STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235477	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pomeroy Living Rochester Skilled Rehabilitation	3500 West South Blvd Rochester Hills, MI 48309

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** 32568 This citation pertains to Intake Number(s): MI00144974. Based on observation, interview, and record review, the facility failed to complete skin assessments on a consistent basis and thoroughly complete assessments of existing pressure ulcers for one (R702) of two residents reviewed for pressure ulcers. Findings include: A review of a complaint submitted to the State Agency revealed an allegation the facility was not providing adequate and appropriate care to prevent and treat pressure sores. On 6/26/24 at approximately 9:15 AM, R702 was observed in bed eating breakfast with the assistance of a staff member. R702 was lying on their back positioned slightly to their left side. On 6/26/24 at 12:23 PM, R702 was heard making a groaning noise from the hallway. R702 was lying in bed on their back positioned slightly to their left side as they were earlier in that day. When asked if he needed help, R702 groaned and was not able to answer the question. At that time, Licensed Practical Nurse (LPN) 'B' asked R702 if he needed to be repositioned and he indicated he did. A review of R702's clinical record revealed R702 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Parkinson's Disease. The record further revealed R702 was receiving hospice services. A review of R702's Minimum Data Set (MDS) assessment dated [DATE] revealed R702 had severely impaired cognition; was dependent on staff for all Activities of Daily Living (ADLs), bed mobility, and transfers; and had one stage 1 pressure ulcer (non-blanchable erythema of intact skin). A review of R702's weekly head to toe skin assessments revealed the last skin assessment was completed on 6/3/24 and documented R702 had a wound. A review of R702's progress notes revealed a wound care progress note completed by the former wound care nurse on 6/6/24 (20 days prior to the current date) that read, Wound to coccyx with 3.5 cm (centimeters) x (by) 4.0 cm, wound to left buttock with 1.0 cm x 0.5 cm wound bed for both wound pink with scanty serosanguineous drainage. The documentation did not reveal any additional descriptions including they type of wounds. (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 - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/24 at 1:50 PM, an interview was conducted with the facility's wound care coordinator, Registered Nurse (RN) 'A'. RN 'A' reported floor nurses did wound treatments daily and head to toe skin assessments weekly. RN 'A' along with the contracted wound provider (Nurse Practitioner - NP 'D') assessed existing wounds. In regards to R702, RN 'A' reported that because R702 was on hospice, NP 'D' evaluated his wounds on a monthly basis and they (RN 'A') assessed the wounds weekly. RN 'A' reported R702 had multiple pressure ulcers that were being treated. RN 'A' explained there was another wound care coordinator working with her until about two weeks ago. At that time RN 'A' was queried about the last time R702's pressure ulcers were assessed by herself and/or NP 'D'. RN 'A' said NP 'D' last saw R702 on 5/14/24, the former wound nurse assessed his wounds on 6/6/24, and they (RN 'A') assessed the wounds weekly since then, but had not documented the assessments in the electronic clinical record yet. When queried about the former wound care nurse's assessment, RN 'A' reported the assessment was not complete. At that time, R702's progress notes were reviewed and revealed a wound consult note dated 5/24/24 completed by NP 'D' that noted R702 had the following wounds: Wound #1 - Coccyx, stage 2 pressure ulcer (partial thickness skin loss with exposed dermis) that measured 2.5 cm in length (L) by 2 cm in width (W) and 0.01 cm in depth (D) with a moderate amount of serous drainage. It was documented the wound was deteriorating. Wound #2 - Right Buttock, stage 2 pressure ulcer that measured 3 cm L x 2 cm W x 0.01 cm D. It was documented the wound was deteriorating. Wound #3 - Right hip, stage 3 pressure ulcer (full thickness skin loss) that measured 1 cm L x 0.3 cm W x 0. 2 cm D. It was documented the wound was stable. Wound #4 - Left hip, Deep Tissue Pressure Injury (DTPI - Persistent non-blanchable deep red, maroon or purple discoloration) that measured 2 cm L x 2 cm W. It was documented the wound was improving. NP 'D' documented, Nursing home staff was instructed to monitor aforementioned wounds for erythema, purulent discharge, fever, any sign of infection, or any worsening of the documented wounds . It was noted the documented assessment conducted by the former wound nurse only mentioned two wounds, one to the coccyx which increased in size, and one to the left buttock. It was also noted there was not an assessment of a wound to the left buttock when NP 'D' conducted their evaluation. At that time, RN 'A' was further interviewed and it was reported by RN 'A' that NP 'D' would be evaluating R702's pressure ulcers on 6/28/24. RN 'A' reported she had notes regarding the last two assessments she did of R702's pressure ulcers. RN 'A' was asked to provide the assessments. On 6/26/24 at 2:15 PM, RN 'A' provided two Skin/Shower Assessment forms for R702 that included the following handwriting documentation labeled on a body diagram (RN 'A' confirmed these forms were not considered part of the resident's clinical record): 6/13/24 1. L (left) Hip 2.3 x 2 DTI (deep tissue injury) (continued on next page)

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