STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235536	A. BUILDING _____ B. WING _____	06/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ADVANTAGE LIVING CENTER - BATTLE CREEK	675 WAGNER DR BATTLE CREEK, MI 49017

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 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to Intake MI 456 and MI 090 Based on interview and record review the facility failed to implement care plan interventions for 1 sampled resident (Resident #5), resulting in care implementations not provided to alterations in skin integrity areas. Findings Include: According the Electronic Medical Record (EMR) Resident #5 (R5) was admitted to the facility on [DATE] and discharged from the facility on 04/02/2020. [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS: resident assessment tool) dated 01/19/20 reflected R5 was cognitively moderately impaired, required extensive-total dependence of 1-2 persons for transfers, dressing, hygiene, bathing bed mobility and toilet use. In addition, R5 had impairment of her upper and lower extremities on one side, and was frequently incontinent of her bowel and bladder. The Change of Condition note for R5 dated 03/20/20 at 04:00 AM reflected, .Noted to under left breast severe excoriation with moisture . However no wound healing record, or head to toe assessments documentation were noted on the day of discovery, of the excoriated breast area. The most recent wound healing record for R5 was dated 10/30/19 reflected no new concerns noted. R5's most recent Head to Toe Assessment sheet, whereby abnormal skin issues were to be checked dated 03/26/20 reflected no concerns. The EMR reflected R5 was unresponsive and sent to a local hospital's Emergency Department on 04/01/20. Hospital records dated 04/01/20 reflected R5 had Wound Moisture Associated Skin Damage Breast Left and Wound Ulcerated Abdomen Right. The local hospital's Significant Event-Flowsheet Notes dated 04/01/20 by Registered Nurse (RN O) reflected, Pt admitted to floor with multiple wounds and sores .Abd (abdominal) folds and groin red and excoriated with strong odor. Hospital Physician P placed an order for [REDACTED]. However R5 had MISSED doses of the prescribed power during the daytime on March: 16, 18, 24, 25 and 29, and MISSED doses at nighttime on March: 3, 23 and 26. The omitted administrations were evidenced by empty boxes without nursing staff initials. -Cleanse right abdomen with NS (Normal Saline), pat dry, apply [MEDICATION NAME] to wound beds, cover with Xeroform gauze, cover with ABD pads and secure with tape one time a day. R5 had MISSED treatments on March: 18, 24, 25 and 29. The omitted treatments were evidenced by empty boxes without nursing staff initials. No documentation was noted in the progress and/or nurses notes reflecting the treatments or medication was administered. R5's Skin Care Plan reflected: Focus: I have potential for impairment to skin integrity r/t (related to) hx (history) of skin breakdown on my buttock . I have hx of rash in my axilla area, under my breasts, abdominal folds . Revised 09/21/2018. Interventions: Administer medication as ordered Date Initiated: 10/16/2014 Follow your Skin Management Program Date Initiated: 10/16/2014 I will be followed by facility physician and wound care nurse. Date Initiated: 09/21/2018 If my skin is impaired - observe and document the location - report it to my nurse as soon as possible. Date Initiated: 10/16/2014 Focus: I have a reddened area in my left abdominal fold and left side r/t yeast. Revision on 11/30/19. Interventions: Provide me with the treatment as ordered by my doctor. Date Initiated: 07/05/2019 Focus: I have a open areas on my right abdomen r/t picking. I have a history of picking at my skin and causing sores. Revision on 10/14/19. Interventions: Monitor/document location, size and treatment of [REDACTED]. to MD. The EMR under Task reflected R5 preferred showers on Monday and Thursday PM. I prefer bed baths on Tuesday/Wednesday/Friday/Saturday/Sunday. On 06/05/20 at 09:57 AM The Director Of Nursing (DON B) provided R5's written documented shower sheets only for February and computer generated shower record only for March 2020. The only shower sheets that DON B revealed she had for February 2020 were dated: 2nd, 5th, 12th (6 day gap), 17th (5 day gap) and the 20th. The shower record reflected: Refusals on the 9th and 16th. No supporting documentation was available, reflecting R5 was re-approached a second time on either day for a shower. Non-Applicable (NA) was documented on R5's shower record on March 12th (6 day between two refusals) and 23rd (6 day gap between two showers). Later the same day at 10:49 AM DON B was informed of the 03/20/20 change of condition note reflecting the excoriated area under R5's left breast. When asked what did the empty boxes on the MAR/TAR mean DON B revealed, empty boxes where care should have been given, means it was an omission, and that they did not give the medication or treatment. Also, that staff should have documented in the treatment record if R5 refused, but to look in nurses notes. When asked what did NA mean on the shower record DON B replied, I'm thinking not applicable, really that's not appropriate documentation. When asked if NA meant not given DON B revealed that was correct, and that it should be documented if a shower was given, not given or that R5 refused.
F 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake number MI 2984. Based on observation, interview, and record review the facility failed to ensure 1 out of 8 residents (Resident #7's) care plan was revised post fall, resulting in the potential for future falls, care needs to not be met. Findings Included: Resident #7 (R7): Per the facility face sheet R7 was admitted to the facility on [DATE], and had a [DIAGNOSES REDACTED]. Review of R7's progress notes revealed she had a fall on 6/20/2020 when she tripped on the metal divider in her room doorframe. The progress notes revealed R7 had another fall on 6/24/2020 when she was found on the floor in her room. The notes did not reveal an immediate intervention that was put into place to prevent or attempt to prevent future falls. Record review of a care plan that was in place for R7 revealed, I have frequent falls r/t (related too) impaired gait, weakness, [MEDICAL CONDITION]'s Chorea, impaired safety and spatial awareness, and potentially due to medication use. Facility anticipates further falls due to disease process. I have a very independent nature, and often attempt to transfer or get up and walk on my own without requesting assistance, I often will not allow staff to apply gait belt, I often will sit myself on the floor, I often remove my nonskid/gripper socks. I often refuse to wear my hipsters, knee and elbow pads. My balance is significantly impaired by my [MEDICAL CONDITION]'s Chorea (causes a lack of coordination and inability to walk). The care plan was dated 08/22/2018 as the date it was initiated, and revealed the a date of 02/20/2020 for the last time R7's care plan was revised. The care plan also revealed that the last intervention added to R7's plan of care for falls was on 6/17/2020 that revealed, resident care plan reviewed by nursing staff, and she continues on closer supervision. The metal divider in R7's door frame was not an intervention on her care plan as a trip hazard for staff to be aware off. Observation of R7's room doorway on 6/26/2020, at 8:20 AM, revealed the metal divider was in R7's room doorframe. Further review of R7's progress notes, dated 6/22/2020, revealed the Interdisciplinary Team (IDT) reviewed R7's fall from 6/20/2020, and her care plan was reviewed. The IDT documented in R7's progress note, resident remains on closer supervision for safety. Falls are anticipated due to resident being impulsive, unsteady gait, poor safety awareness and strong desire to remain independent with her., however this IDT review was not reflected on R7's fall care plan. Review of another progress note, dated 6/23/2020, revealed, Requested for pharmacy

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.

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) consultant to review medications on 6/21 r/t frequent falls. Review was completed and pharmacy recommendations were provided. The pharmacy medication request to review R7's medications was not reflected on her fall care plan. In an interview on 6/26/2020, at 12:20 pm, Director of Nursing (DON) B stated for the fall R7 had on 6/20/2020 a medication review of her medications was conducted, and stated that for the fall she had on 6/24/2020 her bedside table was moved. DON B said she did not know why R7's care plan had been not updated to include her medication review and the moving of her bedside table. DON B stated that she would expect to see R7's fall care plan updated with these interventions after her falls on 6/20 and 6/24/2020.
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 is related to Intake MI 456. Based on interview and record review, the facility failed to administer treatments, showers and/or baths for 1 sampled resident (Resident #5) resulting in the potential for worsening of alteration of skin integrity under the left breast, skin breakdown and body odor. Findings Include: According the Electronic Medical Record (EMR) Resident #5 (R5) was admitted to the facility on [DATE] and discharged from the facility on 04/02/2020. [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS: resident assessment tool) dated 01/19/20 reflected R5 was cognitively moderately impaired, required extensive-total dependence of 1-2 persons for transfers, dressing, hygiene, bathing bed mobility and toilet use. In addition, R5 had impairment of her upper and lower extremities on one side, and was frequently incontinent of her bowel and bladder. The Change of Condition note for R5 dated 03/20/20 at 04:00 AM reflected, .Noted to under left breast severe excoriation with moisture . However no wound healing record, or head to toe assessments documentation were noted on the day of discovery, of the excoriated breast area. The most recent wound healing record for R5 was dated 10/30/19 reflected no new concerns noted. R5's most recent Head to Toe Assessment sheet, whereby abnormal skin issues were to be checked dated 03/26/20 reflected no concerns. The EMR reflected R5 was unresponsive and sent to a local hospital's Emergency Department on 04/01/20. Hospital records dated 04/01/20 reflected R5 had Wound Moisture Associated Skin Damage Breast Left and Wound Ulcerated Abdomen Right. The local hospital's Significant Event-Flowsheet Notes dated 04/01/20 by Registered Nurse (RN O) reflected, Pt admitted to floor with multiple wounds and sores .Abd (abdominal) folds and groin red and excoriated with strong odor. Hospital Physician P placed an order for [REDACTED]. However R5 had MISSED doses of the prescribed power during the daytime on March: 16, 18, 24, 25 and 29, and MISSED doses at nighttime on March: 3, 23 and 26. The omitted administrations were evidenced by empty boxes without nursing staff initials. -Cleanse right abdomen with NS (Normal Saline), pat dry, apply [MEDICATION NAME] to wound beds, cover with Xeroform gauze, cover with ABD pads and secure with tape one time a day. R5 had MISSED treatments on March: 18, 24, 25 and 29. The omitted treatments were evidenced by empty boxes without nursing staff initials. No documentation was noted in the progress and/or nurses notes reflecting the treatments or medication was administered. The medication administration policy used by the facility and provided by the facility pharmacy services entitled, 6.0 General Dose Preparation and Medication Administration revised on 01/01/13 reflected: 5. During medication administration, facility staff should take all measures required by facility policy and 5.4 Administer medications within timeframe's specified by facility policy; 6. After medication administration, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN (as needed) medications, application sight on appropriate forms; The EMR under Task reflected R5 preferred showers on Monday and Thursday PM. I prefer bed baths on Tuesday/Wednesday/Friday/Saturday/Sunday. On 06/05/20 at 09:57 AM The Director Of Nursing (DON B) provided R5's written documented shower sheets only for February and computer generated shower record only for March 2020. The only shower sheets that DON B revealed she had for February 2020 were dated: 2nd, 5th, 12th (6 day gap), 17th (5 day gap) and the 20th. The shower record reflected: Refusals on the 9th and 16th. No supporting documentation was available, reflecting R5 was re-approached a second time on either day for a shower. Non-Applicable (NA) was documented on R5's shower record on March 12th (6 day between two refusals) and 23rd (6 day gap between two showers). Later the same day at 10:49 AM DON B was informed of the 03/20/20 change of condition note reflecting the excoriated area under R5's left breast. When asked what did the empty boxes on the MAR/TAR mean DON B revealed, empty boxes where care should have been given, means it was an omission, and that they did not give the medication or treatment. Also, that staff should have documented in the treatment record if R5 refused, but to look in nurses notes. When asked what did NA mean on the shower record DON B replied, I'm thinking not applicable, really that's not appropriate documentation. When asked if NA meant not given DON B revealed that was correct, and that it should be documented if a shower was given, not given or that R5 refused.
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 is related to Intake MI 456. Based on interview and record review the facility failed to monitor and assess for disruption in skin integrity for 1 sampled resident (Resident #5), resulting in an reddened excoriated area under the left breast, wounds to the abdomen and the potential for infection. Findings Include: According the Electronic Medical Record (EMR) Resident #5 (R5) was admitted to the facility on [DATE] and discharged from the facility on 04/02/2020. [DIAGNOSES REDACTED]. The Annual Minimum Data Set (MDS: resident assessment tool) dated 01/19/20 reflected R5 was cognitively moderately impaired, required extensive-total dependence of 1-2 persons for transfers, dressing, hygiene, bathing bed mobility and toilet use. In addition, R5 had impairment of her upper and lower extremities on one side, and was frequently incontinent of her bowel and bladder. The Change of Condition note for R5 dated 03/20/20 at 04:00 AM reflected, .Noted to under left breast severe excoriation with moisture . However no wound healing record, or head to toe assessments documentation were noted on the day of discovery, of the excoriated breast area. The most recent wound healing record for R5 was dated 10/30/19 reflected no new concerns noted. R5's most recent Head to Toe Assessment sheet, whereby abnormal skin issues were to be checked dated 03/26/20 reflected no concerns. The EMR reflected R5 was unresponsive and sent to a local hospital's Emergency Department on 04/01/20. Hospital records dated 04/01/20 reflected R5 had Wound Moisture Associated Skin Damage Breast Left and Wound Ulcerated Abdomen Right. The local hospital's Significant Event-Flowsheet Notes dated 04/01/20 by Registered Nurse (RN O) reflected, Pt admitted to floor with multiple wounds and sores .Abd (abdominal) folds and groin red and excoriated with strong odor. Hospital Physician P placed an order for [REDACTED]. condition demonstrates that they were unavoidable; and a resident having pressure ulcers receives necessary treatment and services to promote healing, prevent infection and reduce the risk of new ulcers developing. Procedure 1. A licensed nurse checks the resident's body for the presence of pressure ulcers, wounds and other skin conditions: -At admission or readmission to the facility. -Whenever the resident arrives by medical transport. -Weekly on residents, and -Prior to discharge. 2. The licensed nurse documents that the body check was completed on the resident's weekly head to toe skin record. 3. The presence of any pressure ulcer, wound, or other skin condition is documented in the designated area. 9. A licensed nurse assesses and documents that status of existing wounds weekly. 11. The interdisciplinary team will review residents with skin conditions regularly to monitor treatment and support effectiveness and recommend changes as needed. 12. Document skin status in the resident record. The EMR under Task reflected R5 preferred showers on Monday and Thursday PM. I prefer bed baths on Tuesday/Wednesday/Friday/Saturday/Sunday. On 06/05/20 at 09:57 AM The Director Of Nursing (DON B) provided R5's written documented shower sheets only for February and computer generated shower record only for March 2020. The only shower sheets that DON B revealed she had for February 2020 were dated: 2nd, 5th, 12th (6 day gap), 17th (5 day gap) and the 20th. The shower record reflected: Refusals on the 9th and 16th. No supporting documentation was available, reflecting R5 was re-approached a second time on either day for a shower. Non-Applicable (NA) was documented on R5's shower record on March 12th (6 day between two refusals) and 23rd (6 day gap between two showers). Later the same day at 10:49 AM DON B was informed of the 03/20/20 change of condition note reflecting the excoriated area under R5's left breast. When asked what did the empty boxes on the MAR/TAR mean DON B revealed, empty boxes where care should have been given, means it was an omission, and that they did not give the medication or treatment. Also, that staff should have documented in the treatment record if R5 refused, but to look in nurses notes. When asked what did NA mean on the shower record DON B replied, I'm thinking not applicable, really that's not appropriate documentation. When asked if NA meant not given DON B revealed that was correct, and that it should be documented if a shower was given, not given or that R5 refused.

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