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 _____	07/21/2020

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

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake MI 982, MI 162, and MI 309 Based on observation, interview and record review the facility failed to promptly notify the Durable Power of Attorney for Healthcare (DPOA) in a change in condition for two residents (Resident #11 and Resident #14) and inform legal guardian of a room change for Resident #13, resulting in family and legal agents not being aware of residents location within the facility and medical status. Findings Include: Resident 11 According to the clinical record, including the Minimum Data Set ((MDS) dated [DATE]. Resident 11 (R11) was a [AGE] year old male admitted to the facility on [DATE] and expired at the facility on [DATE], His admitting [DIAGNOSES REDACTED]. The MDS reflected R11 scored 1 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status. Further record review reflected R11's spouse was Durable Medical Power of Attorney. The clinical record reflected R11 was running a fever and had been given tested for Covid 19 on [DATE]. The test results returned on [DATE] were positive. There was no documentation from that the Durable Power of Attorney or any other person listed on R11's information sheet was contacted with the positive result. An entry in the Nurses notes dated [DATE] authored by former Director of Nursing J revealed she had a conversation with the family whom was angry about not being kept up to date or informed of R11's [DIAGNOSES REDACTED]. ADON G was aware and of R11's family not being informed of the change in condition. Somehow he just got missed. A request for the facility policy and procedure of notification of changes was requested at that time. On [DATE] at 8:40 am, during an interview with Administrator A, she reported the family/ DPOA of R11 should have been notified of the test results right after the facility received them. Administrator A offered no explanation for the failure to notify. A second request for the facility policy and procedure of notification of changes was made at that time. Resident 13 According to the clinical record , including the Minimum Data Set ((MDS) dated [DATE], Resident 13 (R13) was an [AGE] year old female admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS reflected R13 had long and short term memory impairment and severely impaired decision making skills. further review of the clinical record reflected R 13 had a legal guardian in place. On [DATE] at 9:05 am, during a confidential phone interview with family member H it was reported that R13 has had room changes without informing the guardian. Review of the clinical record reflected R13 had room change on [DATE] to room [ROOM NUMBER]-C, and another room change on [DATE] to room [ROOM NUMBER]-C. Review of the clinical record did not reflect documentation that the legal guardian was informed of the room changes. On [DATE] at 5:30 PM during an interview with the facility Social Worker (SW) F, she reported the Social Work Department was responsible for issuing notification of room changes to family's/guardians. When queried why there was no notification in R13's clinical record, SW F went through the record during the interview and reported the facility had 2 Social Workers , the other Social Worker resigned, and she only works Wednesday evening and Saturday. SW F reported due to the vloume of room changes related to Covid 19 and her limited time spent if the facility, she could not keep up with the work load of notifying families. Resident #14 (R14) Review of the Resident Profile revealed R14 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] revealed R14 scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS). The Resident Profile listed R14's son as her emergency contact. Review of the Physician Determination of Decision Making Capability revealed that in 2017, two physicians deemed R14 incompetent to make her own medical decisions. Review of the Infection Note dated [DATE] revealed R14 was tested for COVID-19 due to temperatures of 99 and 100 degrees Fahrenheit. There was no documentation that R14's son was made aware of the need for testing. Review of the [DIAGNOSES REDACTED]-CoV2 (COVID-19) test results dated [DATE] and faxed to the facility on [DATE] at 10:02 AM, revealed R14 tested positive. There was no documentation in the medical record that R14's son was notified of the change in condition. In a telephone interview on [DATE] at 3:49 PM, Registered Nurse (RN) E reported notification of changes should be documented in the progress notes. RN E reported she did not see where R14's son was notified that R14 tested positive for COVID-19. In an interview on [DATE] at 12:10 PM, Nursing Home Administrator (NHA) A reported notification of changes were documented in progress notes. NHA A reported if a resident was deemed incompetent, their legal representative/emergency contact should be notified of changes in condition.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** This citation is related to Intake MI 922 Based on interview and record review the facility failed to implement and operationalize its abuse policy and procedure for Resident #8, resulting in an allegation of abuse that was not reported to the State Agency timely, not thoroughly investigated and the potential for further allegations of abuse to go unreported Findings Include: On 7/15/20 at 8:30 AM, Resident #8 (R8) indicated during interview that she was not receiving snacks as her physician ordered and she was concerned because she was a diabetic. The Activities Director (AD D) was interviewed on 7/16/20 at 11:18 AM, and queried about concerns residents complained of. AD D revealed that some of the resident's stated they were feeling neglected by Certified Nursing Assistants (CNA's) in May 2020, however she did not document the concerns/grievances on a form. AD D revealed, One lady was crying, and said whenever she needs someone to help her no one comes in to help her, and because the facility was so understaffed, things are a little rough for everyone. When asked who was the resident, RD D revealed Resident #8 (R8). When asked if she had reported the allegation to the Administrator or talked to anyone else about R8's concerns AD D replied, No, I know I probably should have but no. AD D revealed she had received abuse training but did not document R8's allegation of abuse on a concern/grievance form. Once the interview was completed AD D went to report the allegation of abuse to the facility's Administrator (ADM A), after survey discovery. The facility's November 2017 Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy reflected: Purpose: 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, neglect, exploitation, involuntary seclusion or misappropriate of resident property from abuse, neglect, misappropriation of resident property, and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. a. 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, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual mush have acted deliberately, not that the individual must have intended to inflict injury

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 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) or harm. Neglect was defined as: the failure of the facility, its 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. It is the policy of the Facility that each resident will be free from Abuse. Abuse can include verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion. The resident will also be free form physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. Additionally, residents will be protected from abuse, neglect and harm while they are residing at the facility. No abuse or harm of any type will be tolerated, and residents and staff will be monitored for Protection. The facility will strive to educate staff and other applicable individual in techniques to protect all parties. OBJECTIVE OF ABUSE POLICY The objective of the abuse policy is to comply with the seven-step approach to abuse and neglect detection and prevention. The abuse policy will be reviewed on an annual basis or more frequently and will be integrated into the facility Quality Assurance and Performance improvement (QAPI) program. OVERVIEW OF SEVEN COMPONENTS Screening, Training, Prevention, Identification, Investigation, Protection and Reporting and Response. Multiple of the above components were not implemented after R8's allegation complaint to RD D. G. REPORTING AND RESPONSE ABUSE POLICY REQUIREMENTS: It is the policy of this facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of crime against a resident in the facility.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** This citation is related to Intake MI 922 Based on interview and record review the facility failed to immediately report an allegation of abuse for Resident #8, resulting in allegation of abuse that was not reported to the Nursing Home Administrator and the State Agency timely and the potential for on-going exposure to abuse, further allegations of abuse to go unreported, and not thoroughly investigated Findings Include: On 7/15/20 at 8:30 AM, Resident #8 (R8) indicated during interview that she was not receiving snacks as her physician ordered and she was concerned because she was a diabetic. R8 stated she complains to the staff and nothing is ever done to help her. The Activities Director (AD D) was interviewed on 7/16/20 at 11:18 AM, and queried about concerns residents complained of. AD D revealed that some of the resident's stated they were feeling neglected by Certified Nursing Assistants (CNA's) in May 2020, however she did not document the concerns/grievances on a form. AD D revealed, One lady was crying, and said whenever she needs someone to help her no one comes in to help her, and because the facility was so understaffed, things are a little rough for everyone. When asked who was the resident, RD D revealed Resident #8 (R8). When asked if she had reported the allegation to the Administrator or talked to anyone else about R8's concerns AD D replied, No, I know I probably should have but no. AD D revealed she had received abuse training but did not document R8's allegation of abuse on a concern/grievance form. Once the interview was completed AD D went to report the allegation of abuse to the facility's Administrator (ADM A), after survey discovery. The facility's November 2017 Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property policy reflected Abuse as: a. 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, sexual abuse, physical abuse and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual mush have acted deliberately, not that the individual must have intended to inflict injury or harm. Neglect was defined as: the failure of the facility, its 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. G. REPORTING AND RESPONSE ABUSE POLICY REQUIREMENTS: It is the policy of this facility that abuse allegations (abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of property) are reported per Federal and State Law. The facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later that 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. In addition, local law enforcement will be notified of any reasonable suspicion of crime against a resident in the facility.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to Intakes: MI 575, MI 084, MI 927, MI 370, MI 778, MI 955 and MI 035 Based on observation, interview and record review the facility failed to follow the plan of care for 6 sampled residents (Resident #4, Resident #9, Resident #12, Resident #16, Resident #20 and Resident #23) resulting in, delayed call light response for assistance, missed/omitted bed baths/showers, missed/omitted wound dressing changes, soiled clothing, untimely cleaned and unavailable clean clothing, soiled linen, untimely clean linen changes, soiled briefs with delay in changing, malodorous smells, poor body image, being upset, feelings of anger/humiliation/terribleness/being scared, embarrassment to a reasonable person and the potential for infections. Findings Include: Resident #4 (R4) The Electronic Medical Record (EMR) reviewed on 7/15/12 at 12:49 PM reflected R4 was admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. R4's admission Minimum Data Set (MDS: resident assessment tool) with an Assessment Reference Date (ARD) of 4/3/20 reflected R4 was cognitively intact, required total to extensive assistance of 2 persons for bed mobility, toilet use, hygiene, and bathing, impairment on one of her lower extremity and that she was frequently incontinent of bowel/bladder. During a phone interview on 7/17/20 at 8:33 AM R4 revealed while a resident, there were two times when neither the day or afternoon nursing shift changed her brief. R4 revealed a male nurse (whose name she could not recall) reported to work at around 11:00 PM, but was unable to change her until 1:00 AM. The male nurse had another nursing staff person from a different floor come to help him change her. R4 commented that the facility would be very short staffed, with normally 2 aides (Certified Nursing Assistants = CNA's) and one nurse at night-time. However, at times staffing went down to 1 nurse and 1 CNA for the whole hall. R4 revealed when she would push her call light, it would be on for 2 hours at a time, someone would come in and turn it off, say they would come back and never return. When asked how did that make her feel R4 replied, Terrible. Also that, meals would be served at 7:00 PM for dinner routinely, dinner and all the meals were always late. R4 revealed she would be hungry while waiting, and on top of that the food would be cold but what could she do. When asked about snacks R4 revealed, No, I was barely given snacks. For the 6 weeks she was at the facility, she received snacks twice by agency staff and that none of the facility staff gave her snacks. She was told there were none, and that they were out of stuff. R4 stated, I wanted the snacks, which would have helped being that the meals were served late. The bowel incontinence care plan for R4, reflected it was not initiated until 4/20/20 (the MDS dated [DATE] reflected frequently incontinence of bowel/bladder) with interventions that reflected: -Observe pattern of incontinence, and initiate toileting schedule if indicated. -Provide pericare after each incontinent episode The Activities of Daily Living (ADL) care plan initiated on 3/28/20 interventions reflected: -The resident is totally dependent on staff for repositioning and turning in bed and as necessary. -The resident is totally dependent on staff for dressing The Urinary Tract Infection [MEDICAL CONDITION] policy initiated on on 3/28/20

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) reflected R4 had a concern related to incontinence, immobility and [MEDICAL CONDITION]. Interventions included: -Monitor/document/report to medical doctor as needed for signs/symptoms of UTI: Frequency, urgency, malaise, foul smelling urine, dysuria, fever, nausea and vomiting, flank pain, supra-pubic pain, hematuria, cloudy urine, altered mental status, loss of appetite, behavioral changes. The nutritional care care initiated on 4/8/20 reflected as interventions: -Provide and serve diet as ordered -Provide snacks as scheduled and PRN (as needed) R4 also revealed there were a couple of times her dressings did not get changed when they were supposed to. The dressings were not changed about two times, but no more than three times, some staff were rough when assisting to change dressings, and that she would not refuse to have her dressings change for the entire day. The impairment of skin integrity care plan for R4 initiated on 3/27/20 reflected the following interventions: -Evaluate resident for S/SX (Signs/Symptoms) of possible infections. -Resident prefers wound care completed along with ADL care. R4's March 2020 Treatment Administration Record (TAR) reflected the following orders: 1. Wound Care: (L) Posterior Leg Cleanse with Dakin's soaked gauze, Gently pack Dakin's soaked gauze and cover with ABD pads every day (QD) shift for Wound Care -Order Date- 03/30/2020 1:22 PM -D/C Date- 04/22/2020 9:20 AM. The March 2020 TAR reflected the treatments were not administered on: 3/31/20 day shift. 2. Cleanse with NS (Normal Saline) or wound cleanser to skin folds, right mid lateral thigh, and back daily and apply barrier cream to all skin folds every shift (day, pm, night) for skin intertriginous (skin folds and back) -Order Date- 03/27/2020 3:05 PM -D/C Date- 04/22/2020 9:20 AM. The March 2020 TAR reflected treatments were not administered on: Day shift on days: 28, 29, 31. PM shift on day 28. The April TAR reflected the following orders: 1. Wound Care: (L) Posterior Leg Cleanse with Dakin's soaked gauze, Gently pack Dakin's soaked gauze and cover with ABD pads every day shift for Wound Care -Order Date- 03/30/2020 1:22 PM -D/C Date- 04/22/2020 9:20 AM. The April 2020 TAR reflected treatments were not administered on: Day shift on days: 2, 3, 6, 7, 8, 9, 10, 14 and 21. 2. Cleanse with NS or wound cleanser to skin folds, right mid lateral thigh, and back daily and apply barrier cream to all skin folds every shift for skin intertriginous (skin folds and back) -Order Date- 03/27/2020 3:05 PM -D/C Date- 04/22/2020 9:20 AM. The April 2020 TAR reflected treatments were not administered on: Days shift on days: 2, 3, 8, 9, 10 PM shift on day 18 Night shift on days: 3, 5, 11, 15 and 19 No notes were available or provided during the survey and/or prior to exit on the TARS or progress notes, reflecting reasoning for missed administrations of wound treatments. Resident #9 (R9) On 7/17/20 at 11:03 AM the EMR reflected R9 was re-admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. R9's quarterly MDS with an ARD date of 4/24/20 reflected he was cognitively intact, required extensive to total assistance of 1 person for bed mobility, transfers, dressing, toilet use, hygiene/bathing, impaired on one side of the lower extremity and frequently had moderate pain. During a phone interview on 7/17/20 at 12:07 PM R9 revealed, staff did not come when his call light was activated. Nursing staff would close his door, the light would stay on, he would have to wait for about an hour for assistance and his request were mostly for pain medication because his legs would be hurting. R4 revealed his pain would be about an 8, because of swelling, numbing and throbbing pain. The Affirm Health 2020 on-line health educational reference reflected, pain score 0-10 numerical rating 8 as severe utterly horrible pain. The pain care plan for R9 initiated on 1/9/20 reflected the focus as: The resident has actual acute pain related to surgical procedures status [REDACTED]. -provide the resident and family with information abut pain and options available for pain management. Discuss and record preferences. Resident #12 (R12) During a phone interview on 7/17/20 at 9:27 AM R12 revealed that his bed linen was not changed regularly. You would have to complain for linen change, they would offer to change them when I was relaxing, but that was not a good time. Some staff would say they did not do beds and did not change sheets. The EMR reflected R12 was re-admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. R12's admission MDS with an ARD date of 3/7/20 reflected R12 was cognitively intact, required limited to extensive assistance of 1 person for bed mobility and bathing, required supervision of 1 person for transfers, dressing and hygiene, and was occasionally incontinent of his bowel/bladder. The pain care plan for R12 initiated on 3/3/20 reflected the focus as: The resident has actual acute pain related to [MEDICAL CONDITION] and wounds. Interventions included: -anticipate the resident's need for pain relief and respond immediately to any complain of pain. -monitor/record/report to nurse any signs/symptoms of non-verbal pain. R12 also revealed on 7/17/20 at 09:27 AM that, The facility was clustered, Corona had just set in and they were understaffed and overworked. The facility was not ready. I had a leg ulcer on my left leg, I have diabetes and had [MEDICAL CONDITION] near my Achilles on the right leg. The left leg ulcer, I had before I was admitted . They did not change my wounds regularly. My dressings at first were to be changed every other day, then it was changed to daily. They would change it every 3, 5 or every 6th day at a time. My dressings did not look good, you could see the infection on them, the dressings would be yellow and brown. A few times it had a smell because it wasn't changed regularly. Nurses would give excuses as to why it was not done, like the nurse before or after them should have changed it. I felt very irritated. The longer the wounds sat the more infected they got. The previous Director Of Nursing (DON) would verbalize the dressings should have been changed. R12's Intravenous (IV) antibiotics related to wound infection care plan initiated on 3/3/20 reflected the following intervention: -IV flushes and dressing changes per orders. R12's impairment of skin integrity care plan initiated on 3/3/20 reflected the following interventions: -Evaluate and treat per physicians orders. -Evaluate resident for S/SX of possible infections. -Monitor/document location, size and treatment of [REDACTED]. -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth type of tissue and exudate and any other notable changes or observations. The May 2020 TAR reflected the following orders: 1. Wound Care: (L) medial Ankle Cleanse, (L) medial Ankle, cover open area with 4 X 4, wrap with [MEDICATION NAME] QOD (every other day) every day shift every other day for Wound Care: (L) medial Ankle -Order Date- 04/29/2020 3:03 PM -D/C Date- 05/18/2020 9:04 AM. According to the TAR the treatments were not administered on days: 10, 12 and 14. 2. Wound Care: (R) Posterior Ankle Cleanse, ,(R) Posterior Ankle cover open area with Collagen, protect with 4 X 4, wrap with [MEDICATION NAME] QOD every day shift every other day for (R) Posterior Ankle -Order Date- 04/29/2020 3:04 PM -D/C Date- 05/18/2020 9:04 AM. According to the TAR the treatments were not administered on days: 10, 12 and 14. No notes were available or provided during the survey and/or prior to exit on the TARS or progress notes, reflecting reasoning for missed administrations of wound treatments. Resident #16 (R16) The EMR on 7/15/20 at 09:56 AM reflected R16 had been recently re-admitted to the facility on [DATE] (returned from hospital). Her most recent significant change MDS with an ARD of 5/22/20 reflected R4 was severely cognitively impaired, required extensive to total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toilet use, hygiene, bathing and was that she was always incontinent of bowel/bladder. On 7/15/20 at 11:21 AM R16 was observed walking in the hall independently towards the nursing station. R16 was dressed in a gown, brief and fluffy foot coverings (not gripper socks), no staff were visibly observed in the hall where R16 was coming from. Licensed Practical Nurse (LPN V) came out of the nursing station after writer greeted R16, and assisted R16 back to her room. Once in her room writer attempted to ask R16 how was she doing, and R16 replied that her dad and mom were looking for her. The corner of her bathroom was observed to have a pile of soiled clothes on the floor, in front of the bathtub. The ADL care plan for R16 initiated on 11/3/17 reflected as an intervention: -make sure shoes are comfortable and not slippery. The Falls care plan for R16 initiated on 11/6/17 reflected as an intervention: -ensure footwear fits properly. Resident #20 (R20) On 7/14/20 at 1:13 PM R20 was observed in her room. An unused bed pan and urine collection hat was observed on top of her sunflower patterned seat cushion, located on her dresser. R20 was dressed in a gown and was turned to her her left side. A stain was observed on her gown. The EMR reflected R20 was admitted to the facility on [DATE] her [DIAGNOSES REDACTED]. The quarterly MDS with an ARD 6/15/20 reflected R20 was cognitively intact, required supervisory to extensive assistance of 1 person with bed mobility, transfers, dressing, toilet use, hygiene, bathing, had impairment on one side of her upper/lower extremity and was always incontinent of her bowel/bladder. R20 was asked about her frequency of showers. R20 revealed the last shower she had received was on Saturday 7/11/20, she was supposed to get them twice a week, that she was lucky if she got them once a week and prior to 7/11/20 her last shower had been 2 weeks ago. The EMR shower/bathing record reflected R20 had bath preferences of showers 2 times per week and as needed (prn). The shower/bathing record dated 6/18/20 to 7/15/20 reflected: Shower 6/20/20 at 1:22 PM Shower 6/23/20 at 11:29 PM Bed bath 6/29/20 at 2:51 PM All other dates on the shower/bathing record reflected not applicable (N/A). No documentation could be found nor was provided reflecting the reasoning why, and/or that R23 was re-approached for bed baths or showers prior to exit on 7/21/20. When queried how did it make her feel not having a shower for 2 weeks and if she would like to have a gown or clothes on R20 replied, Dirty, and my hair was all matted and I would rather have clothes on. I have new pajamas that are not marked, and I'm afraid to put them on because I might not ever see them again. R20 revealed she did not get a bed bath, that once in a while they (staff) would come bring in a washcloth and wipe her down. This is a poor excuse for a nursing home and I'm not afraid to say that. R20 was observed to not use her left hand, arm or leg when moving about in the bed, and verbalized it was weak. R20 denied staff asked her if she would like to put clothes on. When asked if her brief was changed she revealed, For example, on Saturday 7/11/20 it

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) was 2:00 PM, before they had changed my bed from the night before. My bed was so wet, I thought I was going to float away. The last time I had been changed was Friday 7/10/20 night around 9:00 PM-10:00 PM. They are very lacks on the weekend, you can hardly get any help. R20 revealed her call light wait would be up to 2-3 hours. When asked what was the least amount of time she had to wait for a call light response R20 revealed, there is no least amount, you always have to wait. For example, today they came in and changed me this morning and that's the last I have seen anybody. On 7/15/20 at 10:21 AM R20 was observed in her room dressed in her top and bottom pajamas. R20 revealed she was changed shortly after lunch yesterday 7/14/20, and wasn't changed again until around 9:00 PM. When questioned why she had to wait that long R20 revealed, she had gotten used to it, waiting. She had put her call light on to be changed and had to wait a couple hours, and that they were so short staffed there. When asked how did she know they were short staffed. R20 revealed, You can tell by the amount of time it takes. I asked staff, are you short staffed today? And they say of course we are. Yesterday a girl told me there was only one of them for 44 patients. When asked how did it make her feel having to wait until 9:00 PM on 7/14/20 to be changed R20 replied, At least my bed was not floating. This whole place makes me feel scared. Later the same day at 10:41 AM R20's hard chart was reviewed and her physician's orders [REDACTED]. Bethanecol 5 milligrams (mg) 1 tablet three times a day (tid) for bladder spasms. 6/15/20 U/A & C/S via straight cath stat (immediately) (not completed last week) 6/19/20 [MEDICATION NAME] 150 mg #2 1 tablet every 3 days for yeast infection. [MEDICATION NAME] (antibiotic) 100 mg 1 tablet twice a day (bid) x 7 days. An order dated 7/10/20, reflected R20 was ordered to have a bladder scan every 6 hours if residual >300 cubic centimeters, straight cath x 2 days. [MEDICATION NAME] 100 mg 1 tablet daily was ordered. On 7/21/20 at 1:38 PM R20 revealed she did not have any clothes to put on and had to wear this gown. At 1:41 PM CNA CC entered R20's room and removed her tray. R20 started to complain about not having clean summer clothes. CNA CC revealed she would go down to laundry and check for R20's clothes. When asked if R20 had any clean summer clothes available to put on now CNA CC revealed, No, all she has is long sleeves. CNA CC opened up R20's closet, which were full of only fall and winter clothing. R20 stated, Those are all winter hot clothes. The dressing/grooming care plan initiated 11/8/19 reflected the focus as: Resident has self care deficit in dressing related to left sided weakness and requires assist with dressing. Interventions reflected: -resident dressing and grooming, encourage resident to do some ROM (range of motion) prior to getting dressed. Change from day wear to nightwear daily. Assist in selecting appropriate clothing. The ADL care plan initiated 11/26/20 interventions reflected: -Bathing: prefers showers -Dressing: physical assist -Bathing/Showering: check nail length and trim and clean on bath day as as necessary. Report any changes to the nurse. -Bathing/Showering: the resident needs assistance with showers. Resident #23 (R23) On 7/14/20 at 12:48 PM R23 was observed in his room. A CNA had recently exited his room. R23 revealed that when he hit his call light they (nursing staff) don't come for an hour. Yesterday (7/13/20), I told the nurse I was wet and needed to be changed at breakfast and at lunch. I think she got off at 3:30 PM or 4:00 PM. I did not get changed until 4:00 PM, by the incoming shift. When asked how it made him feel to wait that long to be changed R23 revealed, It made me feel angry and mad. I had been yelling nurse's aide. I was afraid of getting break down. They will tell me they only have 2 CNA's, and one said they were taking care of 24 people. A CNA took my gown at 9:00 PM when I was changed the other night, and did not come back with another gown until 11:30 PM. R23 Revealed he wanted to get up, but nursing staff always say they're short staffed. Also, that he would like to be pushed up/down the hall and look out the window. R23 was queried when was his last shower and revealed, it had been a couple of weeks since he had a shower, because they had not asked him. Also, that his last bed bath was 1-2 weeks ago. They wipe me down with them wipes. On 7/15/20 at 10:28 AM R23's door was closed and upon knocking, nursing staff replied Resident care. Upon entry at 10:29 AM CNA AA was observed giving R23 a bed bath. CNA AA revealed R23 was to get a bed bath twice a week, he was contracted, and did not get showers at all, per his request. The EMR at 10:40 AM reflected R23 was admitted to the facility on [DATE] and readmitted on [DATE]. [DIAGNOSES REDACTED]. The quarterly MDS with an ARD date of 6/5/20 reflected R23 was cognitively intact, required total to extensive assistance of 2 persons for bed mobility, transfers, dressing, toilet use, bathing, extensive assistance of 1 person for eating, hygiene, had bilateral impairment of the upper/lower extremities and was always incontinent of bowel/bladder. The EMR shower/bathing record reflected R23 had bath preferences of bed baths 2 times per week and as needed (prn). The shower/bathing record was dated 6/17/20 to 7/15/20 and reflected: Bed bath 6/17/20 at 3:29 PM done at the exact same time twice Shower 6/24/20 at 3:17 PM and 3:18 PM Bed bath 7/1/20 at 3:18 PM done at the exact same time twice Bed bath 7/8/20 at 3:29 PM Bed bath 7/15/20 at 1:01 PM All other dates on the shower/bathing record reflected not applicable (N/A). No documentation could be found nor was provided reflecting the reasoning why, and/or that R23 was re-approached for bed baths or showers prior to exit on 7/21/20. On 7/14/20 at 12:48 PM R23 also revealed he had a butt sore. On 7/15/20 while receiving a bed bath at 10:28 AM, R23's sacral area was observed to have a dressing on it dated 7/14. The pressure ulcer care plan for R23 initiated on 7/2/20, interventions reflected: -Administer treatments as ordered and monitor for effectiveness. -Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. -Follow facility policies/protocols for the prevention/treatment of [REDACTED]. report lose dressing to treatment nurse. The May 2020 TAR reflected the following order: 1. Wound Care: Sacral Stage-4 - Cleanse with Daken's soaked gauze, pack with Daken's soaked gauze and cover with Border Foam QD every day shift for Wound Care: Sacral Stage-4 -Order Date- 05/12/2020 5:06 PM According to TAR the treatments were not administered on days: 17, 18, 19, 22, 24, 27 and 30. The June 2020 TAR reflected the following order: 1. Wound Care: Sacral Stage-4 - Cleanse with Daken's soaked gauze, pack with Daken's soaked gauze and cover with Border Foam QD every day shift for Wound Care: Sacral Stage-4 -Order Date- 05/12/2020 5:06 PM According to TAR the treatments were not administered on days: 9, 11, 13, 16, 18, 23 and 30. The July 2020 TAR reflected the following order: 1. Wound Care: Sacral Stage-4 - Cleanse with Daken's soaked gauze, pack with Daken's soaked gauze and cover with Border Foam QD every day shift for Wound Care: Sacral Stage-4 -Order Date- 05/12/2020 5:06 PM According to TAR the treatments were not administered on days: 2, 3, 4, 7, 9, 12 and 13. No notes were available or provided during the survey and/or prior to exit on the TARS or progress notes, reflecting reasoning for missed administrations of wound treatments. During the survey 7/14/20 to 7/21/20 when questioned via phone interview about staffing, anonymous Staff R revealed the facility was very short staffed with mostly 2 CNA's per floor, averaged about 2 CNA's for 44 residents on the afternoon/night time shifts, she/he was unable to answer call lights timely, No, barely can give bed baths/showers, there was a lot going on, other residents complain that neighboring residents aren't changed properly/frequently, dinner cart comes up around 5:00 PM -5:30 PM but not passed out until around 8:00 PM, only those with their names on them get snacks and that all residents do not get snacks. The ADL care plan dated 2/26/20 for R23 reflected a focus of: The resident has actual ADL deficit related to [DIAGNOSES REDACTED]. -Bathing: 2 x weekly bed-bath as tolerated -Dressing: The resident is totally dependent on 1 staff for dressing. -Personal Hygiene/Oral Care: The resident is totally dependent on 1 staff for personal hygiene and oral care.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 is related to Intakes MI 095, MI 575, MI 927, MI 084, MI 778, MI 955, MI 370 and MI 084. Based on observation, interview and record review the facility failed to provide Activities of Daily Living (ADL) assistance for 7 sampled residents (Resident #2, Resident #4, Resident #9, Resident #12, Resident #16, Resident #20 and Resident #23) and 5 supplemental residents (Resident #25, Resident #26, Resident #27, Resident #28 and Resident #29) resulting in, delayed call light response for assistance, missed/omitted bed baths/showers, soiled personal clothing, unavailable personal clothing, soiled linen not changed timely, soiled briefs, delayed changing of briefs, malodorous smells, poor body image, embarrassment to a reasonable person, being upset and scared, feelings of: anger, humiliation, terribleness and the potential for urinary tract infections. Findings Include: Resident #4 (R4) The Electronic Medical Record (EMR) reviewed on 7/15/12 at 12:49 PM reflected R4 was admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. R4's admission Minimum Data Set (MDS: resident assessment tool) with an Assessment Reference Date (ARD) of 4/3/20 reflected R4 was cognitively intact, required total to extensive assistance of 2 persons for bed mobility, toilet use, hygiene, and bathing, impairment on one of her lower extremity and that she was frequently incontinent of bowel/bladder. During a phone interview on 7/17/20 at 8:33 AM R4 revealed while a resident, there were two times when neither the day or afternoon nursing shift changed her brief. R4 revealed a male nurse (whose name she could not recall) reported to work at around 11:00 PM, but was unable to change her until 1:00 AM. The male nurse had another nursing staff person from a different

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	235503	A. BUILDING _____ B. WING _____	07/21/2020

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.

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) floor come to help him change her. R4 commented that the facility would be very short staffed, with normally 2 aides (Certified Nursing Assistants = CNA's) and one nurse at night-time. However, at times staffing went down to 1 nurse and 1 CNA for the whole hall. R4 revealed when she would push her call light, it would be on for 2 hours at a time, someone would come in and turn it off, say they would come back and never return. When asked how did that make her feel R4 replied, Terrible. Resident #9 (R9) On 7/17/20 at 11:03 AM the EMR reflected R9 was re-admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. R9's quarterly MDS with an ARD date of 4/24/20 reflected he was cognitively intact, required extensive to total assistance of 1 person for bed mobility, transfers, dressing, toilet use, hygiene/bathing, impairment one side of the lower extremity and frequently had moderate pain. During a phone interview on 7/17/20 at 12:07 PM R9 revealed, staff did not come when his call light was activated. Nursing staff would close his door, the light would stay on, he would have to wait for about an hour for assistance and his request were mostly for pain medication because his legs would be hurting. R4 revealed his pain would be about an 8, because of swelling, numbing and throbbing pain. The Affirm Health 2020 on-line health educational reference reflected, pain score 0-10 numerical rating 8 as severe utterly horrible pain. Resident #12 (R12) During a phone interview on 7/17/20 at 9:27 AM R12 revealed that his bed linen was not changed regularly. You would have to complain for linen change, they would offer to change them when I was relaxing, but that was not a good time. Some staff would say they did not do beds and did not change sheets. The EMR reflected R12 was re-admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. R12's admission MDS with an ARD date of 3/7/20 reflected R12 was cognitively intact, required limited to extensive assistance of 1 person for bed mobility and bathing, required supervision of 1 person for transfers, dressing and hygiene, and was occasionally incontinent of his bowel/bladder. Resident #16 (R16) The EMR on 7/15/20 at 09:56 AM reflected R16 had been recently re-admitted to the facility on [DATE] (returned from hospital). Her most recent significant change MDS with an ARD of 5/22/20 reflected R4 was severely cognitively impaired, required extensive to total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toilet use, hygiene, bathing and was that she was always incontinent of bowel/bladder. On 7/15/20 at 11:21 AM R16 was observed walking in the hall independently towards the nursing station. R16 was dressed in a gown, brief and fluffy foot coverings (not gripper socks), no staff were visibly observed in the hall where R16 was coming from. Licensed Practical Nurse (LPN V) came out of the nursing station after writer greeted R16, and assisted R16 back to her room. Once in her room writer attempted to ask R16 how was she doing, and R16 replied that her dad and mom were looking for her. The corner of her bathroom was observed to have a pile of soiled clothes on the floor, in front of the bathtub. Resident #20 (R20) On 7/14/20 at 1:13 PM R20 was observed in her room. An unused bed pan and urine collection hat was observed on top of her sunflower patterned seat cushion, located on her dresser. R20 was dressed in a gown and was turned to her her left side. A stain was observed on her gown. The EMR reflected R20 was admitted to the facility on [DATE] her [DIAGNOSES REDACTED]. The quarterly MDS with an ARD 6/15/20 reflected R20 was cognitively intact, required supervisory to extensive assistance of 1 person with bed mobility, transfers, dressing, toilet use, hygiene, bathing, had impairment on one side of her upper/lower extremity and was always incontinent of her bowel/bladder. R20 was asked about her frequency of showers. R20 revealed the last shower she had received was on Saturday 7/11/20, she was supposed to get them twice a week, that she was lucky if she got them once a week and prior to 7/11/20 her last shower had been 2 weeks ago. The EMR shower/bathing record reflected R20 had bath preferences of showers 2 times per week and as needed (prn). The shower/bathing record dated 6/18/20 to 7/15/20 reflected: Shower 6/20/20 at 1:22 PM Shower 6/23/20 at 11:29 PM Bed bath 6/29/20 at 2:51 PM All other dates on the shower/bathing record reflected not applicable (N/A). No documentation could be found nor was provided reflecting the reasoning why, and/or that R23 was re-approached for bed baths or showers prior to exit on 7/21/20. When queried how did it make her feel not having a shower for 2 weeks and if she would like to have a gown or clothes on R20 replied, Dirty, and my hair was all matted and I would rather have clothes on. I have new pajamas that are not marked, and I'm afraid to put them on because I might not ever see them again. R20 revealed she did not get a bed bath, that once in a while they (staff) would come bring in a washcloth and wipe her down. This is a poor excuse for a nursing home and I'm not afraid to say that. R20 was observed to not use her left hand, arm or leg when moving about in the bed, and verbalized it was weak. R20 denied staff asked her if she would like to put clothes on. When asked if her brief was changed she revealed, For example, on Saturday 7/11/20 it was 2:00 PM, before they had changed my bed from the night before. My bed was so wet, I thought I was going to float away. The last time I had been changed was Friday 7/10/20 night around 9:00 PM-10:00 PM. They are very lacks on the weekend, you can hardly get any help. R20 revealed her call light wait would be up to 2-3 hours. When asked what was the least amount of time she had to wait for a call light response R20 revealed, there is no least amount, you always have to wait. For example, today they came in and changed me this morning and that's the last I have seen anybody. On 7/15/20 at 10:21 AM R20 was observed in her room dressed in her top and bottom pajamas. R20 revealed she was changed shortly after lunch yesterday 7/14/20, and wasn't changed again until around 9:00 PM. When questioned why she had to wait that long R20 revealed, she had gotten used to it, waiting. She had put her call light on to be changed and had to wait a couple hours, and that they were so short staffed there. When asked how did she know they were short staffed. R20 revealed, You can tell by the amount of time it takes. I asked staff, are you short staffed today? And they say of course we are. Yesterday a girl told me there was only one of them for 44 patients. When asked how did it make her feel having to wait until 9:00 PM on 7/14/20 to be changed R20 replied, At least my bed was not floating. This whole place makes me feel scared. Later the same day at 10:41 AM R20's hard chart was reviewed and her physician's orders [REDACTED]. Bethanecol 5 milligrams (mg) 1 tablet three times a day (tid) for bladder spasms. 6/15/20 U/A & C/S via straight cath stat (immediately) (not completed last week) 6/19/20 [MEDICATION NAME] 150 mg #2 1 tablet every 3 days for yeast infection. [MEDICATION NAME] (antibiotic) 100 mg 1 tablet twice a day (bid) x 7 days. An order dated 7/10/20, reflected R20 was ordered to have a bladder scan every 6 hours if residual >300 cubic centimeters, straight cath x 2 days. [MEDICATION NAME] 100 mg 1 tablet daily was ordered. On 7/21/20 at 1:38 PM R20 revealed she did not have any clothes to put on and had to wear this gown. At 1:41 PM CNA CC entered R20's room and removed her tray. R20 started to complain about not having clean summer clothes. CNA CC revealed she would go down to laundry and check for R20's clothes. When asked if R20 had any clean summer clothes available to put on now CNA CC revealed, No, all she has is long sleeves. CNA CC opened up R20's closet, which were full of only fall and winter clothing. R20 stated, Those are all winter hot clothes. Resident #23 (R23) On 7/14/20 at 12:48 PM R23 was observed in his room. A CNA had recently exited his room. R23 revealed that when he hit his call light they (nursing staff) don't come for an hour. Yesterday (7/13/20), I told the nurse I was wet and needed to be changed at breakfast and at lunch. I think she got off at 3:30 PM or 4:00 PM. I did not get changed until 4:00 PM, by the incoming shift. When asked how it made him feel to wait that long to be changed R23 revealed, It made me feel angry and mad. I had been yelling nurse's aide. I was afraid of getting break down. They will tell me they only have 2 CNA's, and one said they were taking care of 24 people. A CNA took my gown at 9:00 PM when I was changed the other night, and did not come back with another gown until 11:30 PM. R23 Revealed he wanted to get up, but nursing staff always say they're short staffed. Also, that he would like to be pushed up/down the hall and look out the window. R23 was queried when was his last shower and revealed, it had been a couple of weeks since he had a shower, because they had not asked him. Also, that his last bed bath was 1-2 weeks ago. They wipe me down with them wipes. On 7/15/20 at 10:28 AM R23's door was closed and upon knocking, nursing staff replied Resident care. Upon entry at 10:29 AM CNA AA was observed giving R23 a bed bath. CNA AA revealed R23 was to get a bed bath twice a week, he was contracted, and did not get showers at all, per his request. The EMR at 10:40 AM reflected R23 was admitted to the facility on [DATE] and readmitted on [DATE]. [DIAGNOSES REDACTED]. The quarterly MDS with an ARD date of 6/5/20 reflected R23 was cognitively intact, required total to extensive assistance of 2 persons for bed mobility, transfers, dressing, toilet use, bathing, extensive assistance of 1 person for eating, hygiene, had bilateral impairment of the upper/lower extremities and was always incontinent of bowel/bladder. The EMR shower/bathing record reflected R23 had bath preferences of bed baths 2 times per week and as needed (prn). The shower/bathing record was dated 6/17/20 to 7/15/20 and reflected: Bed bath 6/17/20 at 3:29 PM done at the exact same time twice Shower 6/24/20 at 3:17 PM and 3:18 PM Bed bath 7/1/20 at 3:18 PM done at the exact same time twice Bed bath 7/8/20 at 3:29 PM Bed bath 7/15/20 at 1:01 PM All other dates on the shower/bathing record reflected not applicable (N/A). No documentation could be found nor was provided reflecting the reasoning why, and/or that R23 was re-approached for bed baths or showers prior to exit on 7/21/20. During the survey 7/14/20 to 7/21/20 when questioned via phone interview about staffing, anonymous Staff R revealed the facility was very short staffed with mostly 2 CNA's per floor, averaged about 2 CNA's for 44 residents on the afternoon/night time shifts, she/he was usable to answer call lights timely, No, barely can give bed baths/showers, there was a lot going on, other residents complain that neighboring residents aren't changed properly/frequently, dinner cart comes up around 5:00 PM -5:30 PM but not passed out until around 8:00 PM, only those with

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 5) their names on them get snacks and that all residents do not get snacks The Activities Director (AD D) was interviewed on 7/16/20 at 11:18 AM and revealed that residents had shared they have been sending their clothes down to laundry, had to wait 1-2 weeks for their laundry to return, they were tired of wearing gowns and that they would rather wear their clothes. AD D revealed she had went down to laundry to retrieve clothes for Resident #25 (R25) that had been there, R25 had been wating 1-2 weeks for them and was really upset. Also, the residents complained of call light response. AD D revealed she would usually tell the nursing staff they (residents) pushed it, they (nursing staff) would say yes I know, and that they were backed up and busy. Resident #26 (R26) had been waiting for 2 weeks to get his clothes back, he was upset and ready to leave this place. The housekeeping director has a lot on his plate. 5-6 people had complained about laundry. Resident #28 (R28) on 7/16/20 at 12:54 PM revealed she was gifted 3 outfits for Mother's Day, she sent 2 of them to laundry, and the other outfit she had never seen. I reported it and it has been going around in a circle. I am very pissed about my clothes. R28 revealed her roommate had a bowel movement and the room smelled like Sh*t, at 5:00 PM she had told CNA BB and was told to hold on and wait a minute. R28 revealed she had asked staff to change 2 of her roommates briefs, no staff had been in her room since 3:00 PM, however they were changed finally. Also, that staff had told her to ask to be changed to another room. R28 revealed, I don't be getting a shower during the week. They are supposed to give us a shower twice week. Some weeks I don't get a shower at all. When I ask about it they will say, it's marked that I had a shower, when I have not had one. Last week I did not get a shower at all. R28 was asked how did that make her feel not getting a shower twice a week and replied, Everyday I'm here, I'm here I'm pissed. I felt stanky and the bed was stanky. When you lay in the bed for a whole week you smell. The linen is only changed when you get a shower pretty much. Most of the time we don't have any clean linen. There are none in the closet, and usually none on first shift. Normally there are only 2 aides (CNA's) on the hall for 46 people and most are feeders (require staff to feed them). Resident #26 (R26) On 7/16/20 at 12:19 PM R26 revealed it had been over a week and half, since he lost his clothing of pajama pants (scrubs), a pair of gray sweat-pants, white socks and that staffing was aware. This is all I got (pointing at himself), I've been wearing the same dirty clothes all the time. That makes me feel like Sh*t, I'm a clean person. R26 revealed staffing was terrible, and that they had agency workers come. When referring to call light response, R26 revealed one could forget that, and that it could stay on for up to 4 hours, they turn the ringer off at the nursing station, no one comes, they are taking patients and don't have services to provide for them. R26 revealed they (facility) only have 2 CNA's on the floor at night and its horrible. Yesterday I was sick at around 4:55 PM, I put on my call light because I had a bowel movement and was told I could not be changed because they had to pass trays. I was yelling for help and got changed at 8:25 PM. On 7/16/20 at 1:25 PM the Director of CNA's (DOC V) when asked what did N/A mean on the EMR shower/bath record. DOC V replied, Well, not applicable. They are not supposed to do that. If they refuse, you asked them 3 times, ask the nurse or have staff switch with you. We have been educating them on that. During the interview with the Director Of Nursing (DON B) on 7/16/20 at 1:52 PM, she revealed that CNA's document in point of care in the point click care EMR system. When asked what did N/A stand for on the shower/bathing record DON B revealed, the term meant not applicable. CNA's could do a clinical alert, and she would have to drill it down (analyze) to find out what it meant in the shower/bath EMR record. The Housekeeping Director (HD M) was interviewed on 7/16/20 at 3:07 PM and revealed when there were concerns with clothing sometimes staff would email him about it or write it down on paper. When asked if he was aware of complaints of missing clothing and/or personal clothing, HD M revealed not to his knowledge. However, that they were currently 2 persons working in laundry: 1 person from 6:00 AM to 2:30 PM and the second staff person worked from 12:00 PM to 8:30 PM. Laundry staff person W was interviewed on 7/16/20 at 3:39 PM and revealed there were issues with residents missing clothes, there once was staff who did residents personal laundry who not longer worked in that position, linens were priority items, clean personal laundry was not always labeled correctly, there was miscommunication, he made a considerable effort to wash personal laundry/hang it/ return it, and it was overwhelming with just 2 staff working in the area. The facility's 2001 ADL policy provided entitled Shower/Tub Bath reflected: Purpose: The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin. Documentation: The following information should be recorded on the resident's ADL record and/or in the resident's medical record: 1. The date and time the shower/tub bath was performed. Reporting: 1. Notify the supervisor if the resident refuses the shower/tub bath. Perineal Care Purpose: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. 1. Review the resident's care plan to assess for any special needs of the resident. Documentation: The following information should be recorded in the resident's medical record. 1. The date and time that perineal care was given. Shampooing Hair Purpose: The purpose of this procedure is to clean the resident's hair and scalp. Resident #2 (R2) Review of the Resident Profile and Minimum Data Set ((MDS) dated [DATE] revealed R2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS revealed R2 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS), required extensive assistance with Activities of Daily Living (ADLs), including bathing and hygiene, and was frequently incontinent of bowel. In an observation and interview on 7/14/20 at 11:48 AM, R2 was observed in his room, seated in a power wheelchair. R2 stated this morning I sat in my poop for three hours and reported lengthy call light response times. On 7/15/20 at 12:20 PM, R2 reported reported he does not always get baths like he should. R2 reported the staff will document that he refused, but R2 reported he never refused baths. Review of R2's ADL Care Plan dated 10/28/19 revealed an intervention dated 6/29/20 that reflected R2 required assistance by 1 staff with preference of bed bath 2 times a week and PRN (as needed). Review of R2's Bath task records revealed bathing preference of bed bath with one person assist 2x/wk and prn. The record was available for a 30 day look back period and included the following documentation for bathing: marked as N/A (not applicable) 6/16/20 bed bath given on 6/18/20 and 6/22/20 marked as N/A on 6/24/20 bed bath given on 6/25/20, 6/29/20, 6/30/20 marked as N/A on 7/1/20 bed bath given on 7/2/20 marked as N/A on 7/4/20, 7/9/20, 7/11/20 bed bath given on 7/13/20 Review of R2's Behavior Symptoms dated 6/16/20 to 7/15/20 revealed no documentation of rejection of care. Review of the Progress Notes revealed no documentation of refusal of baths for the dates N/A was marked. In an interview on 7/16/20 at 1:50 PM, Director of Nursing (DON) B reported N/A (not applicable) could possibly be marked if that specific day was not a resident's scheduled shower/bath day. DON B reported there was not an option to document why the N/A was marked, but reported staff could do a clinical alert. Review of the facility's Shower/Tub Bath Policy dated 2001 and revised 2010 revealed The following information should be recorded on the resident's ADL record and/or in the resident's medical record: 1. The date and time the shower/tub bath was performed .5. If the resident refused the shower/tub bath, the reason(s) why and the intervention taken. On 7/15/20 at 8:27 am, an observation was made in a 3 bed ward on the Covid Unit. Staff members were throwing the linens from a resident's bed on the floor making a large pile that impeded traffic in the room.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to the following intakes: MI 095, MI 814, MI 857, MI 922, MI 943, MI 290, MI 374, MI 575, MI 2955, MI 084. Based on observation, interview and record review, the facility failed to prevent the formation of pressure sores, obtain physician orders for the care of pressure sores and provide wound care as ordered by the attending physician for 8 sampled residents (#s 2, 4, 7, 8, 12, 22, 23, 24) out of 8 residents reviewed for pressure sores resulting in the likelihood that wounds would not receive appropriate or timely care causing a delay in healing. Findings include: Resident #7 (R7) was admitted to the facility on [DATE] with the following Diagnoses: [REDACTED]. In addition, R7 was morbidly obese and weighed 281 pounds. A record review of R7's electronic medical record (EMS) revealed R7 had a Brief Survey for Mental Status (BIMS) score of 15 out of 15 possible points which indicated R7 had no memory issues. R7 was an extensive 2 person assist with activities of daily living. R7 was no longer at the facility during this abbreviated survey. On 7/14/20, a record review of R7's EMR indicated an admission note on 2/8/20 that stated there was redness and weeping to the abdominal folds and peri-area (area between the legs). On 3/23/20, the following progress note documented a newly acquired sacral wound, dark green wound bed, (the wound measured) 2.4 cm X 1.5 cm X 0.6 cm. There is no drainage and the skin around the wound is red. On 7/14/20, a record review of physician's orders in R7's EMR shows an order written [REDACTED]. Apply hydrogel to wound bed and cover with bordered foam dressing daily. On 7/14/20, a record review of R7's progress notes, dated 3/25/20, revealed the following wound note: coccyx 4.0 X 4.3 X 0.1, calcium alginate on wound. On 7/14/20 in an interview with Licensed Practical Nurse (LPN) O, LPN O provided copies of wound information for R7. A record review of the documentation, dated 4/1/20, indicated the wound measured 4.5 X 3.5 X 0.00. The wound was not staged. Resident 8 (R8) R8

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) was admitted on [DATE] with the following Diagnoses: [REDACTED]. According to her BIMS score (15 out of 15 points), R8 was cognitively intact (able to think and make appropriate decisions). In addition, R8 was an extensive 2 person assist with all activities of daily living. On 7/15/20 at 8:30 am, an observation and interview with R8 was done. R8 was in her bed with both legs supported by pillows and the heels of her feet were in mid-air. R8 complained that the staff did not do her wound care on a daily basis as ordered by her physician. She said sometimes no one would change her dressing for a week. On 7/15/20, a record review of physician orders for wound care stated clean with wound care cleaner or soap and water. Pat dry. Dermagenate AG (silver) to wound bed. Cover with sacral bordered gauze. Change daily and PRN (as needed). On 7/15/20 at 10:45 am, an observation of R8's wound care by wound care by LPN O was done. LPN O entered the room and washed her hands with soap and water in the bathroom and put on clean gloves. At the bedside, LPN O raised the head of R8's bed with her gloved hands and then, with the assistance of LPN Y, rolled R8 to her right side with her gloved hands. Prior to removing the dressing over R8's left sacral area, the date on the dressing was noted to be 7/13/20 which meant there had been no dressing change on a daily basis. LPN O removed the dressing and threw it in R8's trash can. LPN O removed her gloves and, without washing her hands, put on a fresh pair of gloves and cleansed the wound with a gauze pad soaked with normal saline. LPN O threw the gauze pad in R8's trash can and removed her gloves. Without washing her hands, LPN O put on a fresh pair of gloves and used a gauze pad to dry the wound. When she removed her gloves, LPN Y leaned over the bed and whispered something to LPN O who then announced she was going to wash her hands in the bathroom. When LPN O went into the bathroom, LPN Y was asked if she had just told LPN O to go and wash her hands. LPN Y hesitated then admitted telling LPN O to go and wash her hands. LPN O returned to the bedside and pulled out a large gauze dressing and told LPN Y that, when a resident is this far along with wound care, they could change the order for dressing the wound as they wanted. LPN O did not over the wound with Dermagenate AG but put a large border dressing over the wound. On 4/16/20 at 2:00 PM, in an interview with Director of Nursing (DON) B, she was informed of the observations made during wound care. DON B indicated LPN O should have washed her hands every time she changed her gloves. On 7/21/20, a record review of the wounds rounds documentation, provided by LPN O, indicated on 3/25/20, the wound on the coccyx measured 4 x 3.5 x 0.00 cms and the wound was not staged (given a number which corresponded with its size). On 4/1/20, the wound measured 4.5 x 3.5 x 0.00 and was not staged. On 4/7/20, the wound measurement was the same size as documented on 4/1/20 and was not staged. No other measurements were provided after 4/7/20. On 7/21/20 at 11:45 am, LPN O was interviewed. The observations of wound care were reviewed with LPN O. LPN O denied that LPN Y told her to wash her hands even though it was witnessed by the surveyor and also denied omitting placing Dermagenate AG to the wound. Resident #22 (R22) R22 was admitted on [DATE] and discharged on [DATE]. His [DIAGNOSES REDACTED]. R22 was no longer living at the facility during this survey. On 7/14/20, a record review of R22's electronic medical record indicated there was a wound care consult done by the local hospital on [DATE] prior to transfer to the facility. According to the wound consult, a wound to the right calf consisted of multiple fluid-filled filled blisters ranging from 3 cm to 10 cm in diameter. The drainage from the right calf was documented as small and yellow. The dressing was a protective barrier and gauze. The left calf had a single fluid filled blister 8 cm in diameter. There was moderate sero-sanguinous (bloody) drainage and was to be covered with a gauze dressing. The right lower back had a 1 cm area of superficial pink skin from moisture associated with skin damage friction, not a pressure injury. Staff using Z Guard barrier cream. The wound plan was as follows: Hydraguard protective cream and apply Z Guard barrier to open skin on right buttock. [MEDICATION NAME] dressing higher on sacrum. On 7/14/20, a record review of R22's EMR revealed an admission note which indicated R22 had wound to his coccyx, and to his right and left legs. A physician note stated the treatment for [REDACTED]. Resident #24 (R24) R24 was admitted to the facility on [DATE] and re-admitted on [DATE] with the following Diagnoses: [REDACTED]. A record review of his BIMS, done on 6/3/20, indicated R24 had a score of 15 out of a possible 15 points indicating he had no problems with thinking or making decisions. On 7/16/20 at 10:30 am, in a interview with a complainant, she stated R24 is not getting wound care as needed. On 7/16/20, a record review of the TAR for R24 revealed the following information: The physician order stated Dermaseptine QS and cover with [MEDICATION NAME] every shift There was no wound care documented to the thigh and testicular area on the following dates: Day shift: 6/6/20, 6/15, 6/16, 6/20, 6/28 Afternoon shift: 6/6, 6/17 Night shift: 6/2, 6/5, 6/9, 6/11, 6/15, 6/19, 6/20, 6/28, 6/29 Physician order: Dermaseptine QS to left buttock, scrotum, thighs, every shift. There is no wound care documented on the following dates: Day shift: 6/6, 6/16, 6/20 Afternoon shift: 6/6, 6/17 Night shift: 6/2, 6/5, 6/9, 6/11, 6/15, 6/19, 6/20, 6/22, 6/28, 6/29 Physician order indicated Calcium alginate to coccyx every day and as needed. There was no wound care documented on 6/6, 6/13, 6/15, 6/16, 6/20, 6/28. Interviews with wound care nurse LPN O and DON B had no explanations for the missing documentation. Resident #4 (R4) The Electronic Medical Record (EMR) review on 7/15/12 at 12:49 PM reflected R4 was admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. R4's admission Minimum Data Set (MDS: resident assessment tool) with an Assessment Reference Date (ARD) of 4/3/20 reflected R4 was cognitively intact, required total to extensive assistance of 2 persons for bed mobility, toilet use, hygiene, bathing, impairment on one of her lower extremity and was frequently incontinent of bowel/bladder. During a phone interview on 7/17/20 at 8:33 AM R4 revealed there were a couple of times her dressings did not get changed when they were supposed to be. R4 revealed the dressings were not changed about two times, but no more than three times, some staff were rough when assisting to change dressings, and that she would not refuse to have her dressings change for the entire day. The impairment of skin integrity care plan for R4 initiated on 3/27/20 reflected the following interventions: -Evaluate resident for S/SX (Signs/Symptoms) of possible infections. -Resident prefers wound care completed along with ADL (Activities of Daily Living) care. R4's March 2020 Treatment Administration Record (TAR) reflected the following orders: 1. Wound Care: (L) Posterior Leg Cleanse with Dakin's soaked gauze, Gently pack Dakin's soaked gauze and cover with ABD pads every day (QD) shift for Wound Care -Order Date- 03/30/2020 1:22 PM -D/C Date- 04/22/2020 9:20 AM The March 2020 TAR reflected the treatments were not administered on: day shift on day 31 2. Cleanse with NS or wound cleanser to skin folds, right mid lateral thigh, and back daily and apply barrier cream to all skin folds every shift (day, pm, night) for skin intertriginous (skin folds and back) -Order Date- 03/27/2020 3:05 PM -D/C Date- 04/22/2020 9:20 AM. The March 2020 TAR reflected the treatments were not administered on: day shift on days 28, 29, 31 pm day 28. The April TAR reflected the following orders: 1. Wound Care: (L) Posterior Leg Cleanse with Dakin's soaked gauze, Gently pack Dakin's soaked gauze and cover with ABD pads every day shift for Wound Care -Order Date- 03/30/2020 1:22 PM -D/C Date- 04/22/2020 9:20 AM. The April 2020 TAR reflected the treatments were not administered on: day shift on days 2, 3, 6, 7, 8, 9, 10, 14 and 21. 2. Cleanse with NS or wound cleanser to skin folds, right mid lateral thigh, and back daily and apply barrier cream to all skin folds every shift for skin intertriginous (skin folds and back) -Order Date- 03/27/2020 3:05 PM -D/C Date- 04/22/2020 9:20 AM. The April 2020 TAR reflected the treatments were not administered on: days shift on days 2, 3, 8, 9, 10 pm on day 18 night shift on days 3, 5, 11, 15 and 19 No notes were available or provided during the survey and/or prior to exit on the TARS or progress notes, reflecting reasoning for missed administrations of skin treatments. Resident #12 (R12) On 7/17/20 at 09:27 AM R12 called and asked describe his time of stay at the facility. R12 revealed, The facility was clustered, Corona had just set in and they were understaffed and overworked. The facility was not ready. I had a leg ulcer on my left leg, I have diabetes and had [MEDICAL CONDITION] near my Achilles on the right leg. The left leg ulcer I had before I was admitted . They did not change my wounds regularly. My dressing at first were to be changed every other day, then it was changed to daily. They would change it every 3, 5 and 6 days at times. My dressings did not look good, you could see the infection on it, the dressings would be yellow and brown. A few times it had a smell because it wasn't changed regularly. Nurses would give excuses as to why it was not done, like the nurse before or after them should have changed it. I felt very irritated. The longer the wounds sat the more infected they got. The Director Of Nursing (DON) would say the dressings should have been changed. May 2020 TAR reflected wholes with treatments not being done. The EMR reflected R12 was re-admitted to the facility on [DATE] and discharged on [DATE]. [DIAGNOSES REDACTED]. R12's admission MDS with an ARD date of 3/7/20 reflected R12 was cognitively intact, required limited to extensive assistance of 1 person for bed mobility and bathing, required supervision of 1 person for transfers, dressing and hygiene, and was occasionally incontinent of his bowel/bladder. R12's Intravenous (IV) antibiotics related to wound infection care plan initiated on 3/3/20 reflected the following intervention: -IV flushes and dressing changes per orders. R12's impairment of skin integrity care plan initiated on 3/3/20 reflected the following interventions: -Evaluate and treat per physicians orders. -Evaluate resident for S/SX of possible infections. -Monitor/document location, size and treatment of [REDACTED]. -Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth type of tissue and exudate and any other notable changes or observations. The May 2020 TAR reflected the following orders:

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F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) 1. Wound Care: (L) medial Ankle Cleanse, (L) medial Ankle, cover open area with 4 X 4, wrap with [MEDICATION NAME] QOD (every other day) every day shift every other day for Wound Care: (L) medial Ankle -Order Date- 04/29/2020 3:03 PM -D/C Date- 05/18/2020 9:04 AM. According to the TAR the treatments were not administered on days 10, 12 and 14. 2. Wound Care: (R) Posterior Ankle Cleanse, ,(R) Posterior Ankle cover open area with Collagen, protect with 4 X 4, wrap with [MEDICATION NAME] QOD every day shift every other day for (R) Posterior Ankle -Order Date- 04/29/2020 3:04 PM -D/C Date- 05/18/2020 9:04 AM. According to the TAR the treatments were not administered on days 10, 12 and 14. No notes were available or provided during the survey and/or prior to exit on the TARS or progress notes, reflecting reasoning for missed administrations of skin treatments. Resident #23 (R23) On 7/14/20 at 12:48 PM R23 was observed in his room. R23 revealed he had a butt sore. On 7/15/20 while receiving a bed bath at 10:28 AM, R23's sacral area was observed to have a dressing on it dated 7/14. The EMR on 7/15/20 at 10:40 AM reflected R23 was admitted to the facility on [DATE] and readmitted on [DATE]. [DIAGNOSES REDACTED]. The quarterly MDS with an ARD date of 6/5/20 reflected R23 was cognitively intact, required total to extensive assistance of 2 persons for bed mobility, transfers, dressing, toilet use, bathing, extensive assistance of 1 person for eating, hygiene, had bilateral impairment of the upper/lower extremities and was always incontinent of bowel/bladder. The pressure ulcer care plan for R23 initiated on 7/2/20 interventions reflected: -Administer treatments as ordered and monitor for effectiveness. -Assess/record/monitor wound healing weekly. Measure length, width and depth where possible. asses and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD. -Follow facility policies/protocols for the prevention/treatment of [REDACTED]. report lose dressing to treatment nurse. The May 2020 TAR reflected the following order: 1. Wound Care: Sacral Stage-4 - Cleanse with Daken's soaked gauze, pack with Daken's soaked gauze and cover with Border Foam QD every day shift for Wound Care: Sacral Stage-4 -Order Date- 05/12/2020 5:06 PM According to TAR the treatments were not administered on days: 17, 18, 19, 22, 24, 27 and 30. The June 2020 TAR reflected the following order: 1. Wound Care: Sacral Stage-4 - Cleanse with Daken's soaked gauze, pack with Daken's soaked gauze and cover with Border Foam QD every day shift for Wound Care: Sacral Stage-4 -Order Date- 05/12/2020 5:06 PM According to TAR the treatments were not administered on days: 9, 11, 13, 16, 18, 23 and 30. The July 2020 TAR reflected the following order: 1. Wound Care: Sacral Stage-4 - Cleanse with Daken's soaked gauze, pack with Daken's soaked gauze and cover with Border Foam QD every day shift for Wound Care: Sacral Stage-4 -Order Date- 05/12/2020 5:06 PM According to TAR the treatments were not administered on days: 2, 3, 4, 7, 9, 12 and 13. No notes were available or provided during the survey and/or prior to exit on the TARS or progress notes, reflecting reasoning for missed administrations of skin treatments. On 7/16/20 at 1:52 PM the Director Of Nursing (DON B 5/29/20) was asked if documentation of treatments, were to be documented on the TAR. DON B revealed, the wound nurse typically documented on the wound rounds. She could do a progress note as to the treatment. The order comes on the TAR. DON B was informed that they were empty boxes on the TAR without initials and/or signatures, and asked what did that indicate. DON B stated, Not documented, no done. And if there is no progress noted, Not documented, no done. The facility's December 2012 Administering Medication: policy reflected: Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed. 3. Medications must be administered in accordance with the orders, including any required time frame. 4. Medications must be administered within one (1) hour of their prescribed tine, unless otherwise specified. 18. If a drug is withheld, refused or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the Medication Administration Record [REDACTED]. 19. The individual administering the medication must initial the resident's MAR indicated [REDACTED]. 21. Topical medications used in treatments must be recorded on the resident's treatment record (TAR). Resident #2 (R2) Review of the Resident Profile and Minimum Data Set ((MDS) dated [DATE] revealed R2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The MDS revealed R2 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS), required extensive assistance with Activities of Daily Living (ADLs), including bathing and hygiene, was frequently incontinent of bowel, and had a stage 4 facility acquired pressure ulcer. In an observation and interview on 7/14/20 at 11:48 AM, R2 was observed in his room, seated in a power wheelchair and reported he had a wound on his bottom. R2 reported staff was supposed to change his dressing twice a day, but usually changed it every other day. In a second interview on 7/15/20 at 12:20 PM, R2 again reported that staff were not changing his bandage twice a day. R2 stated I have to get in bed for them to do it and they just don't come do it sometimes. They say they forget. How do they forget? I have my light (call light) on. Review of R2's Physician's Orders and Treatment Administration Records (TAR) revealed wound care/dressing changes were ordered and scheduled for twice a day. The May, June, and July TARs, Progress Notes, and Wound Rounds documentation, revealed wound care was ordered twice a day, but only performed once a day on 5/4/20, 5/6/20, 5/8/20, 5/10/20, 5/13/20, 5/15/20, 5/16/20, 5/19/20, 5/20/20, 6/6/20, 6/13/20, 6/23/20, 6/29/20, 6/30/20, 7/1/20, 7/2/20, 7/3/20, 7/4/20, 7/7/20, 7/9/20, and 7/13/20. No PRN (as needed) wound care was documented on the TAR. There were no refusals/rejections of care documented in the progress notes. In an interview on 7/16/20 at 1:50 PM, Director of Nursing (DON) B reported wound care should be documented on wound rounds, progress note or on the TAR. When asked what it meant if the wound care was not signed out on the TAR, DON B reported if it wasn't documented, it wasn't done.
F 0802 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.** The citation is related to Intakes MI 810, MI 575, MI 035 and MI 955 Based on observation, interview and record review the facility failed to properly staff dietary services for 2 sampled residents (Resident #4, Resident #23), 3 supplemental residents (Resident #26, Resident #28 and Resident #29) and up to 98 additional facility residents, resulting in late, cold and non-palatable meals. Findings Include: Resident #4 (R4) On 7/17/20 at 8:33 AM during a phone interview, R4 who had been a resident at the facility from 3/27/20 to 4/21/20 revealed that while as a resident at the facility meals would be served at 7:00 PM for dinner routinely, dinner and all the meals were always late and she would be hungry while waiting. In addition, the food would be cold but what could she do. Resident #23 (R23) During an interview with R23 on 7/14/20 At 12:44 PM meal service was discussed. R23 revealed breakfast to his knowledge would be served between 8:00 AM - 9:00 AM, lunch 11:30 AM and dinner 4:30 PM -5:00 PM. However, that he had been served dinner at 7:00 PM. R23 described himself as a feeder (requiring staff to feed him). R23 revealed he liked breakfast better, but that the food would be cold the majority of the time and staff would inform him that the food was delivered cold. On 7/14/20 at 1:10 PM the meal cart was observed to have been delivered to the third floor (3 South), and a lunch tray was observed being served to a resident at 1:17 PM by nursing staff. Later at 1:45 PM the meal cart for the third floor (3 North), was observed to have just been delivered to the floor. Resident #26 (R26) On 7/16/20 at 12:19 PM R26 when asked about meals revealed, they don't give you enough food, it's always cold. Sunday 7/12/20, we did not get our breakfast until almost 11:00 AM. Also, that he had asked for double potions, got that for half a week and then it went back to regular portions. R26 attributed the reason to short staffing. Resident #28 (R28) On 7/16/20 at 12:54 R28 revealed that milk did not come with the meals all of the time. They just offer milk and juice to drink, and breakfast comes at 10:30 AM. Resident #29 (R29) On 7/16/20 at 12:27 PM R29 revealed the food was horrible, it's a wonder people don't have food poisoning, the food is cold and looks like it's been sitting forever. R29 revealed she observed an ice bucket with no top on it, everyone in the kitchen was basically quitting, on Saturday 7/11/20 and Sunday 7/12/20 breakfast was served between 11:10 AM and 11:30 AM, they only had one person in the kitchen, no menus were and/or have been provided, the place was going down, and that it's horribly awful. During an interview with the Activities Director (AD D) on at 7/16/20 at 11:18 AM, when was asked if any of the residents had any concerns related to the food. AD D revealed, They complain about the food because it does not taste good, they complain about the foods texture, and how they want something different other than hamburgers. One lady said she was so hungry; she could hardly sleep. On 07/14/20 at 11:35 A.M., Regional Director of Food Services K stated: I have been here for two years and have never seen staffing levels this low. Regional Director of Food Services K also stated: Eight staff members tested positive this morning., referring to COVID-19.
F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.**

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F 0804 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 8) This citation is related to Intake Number: MI 810 Based on observation, interview, and record review, the facility failed to provide palatable food products effecting 108 residents, resulting in the increased likelihood for decreased resident food acceptance and nutritional decline. Findings include: On 07/14/20 at 12:35 P.M., Food product temperatures were monitored on the 3rd floor utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded: Turkey Roast - 106.4 degrees Fahrenheit* Mashed Potatoes - 140.9 degrees Fahrenheit* Creamed Corn - 124.9 degrees Fahrenheit* Beverage (Apple Juice) - 33.2 degrees Fahrenheit (*) The 2013 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5C (41F) or less. On 07/15/20 at 12:25 P.M., Food product temperatures were monitored on the 4th floor utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded: Roast Beef - 95.7 degrees Fahrenheit* Sweet Potatoes - 100.1 degrees Fahrenheit* Cauliflower - 100.9 degrees Fahrenheit* Pineapple Dream - 71.5 degrees Fahrenheit* Note: The Pineapple Dream desert was observed to be only pineapple tidbits (no whipped topping present). Beverage (Fruit Juice) - 61.8 degrees Fahrenheit* Note: The stainless-steel transport cart doors were observed open between resident food product tray delivery. (*) The 2013 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under 3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5C (41F) or less. On 07/16/20 at 12:45 P.M., Record review of the Policy/Procedure entitled: (Facility Name) Dining Times revealed the following meal service times: Breakfast 07:30 am - 08:30 am, Lunch 12:00 pm - 01:00 pm, Supper 05:30 pm - 06:30 pm.
F 0809 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.** This citation is related to Intakes: MI 922, MI 575, MI 035 and MI 955 Based on observation, interview and record review the facility failed to offer and distribute snacks to 8 residents (Resident #4, Resident #8, Resident #23, Resident #25, Resident #26, Resident #29, Resident #30 and Resident #31) and the potential for 95 additional facility residents, resulting in snacks not provided, ignored request for snacks and feelings of hunger. Findings Include: During the abbreviated survey from 7/14/20 to 7/21/20, facility staff and residents were asked if facility staff offered and/or passed snacks during the day or night-time. Below are the following responses related to snacks being offered: Resident #8 (R8) On 7/15/20 at 8:30 AM, in an interview with R8, R8 complained that she did not routinely receive snacks during the day or in the evening even though she was diabetic. On 7/16/20 at 11:18 AM Activities Director (AD D) was asked if any of the residents had complained about snacks. AD D revealed that a couple residents on the the fourth floor had. Also, that she had been going to the vending machine to get them chips, candy, pop and water for the residents with the money they gave her. Also, there was another complaint on the second floor by Resident #8 (R8) about snacks. The resident had questioned what was up with getting snacks during the day because she is not getting any, she requested that RD D get her snacks everyday because R8 revealed she did not get them at night. Resident #30 (R30) & Resident #31 (R31) On 7/16/20 at 12:13 PM R30 and R31 both residents stated they had not received snacks during the day or night. R30 revealed, I had not any until I complained to therapy about it, and I got 2 yesterday. I think the staff eat them. Also, that he had been at the facility for 3 weeks and had just got a snack yesterday. Resident #25 (R25) At 12:06 PM R25 revealed she had not received any snacks until last night. Resident #26 (R26) On 7/16/20 at 12:19 PM R26 revealed snacks were supposed to come up, they don't come and he was supposed to get 2 sandwiches last night but I didn't. Resident #29 (R29) On 7/16/20 at 12:27 PM when asked if facility staff offered and/or passed snacks R29, We are never offered a snack during the day or night. Resident #23 (R23) On 7/14/20 at 12:48 PM R23 denied being offered snacks from the facility and that he would eat them if they offered. Resident #4 (R4) On 7/17/20 at 08:33 AM R4 revealed, No, I was barely given snacks. For the 6 weeks she was there, she only got snacks twice by an agency staff and none of the facility staff gave her snacks. Staff would tell here there were none there, and that they were out of stuff. R4 continued, I wanted the snacks, which would have helped being that the meals were served late. Anonymous Staff R revealed the facility was very short staffed with mostly 2 CNA's per floor, averaged about 2 CNA's (Certified Nursing Assistants) for 44 residents on the afternoon/night time shifts, she/he was usable to answer call lights timely. Only residents with their names on them got snacks and that all residents do not get snacks. During the survey period from 7/14/20 to 7/21/20 no facility staff were observed by writer to offer and/or deliver daytime snacks to residents. On 07/16/20 at 01:45 P.M., Record review of the Policy/Procedure entitled: Nourishments (Night-Time Snacks) revealed under Policy: Nourishments will be provided to the clients at approximately bedtime. The Policy/Procedure entitled: Nourishments (Night-Time Snacks) further revealed under Procedure: Food and nutrition services will deliver the bedtime nourishment (snack) as planned on the cycle menu to the nursing units after the evening meal. Clients whose diet order includes specific bedtime nourishment may receive the nourishment with label reflecting the diet order. Clients will receive an appropriate bedtime snack according to their diet order. Nursing will distribute the bedtime nourishments.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** This citation is related to Intake Number: MI 810 Based on observation, interview, and record review, the facility failed to: (1) effectively clean food service equipment, and (2) maintain wall and ceiling surfaces within the food production kitchen effecting 108 residents, resulting in the increased likelihood of bacterial harborage and cross-contamination. Findings include: On 07/14/20 at 11:20 A.M., An initial tour of the food service was conducted with Regional Director of Food Services K. The following items were noted: The Garbage Disposal overhead spray arm support spring was observed heavily soiled with dust, dirt, and grease deposits. The Master-Bilt 3-door reach-in cooler exterior surfaces were observed soiled with accumulated and encrusted food residue. The Stove Top and Stove Door perimeters were observed heavily soiled with accumulated and encrusted food residue. The Convection Oven exterior and interior surfaces were observed heavily soiled with accumulated and encrusted food residue. The Mechanical Dish Machine exterior surfaces were observed heavily soiled with accumulated and encrusted food residue. The exterior surfaces were also observed heavily soiled with accumulated and particulate mineral (lime and calcium) deposits. The 2013 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. Regional Director of Food Services K indicated he would have staff thoroughly clean and sanitize the aforementioned areas as soon as possible. The wall surface ceramic tile, located directly behind the food production kitchen entrance door, was observed broken. The wall surface ceramic tile opening measured approximately four inches wide by six inches long, creating a bacterial harborage and cross-contamination issue. The ceiling surface, adjacent to the mechanical dish machine, was observed (etched, scored, and particulate). The effected ceiling surface measured approximately twenty inches wide by twenty inches long. The missing stainless-steel metal plate was also observed resting on the floor near the wall/floor juncture corner, beneath the stainless-steel table top. The 2013 FDA Model Food Code section 6-501.11 states: PHYSICAL

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 _____	**07/21/2020**

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

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 9) FACILITIES shall be maintained in good repair. Regional Director of Food Services K indicated he would contact maintenance to make necessary repairs as soon as possible. On 07/15/20 at 1:15 P.M., Record review of the Policy/Procedure entitled: Food and Nutrition Services Sanitation and Food Safety Cleaning Schedule revealed under Policy: The healthcare community stores, prepares, distributes, and serves food in a sanitary manner to prevent foodborne illness. Record review of the Policy/Procedure entitled: Food and Nutrition Services Sanitation and Food Safety Cleaning Schedule further revealed under Procedure: A daily cleaning schedule will be posted in the kitchen with specific cleaning assignments to include both routine cleaning/sanitizing tasks along with deep cleaning tasks. The Director of Food and Nutrition Services or someone designated as person in charge will review the cleaning schedule each day to assure the tasks have been completed in a satisfactory manner. On 07/16/20 at 1:00 P.M., Record review of the Policy/Procedure entitled: Preventative Maintenance (TELS) and Inspections revealed under Procedural Components (D) Work Orders and Service Requests: (1) A system for electronic work orders is established in TELS among all staff, and maintenance personnel that provides rapid communication regarding equipment problems. (2) The system includes documentation of: (a) The problem, (b) Date the problem was identified, (c) Who was assigned, and (d) Location of the problem.