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 _____	07/30/2020

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0551 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give the resident's representative the ability to exercise the resident's rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number MI 282. Based on interview and record review, the facility failed to enact policies and procedures to ensure involvement of a Resident Representative in care planning for one (#702) of three Residents reviewed, resulting in a General Durable Power of Attorney (POA) document not being honored, exclusion of the designated General Durable: Power of Attorney in care decisions related to the Resident, and feelings of frustration. Findings include: Review of intake documentation revealed the narrative, I have left numerous messages over the past 2 weeks with all kinds of staff at Westland Rehab and no one ever returns my calls. I am (Resident #702's) power of attorney. (Resident #702) has informed me no one is telling them why they have to stay (at facility) or informs them about what care they are receiving . (The facility) is holding (Resident #702) hostage and violating their rights . Why won't they release (Resident #702) back to the group home where they reside? Why are they not calling me back. (Resident #702) has requested to return to the group home but no one cares to listen at (the facility) or is doing anything about getting (Resident #702) back to the group home . The intake narrative documentation further revealed Resident #702 was asymptomatic but testing positive for Covid-19 on 6/10/20 and sent to the hospital from their group home on 6/13/20. Resident #702 was then transferred from the hospital to the facility on [DATE]. An interview was conducted with Resident #702's General Durable Power of Attorney Confidential Witness K on 7/30/20 at 8:55 AM. When queried regarding Resident #702, Confidential Witness K revealed Resident #702 was their sibling and they had general (POA) due to the Resident's cognitive abilities. Confidential Witness K elaborated that the Resident has the mental capabilities similar to that of an young teenager and is unable to always make the best decisions without guidance. Confidential Witness K stated, (Resident #702) will do whatever someone wants them to if they think that person is their friend. When asked about the Resident's care at the facility, Confidential Witness K revealed the Resident was finally scheduled to return to their group home on Monday. With further inquiry, Confidential Witness K revealed they had been very frustrated with the facility and stated, I had called (the facility) so many times and I couldn't even get anyone to call me back. That is I contacted the State. Confidential Witness K further stated, (Resident #702) just wants to go back to their group home. That is where they live. When queried regarding their involvement in the Resident's admission to the facility and discharge planning process, Confidential Witness K replied, No and indicated they were not involved with the admission process and/or the initial discharge planning process. Record review revealed Resident #702 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident's was moderately cognitively impaired and required supervision to extensive assistance to perform Activities of Daily Living (ADLs). Review of Resident #702's medical record revealed the following documentation: -6/16/20: Social Service Note . Writer completed social service evaluation with the resident. The resident is own responsible party. Resident does have a POA of finance (Sibling) . Resident has elected to be a full code. Form signed and scanned into (Electronic Medical Record -EMR). Resident has a mental health [DIAGNOSES REDACTED]. Psych consent was signed and uploaded into (EMR). Resident discharge plan is to return back to the community. Resident informed writer that group home would not accept them back. Writer will follow up with resident's case worker . and resident's (Sibling) to coordinate a discharge plan. -6/29/20: Social Service Note . This writer spoke with resident regarding NOMNC (Notice of Medicare Non-Coverage). The resident's last cover day is 7/1/2020. The resident reported discharge plan is to return to group home. This writer also spoke with (Resident #702's Sibling) regarding the NOMNC. Writer informed (Sibling) the resident's last cover day would be 7/1/2020. (Sibling) reported writer could call Group Home Manager but stated this writer should talk with (Case Management Worker) . -7/13/20: Social Service Note . This writer spoke with the resident's (Sibling) regarding discharge. Sibling inquired when (Resident's #702) can return to the group home. This writer informed (Sibling) that the resident's case manager stated the resident required two negative COVID tests before return. The resident's last COVID test was positive. This writer informed her that this writer would follow up with the IDT regarding the additional testing needed for the resident to return to their home. This writer will also follow up with (Sibling). 7/23/20: Social Service Note . This writer called the resident's case manager regarding the resident. This writer informed (Case Manager) the results of the resident's COVID-19 testing has not been received and stated this writer will call once the results are in This writer also called the resident's (Sibling) and informed them the resident had been swabbed; however, the results were not back at this time. (Sibling) reported frustration and this writer apologized for the inconvenience . General Durable POA documentation was also present in Resident #702's medical record. The General Durable POA documentation revealed Confidential Witness K was the Resident's attorney-in-fact and designated Confidential Witness K as able to make all financial and medical decisions for the Resident regardless of the Resident's mental status and/or determination of competency and specified, To make each and every judgement necessary for the proper and adequate care and custody of me . may determine to be in the best interests of my health. An interview was conducted with Social Worker E on 7/30/20 at 2:14 PM. When queried regarding Resident's #702's discharge plan, Social Worker E replied, Back to the Assisted Living. That's always been the plan since I became (the Resident's) social worker. Social Worker E was asked when they became the Resident's social worker and replied, The end of June. When queried regarding documentation in the Resident's medical record related to Covid test results, Social Worker E replied, The Covid tests were returned with the incorrect name. There was an error with the test. Social Worker E further revealed they had followed up with nursing staff regarding the testing in order to obtain another Covid test. When queried regarding the Resident's General POA documentation and inclusion of the Resident's Representative in the plan of care, Social Worker E stated, The Resident is their own person, they haven't been deemed incompetent. When queried if a Resident with a General Power of Attorney had to be deemed incompetent, Social Worker E indicated they do and stated, That is our policy. An interview was conducted with the Director of Nursing (DON) on 7/30/20 at 4:45 PM. When queried regarding Resident #702 and involvement in care by their General Durable POA, the DON indicated they were aware the Resident had a POA documentation. The DON was then asked what the difference was between a General Durable POA and a Durable POA and replied, I really don't know. A policy/procedure related to Advance Directives was requested from the facility Administrator on 7/30/20 at 10:20 AM but not received by the conclusion of the survey.
F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Numbers MI 603 and MI 665. Based on observation, interview and record review, the facility failed to identify, prevent, and ensure an environment free of verbal abuse for one (#701) of two Residents reviewed for abuse, resulting in lack of identification and investigation of verbal abuse, lack of comprehensive psychosocial Resident assessment, and Resident verbalization of feeling of fear. Findings include: An interview was conducted with the facility

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

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.

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Administrator on 7/30/20 at 10:20 AM. When queried regarding Resident #701, the Administrator revealed the facility had investigated a concern brought forth by the Resident related to physical abuse. When asked about the incident and facility investigation, the Administrator replied, The CNA (Certified Nursing Assistant A) was in the room providing care following the Resident having a BM (Bowel Movement). When asked, the Administrator indicated the allegation of physical abuse was unable to be substantiated during the facility investigation. On 7/30/20 at 11:05 AM, Resident #701 was observed in their room, positioned on their back in bed. An interview was conducted at this time. Resident #701 was asked how they are treated by staff in the facility and replied, They are rude. At this time, Resident #701 revealed a recent encounter with a Nursing Assistant. Resident #701 stated, I had diarrhea and asked the Aide (Nursing Assistant) to come in and change me. (The Nursing Assistant) wiped me really hard. Resident #701 further specified they told the Nursing Assistant that they were wiping them to hard and stated, (The Nursing Assistant) told me to quit being a baby. Resident #701 stipulated the Nursing Assistant then hit them on their left leg. When asked, Resident #701 was unsure of the Nursing Assistant's name and indicated they are unaware of many facilities staff members names because the staff do not introduce themselves and name tags are not visible and/or flipped backwards. When asked to describe the Nursing Assistant, Resident #701 replied, They were black and had an accent. They are hard to understand. When asked if other staff were present in the room at the time of the incident, Resident #701 replied, No. Resident #701 then stated, I'm just scared to be here. I don't sleep good at night anymore since it happened. When queried if the facility Social Worker and/or Mental Health Provider had discussed the incident with them, Resident #701 replied, They came in but there was really no discussion. Resident #701 was asked for clarification and revealed facility staff asked them if they were okay but did not have a discussion with them. When asked, Resident #701 revealed the Nursing Assistant had cared for them in the past but had never physically hurt them prior to this incident. With further inquiry regarding previous interactions with the Nursing Assistant, Resident #701 revealed the Nursing Assistant was rude and rushed when they provided care to them. When queried regarding treatment by other staff in the facility, Resident #701 indicated some staff are nice but a lot are rude and rush. When asked how it made them feel when staff speak to them rudely or rushed when providing care, Resident #701 replied, I'm just scared to be here. Record review of Resident #701's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required extensive to total assistance to perform Activities of Daily Living (ADLs). The MDS also revealed the Resident had not displayed any behaviors. Additional review of Resident #701's medical record revealed they were seen by a behavioral health care provider on 6/3/20 and 6/18/20. Documentation from both dates revealed the Resident's demeanor was Cooperative, pleasant and engaging and they were Oriented to person, place, time and situation with intact insight and judgement and organized thought processes. The documentation also revealed the Resident had signs and symptoms of depression and did not display any behaviors including delusions/hallucinations. Review of progress note documentation in Resident #701's medical record did not reveal documentation of comprehensive psychosocial assessment following physical abuse allegation nor did it include documentation related to verbal abuse. Review of facility provided Investigation Folder related to the physical abuse allegation on 7/25/20 did not include investigation pertaining to verbal abuse concerns. The investigation also did not not contain documentation of completion of a comprehensive a psychosocial assessment following the allegation, a staffing schedule showing who was assigned to care for Resident #701, and a statement from the Resident describing what had occurred. The staffing assignment sheets for 7/25/20 were requested from the Administrator on 7/30/20 at 1:03 PM. A phone interview was conducted with Nursing Assistant A on 7/30/20 at 1:05 PM. During the interview, Nursing Assistant A revealed they typically work day shift (eight hour shifts) in the facility. When asked, Nursing Assistant A revealed they worked on 7/25/20. When asked if they were assigned to work on the 300 unit/hall, Nursing Assistant A replied, Normally work on Station Three (three hundred hall) but not that day. When asked if they were assigned to care for Resident #701 on 7/25/20, Nursing Assistant A indicated they were. When queried how they were assigned to care for Resident #701 who residing on the 300 hall (Station Three) if they were not assigned to work there on 7/25/20, Nursing Assistant A indicated they normally work in the front part of the hall. When asked if they were saying they were assigned a different set of Residents than they typically are assigned on 7/25/20, Nursing Assistant A confirmed meaning of statement. When queried regarding if anything unusual occurred during on 7/25/20 when providing care to Resident #701, Nursing Assistant A stated, I went there three or four times. Nursing Assistant A indicated they noticed two call lights on in the hall around 2:50 PM and answered Resident #701's call light last. Nursing Assistant A stated, When I went in, (Resident #701) told me they had a BM. They told me the water was cold in the middle of care. I changed (the Resident's) brief and linen. when I was cleaning (Resident #701) they told me they weren't clean enough but there wasn't any BM so I went out in the hall to find someone to validate that (Resident #701) was clean. (Licensed Practical Nurse (LPN) C) was walking by. I called out to validate. I opened (Resident #701's) brief and showed no BM. (LPN C) said they looked clean. When asked if the Resident told them they were being rough when cleaning them, Nursing Assistant A replied, No. When queried if anything else unusual occurred while providing care to the Resident, Nursing Assistant A indicated it had not. When asked if they had hit the Resident during care, Nursing Assistant A replied, Not me, no. When queried if they called the Resident a baby during care, Nursing Assistant A did not respond. Throughout the interview, Nursing Assistant A was very loud and spoke with a curt tone. An interview was conducted with Social Services Director D on 7/30/20 at 1:30 PM. When queried if they were the Social Services staff member assigned to Resident #701, Social Services Director D indicated they were. When asked about the Resident, Social Services Director D stated, (Resident #701) is a nice person to talk to. When queried regarding the Resident's history and any current concerns, Social Services Director D replied, Yes, depression. Social Services Director D was then asked if Resident #701 was followed by psychiatric services and replied, Yes. When queried if they interviewed the Resident following the abuse allegation on 7/25/20, Social Services Director replied, Yes. When queried why the interview was not included in the provided facility investigation, Social Services Director D was unable to provide an explanation. Social Services D then reviewed the facility provided investigation documentation and confirmed the investigation did not include a statement from Resident #701 detailing the incident. Social Services Director D then stated, I was just there with the Resident when the police interviewed them. When asked about the interview, Social Services Director D stated, (Resident #701) said they told the CNA to wipe them and they didn't feel they were wiped well. (Resident #701) said the CNA hit them on their left thigh. When queried if they conducted an assessment of the Resident's psychosocial status and well-being following the incident, Social Services Director D indicated they had. When asked why there was not an assessment in Resident #701's Electronic Medical Record (EMR), Social Services Director D indicated they documented under Psychosocial Notes. Social Services Director D was then asked if they found any concerns and replied, No. When queried regarding Resident #701's verbalization of fear related to being in the facility following the incident, Social Services Director D revealed they were unaware Resident #701 was fearful and indicated they were surprised to hear that. At 1:40 PM on 7/30/20, an interview was conducted with Resident #701 and Social Services Director D in the Resident's room. When asked, Resident #701 indicated they knew Social Services Director D worked at the facility was but were unable to recall their name. Resident #701 was then asked if they had told Social Services Director D how they felt in relationship to their safety in the facility, and Resident #701 stated, Yes and reiterated previous statement that they felt scared in the facility. At this time, Social Services Director D told the Resident, No, you did not and Resident #701 replied, Well then it was the DON (Director of Nursing). I told someone. Social Services Director D did not ask Resident #701 any further questions prior to exiting the room. After exiting the room, Social Services Director D was interviewed further regarding Resident #701 on 7/30/20 at 1:50 PM. Social Services Director D's EMR documentation was reviewed at this time. EMR Psychosocial progress note documentation indicated psychosocial support was provided to Resident #701 by Social Services Director D. When asked what psychosocial support was provided to the Resident, Social Services Director D did not provide a response. Social Services Director D was then asked what questions they asked Resident #701 to determine the Resident was doing okay and that they felt safe in the facility as documented in the Psychosocial progress notes and Social Services Director D replied, I asked them how they were doing. No further explanation was provided. When queried if they had completed any type of formalized assessment with Resident #701 following the incident, Social Services Director D replied, No. When asked if completion of an assessment is included in facility policy/procedure, Social Services Director D indicated it was not. When queried if the facility mental health care provided had evaluated the Resident after the incident occurred, Social Services D revealed they had not. An interview was completed with Police Officer B on 7/30/20 at 3:00 PM. When queried regarding the incident concerning Resident #701 on 7/25/20, Police Officer B revealed they responded to the facility. When asked what had occurred, Police Office B stated, It sounded like the Nursing Assistant was rough with (Resident #701) when providing care. With further inquiry, Police Officer B revealed Resident #701 had told (Nursing

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Assistant A) they were being rough and then (Nursing Assistant A) got mad and hit (the Resident) in the leg. An interview was conducted with LPN C on 7/30/20 at 3:10 PM. When queried if they were working on the 300 hall of the facility on 7/25/20, LPN C stated, No. When asked if they were involved with Resident #701's care on that day, LPN C stated, I was walking in the hallway when the CNA asked me to come into the room. When queried what occurred in the room, LPN C replied, The Resident was upset and screaming. (Nursing Assistant A) opened (Resident #701's) brief to show me (the Resident) was clean. Even though (Resident #701) was clean, (Nursing Assistant A) wiped (the Resident) again. When asked what occurred next, LPN C revealed they left the Resident's room. When asked if Nursing Assistant A was still in the room when they exited the room, LPN C stated, Yes. LPN C was asked how long Nursing Assistant A was in the Resident's room after they left the room and stated, Shortly after. LPN C was unable to provide an estimated length of time. On 7/30/20 at 3:32 PM, the Administrator was queried regarding the provided investigation documentation not including a statement from Resident #701. The Administrator provided a statement at this time and indicated it was in their office. Resident #701's statement was provided at this time. The statement was not signed by the Resident. An interview was conducted with Nurse J on 7/30/20 at 4:10 PM. When queried if they were aware of an incident involving Resident #701 on 7/25/20, Nurse J revealed they had worked on that date but were not involved in the Resident's care. When asked if anything out of the usual had occurred, Nurse J stated, We were really short staffed. There were only two aides for 45 Residents. With further inquiry, Nurse J revealed the Residents on the Third Bay of the facility are high acuity and require additional staff to meet their needs. When asked how many Nursing Assistants and nurses typically work on the unit, Nurse J replied, Should be at least three but four is optimal. When queried if they worked with and observed Nursing Assistant A provide care to Residents, Nurse J indicated they had. When queried regarding their observations of Nursing Assistant A's interactions with Residents and stated, I have noticed (Nursing Assistant A) can be short and abrupt. Rude- not the ideal bedside manner. When asked what they meant, Nurse J stated, Kind of witchy, impatient, rushed. Seems irritated when they have to do the care. I don't understand that- that is what we are here for. When queried if they were interviewed regarding the incident by the facility, Nurse J indicated they were. When asked if they had disclosed their observations of Nursing Assistant A during the interview, Nurse J revealed they did not because they were not asked about the Nursing Assistant and/or Resident #701. Review of the staffing sheets for 7/25/20 revealed LPN L was the nurse assigned to care for Resident #701. A phone interview was attempted to be completed with LPN L on 7/30/20 at 4:00 PM and 4:23 PM. An interview was conducted with the Director of Nursing (DON) on 7/30/20 at 4:45 PM. When queried about Resident #701's allegation and the investigation completed by the facility, the DON indicated the allegation was unable to be substantiated. When queried regarding the length of time Nursing Assistant A was in the room with Resident #701, the DON revealed they did not know a time frame. When asked if there were cameras present in the facility and if the camera footage was reviewed, the DON replied, No cameras. When queried regarding assessment of Resident #701's emotional and psychosocial well-being following the incident including the Resident's statement of being fearful and interview with the facility Social Services Director, the DON did not provide an explanation. When queried regarding staff statements pertaining to observations of Nursing Assistant A, the DON stated, I have not seen that. When asked if verbal abuse concerns were addressed in the investigation, the DON indicated the allegation was related to physical abuse and no concerns related to verbal abuse were investigated. When queried if concerns related to verbal abuse would have been uncovered with additional investigation and use of open-ended questions during the interview process, the DON did not provide a response. When queried if staffing levels on 7/25/20 were sufficient to provide care, the DON indicated there were four staff (two nursing assistants and two nurses) for 45 Residents. When asked about facility staff rushing while providing care, the DON stated, It (incident involving Resident #701) was right at the end of the shift. They were probably trying to get out of there. When asked if staffing levels were considered in the facility investigation, the DON revealed they were not. When asked, the DON denied a potential correlation with staffing levels, rushed care, potential abuse, and Resident perception of care. Review of Nursing Assistant A's personnel file revealed the employee had received an Employee Discipline Form on 7/16/20. The form revealed, Job Performance/Behavior Deficiency: On the date of 7/16/20, staff had double briefed residents . Specific Results Required for Acceptable Improvement: Staff are to check/change Residents every two hours or as needed . An interview was conducted with the Administrator at 17:05 PM on 7/30/20. When queried regarding Resident #701's and staff statements related to observations of care by Nursing Assistant A, the Administrator indicated they were unaware of any concerns. Review of facility policy/procedure entitled, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property (Dated 11/28/17) revealed, It is the practice of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse . Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse . physical abuse and mental abuse . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Investigation of abuse: When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: i. Who was involved ii. Residents' statements a. For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings. iii. Resident's roommate statements (if applicable) iv. Involved staff and witness statements of events v. A description of the resident's behavior and environment at the time of the incident vi. Injuries present including a resident assessment vii. Observation of resident and staff behaviors during the investigation viii. Environmental considerations .
F 0610 **Level of harm -** Actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Numbers MI 603 and MI 665. Based on observation, interview and record review, the facility failed to ensure a thorough and comprehensive investigation related to abuse for one (#701) of two Residents reviewed for abuse, resulting in lack of comprehensive interviews of all potential witnesses, no investigation of verbal abuse concerns, lack of comprehensive assessment of Resident psychosocial status following abuse allegation, and Resident verbalization of feelings of fear. Findings include: Review of intake documentation revealed an allegation of physical abuse occurred within the facility on 7/25/20. The intake documentation included, Allegations . (Resident #701) is bed-bound and does not ambulate on their own. On 7/25/20, (Resident #701) had a bowel movement in the bed. A nurse aide (Nursing Assistant A) cleaned (Resident #701) up; however, doing so roughly. (Resident #701) informed (Nursing Assistant A) that they were being rough . (Nursing Assistant A) then made a fist and struck (Resident #701) on their outer thigh of left leg. Law enforcement was involved . An interview was conducted with the facility Administrator on 7/30/20 at 10:20 AM. When queried regarding the occurrences involving Resident #701, the Administrator stated, Over last weekend we had a concern that staff was rough with (the Resident) when providing care. When asked about the facility investigation pertaining to the incident, the Administrator replied, The CNA (Certified Nursing Assistant A) was in the room providing care following the Resident having a BM (Bowel Movement). The Administrator was then asked what time the incident occurred and stated, Day shift. The Administrator then stated, Early afternoon shift, the Resident made a complaint to the afternoon nurse and we suspended (Nursing Assistant A). When queried if the Nursing Assistant had returned to work, the Administrator replied, Yes. On 7/30/20 at 11:05 AM, Resident #701 was observed in their room, positioned on their back in bed. An interview was conducted at this time. When asked how they are treated by staff in the facility, Resident #701 replied, They are rude. With further inquiry, Resident #701 disclosed a recent interaction with staff. Resident #701 stated, I had diarrhea and asked the Aide (Nursing Assistant) to come in and change me. (The Nursing Assistant) wiped me really hard and I told them. (The Nursing Assistant) told me to quit being a baby. When asked what happened after that, Resident #701 indicated they semi rolled back and stated, (The Nursing Assistant) hit me with their right hand. When asked when the Nursing Assistant hit them, Resident #701 pointed to their left leg, directly above the thigh. Resident #701 was asked if they had a mark or bruise on their skin following the incident and replied, No. When asked the Nursing Assistant's name, Resident #701 replied, I don't know and revealed they were unaware of most of the staff members names because their name tags are flipped around and the staff do not tell them. When queried what the Staff member looked like, Resident #701 indicated they were female and stated, They were black and had an accent. They are hard to understand. Resident #701 was then asked if there were any other staff

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F 0610 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) present in the room at the time of the incident and replied, No. When asked if other staff came into their room later, Resident #701 replied, Yes but were unaware of the nurse's name. Resident #701 then stated, I'm just scared to be here. I don't sleep good at night anymore since it happened. Resident #701 was asked if they had spoken to their Physician and/or the facility Social Worker regarding the incident and how they were feeling. Resident #701 replied, They came in but there was really no discussion. When asked for clarification, Resident #701 revealed facility staff came in the room and asked questions but did not have a discussion with them. When queried, Resident #701 revealed the Nursing Assistant had cared for them in the past but had never physically hurt them prior to this incident but revealed the Nursing Assistant had been rude and rushed in the past. When queried regarding treatment by other staff in the facility, Resident #701 indicated some staff are nice and a lot are rude and rush. Record review of Resident #701's medical record revealed the Resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact and required extensive to total assistance to perform Activities of Daily Living (ADLs). Additional review of Resident #701's medical record revealed they were seen by a behavioral health care provider on 6/3/20 and 6/18/20. Documentation from both dates revealed the Resident's demeanor was Cooperative, pleasant and engaging and they were Oriented to person, place, time and situation with intact insight and judgement and organized thought processes. The documentation also revealed the Resident was not experiencing any behaviors and was not experiencing any delusions/hallucinations but was experiencing signs and symptoms of depression. Review of progress note documentation in Resident #701's medical record revealed the following: -7/29/20: Psychosocial Note . Writer followed up with resident and provided psychosocial support. Resident indicates . doing okay and feels safe in the facility . -7/28/20: Psychosocial Note . Writer followed up with resident today to provide psychosocial support. Resident stated . doing okay and feel safe in the facility. Resident was alert and pleasant while talking to the writer. Psychosocial support was provided to resident. -7/27/20: Psychosocial Note . Writer followed up with resident to provide psychosocial support regarding resident's allegation. Resident stated . doing okay and feel safe in the facility. The resident was laying in bed while writer walked into residents room. This writer provided psychosocial support. -7/25/20: Psychosocial Note . Writer followed up with resident to provide psychosocial support regarding resident's allegation. Resident was laying in bed watching TV when writer walked into residents room. Resident stated . doing okay and feel safe in the facility. This writer provided psychosocial support . -7/25/20: Health Status Note (nurses note) . Resident Reported at 3:18 PM that a day shift aide had hit (them) on the left leg . Resident has skin intact with no redness swelling or pain . No assessment documentation related to the Resident's psychosocial status and well-being was noted in the medical record other than a Brief Interview Mental Status (BIMS) assessment to assess the Resident's cognition. Review of facility provided Investigation Folder related to the incident included: -Multiple Like Resident interview forms. The forms included the following closed-ended questions with areas to check Yes or No or N/A as the response. Did you have any concerns how staff provider care for you over the weekend? and Did you report it to anyone? -Staff statements including a statement from Nursing Assistant A which was signed by the Director of Nursing (DON) but not by Nursing Assistant A and a Statement by Licensed Practical Nurse (LPN) C -A skin and pain assessment for Resident #701 The investigation documentation did not contain documentation and/or a psychosocial assessment, a staffing schedule showing who was assigned to care for Resident #701, and a statement from the Resident describing what had occurred. The staffing assignment sheets for 7/25/20 were requested from the Administrator on 7/30/20 at 1:03 PM. A phone interview was conducted with Nursing Assistant A on 7/30/20 at 1:05 PM. Nursing Assistant A was asked what shift they normally work at the facility and replied, Morning, day shift. Nursing Assistant A was then queried if they had worked on 7/25/20 and indicated they had. When asked if they were assigned to work on the 300 unit/hall, Nursing Assistant A replied, Normally work on Station Three (three hundred hall) but not that day. When asked if they were assigned to care for Resident #701 on 7/25/20, Nursing Assistant A indicated they were. When queried how they were assigned to care for Resident #701 who residing on the 300 hall (Station Three) if they were not assigned to work there on 7/25/20, Nursing Assistant A indicated they normally work in the front part of the hall. When asked if they were saying they were assigned a different set of Residents than they typically are on 7/25/20, Nursing Assistant A indicated that was correct and that they were assigned a different set of Residents. When queried regarding Resident #701 on 7/25/20 and if anything unusual occurred during care, Nursing Assistant A stated, I went there three or four times. Nursing Assistant A then revealed they noticed two call lights on in the hall around 2:50 PM and answered Resident #701's call light last. Nursing Assistant A stated, When I went in, (Resident #701) told me they had a BM. They told me the water was cold in the middle of care. I changed (the Resident's) brief and linen. when I was cleaning (Resident #701) they told me they weren't clean enough but there wasn't any BM so I went out in the hall to find someone to validate that (Resident #701) was clean. (Licensed Practical Nurse (LPN) C) was walking by. I called out to validate. I opened (Resident #701's) brief and showed no BM. (LPN C) said they looked clean. When asked if the Resident told them they were being rough when cleaning them, Nursing Assistant A replied, No. When queried if anything else unusual occurred while providing care to the Resident, Nursing Assistant A indicated it had not. When asked if they had hit the Resident during care, Nursing Assistant A replied, Not me, no. An interview was conducted with Social Services Director D on 7/30/20 at 1:30 PM. When queried if they were the Social Services staff member assigned to Resident #701, Social Services Director D indicated they were. When queried regarding the Resident, Social Services Director D stated, (Resident #701) is a nice person to talk to. When asked about the Resident's psychosocial history and current concerns, Social Services Director D replied, Yes, depression. Social Services Director D was then asked if Resident #701 was followed by psychiatric services and replied, Yes. When queried if they interviewed the Resident following the abuse allegation on 7/25/20, Social Services Director replied, Yes. When queried why their interview was not included in the provided facility investigation, Social Services Director D was unable to provide an explanation. Social Services D then reviewed the facility provided investigation documentation and confirmed the investigation did not include a statement from Resident #701 detailing the incident. Social Services Director D then stated, I was just there with the Resident when the police interviewed them. When asked about the interview, Social Services Director D stated, (Resident #701) said they told the CNA to wipe them and they didn't feel they were wiped well. (Resident #701) said the CNA hit them on their left thigh. When queried if they conducted an assessment of the Resident's psychosocial status and well-being following the incident, Social Services Director D indicated they had. When asked why there was not an assessment in Resident #701's Electronic Medical Record (EMR), Social Services Director D indicated they documented under Psychosocial Notes. Social Services Director D was then asked if they found any concerns during their assessment and replied, No. When queried regarding Resident #701's verbalization of fear related to being in the facility following the incident, Social Services Director D revealed they were unaware Resident #701 was fearful. At 1:40 PM on 7/30/20, an interview was conducted with Resident #701 and Social Services Director D in the Resident's room. When asked, Resident #701 indicated they knew who Social Services Director D was but was unable to recall their name. Resident #701 was then asked if they told Social Services Director D that they did not feel safe within the facility and Resident #701 stated, Yes. Social Services Director D stated to the Resident, No, you did not and Resident #701 replied, Well then it was the DON (Director of Nursing). I told someone. Social Services Director D did not ask Resident #701 any further questions regarding their concerns prior to exiting the room. After exiting the room, Social Services Director D was interviewed further regarding Resident #701 on 7/30/20 at 1:50 PM. Social Services Director D's EMR documentation was reviewed at this time. When asked what psychosocial support was provided as described in the documentation, Social Services Director D did not provide a response. Social Services Director D was then asked what questions they asked Resident #701 to determine the Resident was doing okay and that they felt safe in the facility as documented in the EMR and Social Services Director D replied, I asked them how they were doing. No further explanation was provided. When queried if they had completed any type of formalized assessment with Resident #701 following the incident, Social Services Director D replied, No. When asked if completion of an assessment is included in facility policy/procedure, Social Services Director D indicated it was not. An interview was completed with Police Officer B on 7/30/20 at 3:00 PM. When queried regarding the incident concerning Resident #701 on 7/25/20, Police Officer B revealed they responded to the facility. When asked what had occurred, Police Office B stated, It sounded like the Nursing Assistant was rough with (Resident #701) when providing care. With further inquiry, Police Officer B revealed Resident #701 had told (Nursing Assistant A) they were being rough and then (Nursing Assistant A) got mad and hit (the Resident) in the leg. An interview was conducted with LPN C on 7/30/20 at 3:10 PM. When queried if they were working on the 300 hall of the facility on 7/25/20, LPN C stated, No. When asked if they were involved with Resident #701's care on that day, LPN C stated, I was walking in the hallway when the CNA asked me to come into the room. When queried what occurred in the room, LPN C replied, The Resident was upset and screaming. (Nursing Assistant A) opened (Resident #701's) brief to show me (the Resident) was clean. Even though (Resident #701) was clean, (Nursing Assistant A) wiped (the

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	235332	A. BUILDING _____ B. WING _____	07/30/2020

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) Resident) again. When asked what occurred next, LPN C revealed they left the Resident's room. When asked if Nursing Assistant A was still in the room when they exited the room, LPN C stated, Yes. LPN C was asked how long Nursing Assistant A was in the Resident's room after they left the room and stated, Shortly after. LPN C was unable to provide an estimated length of time. On 7/30/20 at 3:32 PM, the Administrator was queried regarding the provided investigation documentation not including a statement from Resident #701. The Administrator provided a statement at this time and indicated it was in their office. Resident #701's statement was provided at this time. The statement was not signed by the Resident. An interview was conducted with Nurse J on 7/30/20 at 4:10 PM. When queried if they were aware of an incident involving Resident #701 on 7/25/20, Nurse J revealed they had worked on that date but were not involved in the Resident's care. When asked if anything out of the usual had occurred, Nurse J stated, We were really short staffed. There were only two aides for 45 Residents. With further inquiry, Nurse J revealed the Residents on the Third Bay of the facility are high acuity and require additional staff to meet their needs. When asked how many Nursing Assistants and nurses typically work on the unit, Nurse J replied, Should be at least three but four is optimal. When queried if they worked with and observed Nursing Assistant A provide care to Residents, Nurse J indicated they had. When queried regarding their observations of Nursing Assistant A's interactions with Residents and stated, I have noticed (Nursing Assistant A) can be short and abrupt. Rude- not the ideal bedside manner. When asked what they meant, Nurse J stated, Kind of witchy, impatient, rushed. Seems irritated when they have to do the care. I don't understand that- that is what we are here for. When queried if they were interviewed regarding the incident by the facility, Nurse J indicated they were. When asked if they had disclosed their observations of Nursing Assistant A during the interview, Nurse J revealed they did not because they were not asked about the Nursing Assistant and/or Resident #701. An interview was conducted with the Director of Nursing (DON) on 7/30/20 at 4:45 PM. When queried about Resident #701's allegation and the investigation completed by the facility, the DON indicated the allegation was unable to be substantiated. When queried regarding the length of time Nursing Assistant A was in the room with Resident #701, the DON revealed they did not know a time frame. When asked if there were cameras present in the facility and if the camera footage was reviewed, the DON replied, No cameras. When queried regarding assessment of Resident #701's emotional and psychosocial well-being following the incident including the Resident's statement of being fearful and interview with the facility Social Services Director, the DON indicated they did see a concern with the investigation. When queried regarding staff statements pertaining to observations of Nursing Assistant A, the DON stated, I have not seen that. When asked if verbal abuse concerns were addressed in the investigation, the DON indicated the allegation was related to physical abuse. When queried if concerns would have been uncovered with additional investigation and open-ended questions, the DON did not provide further explanation. When queried if staffing levels on 7/25/20 were sufficient to provide care, the DON indicated there were four staff (two nursing assistants and two nurses) for 45 Residents. When asked about facility staff rushing while providing care, the DON stated, It (incident involving Resident #701) was right at the end of the shift. They were probably trying to get out of there. When asked if staffing levels were considered in the facility investigation, the DON revealed they were not. When asked, the DON denied a potential correlation with staffing levels, rushed care, and Resident perception of care. Review of Nursing Assistant A's personnel file revealed the employee had received an Employee Discipline Form on 7/16/20. The form revealed, Job Performance/Behavior Deficiency: On the date of 7/16/20, staff had double briefed residents . Specific Results Required for Acceptable Improvement: Staff are to check/change Residents every two hours or as needed . An interview was conducted with the Administrator at 17:05 PM on 7/30/20. When queried regarding Resident #701's and staff statements related to observations of care by Nursing Assistant A, the Administrator indicated they were unaware of any concerns. Review of facility policy/procedure entitled, Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property (Dated 11/28/17) revealed, It is the practice of the facility to encourage and support all residents, staff, families, visitors, volunteers and resident representatives in reporting any suspected acts of abuse . Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. Abuse includes verbal abuse . physical abuse and mental abuse . Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm . Investigation of abuse: When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include: i. Who was involved ii. Residents' statements a. For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings. iii. Resident's roommate statements (if applicable) iv. Involved staff and witness statements of events v. A description of the resident's behavior and environment at the time of the incident vi. Injuries present including a resident assessment vii. Observation of resident and staff behaviors during the investigation viii. Environmental considerations .
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake numbers MI 992. Based on interview and record review the facility failed to provide sufficient Activity of Daily Living (ADL) care to meet the medical, physical, and psychosocial needs of the residents affecting two sampled residents (R703 and 704) and one confidential resident (CR#1) of three residents reviewed for ADL care with the likelihood of a lack of timely incontinence care and overall resident verbalization of dissatisfaction with care. Findings include: CR#1 On 07/30/2020 at 11:38 AM, CR#1 was interviewed regarding the care at the facility and stated, The care is so-so, there isn't enough help. There are only two aides for this hall and some times they pull one leaving one, of course they don't tell you, but you can tell when you see the nurse more often than the aide. When there are only two aides we wait over 30 minutes for the call light to be answered and sometimes we wait an hour, especially at night. We don't get our showers when there are only two aides. Record review of CR#1's Electronic Health Record (EHR) revealed CR#1 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent Minimum Data Set ((MDS) dated [DATE] revealed CR#1 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicating an intact cognition and needed extensive assistance with personal hygiene and was totally dependent on staff for toileting. Review of CR#1's task form for bathing for the last 30 days revealed CR#1 received a shower on 07/11 and 07/20/2020. R703 On 07/30/2020 at 11:56 AM, R703 was interviewed regarding the care and stated, I've been here over two months and got no therapy, I had to teach myself to walk because I was crapping my pants. If you call for help and you need to go to the bathroom real bad it takes hours and if you are on the bed pan, it takes hours for them to come back to take it away. Then they come by with a wet towel and wipe you off. I've had one shower in the two months that I've been here. I need a shave. They don't help you do any thing. Record review of R703's EHR revealed R703 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS dated , 06/10/2020 revealed R703 had an intact cognition and needed extensive assistance with ADLs including toileting and personal hygiene. Review of R703's task form for bathing for the last 30 days revealed R703 had showers documented on 07/07, 07/10, and 07/21/2020. No bed baths were documented. R704. On 07/30/20 at 7:45 AM, R704's confidential complainant's allegations were reviewed and revealed, The facility failed to give the resident showers and the resident is left on the commode for extended periods of time. Record review of R704's EHR revealed R704 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. The most recent MDS dated , 05/23/2020 revealed R704 had an intact cognition and needed extensive assistance with ADLs including toileting and personal hygiene. R704 was discharged from the facility on 07/28/2020. Review of R704's task form for bathing for the last 30 days revealed R704 had showers documented on 07/03, 07/13, 07/17, 07/20, and 07/24/2020. One bed bath was documented on 07/16/2020. On 07/30/20 at 11:50 AM, Certified Nurses Aide (CNA F) was interviewed regarding staffing assignments at the facility and stated, Today I only have 11 residents because there are five of us, but 11 residents is still a lot. Last weekend I had rooms 24 to 40 because there was only two of us. And when there are only two of us there's no way we can give the showers, pass the trays, feed the residents and then pick up the trays. It's hard to answer a call light on time when you are in a room helping another room. On 09 07/30/20 at 4:08 PM, a Resident who wished to remain anonymous (CR#2) stopped the surveyor and stated, We wait and wait 1 1/2 hours any time of the day. CR#1 was asked about hygiene and stated, I can do a lot for myself. I haven't had

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 5) a shower and they don't even offer showers. They have not changed my linen in three weeks and my roomy went home a couple of weeks ago and they have not cleaned yet.: CR#2npoints to a bed with the linen still in place and a brown stain on the fitted sheet. On 07/30/20 at 4:18 PM, CNA G was interviewed regarding the staffing assignments at the facility and stated, When you have 15 to 27 residents you can't give all of the showers and answer lights. I'd like to sit and talk with them but I can't. On 07/30/20 at 4:40 PM, the Director of Nursing (DON) was interviewed regarding the facility's policy and procedure regarding call light response time and the showering of the residents and stated, The call lights should be answered in five minutes, 10 minutes at the most and the resident's should get two showers a week and they can ask for more. Review of the facility's staffing assignments revealed, on 07/17/2020 the midnight shift two CNAs on unit three were assigned to care for 43 residents. On 07/17/2020, the the afternoon shift, on unit three had two CNAs assigned to care for 43 residents. The day shift CNAs on unit three on 07/19/2020 to care for 43 residents.