

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235254	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/22/2024
NAME OF PROVIDER OR SUPPLIER  Vista Grande Villa		STREET ADDRESS, CITY, STATE, ZIP CODE 2251 Springport Rd Jackson, MI 49202	

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)
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46954</p> <p>Based on observation, interview and record review, the facility failed to develop an anti-coagulant Care Plan for one (Resident #19) of 11 reviewed for Care Plans, resulting in the potential for unmet care needs.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #19 (R19) was admitted to the facility on [DATE] with diagnoses that included generalized anxiety disorder and atrial fibrillation. Review of the Admission Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/24 revealed R19 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 11/19/24 at 11:56 AM, R19 was observed in her room, dressed and seated in her recliner. R19 reported that she had recently admitted for rehabilitation purpose.</p> <p>Review of the R19's Medication list revealed R19 was admitted to the facility on Apixaban Oral Tablet 5 milligram (Eliquis, an anticoagulant medication) with a start date of 10/24/24.</p> <p>Review of the Physician order's revealed no order for monitoring for bleeding, bruising, or any side effects related to taking an anticoagulant.</p> <p>Review of the Care Plan revealed no care plan associated to taking an anticoagulant.</p> <p>In an interview on 11/21/24 at 7:54 AM, Director of Nursing (DON) B stated that the expectation for resident's prescribed an anticoagulant included having Physician orders and a care plan in place for monitoring for skin bruising, labs (if applicable), checking for bleeding after any sort of injury especially a fall.</p> <p>DON B reviewed the Care Plan And Physician Order's for monitoring related to the high risk medication and confirmed the absence of both.</p>

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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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45135</p> <p>Based on observation, interview, and record review, the facility failed to revise, and update a comprehensive, individualized plan of care for two (Resident #15 and Resident #26) of 11 residents reviewed for care plans, had a care plan revised for changes in resident's needs, resulting in the potential for not receiving the care needed and psychosocial well-being.</p> <p>Findings include:</p> <p>Resident #15 (R15)</p> <p>Medical record reflected R#15 was admitted to the facility on [DATE]. Diagnoses of Left sided weakness from a Stroke, Dysphagia from the Stroke, Vascular Dementia, and Alzheimer's Disease.</p> <p>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/2024, revealed R#15 had a Brief Interview of Mental Status (BIMS) of 03 (severe cognitively impaired) out of 15. Under section GG0130, Activities of Daily Living (ADL) assessment revealed R#15 requires substantial/maximum assistance with oral hygiene, toileting and dependent on shower/bathing, getting dressed. R#15 required substantial/maximum assist with repositioning in bed. R#15 is dependent on transfers from bed to wheelchair using a mechanical lift and 2 persons assist.</p> <p>During an interview on 11/19/24 at 11:27 AM, R15's family member O, stated R15 had not had his nails trimmed or cleaned as often as the family had requested that they be done. R15 is a 2-person mechanical lift transfer in and out of bed and is dependent of all care.</p> <p>During an observation on 11/19/24 at 11:53 AM, R15 sitting at the dining room table waiting for lunch to be served. Observed R15s fingernails are long and had a brown substance under the nail.</p> <p>During an observation on 11/20/24 at 11:41 AM, R15 sitting at the dining room table eating lunch. Observed his fingernails remained long with brown substance under the nails.</p> <p>During an interview on 11/20/24 at 2:02 PM, Unit Manager (UM) C stated the CNA's there at the facility provide showers to R15 two times a week. UM C also stated the hospice CNAs gave him showers during the week as well. Writer asked why R15's nails were long and had brown substance under his nails. UM C looked at writer with a blank look and then stated she would take care of this.</p> <p>During an observation on 11/21/24 at 09:11 AM, R15 sitting in his wheelchair sitting in the activity room in front of the TV with his eyes closed. Observed R15's fingernails had been cut and cleaned.</p> <p>Record review of care plan revealed R15 had showers during the last 30 days on 10/23/24, 11/02/24, 11/06/24, 11/13/24, 11/20/24 by the facility CNAs. Hospice CNAs gave R15 showers on 10/21/24, 10/25/24, 10/28/24, 11/07/24, 11/18/24 and his nailcare had not been taken care of. Also noted that the care plan had not been revised or updated to reflect any collaboration between hospice and facility to ensure care was provided for this dependent resident.</p> <p>(continued on next page)</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review did not reveal any coordination of care between the facility CNAs and the hospice CNAs and their task to complete. R15s care plan had not been revised or updated after the hospice admission reflecting any collaboration of care.</p> <p>Resident #26 (R26)</p> <p>Record review of Hospice Binder at the nurse's station contained a calendar dated from July 28, 24 through September 22, 24. Hospice binder did not contain the documents necessary for collaboration of care, current calendar with scheduled visits by the hospice team, plan of care (POC), interdisciplinary group (IDG) notes, certified nursing assistants (CNA) care plan, medication list, or visit notes. Nor were these hospice documents in R26's electronic medical record (EMR).</p> <p>During an interview on 11/20/24 at 12:20 PM, R26 stated his hospice CNA is a male, he helps him with his shower and comes in two times a week. R26 also stated that the facility CNAs would give showers on occasion. R26 stated that the water from the shower felt horrible on his skin and was very painful. R26 also added that he had to pace himself due to pain and shortness of breath.</p> <p>During an interview on 11/20/24 at 3:40 PM, Director of Nursing (DON) B brought a small binder of hospice information they found on a shelf in the nurse's station into the conference room to this writer. This information was not part of the hospice binder.</p> <p>During a record review on 11/21/24 at 09:41 AM, original hospice binder now contains the monthly calendar showing which discipline will be coming on which day, CNA care plan, POC, coordination of care, visit notes and IDG notes. According to the visit notes, R26 had a shower from the hospice CNA on 10/16/24, 10/18/24, 10/24/24, 10/25/24, 10/30/24, 11/01/24, 11/05/24, 11/06/24, 11/07/24, 11/12/24, 11/14/24, and 11/19/24. Record review also revealed that R26 did not have any of these documents uploaded into his EMR, nor was their a collaboration of care noted on the CNA's care plan.</p> <p>Record review of shower's given by facility CNAs for last 30 days were 10/25/24, 11/05/24, with one refusal of care on date 11/01/24. Nursing progress notes for the last 30 days did not show that the CNA's had reported the missed showers, attempts to reapproach or reason for not giving the showers to the nurse in charge.</p> <p>Record review revealed that R26 did not receive a shower on 10/15/24, documented on shower sheets, that the hospice CNA would shower the following day. No shower was provided due to hospice CNA coming that day or following day. On 10/25/24, R26 did not receive a shower due to hospice CNA gave him a shower that morning. On 11/01/24, R26 did not receive a shower because the hospice CNA gave him a shower that morning. On 11/06/24, R26 did not receive a shower due to the hospice CNA gave him one that morning. On 11/07/24, R26 did not receive a shower and documented, hospice CNA gave him his shower. On 11/08/24, R26 did not receive a shower and facility CNA documented hospice gave showers. On 11/12/24, R26 did not receive a shower and facility CNA documented that hospice gave showers. On 11/14/24, R26 did not receive a shower from facility CNA documented that hospice gave him showers. On 11/15/24 R26 did not receive a shower from facility CNA and documented that R26 refused shower due to hospice CNA provided the shower the day before.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of nursing progress notes, revealed a refused shower was documented for 10/18/24. No other refused showers were documented for the other dated and no offer to give him a shower at a different time. CNA care plan had not have any changes made to reflect collaboration of care between facility and hospice.</p> <p>During an interview on 11/21/24 at 10:13 AM, Licensed Practical Nurse (LPN) L reported the facility CNA's do give him showers and he refuses. LPN L also stated R26 would let the hospice CNA give him showers. LPN L stated the facility CNAs filled out a shower form for refusals and she signed off on them and they get turned into medical records and it gets scanned into his EMR.</p> <p>Record review on 11/21/24 at 10:08 AM did not indicate any hospice documents were uploaded other than the medication list dated 1/19/24.</p> <p>During an interview on 11/21/24 at 1:08 PM, hospice CNA M stated they change the linen every time they provide showers for the hospice residents. CNA M also stated she feels the residents like the hospice CNAs to give them showers because they have the time to give undivided attention and can spend quality time with them.</p> <p>During an interview on 11/21/24 at 01:14 PM, CNA N stated she would ask the residents more than one time if she could shower them. CNA N stated that if the hospice CNA was coming in to shower the residents two times a week, then they were the ones who showered them instead of facility CNA's. CNA N also stated she did not know that hospice services were above and beyond of what the facility was to provide. CNA N also stated that happens a lot because facility CNAs didn't know the rules and they just wanted to make sure the residents were getting their showers.</p> <p>During an interview on 11/21/24 at 1:59 PM, DON B stated the hospice CNAs had schedules as to what they do, offer bed bath or shower, if residents refused. DON B also stated CNAs should be telling the nurse. DON B also stated CNAs should offer more than once, if they refused, tell the nurse, check preferences and see how to get them care. DON B stated they would find the root cause of resident's refusals and care plan it. Writer asked DON B when CNAs would chart NA. DON B stated if a resident were out of the building. DON B also stated she would expect them to offer, reoffer, if they still say no, documentation would be on the shower sheet or in nurses progress notes charting. DON B stated she did not know anything about scheduling CNA's here with Hospice CNA's. DON B also stated she would hope the CNAs knew that hospice care is above and beyond.</p> <p>During an interview on 11/21/24 at 2:11 PM, unit manager (UM) C stated the days for showers were preset unless the resident wanted to have the day changed, or requested a different day and could change days or shifts. UM C stated residents get two showers a week. UM C also stated most of the residents that were on hospice, she coordinated care on admission. Hospice scheduled their CNAs days around the facility CNAs scheduled days. UM C stated if hospice residents didn't want a shower, offer bed bath, or ask what they would like. UM C stated that after 30 days of residents not getting their showers, she would have the Social Worker go talk to them. UM C stated that facility CNA's do not understand hospice rules, adding the nurse on the floor had to sign shower sheet stating they asked the residents a second time. Stated that R26 would spend his time outside, as a reason for not getting showers. UM C also stated they never got to his care plan to make any revision or updates on his care plan.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review did not reveal any coordination of care between the facility CNAs and the hospice CNAs and their task to complete. R26s care plan had not been revised or updated after the hospice admission reflecting any collaboration of care.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45135</p> <p>Based on observation, interview, and record review the facility failed to provide necessary care to one (Resident #15) of two residents reviewed who were dependent of all activities of daily living (ADLs), resulting in this resident not receiving the care needed to maintain their highest practicable well-being.</p> <p>Findings include:</p> <p>Resident #15 (R15)</p> <p>Medical record reflected R#15 was admitted to the facility on [DATE]. Diagnoses of Left sided weakness from a Stroke, Dysphagia from the Stroke, Vascular Dementia, and Alzheimer's Disease.</p> <p>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/2024, revealed R#15 had a Brief Interview of Mental Status (BIMS) of 03 (severe cognitively impaired) out of 15. Under section GG0130, Activities of Daily Living (ADL) assessment revealed R#15 requires substantial/maximum assistance with oral hygiene, toileting and dependent on shower/bathing, getting dressed. R#15 required substantial/maximum assist with repositioning in bed. R#15 is dependent on transfers from bed to wheelchair using a mechanical lift and 2 persons assist.</p> <p>During an interview on 11/19/24 at 11:27 AM, R15's family member O, stated R15 had not had his nails trimmed or cleaned as often as the family had requested that they be done. R15 is a 2-person mechanical lift transfer in and out of bed and is dependent of all care.</p> <p>During an observation on 11/19/24 at 11:53 AM, R15 sitting at the dining room table waiting for lunch to be served. Observed R15s fingernails are long and had a brown substance under the nail.</p> <p>During an observation on 11/20/24 at 11:41 AM, R15 sitting at the dining room table eating lunch. Observed his fingernails remained long with brown substance under the nails.</p> <p>During an interview on 11/20/24 at 2:02 PM, Unit Manager (UM) C stated the CNA's there at the facility provide showers to R15 two times a week. UM C also stated the hospice CNAs gave him showers during the week as well. Writer asked why R15's nails were long and had brown substance under his nails. UM C looked at writer with a blank look and then stated she would take care of this.</p> <p>During an observation on 11/21/24 at 09:11 AM, R15 sitting in his wheelchair sitting in the activity room in front of the TV with his eyes closed. Observed R15's fingernails had been cut and cleaned.</p> <p>Record review of care plan revealed R15 had showers during the last 30 days on 10/23/24, 11/02/24, 11/06/24, 11/13/24, 11/20/24 by the facility CNAs. Hospice CNAs gave R15 showers on 10/21/24, 10/25/24, 10/28/24, 11/07/24, 11/18/24 and his nailcare had not been taken care of. Also noted that the care plan had not been revised or updated to reflect any collaboration between hospice and facility to ensure care was provided for this dependent resident.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During a record review on 11/21/24 at 09:26 AM, hospice CNA care plan was not present to indicate what CNAs would be responsible for, during their care provided.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46954</p> <p>Based on observation, interview and record review, the facility failed to document rationale for as needed (PRN) psychotropic medication orders that extended beyond 14 days for one (Resident #19) of five reviewed for unnecessary medications, resulting in the potential for an unnecessary medication regimen and adverse side effects.</p> <p>Findings include:</p> <p>Review of the medical record revealed Resident #19 (R19) was admitted to the facility on [DATE] with diagnoses that included generalized anxiety disorder and atrial fibrillation. Review of the Admission Data Set (MDS) with an Assessment Reference Date (ARD) of 10/30/24 revealed R19 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 11/19/24 at 11:56 AM, R19 was observed in her room, dressed and seated in her recliner. R19 reported that she had recently admitted for rehabilitation purpose.</p> <p>Review of the R19's Medication list revealed R19 was admitted to the facility on Hydroxyzine Pamoate capsules 25 milligrams (Vistaril, an anxiety anxiety medication) with a start date of 10/24/24. Instructions on the medication order included give one tablet by mouth every 12 hours as needed for anxiety. There was no stop date for the medication.</p> <p>No rationale was located in the Electronic Medical Record for the use of the anti-anxiety medication past the 14 day period.</p> <p>In an interview on 11/21/24 at 7:54 AM, Director of Nursing (DON) B stated that the expectation for resident's prescribed a PRN medication would be to have a stop date that didn't exceed the 14 days.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>49272</p> <p>Based on observation, interview and record review the facility failed to ensure proper storage and labeling of medications in one of one medication rooms.</p> <p>Findings include:</p> <p>On 11/20/24 at 4:08 PM, while conducting an observation of the facilities medication room with licensed practical nurse (LPN) L, a vial of Humalog insulin was observed in the medication refrigerator, inside the original box, which had been opened and the vial top had been removed. The vial was not labeled with the date opened or any resident information. The box was observed to have the numbers 1102 handwritten on it. LPN L stated that the insulin would need to be destroyed since it was not properly labeled. During the same observation of the medication room, a box containing Narcan nasal spray (medication used to reverse opioid overdose) was found in an unlocked drawer. The resident label had been removed (with some residual sticker remaining on the box) and the medication was not stored with other resident specific medications.</p> <p>On 11/21/24 at 4:15 PM, LPN L handed the open insulin vial and the box of Narcan nasal spray to director of nursing (DON) B, who reported that they would be discarded into a drug buster container.</p> <p>On 11/21/24 at 12:05 PM, an email was sent to the nursing home administrator (NHA) A requesting a policy specific to medication labeling.</p> <p>On 11/21/24 at 12:13 PM, NHA A, reported (via email) that the facility does not have a policy specific to medication labeling.</p> <p>On 11/21/24 at 3:39 PM, DON B was quired on what the expectation would be for labeling multi-use insulin vials. DON B stated that they should be labeled with the resident's name and room number, physician's name, and date opened. When asked how staff would know the labeling expectation if it's not outlined in a policy, they responded the information would be provided through education.</p> <p>A review of the facility's policy titled Medication Storage Policy, updated 8/24, documented in part .Unused Medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacist for discontinued, outdated, defective or deteriorated medications with worn, illegible, or missing labels .</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45135</p> <p>Based on observation, interview and record review, the facility failed to ensure proper communication/collaboration/documentation of Hospice services provided to two (Resident #15, Resident #26) of two residents reviewed for Hospice services, resulting in a lack of coordination of services and care provided.</p> <p>Findings Include:</p> <p>Resident #15 (R15)</p> <p>Medical record reflected R#15 was admitted to the facility on [DATE]. Diagnoses of Left sided weakness from a Stroke, Dysphagia from the Stroke, Vascular Dementia, and Alzheimer's Disease.</p> <p>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/2024, revealed R#15 had a Brief Interview of Mental Status (BIMS) of 03 (severe cognitively impaired) out of 15. Under section GG0130, Activities of Daily Living (ADL) assessment revealed R#15 requires substantial/maximum assistance with oral hygiene, toileting and dependent on shower/bathing, getting dressed. R#15 required substantial/maximum assist with repositioning in bed. R#15 is dependent on transfers from bed to wheelchair using a mechanical lift and 2 persons assist.</p> <p>During an interview on 11/19/24 at 3:42 PM, Registered Nurse (RN) P came to the conference room and stated that the Unit Manager (UM) C reported that the hospice nurse may have been the one to put the documents in the hospice binder. This writer and RN P looked in the hospice binder of R15 for new orders or visit notes from the nurse visit on 11/18/24 and the hospice nurse did not leave a visit note.</p> <p>Record review revealed the hospice binder behind the nurse's station did not contain a Plan of Care (POC), Certified Nursing Assistant (CNA) care plan, current physician orders, or medication list. There was a 2024 calendar for the months of October and November which were blank.</p> <p>During an interview and observation on 11/20/24 at 11:10 AM, hospice liaison Q was asked to locate the CNA care plan, current plan of care, calendar with scheduled visits from all disciplines of her hospice team, Interdisciplinary group (IDG) notes and medication list. Hospice liaison Q stated she did not know the process for getting the hospice information into the hospice binder. Hospice liaison Q also stated she though the hospice agency e-faxed or emailed all the hospice notes to the facility to be put in the hospice binders for each resident. Hospice liaison Q was observed going through the hospice binder while calling her hospice agency's office for assistance. Hospice liaison Q was heard asking where the CNA care plan would be in the hospice binder. After listening to the hospice liaison Q asking for the information from two different hospice staff, it was determined that the information was not in the hospice binder. Hospice agency would re-fax the information to the facility.</p> <p>Record review revealed some new documents were put in the hospice binder after this writer reviewed the hospice binder at the end of day 11/19/24. R15's hospice binder now includes POC, medication list, admission check list (Not completed), IDG note but not a CNA care plan.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Vista Grande Villa		STREET ADDRESS, CITY, STATE, ZIP CODE  2251 Springport Rd Jackson, MI 49202	
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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/20/24 at 11:45 AM, hospice liaison Q stated that on new admissions, they have 24 hours to get new hospice information to facility Director of Nursing (DON) B and she would print it off for the binder as well as scan it into R15's electronic medical record (EMR). Hospice Liaison Q then stated the hospice agency would e-fax the rest of the hospice admission information approximately eight days later, which would include IDG notes and visit notes from each discipline, would be e-faxed and emailed over to facility. Hospice Liaison Q stated, it is the facilities responsibility to print off the hospice information and put in the binder. R15's hospice admission was 07/25/24 and did not have any of the hospice documents in his hospice binder or his EMR. Hospice liaison Q stated hospice nurse was in the building and would be coming over to this unit by noon and would talk to this writer.</p> <p>During an interview on 11/20/24 at 12:47 PM, hospice RN R stated the hospice CNA would be giving R15 a bed bath instead of a shower due to increased fatigue with activity. Hospice RN stated she discontinued the dressing orders on R15's left gluteal fold on 08/12/24. Writer reported R15 had a dressing change with border foam dressing on his left gluteal fold dated 11/17/24, asked why the facility nurse would have done a dressing change that was discontinued. Hospice RN R stated she had no idea why a discontinued treatment had been completed. Hospice RN R also stated that she was not aware that this treatment was done and included that she wasn't the one that did it as she didn't work on Sunday. Hospice RN R also stated she wasn't aware of what documents were supposed to be in the hospice binder and she was going to get that information from her manager.</p> <p>Record review did not reveal any collaboration of care between hospice agency and facility regarding the wound care on R15's left gluteal fold.</p> <p>During an interview on 11/20/24 at 1:01 PM, Unit Manager (UM) C stated they found a hospice binder and it did not have any of the hospice information in it. UM C also stated they called the hospice agency to fax over the information. UM C also stated that the manager from this Hospice agency was in the facility and reported the binder had everything in it. UM C then stated that she never followed up to ensure the hospice binder had the necessary information in it. Writer asked UM C where the hospice documents would be found in the EMR. UM C stated that it would be under the miscellaneous tab in the EMR. Writer asked UM C if she could pull it up. UM C observed looking under the miscellaneous tab in the EMR and there was not any hospice documentation there. During this interview the DON B stated she identified the problem, the hospice agency had e-faxed the documents which went to her email, and they did not know they were supposed to print this off and put copies in the binders and upload them into EMR.</p> <p>During a record review on 11/21/24 at 09:26 AM, the facility still had not uploaded any hospice documentation that was e-faxed over from the hospice agency to this facility.</p> <p>During a record review on 11/21/24 at 09:41 AM, the hospice binder now contains the calendar for disciplines to write in their scheduled days to make visits, CNA care plan, POC, coordination of care, visit notes and IDG notes.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>According to the visit notes, R26 had a shower from the hospice CNA on 10/16/24, 10/18/24, 10/24/24, 10/25/24, 10/30/24, 11/01/24, 11/05/24, 11/06/24, 11/07/24, 11/12/24, 11/14/24, and 11/19/24. Facility CNAs gave R15 a shower on 10/25/24 and 11/05/24. Facility CNAs marked not applicable on 10/29/24, 11/08/24, 11/12/24, and on 11/19/24. R26 was not provided the personal care on the dates the facility CNA did not follow the showers scheduled for him. Facility CNA care plan did not include collaboration of care between facility and hospice agency.</p> <p>Resident #26 (R26)</p> <p>Medical record reflected R#26 was admitted to the facility on [DATE] and enrolled into the Hospice on 08/03/24. Diagnoses of Congestive Heart Failure, Chronic Obstructive Pulmonary Disease (a group of lung diseases that block airflow), Chronic Migraine Headache, Chronic Respiratory Failure, Spinal Stenosis Lumbar Region (spinal narrowing and can put pressure on the spinal cord), Depression, Anxiety, Chronic Pain Syndrome, Vertebrogenic Low Back Pain and Cardiomyopathy (heart muscle disease).</p> <p>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/08/2024, revealed R#26 had a Brief Interview of Mental Status (BIMS) of 14 (cognitively intact) out of 15. Under section GG0130, Activities of Daily Living (ADL) assessment revealed R#26 requires partial/moderate assistance with personal hygiene, toileting, shower/bathing, getting dressed, transferring from one surface to another.</p> <p>Record review of Hospice Binder at the nurse's station contained a calendar dated from July 28, 2024 through September 22, 2024. Hospice binder did not contain the documents necessary for collaboration of care, current calendar with scheduled visits by the hospice team, plan of care (POC), interdisciplinary group (IDG) notes, certified nursing assistants (CNA) care plan, medication list, or visit notes. Nor were these hospice documents in R26's electronic medical record (EMR).</p> <p>During an interview on 11/20/24 at 12:20 PM, R26 stated his hospice CNA is a male, he helps him with his shower and comes in two times a week. R26 also stated that the facility CNAs would give showers on occasion. R26 stated that the water from the shower felt horrible on his skin and was very painful. R26 also added that he had to pace himself due to pain and shortness of breath.</p> <p>During an interview on 11/20/24 at 3:40 PM, Director of Nursing (DON) B brought a small binder of hospice information they found on a shelf in the nurse's station into the conference room to this writer. This information was not part of the hospice binder.</p> <p>During a record review on 11/21/24 at 09:41 AM, original hospice binder now contains the monthly calendar showing which discipline will be coming on which day, CNA care plan, POC, coordination of care, visit notes and IDG notes. According to the visit notes, R26 had a shower from the hospice CNA on 10/16/24, 10/18/24, 10/24/24, 10/25/24, 10/30/24, 11/01/24, 11/05/24, 11/06/24, 11/07/24, 11/12/24, 11/14/24, and 11/19/24. Record review also revealed that R26 did not have any of these documents uploaded into his EMR.</p> <p>Record review of shower's given by facility CNAs for last 30 days were 10/25/24, 11/05/24, with one refusal of care on date 11/01/24. Nursing progress notes for the last 30 days did not show that the CNA's had reported the missed showers, attempts to reapproach or reason for not giving the showers to the nurse in charge.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review revealed that R26 did not receive a shower on 10/15/24, documented on shower sheets, that the hospice CNA would shower the following day. No shower was provided due to hospice CNA coming that day or following day. On 10/25/24, R26 did not receive a shower due to hospice CNA gave him a shower that morning. On 11/01/24, R26 did not receive a shower because the hospice CNA gave him a shower that morning. On 11/06/24, R26 did not receive a shower due to the hospice CNA gave him one that morning. On 11/07/24, R26 did not receive a shower and documented, hospice CNA gave him his shower. On 11/08/24, R26 did not receive a shower and facility CNA documented hospice gave showers. On 11/12/24, R26 did not receive a shower and facility CNA documented that hospice gave showers. On 11/14/24, R26 did not receive a shower from facility CNA documented that hospice gave him showers. On 11/15/24 R26 did not receive a shower from facility CNA and documented that R26 refused shower due to hospice CNA provided the shower the day before.</p> <p>Record review of nursing progress notes, revealed a refused shower was documented for 10/18/24. No other refused showers were documented for the other dated and no offer to give him a shower at a different time.</p> <p>During an interview on 11/21/24 at 10:13 AM, Licensed Practical Nurse (LPN) L reported the facility CNA's do give him showers and he refuses. LPN L also stated R26 would let the hospice CNA give him showers. LPN L stated the facility CNAs filled out a shower form for refusals and she signed off on them and they get turned into medical records and it gets scanned into his EMR.</p> <p>Record review on 11/21/24 at 10:08 AM did not indicate any hospice documents were uploaded other than the medication list dated 1/19/24.</p> <p>During an interview on 11/21/24 at 1:08 PM, hospice CNA M stated they change the linen every time they provide showers for the hospice residents. CNA M also stated she feels the residents like the hospice CNAs to give them showers because they have the time to give undivided attention and can spend quality time with them.</p> <p>During an interview on 11/21/24 at 01:14 PM, CNA N stated she would ask the residents more than one time if she could shower them. CNA N stated that if the hospice CNA was coming in to shower the residents two times a week, then they were the ones who showered them instead of facility CNA's. CNA N also stated she did not know that hospice services were above and beyond of what the facility was to provide. CNA N also stated that happens a lot because facility CNAs didn't know the rules and they just wanted to make sure the residents were getting their showers.</p> <p>During an interview on 11/21/24 at 1:59 PM, DON B stated the hospice CNAs had schedules as to what they do, offer bed bath or shower, if residents refused. DON B also stated CNAs should be telling the nurse. DON B also stated CNAs should offer more than once, if they refused, tell the nurse, check preferences and see how to get them care. DON B stated they would find the root cause of resident's refusals and care plan it. Writer asked DON B when CNAs would chart NA. DON B stated if a resident were out of the building. DON B also stated she would expect them to offer, reoffer, if they still say no, documentation would be on the shower sheet or in nurses progress notes charting. DON B stated she did not know anything about scheduling CNA's here with Hospice CNA's. DON B also stated she would hope the CNAs knew that hospice care is above and beyond.</p> <p>(continued on next page)</p>		

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<p>F 0849</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/21/24 at 2:11 PM, unit manager (UM) C stated the days for showers were preset unless the resident wanted to have the day changed, or requested a different day and could change days or shifts. UM C stated residents get two showers a week. UM C also stated most of the residents that were on hospice, she coordinated care on admission. Hospice scheduled their CNAs days around the facility CNAs scheduled days. UM C stated if hospice residents didn't want a shower, offer bed bath, or ask what they would like. UM C stated that after 30 days of residents not getting their showers, she would have the Social Worker go talk to them. UM C stated that facility CNA's do not understand hospice rules, adding the nurse on the floor had to sign shower sheet stating they asked the residents a second time. Stated that R26 would spend his time outside, as a reason for not getting showers. UM C also stated they never got to his care plan to make any revision or updates on his care plan.</p> <p>Record review did not reveal any coordination of care between the facility CNAs and the hospice CNAs and their task to complete. R26s care plan had not been revised or updated after the hospice admission reflecting any collaboration of care.</p>		