STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235374	A. Building B. Wing	05/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Oaks Senior Care & Rehab Center	22355 W Eight Mile Rd Detroit, MI 48219

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 - Minimal harm or potential for 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** 46865 This citation pertains to intake MI00143663. Based on observation, interview, and record review, the facility failed to properly assess bilateral heel wounds for one resident (R404) of three residents reviewed for pressure ulcer prevention/intervention, resulting in the potential for the worsening of wounds. Findings include: On 5/7/24 at 11:58 AM R404 was observed lying in bed with loosely wrapped bandages on both feet. R404's heels were not completely covered revealing black dried scabs on both heels. R404's feet were observed to be dry, cracked, and dead skin was seen flaking off their feet onto the mattress. R404's feet were positioned directly on the mattress, there were no pressure relieving devices observed. On 5/7/24 at 12:01 PM Certified Nursing Assistant (CNA) A was asked if the bandages could be observed. CNA A lifted R404's heels. R404's bandages began to unravel onto the mattress and there was no date found on the bandaging. On 5/7/24 at 1:11 PM Wound Care Nurse (WCN) B was interviewed regarding R404's wounds. WCN B said R404 was admitted with the wounds on 2/22/24. During the interview, WCN B was queried about the documentation in the medical record regarding the wounds that were documented on 5/7/24. WCN B said this was the first time that the wounds were assessed by him (WCN B). WCN B said the care plan was revised to include the heel wounds (5/7/24). Initially the care plan did not mention R404's the heel wounds. Orders were placed for wound care (5/7/24) and the wounds were assessed, measured, and documented in the Electronic Medical Record (EMR) (5/7/24). On 5/7/24, upon surveyor query, was the first-time orders were placed for R404's heel wounds. On 5/7/24 at 1:36 PM MDS (Minimum Data Set) Coordinator E was interviewed regarding the MDS reviewed and revised on 2/28/24. MDS Coordinator E said the skin condition section the MDS was documented that R404 had the potential to develop pressure ulcer because she did not see any documentation that supported that R404 developed pressure ulcers. MDS Coordinator E said she looks at the resident's orders for wound care and the wound care assessments to get an idea if the resident had developed pressure ulcers. (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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235374	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2024
NAME OF PROVIDER OR SUPPLIER West Oaks Senior Care & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 22355 W Eight Mile Rd Detroit, MI 48219	

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 - Minimal harm or potential for actual harm Residents Affected - Few	On 5/7/24 at 3:56 PM Wound Care Physician (WCP) C was interviewed regarding R404's heel wounds. According to WCP C, the wounds were assessed. WCP C said the findings revealed R404's heels had dried eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like) on both heels, which were considered unstageable (Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because the wound bed is obscured by slough or eschar). WCP C said typically wounds such as the wounds R404 had would be treated with either alcohol or betadine and wrapped with a dry dressing. On 5/17/24 at 1:47 PM the Director of Nursing (DON) was interviewed regarding the expectation of when a wound is assessed upon admission. The DON said it is the expectation that the WCN assess the wound and then call the primary care physician to get orders for treatment. A review R404's EMR revealed R404 was admitted to the facility initially on 9/22/22 and readmitted on [DATE]. R404 had the following pertinent medical diagnoses: Severe Protein-Calorie Malnutrition, Bacteremia (Bacterial Infection of the blood), and Dementia. A review of R404's Minimum Data Set (MDS) dated [DATE] revealed R404 had a Brief Interview of Mental Status (BIMS) score of 0/15 (severely cognitively impaired). According to the MDS, R404 was dependent and required maximal assistance with bed mobility and transfers. Also, there was no mention of active pressure ulcers for R404, only the potential for pressure ulcers. On 5/7/24, at the time of record review, the skin management care plan revealed no mention of the bilateral unstageable heel pressure ulcers. A review of R404's orders revealed the following wound treatment orders and order date and time: Cleanse right heel unstageable pressure wound with dermal wound cleanser and pat dry, apply Betadine daily. Cover with Abdominal Pad (ABD) and wrap with Kerlix and as needed every evening shift for wound healing AND as needed when dislodged or soiled. Ordered 5/7/24 at 12:37 PM. Cleanse left heel unstageable pressure wound with dermal wound cleanser and pat dry, apply Betadine daily Cover with ABD and wrap with Kerlix and as needed every evening shift for wound healing AND as needed when dislodged or soiled. Ordered 5/7/24 at 12:35 PM. Review of R404's hospital notes dated 2/20/24 revealed R404's heels were staged as deep tissue injuries (Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue). A review of R404's admission progress note dated 2/22/24 revealed, Received patient by stretcher from local hospital. Alert at moment no signs or symptoms of respiratory distress or discomfort. Diagnosis at the time of admission shortness of breath, Cerebrovascular Accident (Stroke). Upon skin assessment wounds on right side of leg, right side of knee, left and right side of heel old wound on coccyx pink color. Nurse Practitioner D notified of admission. A review of R404's admission assessment, dated 2/22/24, revealed documentation under the skin tab that R404 had wounds on bilateral heels. There was no description of the staging of the wounds on the either of R404's heels.