

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235594	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER West Woods of Niles		STREET ADDRESS, CITY, STATE, ZIP CODE 1211 State Line Rd Niles, MI 49120	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>47955</p> <p>This citation pertains to intake MI00144494</p> <p>Based on interview and record review the facility failed to develop care plan interventions to prevent the development of and/or worsening of pressure ulcers and develop interventions for wound vac (a device that applies gentle pressure to assist with wound healing) use for 1 (Resident #101) of 2 residents reviewed for care plan interventions related to pressure wounds resulting in Resident #101's existing pressure ulcer worsening, and the development of additional pressure wound.</p> <p>Findings include:</p> <p>Resident #101</p> <p>Review of an Admission Record revealed Resident #101 had pertinent diagnoses which included: pressure ulcer of the sacral region stage 4, osteomyelitis of the vertebra, sacral and sacrococcygeal region (infection of the vertebra bone in the sacral region), and functional quadriplegia (the complete inability to move).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 4/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #101 was cognitively intact.</p> <p>Review of Wound Measure 2.2 for Resident #101 dated 4/11/24 revealed .sacrum pressure wound present at admission .fragile-skin at risk for further breakdown .plan of care and person centered interventions in place yes .no complaints of pain during dressing change wet-to dry dressing removed and wound vac placed as per hospital order she is on an APM (alternating pressure mattress) mattress .</p> <p>Review of Physician Order for Resident #101 dated 4/11/2024 revealed .Apply moist to moist saline dressing gauzed packed to sacral wound until able to place wound Vac dressing, as needed for soilage or accidental removal .</p> <p>Review of Physician Order for Resident #101 dated 4/11/2024 revealed . Wound care: Apply NP (negative pressure) Wound Vacuum to sacrum wound at 125mm/hg 3/week (3 times a week) every day shift every Mon, Wed, Fri, for wound care .</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Physician Order for Resident #101 dated 4/19/2024 revealed . Wound care apply Santyl to wound bed, apply adaptic layer to bone present in wound bed, and then apply NP wound vacuum to sacrum wound at 150mm/hg 3/week every day shift every Mon, Wed, Fri, for wound care .</p> <p>In an interview on 7/3/24 at 10:04 AM., Clinical Care Coordinator(CCC) I reported that Resident #101 was not being turned and repositioned, that Resident #101 preferred to be on her back in bed or sitting up in her wheelchair.</p> <p>Review of Care Plan for Resident #101 dated 4/11/24 revealed : .focus .potential for impaired skin integrity related to stage IV (4) pressure wound to sacrum .goal . will show improvement .interventions .assess postural alignment, weight distribution, sitting balance, and pressure redistribution .assist with repositioning . use a draw sheet .bridge heels in bed .pressure reducing cushion in wheelchair .pressure reducing mattress .</p> <p>Review of Care Plan for Resident #101 dated 4/11/24 revealed no noted person centered care plan interventions related to turning and/or repositioning, wound vac use, or resident's choices or preferences related to mobility, repositioning, and/or turning.</p> <p>In a telephone interview on 7/3/24 at 1:50 PM., Registered Nurse (RN) G reported that Resident #101 did not like to be moved or repositioned. RN G reported that she educated Resident #101 on the benefits of moving and repositioning off her wound. When asked by this surveyor if RN G documented Resident #101 preference to not be repositioned and the education she provide about being repositioned, RN G replied I do not recall documenting education or refusal of care.</p> <p>In an interview on 7/3/24 at 1:59 PM., CCC I reported that Resident #101 didn't like to be positioned on her sides, she didn't like to be moved. CCC I reported that Resident #101 preferred to be on her back when in bed and/or sitting in her wheelchair. This surveyor asked CCC I if there were any resident centered care plan interventions related to Resident #101's wound, positioning, wound vac use, or preferences for positioning. CCC I reported she would find out what Resident #101's care plan interventions were.</p> <p>Review of Care Plan for Resident #101 dated 4/11/24 revealed no noted care plan intervention related to resident refusal to be turned or repositioned in bed and/or wheelchair or wound vac use.</p> <p>In an interview on 7/3/24 at 3:00 PM with Nursing Home Administrator (NHA) A and CCC I, and both were unable to provide any documentation that Resident #101 refused to be repositioned by staff in her bed and/or in her wheelchair. NHA A and CCC I were unable to provide a care plan for Resident #101 that had resident specific interventions and/or preferences related to positioning in bed and wheelchair or the use of a wound vac.</p>		

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<p>F 0684</p> <p>Level of Harm - 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** 47955</p> <p>This citation pertains to intake MI00143902</p> <p>Based on interview and record review the facility failed to ensure a timely assessment for a change in condition in 1 (Resident #100) of 1 resident reviewed for timely assessment for a change in condition resulting in the delay of communication with a provider, delay of transfer to acute care setting for evaluation and a delay of treatment.</p> <p>Findings include:</p> <p>Resident #100</p> <p>Review of an Admission Record revealed Resident #100 had pertinent diagnoses which included: rhabdomyolysis (muscle breakdown that causes toxins to leak into the bloodstream), abnormalities of gait (walking) and mobility, and acidosis (blood becomes too acidic due to problems related to kidneys or lungs).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] which indicated Resident #100 was cognitively intact.</p> <p>In a telephone interview on [DATE] at 3:49 PM., Family Member (FM) S reported that he had visited Resident #100 on the Friday before she was sent to the hospital, and Resident #100 was as good as she had been. FM S reported that Resident #100 was sent to the acute care hospital (Name Omitted) by the facility on the Monday after the visit. FM S reported that Resident #100 was sent to the local emergency room (Name Omitted) and was then transferred to a larger hospital (Name Omitted) in another town for further evaluation and treatment. FM S reported he received a call from the acute care hospital (Name Omitted) and the caller told him that he needed to get there pretty quickly, that Resident #100 had declined, and her condition was grave. FM S reported that Resident #100 died at the acute care hospital (Name Omitted) on Monday, [DATE].</p> <p>Review of Progress Note/Alert Note for Resident #100 dated [DATE] at 22:49 PM., authored by Contract Nurse (CN) D revealed . Resident left arm observed swollen, red, and warm to touch, DR (doctor) called unable to contact, voice mail left, note put into Dr's book.</p> <p>Review of Progress Note/Alert Note for Resident #100 dated [DATE] at 5:04 AM., authored by CN D revealed .upon transferring resident to restroom resident stated she felt dizzy, resident was transferred back to bed, bp (blood pressure) was obtained ,d+[DATE] called MD (doctor), per dr order push fluids, lay head flat, and raise legs, recheck bp, ,d+[DATE], ,d+[DATE], ,d+[DATE]. Resident showing no signs of distress, no signs of hypotension (low blood pressure). Resident stated laying back in bed she felt better. Resident stated she cannot consume large amounts of water due to a previous surgery, writer explained to resident the urgency of drinking water to help raise her bp. Resident in bed, comfortable .will continue to monitor bp throughout the day.</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>Review of Progress Note/Interdisciplinary Documentation for Resident #100 dated [DATE] at 9:43 AM., revealed .complains of not feeling well, color is pallor, left hand is swollen, elevated on a pillow. Noted left hand open area clean with a small amount of drainage, left hand and arm almost up to the elbow is very warm to touch and red, skin turgor- skin's ability to change shape and return to normal) return is very slow. (Name Omitted) doctor was notified, left message about pts (patients) condition. Waiting for return call .</p> <p>Review of Progress Note/Interdisciplinary Documentation for Resident #100 dated [DATE] at 9:45 AM., revealed .pt had 4 large episodes of diarrhea (diarrhea) with a foul smell, blood pressures times 5 within 30 min period runs ,d+[DATE] p85 (pulse) .</p> <p>Review of Progress Note/Interdisciplinary Documentation for Resident #100 dated [DATE] at 12:35 PM., revealed . Orders received from Dr. to send Resident #100 to the hospital for further evaluation of decreased B.P., weakness and fatigue and redness and warmth to the left arm.</p> <p>In an interview on [DATE] at 4:10 PM., Nurse Practitioner (NP) R reported that the nurses know to contact her directly if they are unable to reach an on-call provider. NP R reported that the nurses should not let the patient suffer, there needs to be some action to resolve the situation.</p> <p>In an interview on [DATE] at 4:22 PM., Licensed Practical Nurse (LPN) C reported when a call was placed to the on-call provider after hours, that call was answered by the call service. The call service would take note of the resident specific information, and then the call service would transfer the nurse call to the provider to speak to them.</p> <p>In an interview on [DATE] at 4:33 PM., Registered Nurse (RN) G reported that non-urgent resident situations are placed into the doctor's book. RN G reported that the provider looks at the doctor's book and follows up with requests when they are in the building. RN G reported that non-urgent things like a fall without injury or a resident request to see the doctor are things to put in the doctor's book. RN G reported that a decreased blood pressure or signs of an infection were not something that should go in the doctor book, for those situations the doctor should be called.</p> <p>In an interview on [DATE] at 4:33 PM., Infection Preventionist (IP) F reported that if the on-call provider did not call back within 5 minutes, the nurse should call back. The nurse practitioner was here every day during the week, and you could call her 24 hours a day 7 days a week. There was an on call answering service to use during non-business hours. IP F reported that she did not recall any staff having difficulties getting ahold of a provider after hours.</p> <p>In an interview on [DATE] at 9:37 AM., NP Q reported that the expectation was that if the on-call provider did not respond within 15 minutes, the nurse needed to call back. NP Q stated that if the symptoms were manageable with the resources available, then do that, if not send them to the hospital. NP Q stated If their vitals are crashing then they need to be sent out. NP Q reported that she would not question a resident transfer to the emergency room in an urgent situation. NP Q reported that she would expect that she or the on-call provider were notified of the resident transfer.</p> <p>In an interview on [DATE] at 10:04 AM., Clinical Care Coordinator (CCC) I reported that she did not recall what happened with Resident #100 before she was sent to the hospital. CCC I accessed Resident #100's online hospital record and reported that she was admitted to the ICU (Intensive Care Unit) for septic shock, cellulitis of the left upper arm and a UTI (urinary tract infection).</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 11:35 AM., CCC I provided this surveyor a handwritten timeline related to Resident #100's condition prior to transfer to acute care hospital (Name Omitted). CCC I reported that from the first documented sign and symptom of infection were noted in Resident #100's left arm on [DATE] at 22:49 to the documented order to transfer to the emergency roiaognom on [DATE] at 12:35 PM., was too long for the resident to wait for physician order to transfer.</p> <p>In an interview on [DATE] at 1:19 PM., IP F reported that Resident #100's blood pressure reading was critical, and she should have been sent out. IP F reported that the nurse would call the on-call provider through the answering service, if they didn't call back, then the nurse should call again. IP F reported that if there still was no response from the on-call provider the nurse should have called the on-call manager for guidance.</p> <p>In a telephone interview on [DATE] at 2:38 PM., Call Center Coordinator (CCC) W reported that the on-call answering service does not have the option for a nurse calling in to leave a voice mail message (this is in contrast to CN D's written note). CCC W reported that the operator asks the nurse calling specific questions related to the patient such as name, date of birth, and reason for the call. The operator would then put the nurse calling on hold and would then call the provider on call. If the provider answered the phone the nurse's call was transferred to the provider. If there was no answer by the provider, the operator should instruct the nurse if they had not received a call back within 15 minutes to call again. CCC W reported that the operator would continue to reach out to the on-call provider every 15 minutes. If contact was not made with the on-call provider, the operator had instructions to continue to reach out to a provider every 15 minutes until someone was reached. CCC W reported that calls related to nursing home residents were considered priority calls.</p> <p>In a telephone interview on [DATE] at 3:28 PM., Director of Nursing (DON) B reported that she remembered Resident #100 going to the hospital. DON B reported that she went to look at Resident #100, remembered her arm was swollen, and the nurse had gotten an order to transfer her to the hospital for treatment. DON B reported that her expectations for contacting the on-call provider was to call and speak to them. DON B reported that if the nurse had to leave a voice mail for the on-call provider her expectation was that the nurse would call back until they spoke with an on-call provider. DON B reported that if the nurse could not get ahold of the on-call provider, the nurse should call her, she was available 24 hours a day, 7 days a week. This surveyor while on the phone with DON B read the progress note entries for Resident #100 from the dates of [DATE] and [DATE] and DON B reported that her expectations were that the nurse should have continued to try to contact the on-call provider regarding Resident #100's condition. DON B reported that nurse definitely should have called back to the on-call provider after the repeated blood pressure readings were low and Resident #100 should have been sent out to the hospital long before she was sent. DON B reported that Resident #100's blood pressure readings were low enough to be emergent and the nurse should have sent her to the hospital when her blood pressure readings did not improve.</p> <p>In a telephone interview on [DATE] at 3:57 PM., Certified Nurse Assistant (CNA) N reported that she recalled on the day Resident #100 was sent to the hospital from the facility, Resident #100 looked very pale, and she was very nauseous. CNA N stated I remember the nurse telling me Resident #100 was being sent to the hospital. I remember I checked her vitals and got her ready for the hospital, Resident #100 had loose stools (diarrhea), her blood pressure was very low, and her heart rate was high.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In a telephone interview on [DATE] at 4:18 PM., CN D reported that she worked with Resident #100 on the night shift before she was transferred to the hospital. CN D reported that she made a note in the doctor book that Resident #100's arm was swollen. CN D reported that Resident #100's blood pressure was low, and she contacted the on-call provider. CN D reported that on-call provider gave her orders to push fluids, lay her head flat, and elevate her legs. CN D reported that she felt that Resident #100 needed to go to the hospital, and that her blood pressure was too low. This surveyor asked CN D if she called any nursing managers, or Resident #100's family, or the on-call provider again and CN D stated I don't remember calling anyone else, but I spoke to the other nurses, and no one said to do anything else. CN D stated, I learned after that night, you can call the family and ask would they want their family member sent to the hospital. CN D stated I don't know if I should have called back again and again to try to convince the on-call to send her (Resident #100) to the hospital, but I just monitored her all night.</p> <p>Review of ED Provider Note dated [DATE] revealed . diagnosis septic shock, urinary tract infection without hematuria (blood in the urine), Cellulitis of the left upper extremity, lactic acidosis, elevated liver function tests, AKI (acute kidney injury), Sepsis with multi-organ dysfunction .</p> <p>Review of H&P Notes dated [DATE] at 19:55 PM., revealed .speak with patient's family who stated they saw her on Friday ,(d+[DATE]) and that at that time she was able to ambulate and that her left arm had the healing wound but that it was not erythematous. They stated that she typically has some swelling in that forearm (midway) and hand that worsens with ambulating when she lets it hang down .</p> <p>Review of Critical Care History and Physical Exam dated [DATE] at 10:16 PM., revealed . 65 yo (year old) F (female) presented to (Name Omitted) ED (emergency department) ,d+[DATE] for generalized weakness, diarrhea, and abdominal pain. Hx (history of) L (left) forearm pressure ulcer now appearing celluilitic for the past several days. She was hypotensive on arrival, received 3L (liters) of IVF (intravenous fluids) .for septic shock. Urinalysis without a clean sample, nitrite positive however not convincing for infection, only other current source is LUE (left upper extremity) cellulitis .</p> <p>Review of ED to hosp-admission . dated [DATE] at 11:17 AM., revealed .patient's vitals are significant for severe hypotension of ,d+[DATE] .patient is significantly ill appearing pale .pulses are weak though 1+ . immediate concern for septic shock related to infection, likely cellulitis of the left upper extremity . patient leaving with EMS, vitals currently stable .</p> <p>Review of Physician Discharge as deceased Summary dated [DATE] at 6:17 AM., .admitted [DATE] .reason for admission septic shock .not long after ICU arrival pt lost pulses, PEA (pulseless electrical activity, a type of cardiac arrest that occurs when the heart stops beating due to weak electrical activity) arrest . ROSC (return of spontaneous circulation) was achieved after 10 minutes .discussed care with family member who requested that patient be made a DNR (do not resuscitate) .was noted to be in asystole again at 0611 when TOD (time of death) was called, patient without any heart tones auscultated, no central pulses .</p>		

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<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>47955</p> <p>This citation pertains to Intake MI00144494</p> <p>Based on interview and record review the facility failed to prevent the worsening of a pressure ulcer in 1 (Resident #101) of 2 residents reviewed for pressure ulcers resulting in Resident #101 being sent to the hospital for evaluation and/or treatment.</p> <p>Findings include:</p> <p>Resident #101</p> <p>Review of an Admission Record revealed Resident #101 had pertinent diagnoses which included: pressure ulcer of the sacral region stage 4, osteomyelitis of the vertebra, sacral and sacrococcygeal region (infection of the vertebra bone in the sacral region), and functional quadriplegia (the complete inability to move).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 4/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 13/15 which indicated Resident #101 was cognitively intact.</p> <p>Review of Wound Measurement 2.2 for Resident #101 dated 4/11/24 15:32 PM., revealed .sacral wound measures 13.9 X 14.6 X 4.2 stage IV present on admission .wet to dry dressing removed and wound vac placed as per hospital orders .</p> <p>Review of Office Visit (Name Omitted) for Resident #101 dated 4/19/24 revealed .Physical exam .wound length 10.6 cm (lying on left side), wound width 11 cm, wound depth 4.2cm .Negative Pressure Wound Therapy (wound vac, machine to apply constant pressure to a wound to promote healing) sacrum mid wound vac placement date 4/19/24 .cycle is continuous, target pressure is 150mm/HG . no signs of infection . Negative dressing pressure machine to sacral wound: cleanse with saline .apply adaptic to exposed bone, apply santyl (nickel thickness) to wound bed and NPWT (negative pressure wound therapy) at 150 mm/HG, change 3 x (times) a week and as needed .</p> <p>Review of Wound Measurements 2.2 for Resident #101 dated 4/19/24 14:49 PM., revealed .sacrum to coccyx wound-measuring 10.6 X 11X 4.2 .Large amount of tan serosanguineous (tan in color) drainage noted .</p> <p>Review of Wound Measurements 2.2 for Resident #101 dated 4/29/24 13:50 PM., revealed . sacrum to coccyx wound - measuring 13.6 X 14.2 X 3 . large amounts of tan serosanguineous drainage noted .</p> <p>Review of Wound Measurements 2.2 for Resident #101 dated 5/3/24 14:56 PM., revealed .new area observed to L (left) buttock during skin check. Area measured 2 X 4.8 X 0.1, areas is superficial, no drainage .</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 Physician Orders for Resident #101 dated 5/8/24 revealed .sacrum-cleanse with normal saline pack Dakins soaked kerlix wound, cover with ABD (abdominal) and secure with tape and change daily and PRN (as needed) . dated 5/9/24 .wound consult and possible surgical consult for pt (patient) bilateral lower extremities. Pt. has swelling on both feet and blisters under great toes .</p> <p>Review of Office Visit (Name Omitted) for Resident #101 dated 5/10/24 revealed .Left ischial (area of the buttock that covers the pelvic bone) wound, Stage 4 Sacral ulcer, malodor (foul odor), Left plantar (bottom of the foot) blister, Right heel pressure ulcer, Blister to right D1-D5 (base of the toes on the right foot) Erythema (redness) to the base of the right great toe . Patient with worsening sacral wound with known osteomyelitis. She is c/o (complaint of) nausea, fever, chills, and sweats. I feel it is prudent to ensure patient is not becoming septic (systemic infection of the blood). Updated the ER and we will send her by non-emergent EMS (emergency medical services).</p> <p>Review of Physician Orders for Resident #102 revealed .5/10/24: VO/TO (voice order/telephone order) transfer to ED (emergency department) for evaluation and treatment ordered on 5/13/24 .</p> <p>In an interview on 7/3/24 at 8:29 AM., Certified Nurse Assistant (CNA) J reported that Resident #101 had a wound on her buttock with a wound vac. CNA J reported that the wound vac was making the wound worse because the wound vac would dislodge from the wound. CNA J reported that Resident #101 was not able to reposition herself in bed or in the wheelchair, and she could wash her face, but not much else. CNA J reported that Resident #101 was dependent for all her cares. CNA J reported that Resident #101 did not like to get out of bed and when she was in her wheelchair she didn't like to go back to bed. CNA J did not indicate where this would be documented in the medical chart.</p> <p>In an interview on 7/3/24 at 8:43 AM., Licensed Practical Nurse (LPN) K reported that Resident #101 had a large wound on her buttock and had a wound vac. LPN K reported that the wound vac was making her wound worse. LPN K reported that Resident #101 did not like to be turned or repositioned in bed or in her wheelchair because it hurt her to move. LPN K reported that Resident #101's lack of turning and repositioning could contribute to the wound deteriorating, and continuing to have pressure on an existing wound would continue to cause the wound to get worse. LPN J did not indicate why this was not documented in the medical chart</p> <p>In an interview on 7/3/24 at 9:37 AM., Nurse Practitioner (NP) Q reported that Resident #101 had a wound on her sacral region, with a wound vac, that did get worse while she was in the facility. NP Q reported that she was unaware if Resident #101 allowed staff to provide care and position her.</p> <p>In an interview on 7/3/24 at 10:04 AM., Clinical Care Coordinator (CCC) I reported that Resident #101 was admitted with a stage 4 sacral wound and the wound vac was applied when she admitted to the facility. CCC I reported that Resident #101's wound was getting worse. CCC I reported that Resident #101 did not like to be positioned off her wound. CCC I reported that Resident #101 would tell staff no when staff asked to reposition her off her wound area. CCC I reported that Resident #101 was not being turned or repositioned as frequently as she should have been. CCC I reported that Resident #101's wound did deteriorate while she was in the facility and that she was developing other wounds where the wound vac drape was positioned.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235594	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/03/2024
NAME OF PROVIDER OR SUPPLIER West Woods of Niles		STREET ADDRESS, CITY, STATE, ZIP CODE 1211 State Line Rd Niles, MI 49120	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Care plan for Resident #101 initiated 4/12/24 revealed focus .potential risk for impaired skin integrity related to stated IV pressure wound to sacrum .will show improvement of impaired skin integrity as evidence by no s/s (signs and symptoms) of infection and decreased measurements and/or prevention of avoidable impaired skin integrity .Interventions .assist with re-positioning with use of draw sheet as needed . bridge heels in bed if indicated .measure open areas on admission and weekly, PRN (as needed), pressure reducing cushion to wheel chair .pressure reducing mattress .</p> <p>Review of Care Plan for Resident #101 revealed no noted care plan interventions related to turning scheduled, repositioning schedule, wound vac use, or resident's choices or preferences related to mobility, repositioning, and/or turning. No noted care plan intervention related to resident refusal to be turned or repositioned in bed or wheelchair. No noted care plan related to the use of a wound vac.</p> <p>In a telephone interview on 7/3/24 at 1:50 PM., Registered Nurse (RN) G reported that Resident #101 didn't like to be moved or repositioned, it hurt her. RN G reported that she educated Resident #101 on the benefits of moving and repositioning off her wound. When asked by this surveyor if RN G documented Resident #101 preference to not be repositioned, RN G replied I do not recall documenting refusal of care.</p> <p>In an interview on 7/3/24 at 1:59 PM., CCC I reported that Resident #101 didn't like to be positioned on her sides, she didn't like to be moved, it hurt her. CCC I reported that Resident #101 preferred to be on her back when in bed and/or sitting in her wheelchair. This surveyor asked CCC I if the staff documented that Resident #101 was refusing to be repositioned in bed or in her wheelchair. CCC I reported she would find out where the refusal of care was documented.</p> <p>In an interview on 7/3/24 at 3:00 PM Nursing Home Administrator (NHA) A and CCC I were in NHA's office, and both were unable to provide any documentation that Resident #101 refused to be repositioned by staff in her bed and/or in her wheelchair. NHA A and CCC I were unable to provide a care plan for Resident #101 that had resident specific interventions related to positioning in bed and wheelchair.</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>47955</p> <p>Based on observation, interview, and record review the facility failed to ensure infection control practices were maintained during wound care dressing change in 1 (Resident #102) of 1 resident reviewed for wound care dressing changed resulting in the potential for the introduction of infection, cross-contamination, and disease transmission.</p> <p>Findings include:</p> <p>Resident #102</p> <p>Review of an Admission Record revealed Resident #102 had pertinent diagnoses which included: pressure ulcer of the sacral region stage 4, osteomyelitis of the vertebra, sacral and sacrococcygeal region (infection of the vertebra bone in the sacral region), and muscle weakness (generalized).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 3/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #102 was cognitively intact.</p> <p>Review of Physician Orders for Resident #102 revealed . enhanced barrier precautions during high contact resident activities every shift for . wound care active on 3/28/24 .Wound care: coccyx- cleanse with normal saline, apply collagen to wound bed, and then pack lightly with calcium alginate and cover with bordered foam dressing. Change daily and PRN (as needed) for soiling saturation or accidental removal every day shift for wound care active on 6/25/24.</p> <p>During an observation on 7/3/24 at 10:58 AM., Licensed Practical Nurse (LPN) K and Infection Preventionist (IP) F were present in Resident #102's room, wearing gowns and gloves, performing wound care dressing change. LPN K removed the wound wash from the table clean supply area, sprayed wound wash directly into Resident #102's wound, wiped the wound with gauze, and replaced wound wash onto the table in the clean supply field. LPN K retrieved the bottle of Dakins solution with gloved hands from the clean supply area and poured the Dakins solution into a plastic med cup in the clean supply field, and then applied Dakins solution to the wound bed and wiped with gauze. LPN K, changed gloves and retrieved collagen from the clean supply table with gloved hands and applied the collagen to Resident #102's wound bed. With the same gloved hands, LPN K reached to move the gown she was wearing to expose the pocket of her left pant leg, and reached with gloved hands into the pocket to retrieve scissors. LPN K then used the scissors in her gloved hands to cut the calcium alginate to the size of the wound and then placed the scissors into the clean supply field and applied the calcium alginate to Resident #102's wound over the collagen in the wound bed. LPN K then retrieved the Allevyn (foam with boarder dressing) dressing from the clean supply field and applied it to cover the wound on Resident #102's sacral region.</p> <p>In an interview on 7/3/24 at 11:20 AM., LPN K reported that she did not know she was not to use the wound wash directly on the wound she was cleaning. LPN K reported that she should have poured the Dakins solution into the medication cup when she set up the clean supply field. She should not have reached for it with gloved hands. LPN K reported that she should not have used the scissors from her pocket.</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>In an interview on 7/3/24 at 11:25 AM., IP F reported that LPN K should have used the medication cups in the clean supply field for the wound wash and the Dakins solution. IP F reported that she did not see LPN K pick up the Dakins and put it back into the clean supply field. IP F reported that her expectations were that LPN K should not have retrieved or used the scissors in her pocket during the wound dressing change without cleaning them before use and performing hand hygiene.</p>		