

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235320	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/30/2024
NAME OF PROVIDER OR SUPPLIER  Lahser Hills Care Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 25300 Lahser Rd Southfield, MI 48034	

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)
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39592</p> <p>This citation pertains to Intake MI00148859</p> <p>Based on observation, interview and record review, the facility failed to prevent pressure ulcer formation, document accurate skin assessments, implement interventions and complete pressure ulcer wound care per physician orders for two (R903 and R904) of three residents reviewed for pressure ulcers resulting in R903 acquiring one Stage 4 (full-thickness skin and tissue loss) which became infected and required antibiotics and acquired a Deep Tissue Pressure Injury (DTPI - persistent non-blanchable deep red, maroon or purple discoloration) and R904 who acquired an unstageable wound to their coccyx. Findings include:</p> <p>R903</p> <p>A complaint was filed with the State Agency (SA) that alleged in part, .the resident . has developed a wound on (their) buttocks . it's the size of a silver dollar . can see deep inside the hole and it smells bad .</p> <p>On 12/30/24 at 10:02 AM, R903 was observed lying in bed. R903 was asked if they had any wounds or sores on their body. R903 indicated they did and pointed to their right buttock.</p> <p>Review of the clinical record revealed R903 was admitted into the facility on [DATE] with diagnoses that included: encephalopathy, diabetes and dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R903 had severely impaired cognition and required the assistance of staff for all activities of daily living (ADL's), including bed mobility. The MDS assessment also indicated R903 had one facility acquired Unstageable (obscured full-thickness skin and tissue loss) pressure ulcer.</p> <p>On 12/30/24 at 10:12 AM, Licensed Practical Nurse (LPN) B, who served as the Wound Treatment Nurse, was interviewed and asked about R903's wounds. LPN B explained R903 was admitted with a wound on their left upper buttock, but that wound was resolved; a wound on their right ischium (lower back/hip) that was facility acquired, it had become necrotic (dead tissue) and required debridement (removal of dead, damaged, or infected tissue); and a DTPI on their left heel that was facility acquired.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/30/24 at 10:30 AM, observation of R903's wounds with LPN B and Certified Nursing Assistant (CNA) C revealed the wound on the right ischium appeared obscured by slough (non-viable tissue) approximately 3.5 centimeters (cm) x 3 cm and had depth. The wound on the left heel appeared to have an approximately 1.5 cm x 2.5 cm darkened area surrounded by an outer ring approximately 4 cm x 5.5 cm that appeared to have been from a blister.</p> <p>Review of documentation of R903's wounds revealed:</p> <p>A nursing progress note dated 11/7/24 at 10:22 PM read in part, .New wound identified. Right buttock .</p> <p>A Skin &amp; Wound Evaluation dated 11/7/24 documented, .Type: .Moisture Associated Skin Damage (MASD) . Right Gluteus . New . Length: 2.4 cm . Width: 2.0 cm . 100% of wound covered, surface intact .</p> <p>A Wound Evaluation dated 11/7/24 at 7:54 PM documented .#4 - MASD . Right Gluteus a picture revealed an open area, obscured by slough</p> <p>A physician progress note dated 11/12/24 at 11:13 AM read in part, .Developed an unstageable ulcer to the right Ischial area. Covered entirely with yellow necrotic slough that is tightly adherent .</p> <p>A Wound Evaluation dated 11/12/24 at 11:11 AM documented, .#4 - Pressure - Unstageable . Right Gluteus . Length 2.83 cm . Width 1.7 cm .</p> <p>A physician progress note dated 11/26/24 at 12:02 PM read in part, .Stage 4 ulcer to the right Ischial area with scattered thin fibrinous exudate .</p> <p>A physician progress note dated 12/10/24 at 12:53 PM read in part, Stage 4 ulcer to the right Ischial area entirely covered with dark, necrotic eschar (dead or devitalized tissue). Requires a round of surgical debridement . Superficial layer of the necrotic eschar debrided at bedside using scalpel and forceps. At his point, patient started feeling pain. So debridement was discontinued although the base was still dark/necrotic. Depth 2.5 cm . Start PO (by mouth) Abx (antibiotics) Augmentin 875 mg (milligrams) bid (two times a day) x 1 week .</p> <p>A physician progress note dated 12/17/24 at 1:32 PM read in part, .Stage 4 ulcer to the right ischial fold with fibrinous necrotic slough that ' s hanging loose. Picked off the hanging slough using the scalpel and forceps . Current depth at 3 cm . Developed hemorrhagic blister with underlying [sic] dark discoloration to the left heel related to DTPI .</p> <p>A physician progress note dated 12/24/24 at 1:59 PM read in part, .Stage 4 ulcer to the right ischial fold with fibrinous necrotic slough that ' s coming loose. Picked off using the scalpel and forceps. Current depth at 3 cm . Hemorrhagic blister with underlying dark discoloration to the left heel related to DTPI .</p> <p>Review of R903's November 2024 Treatment Administration Record (TAR) revealed an order for Wound care: Rt (right) gluteal: Med Honey on 4x4 gauze and cover with dry border gauze daily and prn (as needed) - Start Date - 11/12/24 revealed blank boxes on 11/16/24 and 11/17/24, indicating the treatment was not done.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R903's December 2024 TAR revealed an order for Wound Nurse: Right Ischial loose packing with quarter strength Dakin's solution moistened gauze and cover with dry dressing daily and prn every day shift for wound care - Start Date - 12/11/24 revealed blank boxes 12/11/24, 12/12/24, 12/13/24, 12/14/24, 12/15/24.</p> <p>Review of R903's December 2024 Medication Administration Record (MAR) revealed an order for, Amoxicillin-Pot Clavulanate (Augmentin) Oral Tablet 875-125 MG . Give 1 tablet by mouth every 12 hours for wound infection . The Augmentin was started on 12/10/24 and ended on 12/17/24.</p> <p>On 12/30/24 at 1:45 PM, the Director of Nursing (DON) was interviewed and asked about the first identification of R903's right ischial wound being labeled as MASD when the picture showed an unstageable pressure ulcer. The DON agreed a wound should be identified before it became an unstageable pressure ulcer. When informed of the missing documentation on the TAR's, the DON explained he would look into it.</p> <p>On 12/30/24 at 2:56 PM, the DON explained LPN G had written a couple progress notes about the wound treatments were done on those days. The DON was asked if it was acceptable for a nurse to write a progress note instead of signing off on the TAR. The DON explained the TAR needed to be signed off whether there was a progress note or not.</p> <p>Review of nursing progress notes written by LPN G revealed a note dated 12/12/24 at 1:40 PM that read in part, .Writer gave resident PRN norco before doing wound tx (treatment) .</p> <p>On 12/30/24 at 3:29 PM, LPN G was interviewed by phone and asked if she had done the wound treatment for R903 on 12/12/24 when she wrote the progress note. LPN G explained she did not do the treatment, she only gave the resident the pain medication before the Wound Treatment Nurse did the treatment. LPN G was asked who signed off that the treatment was done, the Wound Treatment Nurse, or the floor nurse. LPN G explained the TAR is signed by the nurse that does the treatment, if the floor nurse does it, she signs it, if the treatment nurse does it, she signs it.</p> <p>On 12/30/24 at 3:47 PM, the DON was informed LPN G had been interviewed and said she had only given the pain medications, not completed the treatments. The DON had no explanation as to why there were five consecutive days with no treatments documented as done.</p> <p>34275</p> <p>R904</p> <p>Complaints were filed with the SA that alleged residents were not provided with needed care to prevent pressure ulcers.</p> <p>A review of R904's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: alcohol induced chronic pancreatitis, depression and calorie malnutrition. Review of the resident's MDS noted the resident had a BIMS score of 10/15 (moderately cognitively impaired). An initial assessment noted that R904 had no skin conditions, including pressure ulcers. The original Braden Scale (a tool used to predict the risk of pressure ulcers in patients) dated 8/20/24 noted a score of 14 (Moderate Risk).</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Continued review of R904's clinical record revealed the following:</p> <p>8/27/24: [NAME] Scale (updated): Score 11 (High Risk). *Noted change in the scale from Moderate to High.</p> <p>Care Plan: Focus: Skin management (date initiated 8/20/24) .Sacrum (revised 11/26/24) . Interventions: Assist me with floating my heels (8/20/24) .CNA's will check my skin daily with care and report anything unusual they notice to the nurse (8/20/24) .Encourage me to make small, shifts in my position (8/20/24) . Supplements as ordered (8/20/24) .Treatment mediation as ordered (8/20/24) . *It should be noted that there were no additional interventions in place other than those placed in the care plan on 8/20/24.</p> <p>11/24/24 - Nurses Note: Nurse noted fragile area on sacrum .</p> <p>11/24/24- Order NS (normal saline) cleanse to sacrum area apply triad paste QS (every shift) to fragile area every shift for wound care. A review of the MAR/TAR (Medication/Treatment Administration Record) noted the resident did not receive treatment to the sacrum as ordered on 11/25/24 (Day), 11/27/24 (Day), 11/28/24 (Evening), 12/1/24 (Day) .</p> <p>11/27/24 - Skin and Wound Evaluation (Lock Date: 12/30/24): Describe - Type: other .Location (blank) . acquired: In-House Acquired .How long has this wound been present: New .Exact Date: (blank) . Staged by: health care provider .Wound Measurements: Area 4.4 cm .length 6.4 cm .Width cm .Granulation .Notes: Open area to sacrum. Dr (name redacted) to assess.</p> <p>12/3/24 .Progress: New . *It should be noted that this evaluation was not fully complete and not locked until 12/30/24 over one month after it was started.</p> <p>12/3/24: Physicians Note (late entry): Wound rounds correction/Addendum note: Developed non-intact area of dark discoloration to the coccyx and adjoining buttocks .related to DTPI .currently base with necrotic slough that's separating from the margin and appears as unstageable .</p> <p>12/3/24 -Skin and Wound Evaluation (Lock Date: 12/30/34): Describe: Pressure .Stage: Deep Tissue Injury . Location: (blank) .acquired: In house acquired .How long has the wound been present (new) .exact date (blank) .Wound measurements: Area 14.1 mg .Length 6.1 cm .Width 3.0 cm .Wound bed (slough) .Type: Serosanguineous .Goal of care: Slow to heal Additional Care: (blank) .Progress: deteriorating .Notes (blank). *It should be noted that this evaluation was not completed/locked until 12/30/24 and the evaluation regarding the stage of the pressure ulcer.</p> <p>12/6/24: Order: Wound Care: Coccyx and adjoining buttocks cleanse with wound cleanse with wound cleanse pat dry and apply Medi Honey to 4x4 gauze and cover with border gauze change daily and PRN . every day shift for wound care. The MAR/TAR noted the treatment was done only on 12/7/24 as the resident was discharged to the hospital on 12/7/24.</p> <p>(continued on next page)</p>

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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/30/24 at approximately 2:20 PM, an interview was conducted with Wound Nurse B. Nurse B was queried as to their involvement regarding treatment for residents with wounds. Nurse B noted that when facility staff notify them of a resident with skin/wound concerns they will assess the resident, attempt to determine the resident's nutrition status, ensure labs have been reviewed and then implement interventions into the resident's care plan. When asked if they had been informed by staff that the resident had a change in their Braden Scale early in August 2024, Nurse 'B stated they were not made aware. When asked if they had been made aware of any nutritional concerns prior to the finding of skin concerns, Nurse B reported that they had been made aware following the residents' wound status. Nurse B was asked if they were aware that the resident's MAR/TAR revealed several missing treatments. Nurse B responded that they had not been made aware, but noted documentation should have been noted in the resident's record. When asked about interventions that might have been put into place to attempt to reduce the chance of acquiring a wound at the facility, Nurse B noted that they believed that an order had been placed for an air loss mattress. *It should be noted that an order was placed on or about 12/1/24. The intervention was not placed in the resident's care plan.</p> <p>On 12/30/24 at approximately 3:06 PM, an interview was conducted with the DON. The DON was asked about R904's development of an unstageable pressure ulcer to their coccyx. The DON reported that they were aware of R904's pressure ulcer and was aware of concerns pertaining to their food and fluid intake. When queried as to what interventions other than those noted on 8/20/24 (admitted ) were put in to protect R904 from acquiring an unstageable pressure ulcer, the DON was able to confirm that an order for an air loss mattress was put in place on 12/1/24. However, when asked if R904 who had a documented change in their Braden Scale status and obvious concerns with food and fluid intake, should have received additional interventions, the DON noted that further attempts could have been made. When asked if treatment orders should be administrated as ordered, the DON noted that they should have been.</p> <p>The facility policy titled, Pressure Ulcer Prevention Program was reviewed and documented, in part: Policy: It is our policy that newly admitted residents will be assessed for the presence of pressure ulcers or other skin breakdown. Residents will also be assessed for risk of development of pressure ulcers. Interventions to eliminate, modify or minimize risk factors will be introduced at the earliest time possible. Our goal will be to prevent facility acquired pressure ulcers unless the resident's clinical condition demonstrates that they were unavoidable .A risk assessment will be completed .using the Braden Scale upon admission, weekly for four weeks, then quarterly .The Braden Scale will reflect the minimum interventions .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39592</p> <p>Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices related to enhanced barrier precautions (EBP) for two residents (R903 and R904) of three residents reviewed for wounds, resulting in the potential for the spread of infection. Findings include:</p> <p>Review of a facility policy titled, Enhanced Barrier Precaution (EBP) Policy and Procedure dated 9/23/22 read in part, .Enhanced Barrier Precautions expand the use of PPE (personal protective equipment) and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs (multi-drug resistant organisms) to staff hands and clothing. High-Contact Resident Care Activities include: Dressing; Bathing/showering; Transferring; Providing hygiene; Changing linens; Changing briefs or assisting with toileting; Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator; Wound care: any skin opening requiring a dressing .</p> <p>On 12/30/24 at 10:02 AM, R903 was observed lying in bed. No EBP sign was posted on the door into R903's room, the only PPE in R903's room was a box of gloves on the wall. No isolation cart of PPE supplies was observed inside or outside R903's room, in the hallway or at the nurse station.</p> <p>Review of the clinical record revealed R903 was admitted into the facility on [DATE] with diagnoses that included: encephalopathy, diabetes and dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R903 had severely impaired cognition and required the assistance of staff for all activities of daily living (ADL's), including bed mobility. The MDS assessment also indicated R903 had one facility acquired Unstageable (obscured full-thickness skin and tissue loss) pressure ulcer.</p> <p>On 12/30/24 at 10:25 AM, Certified Nursing Assistant (CNA) C was observed in R903's room changing R903. CNA C was not wearing an isolation gown, the only PPE used were gloves.</p> <p>On 12/30/24 at 10:30 AM, observation of wound care for R903 with Licensed Practical Nurse (LPN) B, who served as the Wound Treatment Nurse, and CNA C revealed neither wearing isolation gowns while providing direct wound care to R903.</p> <p>Review of R903 ' s physician orders revealed an active order with a start date of 10/24/24 that read, enhanced barrier precautions as directed. This includes gowns and gloves for high-contact resident care activities, Specify why: wounds</p> <p>On 12/30/24 at 1:30 PM, LPN D, R903's assigned nurse, was interviewed and asked if R903 was on EBP. LPN D explained yes, since R903 had wounds, they would be on EBP. LPN D was asked why there was no sign on R903 ' s door, or PPE supplies. LPN D looked in R903's room and at the nurse station and found no PPE. LPN D explained when R903 was admitted into hospice, the hospice staff came and took all of the facility's supplies out of the room and brought their own, and explained the PPE supplies were probably removed at that time as well.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/30/24 at 1:35 PM, Registered Nurse (RN) F, who served as Unit Manager for R903's unit, was interviewed and asked if R903 was on EBP. RN F explained R903 was on EBP for wounds. When informed there was no sign, and no PPE available, RN F had no explanation.</p> <p>On 12/30/24 at 1:40 PM, RN E, who served as the Infection Control Nurse, was interviewed and informed there was no EBP sign on R903 's door, no available PPE, and hygiene care and wound care had been observed performed without staff wearing gowns, RN E had no answer.</p> <p>On 12/30/24 at 1:45 PM, the Director of Nursing (DON) was interviewed and informed of R903 having no EBP sign on their door, and no available PPE. The DON explained the PPE is usually stored at the nurse station on that unit. The DON was informed there was no PPE found at the nurse station and it had been observed R903 had received hygiene and wound care without staff wearing gowns. The DON had no explanation.</p> <p>34275</p> <p>R904</p> <p>A review of R904s clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: alcohol induced chronic pancreatitis, depression and calorie malnutrition. Review of the resident's MDS noted the resident had a BIMS score of 10/15 (moderately cognitively impaired). An initial assessment noted that R904 had no skin conditions, including pressure ulcers.</p> <p>11/24/24 - Nurses Note: Nurse noted fragile area on sacrum .</p> <p>11/24/24- Order NS (normal saline) cleanse to sacrum area apply triad past QS (every shift) to fragile area every shift for wound care. A review of the MAR/TAR (Medication/Treatment Administration Record) noted the resident did not receive treatment to the sacrum as ordered on 11/25/24 (Day), 11/27/24 (Day), 11/28/24 (Evening), 12/1/24 (Day) .</p> <p>11/27/24 - Skin and Wound Evaluation (Lock Date: 12/30/24): Describe - Type: other .Location (blank) . acquired: In-House Acquired .How long has this wound been present: New .Exact Date: (blank) .Staged by: health care provider .Wound Measurements: Area 4.4 cm (centimeters) .length 6.4 cm .Width cm . Granulation .Notes: Open area to sacrum. Dr (name redacted) to assess 12/3/24 .Progress: New . *It should be noted that this evaluation was not fully complete and not locked until 12/30/24 over one month after it was started.</p> <p>12/3/24: Physicians Note (late entry): Wound rounds correction/Addendum note: Developed non-intact area of dark discoloration to the coccyx and adjoining buttocks .related to DTPI (deep tissue pressure injury) base with necrotic slough that's separating from the margin and appears as unstageable .</p> <p>There was no order placed for the resident to be on enhanced barrier precautions when treatment to the wound was ordered.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/30/24 at approximately 3:06 PM, an interview was conducted with the DON. The DON was asked if residents who were being treated for pressure wounds should be placed on Enhanced Barrier Precautions. The DON reported that was the facility's protocol to do so. The DON attempted to locate an order but nothing was found in R904's record prior to the end of the survey. The DON confirmed that an order should have been placed.</p>		