STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsdale CO Medical Care Faci	140 W Mechanic St Hillsdale, MI 49242

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 - Actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 This citation pertains to intake number MI00143720. Based on observation, interview, and record review the facility failed to ensure that five out of seven residents (Resident #1, 2, 3, 5 & 7) received appropriate care and treatment for facility acquired pressure ulcers. Findings Included: Resident #1 (R1): Per the facility face sheet, R1 was admitted to the facility on [DATE]. R1's diagnosis list revealed she had a stage 4 (a deep ulcer that can involve bone, muscle, tendons, with a high chance of infection) pressure ulcer to her sacrum (bone at the base of the spine), which had developed at the facility. R1's wound was not observed due to R1's hospitalization on [DATE]. Review of a Skin & Wound Evaluation V7.0 dated 12/18/2023, revealed R1 had moisture associated skin damage (MASD-skin irritation from prolonged moisture to the skin) from IAD Incontinence Associated Dermatitis (swelling and irritation of the skin). The evaluation revealed the MASD was In-House Acquired, meaning it occurred at the facility and was not present on admission. The evaluation revealed the wound was new. The evaluation had no further documentation. There was no documentation that the physician was made aware. Review of a picture taken on 12/18/2023, for a WOUND EVALUATION of R1's sacral MASD revealed R1 had facility acquired sacral and coccyx (tail bone) areas that had reddened skin with approximately four areas with the top layer of skin missing. There were no wound measurements, description, treatment, nor signature documented on the WOUND EVALUATION. Review of R1's progress notes dated 12/20/2023, revealed R1's bilateral buttocks and peri area had increased redness over the past few days. The note revealed that R1 was noted to have an open area on her left buttock, and the wound care nurse was notified. (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 0686 Level of Harm - Actual harm Residents Affected - Some	Record review of a SKIN OBSERVATION TOOL dated 12/21/2023, revealed the assessment was blank having no documentation on the assessment. No Wound Evaluation, or Skin & Wound Evaluation was completed again until 1/2/2024. Review of a picture dated 1/2/2024, taken for a wound evaluation revealed an increase in open wounds that were on both sides of R1's sacral area including R1's coccyx area. There were no wound measurements, was described as MASD, IAD, in house acquired that were new, with pink or red open areas. The treatment documented was to cleanse with water, apply Viscopaste (cream that can be used for chronic dermatitis), and place a wedge pillow under R1. The evaluation revealed R1's wound was deteriorating, and the treatment was changed as a result. However, no previous treatment was noted to have been ordered for R1's wounds dated 12/18/2023, per review of December 2023 Physician's orders, and R1's medication administration record (MAR) and treatment administration record (TAR). Review of R1's Physician orders dated 12/1/2023 through 4/17/2024 revealed no Physician's order was written for a wound treatment of Viscopaste and cleanse with water. However, the treatment was on R1's Treatment Administration Record (TAR) from 1/2/2024 through 1/12/2024 and was documented to have been provided by nursing staff. Review of a wound evaluation dated 1/12/2024, revealed no wound measurements, the wound was improving, no odor was present, the treatment was changed to Medihoney (dressing or gel medication) however, did not indicate why the dressing treatment was changed from Viscopaste to Medihoney. The wound was documented to be MASD. Review of R1's Physician's orders dated 12/1/2023 through 4/17/2024 revealed no order for Medihoney. However, the TAR for January 2024 revealed the Medihoney treatment was documented as provided on 1/13 and 1/14/2024. Review of a wound evaluation dated 1/23/2024 revealed R1's sacral and coccyx wound covered a larger area and had merged into all one wound. The wound evaluation revealed the wound continued to be documented as MASD, was pink or red, excoriated (irritated) skin, and the treatment was changed to Aquacel dressing (used as a sterile dressing to cover wounds that are draining pus or other fluids), and covered with a foam dressing. Review of Physician's order dated 21/1/2023 through 4/17/2024 revealed no Physician's order for Aquacel. Review of a Skin & Wound Evaluation dated 1/31/2023 revealed R1's sacral/coccyx wound was documented as MASD, and there were no measurements. Review of a Skin & Wound Evaluation dated 2/8/2024 revealed R1's sacral/coccyx wound was documented as MASD, and measurements of 27.1 cm (centimeters) area X 5.8 cm length X 7.8 cm width. The evaluation revealed R1's wound was slow to heal, and the current treatment (Aquacel) would continue. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of a WOUND EVALUATION dated 2/13/2024, revealed a picture of R1's wound on her sacral and coccyx area. The wound was noted to be one wound that was open with some slough (dead tissue) in a small portion of the wound bed, which also had a blackened area, with full thickness tissue loss in R1's coccyx area. The wound evaluation had no measurements, was documented to be MASD, slow to heal, and was improving. The assessment was not signed. Per the Resident Assessment Instrument (RAI) manual (manual used to assist with resident Minimum Data Assessment or MDS) dated [DATE], Version 1.18.11, a stage 3 pressure ulcer was defined as, Full thickness tissue loss. Subcutaneous (the first layer under the layer of skin) fat may be visible, but bone, tendon, or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss . Review of a Skin & Wound Evaluation V7.0 dated 2/13/2024, revealed R1's sacral/coccyx wound was documented to be MASD, no wound description, treatment, nor measurements were documented. It was documented that R1's wound was improving. Additionally, on R1's right sacrum a separate wound was present. Review of a WOUND EVALUATION dated 2/21/2024, revealed R1's wound measured 13.82 cm X 4.35 cm X 8.52 cm, however observation of the picture revealed R1 had a stage 3 wound on her right sacrum that was separate from the larger wound, and did not have any measurements documented. The evaluation revealed the wound remained documented as MASD, was slow to heal, and improving. Review of a Skin & Wound Evaluation V7.0 dated 2/21/2024, revealed no documentation under, C. Wound Bed which described the bed of the wound, evidence of infection, and other. Under D. Exudate (drainage), there was no documentation whether there was any exudate present or not. Under E. Periwound (the skin edge around the wound) there was no documentation. There was no documentation of whether R1 had any pain from the wound area. Under G. Orders it was documented that R1's wound was slow to heal. No treatment was documented under H. Treatment. The evaluation under 1. Progress revealed improving. The wound was documented to be MASD. Review of a Skin & Wound Evaluation V7.0 dated 2/28/2024, revealed R1's sacral wound was now documented as a stage 4 (full-thickness skin and tissue loss) pressure ulcer (ulcer that develops from constant pressure). The measurements were 13.8 cm X 4.4 cm X 3.7 cm, with no depth of the wound documented. The description of the wound bed, drainage, and periwound was not documented. There was no documentation of whether R1 had pain, no treatment, nor interventions were documented. Under Progress it was documented that the wound was improving. (pressure ulcer staging is stage 1 to stage 4 with stage 4 being the worst). Under Notifications: there was no check mark that the Physician was notified of the worsening of R1's sacral/coccyx wound. Review of a Monthly Physician's Progress Note dated 3/2/2024, revealed the only documentation regarding R1's pressure ulcer was under Summary of Findings and stated Sacral pressure ulcer. Review of a Monthly Physician Progress Note dated 3/6/2024, revealed the only documentation of R1's pressure ulcer was under SUMMARY OF FINDINGS which stated, .Sacral pressure ulcer . There was no documentation that the Physician had observed R1's pressure ulcer. Review of a Skin & Wound Evaluation V7.0 dated 3/6/2024, revealed wound measurements of 9.1 cm X 3.7 cm X 3.7 CM, and was slow to heal. There was no other documentation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of a Skin & Wound Evaluation V7.0 dated 3/13/2024, revealed stage 4 sacral pressure ulcer, in-house acquired, no measurements, the wound had slough in 70% of the wound bed, was having some seropurulent drainage with a faint odor (drainage and odor can be signs of infection), and was documented to be slow to heal. Under Notifications: there was no check mark that the Physician was notified of the drainage and faint odor of R1's sacral/coccyx wound. Review of a Skin & Wound Evaluation V7.0 dated 3/26/2024, revealed R1's sacral/coccyx wound had 100% slough in it, no measurements were documented, now had a Foul odor, with moderate drainage, and was deteriorating. Under, 3. Notes: Resident has appointment for debridement (removes dead or infected tissue) on Thursday (3/7/2024) at Wound Clinic at (name redacted) Hospital. The evaluation had no documentation that the Physician was made aware of the foul odor. Review of a Skin & Wound Evaluation V7.0 dated 4/2/2024 revealed R1's pressure ulcer measurements were 27.7 cm X 5.3 cm X 6.9 cm with no depth documented. There was no documentation of the description of the wound, the treatment, drainage, or pain. Review of a WOUND EVALUATION dated 4/10/2024 revealed a picture of R1's pressure ulcer. The pressure ulcer was a stage 4 with dark slough, dark periwound skin, measured 18.46 cm X 5.29 cm X 4.32 cm, was slow to heal, and was improving. Review of a Skin & Wound Evaluation V7.0 dated 4/10/2024, revealed no documentation of the description of R1's sacral/coccyx wound, no documentation of drainage nor odor, and no documentation of the treatment for R1's pressure ulcer. Review of R1's wound clinic notes dated 2/29/2024 revealed, R1 had an unstageable (cannot stage due to slough obscuring the wound bed) sacral pressure ulcer with full-thickness skin and tissue loss. Measurements were 5.7 cm X 5.9 cm, and an area of 33.63 square cm. The notes revealed there was a copious (abundant) amount of drainage. The wound clinic notes revealed a Physician's order to cleanse R1's left buttocks (sacral), cut to fit collagen (helps build healthy tissue) sheet to wound bed and then cover both wounds (coccyx and sacral) with border superabsorbent sacral dressing. Review of R1's Physician orders dated 12/1/2023 through 4/17/2024, revealed the wound clinic's order from R1's visit on 2/29/2024 was not transcribed on to R1's facility Physician's orders. Upon review of R1's MAR for the month of February 2024 revealed no orders for treatment to R1's coccyx pressure ulcer but only treatment for R1's sacral ulcer. Review of a wound consult documentation dated 3/28/2024, revealed a culture of R1's sacral pressure ulcer was taken, and the pressure ulcer was unstageable, would need additional debridement, and a wound vac (vacuum placed on wound that drains fluids and promotes blood flow to the wound) was the future plan. Review of Physician's orders revealed that on 4/1/2024 R1 had a PICC (peripherally inserted central catheter-IV line that goes into a vein in the upper arm and into a large vein above the right side of the heart) inserted on 4/1/2024 for IV antibiotics. Further review of R1's Physician orders revealed that on 4/1/2024 Vancomycin (high spectrum antibiotic used for serious infections) was ordered to be administered one time a day for 14 days via R1's PICC line for wound infection. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Review of an MRI (magnetic resonance imaging-scan of the body that provides detailed images) of R1's sacrum and coccyx dated 4/12/2024, revealed R1's coccyx wound had early signs of osteomyelitis (inflammation of the bone caused by infection). Review of R1's progress notes revealed that on 4/15/2024, R1 was transferred to the emergency room due to confusion and not feeling well. Review of a wound clinic assessment dated [DATE], revealed a, 7.6 cm X 6.1 cm X 4.7 cm sacral pressure ulcer with exposed necrotic (dead tissue) adipose (fat) and muscle. Moderate brown .drainage present in the wound. Reddened periwound . Review of hospital records dated 4/17/2024 revealed, .Patient (R1) with large, baseball size wound to her coccyx that is foul-smelling. Visible muscle .sloughing skin. Wound bed is unable to be fully assessed due to the sloughing . Under ASSESSMENT/PLAN it was documented R1 had coccygeal osteomyelitis with surrounding cellulitis (inflammation). Review of R1's progress notes revealed that on 4/18/2024 R1 returned to the facility on hospice services, her PICC line was removed, and R1 was place on comfort care. Review of R1's care plans revealed a care plan was put into place on 12/7/2023, because R1 was at risk for skin breakdown. The care plan was last updated on 3/8/2024 with no further updates made to R1's plan of care. Resident #5 (R5): Per the facility face sheet R1 was admitted to the facility on [DATE]. Diagnosis included METHICILLIN RESISTANT STAPHYLOCOCCUS AUREUS (MRSA-a staph infection) INFECTION . The diagnosis was dated 1/16/2024, and was acquired during R5's stay at the facility. Per the RAI (resident assessment instrument) manual, under section M0300G, a DTI is purple or maroon area of discolored intact skin due to damage of underlying soft tissue. Review of R5's progress notes dated 11/29/2023 revealed R5's weekly skin assessment was completed, and no skin issues were found. Review of progress notes dated 12/6/2023 revealed, Skin assessment was completed by wound care manager (RN E) today. New issue is 2.16 X 1.58 cm red area right heel. Treatment is in place. Review of a WOUND EVALUATION dated 12/6/2024, revealed R5 was identified to have a deep tissue injury (DTI) pressure ulcer. The wound was measured 2.24 cm X 2.16 cm X 1.58 cm. The picture taken along with the assessment revealed R5's right heel was red and was not purple or maroon as defined by the RAI manual. Unable to conclude if the skin was intact per the picture. Per the RAI manual, under section M0300A, a stage 1 pressure ulcer was defined as an observable, pressure related alteration of intact skin that had a defined area of persistent redness. On 12/8/2023 the notes revealed R5 had an appointment with his vascular surgeon. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Record review of progress notes dated on or around 12/6/2023 revealed no documentation that R5's Physician was made aware of his right heel redness. A Physician's order to place comfort foam to R5's right heel, and change every Monday, Wednesday, and Friday was placed on 12/6/2023, however the order was discontinued on 12/7/2023. Another Physician's order was put into place on 12/7/2023 for a Duoderm (dressing) to be place on R5's right heel and changed three time a week on Monday, Wednesday, and Friday. The order was discontinued on 12/8/2023 and re-written on 12/8/2023 to only change the Duoderm on Mondays. Review of a nursing progress note dated 12/13/2023 revealed R5 had been seen by the vascular surgeon on 12/13/2023 and was found to have venous ulcerations (ulcers cased by lack off or no blood flow). Review of progress notes dated 12/15/2024, revealed R5 was moaning and crying out that his right foot was painful. There was no WOUND EVALUATION done again for two weeks which was on 12/20/2023. The evaluation revealed that R5's right heel was 14 days old and was deteriorating. There were no wound measurements, the picture revealed an open wound with black tissue present in the wound. Registered Nurse RN E who was the wound nurse, had documented the wound to be a DTI pressure ulcer that was acquired at the facility. Review of a Skin & Wound Evaluation V7.0 dated 12/20/2023, revealed RN E had documented R5's right heel wound as a pressure ulcer that was a DTI, and was acquired at the facility. No wound measurements were documented, and had no treatment documented other than a foot buddy which was a boot worn on the foot for pressure relief. There was no documentation that the Physician was made aware. Review of Skin & Wound Evaluation V7.0 dated 1/15/2024, revealed R5's right heel wound was documented as a pressure ulcer, DTI, treatment was Santyl (used to remove damaged tissue), a moist sterile 4 X 4 dressing with a dry 4 X 4 dressing on top, and then wrapped with an ACE (elastic/compression bandage). Review of a radiology consultation dated 1/16/2024, revealed R5 had a PICC line put in. Review of Physician's orders revealed R5 was started on Vancomycin IV to be administered one time a day for MRSA (Methicillin-Resistant Staphylococcus aureus-a staph bacterial infection) in his wound. A Skin & Wound Evaluation V7.0 dated 1/22/2024, revealed the evaluation was performed by RN E. RN E continued to document R5's right heel wound as a pressure ulcer that was a DTI. No measurements were documented, no wound description, and no treatment was documented on the evaluation. There was no documentation that the Physician was made aware. Review of progress notes dated 1/25/2024, revealed R5's right heel was documented to be necrotic gangrenous (death of body tissue due to lack of blood flow or a serious bacterial infection) ulcer right heal, with MRSA in right foot. A diagnosis of diabetic foot ulcer with infection in right heel with possible Osteomyelitis (bone infection) was documented. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	Another progress note dated 1/25/2024 revealed, R5's vascular surgeon wanted to discuss with R5's family that R5 will eventually need an inevitable amputation (right foot). Review of a vascular surgeon note dated 1/31/2024, revealed R5's right heel was debrided (removal of dead tissue), the size of the wound was larger with necrotic tissue present. Review of a Skin & Wound Evaluation V7.0 dated 2/8/2024 revealed, RN E documented R5's right heel to be a pressure ulcer that was a DTI, and measured 19.7 cm X 5.9 cm X 4.3 cm. The evaluation also revealed R5's wound had drainage and a strong foul odor. Review of progress notes dated 2/13/2024 revealed, necrotic area spreading up heel and foot. Foul smell noted. Review of progress notes dated 2/17/2024, revealed R5 signed on to Hospice, had a significant wound on his heel that was no longer being treated, and R5 did not want to amputate his foot/leg. Review of a Skin & Wound Evaluation V7.0 dated 2/15/2024 revealed RN E documented R5's right heel to be a vascular wound that measured 3.8 cm X 2.5 cm X 2.1 cm, with an increase in pain, light drainage, and a faint odor. The evaluation had no documentation that the Physician was made aware of the odor or drainage. Review of a 2/20/2024 picture of R5's right heel revealed the wound to have necrotic tissue and small amount of slough in the bed of the wound, measurements were 20.74 cm X 5.38 cm X 5.49 cm. Review of a Wound Evaluation dated 3/5/2024, revealed only a picture was taken. No measurements or description of the wound was documented. Review of a Physician's monthly progress note dated 2/20/2024, revealed R5 was being treated with Vancomycin IV for 14 days due to MRSA in R5's right heel wound. Furthermore, the note revealed that the Physician spoke with R5's vascular surgeon who state that R5's wound (right heel) was too far gone, and he recommended Hospice care. Review of a picture of R5's right heel dated 2/28/2024 revealed the wound bed was completely necrotic, and measured 17.5 cm X 4.03 cm X 5.36 cm. Review of a Physician's monthly progress note dated 3/5/2024, revealed under HISTORY, SUMMARY OF FINDINGS, AND PLAN no documentation regarding R5's right foot ulcer. Review of a Physician's monthly progress note dated 4/2/2024 revealed no documentation of R5's right heel wound. Review of R5' progress notes revealed on 4/11/2024 R5 was complaining of being in extreme pain and was witnessed to be in tears from pain in his right foot. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	In an observation and interview on 4/18/2024 at 10:10 AM, Registered Nurse (RN) C and RN D stated that diabetic/vascular ulcers were not staged but rather were given a grade for severity. RN C said R5 had a cap of slough when she first saw him on 4/8/2024 which fell off. A strong odor present upon removal of the dressing from R5's right heel. RN C stated that she noted the odor yesterday 4/17/2024, and said she alerted the Physician right away, and R5 was placed on an antibiotic for 7 days. RN C said with the first noted odor of a wound the Physician was to be notified due to a suspected infection. R5's right heel wound was observed to be filled with slough, and painful for R5 to raise his leg up off the bed. In a continued interview RN C and RN D stated that no Physician nor Nurse Practitioner (NP) had ever accompanied them while doing wound rounds and treatments and said there was no Physician or NP oversite for wound care and treatments. No Physician or NP was observed to be present during wound treatments with RN C and RN D on 4/18/2024. In an interview on 4/18/2024 at 11:14 AM, RN C and D stated they both had identified concerns with wound care which included lack of documentation, skin/wound assessments not being done, facility acquired pressure ulcers that had progressed to stage 4 pressure ulcers. RN C said that her and RN D told the Director of Nursing (DON) B about their concerns. RN C and D both stated that they had changed wound treatment orders and dressings for many residents, because the RN Es wound treatments were incorrect. RN C and D both restated that they had identified the lack of wound care and treatments and the several stage 4 pressure ulcers that were all infected. RN C reiterated that the wound program did not have any oversight, and needed to be put back in order, because everything (wound treatments, assessments,) was not being done. RN C stated that her and RN D began an all-resident skin assessment starting 4/5/2024. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Some	In an interview on 4/19/2024 at 9:30 AM, RN E, who was the wound nurse, stated that R1's wound started as red skin which opened fast, and said R1 then had a stage 1 pressure ulcer on her coccyx. RN E said she did not know if R1's wound was MASD but said she had the staff put a cream on it. RN E said the following Monday when she returned to work R1's coccyx wound was open and had become one wound which she stated was a stage 2 pressure ulcer. RN E said the Physician wanted her to make treatment suggestions which he would then approve of. RN E said she knew the treatment to use for each type of wound, because she had worked in home care. RN E said a stage 3 pressure ulcer was identified when there was tissue involved. RN E just repeatedly stated there was tissue involved but was not able to state the characteristics of a stage 3 pressure ulcer. RN E, upon asking what where the immediate interventions she put into place to stop the worsening of R1's wound, RN E was not able to answer the question. RN E said she did not report to DON B any concerns with the identified facility acquire pressure ulcers or worsening of them. RN E said it was because DON B had no wound background or experience. RN E said she received wound education from a sales representative (for wound treatments) that would visit the facility one time a month. RN E said R1's wound became infected, so R1 had a PICC line put in and was started on IV Vancomycin. RN E said she had no wound education from the facility on hire. RN E said she did not have any oversite for wound care, no Physician or NP would go to the facility and do wound rounds and treatments with her, said it would have been nice to have someone for oversite to make sure she was doing the correct treatment for wounds. RN E was not able to answer why several of R1 and R5's wound assessments did not have measurements, she could not answer why the wound evaluations were not completed, but rather stated there were to many residents and she could not complete wound evaluations and treatments on all the residents. RN E said the wound evaluations that were not completed were because she never went back to finish them. RN E then said she did not complete them because she had other residents to do wound evaluations on. RN E said that she did not make DON B aware that she could not complete all the resident's wound evaluations, because it was her responsibility and felt she should be able to complete all of them. RN E was asked where she would get the diagnosis for the type of wound, she said she could not recall what she did to get the correct diagnosis of a wound. Regarding the wound clinic orders RN E said she did not always agree with the wound clinic Nurse Practitioner (NP), and would 'get into it with her, because she did not agree with the NP's treatments that she ordered. RN E said she would call the wound clinic NP about her orders and ask her, are you sure?, and said the NP would tell her yes. RN E said she would not use the NP's wound clinic treatment orders and would change the orders to what she knew to be the right orders. RN E further stated that she questioned the wound clinic NP's background and wound education. RN E said she talked to DON B about the wound clinic but not about all the wounds in the facility that were deteriorating. RN E said she would send the Physician a text message for a wound treatment order, and he would just agree with her. Regarding R5, RN E stated that the sales representative told her to treat R5's right heel wound it like it was a pressure ulcer. RN E said the wound clinic did not debride R5's right heel wound on either of his two visits, so she did it herself and scrubbed his wound clean. Review of R5's electronic medical record (EMR) revealed R5 never went to the wound clinic, only the vascular surgeon. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235197	A. Building B. Wing	04/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillsdale CO Medical Care Faci	140 W Mechanic St Hillsdale, MI 49242

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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 - Some	Review of RN E education file revealed she received Wound Care Orientation Packet & instruction on 10/18/2022 per her signature that included, Admission Skin Assessment, Weekly Skin Assessment, Preventative Skin Care ,Skin Protection Guidelines, Application of Ointments, Ice Bag Treatments, Arm & Leg Protectors, Ostomy Care Policy, Orientation to Wound Care General Information. In an interview on 4/19/2024 at 1:11 PM, DON B stated that she started looking into the facility acquired wounds in January 2024 because a concern with resident's wound care and treatments were identified. DON B said she wanted to start over and assess all residents skin, and make sure all the wound treatments matched the treatment orders. DON B said she did find wound care orders that were discontinued, but not discontinued on the resident's treatment administration record (TAR). DON B said she did have concerns form the previous last week regarding RN E's wound treatment orders. DON B said she could not be certain that the Physician had ever seen any of the resident's wounds. DON B said the wound assessments were not being done, and wound prevention interventions were not in place, including at the time a resident wound was initially identified. In an interview on 4/23/2024 at 11:30 AM, (this interview took place after the exit on 4/19/2024) with NP H, who was the wound clinic NP, stated she had been employed at the wound clinic since October 2022. NP H said that R5 had never been a patient at the wound clinic before. NP H said R1 was not referred to the wound clinic until 3/28/24, and said she questioned why the facility waited that long to send her to the clinic. NP H said she debrided R1's wound, and that the last time she debrided it he was into the muscle and felt bone. Review of facility policy and procedure titled, Pressure Ulcer Protocol dated 11/2022, revealed that on page 1 all the stages of a pressure ulcer were listed along with their descriptions. The policy under Pressure Ulcer Assessment Procedure revealed that wounds were to have the location, measurements, staging, wound description, appearance, and status documented. The policy also revealed that the wound care nurse was to notify the DON of any changes to a pressure ulcer such as a stage 1 that had declined to a stage 2, and such forth. The policy was not signed by the facility Medical Director. 45135 Resident #3 (R3) Review of the medical record revealed Resident #3 (R3) was initially admitted to the facility on [DATE] with diagnoses that included encounter for orthopedic aftercare following surgical amputation, peripheral vascular disease, atherosclerosis of native arteries of extremities, with rest pain, right leg, chronic obstructive pulmonary disease, and diabetes 2. According to Resident #3 (R3)'s Minimum Data Set (MDS) dated [DATE], revealed R3 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS- a cognitive screening tool) and had no behaviors. R#3's Braden scale results were a score of 13, showing R3 was at moderate risk for skin breakdown. (continued on next page)

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	235197	A. Building B. Wing	04/22/2024

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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 - Some	Record review revealed the admission assessment of the wounds on R3. Coccyx pressure ulcer 0.5cm x0.3cm x0.1cm, Stage 2. Right heel pressure ulcer 5.0cm x5.0cmx0.0cm suspected deep tissue injury (Record review revealed the admission assessment of the wounds on R3. Coccyx pressure ulcer 0.5cm x0.3cm x0.1cm, Stage 2. Right heel pressure ulcer 5.0cm x5.0cmx0.0cm suspected deep tissue injury (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. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer, or cooler as compared to adjacent tissue). A second skin assessment dated [DATE] describes the heel pressure ulcer with no measurements and wound bed is filled with 100% eschar. Right toe pressure ulcer 0.5cm x0.5cm x0.0cm suspected deep tissue injury. Right dorsum foot pressure ulcer stage 1, no measurements. Left elbow other type of wound 1.0cm x1.0cm x0.0cm. Left knee, surgical incision, 19cm. Minimum Data Set (MDS) for admission assessment documented R3 had 1 stage 1 pressure ulcer, 1 stage 2 pressure ulcer, and 2 unstageable pressure ulcers under section MO300 current number unhealed pressure ulcers/injuries at each stage. Record review of 11/01/23 revealed a skin/wound assessment. Left lower leg amputation surgical site with 21 staples, was stable with a small amount of blood on the dressing covering it. Coccyx pressure ulcer 0.5x0.3x0.1. Right heel pressure ulcer 5.0x5.0x0.0 suspected deep tissue injury. Right toe pressure ulcer is unstageable due to eschar. Marked as deteriorating. Right dorsum foot pressure ulcer stage 1, no measurements. Left elbow other type of wound 1.0cm x1.0cm x0.0cm. Left knee, surgical incision, 19cm. No documentation to support a provider oversight of the wound/pressure ulcer program. Record review revealed no weekly skin/wound assessment on 11/08/23 was completed on the right heel, right dorsal foot, right anterior foot, coccyx, left elbow or surgical site for the left lower leg amputation site. Record review revealed on 11/10/23 in the nursing progress notes that the nurse called the vascular surgeons office with concerning areas on the right foot. New order received to not wrap the right foot. Record review revealed on 11/13/23 in the nursing progress notes that the nurse identified the right heel with a dark unstageable area on the heel, removed protective dressing and heel is soft and looks like it a blood blister about the size of a half a dollar, left message for wound care to assess. Record review revealed on 11/14/23 at 10:41 in the nursing progress notes documented the wound care nurse assessed areas. Right heel with dark area and dark unstageable area also on middle toe have become soft and developed what looks like a blister. Record review of 11/14/23 revealed a skin/wound assessment. Left lower amputation surgical site with 21 sta[TRUNCATED]