STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE VILLA AT PARKRIDGE	28 S PROSPECT ST YPSILANTI, MI 48198

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 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 intake pertains to MI 084. Based on interview and record review, the facility failed to provide treatment and services based on the comprehensive assessment in one of three reviewed for quality of care (Resident #81), resulting in unmet goals and readmission to the hospital. Findings include: Resident #81 (R81) R81's hospital History and Physical dated [DATE], indicated he was a [AGE] year-old with a history of mental impairment and [MEDICAL CONDITION] disorder who presented to the emergency room from the group home where he previously lived, after a four and a half minute [MEDICAL CONDITION] on this same day and multiple [MEDICAL CONDITION] the day prior. The same note had conveyed R81 was very particular in who could feed him, that he had contractures in the lower extremities, and would need to discuss a Percutaneous Endoscopic Gastrostomy (PEG, feeding tube) tube with his power of attorney (POA). R81's hospital transfer progress notes dated [DATE], revealed he had the [DIAGNOSES REDACTED]. R81's hospital Physical Therapy (PT) evaluation dated [DATE] indicated he could potentially benefit from passive range of motion or a splinting program for his contractures. Hospital Case Manager note dated [DATE] indicated hospice was discussed with R81's power of attorney (POA), but she declined initiation. physician progress notes [REDACTED]. The same note indicated his POA indicated R81 was more compliant with medications if given up waking, instead of waking him up at 7:00 AM, as well as give medications with fruit. R81's Activities of Daily Living (ADL) care plan dated [DATE], revealed he was admitted to the nursing home on [DATE], and did not include a PT referral for passive range of motion exercises or splinting program, to give medications upon rising and with fruit. These instructions were not included in any care plan, physician orders, or on the medication record. Speech Therapy (ST) Evaluation and Plan of Treatment dated [DATE], revealed R81 had a cognitive communication deficit, dysphasia (difficulty in swallowing), dehydration, and failure to thrive diagnoses. R81 presented coughing after swallowing thin liquids. ST recommendations included 1:1 feeding assistance with close supervision for safety, alternation of liquids and solids, bolus size modifications, general swallow techniques/precautions, lingual sweep/re-swallow, rate modification and second swallow, upright posture during meals and at least 30 minutes after meals. ST's recommendations were not added to R81's care plan. R81's medical record included a Do Not Resuscitate Order, signed by the POA on [DATE], that indicated in the event his heart and breathing should stop, no person should attempt to resuscitate him. R81's wishes were not transferred onto his care plan. R81's physician orders [REDACTED]. R81's [DATE] Medication Administration Record [REDACTED]. During an interview on [DATE] at 11:45 AM, Certified Nurse Assistant (CNA) F stated on [DATE] at lunch, she noticed R81 had regular food on his lunch tray and should have had pureed. CNA F stated she reported R81's lunch tray issue to the nurse, did not feed R81 food from his lunch tray, and gave him a magic cup (frozen supplement). CNA F stated during the same interview R81 coughed when he was fed the magic cup, and his lips started to turn purple. CNA F stated she reported R81's condition to the nurse, and everyone freaked out. On [DATE] at 3:51 PM, Registered Nurse (RN) G confirmed she initiated R81's transfer to the ED on [DATE], and she wasn't aware speech recommendations for feeding assistance. RN G stated in the same interview she felt R 81 was pocketing his food (holding food in mouth and not swallowing). RN G stated she did not listen to R81's lung sounds as part of her assessment. RN G stated she stated she initiated oxygen and suctioned R81 prior to his transfer to the ED. Situation, Background, Assessment Recommendation (SBAR) dated [DATE] indicated R81 had a change in condition, altered mental status, peripheral capillary oxygen saturation (SPO2, estimate of amount of oxygen in the blood) in the 80's, [MEDICAL CONDITION] (low levels of oxygen in blood), weakness, fatigue, labored breathing with accessory muscle use, low pulse, and signs of dehydration. There was no record of when oxygen was initiated, what R81's exact SPO2 readings were and what time. The same document indicated R81's SPO2 was last obtained at 7:55 AM, 96 percent (%) on room air. The Skilled Nursing Facility (SNF) to ED Handoff form dated [DATE], indicated R81's medication sheet was sent to the ED, specifying he was a full code. Emergency Department (ED) records titled Pre-hospital Care Report Summary, dated [DATE], revealed a call was received at 2:34 PM, emergency medical services (EMS) arrived on the scene to find R81 lying in bed, the nurse reported he had choked on some food that morning, had to be suctioned, oxygen was initiated and he had been having difficulty breathing since. R81 was transferred to the ED. ED records dated [DATE] revealed under chief complaint that R81 was lethargic and had choked at lunch around 12:00 PM. The same notes indicated EMS had stated R81 was a full code. The same notes indicated shortly after R81 arrived, he underwent Cardiac [MEDICAL CONDITION] Restitution (CPR), and endotracheal intubation (tube placed into the windpipe to maintain open airway). The same records revealed after multiple rounds of CPR, R81's POA was called and stated she did not want life support measures to be provided. Hospital Emergency Department Records dated [DATE] revealed R81 was pronounced dead at 5:42 PM and suspect patient died from hypoxic [MEDICAL CONDITION] (inadequate gas exchange by the respiratory system) secondary to aspiration (fluid entering airway or lungs). Director of Nursing (DON) B was interviewed on [DATE] at 4:00 PM and stated she was not aware of R81 choking during lunch on [DATE], was not sure if an intravenous line (IV) or PEG tube was discussed with his POA, and wasn't sure if his POA was previously contacted to come in the facility to assist in feeding R81. In a follow-up to the interview, DON B sent an electronic mail (email) on [DATE] at 3:08 PM indicating there was not an accident report related to R81 choking, as no choking incident was documented in the facility. Occupational therapy screened R81 but did not pick him up because he was not a candidate for rehabilitation and was unable to follow demands. The same email indicated R81's DNR was signed by community primary care physician, not by facility physician; and the unit manager contacted the family to determine care wishes.

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