STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	07/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Parkridge	28 S Prospect St Ypsilanti, MI 48198

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Number MI00120849 Based on interview and record review, the facility is placed in Immediate Jeopardy for its failure to provide acceptable quality of care in accordance with professional standards of practice and the resident's care plan for one resident (Resident #1), by its failure to provide appropriate care for a change of condition, including new seizure activity and respiratory distress. Immediate Jeopardy: Resident #1 had a history of respiratory failure and COPD and was to receive oxygen therapy at 2 liters (L) a minute continuously and a Bipap machine (bilevel positive airway pressure/ a type of ventilator that helps with breathing) machine at night. The resident did not have on either when EMS (Emergency Medical Services) arrived for a change of condition with respiratory distress. The nurse caring for the resident did not apply oxygen for a low oxygen saturation rate of 88%;. The resident began to vomit and had seizure-like activity. The nurse called 911 for assistance and then called 911 again to cancel because the resident had an Advance Directive for Do Not Resuscitate (DNR). The resident was still breathing and had a pulse. When EMS entered the building, the Nurse met them at the elevator and said they were not needed because the resident had an Advance Directive for DNR. The Advance Directive did not indicate not to treat the resident for a change of condition. Upon EMS's entry into the resident's room, the nurse left the unit and did not return until EMS was leaving for the hospital with the resident. The resident's oxygen saturation rate (O2sat) had decreased to 70% (normal range > ,d+[DATE]% via pulse oximeter reading) on room air. The lack of appropriate care was likely to lead to a further decline in condition, serious harm, injury, or death. On [DATE] at 5:20 AM, Resident #1 was found in her room by a nurse aide with a change of condition. The Nurse K assessed the resident to have respiratory distress with dried vomit on her face. The facility failed to provide any immediate care or interventions. The facility contacted the physician and was advised to call 911. The facility called EMS. Upon EMS arrival, the facility tried to prevent EMS from seeing the resident by reiterating that the resident was a DNR, EMS was not needed and that they should leave. (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] after arrival to the 2nd Floor, EMS went to Resident #1's room, heard the resident gurgling and saw the resident vomiting black fluid. EMS indicated Resident #1 was in the process of having a seizure. EMS responded that the resident was still breathing, had a heartbeat, and required care. The Nurse K left the floor to try to obtain discharge paperwork. A nurse aide was the only staff member left on the floor for approximately 40 residents. The nurse returned immediately prior to the resident's transfer without paperwork. The facility did not provide all the necessary transfer paperwork. EMS obtained a copy of the resident's diagnoses from the paper chart, but the nurse was unable to provide a copy of the resident's orders including medications. Resident #1 died at the hospital on [DATE]. The Immediate Jeopardy began on [DATE]. The Immediate Jeopardy was identified on [DATE]. The Administrator was notified on [DATE] of the IJ that began on [DATE]. The IJ Abatement (Removal) Plan was approved on [DATE] with a Removal Date of [DATE]. Findings Include: Resident #1: A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: history of respiratory failure, COPD, Dementia, diabetes, heart failure, history of ovarian cancer, Bipolar disorder, history of myocardial infarction, hypertension, and depression. The MDS assessment, dated [DATE], revealed that the resident had severe cognitive loss and needed assistance with all care. A review of the Care Plans for Resident #1 indicated the following: The resident has Congestive Heart Failure, date initiated [DATE], with Interventions: Give cardiac medications as ordered, dated [DATE]. The resident has Diabetes Mellitus, date initiated [DATE] with Interventions: Diabetes medication as ordered by doctor . dated [DATE]. The resident has diagnosis of COPD, date initiated [DATE] with Interventions: Monitor for signs and symptoms of acute respiratory insufficiency: Anxiety, Confusion, Restlessness, Shortness of Breath at rest, Cyanosis, Somnolence, dated [DATE]. The resident has shortness of breath r/t use of CPAP (continuous positive airway pressure)/Bipap. Settings are: Rate 12 breaths a minute, Ipap cm water - 16 cm water, Epap cm water- 8 cm water, Fi02 30%, date initiated [DATE] with Interventions: (specify interventions) help to decrease/mange shortness of breath, date initiated [DATE]. The interventions were never specified; Monitor/document breathing patterns. Report abnormalities to MD Date initiated [DATE]; Monitor/document changes in orientation, increased restlessness, anxiety, and air hunger, date initiated [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The resident has oxygen therapy 2 L (liters) nasal cannula during the day related to diagnoses of COPD, date initiated [DATE] with Interventions: Staff to monitor and encourage resident to keep oxygen on at all times, date initiated [DATE]; Oxygen settings: 02 (oxygen) via nasal prongs @ 2 L ATC (around the clock), dated 2//,d+[DATE]. The care plan contradicted itself; it said oxygen 2 L during the day and oxygen 2 L around the clock (continuous). A review of the physician orders provided the following: 02 continuous via Nasal Canula at 2L/min, every shift, document L/min, dated [DATE]. Bipap ,d+[DATE] with backup rate of 12 and 2L/min, 02 bleed in, every night shift . dated [DATE]. Do Not Resuscitate, no directions specified . dated [DATE]. A review of the progress notes identified a nurses note written for [DATE] at 5:20 AM by Nurse K, Resident observed to be in respiratory distress with small amount of vomit, respirations 26, P (pulse) 110, unable to access blood pressure. Dr. (L) called, ordered to send resident to hospital. 911 called. A progress note dated [DATE] at 6:41 AM, Resident left via ambulance with 2 attendants (responsible party) called . On further review of the medical record, there was no additional assessment data or description of the resident's change of condition. There was no documentation of interventions provided for the resident's respiratory distress or vomiting. There was no mention if the resident was wearing the oxygen or Bipap when the nurse entered the room. The last documented oxygen saturation rate was on [DATE] at 8:25 PM- 98% on Room Air, documented by Nurse K. There was no mention if oxygen or the Bipap was applied at this time. On [DATE] at 12:29 PM, an interview with Confidential Person D provided, On [DATE] she (Resident #1) went to the hospital. They had to intubate her. When I got to the hospital, they said she almost died . The doctor asked about intubation, and I said 'Yes'. The Paramedic was there and told me what happened at the facility. He said she was having seizures. They were trying to help her, and the Nurse said she was a DNR. At the hospital, the doctor came out and talked to me. They were working hard to save her; a lot of people were in the room at the hospital. The first time I saw her she was lying flat. It was awful. I asked if she was going to die. The doctor said she was on two life supports. I had a bad feeling. They did all the tests, but her brain activity was low. DNR does not mean you let a person suffer. The facility didn't call me. A doctor called and asked how fast could I get there (to the hospital). She died a few days later. An interview with facility Physician L on [DATE] at 3:40 PM revealed, I saw her (Resident #1) twice. I just took over for the other doctor. The nurse called me, and they told me she vomited and was having seizures. She did not have a history of seizures. She was seizing and they took her to the hospital. She may have aspirated when she had a seizure. I had just saw her a few days before. She was not actively dying. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:14 PM, Nurse K was interviewed about Resident #1 and stated, She was 'OK' at night, then the aide said she was having trouble breathing. When I looked in there, she had a little vomit and looked pale. Her vitals weren't good: pulse ox (oxygen saturation level) was 88%. I couldn't get a blood pressure; the pulse ox was low. I called the Unit Manager, the doctor and I called 911 right away. I didn't put her on oxygen. The Unit Manager said she was a DNR and didn't need to go. EMS arrived and I was trying to get her paperwork around. I said she was DNR. They said they were allowed to see her. I told them she was DNR, and they said they were taking her anyway. I left EMS in there. There was one aide on the floor. I went to the 3rd floor and then the 4th floor to try and get the paperwork to print. I couldn't get the paperwork to print, and I pulled it out of the chart: Facesheet and DNR form. I couldn't get the med sheets. I didn't give them the med sheets. During an interview with the Director of Nursing and Administrator on [DATE] at 4: 30 PM related to Resident #1's change of condition and lack of appropriate care prior to transfer to the hospital on [DATE], the Director of Nursing was asked what the process was for care of a resident with a serious change of condition, she said the resident was vomiting and had decreased mentation and the doctor was contacted and the resident sent to the hospital. Reviewed with the Director of Nursing and Administrator that the nurse had said she tried to cancel the 911 call, based on the Unit Manager's recommendation, because the resident was a DNR and then the nurse left the floor upon EMS's arrival, leaving the resident without care. The nurse did not provide any documented interventions for the resident's signs and symptoms and when EMS left, she could not provide all of the necessary paperwork for continuity of care at the hospital, including the medication list. The Director of Nursing said she would check into the issues. An interview with Certified Nursing Assistant E on [DATE] at 1:50 PM provided, I worked with (Nurse K) and Nurse Aide G we divided the hall. When I was doing my rounds, at 5:20 AM she (Resident #1) had something like blood coming from her mouth, then she was breathing fast. Her eyes were rolling up and down. Her face was shaking. I went and called the nurse. (Nurse K) came and when she saw that, she said (Resident #1) had to go to the hospital. She went to the nursing station. I wanted to change the resident, but I couldn't change her by myself because of her condition. (Nurse K) called EMS for help. After she called, she asked for the number for the Unit Manager. I gave her the number and she said call her right away. The Unit Manager said did you check the DNR or CPR and (Nurse K) said, 'She is a DNR.' The Unit Manager told her if it is DNR you don't need to send her. You can cancel that. (Nurse K) called 911 and said I have to cancel. Then the bell rand and it was 911 at the door. I went to (the resident's) room and (Nurse K) went to meet them. They came in the room, and I was there. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:07 PM, Paramedic C was interviewed about Resident #1 and stated, We were called for difficulty breathing and altered mental status. Then one of the dispatchers sent us a message and said they (the facility) tried to cancel us. Our policy said we are supposed to make contact. We were at the first-floor elevator, and someone met us- a female. She said they had just called and canceled us. They didn't need us anymore. She said the patient was a DNR and we didn't need you. We asked if she died and they said, 'No,' so we went upstairs, and she was in poor condition. She was on room air. We assessed her and put her on a non-rebreather (oxygen mask with higher oxygen flow). One of us suctioned her. We were concerned about her pulse ox of 70%. She was gurgling. She had been vomiting black fluid and was sitting upright with her head leaning back. Her entire body was tensed up with rapid side to side eye twitches. We gave her Versed (a medication commonly used emergently with seizures). We were slightly delayed in leaving for the hospital because the facility did not have paperwork ready. The one who talked to me at the elevator, separated from me. Then we ran into the one we originally met at the elevator, and she gave us some paperwork out of the patient's chart. We turned over the paperwork at the hospital. A review of the Facility Video of the front entrance, main floor hallway and elevator door and 2nd floor elevator door was completed on [DATE] at 3:30 PM with the Administrator. On [DATE] at approximately 5:40 AM, EMS was observed at the Main entrance to the facility and walking to the front entrance doors; At 5:41 AM, Nurse K (identified by the Administrator) as the staff member who was observed standing in the doorway to the elevator on the first floor, talking to the two EMS personnel. All 3 wore masks and there was no sound on the video, but their heads were moving slightly and per body language, appeared to be talking. Nurse K then moved aside and the 2 EMS personnel entered the elevator. All 3 were seen exiting the 2nd floor elevator at approximately 5:42 AM. The EMS personnel were seen walking towards the 2nd floor elevator with Resident #1 on a stretcher approximately 5:56 AM. Then one EMS person ran out of the elevator towards the Nurses' desk and came back with paper in her hands and entered the elevator. Per the Administrator the cameras did not have a view down the hallway towards the resident's room. A review of the Hospital records dated [DATE]-[DATE] for Resident #1 revealed the following: Prehospital Care Report (EMS), dated [DATE]: 5:35:06 AM- Call Received. 5:35:06 AM- Dispatched. 5:35:13 AM- En Route. 5:40:01 AM- On Scene. 5:42:01 AM- Patient Contact. 5:56:12 AM- Left Scene. 6:04:04 AM- At Destination (hospital). 6:04:04 AM- Transfer of Care. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Current Meds: Plavix, Levothyroxine, Carvedilol: No known Medications, Patient list not available . Dispatch Reason: Breathing Problems; abnormal breathing . Chief Complaint: AMS (Altered mental status); Secondary Reason: Seizure, vomiting, Respiratory failure . 5:42:01 AM- Airway: Partially Obstructed: Choking, Nasal flaring, Intercostal Retraction; Breathing rate: rapid; Quality: labored; Lung sounds: Left Rhonchi; Lung sounds: Right Rhonchi; Skin color: Pale; Skin Temperature: Hot; Skin Condition: Diaphoretic, Moist . 5:45:58 AM- BP: Systolic unable to complete/Diastolic unable to complete; Pulse: 160 (high); Resp: 40 (high); SPo2: 75 (low). 5:50:11 AM- . Resp: 0 Effort: Absent . 5:59:11 AM- . Resp: 0 Effort: Mechanically Assisted . Narrative History Text: Pt (patient) is 75F ([AGE] year-old female) with an active seizure, evidence of recent vomiting, and respiratory failure, time of onset unknown . (facility) staff called 911 for (Altered Mental Status and Difficulty in Breathing) called back to cancel EMS as EMS was arriving, stating the pt is DNR and EMS was no longer needed. Staff met EMS at elevator to cancel, was asked if the pt had lost pulses, stated she had not but she was a DNR, that treatment/transport was not needed, and that her supervisor had instructed her not have the patient transported. Staff was informed that EMS would be making contact regardless, and that any decisions regarding transport would be made after assessment. Pt history largely unavailable to EMS due to difficulty obtaining report/paperwork and pt condition requiring continuous airway management. (At the facility) pt actively seizing with full body tonic/clonic activity, black vomit present on face/torso, gurgling respirations audible from hallway. Pt SPO2 70% on room air. Unable to suction initially due to jaw clenched from seizure activity; placed on 15 L per minute by NRB (non-rebreather mask), versed administered. Pt moved to stretcher via sheet lift. Pt's roommate stated that the pt had been like this for a while now, but was unable to specify further . By arrival to ambulance, pt had relaxed sufficiently to open her [NAME] and airway was clear at this time. OPA (oropharyngeal airway), which pt tolerated. Pt's respiratory effort and rate was rapidly declining, respirations appearing almost agonal . Pt transported remaining distance to ER, pulling over once en route for a pulse check due to concern for cardiac arrest . A Hospital physician progress note written by Physician N dated [DATE] at 6:06 AM, . unresponsive female . presenting with hypoxic respiratory failure . Patient was intubated . Airway was clear without significant evidence of aspiration . possible left sided pneumonia . The patient was admitted to (Medical Intensive Care Unit) for when this episode of new onset seizure, acute hypoxic respiratory failure secondary to seizure, demeaning ischemia, and probable left lower lobe pneumonia A progress note in the Hospital chart written by Physician M, dated [DATE] at 7:15 AM, Patient signed out to me from prior provider who reports patient presents with altered mental status, decreased blood pressure, hypoxemia and new onset seizure with likely aspiration from nausea and vomiting . (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A hospital note by Physician O written on [DATE], Assessment: Acute-on-chronic hypoxic respiratory failure, New-onset seizures, Bacteremia with (Gram positive cocci) in clusters, possible vegetation noted on TEE (cardiac test), Suspected left lower lobe pneumonia and E. Coli UTI, Chronic diastolic CHF . A progress note by Hospital Physician P dated [DATE], Staph epidermidis bacteremia, usually discounted as contaminant, but could be a true infection in this case given the overall picture and the TEE findings of cardiac vegetation . Sepsis secondary to above as well as possible left lower lobe pneumonia . Recommendations: Continue vancomycin (antibiotic) . for bacteremia as well as ceftriaxone (antibiotic) . A discharge note by Physician Q, dated [DATE], Active Problems: Hypoxemia . Patient died on [DATE] . Patient had new onset seizures and was hypoxic to 75% on presentation requiring intubation . Transitioned to comfort care, terminal wean and passed away shortly after . A review of the facility policy titled, Notification of Changes Guideline, dated [DATE] and revised [DATE], Purpose: It is the practice of this facility that changes in a resident's condition or treatment are immediately shared with the resident and /or the resident representative, according to their authority, and reported to the attending physician . All pertinent information will be made available to the provider by the facility staff . Significant Change in status- deterioration in health, mental or psychosocial status in life threatening conditions or clinical complications . The intent of the guidelines is to provide appropriate and timely information about changes relevant to a resident's condition . to the parties who will make decisions about care, treatment, and preferences to address the changes . In life threatening conditions, activate the emergency response system immediately . A review of the facility policy titled, Advance Directives and Care Planning Guidelines, dated [DATE] and revised [DATE], Guideline Purpose: It is the practice of the facility to establish, implement and maintain written guidelines for advance directives . The resident has the right to accept, request, refuse and /or discontinue medical or surgical treatment . Treatment refers to interventions provided for purposes of maintaining/restoring health and well-being, improving functional level, or relieving symptoms . Facility Removal/Abatement Plan for IJ for F-684 received and approved on [DATE]. A tour of the facility and review of the facility training and audits was completed on [DATE] to confirm enactment of the Abatement Plan that included the following: 1. [DATE]- A 100% audit was completed on very resident (109 of 109 residents) by the Nursing Administration Department for the potential of a change in baseline condition. The Nursing Administration Department documented all physical findings on the General SBAR (Situation, Background, Assessment, Recommendation) Tool. Findings were documented. Interventions and recommendations were implemented as indicated. 2. [DATE]- In-servicing for current Nursing Staff was initiated by the Nursing Administration Department. In-servicing included that they are not to delay emergency response treatment at any time. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3. [DATE]- In-servicing for all Licensed Nurses was initiated by the Nursing Administration Department to include that the Nurses are to provide all necessary transfer paperwork to the Emergency Response Team upon transfer from the facility. 4. [DATE]- Education was initiated for all licensed nursing staff on the definition of Do-Not-Resuscitate and the proper protocol by Nursing administration. 5. [DATE]- The Clinical Management Team began monitoring- If 911 is dispatched to the facility, a member of the Clinical Management Team will directly monitor the Nursing Staff for proper coordination of emergency care. 6. [DATE]- The Clinical Management Team began monitoring if 911 is dispatched to the facility, a member of the Clinical Management Team will directly monitor the Licensed Nurses to ensure all necessary paperwork has been provided to the emergency dispatch team prior to resident transfer. 7. [DATE]- DON/Designee will review every 911 discharge from the facility to ensure that no delay in emergency treatment services occurred and that the facility provided all the necessary transfer paperwork. This audit is to be continued ongoing. 8. [DATE]- Audit Results will be reported to the QA committee for monitoring and follow-up. While the Immediate Jeopardy was removed on [DATE], the facility remained out of compliance at a Scope of No actual harm with potential for more than minimal harm that is not immediate jeopardy and a Severity of Isolated until compliance can be verified by the State Agency (SA).

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake Number MI00120849. Based on observation, interview and record review, the facility failed to provide a safe and monitored environment to prevent a fall with a serious head injury for one resident (Resident #3) of three residents reviewed for falls from a total sample of eight residents, resulting in Resident #3 having an unwitnessed fall in her room, hitting her head and obtaining a deep laceration on the middle of her forehead, above her nose, into her hairline. Findings Include: On 6/25/21 at 10:45 AM, a tour of the 300 Hall identified a census of 27 residents with 3 nurse aides, 2 nurses and a Nurse Manager. While walking down the hall, Resident #3 was observed in the hallway, sleeping in a wheelchair; her feet were extended straight out in front of her. She had a line of sutures and staples observed in the middle of her forehead, beginning above the bridge of her nose and extending into her hairline. Her eyes were very puffy and discolored purple, yellow and green. The resident had dried food on her face. A bedside table was sitting at the end of her feet. Her breakfast tray was still on it and food was all over the table and on the floor. Staff were observed walking by and no one assisted the resident to bed or made an attempt to clean up the resident, meal tray or food on the floor. The resident looked as if she could slide right out of the wheelchair. During an interview with Unit Manager J on 6/25/21 at 11:00 AM, the nurse was asked why Resident #3 had bruises on her face and sutures and staples on her forehead and stated, She fell forward and hit her head. The nurse walked into the room to the second bed by the window. There was another resident in the first bed. The room had a narrow path to the other side of the room. The bed was placed next to the wall with a small open area in front of it and a bathroom directly across from it with approximately 6 feet from bed to the door of the bathroom. The nurse pointed at a piece of furniture and said they thought the resident tried to get up and hit her head on the furniture. Nurse J said the bed was in a different position at that time, with the bed closer to the dresser. Resident #3: A record review of the Face sheet progress notes and MDS assessment indicated Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Dementia, COPD, heart failure, diabetes, weakness, anxiety, hypertension, hearing loss, and obesity. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss and needed assistance with all care, including 2-assist with transfers. The resident fell in her room on 6/22/21 and was transferred to the hospital with a laceration on her forehead. She returned to the facility on [DATE]. A review of a progress notes revealed the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	6/22/2021 at 5:52 PM, CNA (Certified Nursing Assistant) alerted nurse that a resident experienced an unwitnessed fall and there was blood visible on the floor. LPN entered resident room and discovered resident on floor, in side lying position . noted a 6-7-inch laceration across the resident's forehead . MD made aware of fall and (EMS) transport to hospital at 5:43 PM . 6/22/2021 at 6:52 PM, Fall Risk Evaluation . Fall risk score is 20; Fall risk scored above 5, resident is high risk for falls . 6/23/2021 at 1:15 AM, Resident returned to the facility by 1:15 AM via stretcher . 5 staples and 11 sutures noted to right midline in the frontal region of her forehead . 7/2/2021 Resident moved to larger space for easier monitoring . A review of the Incident and Accident Report, dated 6/23/2021- 6/30/2021 for the fall involving Resident #3 on 6/22/2021 revealed, Event date 6/22/2021 at 5:40 PM . Resident was observed lying on floor at foot of bed. A wound approximately 6 inches was observed in forehead, and blood was observed to be on the floor next to head . Fall to floor Unwitnessed . Was the resident injured; Yes . Major Injury . deep laceration in mid-forehead . A new Plan of Care/Intervention has been completed to prevent further events. Note: A new Plan of Care/Intervention Must be completed to prevent further events and these new changes communicated to staff . A review of the physician orders provided, 6/23/2021 at 7:00 PM, Hourly safety checks, every hour for fall risk. A review of the Medication Administration Record (MAR) for June 2021 revealed, Hourly safety checks. Every hour for fall risk, order date 6/23/2021 at 6:18 PM. The Nurses began the checks at 12:00 AM on 6/24/2021. They were not completed every hour as ordered. On 6/26/2021 there was no documentation of Safety checks for 6:00 AM nor 7:00 AM. A review of the MAR for July 2021 revealed the Hourly safety checks were not completed as ordered. On July 1st, 2021, there were 6 missing entries with no explanation: 2:00 AM, 3:00 AM, 4:00 AM, 5:00 AM, 6:00 AM and 7:00 AM. The facility was not providing the care designated to ensure the resident's safety. A review of the resident's Care Plan revealed the following: The resident has potential for an ADL (activities of daily living) self-care performance deficit related to decreased mobility, date initiated 4/21/2018 with Interventions: Transfers: Resident requires Sit-to-Stand mechanical lift, dated initiated 3/25/2020; Bed Mobility: Physical assist every 2 hours and as needed, dated initiated 4/21/2018. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0689 Level of Harm - Actual harm Residents Affected - Few	The resident is High risk for falls related to history of falls, dementia and poor safety awareness. Resident has behavior of placing self on floor, date initiated 4/30/2020 with Interventions: Anticipate and meet the resident's needs, date initiated 11/20/2018; Check on resident regularly and provide assistance if she is awake and preferring to change position or get out of bed, date initiated 1/12/2020; Follow facility fall protocol, date initiated 5/1/2018; Monitor resident while in bed or wheelchair. During sleep and awake times, date initiated 6/22/2021; Floor mats placed at bedside, dated initiated 6/22/2021; The resident needs a safe environment with even floors free from spills and/or clutter . date initiated 11/20/2018. A review of the Visual/Bedside Kardex Report, for Resident #3 identified the following: The resident needs a safe environment with even floors free from spills and/or clutter . Monitor resident while in bed or wheelchair During sleep and awake times- 6/22/2021; Transferring: Transfers requires Sit-to-Stand; Check on Resident Regularly . Transferring physical assistance with 2-persons with full body sling and Hoyer lift . Monitoring: Monitor the resident for safety . The Kardex had no mention of the 1-hour Safety Checks and the Transfer section had 2 identified means of transfer using either the Sit-to- Stand lift or the Hoyer lift. The Care Plan did not mention the Hoyer lift. Neither lift would fit in the resident's room as observed on 6/25/2021 and 6/29/2021. A review of the Tasks, POC Response History for Transfer physical assistance of two persons with full body sling and Hoyer lift, from 6/16/2021 to 6/29/2021 revealed Did you use a mechanical lift for transferring? and No, was documented 18 times. There was great inconsistency in following safety precautions for Resident #3. On 6/29/21 at 11:15 AM, the Director of Nursing was present when Resident #3 was viewed sleeping in her bed. There was just enough room to walk from one side of the room to the other. The room smelled of urine and was very cluttered with furniture, bedside tables and wheelchairs. The bed was moved again and pointed out into the room towards the bathroom door. There was about 2 feet from the bed to the bathroom door and approximately 2 from the bed to the window on the side; the Director of Nursing said the bed couldn't be by the wall. The Director of Nursing was asked how the staff had room to transfer the resident, as she was care planned for transfer with a Sit-to-Stand lift with 2-person assist. The Director of Nursing said they moved the furniture around. The Director of Nursing was asked if this was safe for the resident, if she attempted to transfer herself again and stated, We don't have a lot of options. On 6/30/21 at 10:29 AM, Nurse W was interviewed and was asked about staffing on the 300 Hall., Nurse W said she was the nurse for Resident #3 on 6/22/21 when the resident fell . She said the nurse aide assigned to Resident #3 was off the floor working with the Director of Nursing on staffing schedules, Nurse W herself was off the floor in the supply room. Nurse W said CNA X happened to walk down the hall and see that Resident #3 was not in bed and went into the room to see why. She said there were four nurse aides scheduled for the shift 3:00 PM to 11:30 PM, but 1 was moved to another floor, so there were three. There were 2 nurse aides and 1 Nurse on the hall at the time of the resident's fall. The Nurse was asked about staffing and said, there were usually enough nurses, but it was common to have to pull CNAs from one floor and move them to another floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy titled, Fall Evaluation Safety Guideline, effective date 11/28/17 provided, Purpose: To consistently identify and evaluate residents at risk for falls and those who have fallen to treat or refer for treatment appropriately and develop an organization-wide ownership for fall prevention . The intent of this guideline is to ensure this facility provides an environment that is free from hazards over which this facility has control and provides appropriate supervision to each resident . Develop and implement interventions . Provide safe, clutter free environment . eliminate hazards .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation pertains to Intake Number MI00120849 Based on observation, interview and record review the facility failed to ensure that there was adequate staff to meets the needs of the residents for two residents (Resident #1 and Resident #3)) of four residents reviewed for staffing and potentially effecting all residents, resulting in staff verbalizations of being unable to adequately provide care, residents waiting for assistance with Activities of Daily Living (ADL), residents with a change of condition not receiving necessary care and a lack of staff to monitor and provide resident safety, leading to residents waiting for care, falling (Resident #3) and developing a rapid decline in condition (Resident #1). Findings Include: On [DATE] at 10:15 AM, during a tour of the facility on the 200 Hall, the hall smelled strongly of urine. Residents were yelling out from their rooms; there were many in their pajamas. Two Certified Nursing Assistants (CNA's)were observed working on the hall. The CNA's R and S were observed carrying bags of soiled linen out of a resident's room. The CNA's were asked about staffing on the 200 Hall and said they were the only nurse aides on the hall for about 45 residents. There were also 2 floor nurses I and V. The CNA's were asked if they had enough time in their 8 hour shift to assist resident's with meals, activities of daily living- including baths and repositioning and toileting and they both just said they try. On [DATE] at 10:45 AM, a tour of the 300 Hall identified a census of 27 residents with 3 nurse aides, 2 nurses and a Nurse Manager. While walking down the hall, Resident #3 was observed in the hallway, sleeping in a wheelchair; her feet were extended straight out in front of her. She had a line of sutures and staples observed in the middle of her forehead, beginning above the bridge of her nose and extending into her hairline. Her eyes were very puffy and discolored purple, yellow and green. The resident had dried food on her face. A bedside table was sitting at the end of her feet. Her breakfast tray was still on it and food was all over the table and on the floor. Staff were observed walking by and no one assisted the resident to bed or made an attempt to clean up the resident, meal tray or food on the floor. The resident looked as if she could slide right out of the wheelchair. Nurse J was asked why the resident had bruises and sutures and staples on her forehead and stated, She fell forward and hit her head. Centers for Disease Control and Prevention (CDC), Coronavirus Disease 2019 (Covid-19), Strategies to Mitigate Healthcare Personnel Staffing Shortages, Updated [DATE]: . Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for healthcare personnel (HCP) and safe patient care . Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate these, including communicating with HCP about actions the facility is taking to address shortages and maintain patient and HCP safety . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 4:14 PM, Nurse K was interviewed about Resident #1 and stated, She was 'Ok' at night, then the aide said she was having trouble breathing. When I looked in there, she had a little vomit and looked pale. Her vitals weren't good: pulse ox (oxygen saturation level) was 88%. I couldn't get a blood pressure; the pulse ox was low. I called the Unit Manager, the doctor and I called 911 right away. EMS arrived and I was trying to get her paperwork around. I left EMS in there. There was one aide on the floor. I went to the 3rd floor and then the 4th floor to try and get the paperwork to print. I couldn't get the paperwork to print, and I pulled it out of the chart: Facesheet and DNR form. I couldn't get the med sheets. I didn't give them the med sheets. An interview with the Director of Nursing on [DATE] at 4:30 PM, about staffing levels on the units with 2 CNAs for 47 residents on the day shift provided, We are working on staffing. The Director of Nursing was asked if staff were able to care for the needs of the residents, as foul urine smell, soaked beds and yelling residents was observed on the 200 hall, she said, I'll look into it. An interview with Certified Nursing Assistant E on [DATE] at 1:50 PM provided, I worked with (Nurse K) and Nurse Aide G we divided the hall. When I was doing my rounds, at 5:20 AM she (Resident #1) had something like blood coming from her mouth, then she was breathing fast. Her eyes were rolling up and down. Her face was shaking. I went and called the nurse. (Nurse K) came and when she saw that, she said (Resident #1) had to go to the hospital. She went to the nursing station. I wanted to change the resident, but I couldn't change her by myself because of her condition. On [DATE] at 12:07 PM, Paramedic C was interviewed about Resident #1 and stated, We were called for difficulty breathing and altered mental status. We were at the first-floor elevator, and someone met us- a female . So, we went upstairs, and she (Resident #1) was in poor condition. She was on room air. We assessed her and put her on a non-rebreather (oxygen mask with higher oxygen flow). One of us suctioned her. We were concerned about her pulse ox of 70%. She was gurgling. She had been vomiting black fluid and was sitting upright with her head leaning back. Her entire body was tensed up with rapid side to side eye twitches. We were slightly delayed in leaving for the hospital because the facility did not have paperwork ready. Paramedic C said the Nurse left the floor and did not enter the resident's room while they were in the building. They said the Nurse returned to the floor when they were taking Resident #1 to the elevator. Resident #1 A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: history of respiratory failure, COPD, Dementia, diabetes, heart failure, history of ovarian cancer, bipolar disorder, history of myocardial infarction, hypertension, and depression. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss and needed assistance with all care. A review of the progress notes indicated Resident #1 experienced a change of condition and was transferred to the hospital on [DATE]. The resident died on [DATE] at the hospital. Resident #3 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the Face sheet progress notes and MDS assessment indicated Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Dementia, COPD, heart failure, diabetes, weakness, anxiety, hypertension, hearing loss, and obesity. The MDS assessment dated [DATE] revealed the resident had severe cognitive loss and needed assistance with all care, including 2 The resident fell in her room on [DATE] and was transferred to the hospital with a laceration on her forehead. She returned to the facility on [DATE]. On [DATE] at 10:29 AM, Nurse W was interviewed and was asked about staffing on the 300 Hall., Nurse W said she was the nurse for Resident #3 on [DATE] when the resident fell . She said the nurse aide assigned to Resident #3 was off the floor working with the Director of Nursing on staffing schedules, Nurse W herself was off the floor in the supply room. Nurse W said CNA X happened to walk down the hall and see that Resident #3 was not in bed and went into the room to see why. She said there were four nurse aides scheduled for the shift 3:00 PM to 11:30 PM, but 1 was moved to another floor, so there were three. There were 2 nurse aides and 1 Nurse on the hall at the time of the resident's fall. The Nurse was asked about staffing and said, there were usually enough nurses, but it was common to have to pull CNA's from one floor and move them to another floor. A review of the Staffing Schedules for a census of approximately 109 residents from 6 /,d+[DATE] - 6 /, d+[DATE] and [DATE]-[DATE] revealed the following staff assignments: Day shift and Afternoon shift usually had 2 nurses on each shift. Nightshift had 1 nurse. [DATE]- 200 Hall with approximately 47 residents: Day shift- 2 CNA's; Afternoons (Evening) Shift- 2 CNA's; Nightshift- 2 CNA's: 300 Hall with approximately 30 residents: Day shift- 2 CNA's; Afternoon Shift- 2 CNA's; Nightshift- 2 CNA's: 400 Hall with approximately 30 residents: Day shift- 0 CNA's; Afternoon Shift- 2 CNA's; Nightshift- 2 CNA's. [DATE]- 200, 300 Halls with 2 CNAs on Afternoons and Nightshifts. 400 Hall- 0 CNA's Day shift; 1 CNA Afternoons and Night shift. [DATE]- Day shift 300 Hall: 2 CNA's; 400 Hall 2 CNA's Day shift and Afternoons; 1 CNA nights: 1 Nurse on each shift on the 4th hall (floor). [DATE]- Day shift: 2 CNA's 200, 300, 400 floors; Afternoons: 2 CNA's 300 Hall 1 CNA 4th floor/400 Hall; Nightshift: 2 CNA's [DATE]- Afternoon shift: 2 CNA' 400 hall and also with 1 nurse 200 and 400 hall; Night shift 2 CNA's each hall, with 1 nurse each hall. [DATE]- Day shift: 2 CNA's 300 and 400 Halls with 1 nurse 400 hall; Afternoons- 2 CNA's and 1 nurse 400 hall; Nightshift; 1 nurse each hall, 2 CNAs on 400 hall. [DATE]- Day shift 2 CNA's, 1 call in (were 3) 200 hall and 400 halls with 2 CNA's; Afternoons: 2 CNA's 200 Hall and 1 CNA 400 Hall; Nightshift 1 nurse each hall and 1 CAN 300 and 400 Halls; 2 CNA's 200 Hall. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE]- Day shift: 2 CNA's 200 and 300 Halls and 1 CNA 400 hall; Afternoons 1 CAN 200 Hall and 2 CNA's 400 Hall with 1 nurse 400 hall; Nightshift: 1 nurse each hall and 2 CNA's each hall. [DATE]- Day shift: 1 CNA 400 hall, 2 CNA's 300 hall and 1 nurse 200 hall; Afternoon shift: 1 nurse 200 and 400 halls and 2 CNA's 400 hall; Nightshift: 1 nurse each floor 200, 300, 400 and 2 CNA's 200 and 300 floors. [DATE]- Day shift: 2 CNA's 200 hall and 1 nurse 400 hall; Afternoons: 1 nurse and 2 CNA's 400 hall; Nightshift: 1 nurse and 2 CNA's each floor. [DATE]- Afternoon shift: 2 CNA's 300 hall; Nightshift 1 nurse each hall/floor and 2 CNA's 300 and 400 halls. Multiple CNA's and Nurses were observed on the schedule to be working double shifts/each eight hours. There were several instances when there was only 1 CNA or 1 Nurse on a shift for approximately ,d+[DATE] residents. On the morning that Resident #1 had a change of condition and was transferred to the hospital, Nurse K had worked a double shift from the Afternoon of [DATE] (3:00 PM-11:30 PM) to the Nightshift (11:00 PM-7:30 PM) on [DATE] to the morning of [DATE]. This was a 16 -hour double shift for the nurse. The same night 1 aide on the 300 hall worked a double shift/Afternoon and Nightshift and both aides on the 400 hall worked a double from Afternoons to Nightshift. On [DATE], the evening when Resident #3 fell on the 300 hall and severely injured her head, there was only 1 aide on the 400 hall with 1 nurse. Nurse aides were transferred from the 300 hall to the 400 hall to assist the 1 aide. United States Department of Labor, Occupational Safety and Health Administration: Long Work Hours, Extended or Irregular Shifts, and Worker Fatigue: .Long work hours may increase the risk of injuries and accidents and can contribute to poor health and worker fatigue. Studies show that long work hours can result in increased levels of stress . RN Journal ,d+[DATE], Literature Review: Safe Nurse Staffing, . Safe nurse staffing poses substantial issues at the clinical level including its tremendous impact on patient mortality, patient satisfaction, increased incidence of medical errors, and nurse dissatisfaction and burnout . Medicare.gov, undated, Your Rights and Protections as a Nursing Home Resident What are my rights in a nursing home? As a nursing home resident, you have certain rights and protections under Federal and state law that help ensure you get the care and services you need. You have the right to be informed, make your own decisions . At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to: Be Treated with Respect: You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose. You have the right to decide when you go to bed, rise in the morning, and eat your meals . 31997 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a phone interview conducted on [DATE] at 4:50 PM, Licensed Practical Nurse Y was asked how staffing was in the facility, and verbalized several concerns related staffing. LPN Y verbalized she had been employed at the facility for several months, and that staffing had been a problem and very challenging at times and still was. LPN Y indicated that on a specific day, Saturday, [DATE], she was the only staff member scheduled to work the 4th floor. LPN Y went on to indicate on that day, she was in care of 23 residents with out a nursing assistant to help care for the residents. LPN Y verbalized that she was responsible to provide all Activities of Daily Living care. LPN Y indicated she had 4 residents that needed help with eating and had to be fed, and there were residents with behavioral problems and needed close supervision, and also some that needed 2 person assist. LPN Y indicated she was responsible to check and change all 23 residents every 2 hours. LPN Y indicated she was responsible for everything that all 23 residents needed. LPN Y verbalized she was responsible to pass all the trays at 2 meal times, breakfast and lunch, and complete her Charge Nurse responsibilities such as passing medications and performing the treatments assessments, and all other responsibilities a Charge Nurse does. LPN Y said, I just could not do all the work as a nurse and as a nursing assistant. I was very frustrated and angry. I put a call out to upper management to tell them I was overwhelmed and nothing was done. The Administrator and the Director of Nursing were aware of the situation, but did nothing to change it. There were 3 other nurses on other floors and no one came to help out. LPN Y was asked if she had to work alone because of call ins, and verbalized No, it was scheduled that way. I just couldn't do all the work that 2 or 3 staff members are normally supposed to do. I just couldn't give good care. I tried, but I am only one person. LPN Y verbalized that on [DATE]th, there were only 4 scheduled nurses for the whole building. Staffing was a problem and still is. The upper management just don't care. I called the State Agency to get them involved. This is wrong. The residents deserve better than what is going on. There have been times when residents are trying to get out, not being supervised, or cared for as needed. There is just not enough help here to give good care. I hope someone does something for these residents because they deserve better care than what they are receiving. Review of staffing assignment sheet dated [DATE], reflected there was not a scheduled Nursing Assistant assigned to work the day shift on the 400 floor.