

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235365	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER Skld Livonia		STREET ADDRESS, CITY, STATE, ZIP CODE 29270 Morlock Livonia, MI 48152	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220</p> <p>This citation pertains to Intake MI00147709.</p> <p>Based on observation and interview, the facility failed to ensure resident wound care treatments were documented and skin maintained intact for one resident (R901) of three whose skin management was reviewed. Findings include:</p> <p>A review of the record for R901 revealed:</p> <p>R901 was admitted into the facility on [DATE] and discharged on [DATE]. Diagnoses included Pain, Anxiety, Kidney Disease and Heart Disease. A review of the Minimum Data Set (MDS) assessment dated [DATE] documented R901 had severely impaired cognition with a 2/15 Brief Interview for Mental Status score and the need for dependance of one or two persons for toileting hygiene, bathing, lower body dressing, rolling left or right in bed, and going from sitting to lying and back again. The MDS further documented R901 had Moisture Associated Skin Damage (MASD).</p> <p>A physician order updated 09/26/24 documented MASD/Buttocks: Cleanse with soap and water. Pat dry. Apply barrier cream/AD. Cover with border guaze (two times a day/as needed) BID/PRN. Every day and night shift for treatment.</p> <p>A review of the Treatment Administration Record (TAR) for August 2024 revealed treatment for a MASD buttocks wound began 08/29/24.</p> <p>A review of the Treatment Administration Record (TAR) for September 2024 revealed six missed or undocumented treatments on the day shift and eight missed or undocumented treatments on the night shift for the MASD buttocks wound.</p> <p>A review of the Treatment Administration Record (TAR) for October 2024 revealed two missed or undocumented treatments on the day shift and four missed or undocumented treatments on the night shift for the MASD buttocks wound.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 11/21/24 at 1:00 PM, the missing treatments and description of the buttocks wound were reviewed with the wound care nurse staff A. The wound care nurse acknowledged some of the treatments may have been completed but not documented by them. The wound nurse supplied a wound assessment for September which documented the MASD to the buttocks and when asked, reported the area to the buttocks as excoriation or as something from a skinned knee. The wound nurse confirmed R901 was incontinent of urine and stool and this as the likely cause of the MASD.</p> <p>On 11/21/24 at 4:27 PM, the missing documentation concern for R901 was reviewed with the Director of Nursing (DON). The DON reported R901 had a decline in condition and the buttocks wounds were recurring. Documentation of the the missing treatment was requested.</p> <p>On 11/21/24 at 5:08 PM, Certified Nursing Assistant (CNA) B was asked about the care provided to R901 on 10/22/24 and reported there was a wound to the buttock that did not have dressing on it and needed they to clean it and have the nurse put a dressing on it. The CNA was asked to describe the wound and reported it to be around the size of a quarter and was red in the middle.</p> <p>On 11/21/24 at 5:40 PM, the DON was asked about the missing documentation. The DON acknowledged the missing documentation and noted the treatment as an order with a dressing and confirmed an order with a dressing required documentation. No further documentation of the buttocks wound treatment was provided prior to survey exit.</p> <p>A review of the facility policy titled, Skin Monitoring and Management: Pressure Ulcer adopted 07/11/18, revealed, .Once a wound has been identified, assessed and documented, nursing shall administer treatment to each affected area as per the Physician's order. All wound or skin treatments should be documented in the resident's clinical record at the time they are administered.</p>		