STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235444	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTWOOD NURSING CENTER	16588 SCHAEFER DETROIT, MI 48235

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0684 **Level of harm -** 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 intake MI 1766, MI 1925, MI 1893 Based on interview and record review the facility failed to 1. Provide consistent assessment and treatment of [REDACTED]. Follow Physician's wound care orders, effecting three residents (R#96, R#98, R#99) out of three residents reviewed for wound care, resulting in opportunities to treat and evaluate wounds to encourage healing and worsening of R#96's wound requiring hospitalization and possible amputation of limb. Findings Include: R#96 On 4/30/20 at 8:30 a.m., during phone conversation with complainant/ Emergency Medical Technician (EMT), when asked the condition of the wound , EMT stated, When I came to transport the resident to the hospital the wound was exposed with no bandages applied and had a bad odor. I had to wait almost an hour before staff would wrap the resident's foot so that I could transport to hospital. On 4/30/20, record review revealed R#96 had been admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to Minimum Daily Set ((MDS) dated [DATE], R#96 had impaired cognition and was total dependent of most Activities of Daily Living (ADLS) and transfers. On 4/30/20, Review of Nurse Progress Notes revealed on admission resident had . R (right) and L (left) necrotic heels noted, wound consult needed. Physician notes dated 3/31/20, . She was noted to [MEDICAL CONDITION] secondary to MD (multi-drug) resistant UTI (urinary tract infection) and necrotic bilateral decubitus heel ulcer . Review of Podiatrist order noted on 4/6/20 After speaking with staff nurse and DON (Director of Nursing), recommend patient be sent to hospital (Provider Name) due to worsening right ankle ulcer, patient has active purulence to right ankle with necrosis. Patient would benefit from radiographs (X-rays), CBC with diff (lab test), IV (intravenous) antibiotics and podiatry and vascular consults. Review of Physicians orders, laboratory results and radiology related to above order was not implemented by facility. Physician order [REDACTED]. Noted malodor. I did speak with day nurse in person and DON via phone, we will order stat (as soon as possible) radiographs. Patient needs ER (emergency room) visit CBC with diff, ESR, CRP (tests), podiatry consult. Review of Nurse Progress notes revealed resident was not sent to ER until 4/15/20. Review of Treatment Administration Record revealed first order Cleanse bilateral feet with ns (normal saline), pat dry, apply kerlix every 2 days. Second order noted Med honey CA alginate (wound dressing). Apply to Right heel topically every day shift every 2 days for diabetic ulcer . Documentation revealed treatments were not performed on 4/1,4/5,4/7,4/9 and 4/11. Review of progress notes revealed no assessment or measurement of wounds performed by nursing staff at facility from 4/1/20- 4/13/20. Review of Discharge Summary by primary physician documented She was sent to ER via EMS (Emergency Medical Services), case discussed with vascular surgery, patient may need amputation. R#99 On 4/30/20, during record review revealed R#99 was originally admitted into facility on 3/26/14 with [DIAGNOSES REDACTED]. According to MDS dated [DATE], R#99 had intact cognition and was extensive assist with ADLs. On 4/30/20, record review revealed R#99 had multiple wounds. Review of Treatment Administration Record noted first order [MEDICATION NAME] Extra AG+Pad (wound dressing) - Apply to left lateral ankle topically one time a day . ; second order noted [MEDICATION NAME] Extra AG+Pad (wound dressing) - Apply to sacral topically one time a day . Review found no documentation that treatment was performed for first order on 4/4, 4/5, 4/8, 4/9, 4/14 and 4/28. Review of second order revealed no documentation that order was performed on 4/4, 4/5, 4/8,4/9,4/14. Review of Assessments revealed no weekly documentation of wound observations or measurements. On 5/1/20 at 1:15pm, during a phone interview with DON, when asked if Physicians orders should always be followed, DON stated, Yes. When asked if nursing staff are not sure how to follow Physician orders [REDACTED]. After reviewing TAR and Assessments, DON was asked if staff should document after administering treatment and provide weekly documentation of observation and measurements of resident's wounds, DON stated, Yes. Resident #98 On 4/30/20 at 9:57 a.m., the complainant reported to the State Agency that the facility did not provide adequate and appropriate care to treat pressure sores and ensure R98 was properly assessed in a timely manner. On 5/1/20 at 9:34 a.m., review of R98's clinical record documented the Resident was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The Resident left the facility against medical advice on 4/26/20. According to the admission MDS assessment dated [DATE], the Resident was cognitively intact and required one-person extensive assistance with ADLs. Further record review revealed in the nurses notes the following: 4/16/2020 19:08 .Pain was indicated from coccyx, wound on coccyx. 4/25/2020 04:29 .Dressing in dry and intact with moderate amount of drainage. 4/25/2020 19:11 Cleanse sacrum with wound cleanser, pat dry, apply dry dressing and foam pad. Two times a day for Wound care. discharged . According the physician's orders [REDACTED]. Review of the Treatment Administration Record (TAR) documented the following wound care treatments were applied: 4/23/20 Cleanse sacrum with wound cleanser, pat dry, apply dry dressing and foam pad. Two times a day for wound care -order Date 04/23/2020, hours 0900 and 1700, 4/23/20 at 0900 not administered; 1700 administered; 4/24 and 4/25 administered at both times indicated by nurse initials. Review of the Skin Care Plan dated 4/19/20 documented: Resident is at risk for skin breakdown related to impaired mobility and medical condition. Interventions: Assess skin during care, report any red, bruised medical condition. Interventions: Assess skin during care, report any red, bruised areas to be completed on shower days. Skin assessment upon admission. Prompt incontinence care with barrier cream prn (as needed). On 5/1/20, review of policy Provision of Physician Ordered Services revised on 4/6/20 documented the following: The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. Definition: Professional Standards of Quality means that care and services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a clinical discipline or in a specific clinical situation or setting. Policy Explanation and Compliance Guidelines: 1. Facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders [REDACTED]. 2. Qualified nursing personnel will submit timely requests for physician ordered services (laboratory, radiology, consultations) to the appropriate entity. 3. Qualified nursing personnel will receive and review the diagnostic test reports or consults and communicate the results to the ordering Physician, physician assistant, nurse practitioner or clinical nurse specialist within 24 hours of receipt unless the reports fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders [REDACTED]. 4. Documentation of consultations, diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record. 5. In instances where diagnostic testing or consultations are not available to be performed on-site OR the Physician has requested that the services be performed at an off-site facility, this facility will work with the resident and their family to secure appropriate transportation arrangements for such appointments.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.**

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intakes: MI 3, MI 6, MI 5 Based on interview and record review, the facility failed to properly maintain infection control practices during a COVID-19 Infection Control Survey by failing to assess, monitor, develop and follow plan of care for four (R#96, #98, #101, and #105) of 8 residents reviewed for infection control, potentially resulting in the spreading of the coronavirus and other harmful pathogens among other residents that reside in the facility. Findings include: R#96 On [DATE], record review revealed R#96 had been admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to Minimum Daily Set ((MDS) dated [DATE], R#96 had impaired cognition and was total dependent of most Activities of Daily Living (ADLS) and transfers. On [DATE], record review of R#96 vital signs revealed from [DATE] to [DATE] temperatures were not recorded consistently every shift as ordered by Physicians. Review of Covid-19 care plan documented Temperature Q (every) shift. R#99 On [DATE], during record review revealed R#99 was originally admitted into facility on [DATE] with [DIAGNOSES REDACTED]. According to MDS dated [DATE], R#99 had intact cognition and was extensive assist with ADLs On [DATE], record review of R#99 vital signs revealed from [DATE] to [DATE] temperatures were not recorded consistently every shift as ordered by Physicians. Review of Covid-19 care plan documented Temperature Q (every) shift. R#101 On [DATE], during record review revealed R#100 was originally admitted into facility on [DATE] with [DIAGNOSES REDACTED]. According to MDS dated [DATE], R#100 had intact cognition and was independent with ADLs On [DATE], record review of R#100 vital signs revealed from [DATE] to [DATE] temperatures were not recorded consistently every shift as ordered by Physicians. Review of Covid-19 care plan documented Temperature Q (every) shift. On [DATE] at 1:15 p.m., during phone interview with Director of Nursing (DON), when asked if resident's temperature should be monitored as ordered, DON stated, Yes. When asked if temperatures are monitored to detect possible infection of Covid-19, DON stated, Yes. R#105 On [DATE] at 3:48 p.m., record review of R105's clinical record documented the Resident was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The Resident discharged from the on [DATE] (expired in the facility). According to the admission MDS assessment dated [DATE], the Resident's cognition was moderately impaired and required extensive one-person assistance with ADL's. On [DATE] upon further record, the following nurses' notes documented the following: [DATE] 04:40 Note Text: Resident arrival into facility via stretcher @ 9:30pm,COVID-19 positive . into room ,[DATE] (one of the designated droplet precaution rooms for COVID-19 patients) . Vitals BP (Blood Pressure)-,[DATE], HR (Heart Rate)-79, O2(Oxygen)-93, Temp(Temperature)-97.9, Res (Respiration)-18; will continue nursing plan of care. The following admission note documented: [DATE] 10:48 Admission Note Text: H&P (History and Physical): presented from hospital with COVID, was positive and treated . Diagnoses: [REDACTED]. The last documented nurses' note documented: [DATE] 11:43 Nurses Progress Notes Note Text: At Approximately 10:50am resident observed lying in bed without a pulse . Resident was pronounced at 11:03 am . There were no nurses notes documenting monitoring for the dates of [DATE] day shift, afternoon shift and midnight shift; [DATE] all shifts; [DATE] afternoon shift and midnight shift; [DATE] day shift and afternoon shift; [DATE] day all shifts (Skilled Nursing Note documented for [DATE] at 5:00 am-midnight shift of [DATE]); [DATE] day shift and afternoon shift. A Skilled Nursing note was documented on the midnight shift at 2:26 am. The following temperatures were monitored and documented on: [DATE] 02:19 am 97.8 F; [DATE] 04:54 am 98.1 F; and [DATE] 03:52 97.9 F. There were no other temperatures documented. There was no plan of care formulated for the R105 with the exception of a Therapy Care Plan, date initiated on [DATE]. On [DATE] the Infection Control Surveillance Report for the month of April was reviewed. R105 was not identified on the Surveillance Report being monitored for signs and symptoms for COVID-19 upon admission. On [DATE] at 5:53 p.m., the Director of Nursing was interviewed and asked why the Resident was not monitored adequately per policy. The DON stated, Interventions and monitoring were put in place but were not documented. We dropped the ball. According to the CDC (Center for Disease Control) Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, updated [DATE] documented the following: .healthcare facilities could consider foregoing contact tracing for exposures in a healthcare setting in favor of universal source control for HCP and screening for fever and symptoms before every shift. Review of the facility's policy titled Pandemic COVID-19, Infection Control Measures: .aggressive infection control measures will be implemented to prevent introduction of [MEDICAL CONDITION] to residents . strict adherence to standard and transmission-based precautions and other infection control measures will be implemented according to the most current CDC recommendations for pandemic COVID-19.