STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235429	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at the Bay	1500 Spring St Petoskey, MI 49770

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 This citation pertains to intake numbers: MI00150212 and MI00150297. Based on interview and record review, the facility failed to notify the residents emergency contact and attending physician of a change in condition for one Resident (#3) of three residents reviewed for notifications. Findings include: Resident #3 (R3) Review of complaint intake number MI00150212 to the State Agency (SA), dated 2/11/25 revealed, R3 was transfer to a local hospital by emergency medical services (EMS) in critical condition after a four-day admission from the facility. Family was notified by hospital intensive care unit (ICU) doctor. Family/emergency contact was not notified by facility of the transfer to the local hospital. Review of complaint intake number MI00150297 to the SA, dated 2/13/25 revealed, on the early morning of 2/9/25, R3 was transferred to a local hospital by EMS. The facility never contacted family to let them know R3's condition was declining or that R3 was taken to the hospital. This resulted in R3 being all alone in the local hospital on 2/9/25. Review of R3's face sheet revealed an admission to the facility on [DATE], with Family Member E noted as their emergency contact. R3's medical diagnoses included, hypertension, perforation of intestine (a hole in the intestine), and colostomy (a surgical procedure that creates an opening [stoma] in the abdominal wall to divert stool [fecal material] from the colon [large intestine] directly into a bag or pouch). On 2/18/25 at 4:00 PM, an interview was conducted with Family Member E, who stated, No one voiced any concerns to me. Talked to the staff at the facility while (R3) was there and stated everything was fine. I was assured by staff at the facility that (R3) would be taken care of. (R3) was transferred to the local hospital on 2/9/25 and the facility never call me to let me know (R3) was declining. I was called by the local hospital from the ICU doctor that (R3) had been admitted and was in critical condition. I was planning on going to see him at the facility on 2/10/25. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's progress note dated 2/9/25 at 6:33 AM, read in part, R3 was transferred to [local hospital] at 6:00 AM. Vital signs; blood pressure 77/30, respirations 16, pulse 100, oxygen saturation 46% at 2 liters per minute [via nasal cannula] increased to 5 liters per minute oxygen saturation came up to 93%, unresponsive. Pupils non-reactive. R3 was moaning most of the night shift. R3 was moaning this am [morning] . On 2/20/25 at 11:30 AM, an interview was conducted with Licensed Practical Nurse (LPN) C, who was asked if she recalled R3 and their transfer out and replied, Yes. I sent (R3) out at 6:00 AM and had to finish up the medications for the other residents on the hall. I added the progress note at 6:33 AM. I recall going to see him at 6:00 AM to hook up his intravenous (IV) and his peripherally inserted central catheter (PICC) line [a medical device that is this thin, soft, and long to administer medication through a vein] looked funny and not right. I had the certified nurse aide (CNA) come in his room and take his vitals. I do not recall notifying the physician or the family, but (R3) needed to go to the hospital because his blood pressure was really low, and his oxygen saturation was really low. On 2/20/25 at 12:15 PM, an interview was conducted with the Nurse Practitioner (NP) F, who was asked if she was notified of R3's transfer to the hospital. NP F replied, No one called me about anything with (R3) and I was on-call the weekend he was sent out. I was not notified that R3 had declined, had respiratory distress, or was moaning in pain all night. On 2/20/25 at 1:00 PM, an interview was conducted with the Nursing Home Administrator (NHA), who confirmed that the physician on-call and the family should have both been notified when R3 was sent to the hospital. Review of facility policy Notification of Changes Guideline, dated 7/24/19, read in part Purpose: It is the practice of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician .The resident and/or their representative will be educated about treatment options and supported to make an informed choice about care .All pertinent information will be made available to the provider by the facility staff .Overview of Components of the Guideline: 1.) Requirements for notification of resident, the resident representative and their physician .2.) A significant change in the resident's physical, mental, or psychosocial status. (i) A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications .Procedure: 1.) The nurse will immediately notify the resident, resident's physician and the resident representative (s) for the following (list is not all inclusive). If the resident's physician is not available contact the Medical Director .e. A decision to transfer or discharge the resident from the facility .

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 This citation pertains to intake numbers; MI00150212, MI00150215, and MI00150297. Based on interview and record review, the facility failed to ensure 1. New admission orders were double checked, 2. Appropriate assessments and wound care were provided, and 3. Timely notification of a change in condition were completed per professional standards for one Resident (#3) of three residents reviewed for new admissions, resulting in R3 being transferred to the emergency department with post-surgical infection, respiratory distress, low blood pressure, sepsis, and subsequent death. Findings include: Resident #3 (R3) Review of complaint intake number MI00150212 to the State Agency (SA), dated 2/11/25 revealed, R3 was transfer to a local hospital by emergency medical services (EMS) in critical condition after a four-day admission from the facility due to his colostomy not being cared for resulting in stool contaminating surgical incision and drains. R3 now had positive blood cultures for VRE (vancomycin-resistant enterococcus) and was in septic shock. Supporting evidence of neglect by the facility can be substantiated by local hospital documentation. Review of complaint intake number MI00150215 to the SA, dated 2/11/25, revealed, on 2/5/25, R3 was discharged from the hospital in stable condition to the facility to recover. On 2/9/25, R3 was admitted to the local hospital in critical condition. R3's oxygen was extremely low, he had low blood pressure, his binder that was over his incision had feces in it, his incision also had feces in it. R3 was in septic shock, he had positive blood cultures, and he was in critical condition. Hospice had been consulted, there was a concern that R3's care was neglected while he was at the nursing home. Review of complaint intake number MI00150297 to the SA dated 2/13/25 revealed on the early morning of 2/9/25, R3 was transferred to a local hospital by EMS. At the time of R3's transfer, his oxygen was in the 40's. R3's abdominal binder that was covering his incision, drains and colostomy bag was off as well as his colostomy bag. He was covered in stool. R3's gown was soaked in feces and fluids and his surgical wounds were packed with stool. R3's blood pressure was also 66/40. R3 was in septic shock before arriving to the local hospital. R3's PICC (peripherally inserted central catheter) line was dirty and dislodged. R3 was treated like garbage by facility staff and his condition was horrific. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R3's emergency department (ED) records, dated 2/9/25, read in part .History of Present Illness . presents to the ED for evaluation of low oxygen saturation. He is brought in by EMS. He was brought from the [facility name] .will open his eyes and answers some questions however he is moaning, seems to be in a good amount of pain. According to EMS, they did not get much of a history from the nursing staff over at the [facility name]. Apparently, they checked on him this morning and he had an oxygen saturation of 43% .He does have audible rhonchorous (coarse, low-pitched, rattling sounds heard in the lungs during breathing) breath sounds heard at bedside. He moans and complains of pain basically diffusely with palpation .Patient came into the ED saturated in fluid and feces. His gown is almost completely soaked in fluid .He has an abdominal binder in place. When this is removed his ostomy bag is off and he has a large amount of brown stool covering his abdomen under the binder. He has palpable edema noted to his abdomen as well. With any manipulation he does have fluid expressed from the drain sites .He has a right upper extremity PICC line. When nursing staff went to clean for and wipe around the PICC .it then almost immediately fell out, certainly did not look like it was in the right spot I will place a central line in the patient's left groin. norepinephrine (medication to support low blood pressure) is running through his peripheral IV in the left upper extremity while central line being inserted .Lactic acid (a lab value that measures the lactic acid in the bloodstream) is elevated at 3.2 (normal level is < 2), procalcitonin (a lab value that is a protein hormone used to detect and monitor bacterial infections) is elevated at 5.62 (normal range is between 0.05-2.0 and > 2.0 indicates severe infection), high-sensitivity troponin (a protein found in heart muscle that leaks into the blood when the heart is damaged) is elevated at 148 (normal level is between 0-14) and BNP (a hormone in the blood that indicates how well the heart is pumping) is 5114 (normal level is < 450 in adults over the age of 75) .I did order him 40 mg of IV Lasix (a diuretic to help eliminate excess body fluid) .He will admit the patient to the ICU (intensive care unit) He is obviously in critical condition .Final Impression/Diagnosis: Acute sepsis (life threatening complication of an infection), acute hypotension, acute hypoxic (an absence of enough oxygen in the tissues to sustain bodily functions) respiratory failure .acute lactic acidosis (a metabolic condition that occurs when the body builds up too much lactic acid in the bloodstream) . Review of R3's ED nursing note, dated 2/9/25, read in part .The patient came in altered. This patient had an ostomy bag that was stuck and not attached anymore under an abdominal binder and covered in feces. This patient had 2 (brand name surgical) drains with one that was coming out and the sutures were coming undone. The patient had drainage from both drain sites and his abdominal staples sites. The patient had not been cleaned up in a while .Patient had a PICC line that he came in with and when ED staff went to check patency, the PICC line dislodged and appears to possibly have broken off .When I called the [facility name], the nurse that card for the patient, [facility nurses name], told me she did not know much about the patient. When I told her the patient had an ostomy, she was surprised to find out he had an ostomy. She stated that the CNAs (certified nurse aides) take care of all of that, including the wound changes. I let this nurse know our findings and how critical this patient appears. I would like to express my concerns about the care this patient received . Review of R3's hospital history and physical, dated 2/9/25, read in part .He was in shock (a condition that occurs when organs don't get enough blood), hypotensive (low blood pressure), altered mentation, cold to touch, abdominal pain/guarding, hypoxia (low oxygen saturation) - 43% per history, and wet cough .He had a PICC line he was supposed to be getting antibiotics through that was mostly out. Abdominal binder was in place covering his ostomy from last admission and drains - there was extensive stool saturating between skin and binder, stool in wounds, ostomy was off. SNF (skilled nursing facility) may not have known he had an ostomy I was told .Patient said he has eaten very little, maybe none .purulent drainage from midline incision. Mucosa of ostomy initially pale . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R3's hospital records, dated 2/9/25 through 2/12/25, revealed the following: a.) Underwent a blood transfusion b.) Received IV blood pressure support medications c.) Had an insertion of a central line in the groin area for cardiac monitoring and IV medication administration d.) Had a nasogastric tube inserted for nutritional purposes e.) Was found to have new wound infection in his abdominal cavity that was stool covered and with VRE (vancomycin resistant enterococcus) bacteremia f.) Had lower abdominal staples removed to allow for drainage g.) Possible PICC line infection h.) Urinary catheter with urinary tract infection i.) Weight gain of 11 pound 7 ounces from 2/6/25 - 2/9/25 j.) Severe protein calorie malnutrition k.) admitted to the ICU l.) Surgical consultation m.) Infectious diseases consultation n.) Went from a full code to Hospice services o.) Death occurred on 2/12/25 Review of R3's face sheet revealed an admission to the facility on [DATE], with diagnoses including, hypertension, perforation of intestine (a hole in the intestine), and colostomy (a surgical procedure that creates an opening [stoma] in the abdominal wall to divert stool [fecal material] from the colon [large intestine] directly into a bag or pouch). Review of Minimum Data Set (MDS) assessment, dated 2/9/25, revealed Section GG of the MDS assessment revealed R3 was dependent on staff for all activities of daily living cares including eating, oral hygiene, toileting, upper and lower body dressing, and personal hygiene. R3 was also dependent on staff for all mobility such as rolling from left to right, sit to lying position, and lying to sitting position. (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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R3's progress note dated 2/9/25 at 6:33 AM, read in part, R3 was transferred to [local hospital] at 6:00 AM. Vital signs; blood pressure 77/30, respirations 16, pulse 100, oxygen saturation 46% at 2 liters per minute [via nasal cannula] increased to 5 liters per minute oxygen saturation came up to 93%, unresponsive. Pupils non-reactive. R3 was moaning most of the night shift. R3 was moaning this am [morning] . Review of R3's hospital discharge paperwork, dated 2/3/25, read in part .Cefazolin 6 g (grams) per 24 hours continuous infusion (or 2 g IV [intravenous] q [every] 8 hours . Review of R3's progress note, dated 2/5/25 at 9:35 PM, read in part Resident admitted from (local hospital) . Unable to use any or all devices. Needs assistance with devices .Medication review: A medication reconciliation/review occurred. Findings and actions: Clarified with (local hospital). Review of R3's progress note dated 2/5/25 at 10:26 PM, read in part Received report .Cefazolin last given at 5:00 PM (at local hospital) . Review of R3's new admission phone report form, dated 2/5/25, read in part .Arrived by: EMS (emergency medical services) 1800 ish (approximately 6:00 PM) . Antibiotics: cefazolin - PICC (peripheral inserted central catheter) Q (every) 8 hours last dose 17:00 (5:00 PM) . Review of R3's order recap, dated 2/5/25 through 2/9/25, revealed an order added by Registered Nurse (RN) D on 2/5/25 for cefazolin sodium injection solution reconstitute 2 GM (grams). Use 50 ml (milliliters) intravenously three times a day until 3/7/25 (every 8 hours, last dose at 5:00 PM), and was scheduled to be given at 1:00 AM, 9:00 AM, and 5:00 PM. Order was verified by the same nurse who added the initial order. Review of R3's order recap, dated 2/5/25 through 2/9/25, revealed an order added on 2/6/25 at 10:33 AM for cefazolin sodium injection solution reconstitute 2 GM. Use 2 gram intravenously, every 8 hours, for of cervical hardware infection until 3/7/25, and was scheduled to be given at 6:00 AM, 2:00 PM, and 10:00 PM. Order was added by the Nurse Practitioner (NP) F and verified by Licensed Practical Nurse (LPN) B. Review of R3's medication administration record (MAR), dated February 2025, revealed R3 did not receive a 6:00 AM dose. R3 should have received a dose of antibiotics at 1:00 AM based on the last dose he received prior to being discharge from the local hospital per written orders. R3 did not receive antibiotics for 19 hours, based on the last dose he received at the local hospital. R3 missed two doses of his antibiotics on 2/6/25 at 1:00 AM and at 9:00 AM. On 2/19/25 at 10:15 AM, an interview was conducted with RN D who was asked about the new admission process for entering medication orders. RN D replied, The admitting nurse or the nurse manager adds the orders from the admission paperwork and then a second nurse is to verify that the orders are correct. RN D was asked why the antibiotic order from R3 was not verified with a second nurse. RN D replied, I do not recall, maybe at that time there was not anyone to verify the orders were correct. On 2/19/25 at 3:49 PM, an interview was conducted with LPN B who was asked if she remembered R3. LPN B replied, I remember R3 coming in. R3 had a PICC line, and I think R3 missed his first dose of antibiotics because the order got put in wrong with administration times. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/20/25 at 12:15 PM, an interview was conducted with NP F who was asked about R3's antibiotic orders. NP F replied, New admission orders should be verified by another nurse and double checked. It was noted by facility staff that R3 did not receive any antibiotic therapy since admitting to the facility despite having the medication in back-up and a new order was placed. On 2/20/25 at 2:00 PM, an interview was conducted with the Regional Nurse Consultant G who was asked about the admission process. The Regional Nurse Consultant G replied, We recognized a problem and have started a past non-compliance, but it is not completed yet. Nurses are to double check orders with a second nurse to verify the order input is being added correctly. R3 should not have missed any doses of antibiotics. Review of R3's admission phone report document, dated 2/5/25, revealed that R3 had recent abdominal and cervical surgery. R3 had two (name brand surgical) drains in his abdominal cavity, a colostomy in his LUQ (left upper quadrant), an abdominal surgical incision with staple, a PICC line in his RUE (right upper extremity), was receiving IV antibiotics with the last dose indicated, a c-collar (a device to help secure the neck), a urinary catheter, was on oxygen at 3 liters via nasal cannula (soft plastic device to deliver oxygen through the nose), had edema in his upper and lower extremities, was on narcotic (controlled substance used to treat moderate to severe pain) pain medication, and wore an abdominal binder at all times. Review of R3's care plan, dated 2/7/25, read in part Focus: The resident has an ostomy to (Specify where) r/t (related to). Goal: Resident will have no complications with ostomy through the review date. Interventions: Monitor for signs or symptoms of pain with ostomy or stools and notify physician as needed. Review of R3's physician order, dated 2/5/25, revealed an order for ostomy care to check bag and empty, cleanse skin and pat dry if any leakage every shift. Review of R3's treatment administration record (TAR), dated 2/5/25 through 2/9/25, revealed no documented checking or emptying on 2/5/25 during the night shift. On 2/19/25 at 2:54 PM, an interview was conducted with LPN H who was asked about R3 and the care that was provided on the night of 2/8/25. LPN H stated there was a nurse call-in that night. Nurse-to-nurse reports are not really that great or helpful. LPN H was asked about ostomy care on the night of 2/8/25. LPN H replied, I should have taken more time to do a head-to-toe assessment on him on 2/8/25. The North end is very heavy with as needed narcotic medications and all I had time to do was pass as needed narcotics. I did not look at his ostomy and I don't recall having to do anything with the (brand mane surgical) drains either, because it would have come up on the TAR. I feel terrible that his ostomy opened underneath his binder. I only gave him pain medication and reassessed his pain. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/19/25 at 3:18 PM, an interview was conducted with RN I who was asked about the care she provided to R3. He was too heavy acuity. I took care of him on 2/8/25 during day shift until 6:30 PM. He was very sleepy. I attempted to do a dressing change on him, and he refused. I drew labs on him and put them in the refrigerator because I could not take them to the lab, and I am not sure if the driver was out or why they were not taken to the lab or if they were. RN I was asked if she attempted to try again later to complete the dressing changed. RN I replied, No. RN I was asked if she recalled R3's colostomy. RN I replied, He had a midline abdominal incision with staples below his umbilicus that had purulent (discharging pus) drainage. He had a colostomy and an abdominal binder that had some yellow serosanguinous (fluid that contains clear, watery liquid and blood) on the binder. I don't recall what the stoma looked like. RN I clarified that she did not report the purulent drainage to the physician. Review of R3's TAR, dated 2/5/25 through 2/9/25, revealed that R3 had labs drawn by RN I on 2/8/25 at 1:12 PM. On 2/20/25 at 11:30 AM, an interview was conducted with LPN C who was asked about R3 and the care provided on 2/9/25. LPN C replied, I got called in early on 2/9/25 and arrived around 3:00 AM. I got report from LPN 'H' that R3 was moaning, and he gave R3 some pain medication. LPN C was asked if she did any kind of assessment or observed R3's colostomy/stoma. LPN C replied, I probably did not document an assessment on his drains and abdominal area. I did not pull the abdominal binder off or look at it. I had to finish up night shift medications. I went in to see him at 6:00 AM to hook up his IV and his PICC line looked funny, and I had the certified nurse aide (CNA) come into do his vitals. I sent him out at 6:00 AM to the local hospital. That was the first time I took care of him. All I was told was that R3 was in pain and received pain medication and I got no other report on the other residents. R3's oxygen was very low at 46% and (nasal cannula) was only in one nostril. I did not listen to lungs. R3 had quite a bit of edema and I am not sure how we were monitoring that. I normally work the back half. Review of R3's hospital discharge paperwork, dated 2/5/25, revealed discharge instructions for surgical (brand name) drains to remain in place and care instructions that included keeping the skin around the drains dry and covered. There were also instructions for emptying along with how to compress the bulb of the drains for proper function. Instructions also included recording the amount of output in a 24-hour period and to contact the provider if you have less than 30 ml (milliliters) of output. The instructions also stated to monitor daily for signs and symptoms of infection. Laxative instructions were to take one capful of polyethylene glycol 3350 milligrams (mg), mixed in 4-8 ounces of beverage every morning. If in 2 to 3 days your bowel movement is too soft: Reduce polyethylene glycol 3350 mg to 1/2 capful mixed in 4-8 ounces of beverage every morning. R3's MAR/physician orders had no polyethylene glycol order written. Review of R3's care plan, dated 2/7/25, read in part .I have alteration in skin integrity d/t (due to) placement of (Specify: Drain) post-surgical procedure. Goal: The resident will have no complications with drain sites through the review period. Interventions: Observe and record fluids drained from drain sites . R3 had no other interventions noted for monitoring abdominal surgical incision with staples and staples were not counted to ensure wound did not dehisce (to split open or burst along a natural line or seam). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/18/25 at 4:00 PM, an interview was conducted with Family Member (FM) E, who stated, No one voiced any concerns to me. Talked to the staff at the facility while (R3) was there and stated everything was fine. I was assured by staff at the facility that (R3) would be taken care of. (R3) was transferred to the local hospital on 2/9/25 and the facility never called me to let me know (R3) was declining. I was called by the local hospital from the ICU doctor that (R3) had been admitted and was in critical condition. I was planning on going to see him at the facility on 2/10/25. FM E was tearful and hurt during the phone interview and felt very frustrated with the facility staff by the lack of care and communication. FM E stated that she was led to believe R3 was being taken care of and that he was going to be fine. On 2/21/25 at 1:15 PM, an interview was conducted with FM J who was asked about R3 and if they had visited them at the facility while he was there. FM J replied, Yes. I went to see R3 on 2/7/25 on a Friday. R3 was asleep when I arrived, but I called out his name and he opened his eyes. He looked like he was in bad shape. I noticed a banana that had been cut up, appeared to be there for a while and I asked him is he wanted me to go get him something to eat. He said yes, so I checked with the nurse first and they said it was ok. I brought him back a hamburger and a shake. He only took two pea sized bites of the burger and was unable to suck out of the straw. I lifted up R3's gown to see his drains and they were both expanded and not compressed, and I thought that did not look right. His gown was soiled with some blood on it and needed to be changed. R3 was unable to talk to me like he was the last time I saw him the last week in January around the 25th when he carried on a conversation and had a little sense of humor. I noticed that he could not reach his banana or his drink. He need assistance with feeding because he does not have the dexterity to pinch has hands together to grasp a cup. He was having difficulty sitting himself up to reach the cup. All R3's belongings where just lined up along the windowsill and not put away. I felt like I walked into a dump. On 2/21/25 at 2:17 PM, an interview was conducted with FM K who was asked about R3 and if they visited them at the facility while he was there. FM K replied, Yes, I went to see him on 2/6/25 it was a Thursday. I gave him yes or no questions because he had a hard time with his breathing. I noticed his nasal cannula was only in one of his nostrils and he seemed a little confused when I talked to him. I went to get the nurse, and she came in and checked his oxygen saturation. I had my wife on the phone, and she asked me what the oxygen saturation level was, and the nurse told me it was in the 50's. My wife was freaking out! The nurse went to get a second nurse, and they stayed for a while and rechecked his level and it had come back up. The second nurse seemed to just kind of brush it off like it was not a big deal. No one was checking on him prior to me going to get someone. When he was at the hospital either we as family would assist him in eating or the hospital staff would assist, because he was unable to feed himself. Review of R3's tasks and task list, dated 2/5/25 through 2/9/25, revealed no bed baths or showers were provided during R3's stay at the facility. R3's food acceptance for 2/6/25 was recorded as zero during lunch and no breakfast was recorded. R3's food acceptance for 2/7/25 was recorded for dinner only between 1-25 %. R3's food acceptance for 2/8/25 lacked any documentation. R3's task list indicated that staff was to record food acceptance for each meal offered. No documentation that R3 had low or poor intake to the physician was found. Review of R3's physician order, dated 2/5/25, revealed oxygen was to be delivered continuous via nasal cannula or mask at 2 to 6 liters per minute. R3's oxygen order had no directions for how nursing was to titrate to a certain oxygen saturation level or record how many liters R3 required. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R3's physician order, dated 2/5/25, revealed an order for IV PICC: Document signs and symptoms of infection one time a day every 7 days for per protocol. Nursing staff did not measure the initial length of R3's PICC line and had no way of assessing proper placement. Review of R3's MAR, dated 2/5/25 through 2/9/25, revealed on 2/6/25 PICC line dressing change was marked as 9 (see progress notes). Review of R3's progress note, dated 2/6/25 at 1:56 PM, read in part .Dressing is clean, dry and intact. Progress note completed by LPN B. There were no other notes in the EMR indicating the PICC line dressing change was completed as ordered. Review of R3's care plan dated 2/7/25, read in part, .Focus: The resident has actual impairment to skin integrity (SPECIFY location) r/t [related to]. Goal: The residents will have no complications r/t documented skin impairment through the review dated (5/7/25). Interventions: Evaluate and treat per physicians' orders (2/6/25). Evaluate resident for S/SX [signs and symptoms] of possible infections (2/6/25). Monitor IV site q/shift [every shift] and complete dressing change as ordered (2/7/25) . R3 had no interventions to monitor length of the PICC line tubing extending from the insertion site to ensure proper placement. Review of policy titled, Infusion Therapy: Clinical and Pharmacy Services Policies and Procedures for Long-Term Care, dated 05/2022, read in part, Policy: Midline and Central Line IV catheters (CVADs [central venous access devices]) will be flushed to maintain patency; to prevent mixing of incompatible medications and solutions; and to ensure entire dose of solution or medication is administered into the venous system. General Guidelines: 1.) Prior to procedure, assess catheter type for flushing protocols .Types of peripheral catheters .d.) Peripherally Inserted Central Catheter (PICC) .(5) Length of catheter is specific to resident. This length needs to be documented in the medical record .(6) Catheter length is measured for baseline comparison .(8) This is a very fragile catheter and can be broken easily .(12) Anchor catheter to skin to prevent accidental removal . Review of R3's electronic medical record, dated 2/5/25 through 2/9/25, revealed no documented initial admission weight, and no weight obtained on 2/7/25. R3 had one weight recorded on 2/6/25 which was the exact same weight documented in his hospital discharge paperwork. Review of policy titled, Weight Monitoring Guideline, dated 7/1/19, read in part, Purpose: The facility measures and records weights to ensure accuracy and provide information for the evaluation of clinical status unless clinically contraindicated with physician justification. To provide guidance on timely consultation and weight parameters .Guidelines: Residents will be weighed; documentation will be recorded in (EMR): Upon admission and re-admission. Hospital weights should be verified and compared to facility admission and/or re-admission weight. Daily for three days . (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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of R3's skilled daily nursing assessments, dated 2/6/25 through 2/8/25, revealed no documented skilled nursing assessment on 2/6/25. On 2/7/25 R3's assessment created by LPN H revealed a note identified as a late entry added on 2/8/25 which used the same vital signs from 2/8/25, with lungs clear and no shortness of breath and surgical wound well approximated. On 2/8/25 the nursing assessment created by RN I revealed R3 had left side weakness, edema; 3+ (noticeable deep, last more than 1 minute) arms, hands, legs, and feet. R3's lung sounds were with rhonchi present, had a cough, had increased or purulent sputum, and had abnormal lung sounds. R3 had shortness of breath when lying flat. R3 had a surgical wound that was an abdominal midline incision with staples wound approximated intact with purulent serosanguinous drainage from the site. There was no documentation showing the left sided weakness, purulent drainage, or edema was reported to the physician. On 2/20/25 at 12:15 PM, an interview was conducted with the Nurse Practitioner (NP) F, who was asked if she was notified of R3's decline and transfer to the hospital. NP F replied, No one called me about anything with R3 and I was on-call the weekend he was sent out. I was not notified that R3 had declined, had respiratory distress, or was moaning in pain all night. I ordered labs on 2/7/25 and they were drawn but never sent to the lab. I can't tell you what happened Friday night into Saturday morning. NP F was asked what kinds of assessments the nursing staff should have been completed on R3. NP F replied, The nursing staff should have been assessing vital signs, weights, and monitoring his ostomy, drains, and surgical sites for signs of infection. NP F stated that the only thing she knew was one day R3's (name brand surgical) drain was not draining, and she assisted nursing staff to get it back working and recalled the abdominal binder being saturated. Review of policy titled, Charting and Documentation, dated 7/2017, read in part Policy Statement: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Policy Interpretation and Implementation .2. The following information is to be documented in the resident medical record: a. Objective observations .d. Changes in the resident's condition .7. Documentation of procedures and treatments will include care-specific details, including .c. the assessment data and/or any unusual findings .f. notification of family, physician or other staff . Review of facility policy Notification of Changes Guideline, dated 7/24/19, read in part Purpose: It is the practice of this facility that changes in a resident's condition or treatment are immediately shared with the resident and/or the resident representative, according to their authority, and reported to the attending physician .The resident and/or their representative will be educated about treatment options and supported to make an informed choice about care .All pertinent information will be made available to the provider by the facility staff .Overview of Components of the Guideline: 1.) Requirements for notification of resident, the resident representative and their physician .2.) A significant change in the resident's physical, mental, or psychosocial status. (i) A significant change includes deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications .Procedure: 1.) The nurse will immediately notify the resident, resident's physician and the resident representative (s) for the following (list is not all inclusive). If the resident's physician is not available contact the Medical Director .e. A decision to transfer or discharge the resident from the facility .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 This citation pertains to intake numbers: MI00150212, MI00150215, and MI00150297. Based on interview and record review, the facility failed to ensure sufficient staff to provide for resident's care needs, for one Resident (#3) of three residents reviewed for staffing. Findings include: Resident #3 (R3) Review of complaint intake number MI00150212 to the State Agency (SA), dated 2/11/25 revealed, R3 was transferred to a local hospital by emergency medical services (EMS) in critical condition after a four-day admission from the facility due to his colostomy not being cared for and resulting in stool contaminating the surgical incision and drains. R3 now had positive blood cultures for VRE (vancomycin-resistant enterococcus) and was in septic shock. Review of complaint intake number MI00150215 to the SA, dated 2/11/25, revealed, on 2/5/25, R3 was discharged from the hospital in stable condition to the facility for rehabilitation. On 2/9/25, R3 was admitted to the local hospital in critical condition with low oxygen saturation and blood pressure. R3 had an abdominal binder over his incision which had feces on it, and in his incision. R3 was in septic shock, he had positive blood cultures and was in critical condition. Hospice was consulted, and was a concerned R3 was neglected while he was at the nursing home. Review of complaint intake number MI00150297 to the SA dated 2/13/25 revealed on the early morning of 2/9/25, R3 was transferred to a local hospital by EMS. At the time of R3's transfer, his oxygen was in the 40's. R3's abdominal binder that was covering his incision, drains and colostomy bag was off as well as his colostomy bag. R3 was covered in stool. R3's gown was soaked in feces and fluids and his surgical wounds were packed with stool. R3's blood pressure was also 66/40. R3 was in septic shock before arriving to the local hospital. R3's PICC (peripherally inserted central catheter) line was dirty and dislodged. R3 was treated like garbage by facility staff and his condition was horrific. Review of R3's face sheet revealed an admission to the facility on [DATE], with diagnoses including, hypertension, perforation of intestine (a hole in the intestine), and colostomy (a surgical procedure that creates an opening [stoma] in the abdominal wall to divert stool [fecal material] from the colon [large intestine] directly into a bag or pouch). (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 - Few	On 2/19/25 at 2:54 PM, an interview was conducted with Licensed Practical Nurse (LPN) H who was asked about nurse-to-nurse report and staffing for the night of 2/8/25. LPN H replied, I first arrived at 2:30 PM and worked the back cart, which is the [NAME] side. Then at 11:00 PM I took over the whole North end and had both East and [NAME] ends. I went from having 20 to 40 residents to care for and I did not get much for report. There was a nurse call-in that night. Nurse-to-nurse reports are not really that great or helpful. LPN H was asked about their note entered on 2/7/25 at 5:56 PM with vital signs dated from 2/8/25 (future date) and replied, If you don't have time to do the charting on that same day, then you add it the next day. I should have taken more time to do a head-to-toe assessment on him on 2/8/25. The North end is very heavy with as needed narcotic medications and all I had time to do was pass as needed narcotics. On 2/19/25 at 3:18 PM, an interview was conducted with Registered Nurse (RN) I who was asked about staffing and nurse-to-nurse report. RN I replied, Sometimes you don't get all the information about a new resident in report. Information that is important like wounds, incisions, and drains. I do my best to provide care. RN I was asked if she recalled R3 and replied, I recall him. I took report from an agency nurse. I normally work the South end, and I am casual. He was too heavy of acuity. I took care of him on 2/8/25 during day shift until 6:30 PM. He was very sleepy. I attempted to do a dressing change on him, and he refused. RN I was asked if she attempted to try again later to complete the dressing changed. RN I replied, No. RN I was asked if she recalled R3's colostomy. RN I replied, He had a midline abdominal incision with staples below his umbilicus that had purulent (discharging pus) drainage. He had a colostomy and an abdominal binder that had some yellow serosanguinous (fluid that contains clear, watery liquid and blood) on the binder. I don't recall what the stoma looked like. On 2/19/25 at 3:49 PM, an interview was conducted with LPN B who was asked about R3. LPN B replied, I took care of him on 2/6/25 during the day shift. He had an intravenous line (IV), and I think he missed his first dose of antibiotics because the order got entered wrong. I felt he was not stable for our facility. For my scope he was too critical for me. He had some breakdown on his butt, but it was not open and non-blanchable. I don't recall getting a weight on him. I did the skin assessment with the unit manager and the provider. He had a urinary catheter and a colostomy. On 2/20/25 at 11:30 AM, an interview was conducted with LPN C who was asked about R3 and staffing. LPN C replied, Staffing is not the greatest. I got called in early on 2/9/25 and arrived around 3:00 AM. I got report from LPN 'H' that R3 was moaning, and he gave R3 some pain medication. LPN C was asked if she did any kind of assessment or observed R3's colostomy/stoma. LPN C replied, I probably did not document an assessment on his drains and abdominal area. I did not pull the abdominal binder off or look at it. I had to finish up night shift medications. I went in to see him at 6:00 AM to hook up his IV and his PICC line looked funny (it did not look to be in the correct position), and I had the certified care assistant (CNA) come into do his vitals. I sent him out at 6:00 AM to the local hospital. That was the first time I took care of him. Nurse-to-nurse report is bad. All I was told was that R3 was in pain and received pain medication and I got no other report on the other residents. The acuity is high. We really need a wound nurse, an admission nurse, a discharge nurse, and a nurse to do the treatments. I don't feel like us nurses have adequate time to complete all our tasks. Charting gets put on the back burner. R3's oxygen was very low at 46% and was only in one nostril. I did not listen to lungs. R3 had quite a bit of edema and I am not sure how we were monitoring that. I normally work the back half. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/20/25 at 12:15 PM, an interview was conducted with the Nurse Practitioner (NP) F, who was asked if she was notified of R3's transfer to the hospital. NP F replied, No one called me about anything with R3 and I was on-call that weekend he was sent out. I was not notified that R3 had declined, had respiratory distress, or was moaning in pain all night. Nursing needs better communication; they should have called me. Labs should have been sent out and the facility needs two nurses for each hall on all three shifts. On 2/20/25 at 2:00 PM, an interview was conducted with the Regional Nurse Consultant G who was asked about nurse-to-nurse report. The Regional Nurse Consultant G replied, We recognized a problem and have started a past non-compliance, but it is not completed yet. Nurses are expected to give a good report to ensure critical things are communicated regarding resident cares. Review of policy, Facility Assessment Tool, dated 1/9/25, read in part .page 7 Acuity: Describe your residents' acuity level that helps you to understand potential implications regarding the intensity of care and services needed.page 13 Staffing plan .This is building specific. Determine level of care necessary to meet resident needs. Consider each unit, shift, such as day (including weekends), evening, night and adjust, if necessary, based on changes to resident population .page 15 Staff: Plan: Licensed nursing staff operate on a budget .As acuity increases the facility has the liberty to add additional care staff .to accommodate .

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45123 This citation pertains to intake numbers: MI00150212, MI00150215, and MI00150297. Based on interview and record review, the facility failed to ensure competent staff to provide for resident's care needs, for one Resident (#3) of three residents reviewed for staffing. Findings include: Resident #3 (R3) Review of complaint intake number MI00150212 to the State Agency (SA), dated 2/11/25 revealed, R3 was transferred to a local hospital by emergency medical services (EMS) in critical condition after a four-day admission from the facility due to his colostomy not being cared for and resulting in stool contaminating the surgical incision and drains. R3 now had positive blood cultures for VRE (vancomycin-resistant enterococcus) and was in septic shock. Review of complaint intake number MI00150215 to the SA, dated 2/11/25, revealed, on 2/5/25, R3 was discharged from the hospital in stable condition to the facility for rehabilitation. On 2/9/25, R3 was admitted to the local hospital in critical condition with low oxygen saturation and blood pressure. R3 had an abdominal binder over his incision which had feces on it, and in his incision. R3 was in septic shock, he had positive blood cultures and was in critical condition. Hospice was consulted, and was a concerned R3 was neglected while he was at the nursing home. Review of complaint intake number MI00150297 to the SA dated 2/13/25 revealed on the early morning of 2/9/25, R3 was transferred to a local hospital by EMS. At the time of R3's transfer, his oxygen was in the 40's. R3's abdominal binder that was covering his incision, drains and colostomy bag was off as well as his colostomy bag. R3 was covered in stool. R3's gown was soaked in feces and fluids and his surgical wounds were packed with stool. R3's blood pressure was also 66/40. R3 was in septic shock before arriving to the local hospital. R3's PICC (peripherally inserted central catheter) line was dirty and dislodged. R3 was treated like garbage by facility staff and his condition was horrific. Review of R3's face sheet revealed an admission to the facility on [DATE], with diagnoses including, hypertension, perforation of intestine (a hole in the intestine), and colostomy (a surgical procedure that creates an opening [stoma] in the abdominal wall to divert stool [fecal material] from the colon [large intestine] directly into a bag or pouch). (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy, Facility Assessment Tool, dated 1/9/25, read in part .page 7 Acuity: Describe your residents' acuity level that helps you to understand potential implications regarding the intensity of care and services needed.page 13 Staffing plan .This is building specific. Determine level of care necessary to meet resident needs. Consider each unit, shift, such as day (including weekends), evening, night and adjust, if necessary, based on changes to resident population .page 15 Staff: Plan: Licensed nursing staff operate on a budget .As acuity increases the facility has the liberty to add additional care staff .to accommodate .

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	235429	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at the Bay	1500 Spring St Petoskey, MI 49770

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 45123 Based on interview and record review, the facility failed to administer physician ordered antibiotic medication for one Resident (#3) of three residents reviewed for medication administration. Findings include: Resident #3 (R3) Review of R3's hospital discharge paperwork, dated 2/3/25, read in part .Cefazolin 6 g (grams) per 24 hours continuous infusion (or 2 g IV [intravenous] q [every] 8 hours . Review of R3's progress note, dated 2/5/25 at 9:35 PM, read in part Resident admitted from (local hospital) . Unable to use any or all devices. Needs assistance with devices .Medication review: A medication reconciliation/review occurred. Findings and actions: Clarified with (local hospital). Review of R3's progress note, dated 2/5/25 at 10:26 PM, read in part Received report .Cefazolin last given at 5:00 PM . Review of R3's new admission phone report form, dated 2/5/25, read in part .Arrived by: EMS (emergency medical services) 1800 ish (approximately 6:00 PM) . Antibiotics: cefazolin - PICC (peripheral inserted central catheter) Q (every) 8 hours last dose 17:00 (5:00 PM) . Review of R3's order recap, dated 2/5/25 through 2/9/25, revealed an order added by Registered Nurse (RN) D on 2/5/25 for cefazolin sodium injection solution reconstitute 2 GM (grams). Use 50 ml (milliliters) intravenously three times a day until 3/7/25 (every 8 hours, last dose at 5:00 PM), and scheduled to be given at 1:00 AM, 9:00 AM, and 5:00 PM. Order was verified by the same nurse who added the order. Review of R3's order recap, dated 2/5/25 through 2/9/25, revealed an order added on 2/6/25 at 10:33 AM for cefazolin sodium injection solution reconstitute 2 GM. Use 2 gram intravenously every 8 hours for infection cervical until 3/7/25, and with schedule to be given at 6:00 AM, 2:00 PM, and 10:00 PM. Order was added by the Nurse Practitioner (NP) F and verified by Licensed Practical Nurse (LPN) B. Review of R3's medication administration record (MAR), dated February 2025, revealed R3 did not receive a 6:00 AM dose. R3 should have received a dose of antibiotics at 1:00 AM based on the last dose he received prior to being discharge from the local hospital. R3 did not receive antibiotics following the 5 PM dose at the local hospital for 19 hours. R3 missed two doses of his antibiotics on 2/6/25 at 1:00 AM and at 9:00 AM. On 2/19/25 at 10:15 AM, an interview was conducted with RN D who was asked about the new admission process for entering medication orders. RN D replied, The admitting nurse or the nurse manager adds the orders from the admission paperwork and then a second nurse is to verify that the orders are correct. RN D was asked why the antibiotic order from R3 was not verified with a second nurse. RN D replied, I do not recall, maybe at that time there was not anyone to verify the orders were correct. (continued on next page)

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	235429	A. Building B. Wing	02/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/19/25 at 3:49 PM, an interview was conducted with LPN B who was asked if she remembered R3. LPN B replied, I remember R3 coming in. R3 had a PICC line, and I think R3 missed his first dose of antibiotics because the order got put in wrong with administration times. On 2/20/25 at 12:15 PM, an interview was conducted with NP F who was asked about R3's antibiotic orders. NP F replied, New admission orders should be verified by another nurse and double checked. On 2/20/25 at 2:00 PM, an interview was conducted with the Regional Nurse Consultant G who was asked about the admission process. The Regional Nurse Consultant G replied, We recognized a problem and have started a past non-compliance, but it is not completed yet. Nurses are to double check orders with a second nurse to verify the order input is being added correctly. R3 should not have missed any doses of antibiotics.