STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235102	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador, A Villa Center	8045 E Jefferson Ave Detroit, MI 48214

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI00151504. Based on observation, interview and record review the facility failed to ensure an injury of unknown origin for one resident (R905) of four sampled residents reviewed for abuse was reported to the State Agency, resulting in the potential for further injury of unknown origin or abuse to go unreported and not investigated. Findings include On 6/9/25 at 3:00 P.M. R905 was observed sleeping in a low bed with a fall mat placed on the right side. On 6/10/25 at 8:30 A.M. during a meal observation R905 was observed in a low bed with bilateral fall mats on both sides of the bed. The resident appeared alert but responded to questions in short, simple words. During the interview a dark faded area was observed on the resident's left cheek area. On 6/10/25 at 1:50 P.M. review of the admission Record revealed R905 was admitted to the facility on [DATE], with pertinent diagnoses of chronic obstructive pulmonary disease, communication deficit, chronic kidney disease, vascular dementia, metabolic encephalopathy, cerebral infraction due to occlusion stenosis of cerebral artery and severe protein-calorie malnutrition. According to the Minimum Data Set (Significant change) dated 6/5/25, R905 had a Brief Interview For Mental Score (BIMS) of 6 of 15 (indicating R905 was cognitively impaired), required substantial/maximal assistance to perform Activities of Daily Living (ADL's) and was always incontinent of urine and frequently incontinent of bowel. On 6/10/25 at 2:00 P.M., review of the care plan section of R905's clinical record stated: The resident has a behavior problem r/t (related to) dementia AEB (as evidenced by) accusatory behavior against staff and other residents. Resident has a skin tear on her face and accused staff of hitting her. (initiated 5/14/25). At 2:05 P.M. the Acting Director of Nursing (ADON) was asked about the incident and whether it was determined how the resident received the facial skin tear. A request was made to review the investigation related to the incident. (continued on next page)

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.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 2:30 P.M. Unit Manager (UM) D was interviewed concerning what happened to R905's face. UM D stated, It was reported to me, I observed the area, it appeared to be a broken, open blister. When I observed the area, I reported it to the wound care team. No one knew how the resident got the dark area on her left cheek, and I did not want anybody to think we had done anything to her. The resident said we hit her. UM D was not able to provide any additional information as to how R905 sustained and injury on her left cheek. On 6/10/25 at 2:45 P.M. interview with Wound care nurse A confirmed UM D had requested the team to evaluate R905's skin tear to the face. Per nurse A the area in questioned was described as: Left cheek abrasion as reported given per UM D open area measures 1.0 x 1.1 cm, pale, pink base scanty serious drainage peri skin normal new treatment (TX): Apply Gentamicin ointment everyday x 14 days PO (Physician Order) Dr E. Record review of the Physician Order's dated 5/14/25, confirmed the same description and treatment indicated by nurse A. On 6/10/25 at 3:00 P.M. ADON reported he couldn't confirm or locate an investigation for R905 related to the incident involving the skin tear but would ask the Administrator for assistance. On 6/10/25 at 3:15 P.M. the Administrator confirmed the incident had not been reported to the State Agency. In retrospect the Administrator verbally acknowledged and indicated because staff did not know how R905 sustained the injury the incident should have been investigated and reported to the State Agency. The Administrator stated, Information wasn't forwarded to me until now. Review of the facility's policy dated 11/28/2017, titled: Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property including injuries of unknown sources under the subtitled: Abuse Reporting stated: . It is the policy of this facility that (abuse, neglect, exploitation or mistreatment including injury of unknown source and misappropriation of resident property) are reported per State and Federal, law. Employees must always report any abuse or suspicion of abuse immediately to the Administrator. (I). Investigation of injury of unknown origin or suspicious injuries must be investigated to rule out abuse. (I) injuries included but not limited to bruising, the inner thigh, chest, face and breast, bruises of an unusual size, multiple unexplained bruises and or bruising in an area not typically vulnerable to trauma. On 6/10/25 at 4:10 P.M. no additional information was provided upon exiting the facility.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake MI00151504 Based on observation, interview and record review the facility failed to ensure an injury of unknown origin was investigated for one (R905) of four sampled residents reviewed for abuse, resulting in the potential for abuse to occur. Findings include: On 6/9/25 at 3:00 P.M., R905 was observed sleeping in a low bed with a fall mat placed on the right side. On 6/10/25 at 8:30 A.M. during a meal observation R905 was observed in a low bed with bilateral fall mats on both sides of the bed. The resident appeared alert but responded to questions in short, simple words. During the interview a dark faded area was observed on the resident's left cheek area. On 6/10/25 at 1:50 P.M. review of the admission Record revealed R905 was admitted to the facility on [DATE], with pertinent diagnoses of chronic obstructive pulmonary disease, communication deficit, chronic kidney disease, vascular dementia, metabolic encephalopathy, cerebral infraction due to occlusion stenosis of cerebral artery and severe protein-calorie malnutrition. According to the Minimum Data Set (Significant change) dated 6/5/25, R905 had a Brief Interview for Mental Status (BIMS) of 6 of 15, indicating R905 was cognitively impaired (the ability to think), required substantial/maximal assistance to perform Activities of Daily Living (ADL's) and was always incontinent of urine and frequently incontinent of bowel. On 6/10/25 at 2:00 P.M., review of the care plan section of R905's clinical record stated: The resident has a behavior problem r/t (related to) dementia AEB accusatory behavior against staff and other residents. Resident has a skin tear on her face and accused staff of hitting her. (initiated 5/14/25). At 2:05 P.M. the Acting Director of Nursing (ADON) was asked about the incident and whether it was determined how the resident received the facial skin tear. A request was made to review the investigation related to the incident. On 6/10/25 at 2:30 P.M. Unit Manager (UM) D was interviewed concerning what happened to R905's face. UM D stated It was reported to me, I observed the area, it appeared to be a broken, open blister. When I observed the area, I reported it to the wound care team. No one knew how the resident got the dark area on her left cheek, and I did not want anybody to think we had done anything to her. The resident said we hit her. UM D was not able to provide any additional information as to how R905 sustained and injury on her left cheek. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 2:45 P.M., interview with Wound care nurse A confirmed UM D had requested the team to evaluate R905's skin tear to the face. Per nurse A the area in questioned was described as: Left cheek abrasion as reported given per UM D open area measures 1.0 x 1.1 cm, pale, pink base scanty serious drainage peri skin normal new treatment (TX): Apply Gentamicin ointment everyday x 14 days PO (Physician Order) Dr E. Record review of the Physician Order's dated 5/14/25, confirmed the same description and treatment indicated by nurse A. On 6/10/25 at 3:00 P.M., the ADON reported he couldn't confirm or locate an investigation for R905 related to the incident involving the skin tear but would ask the Administrator for assistance. On 6/10/25 at 3:15 P.M., the administrator confirmed there was no investigation related to the injury of unknown origin and based on the information reviewed the incident should have been investigated and reported to the state agency. Review of the facility's policy dated 11/28/2017, titled: Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property stated: It is the policy of this facility that reports of abuse, mistreatment, neglect, or abuse including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. (I). Investigation of injury of unknown origin or suspicious injuries must be investigated to rule out abuse. (I) injuries included but not limited to bruising, the inner thigh, chest, face and breast, bruises of an unusual size, multiple unexplained bruises and or bruising in an area not typically vulnerable to trauma. On 6/10/25 at 4:10 P.M., no additional information was provided upon exiting the facility.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to ensure enhanced barrier precautions (EBP) were implemented during wound care for two residents (R911 and R912) out of two residents reviewed for quality of care. Findings include: R912 Review of R912's electronic medical records (EMR) revealed resident was diagnosed with a stage 3 pressure ulcer (injury to skin from prolonged pressure) located on the sacrum (upper area of buttocks). On 6/9/25 at 12:00 PM, a wound care observation was conducted in R912's room. A sign was posted on the door indicating the requirement for enhanced barrier precautions. Additionally, a door - mounted storage unit containing gloves, gowns and masks were observed. The three staff members -Registered Nurse (RN) A, Licensed Practical Nurse (LPN) B, and LPN C entered the room and participated in this high contact wound care without donning (applying) gowns prior to initiating the procedure. Further review of R912's EMR revealed an admission date of 12/24/24, with a pertinent diagnosis of pressure ulcer of sacral (sacrum) area. Documentation also indicated the resident had moderate cognitive impairment and required substantial to maximal assistance with activities of daily living (ADLs). Review of R912's care plan dated 6/9/25 documented The resident requires enhanced barrier precautions r/t (related to) wounds. R912's Interventions documented Donn (apply) PPE (gown and Gloves) before entering the room when providing high contact res (residents) activities and doff (remove) PPE before exiting the room. Perform hand hygiene every time you enter and every time you exit the room, refer to door sign as needed. R911 Review of R911's EMR revealed resident was diagnosed with the following: right heel vascular (poor circulation) ulcer, right anterior (front) knee abrasion, right lateral (on side) hip/buttock stage four pressure ulcer, sacrum-stage four (full thickness skin loss) pressure ulcer, and left lateral hip-stage three pressure ulcer. Further review of R911's EMR revealed an admission date of 4/23/25, with a pertinent diagnosis of Fournier gangrene (a rare life-threatening infection that rapidly destroys soft tissues). Documentation also indicated the resident had intact cognition and required substantial to maximal assistance with bed mobility. On 6/9/25 at 12:37 PM, a wound care observation was conducted in R911's room. A sign was posted on the door indicating the requirement for enhanced barrier precautions. Additionally, a door - mounted storage unit containing gloves, gowns and masks were observed. The three staff members -Registered Nurse (RN) A, Licensed Practical Nurse (LPN) B, and LPN C entered the room and participated in this high contact wound care without donning gowns prior to initiating the procedure. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R911's care plan dated 4/23/25 documented The resident requires enhanced barrier precautions catheter (indwelling urinary), wounds requiring dressings. Further review of care plan documented, . Interventions-Staff will wear gloves and gowns for device care or use of central lines (tubing inserted into large veins; used to administer medications, fluids and blood), urinary catheters (tube inserted to remove urine), feeding tubes(tube inserted into stomach to provide nutrition, hydration and medication), tracheostomy (tube inserted into throat to maintain breathing), colostomy/ileostomy (a surgical incision to allow removal of waste) or any wound care. Gown and glove one use only and for only one resident. An interview conducted on 6/9/25 at 1:05 PM with RN A, it was reported that a gown was not donned before providing treatment to residents R911 and R912. It was further reported that enhanced barrier precautions should be worn before providing wound care treatments. An interview conducted on 6/9/25 at 1:06 PM with LPN B, it was reported that a gown was not donned before providing treatment to residents R911 and R912. It was further reported that enhanced barrier precautions should be followed before providing wound care treatments. An interview conducted on 6/9/25 at 1:07 PM with LPN C, it was reported that a gown was not donned before providing treatment to residents R911 and R912. It was further reported that enhanced barrier precautions should be followed before providing wound care treatments. An interview conducted on 6/9/25 at 2:30 PM with Acting Director of Nursing (ADON). It was reported that staff are expected to follow the facility's policies and procedures for implementing enhanced barrier precautions when providing care to residents identified as requiring such measures. Review of facility's policy Personal Protective Equipment Guideline dated 4/12/24 documented the following: Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs (Multidrug-Resistant Organisms) to staff hands and clothing. MDROs may be indirectly transferred from resident to resident during these high contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high contact resident care activities is indicated, when Contact Precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.