STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235102	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ambassador, A Villa Center	8045 E Jefferson Ave Detroit, MI 48214

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39465 Based on observation, interview, and record review the facility failed to ensure the dignity for one resident (R110) of three residents reviewed for dignity, resulting in verbalized feelings of embarrassment and frustration. Findings included: On 9/25/24 at 11:47 a.m. R110 reported that the physician placed an order at least two months ago to be seen by a podiatrist to get the residents toenails cut and for the dry skin and it has not happened. R110 stated, I want my long thick toenails to be cut on both feet because I don't want anyone to see my toenails like that. Its embarrassing and that is why I got very angry. R110 pointed to their feet and the great toe and the second toe on the left foot were observed with dry scaly skin on top of the toes and between the toes with dark areas and long thick toenails with an unpleasant odor. The right foot also had long, thick, discolored toenails and dry skin between the toes. The fifth toenail on the right foot appeared to have been broken and exposed thick dried skin from the top of the toe to the top of the nail. According to the electronic health record (EHR), R110 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses of Neuropathy, major depressive disorder, and functional quadriplegia. R110 's annual Minimum Data Set (MDS) with a reference date of 9/1/2024 indicated R110 was cognitively intact with a BIMS (brief interview for mental status) score of 14/15 and required one person-assistance for hygiene. Review of the Activity Daily Living (ADL) care plan-initiated date of 8/27/2022 documented, The resident has an ADL self-care performance deficit related to impaired mobility related to Neuromyelitis Optica, functional quadriplegia. Interventions: Check nail length and trim and clean on bath days and as necessary. Report any changes to the nurses. On 9/27/24 at 12:10 p.m. the Director of Nursing (DON) was interviewed regarding the lack of foot care for R110. The DON confirmed R110 was not seen by the podiatrist and could not explain why nursing staff did not provide basic hygiene to the resident's feet. The DON said that R110 had a reason to be frustrated and embarrassed about the long thick toenails and malodorous feet. (continued on next page)

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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's 11/28/2017 Resident Rights policy: Our facility will treat each resident with respect and dignity and care for each resident in a manner an in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 Based on interview and record review, the facility failed to ensure the Preadmission Screening (PAS)/ Annual Resident Review (ARR) form for Mental Illness/ Intellectual Disability/ Related Conditions Identification (DCH-3877) document was accurate, complete, and sent to the local state agency for an evaluation for a Level II determination for one (R57) of seven residents reviewed for PASSARs, resulting in the potential for unmet intellectual/ developmental disability care needs. Findings include: R57: According to the Electronic Health Record (EHR), R57 admitted to the facility on [DATE] with diagnoses that included Adjustment Disorder, Bipolar Disorder, Anxiety, and Depression. R57 was prescribed two antipsychotic medications; Cymbalta (an anti-depressant) 30 milligrams (mg) twice a day and Olanzapine (an anti-psychotic) 2.5 mg twice a day (used to treat schizophrenia). On 8/24/24 a care plan was initiated for 'use of psychiatric medications'. A review of the only DCH-3877 form in the resident's EHR was dated 8/21/24 and indicated that R57 had no mental illness and was not being treated with antidepressants or antipsychotic medications. On 9/11/24, R57 was seen by Psychiatric services and the following was documented; Complaints of bipolar, depression, insomnia, and anxiety. Resident was tearful during interview and said they were emotionally and physically not well. Olazapine was added during resident's hospital stay. On 9/26/24 at 10:15 AM Social Worker (SW) D was asked to review if R57 had an updated PAS/ARR (DCH-3877 form). SW D reviewed the resident's EHR and acknowledged that it was inaccurate and had not been updated at this time. SW D said, Yes, we missed it (DCH-3877). It should have been done upon admission. It was on my list to do, I hadn't completed it yet. According to the facility's PASARR Guideline Effective dated 11/28/17 in part: Purpose: This facility promotes and supports a resident centered approach to care. The purpose of this guideline is to define and set expectations regarding the appropriate preadmission assessment of all individuals with a mental disorder and individuals with intellectual disability. It is the practice of the facility to coordinate the assessment process with the preadmission screening and annual resident review (PASARR) program under Medicaid in Subpart C to the extent practicable to avoid duplicative testing and effort. This includes incorporating the recommendations from the PASARR level II determination and evaluation in the residents' assessment, care plan, and transition of care: and referring all level II residents and all residents with new or evident conditions related to Level II review upon significant change in status assessment. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility will not admit any new residents with: Mental Disorder- unless the State mental health authority has determined, prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by the facility and whether the individual requiresspecialized services: or Intellectual Disability - unless the State intellectual disability or developmental disability authority has determined, prior to admission that, because of the physical and mental condition of the individual, the individual requires the level of services provided by the facility: and if the individual requires such level of services, whether the individual requires specialized services for intellectual disability. The PASARR process consists of the completion of a Level I screen per State and Federal requirements as well as the review and implementation of the Level II recommendations upon admission into the facility.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39465 Based on observation, interview, and record review the facility failed to ensure podiatry services and treatment were provided in a timely manner for one resident (R110) of one resident reviewed for foot care, resulting in the growth of long toenails, build-up of flaky skin on resident's feet, and delay in needed treatment. Findings include: On 9/25/24 at 11:47 a.m. R110 was observed resting in bed. During the resident interview, the resident complained of needing to be seen by the podiatrist due to long thick toenails. R110 pointed to both feet and said, The physician placed an order for a podiatrist appointment at least two months ago to get the toenails cut and for the dry skin and it has not happened. I don't know if they put my name on the list or not, but I have been mentioning it for about two months. R110's great toe and the second toe on the left foot had dry scaly skin on top of the toes and between the toes with dark areas and long thick toenails. The right foot also had long, thick, discolored toenails and dry skin between the toes. The fifth toenail on the right foot appeared to have been broken and exposed thick dried skin from the top of the toe to the top of the nail. R110 stated, I do not want my toes to get infected. I want the long thick toenails to be cut on both feet. On 9/25/24 at 12:12 p.m., the wound care nurse, Licensed Practical Nurse (LPN) E assessed R110's feet and said, The resident toes had dry skin, an odor, the left foot third toe had some discolorations, the toenails were long and the fifth toe on the right foot appeared to be detached. LPN E agreed R110's toenails needed to be cut and the resident should have been seen by a podiatrist for the dry skin and discoloration on the toes. According to the electronic health record (EHR), R110 was initially admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses of Neuropathy, pressure ulcer of sacral region stage four, major depressive disorder, and functional quadriplegia. R110 's annual Minimum Data Set (MDS) with a reference date of 9/1/2024 indicated R110 was cognitively intact with a BIMS (brief interview for mental status) score of 14/15. A care plan initiated 9/3/2024 for Activity Daily Living (ADL)' had the following: The resident has an ADL self-care performance deficit related to impaired mobility related to neuromyelitis Optica and functional quadriplegia. Interventions as following: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. Review of the physician orders documented the following: Podiatrist consult as needed dated 1/26/2024. Refer to podiatry for toenails fungus, and trim dated 8/27/2024. Further review of the R110's EHR did not revealed any podiatry consults or progress notes. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/27/24 at 12:10 p.m. the Director of Nursing (DON) was interviewed regarding the delay in foot care for R110. The DON confirmed R110's podiatrist consult order was missed, and the resident was not seen by the podiatrist. The DON could not explain why R110 was not seen by the Podiatrist during his monthly visit to the facility and was unable to provide any evidence of podiatry consult for R110 for 8/24/2024. According to the facility's 11/2023 Foot Care policy: 1. Residents will be provided with foot care and treatment in accordance with professional standards of practice . 3. Residents will be assisted in making transportation appointments to and from specialists (podiatrist) as needed.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 Based on observation, interview and record review the facility failed to provide medically related social services for one resident (R70) of two residents reviewed resulting in the delay of obtaining a legal guardian to initiate discharge planning in a timely manner and the resident expressing frustration. Findings include: On 9/27/24 at 10:00 AM, R70 was observed sitting on the side of the bed. R70 was queried about any concerns regarding the care by the facility, R70 responded, I want to be discharged , I don't want to be here. Review of R70's electronic health record (EHR) revealed admission into the facility on [DATE] with a pertinent diagnosis of vascular dementia (brain damage caused by multiple strokes). According to the Minimum Data Set (MDS) dated [DATE], R70 scored 8 out of 15 on Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. Further review revealed resident did not have a guardian. Review of Report of Physician or Mental Health Professional dated and signed by the Psychiatrist on 4/18/23, documented, I believe the individual due to these described conditions, is not presently able to make informed decisions in the following areas: determining where to live, consenting for supportive services, handling financial affairs, authorizing or refusing medical treatment. Further review of R70's EHR revealed, on 9/28/23, SW (Social Worker) received a call from the receptionist reporting resident is attempting to leave facility AMA (Against Medical Advice). On 8/5/24, SW was asked to talk to resident because is adamantly seeking to D/C (discharge) back into the community with no real discharge plan in place because he is homeless. Interview on 9/27/24 at 10:48 AM with Social Worker (SW) D, acknowledged that R70 had made several requests to be discharged from the facility, but had no legal guardian to assist with discharge planning. SW D reported that a decision could not have been made to discharge to another location because a legal guardian had not been obtained. SW D stated, In all honesty, I should have been more consistent in monitoring why the resident did not get a legal guardian sooner and the (discharge) process initiated related to the courts. An interview on 9/27/24 at 12:52 PM the Nursing Home Administrator (NHA), said, When a resident is determined to be clinically unable to make decisions, a legal guardian should be obtained. The Social Worker did not try to obtain a legal guardian in a timely manner. If a guardian had been obtained, a decision could have been made to ensure the best discharge or placement for the best interest for the resident.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 15194 Based on observation, interview and record review the facility failed to post and plan alternate meals and All Time Available food choices, resulting in numerous complaints of dissatisfaction with meal choices and food. This deficient practice affected 159 of 170 residents who received meals from the kitchen. Findings include: On 9/25/24 at 9:38 A.M. during an observation in the kitchen, the menu posted identified the following meal choices: Crusted Chicken, Buttered pasta, Buttered Carrots, Apple Crumble, Beverage. There were no alternates written on the menu or posted. On 9/25/24 at 1:40 P.M. on the 2 south and 2 north Units during a lunch meal observation, no alternate meal selection was posted. The menu board had one meal (Today's Meal) posted and there was no other food items or choices for the residents. During the observation resident's H, J, K and L (who wanted to remain anonymous) were observed requesting nursing staff for alternates. Each of these residents were identified as being cognitively intact. On 9/26/24 at 12:35 P.M., during an observation on the tray line Dietary Manager G answered a call from the unit requesting an alternate food item for residentsH and J. Dietary Manager G asked the cook, what was the alternate for today's meal? The cook responded, I have chicken and rice. Dietary Manager G was asked why the residents were served the same food choices as the meal served the previous day for lunch? During the observation Dietary Manager G was asked how residents knew what alternate meal was served and where was it posted? Dietary manager G explained the facility had an ALL Time Available menu and it was posted in the dining rooms on each floor. Dietary Manager G was asked to show the location of the Alternate Menus for the residents. Escorted by Dietary managers G the 2 south, 2 north and 3 rd floor menu boards and dining areas were checked. There were no alternates, or All times Available menu posted on any of the floors. Dietary manager's G provided no explanation why the Alternates were not posted or planned. On 9/26/24 at 2:30 P.M. review of the Food Committee minutes from the Resident Council for May, June, and August 2024 indicated there had been identified concerns with alternate menus not being posted and not being followed. No minutes were provided for the month of July, 2024. On 9/27/24 at 12:30 P.M. review of the facility's policy under #2. stated in part . Menus will be periodically presented for resident review, including the resident council . The menu will identify the primary meal, the alternate meal, and any always offered food and beverage items. #8. Menus will be posted in the Dining Services Department, dining rooms and resident/patient care areas. Upon exiting the facility 9/27/24 at 3:30 P.M.,no additional information was provided concerning why the resident's Alternates food choices and alternate meals were not planned and posted.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 15194 Based on observation, interview and record review, the facility failed to provide at least 80 square feet per resident in multiple resident bedrooms affecting 38 Resident rooms (#'s113, 115, 117, 119, 120, 121, 122, 123, 124, 125, 126, 127, 129, 130, 131, 132, 133,135, 138, 213, 215, 217, 219, 221, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 234, 235, 236, and 238). Findings include: Observation of the Resident rooms on 9/27/2024 at 2:00 P.M., and review of the Facility Bed Count Information sheet revealed the following: ROOM # SQ. FT # OF BEDS # of Residents 113 141' 1.5 2 2 115 141' 1.5 2 2 117 141' 1.5 2 2 119 141' 1.5 2 1 120 141' 1.5 2 2 121 141' 1.5 2 2 122 141' 1.5 2 2 123 141' 1 2 2 124 141' 1 2 2 125 141' 1 2 2 126 141' 1 2 2 127 141' 1.5 2 1 129 141' 1.5 2 2 130 141' 2 2 2 131 141' 1.5 2 2 132 141' 1.5 2 2 (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	133 141' 1.5 2 2 135 141' 5 2 2 138 141' 1.5 2 2 213 150' 5 2 2 215 150' 6 2 2 217 150' 6 2 2 219 150' 6 2 2 221 150' 6 2 2 223 150' 5.5 2 2 224 150' 6 2 2 225 150' 6 2 2 226 2 2 227 150' 6 2 2 228 150' 5.5 2 2 229 150' 5.5 2 2 230 150' 5 2 2 Interviews conducted on 9/27/2024 at 2:30 PM with residents in the rooms listed above, express no concerns regarding room size in relation to their health and safety.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 15194 Based on observation, interview and record review the facility failed to maintain the physical plant and steam table wells used in the kitchen, affecting 159 of the 170 residents who consume food from the kitchen, resulting in the potential for cross contamination, bacterial harbage and staff injury. Findings include: On 9/25/24 at 9:38 A.M. during an observation of the kitchen the grease trap drain was observed overflowing with water from the three-compartment sink. Dietary Manager G indicated the grease drain had been cleaned out a couple of weeks ago but was now draining slow again. On 9/26/24 at 12:35 P.M., the grease trap drain overflowed during an observation of the lunch service. Employees on the tray line was observed standing,and sliding through standing water, attempting to complete the lunch service. During this observation two rubber tubs used to maintain food temperatures on the trayline leaked water between two tables running into the pathway under the tray line. During each of the above observations the wells on the steam table were observed with pieces of old food particles, ash, and burnt on residue. On 9/26/24 at 12:45 P.M. Dietary manager G was queried concerning the steam wells being cleaned. The manager indicated the wells had not been cleaned since starting the job, and acknowledged the wells needed cleaning. A request was made to review the master cleaning schedule, but was not presented as requested. Review of 2022 Food Code Titled Cleaning of Equipment and utensils Section 4-601.11 Equipment, Food-Contact Surfaces, Non-Food Contact Surfaces, and Utensils under (C) Nonfood contact surfaces of equipment shall be kept free of an accumulation of dust, food residue and other debris. On 9/27/24 at 1:40 P.M. interview with Corporate Maintenance Director N concerning the cleaning of the grease trap reported the drain had been cleaned 9/20/24, and the company was scheduled to return on 9/26/24 however did not return. At 2:40 P. M, towels and old rags were observed being used as a barrier for the spilling water from the grease drain. Upon exiting the facility on 9/27/24 at 3:30 P.M. no other additional information was provided.