STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235123	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Durand Senior Care and Rehab Center, L L C	8750 E Monroe Rd Durand, MI 48429

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(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** 27306 This Citation Pertains To Intake # MI00143774 and MI00143825 Based on observation, interview and record review, the facility failed to respond, assess and render immediate aid in a timely manner for one resident (resident #105) of three reviewed for falls. Findings Include: Review of the clinical record reflected R105 was a [AGE] year-old male admitted to the facility on [DATE]. R105 transferred to another facility on 4/5/24. Review of the Minimum Data Set (MDS) dated [DATE] reflected R105 had a diagnosis of Multiple Sclerosis (MS) and scored 15 out of 15 on the Brief Interview for Mental Status (BIMS). Further review of the MDS reflected assistance was required for all transfers. Review of R105's Social Work progress notes dated 2/7/24 reflected R105 had periods of confusion related to a famous Hollywood actress coming to pick him up and threatening self-harm if she doesn't. On 05/01/24 at approximately 10:25 am during an interview with Receptionist V she reported she was aware of R105 falling while shopping next door but stated she was not on duty at that time and referred writer to Receptionist E who was on duty at the time of R105's fall. On 05/01/24 at 1:15pm during a phone interview with complainant/ random stranger R she reported that she frequents the apartment complex next door to the facility and behind [name redacted] store. Random Stranger R stated she had repeatedly observed the same man in a wheelchair at local store lying on the pavement. Random Stranger R stated she did not know the man's name but assumed he was a resident of the facility since the buildings were right next door to one another - separated by a side street. Random Stranger R stated April 4th of 2024 was the last straw, stating this time she observed R#105 fall out of his wheelchair onto the pavement behind the store and in front of the apartment complex with blood coming from the [NAME] forehead. Random Stranger R stated the same resident was always alone and due to the 4/4/2024 fall she was so concerned for his wellbeing thought it was best to file a complaint with the State Agency. On 05/01/2024 at 1:40 pm, during a phone interview with a separate Complainant/ Random Stranger S she reported on 4/4/24 she was in her car and observed a man on the ground behind the store next to the facility and in front of the apartment complex. Random Stranger S stated that on way back into the apartment complex noticed the man was still on the ground, she reported she could not get him up by herself and called a neighbor and they together helped the man off the cement and back into his wheelchair. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Random Stranger S stated she does not know who the man is but has watched him struggle on more than one occasion at the local nearby stores, when asked to clarify struggle she elaborated that man was always alone and the area was very hilly and he struggles to get up and down the hills in his wheelchair, and on another occasion Random Stranger S stated she had observed the same man lying in the road in front of the facility and on that occasion a passerby stopped his car and assisted him back into his wheelchair. Random Stranger S stated she then personally went next door into the facility and told the receptionist an unknown man, that appeared to be a resident of the facility, fell out of his wheelchair next door and was bleeding from his head. Random Stranger S stated she was dismissed by the receptionist and when leaving the facility she was a staff member (name unknown) in the parking lot and tried to explain to the facility staff her concern to that person, that man appeared to be resident of the facility as well but was again dismissed by facility staff. Random Stranger S stated she waited 10 to 15 minutes with the man but nobody from next door (the facility) came to check on him, to see if he lived at the facility. Random Stranger S then called her neighbor and the two of them picked the man up off the ground and placed him back in his wheelchair and helped him back. Random Stranger S stated she was concerned about the man's safety and given her prior observations of him falling in the road, parking lots and being dismissed by the facility staff , she thought a formal complaint was warranted after learning that the man did live in the facility. On 05/01/2024 at approximately 2:00pm during a phone interview with Receptionist E she reported she worked on 4/4/24 and recalled a random stranger came into the facility and reported she thought one of our residents fell out of his wheelchair, was bleeding from the head lying on the cement/parking lot next door. Receptionist E stated she automatically assumed it was R105 because he would often sign himself out and go alone to local stores. Receptionist E stated she called the nurses station where R105 resided and relayed the message (Receptionist E could not recall whom at the nurses stated she spoke with) from the unknown woman. On 5/1/24 at 11:21am during a phone interview with Licensed Practical Nurse (LPN) D she reported she was assigned to R105 on 4/4. LPN D stated on 4/4/24 she received a call from the front desk that R105 fell while shopping next door. When queried if she was notified, that a resident was lying on the pavement and had a head wound LPN D stated she could not recall the exact conversation with the receptionist. When queried if she looked out of any facility window to check to see if one of her residents was lying on the pavement, LPN D stated no R105 was on an LOA. Of note, R105 was not documented as being on an LOA on 4/4/24. LPN D further stated she went on break and did not assess the resident upon his return until her return from break. LPN D stated R105 was alert and oriented but did have periods of confusion. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Incident and Accident report dated 4/04/2024 reflected R105 fell while on a Leave of Absence (LOA) LN (licensed Nurse) alerted that while resident was out of center going to [name redacted] (store next to facility) he was going down the hill by the apartment complex causing him to go at an unsafe speed. Resident then placed feet down on the ground trying to slow him self-down causing him to come forward out of his wheelchair causing abrasion to right forehead 10-millimeter (mm) x 10 mm, right knee (5 mm x 5 mm) and right pinky knuckle (3 mm x 3 mm). Resident stated he then placed himself back in his wheelchair and continued to [name of store redacted] for shopping. When resident returned to center he was assessed. R.O. M. (Range of Motion) and pain assessed as well. {sic} neuro's started and resident alert and verbal. Resident states he has pain 5 out of 10. Resident speech is appropriate for resident pupils plus two active to light. extremities strength and length are equal with no issues noted. education complete for LOA safety. On 05/02/24 at 8:22 am during an interview with Unit Manager/Registered Nurse (UM/RN) C the scenario of the fall was given, and it was queried what the expectation of the staff was, UM/RN C stated the scenario was so weird and ridiculous she could not answer the question. UM/RN C was then queried if facility staff should have responded to the concern that a facility resident was lying on the ground, for example by walking next door to see if it was a facility resident or calling 911 opposed to random strangers picking up facility resident R105 off the cement, UM/RN C reported she was not in charge of the staff at [store name redacted]. When queried if she expected staff to look out of the facility window to verify the report of the man was a resident of the facility, as the safety of the facility resident was a concern, UM/RN C stated if they are on LOA there was nothing to be done. Review of the LOA book did not reflect R105 was ever signed out on 4/4/24 when queried how the facility would know it was R105 as he never signed out, would that not prompt someone to look out the window to ensure a facility resident did not elope? UM/RN C had no response to the question. On 05/02/24 at 11:45 am during an interview with Director of Nursing (DON) B stated Resident #105 had periods of confusion and believed movie stars and famous wrestlers were coming to see him. DON B further stated R105 was on an approved LOA on 4/4/2024 when DON B was informed the sign out log reflected R105 never left the faciity on [DATE] DON B replied not technically signed out. When asked for clarification of not technically DON B stated he thinks R105 just wrote the wrong date on the sign out sheet. When queried about the incident DON B stated he did not expect his staff to walk next door or look out the window to verify if the person was on the ground was a resident of the facility, citing the fact it didn't matter because it would have been a LOA and he was not responsible. When queried even after being notified of a facility resident with an alleged head injury, alone, and unable to get up that could be visualized from the end of the 400 hall, 100 hall and lobby window? DON B stated LOA meant he and the facility were completely not responsible for the facility resident and it was up to the staff at [name redacted] store to call 911. When queried if the facility had a LOA policy, DON B stated no.

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(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 - 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** 34705 Based on observation, interview and record review facility failed to: 1) accurately assess, monitor, treat and prevent the development of pressure ulcers consistent with professional standards of practice to prevent avoidable pressure ulcers; and 2) implement care-planned and non-care-planned interventions for three Residents (R103, R107 and R109) of four reviewed for pressure ulcers, resulting in R109 facility acquired stage 2 pressure ulcer, and the increased likelihood for delayed wound healing and or worsening of wounds and overall deterioration in health status, and worsening of pressure ulcer wounds with sepsis. Findings include: Resident #103(R103) Review of the Face Sheet and Minimum Data Set (MDS) with ARD date [DATE], reflected R103 was a [AGE] year old female admitted to the facility on [DATE] related to cerebral infarct with dysphasia, diabetes mellitus, dementia, metabolic encephalopathy, hypertension (high blood pressure), renal failure, The MDS reflected R103 had a BIM (assessment tool) of 13 which reflected R103 was cognitively intact. The MDS assessment reflected R103 had no behaviors including no rejection of care. According to the National Pressure Ulcer/Injury Advisory Panel (NPUAP); Unstageable Pressure Ulcer/Injury is full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar (necrotic dead tissue). If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Pressure Injury: A pressure injury is localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co morbidities and condition of the soft tissue. Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. Stage 4 Pressure Injury: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration. Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Review of the facility, Wound Management Program, revised [DATE], reflected, Policy: To assure that residents who are admitted with, or acquire, wounds receive treatment and services to promote healing, prevent complications and prevent new skin conditions from developing .forms or documentation applicable to this policy .care plan/kardex, weekly hydration and skin assessment .point of care(POC) .Unless otherwise specified, the Charge Nurse is responsible for the following .Monitor skin changes during routine daily care(CNA) .Report concerns/observations to the Charge Nurse(Nurse) via POC alert .Report any abnormal findings to the physician and Certified Dietary Manager(CDM) or Registered Dietician(RD) via Alert in PCC . Initiate treatment according to physician guidance .Assess protein and calorie needs, hydration status and overall nutritional status admission and as needed .Initiate interdisciplinary plan of care .Monitor any acute illness or change in condition .Process (Management of Pressure Ulcers/Non Pressure Wounds) .Complete the following steps if pressure ulcer identified: 1.1.Refer to the [named facility corporation] health System Managed Community Wound Protocol and Support Surface Product Formulary for treatment and intervention options .Complete the following daily (Charge Nurse): 3.1.Verify that resident-specific Care Plan interventions are in place (pressure relieving devices, turning schedules, etc.). 3.2. Inspect dressing to assure it is intact. 3.3. Inspect skin surrounding pressure ulcer. 3.4.Inspect any pressure ulcer that does not require a dressing . Review of the facility Matrix(802), dated [DATE], reflected no residents with pressure ulcers not present on admission. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on [DATE] at 12:22 p.m. Complainant G reported R103 admitted to the facility [DATE] after short hospital stay related to stroke for rehabilitaiton. Complainant G reported R103 had poor oral intake, was sedated, and small wound to coccyx area that significantly worsened including odor and increase in size and fever. Complainant G reported R103 was transferred to the hospital on [DATE] and admitted and treated for septic shock and later died related to complications related to coccyx wound. Review of the Hospital Records, dated [DATE] through [DATE], reflected Occupational Therapy Assessment that included, Bed Mobility: sit to supine: Moderate Assistance of 2, Supine to Sit: moderate assistance of 2 . upon OT evaluation, pt is physically and cognitively functioning significantly below her baseline status of independence. She is currently alert to self. She is requires max pa x 1 for all aspects of badl routine and mobility at this time . Review of the Hospital Lab Results, dated [DATE], reflected R103 GFR result was 42. (GFR is indicator for chronic kidney disease. GFR healthy adult 90 or greater. Stage 3b = moderate to severe loss of kidney function ,d+[DATE], Stage 4=severe loss of kidney function ,d+[DATE]. The Labs reflected R103 BUN was elevated at 27(indicator of kidney function but also may be elevated if dehydrated). Review of the Lab Results, dated [DATE], reflected R103 GFR was 38 (worsened) and BUN was 33 (worsened). Review of the Skin Care Plan, dated [DATE], reflected R103 had interventions that included, Please help me turn and reposition while in bed or in my wheelchair as needed .Bed mobility with 1 assist as needed . Review of the Physician Orders, dated [DATE], reflected, Cleanse coccyx with soap & water, pat dry, apply zinc oxide twice daily for skin protection for 30 Days -Start Date-[DATE] 0700-D/C Date- [DATE]. Review of the Physician Orders, dated [DATE], reflected, Cleanse coccyx with wound cleanser, pat dry, an Aquacel foam dressing. every day shift every 3 day(s) for pressure injury wound care -Start Date-[DATE] (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an interview on [DATE] at 10:05 a.m., Wound Nurse(WN) RN I reported had been facility wound nurse for one year and reported had not completed certified wound training. WN I reported completed weekly wound rounds including pictures and documented in Electronic Medical Record(EMR) Skin and Wound Evaluations and Progress Notes. WN I reported new admission residents are assessed next business day then every seven days. WN I verified R103 admitted on Monday [DATE] with pressure ulcer documented on admission assessment with no description including measurement. WN I reported admitting nurses inform her or Clinical Care Coordinator (CCC)RN C of wounds and seen by next business day. WN I verified R103 was assessed by RN C on [DATE] and reported she (WN I) had been on vacation at that time and was unsure why delay in treatment. WN I reported facility had standing physician orders for wound care treatments and physicians not contacted unless need for change in treatment or new or worsening wounds noted. WN I reported R103's coccyx wound was documented on [DATE] as deep tissue injury pressure ulcer, present on admission, staged by in-house nursing that measured 3.9cm by 2.2 cm by 0.2cm depth with 100% of wound covered with epithelial and surface intact, serous drainage(however documented as intact skin) and no odor. WN I reported R103 intervention included roho cushion for wheelchair, low air loss mattress, daily multivitamin, repositioning devices, aquacel foam dressing every three days and an needed. Review of R103, Skin & Wound Evaluation V7.0, dated [DATE] and edited [DATE], reflected R103 had deep tissue injury pressure wound to coccyx present on admission. The document reflected notes, Resident admitted with pressure injury. Segments of wound are maroon in color & persistently non-blanchable. Treatment order in place: Cleanse coccyx with wound cleanser, pat dry, an Aquacel foam dressing q3 days & prn soiled or dislodged dressing. Roho cushion placed on wheelchair. Low air loss mattress ordered. Multivitamin ordered daily to promote wound healing .Resident educated regarding;*Weekly wound rounding program*Importance of frequent repositioning while in bed, wheelchair, and chair to promote wound healing and hinder any further tissue damage. *Use of APM mattress, roho cushion, and daily multivitamin to promote wound healing. *Treatment order in place . Review of the attached picture dated [DATE] reflected evidence of deep tissue injury with open area. Review of R103, Skin & Wound Evaluation V7.0, dated [DATE], reflected R103 had deep tissue injury pressure wound to coccyx that measured 2.7cm by 1.8cm by 0.1cm depth. The document reflected 70% epithelial and 30% granulation with notes that reflected, PUSH score indicates wound progress is stable. Segments of wound remain maroon in color & persistently non-blanchable. Tx order in place: Cleanse coccyx with wound cleanser, pat dry, an Aquacel foam dressing q3 days & prn soiled or dislodged dressing. Document did not reflect physician notified. Review of the attached picture, dated [DATE], reflected large open area with non viable skin, continued deep tissue injury, discolored peri area with overall worsening in wound. Review of R103 EMR, dated [DATE] through [DATE], reflected R103 admission weight was 132 pounds on [DATE] and 127 pounds on [DATE](5 pound weight loss in 14 days). Review of the food acceptance reflected food acceptance that included R103 had eight entries of ,d+[DATE]% eaten and 16 entries of , d+[DATE]% eaten documented in 14 days prior to transfer to hospital. Review of R103 vitals with slowly elevated blood pressure and heart rate over 14 days. Review of the EMR reflected no mention of urine output or fluid input. Continued review of EMR reflected R103 was transferred to the hospital on [DATE] related to altered mental status, abnormal vitals, fever, increased assistance with ADLS, decline in mobility and eating, tachycardia. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of the facility POC Task charting(Certified Nurse Aid documentation), dated [DATE] through [DATE], reflected no evidence of frequent repositioning, repositioning devices, hydration, toileting or skin observations. During an interview on [DATE] at 11:30 a.m. Director of Nursing (DON) B was asked how CNA staff know what resident needs are DON B reported they follow the care plan and kardex and reported turning and reposition residents was a standard of care every two hours and just know to do and they do not document task as completed. When asked why, DON B repeated because standard of care. DON B reported does not no a lot about wound care but has a wound team at facility that included wound care nurse WN I who he trusts with wounds. During an interview on [DATE] at 1:36 p.m., CNA J reported know how to care for residents by following kardex. CNA J reported assist with Activities of Daily Living(ADL) including repositioning or input or output as needed but unable to document ADL tasks performed. CNA J reported if resident did not have output for shift or change in condition would verbally report to nurse. During an interview on [DATE] at 1:40 p.m., CNA K reported CNA charting changed about one year ago and no longer document several ADL tasks as completed because they are standard of care. CNA K reported if CNA staff notice change in resident verbally report to nurse but not able to document in EMR. During an interview on [DATE] at 2:15 p.m., CNA L reported know how to care for residents by reviewing kardex. CNA L reported about one year ago documentation changes with no need to document ADL tasks as completed including turn and reposition, toileting/check and change, input/output, grooming, and oral care. CNA L reported if cna staff notice change for resident verbally report to nurse or can enter new alert in charting for including change in wound, new skin breakdown, or change in input or output. During an interview on [DATE] at 2:47 p.m., CNA M reported had worked at the facility for more than a year and had changed resident dressings occasionally after nurse provided dressing supplies and asked CNA M to change dressings. CNA M reported had not been asked to perform dressing changed in several weeks and reported aware nurse tasks and reported would help when asked. During an interview on [DATE] at 2:57 p.m., CNA N reported occasional changed resident dressings if asked to complete by nurse and reported knows was not ok because he does not have skills to assess or recognize change in wound. During an interview on [DATE] at 3:18 p.m., CNA O reported had worked at the facility for about one year reported knows what resident needs are by reviewing the care plan and speaking to residents and staff. CNA O reported only able to document limited ADL tasks in EMR including amount eaten, showers, ambulation if ordered and weights. CNA O reported not able to document change in input or output or change in skin and can verbally report to nurse. CNA O reported was not aware of alert charting until recently. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview on [DATE] at 4:50 p.m., Confidential Staff(CS) P reported had worked at facility for several years. CS P reported had changed resident dressings several times, at least one to two times weekly as asked by the nurse staff. CS P reported was not part of job duties because not trained as nurse to assess for changes in wounds including infections and reported management staff was aware. CS P reported about one year about POC charting changed and now only document limited ADL tasks and if change for resident verbally report to nurse and or can complete new alert. CS P reported R109 has had open wound on right hip for several weeks that has worsened with R109 showing signs of increased pain and nurses have been informed. CS P reported observed dressing had been changed from foam dressing to bandaid after after worsening of wound bed from pencil tip size to nickel size open area currently on right hip. Review of the Hospital Records, dated [DATE] at 5:15 p.m., reflected Emergency Department Note that reflected R103 vitals were Temperature 103, heart rate 95, respirations 27, blood pressure , d+[DATE](abnormal). Continued review of the records reflected, Skin: There is a stage II decubitus ulcer with surrounding erythema, warmth and foul odor. Continued review of the records reflected wound assessment completed on [DATE] that included measurements 3.2cm by 2.5cm pressure injury with yellow/gray/eschar with skin note,bright red ring of skin around open area then darker red/purple skin-nonblanchable measuring 8x7 . Review of the History and Physical(H&P), dated [DATE], reflected reason for visit was septic shock. The H&P reflected, Septic Shock .Patient was positive SIRS criteria with temperature of 103, heart rate of 95 white blood count of 21.5 initial lactic acid 3.2. blood pressure is ,d+[DATE] despite receiving 30cc/kg of normal saline .fluid bolus .Was likely source of infection is UTI and sacral decubitus ulcer with surrounding cellulitis in the presence of urinary and fecal incontinence Review of the Hospital wound consult, dated [DATE], reflected,Pt has 3cm x 3cm sacral pressure ulceration present. Wound bed is covered with a thin layer of slough/escar making staging difficult, however she has [NAME] little fatty tissue under this ulcer, thus this is most likely a stage 4 . Review of the Discharge Summary, dated [DATE], reflected R103 had admitting diagnosis of generalized weakness, decubitus ulcer of sacral region(unstageable), urinary tract infection, encephalopathy, cellulitis, chronic kidney disease 3b. The summary included, Moderate parenchymal atrophy. Patient was given IV fluids and broad-spectrum antibiotics in ED. Initially during her stay the patient had hypotension requiring Levophed which was discontinued following fluid resuscitation. Patient completed 7 days of antibiotics for her cellulitis which appears to have improved. Patient underwent chemical debridement and wound care of her chronic sacral pressure ulcer . Review of the Hospital Discharge Summary, dated [DATE], reflected R103 was admitted to the hospital on [DATE]. The record reflected, Patient admitted with large sacral decubitus ulcer with osteomyelitis status post debridement on [DATE], with wound cultures growing Proteus, staph and Vanco resistant Enterococcus with Candida .) Review of the Death Certificate, dated [DATE], reflected R103's cause of death was sepsis, osteomyelitis, and protein calorie malnutrition. During a telephone interview on [DATE] at 3:00 p.m. Medical Director (MD) Q reported would expect staff to notify physician of change in wound or new wounds. MD Q reported was not aware of R103 coccyx wound and verified review of physician visit with no mention of pressure wound and reported wound have mentioned if made aware by staff. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235123	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Durand Senior Care and Rehab Center, L L C	8750 E Monroe Rd Durand, MI 48429

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(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 - Actual harm Residents Affected - Few	Resident #107(R107) Review of the Face Sheet and Minimum Data Set (MDS) with ARD date [DATE], reflected R107 was a [AGE] year old male admitted to the facility on [DATE] related to pneumonia, diabetes mellitus, heart disease, hip replacement, hypertension (high blood pressure), The MDS reflected R103 had a BIM (assessment tool) of 14 which reflected R107 was cognitively intact. The MDS assessment reflected R103 had no behaviors including no rejection of care. During an observation and interview on [DATE] at 330 pm. R107 was lying in bed and reported had open area on bottom with very painful to sit on. R107 appeared to be able to answer questions without difficulty. During an interview and record review on [DATE] at 10:05 am WN I reported R107 was readmitted to facility on [DATE] had was seen by RN C for wound assessment and determined to be moisture associated dermatitis related to irregular borders on both sides of buttock cheeks. WN I reported she stages wounds and follows standing orders for treatments until communication with provider. RN I verified R107 had picture taken of wound on [DATE] that was described with escar present.(no eschar present on moisture associated wounds). WN I reported difficult to change staging after initial identification. Resident #109(R109) Review of the Face Sheet and Minimum Data Set (MDS) with ARD date [DATE] , reflected R109 was a [AGE] year old male admitted to the facility on [DATE] related to bipolar disorder, seizure disorder, hypertension (high blood pressure). The MDS reflected R103 had a BIM (assessment tool) which reflected R107 was severely impaired. During an observation on [DATE] at 8:30 a.m. R109 was laying in bed directly on right hip. During an interview on [DATE] at 835 am, RN R reported R109 had a facility acquired pressure ulcer on the right hip with treatments in place. Review of the EMR dated [DATE] to current reflected no mention of pressure ulcer including weekly skin notes or MDS records. Continued review of R109 EMR reflected nurse progress notes that included,[DATE] 09:08 Nurses Note DOCUMENT RELEVANT INFORMATION ABOUT THE RESIDENT:: Right hip area assessed. Skin is light red in color & blanchable. Area of excoriation has increased, measuring approximately 0.4cm x 0.5cm. Skin is dry & flaky. No s/sx of pain noted. New treatment order placed: Cleanse R hip with wound cleanser, pat dry.Apply wound gel and cover with Aquacel foam dressing BID. During an interview on [DATE] at 10:14 am, DON B escorted CNA N to this surveyor, DON B reported CNA N wanted to clarify statement made yesterday. CNA N reported he meant he assisted nurse with dressing changes. DON remained present during interview. During an interview on [DATE] at 1115am RN T reported R109 would not allow dressing change at this time and might after lunch. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on [DATE] at 12:20 p.m., CNA U entered R109 room with full Personal Protective Gear(PPE) related to current contact isolation with MRSA, in attempt to get R109 out of bed. Observed dressing in place on right hip dated [DATE]. CNA U reported plan to get nurse for dressing change prior to getting R109 out of bed. This surveyor remained in room. R109 continued to lay directly on right hip with facial grimacing observe with position changes with staff assistance. At 12:40 p.m. RN C and WN I entered room to performed wound care. Foam border dressing was removed from R109 right hip with dime size open area that appeared to be stage 2 pressure ulcer with possible fatty tissue observed. Peri wound was bright red non-blanchable about baseball size. RN C changed dressing and cleaned area with wound cleanser, used lounge depressor to apply get directly to open area on R109 right hip and covered with aquacel foam dressing. During an interview on [DATE] at 1:09 p.m. WN I and RN C entered conference room. When asked what type of wound R109 had on right hip RN C responded stage 2 pressure ulcer that was identified today. WN I reported observed R109 skin on [DATE] and completed progress note. When asked WN I what type of would it was at that time RN C could not stay and stated, what the note said it was. WN I verified was area of excoriation and explained as red, raised streaks but not open. WN I reported saw R109 right hip skin on [DATE] and changed treatment to zinc oxide and reported no discussion with physician. WN I reported saw R109 on [DATE] and continued worsening of excoriation to right hip and treatment changed to wound gel and and cover with dressing twice daily. WN I reported area improved and saw again on [DATE] and changed treatment to A & D ointment. WN I reported right hip skin area worsened and seen on [DATE] (not above). RN C reported today R109 hip was open stage 2 with blanchable peri wound. When asked if RN C would explain, blanchable, RN C could not say what blanchable was and stated, Do you want me to Google blanchable? This surveyor ask for RN C professional judgement. RN C reported when pressure applied to red area turns white. RN C and WN I verified R109 was not followed weekly for wound because was not pressure ulcer until today and did not report to physician because they followed standing orders. During a telephone interview on [DATE] at 2:30 p.m. Medical Director (MD) Q reported was not aware R109 had skin breakdown on right hip. MD Q reporter would expect staff to contact physician with new or change in skin breakdown.