STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235374	A. BUILDING _____ B. WING _____	**05/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST OAKS SENIOR CARE & REHAB CENTER	**22355 W EIGHT MILE RD DETROIT, MI 48219**

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 555. Based on observations, interviews, and record reviews, the facility failed to perform timely skin assessments, including wound measurements, and ensure interventions were being implemented for one of three residents (R#57) reviewed for pressure ulcer care, resulting in the worsening of an existing pressure ulcer by increasing in size and depth. Findings include: During an observation on 5/7/20 at 10:30 AM R#57 was sitting up in bed with a fecal pouch draining liquid stool into a bag, and a supra-pubic catheter draining clear yellow urine into a privacy bag. The resident was alert, but non-verbal. Certified Nursing Assistant (CENA) 'E' was at the resident's bedside and assisted with repositioning the resident. At this time the resident's sacral pressure ulcer dressing was observed to be wet, soiled and not intact over the pressure ulcer area. The resident had bilateral soft booties in place to protect her heels. According to the medical record, R#57 initially admitted to the facility with multiple [DIAGNOSES REDACTED]. R#57 had admitted to the facility with a pressure ulcer on her sacral area. On 3/30/20, the last wound care photo revealed intact skin to the sacral area, and documented 98% closure. On 4/1/20, the 'wound care note' documented the following: measurements 1.5 centimeter (cm) by 0.6 cm, no odor, no s/s (signs and symptoms) of infection, sanguineous drainage is present. Will continue to monitor. There are no other wound care notes until 4/16/20 (16 days later). On 4/16/20, the 'treatment nurse progress notes' are as follows: Resident was admitted with open area to sacrum and excoriated buttocks. There is no further description of the sacral area. A review of the 'task notes' on 4/19/20 during the afternoon shift indicated there is a new open skin area. There are no additional progress notes related to this entry. The next wound care note is dated 4/25/20 (9 days later), and documents the sacral/coccyx area pressure ulcer is 4.5 cm x 2.5 cm x 2.5 cm, is red with sanguineous drainage. There is no physician assessment or new treatment orders for R#57's opened pressure ulcer. A review of the skin treatment orders for R#57 revealed that on 4/22/20 (six days after readmission), santyl was added to the treatments, three days a week; Monday, Wednesday, and Friday, and prn (as needed). A review of R#57's TAR (treatment administration records) for April and from May 1st - 6th 2020 revealed that the resident had never received a skin treatment as needed, only on the scheduled days of Monday, Wednesday, and Friday. On 5/7/20 at 1:00 PM, during an interview with the wound care nurse, staff C, she said that the skin assessments should have been done weekly and during re-admission for R#57. Staff C said she did a wound note on 4/8/20, but it was not documented in the resident's medical record. Staff C reported that R#57 went out to the hospital on [DATE] for medical decline and returned to the facility on [DATE]. She did not provide an explanation as to why there was not description or measurements for R#57's wound on 4/16/20, just that the area was open. During an interview with the Director of Nursing (DON) on 5/7/20 at 1:30 PM, she said it is the facility's policy to complete weekly skin assessments and as needed if there were new areas. The DON confirmed that R#57 readmitted to the hospital on [DATE] and no skin assessments with measurements had been done until 4/25/20, nine days later. The DON also confirmed that there were no new skin treatment orders, and they continued to be ordered only three times a week, on Monday, Wednesday, and Friday. According to the facility's Wound Management Program revised on 8/17/2017 the policy is to ensure that residents who are admitted with, or acquire wound received treatments and services to promote healing, prevent complications, and prevent new skin conditions from developing. Forms applicable to this policy included weekly hydration and skin assessments, weekly pressure ulcer wound documentation, and wound rounds. Process: The charge nurse is responsible for the following: 1. Complete Braden Risk assessment on the following schedule - upon admission, weekly for 4 weeks after admission, quarterly, when resident's condition changes. 2. Complete skin assessment as portion of the admission assessments. 4. Monitor skin changes during routine daily care (CNA) , report concerns/observations to charge nurse via POC alert. 5. Complete weekly hydration and skin assessment according to schedule.

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