

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/15/2024
NAME OF PROVIDER OR SUPPLIER  The Villa at City Center		STREET ADDRESS, CITY, STATE, ZIP CODE  11700 E Ten Mile Rd Warren, MI 48089	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32220</p> <p>This citation pertains to Intake MI00146289.</p> <p>Based on interview and record review, the facility failed to ensure the resident's responsible party was informed of skin changes for one resident (R901) of three residents reviewed for skin management. Findings include:</p> <p>A review of the skin observation dated 06/18/24 at 1926 (7:26 PM) documented, Does the resident have any new skin issues? The yes box was checked. The form identified the right buttock as an open area and the left as excoriation (rash like area of skin disruption). Measurements for the areas were not included or documented. The observation and related progress note did not indicate the responsible party was notified.</p> <p>A review of the progress note for R901 dated 06/20/24 by Wound Care Nurse, Licensed Practical Nurse (LPN) A revealed, Writer alerted by (midnight) MN (certified nursing assistant) CNA regarding new skin impairment observed during (activities of daily living) ADL care. It was noted that the resident has a new skin impairment observed to sacrococcyx/bilateral buttocks. Treatment initiated and rendered to affected area. Resident has pain medication in place to aid in healing and comfort as needed. Resident repositioned for comfort with bed in lowest position and call light within reach. Wound care will continue to follow and treat as indicated. Notification to the responsible party was not documented.</p> <p>A review of the treatment record for June 2024 documented wound treatments to the right lateral calf 06/04 to 06/30/24 and the sacrococcyx/bilateral buttocks 06/20 to 06/30/24. The treatment record for July 2024 documented treatments to the right lateral calf, sacrococcyx/bilateral buttocks and the right foot.</p> <p>A skin observation note dated 07/29/24 documented wounds to the right knee, left knee, right lower leg, right heel, left ankle, and sacrum.</p> <p>On 08/14/24 at 11:18 AM, the Director of Nursing (DON) was asked about quality assurance meetings and reported that infections, falls, wound care and skin management are review at the daily risk meetings.</p> <p>(continued on next page)</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 08/14/24 at 11:34 AM, the responsible party (RP) was asked about their knowledge of the wound to the buttocks and reported R901 had seven wounds now and they had only been aware of one, a leg wound. The RP reported they were not made aware of the buttock and sacral wound until 7/14/24 when the resident was at the hospital. They also noted the leg wound had become larger. The RP also denied having received any updates on any wounds or a copy of the care plan. The RP reported someone visited R901 approximately two or three times a week.</p> <p>On 08/14/24 at 5:20 PM the wounds were reviewed with the DON. The DON acknowledged the RP of R901 should have been notified of the buttocks wounds. It was noted that documentation of the RP's notification was requested and documentation of the sacral wound assessments prior to 7/10/24 was requested.</p> <p>On 08/16/24 at 6:18 PM, the Administrator brought in care conference notes dated 07/01/24 and confirmed the note did not specifically address the RP was notified of the wound to the sacrum and updated accordingly with wound changes until notification on 07/10/24 per a progress note. R901 was subsequently hospitalized on [DATE] for the change in condition, infection and wounds. Documentation of notification to the RP about the initial buttocks wound and subsequent wound changes was requested but not received prior to survey exit.</p> <p>A review of the record for R901 revealed R901 was admitted into the facility on [DATE]. Diagnoses included Dementia, Chronic Kidney Disease, and High Blood Pressure. The Minimum Data Set (MDS) assessment dated [DATE] documented moderate to severely impaired cognition, functional range of motion limitations to one upper and both lower extremities and substantial/maximal assistance to roll left and right, sit up in bed, bathing and personal hygiene.</p> <p>A review of the policy titled, Change in a Resident's Condition or Status dated 06/29/21 revealed, Our facility shall promptly notify the resident, consult with his or her Attending Physician, and notify, consistent with his or her authority, the resident representative(s) of changes in the resident ' s medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.) .Unless otherwise instructed by the resident, the Nurse Supervisor/Charge Nurse will notify the resident ' s representative when: There is a significant change in the resident ' s physical, mental, or psychosocial status .</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 32220</p> <p>This citation pertains to Intake MI00146289.</p> <p>Based on observation, interview, and record review, the facility failed reposition a dependent resident while in bed for one resident (R902) of three reviewed for skin management resulting in the re-opening of a sacral wound. Findings include.</p> <p>On 08/14/24 at 8:45 AM, 10:50 AM, 11:10 AM, R902 was observed to be on their back in bed. The arms were to the sides and the legs were crossed at the feet. Large puffy green boots which covered the foot and ankle were in place on both feet. R902 was dressed in a hospital style gown and the head of the bed was up around 45-60 degrees. No pillow, wedge or other device was observed to off load pressure from the back and buttocks area. At 1:15 PM, a staff member was observed standing at the left side of the bed assisting R902 to eat. The head of the bed was up 45-60 degrees, with R902 on their back in bed without any offload devices at the sides. At 3:44 PM, the head of the bed was lower around 30-45 degrees and R902 was on their back in bed arms to the sides, without a device to off load pressure at the sides.</p> <p>On 08/14/24 at 3:48 PM, Certified Nursing Assistant (CNA) D reported R902 required total care and need help to eat, bath and to be change when incontinent. CNA D reported You have to move (R902). (R902) does not move themselves, observed resident (themselves). R902 was observed with CNA D and noted without pillows or devices to the sides to off load pressure.</p> <p>On 08/14/24 at 4:50 PM, a skin observation was conducted with Lincensed Practical Nurse (LPN) E. Observation of the coccyx/tailbone area revealed a nickel to quarter size area of non intact skin. The distal end was loose and the base of the wound area appeared as a dusky purple to pink color.</p> <p>On 08/14/24 at 5:20 PM, the Director of Nursing (DON) acknowledged the concern for the repositioning of R902.</p> <p>On 08/14/24 at 6:06 PM, Wound Care Nurse LPN C reported staff would be re-educated on the need to reposition resident per the plan of care.</p> <p>A review of the record for R902 revealed, R902 was admitted into the facility 04/01/19. Diagnoses included Dementia, Contracture and Depression. A review of the Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognition and the need for substantial/maximal assistance to roll left and right, and sit up in bed. R902 was documented as dependent for personal hygiene, bathing, dressing and toileting hygiene.</p> <p>The has potential for impairment to skin integrity care plan initiated 09/13/22 documented, .Apply barrier cream per facility protocol to help protect skin from excess moisture .use wedge to improve positioning . The has actual impairment to skin integrity care plan initiated 09/13/22 and last updated 03/12/24 documented, . assist with reposition frequently while in bed .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy titled, Skin Management Guidelines dated 11/28/17 revealed, Purpose: To ensure residents that are admitted to the facility are evaluated to determine appropriate measures to be taken by the interdisciplinary care team to determine appropriate measures and individualized interventions to prevent, reduce and treat skin breakdown. It is the practice of this facility to properly identify and evaluate residents whose clinical conditions increase the risk for impaired skin integrity, and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care .Interventions for prevention, removing and reducing predicting factors and treatment for skin may include: Pressure redistribution surface for bed and seating surfaces: Specified through clinical evaluation and determination. Adaptive equipment and seating to support and encourage correct anatomical alignment. Elevating heels: For residents that cannot turn and reposition themselves. For residents that have diminished sensory perceptions of the lower extremities that may affect and independent ability to turn, reposition and off load pressure. Offloading devices may vary, may include pillows and should be selected based on resident comfort and positioning needs .</p>		