transition/observation unit) to begin with. On 7/8/20 at 2:30 PM, the DON was again interviewed and asked if she felt R801's new onset respiratory symptoms warranted putting the resident into isolation. The DON stated, Yes, I would have put (R801) in isolation. The nurse stated when she called the doctor, normally the doctor will give orders for isolation and testing, but the doctor just told her to give the [MEDICATION NAME] and get the chest X-ray. The nurse just followed the doctor's order and did not think passed that. When queried regarding the infection control protocol for new admissions, the DON indicated the facility was currently still putting newly admitted residents under observation for COVID-19 signs and symptoms, and stated, Even if they have a negative test. Then we are doing a test on admission usually within about 72 hours but try to get it right away. On 7/8/20 at 2:55 PM, the Nursing Home Administrator (NHA) was queried regarding newly onset respiratory symptoms and new admissions. The NHA stated, We are following the guidelines in the COVID protocol for isolation and respiratory symptoms. The DON was present and indicated there were currently no available COVID-19 test results for R801 after 6/22/20. A review of R801's medical record and Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was admitted into the facility on [DATE] and most recently re-admitted on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed a Brief Interview for Mental Status of 12/15 indicating mildly impaired cognition, and that the resident required extensive to total assistance from staff for bed mobility, transfers, dressing, toileting, and hygiene. A review of R804's medical record revealed that the resident was admitted into the facility on [DATE] with medical [DIAGNOSES REDACTED]. Further review revealed the resident was cognitively intact and required limited assistance from staff. A review of the facility's policy/procedure titled, COVID-19 Interim Pandemic Guidelines, updated 7/1/20, revealed the following: 4. Symptomatic residents and employees are to be considered potentially infected and are to be isolated .The nursing staff will be responsible for: monitoring residents and other team members for symptoms of infections, Notifying the Director of Nursing, Infection Preventionist and physician of symptomatic residents .initiating isolation barriers as directed or as necessary; Screen residents on a daily basis for signs and symptoms of COVID-19, including fever, new or changed cough, or shortness of breath; Symptomatic resident identified: Isolate the individual into a private room, cohorted with like resident or unit designated for residents with symptoms to avoid potential cross contamination with other residents, place in contact/droplet precautions; Symptomatic residents: if resident has a fever >100 with one or 2 symptoms: request COVID testing, isolate in room with droplet/contact precautions until [DIAGNOSES REDACTED].

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