STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235332	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTLAND, A VILLA CENTER	**36137 W WARREN WESTLAND, MI 48185**

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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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intakes: MI 406 and MI 272. Based on interview and record review, the facility failed to ensure comprehensive assessment and documentation for one (Resident #701) of three Residents reviewed for change in condition, resulting in lack of timely and comprehensive assessment, including temperature monitoring, and documentation of a change in condition, need for emergency medical treatment, decline in overall health status, and hypothermia (body temperature less than 95 degrees Fahrenheit- F). Findings include: Record review of intake documentation from Confidential Witness A revealed the following, On [DATE] we received a called from the hospital saying that (Resident #701) was admitted to the hospital . The ER doctor told me that they strongly believe(d) that (Resident #701) was left unattended for several hours (the Resident) was cold, confused, little clothing and temperature was very low. Review of intake documentation, submitted by Emergency Department (ED) Registered Nurse (RN) B revealed the following, (Resident #701) resides in a nursing home. (Resident #701) is bedridden and has Dementia . sometimes non-verbal. On [DATE], (Resident #701) was admitted into the hospital. When (Resident #701) arrived, their temperature was 86 degrees (F) rectal (normal body temperature is 98.6 F). The (Physician) was concerned . unlikely for someone to get that cold without being near an open window or in a cold room with no clothes on. If (Resident #701) would have been another degree or two colder, (they) would be dead. It is unknown exactly how they became so cold. If (Resident #701) was septic (infection throughout body) or had an infection, (Resident #701) would still take a long time to become that cold . (Resident #701) was not being properly checked on at the nursing home . An interview was attempted to be completed with ED RN B on [DATE] at 9:08 AM. However, ED RN B was not working. A message was left with a return number. An interview was conducted with Confidential Witness A on [DATE] at 9:21 AM. When queried regarding Resident #701, Witness A stated, (Resident #701) died on [DATE]th (2020). When asked about events prior to the Resident's death, Witness A revealed they had received a call on [DATE]th (2020) from the facility. During the call, facility staff informed them that Resident #701 was acting funny and they were going to give (Resident #701) some IV (intravenous) fluids. With further inquiry regarding the Resident acting funny, Confidential Witness A revealed they were told the Resident was dehydrated and the (facility) nurse told them they thought the Resident would perk up with some fluids and indicated they would let them know if anything changed. Confidential Witness A proceeded to state, Then the hospital called and said (Resident #701) was admitted . When queried, Witness A stated, The Doctor at the hospital talked to me. They were really upset. They (Doctor) said (Resident #701's) temperature was 86 (degrees Fahrenheit- F) and that (Resident #701) had pneumonia, was very dehydrated, and that their body was shutting down. Witness A then stated, The ER Doctor told me they strongly believed (Resident #701) was left unattended and not checked on because of their temperature. They said (Resident #701) was cold and confused. Record review revealed Resident #701 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set Assessment ((MDS) dated [DATE] did not include a cognitive assessment but did indicate the Resident required supervision to perform Activities of Daily Living (ADLs) at that time. Review of Resident #701's medical record revealed the following progress note documentation: -[DATE] at 6:23 AM: Health Status Note (nurses note) . Received in bed . alert and verbal . Resident seems to be failing to get well . -[DATE] at 7:09 AM: Health Status Note (nurses note) . Resident was received in bed during shift change, alert, but barely talk. Resting in bed . Fluids offered and accepted . -[DATE] at 2:42 PM: Health Status Note (nurses note) . Resident is alert and verbal, oriented to name only. resident has graduated off of Covid status. has increase weakness and is being seen by therapy . -[DATE] at 11:25 AM: (Health Status Note (nurses note) . Writer spoke with (Physician) and (Physician Assistant) in house this morning regarding resident declining status. Resident is a feeder with meals, sleeps with eyes closed, easy to arouse at times but only for few minutes. Increase weakness. New orders were written . STAT labs . Writer will notify (family). -[DATE] at 11:30 AM: Respiratory Therapy Note . Resident seen awake in bed on room air continues with congested cough BRS (Bilateral Respiratory Sounds) bilaterally diminished with scattered rhonchi . appears tired with weakness . -[DATE] at 12:11 PM: Physician/PA/NP Progress Note . Altered mental status . Patient was seen in room . sleepy and not getting up for breakfast which is not like them. Nurse made aware. CNA was having a hard time getting (Resident #701) to eat drink this morning as well . vitals were reviewed. Will get stat labs and start IVF's (Intravenous Fluids) now. Nurse to check glucose. No [MEDICAL CONDITION] activity noted . Vitals . BP (Blood Pressure): ,[DATE] (Normal is ,[DATE]), HR (Heart Rate): 52 (Normal range is 60 to 100) . Temp: 96.8 (F) . General Appearance . appears lethargic . moist mucus membranes (normal- dry in dehydration) . [MEDICAL CONDITION]: diminished (abnormal) . -[DATE] at 1:43 PM: Health Status Note (nurses note) . IV Access in to start IV line and draw blood for lab work. -[DATE] at 3:22 PM: Health Status Note (nurses note) . Writer called (family) updated them resident was started on IV fluids and blood work completed and sent for pick up. -[DATE] at 1:25 AM: Health Status Note (nurses note) . Resident received in bed at the beginning of the shift with IV infusing . not easily arousable and not verbal. About an hour to the start of the shift, critical lab results were received and (Doctor) was notified. No new order at this time but will come in the morning to see resident. Writer continued to monitor resident but (Resident #701) condition was not getting better and vitals abnormal. Writer called Dr. to get order to send resident to hospital but (Doctor) didn't answer or return call. Then writer called on call manager to get resident sent to hospital. -[DATE] at 2:04 AM: SBAR-General Situation: Background: Vitals: BP ,[DATE] - [DATE] 02:06; P 43 -[DATE] 02:07 Pulse Type: Irregular - new onset; R 16.0 -[DATE] 09:23 (AM); T 96.8 - [DATE] 09:23 (AM) Route: Oral ; O2 93 % - [DATE] 02:08 (AM) Method: Room Air ; BS 122.0 - [DATE] 12:24 (PM) . Signs and Symptoms: Has fatigue . Resident not easily arousable and weakness . Assessment: Has facial droop. Has confusion. Has signs of dehydration . Review of vital sign documentation in the medical record revealed Resident #701's last assessed and documented respiratory rate and temperature in the facility occurred on [DATE] at 9:23 AM. Review of Resident #701's health care provider orders in the medical record revealed an order, Vitals: BP/Pulse/Resp/Temp/02 Sats one time a day. Reason: vitals done every shift every day. (Start Date: [DATE]). On [DATE] at 11:40 AM, an interview was conducted with Licensed Practical Nurse (LPN) D. When queried if they had provided care to Resident #701 prior to being transferred to the hospital, LPN D revealed they had cared for the Resident but were not the Resident's nurse when they were transferred to the hospital. LPN D further revealed Resident #701 was in the Covid Unit of the facility when they provided care to them and when they were discharged . When queried regarding Resident #701's clinical condition and documentation in the medical record indicating the Resident's medical condition was not improving and/or declining beginning on [DATE], LPN D reviewed the Resident's medical record and stated, The change and decline really started on ,[DATE]. (Resident #701) wasn't talking and then declined further on ,[DATE]. When asked if Resident #701 was normally verbal, LPN D replied, Yes and indicated the Resident not talking was a definite change. When queried regarding the Physician order [REDACTED]. When queried regarding facility policy/procedure pertaining to frequency of vital sign

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) monitoring for Residents on the Covid-19 unit, LPN D indicated temperatures were supposed to be taken twice a day. LPN D was then queried where temperatures are documented per facility policy/procedure and indicated that vital signs are documented in the vital signs tab in the medical record. LPN D was then asked about facility policy/ procedure pertaining to Resident transfers to the hospital and documentation and replied, We get an order (from Health Care Provider), notify the DON (Director of Nursing), have a full set of vitals, send a copy of most recent labs, meds, face sheet and orders. With further inquiry regarding documentation completed in Resident medical records at the facility, LPN D stated, Do an SBAR assessment and then a Transition to Hospital Assessment (SNF to ED Handoff Form). When asked if a full set of vitals included temperature, LPN D indicated it did. Resident #701's medical record was reviewed with LPN D at this time. When queried regarding Resident #701's temperature at the time of their discharge, LPN D reviewed the medical record and stated, The last temperature documented was on [DATE] at 9:23 AM. When asked if a temperature should be assessed, prior to the Resident being transferred per facility policy/procedure, LPN D indicated it should be. LPN D was then asked if the nursing staff on that unit worked eight or 12 hour shifts and revealed nurses at the facility work both eight and 12 hour shifts. LPN D further revealed the the nurses on the unit that Resident #701 had been on were supposed to work 12 hour shifts but often ended up having to utilize a nurse who works eight hour shifts to provide coverage and stated, It ends up being a mix. An interview was attempted to be completed with Nursing Assistant G on [DATE] at 1:24 PM. The phone number provided for Nursing Assistant G was no longer in service. An interview was attempted to be completed with Nursing Assistant E on [DATE] at 1:27 PM. A voicemail message was left with a return number, but a return call was not received by the conclusion of the survey. An interview was conducted with Licensed Practical Nurse (LPN) C on [DATE] at 12:10 PM. When asked if they recalled Resident #701, LPN C indicated they did. When queried what occurred when the Resident was transferred to the Emergency Department on [DATE], LPN C stated they don't remember exactly what happened. When asked if they take Resident's temperatures, as part of their vital signs (vital signs include but are not limited to: pulse rate, temperature, respiration rate, and blood pressure), and if Resident vital signs and temperatures are assessed prior to transferring a Resident, LPN C replied, No, not always take a temperature. It depends on the vital signs. When asked if they recalled if Resident #701's skin felt warm or cold when they were transferred, LPN C replied, I don't remember. When asked about the temperature of Resident #701's room, LPN C replied, I don't remember. When queried approximately how often staff, including themself and other facility staff checked on Resident #701 throughout the shift, LPN C stated, I don't remember. LPN C was then queried regarding facility policy/procedure pertaining to obtaining Resident vital signs including frequency of monitoring and stated, Sometimes at the beginning of the shift, sometimes at the end. It depends on the Resident. When asked if they obtained Resident #701's vital signs prior to transferring them, LPN C indicated vital signs would be documented in the Resident medical record. When queried why the temperature documented on the transfer information was from 12 hours prior to the time of the transfer, LPN C did not provide an explanation. An interview was conducted with the Director of Nursing (DON) on [DATE] at 2:45 PM. When queried regarding Resident #701's transfer to the hospital and lack of comprehensive vital sign documentation, the DON replied, It was a 911 call. I would just worry about getting the Resident stable and transferring them out. When queried why vital signs were not obtained and documented during the shift, prior to the Resident requiring an emergency transfer to the hospital, the DON indicated vital signs only needed to be measured once per shift. When asked if vital signs should be monitored more frequently than once a shift when the Resident is having a decline in condition, the DON reiterated that vital sign assessment was only required once per shift. When queried regarding documentation of Resident #701 having a progressive decline in condition, including facial droop, the DON replied, Facial droop was (Resident #701's) baseline. When asked why nursing would document facial droop if the facility documents by exception (documentation in medical record occurs only when there is a deviation from the baseline or expected outcome) in the medical record, the DON did not provide an explanation. A policy/procedure pertaining to vital sign monitoring and assessment including documentation was requested from the facility Administrator on [DATE] at 12:34 PM via email. The Administrator replied, We do not have a policy on vital signs via email on [DATE] at 1:01 PM. Review of facility policy/procedure entitled, Notification of Changes Guideline (Revised [DATE]) revealed, Purpose: It is the practice of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative . and reported to the attending physician or delegate (hereafter designated as the physician). The resident and/or their representative will be educated about treatment options and supported to make an informed choice about care . All pertinent information will be made available to the provider by the facility staff. Nurses and other care staff are educated to identify changes in a resident's status and define changes that require notification of the resident and/or their representative, and the resident's physician, to ensure best outcomes of care for the resident .1. In addition to a change in the resident's condition, the resident and/or representative(s) shall be notified promptly if there is: a. A decision to transfer or discharge the resident from the facility (only for a discharge prompted by the facility). Notice must be given before the discharge occurs . Review of facility policy/procedure entitled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property (Effective [DATE]) revealed, e. Mistreatment means inappropriate treatment or exploitation of a Resident . f. Neglect is the failure of a the facility, itls employees or service providers to provide goods and services to a Resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .Resident Assessment . Every Resident is unique and may be subject to 'abuse' based on a variety of circumstances, including facility physical plant, environment, the Resident's health behavior, or cognitive level .