STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235532	A. Building B. Wing	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashley Healthcare Center	103 West Wallace Street Ashley, MI 48806

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 0656 Level of Harm - Actual harm Residents Affected - Few	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** 28101 Based on observation, interview, and record review, the facility failed to update and implement interventions on careplans for 1 Resident (R 2) reviewed for pressures ulcers, resulting in R 2 developing 2 unstageable facility acquired pressure ulcers, one on his buttock and one on his left heel. Findings include: Review of R 2's face sheet dated 8/31/21 revealed he was an [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Vascular dementia, major depressive disorder, anxiety, lymphedema, schizophrenia, polyneuropathy, COVID-19, muscle weakness and history of falling. R 2 had a guardian. Review of R 2's Kardex dated 8/31/21 revealed interventions for skin that included: Turn resident side to side using wedge cushions while in bed Q1h (every hour) and PRN (as needed) as resident allows. Encourage resident to not lay on his back. Review of R 2's ADL (activities of daily living) care plan date of revision 3/24/21 revealed he required extensive assistance of 2 people for bed mobility especially with lower extremities dated, 10/11/19. For eating he was independent with set up, I am needing monitoring as I decline in my swallowing abilities dated, 10/11/19. Review of R 2's pain care plan dated revision 6/21/21 revealed, I have pain to my lower back and bilateral lower extremities. I often report relief with main management interventions and laying down in my bed. I do have complaints of pain when I sit up for long periods of time. My fentanyl patch in place for pain management has been increased and I am able to vocalize my pain management needs. I have pain to my lower extremities and buttock. My current pain med orders are fully effective but prefer not to increase the dosages. My acceptable level of pain is 7/10. Interventions included, encourage me to request pain medication before pain becomes unbearable, dated 10/11/19. Monitor and record any non-verbal signs of pain (e.g., Crying, guarding, moaning). Review of R 2's skin integrity care plan dated 11/6/19 and revised on 2/22/19 revealed a history of venous ulcers both lower extremities. There was no indication of a pressure ulcer on his heel or his buttock. Review of R 2's full care plan revealed no care plan was implemented for his pressure ulcers. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Actual harm Residents Affected - Few	R 2 was observed on his back in bed on 8/31/21 at 9:40 AM, (breakfast is served around 8:00 am). On 8/31/21 at 10:00 AM, Licensed Practical Nurse (LPN) P said she normally changes R 2's dressing on his buttock between 10:00 AM and 11:00 AM daily. LPN P said she gives he narcotic pain medication around 8:00 AM as she was aware that turning and the dressing change was painful for R2. LPN P said the Director of Nursing (DON) had been doing wound measurements. LPN P and Certified Nurse Aide (CNA) L turned R 2 on his right side to do his dressing change. When R 2's brief was removed there was no dressing over the coccyx. The coccyx was covered by several red saturated 2 x 2 gauze pads. LPN P said R 2 was having a bowel movement and they would have to wait to do the dressing change. On 8/31/21 at 10:10 AM, the DON said R 2 had a history of excoriation on his buttock and was noted to be open over the coccyx on 8/19/21. The DON said she had been doing the weekly wound measurements but did not have time to chart the measurements. The DON had a dressing with dates and sizes marked. The DON said she would do a late entry with the wound measurements. On 8/31/21 at 10:50 AM, the DON measured R 2 coccyx wound 2.6 cm x 2.2 cm by 2.0 cm deep. The DON said the wound was narrower but deeper. Review of R 2's order revealed an order dated 8/19/21 at 4:45 PM Nystatin/AntAcid/DesitinCream, Apply to testicles and bilateral gluteal folds TID (3 times a day) and PRN. Review of R 2's orders revealed an order dated 8/23/21 at 2:30 PM, Cleanse coccyx with normal saline, pat dry, apply opticell ag to wound bed, and cover with bordered foam dressing every day shift for wound care AND as needed for wound care. (This was not in place for observation 8/31/21 at 10:00 AM). Review of R 2's progress note dated 7/29/21 at 3:01 PM revealed, Resident continues with increase in norco (narcotic pain medication) for complaints of pain. Resident did complain of some buttock discomfort relieved with repositioning. Treatment changed to buttocks. Noted excoriation to right buttock, 2 areas. One area 1 cm x 2 cm and the other area 1 cm x 1.5 cm. Left buttock 1 cm x 0.5 cm. Overall fragile area 8.5 cm x 7.5 cm. New treatment Optifoam Gentle SA foam applied to area every 7 days. No wound assessment charting located in R 2's medical record could be located for this wound. The next progress notes for R 2's wound on his buttock was dated 8/19/21 at 5:24 PM and was signed by the DON. Review of R 2's progress noted dated 8/19/21 at 5:24 PM revealed, Resident with 2.5 x 3.5 unstageable pressure ulcer to coccyx. Medium amount of serous drainage. No odor noted. Resident continues to decline. New order cleanse coccyx with normal saline, pat dry, apply opticell ag cove with border foam dressing everyday and prn. Guardian notified and updated on resident's condition. Guardian was asked about prior recommendations to hospice. Options were discussed and guardian wishes to meet with name of hospice to sign resident on for services Monday at 10 am. No wound assessment was located in the assessment section for this wound. This was the last note in the progress note section of R 2's electronic medical record as of 9/1/21. Review of R 2's History and Physical dated 8/6/21 revealed under Assessment and Plan: 1. Coccyx large excoriation, surrounding erythema continued wound car, clean with NS (normal saline), Magic Butt Cream (nystatin, Maalox, desitin) and Heel protectors, follow with wound care, turning patient and protein supplementation. (No measurement of open areas as noted on 7/29/21). (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	The DON provided a typed timeline of R 2's pressure ulcers: No wound measurements for May, June and July 5/19/21 Magic butt cream order PRN every 12 hours for excoriation. 7/29/21 Treatment initiated to cleanse bilateral buttock and apply optifoam gentle foam every 7 days and prn for excoriation. 8/11/21 Treatment changed to cleanse coccyx with wound cleanser pat dry apply therahoney sheet cut to fit and cover with optifoam daily. 8/19/21 Unstageable pressure ulcers noted to coccyx 2.5 cm x 3.5 cm. 8/19/21 New treatment initiated to cleanse coccyx with normal saline pat dry apply opticell ag to wound bed and cover with bordered foam dressing daily 8/25/21 unstageable pressure ulcer to the left heel 1.0 cm x 1.5 cm. 8/25/21 New treatment initiated to left heel to apply sin prep TID. 8/31/21 Pressure ulcer to coccyx remains unstageable due to center of wound being necrotic. Necrotic area decreasing. 2.6 cm x 2.2 cm x 2.0 cm overall size of wound decreased wound improving. Depth increased, width decreased, and length decreased. During an interview with the DON on 9/2/21 at 10:20 AM, the timeline she provided for R 2 was reviewed. The DON admitted the facility did not have proper wound measurements, evidence of prevention and treatment in place prior to the wound and once the wounds were noted. The DON was not sure when the pressure ulcer started and said skin assessments did not indicate when the ulcer started. At this time surveyor requested the pressure ulcer care plan, all wound assessments/treatments/orders. Upon exit these documents were not provided.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observation, interview and record review, the facility failed to prevent, assess, and treat 1 Resident (R 2) for pressures ulcers, resulting in R 2 developing 2 unstageable facility acquired pressure ulcers, one on his buttock and one on his left heel. Findings include: Review of R 2's face sheet dated 8/31/21 revealed he was an [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Vascular dementia, major depressive disorder, anxiety, lymphedema, schizophrenia, polyneuropathy, COVID-19, muscle weakness and history of falling. R 2 had a guardian. Review of R 2's Kardex dated 8/31/21 revealed interventions for skin that included: Turn resident side to side using wedge cushions while in bed Q1h (every hour) and PRN (as needed) as resident allows. Encourage resident to not lay on his back. Review of R 2's ADL (activities of daily living) care plan date of revision 3/24/21 revealed he required extensive assistance of 2 people for bed mobility especially with lower extremities dated, 10/11/19. For eating he was independent with set up, I am needing monitoring as I decline in my swallowing abilities dated, 10/11/19. Review of R 2's pain care plan dated revision 6/21/21 revealed, I have pain to my lower back and bilateral lower extremities. I often report relief with main management interventions and laying down in my bed. I do have complaints of pain when I sit up for long periods of time. My fentanyl patch in place for pain management has been increased and I am able to vocalize my pain management needs. I have pain to my lower extremities and buttock. My current pain med orders are fully effective but prefer not to increase the dosages. My acceptable level of pain is 7/10. Interventions included, encourage me to request pain medication before pain becomes unbearable, dated 10/11/19. Monitor and record any non-verbal signs of pain (e.g., Crying, guarding, moaning). Review of R 2's skin integrity care plan dated 11/6/19 and revised on 2/22/19 revealed a history of venous ulcers both lower extremities. There was no indication of pressure ulcer on his heel or his buttock. Review of R 2's full care plan revealed no care plan was implemented for his pressure ulcers. R 2 was observed on his back in bed on 8/31/21 at 9:40 AM, (breakfast is served around 8:00 am). On 8/31/21 at 10:00 Licensed Practical Nurse (LPN) P said she normally changes R 2's dressing on his buttock between 10:00 AM and 11:00 AM daily. LPN P said she gives he narcotic pain medication around 8:00 AM as she was aware that turning and the dressing change was painful for R2. LPN P said the Director of Nursing (DON) had been doing wound measurements. LPN P and Certified Nurse Aide (CNA) L turned R 2 on his right side to do his dressing change. When R 2's brief was removed there was no dressing over the coccyx. The coccyx was covered by several red saturated 2 x 2 gauze pads. LPN P said R 2 was having a bowel movement and they would have to wait to do the dressing change. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 8/31/21 at 10:10 AM, the DON said R 2 had a history of excoriation on his buttock and was noted to be open over the coccyx on 8/19/21. The DON said she had been doing the weekly wound measurements but did not have time to chart the measurements. The DON had a dressing with dates and sizes marked. The DON said she would do a late entry with the wound measurements. On 8/31/21 at 10:50 AM, the DON measured R 2 coccyx wound 2.6 cm x 2.2 cm by 2.0 cm deep. The DON said the wound was narrower but deeper. Review of R 2's order revealed an order dated 8/19/21 at 4:45 PM, Nystatin/AntAcid/DesitinCream, Apply to testicles and bilateral gluteal folds TID (3 times a day) and PRN. Review of R 2's orders revealed an order dated 8/23/21 at 2:30 PM, Cleanse coccyx with normal saline, pat dry, apply opticell ag to wound bed, and cover with bordered foam dressing every day shift for wound care AND as needed for wound care. (This was not in place for observation 8/31/21 at 10:00 AM). Review of R 2's progress note dated 7/29/21 at 3:01 PM revealed, Resident continues with increase in norco (narcotic pain medication) for complaints of pain. Resident did complain of some buttock discomfort relieved with repositioning. Treatment changed to buttocks. Noted excoriation to right buttock, 2 areas. One area 1 cm x 2 cm and the other area 1 cm x 1.5 cm. Left buttock 1 cm x 0.5 cm. Overall fragile area 8.5 cm x 7.5 cm. New treatment Optifoam Gentle SA foam applied to area every 7 days. No would assessment charting located in the assessment of R 2's medical record could be located for this wound. The next progress notes for R 2's wound on his buttock was dated 8/19/21 at 5:24 PM and was signed by the DON. Review of R 2's progress noted dated 8/19/21 at 5:24 PM revealed, Resident with 2.5 x 3.5 unstageable pressure ulcer to coccyx. Medium amount of serous drainage. No odor noted. Resident continues to decline. New order cleanse coccyx with normal saline, pat dry, apply opticell ag cove with border foam dressing everyday and prn. Guardian notified and updated on resident's condition. Guardian was asked about prior recommendations to hospice. Options were discussed and guardian wishes to meet with name of hospice to sign resident on for services Monday at 10 am. No wound assessment was located in the assessment section for this wound. This was the last note in the progress note section of R 2's electronic medical record as of 9/1/21. Review of R 2's History and Physical dated 8/6/21 revealed under Assessment and Plan: 1. Coccyx large excoriation, surrounding erythema continued wound car, clean with NS (normal saline), Magic Butt Cream (nystatin, Maalox, desitin) and Heel protectors, follow with wound care, turning patient and protein supplementation. (No measurement of open areas as noted on 7/29/21). The DON provided a typed timeline of R 2's pressure ulcers: No wound measurements for May, June and July 5/19/21 Magic butt cream order PRN every 12 hours for excoriation. 7/29/21 Treatment initiated to cleanse bilateral buttock and apply optifoam gentle foam every 7 days and prn for excoriation. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	8/11/21 Treatment changed to cleanse coccyx with wound cleanser pat dry apply therahoney sheet cut to fit and cover with optifoam daily. 8/19/21 Unstageable pressure ulcers noted to coccyx 2.5 cm x 3.5 cm. 8/19/21 New treatment initiated to cleanse coccyx with normal saline pat dry apply opticell ag to wound bed and cover with bordered foam dressing daily 8/25/21 unstageable pressure ulcer to the left heel 1.0 cm x 1.5 cm. 8/25/21 New treatment initiated to left heel to apply sin prep TID. 8/31/21 Pressure ulcer to coccyx remains unstageable due to center of wound being necrotic. Necrotic area decreasing. 2.6 cm x 2.2 cm x 2.0 cm overall size of wound decreased wound improving. Depth increased, width decreased, and length decreased. During an interview with the DON on 9/2/21 at 10:20 AM, the timeline she provided for R 2 was reviewed. The DON admitted the facility did not have proper wound measurements, evidence of prevention and treatment in place prior to the wound, and once the wounds were noted. The DON was not sure when the pressure ulcer started and said skin assessments did not indicate when the ulcer started. At this time surveyor requested the pressure ulcer care plan, all wound assessments/treatments/orders. Upon exit these documents were not provided.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on observation, interview and record review, the facility failed to effectively control 1 Resident's pain (R 2), resulting in R 2 having to experience high levels of pain. Findings include: Review of R 2's face sheet dated 8/31/21 revealed he was an [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Vascular dementia, major depressive disorder, anxiety, lymphedema, schizophrenia, polyneuropathy, COVID-19, muscle weakness and history of falling. R 2 had a guardian. Review of R 2's ADL (activities of daily living) care plan date of revision 3/24/21 revealed he required extensive assistance of 2 people for bed mobility especially with lower extremities dated, 10/11/19. For eating he was independent with set up, I am needing monitoring as I decline in my swallowing abilities dated, 10/11/19. Review of R 2's pain care plan dated revision 6/21/21 revealed, I have pain to my lower back and bilateral lower extremities. I often report relief with main management interventions and laying down in my bed. I do have complaints of pain when I sit up for long periods of time. My fentanyl patch in place for pain management has been increased and I am able to vocalize my pain management needs. I have pain to my lower extremities and buttock. My current pain med orders are fully effective but prefer not to increase the dosages. My acceptable level of pain is 7/10. Interventions included, encourage me to request pain medication before pain becomes unbearable, dated 10/11/19. Monitor and record any non-verbal signs of pain (e.g., Crying, guarding, moaning). On 8/31/21 at 10:00 AM, Licensed Practical Nurse (LPN) P said she normally changes R 2's dressing on his buttock between 10:00 AM and 11:00 AM daily. LPN P said she gives his narcotic pain medication around 8:00 AM as she was aware that turning and the dressing change was painful for R2. LPN P said the Director of Nursing (DON) had been doing wound measurements. LPN P and Certified Nurse Aide (CNA) L turned R 2 on his right side to do his dressing change. When R 2's brief was removed there was no dressing over the coccyx. The coccyx was covered by several red saturated 2 x 2 gauze pads. LPN P said R 2 was having a bowel movement and they would have to wait to do the dressing change. On 8/31/21 at 10:50 AM, the DON measured R 2 coccyx wound 2.6 cm x 2.2 cm by 2.0 cm deep. The DON said the wound was narrower but deeper. Review of R 2's progress note dated 7/29/21 at 3:01 PM revealed, Resident continues with increase in norco (narcotic pain medication) for complaints of pain. Resident did complain of some buttock discomfort relieved with repositioning. Treatment changed to buttocks. Noted excoriation to right buttock, 2 areas. One area 1 cm x 2 cm and the other area 1 cm x 1.5 cm. Left buttock 1 cm x 0.5 cm. Overall fragile area 8.5 cm x 7.5 cm. New treatment Optifoam Gentle SA foam applied to area every 7 days. No would assessment charting located in the assessment of R 2's medical record could be located for this wound. The next progress notes for R 2's wound on his buttock was dated 8/19/21 at 5:24 PM and was signed by the DON. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R 2's progress noted dated 8/19/21 at 5:24 PM revealed, Resident with 2.5 x 3.5 unstageable pressure ulcer to coccyx. Medium amount of serous drainage. No odor noted. Resident continues to decline. New order cleanse coccyx with normal saline, pat dry, apply opticell ag cove with border foam dressing everyday and prn. Guardian notified and updated on resident's condition. Guardian was asked about prior recommendations to hospice. Options were discussed and guardian wishes to meet with name of hospice to sign resident on for services Monday at 10 am. No wound assessment was located in the assessment section of R 2's electronic medical record for this wound. The progress note dated 8/19/21 at 5:24 PM was the last note in the progress note section of R 2's electronic medical record as of 9/1/21. R 2 was observed in bed on 9/1/21 at 9:49 AM. R 2 was on his right-side groaning in pain. R 2 rated the pain in his buttock at 9 on a scale of 1 to 10. The Surveyor reported R 2's pain complaint to RN S. RN S said she had changed R 2's dressing on his buttock at 8:00 AM and he was not in pain at that time. RN S said she did not give any pain medication prior to doing the dressing change. RN S reviewed R 2's pain medication and said the last time R 2 had pain medication was at 9:00 PM on 8/31/21. RN S said she would get R 2 pain medication now. Review of R 2's pain medication orders revealed, Gabapentin capsule 300 MG started 10/19/19, give 1 capsule by mouth 3 times a day, Fentanyl patch 72 hour 12 MCH/HR apply 1 patch every 72 hours started 8/18/21, Norco Tablet 10-325 MG, give 1 tablet by mouth every 6 hours for pain, started 8/14/21, Tramadol HCL Tablet 50 MG give 1 tablet by mouth every 8 hours as needed for break through pain started 8/14/21 and Morphine Sulfate Solution 20 MG/ML, Give o.25 ml sublingual every 4 hours as need for pain. Review of R 2's Medication Administration Record (MAR) dated 8/31/21 revealed the last dose of Norco was given at 1900 (7:00 PM). The last dose of Norco ordered on 8/31/21 was not marked as given. The last dose of Tramdol HCL was given at 2139 (9:39 PM). Review of R 2's MAR for 9/1/21 reveal Norco 10-325 MG was given at 12:07 AM, 4:01 AM and 10:02 AM (Norco could have been given prior to the dressing change at 8:00 AM), Tramadol HCL Tablet 50 MG was given at 1:01 PM and Morphine Sulfate was given at 11:11 AM.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 38659 This citation pertains to MI00121548, MI00121543, MI00121653, MI00121754, MI00121826 and MI00121915 Based on observation, interview, and record review, the facility failed to provide sufficient numbers of staff to meet the physical and psychosocial needs for 5 residents (R1, R2, R3, R4, and R5), of 5 residents reviewed, resulting in unmet care needs, worsening skin conditions, anxiety, and embarrassment and the potential for unmet needs and anxiety of all facility residents unable to care for themselves Findings include: On 08/31/2021 at 9:47 AM, an interview was completed with staff E regarding resident care. Staff E stated they were working on the morning on 8/1/21 when the building ownership transferred and there residents had not received proper care the night before. Staff E stated they could hear R 1 screaming in her room. R 1 told staff E she had been left on a bed pan all night. Staff E observed R 1 laying on a bedpan with reddened and indented buttocks that supported R 1 had been left on the bedpan for an extended time. R 1's call light was observed by Staff E to be not in reach and on the floor. Staff E stated on the morning on 08/31/21 they also observed R 2 to be extremely soiled. Staff E stated R 2 was visibly upset and stated he had been laying in poop all night. Staff E stated she was told there were only two aides in the building overnight, and this is not enough to care for resident needs. Staff E stated minimally 4 aides would be necessary to provide basic care. Staff E stated at times activity staff was on the locked dementia unit trying to provide care. On 08/31/21 at 10:11 AM, an interview was completed with staff G regarding resident care. Staff G stated they were working on 8/1/21 and there was not enough staff to care for residents. Staff G stated they were aware that on more than one day during the week of 8/1/21, there was only 2 certified nurses aides in the building and activities and kitchen staff were trying to assist. Staff G stated on 8/1/21 they observed R 1 screaming due to being left on a bed pan and R 2 was also screaming because he was extremely soiled. Staff G stated R 2 told them he had not been changed all night. Staff G stated this was concerning because R 2 has pressure sores. Staff G stated the phones were ringing constantly and no one was answering them. R 4 Review of R 4's face sheet revealed they were a [AGE] year old resident who admitted to the facility on [DATE] with diagnosis that included nontraumatic intracerebral hemorrhage (stroke), muscle weakness and chronic kidney disease. R 4 was not her own responsible party. On 08/31/21 at 10:34 AM an interview was completed with a family member H of R 4 regarding staffing. Family H stated they were trying to moved their family out of the building prior to 8/1/21 and there were delays. Family H stated he kept calling the facility the week of 8/1/21 and the phone rang and rang, no one answered. Family H stated they came to the building in person on 8/4/21 at around 3:00 PM and there were only 2 aides in the building providing care. Family H stated they observed this and the staff on the floor confirmed it. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R 3 Review of R 3's face sheet revealed he was a [AGE] year old who admitted to the facility on [DATE] with diagnoses that included: malignant neoplasm (cancer) of bladder, acute kidney failure and major depressive disorder. R 3 was his own responsible party. Review of R 3's kardex/care plan revealed he required assistance for hygiene and toileting. On 08/31/21 at 10:52 AM, an interview was completed with former resident, R 3 by phone. R 3 stated that the care he received after the change of ownership on 8/1/21 was very delayed and there were not enough staff there. R 3 stated that meals were served very late a couple days and recalled one day he did not receive breakfast until 9:30 AM when it was supposed to be served at 7:30 AM. R 3 stated that on 8/11/21 he sat in urine for over two hours. R 3 stated he has a urostomy and it had leaked that day. He used his call light at about 8:30 AM and he was sitting in urine and not cleaned up until after 10:30 AM. They changed his urostomy equipment later that day as well. R 3 stated his urostomy also leaked again and that was in the afternoon and he waited over an hour to be cleaned up. R 3 stated he believed that happened on 8/14/21. Review of R 3's progress notes revealed a nursing note on 8/11/21: Resident's urostomy changed around 12pm supplies had arrived around 11:35 am, residents abdomen had to be shaved by writer in order to ensure the urostomy bag fully intact, previous attempts to keep the bag intact had be (sic) all week and the bag was changed numerous times on 8/9/21 . On 08/31/21 at 2:30 PM, an interview was completed with the Director of Nursing (DON). The DON admitted that on 08/11/21 they realized that they were out of R 3's urostomy supplies. They had other supplies in house, but they did not fit. They were able to get supplies delivered from another facility since ordering supplies would take several days. The DON admitted there was a lot of problems with R 3's urostomy leaking and they ended up shaving the area, which helped. The DON stated the issues with the urostomy on 8/9/11 was not because they did not have the correct supplies and the supplies that fit R 3's urostomy must have ran out due to the many changes should have been reordered. The DON stated they try to keep one month of supplies in house. 28101 On 9/1/21 at 10:20 AM, R 2 said he had not had breakfast. RN S said she would check to see which Certified Nurse Aide (CNA) was assigned to provide R 2 breakfast. CNA J was assigned to feed R 2. CNA J said she did not know she was assigned to feed R 2 and reported she feed two other residents at breakfast. RN S spoke to the 2 other CNA's working at that time and one CNA feed two other residents and the 3rd CNA M said she fed one other resident. RN S asked CNA M (the one that had only one resident to feed) to take over feeding R 2 at lunch along with the one resident on her assignment. CNA M said the person she had to feed has tremors and takes 30 minutes to feed so she would not have time to fed R 2. On 9/1/21 at 10:30 AM, the surveyor reported R 2 had not been fed breakfast and staff said they did not have enough time to feed all residents lunch to the Director of Nursing (DON) and Nursing Home Administrator (NHA). The DON met with staff, changed assignments, and had other facility staff assist with passing lunch trays, picking up trays and started a system of reporting when trays return to the kitchen untouched. The DON said on weekend activity staff would be assisting with meals. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235532	A. Building B. Wing	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashley Healthcare Center	103 West Wallace Street Ashley, MI 48806

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/1/21 at 11:55 AM, food trays were delivered. The DON, NHA and two other facility staff assisted the CNA's pass lunch trays and feed resident. All residents that needed assistance eating were provided assistance and all residents ate lunch.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28101 Based on interview and record review, the facility failed to provide collaborative hospice care for 1 Resident (R 2), resulting in all care staff not being aware of what services were being provided and the potential for services not to be delivered. Findings include: Review of R 2's face sheet dated 8/31/21 revealed he was an [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Vascular dementia, major depressive disorder, anxiety, lymphedema, schizophrenia, polyneuropathy, COVID-19, muscle weakness and history of falling. R 2 had a guardian. Review of R 2's full care plan revealed there was no hospice care plan in place. Review of R 2's orders revealed, 7/26/21, Okay for name of hospice company admission. Review of the Hospice company medical records revealed R 2 was evaluated by a hospice social worker on 8/23/21 and a hospice registered nurse on 8/24/21. Review of R 2's facility medical records for 8/23/21 and 8/24/21 did not reveal any indication R 2 had any hospice services on these dates. During an interview with the Director of Nursing (DON) on 8/31/21 at 10: 10 AM, the DON said R 2 was on hospice services. The Surveyor requested facility medical records that showed what hospice services hospice was providing for R 2. The DON said she would provide the records. The DON returned and reported the hospice service had the wrong information to send the facility their medical records, but they would provide the medical records today. The DON said the facility did not have a care conference with hospice staff and there was no indication of treatments or service hospice had provided for R 2 in the facility medical record at this time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235532	A. Building B. Wing	09/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ashley Healthcare Center	103 West Wallace Street Ashley, MI 48806

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38659 This citation pertains to MI00119345 Based on observation, interview, and record review, the facility failed to follow accepted and expected Infection Control practices, resulting in the potential for the spread of contagious and infectious disease and illnesses to all facility residents who are susceptible, elderly and/or physically compromised. Findings include: On arrival to the facility on [DATE] at approximately 1:00 PM, staff member Q was viewed from the door to be in the facility wearing no mask or face covering. On 08/27/21 at approximately 1:11 PM, 2 visitors were viewed to be within 6 feet of a resident in the resident room and none were wearing a mask over their mouth and nose. A staff member was viewed to enter the room and talk with the visitors and did not ask the visitors to put a mask over their mouth and nose. At 1:27 PM, the 2 visitors were viewed again to not be wearing a mask and still visiting with a resident in their room. The visitors were asked if anyone had talked to them about wearing a mask in the building, one of the visitors stated yes, we were given a mask when we came in, but (the resident) is hard of hearing so we take if off when we visit. The other visitor stated we will put them back on when we leave the building. On 8/31/21 at approximately 8:30 AM, the Director of Nursing (DON) informed the survey team that a contract staff member had tested positive for COVID-19 and N95 masks were now required on the floor. On 09/01/21 at approximately 11:45 AM, the Nursing Home Administrator (NHA) was viewed in the resident halls and stopping by resident rooms while wearing a surgical mask. On 09/02/21 at approximately 08:35 AM, kitchen staff R was viewed in the dining area handling soiled dishes and her N95 mask was viewed on top of her head and not covering her nose or mouth. Staff R was within 6 feet of another staff member and talking to them during the time they were observed as well.