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	05/08/2024

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 49310 This citation pertains to Intake #MI00143565 Based on interview and record review, the facility failed to ensure resolution of resident grievances for Four Residents (R4, R5, R6, and R7) of six residents reviewed for grievance resolution. Findings include: The Resident Council Meeting minutes for February 2024 documented residents' concerns including but not limited to: (a) slow call light response, (b) staff not checking on residents during the night for incontinence care/brief checks, (c) lack of staff in the dining room during meal times, (d) staff being loud at the nurses' station in the mornings, and (e) receiving fresh water only once per day. The Resident Council Meeting minutes documented these issues as ongoing concerns that had been discussed in previous Meetings. The documentation indicated the Resident Council members reported these issues were not better. The section of the February meeting minutes titled Concerns continued from last month documented staff were educated to communicate at an appropriate volume while on the units. The meeting minutes indicated Staff were educated to pass water at the beginning of each shift, and to check every resident every two hours during third shift. A question on the February meeting minutes form read Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations? The response from the Resident Council was recorded as No. The Resident Council Meeting minutes for March 2024 documented the same as the previous month, February 2024, with no documented resolution to the Resident Council concerns. There was no documentation indicating the residents' concerns had been addressed or rectified. The same intervention of staff education was documented on the form. The question Does the facility consider the views of the resident or family groups and act promptly upon grievances and recommendations? was answered No. The meeting minutes were signed by the Nursing Home Administrator (NHA). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The first page of The Resident Council Meeting minutes for April 2024 was blank. Subsequent pages of documentation revealed residents were asked Do you get help and care you need without waiting a long time? The response was documented No. Everyone complained that sometimes the wait is 1-3 hours. The April Meeting minutes had attached pages documenting residents' statements in quotation marks. The statements included but were not limited to: I ask many times just to get help from dining room to my room and sometimes I have to wait 3 hours [sic]. I don't leave my room as much as I would like because I can't ever get help getting back . I wish call lights would remain on until I have been helped. Nobody checks on us during the night, sometimes I don't even see the night staff at all. There was a hand-written notation that read Everyone . does not like that the dining room is left unattended . The meeting minutes were signed by the NHA. The Residents' Food Council meeting minutes for February 2024 and March 2024 documented grievances concerning food temperatures. Residents voiced concerns that hot food was not being served hot and cold foot was not being served cold. Quotes from residents in the March 2024 meeting minutes included residents stating, It's horrible. Confidential Resident #4 (R4) was interviewed on 5/8/24 at 8:00 a.m. R4 said there were not enough CNAs (Certified Nurse Aides) to help the residents in the facility, and residents had to wait a long time for call lights to be answered or their needs to be met. R4 said the residents receive water only once daily. When asked regarding staff in the dining room, R4 said, What staff in the dining room? That's the reason I stopped going to the dining room - there's never anyone in there to help. R4 confirmed the issues voiced by The Resident Council and confirmed facility leadership was aware of the concerns. R4 said nothing had been done to address the concerns. Confidential Resident #5 (R5) was interviewed on 5/28/24 at 8:08 a.m. R5 said she had limited physical mobility and required staff assistance with turning in bed, dressing, toileting, transferring, and personal hygiene. R5 said the previous week she was in her wheelchair for twelve hours, from 6:00 a.m. until 6:00 p.m. , before staff assisted her with transferring and toileting hygiene. When asked if she turned on her call light to summon staff assistance, R5 said, the light was on, but it doesn't do any good - there aren't enough people to help! R5 said the members of the Resident Council had voiced the same concerns every month but there has been no resolution of the issues. R5 added concerns with only getting fresh water once a day. R5 said there are no staff members in the dining room and added, We have to look out for each other. Confidential Resident #6 (R6) was interviewed on 5/8/24 at 8:20 a.m. R6 said there was a very slow call light response time and he sometimes waited 40 minutes for the call light to be answered. R6 said he used to go to the dining room for meals, but he now eats in his room because there are not enough staff in the dining room to help him get back to his room when he is finished eating. R6 said, The same problems are brought up every month [in Resident Council] but no one ever does anything about it. Confidential Resident #7 (R7) was interviewed on 5/8/24 at 8:27 a.m. R7 said he had Parkinson's disease (a chronic and progressive disease that causes problems with movement). R7 said, We always have to wait for a very long time to get any help. R7 said he attended Resident Council and concerns were conveyed by residents on numerous occasions, but the concerns persisted without resolution. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff G and Staff H were interviewed on 5/8/24 at 8:50 a.m. Staff G and Staff H established they were the Activities Director and Activities Assistant, and confirmed they were responsible for assisting the residents during Resident Council Meetings and documenting meeting minutes. Staff G was asked the process for grievances voiced by residents during Resident Council. Staff G said the Council concerns were discussed at the next morning meeting with the department heads. Staff G said the grievances were issued to the appropriate department head, then put in QA (Quality Assurance). Staff G and Staff H were asked what they did if the grievances were not addressed. Staff G said, You'll have to ask (name of NHA) about that. Staff G was asked if the same grievances had been voiced in resident council every month. Staff G said, yes. When asked why no new interventions were implemented to address the residents' concerns, Staff G said, I don't know. I'm new in this role. I've only been here since September and now I'm transitioning out of this role. The NHA was interviewed on 5/8/24 at 10:40 a.m. The NHA said he was aware of the concerns in the Resident Council but did not offer a response when asked how and why the concerns had not been addressed. The NHA said they were working on some programs to address the grievances voiced by the members of the Resident Council. The policy Residents' Rights dated 11.28.2017 read, in part: It is the practice of this facility to provide for an environment in which residents may exercise their rights, each day . The right to voice grievances to the staff of the facility, or any other person, without fear of discrimination or reprisal. The facility must resolve the issues promptly .

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49310 This citation pertains to Intakes #MI00144121 and MI00144264 Based on interview and record review, the facility failed to develop a care plan and implement interventions to reduce hazards and risks to prevent falls for one Resident (R1) of two residents reviewed for falls. Findings include: Resident #1 (R1) was admitted to the facility on [DATE]. An admission Fall Risk Assessment (FRA) evaluation was completed on 4/19/24 and identified R1 at high risk for falls. The FRA indicated R1 had a history of falls. Factors contributing to the fall-risk included weakness, poor mobility, confusion, and psychotropic medication use. Nurses' progress notes for R1 documented two unwitnessed falls, both occurring on 4/21/24. No other falls were documented in the nurses' progress notes. The incident reports for R1 were requested. Two incident reports were provided by the facility. One incident report documented one fall occurrence on 4/19/24. The second incident report documented one fall occurrence on 4/21/24. R1's care plans were reviewed. The care plan for falls was initiated on 4/21/24. The focus portion of the care plan read, The resident has had an actual fall with (SPECIFY: no injury, minor injury, serious injury. There was no specification regarding injury or lack thereof. The interventions portion of the care plan documented one intervention. The intervention read, *Date and description of other interventions put in place after a fall: (specify). The fall care plan did not contain interventions to minimize hazards and risks associated with falls. A facility document Falls Investigation Guideline with a revision date of 11/12/23 read, in part: . It is the practice of this facility to evaluate a resident following every fall .7. Notify the interdisciplinary team and perform team huddle to discuss fall and possible causal factors to identify the root cause analysis to support determination of the intervention with modifying the plan of care [sic] .It is the practice of this facility to complete a Post Fall Investigation on each resident after every fall .The Post Fall Investigation will be initiated after each fall in Risk Watch and any changes in interventions, based on the root cause analysis, will be inputted on the resident's care plan . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing (DON) was interviewed on 5/8/24 at 11:08 a.m. The DON said R1 fell three times and provided the dates of 4/19/24, 4/21/24, and 4/22/24 as the dates of R1's falls. When asked why there was no documentation or incident report for a fall on 4/22/24, the DON replied, it hasn't been closed out in the system. When asked the expectations for fall care plan updates, the DON said floor nurses are expected to update fall care plan interventions immediately after a fall. The fall care plan for R1 was reviewed with the DON. When asked about the fall care plan's one intervention, the DON replied, that care plan is insignificant. The DON confirmed there were no additional fall care plans or interventions for R1. The DON was asked if the root cause of the falls, care plan updates, and post-fall investigations were completed as indicated in the facility procedure as outlined in the Falls Investigation Guideline. The DON confirmed these components had not been completed. The facility policy Care plan Standard Guideline dated 11.28.17 read, in part: . The resident care plan will incorporate risk factors identified in .admission evaluations . 1. The interdisciplinary team will collect and record data within 24 hours for the admission baseline Care Plan. 2. The interdisciplinary team will continue develop a resident/client centered care plan that includes problem, need, or strength statements, measurable goal statements and resident/client specific interventions . 4. Interventions should be specific to reflect the specific goal. The intervention should be individualized to the resident . It is the practice of this facility to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 49310 This citation pertains to Intakes #MI00143557, #MI00143565, #MI00143601 Based on observation, interview, and record review, the facility failed to provide sufficient numbers of Certified Nursing Assistants (CNAs) to provide necessary care and services for four Residents (R4, R5, R6, and R7) of six residents reviewed for sufficient staffing. This deficient practice had the potential for unmet care needs and the provision of inadequate care for all 69 residents in the facility. Findings include: Confidential Resident #4 (R4) was interviewed on 5/8/24 at 8:00 a.m. R4 said there were not enough CNAs to help the residents in the facility, and residents had to wait a long time for call lights to be answered or their needs to be met. R4 was alert and oriented, scoring 15 of 15 on a Brief Interview for Mental Status (BIMS) examination on 3/16/24, indicating R4 was cognitively intact. Confidential Resident #5 (R5) was interviewed on 5/28/24 at 8:08 a.m. R5 said she had limited physical mobility and required staff assistance with turning in bed, dressing, toileting, transferring, and personal hygiene. R5 said the previous week she was in her wheelchair for twelve hours, from 6:00 a.m. until 6:00 p.m. , before staff assisted her with transferring and toileting hygiene. When asked if she turned on her call light to summon staff assistance, R5 said, the light was on, but it doesn't do any good - there aren't enough people to help! R5 was alert and oriented, scoring 15 of 15 on a Brief Interview for Mental Status (BIMS) examination on 4/1/24, indicating R5 was cognitively intact. Confidential Resident #6 (R6) was interviewed on 5/8/24 at 8:20 a.m. R6 said there was a very slow call light response time and he sometimes waited 40 minutes for the call light to be answered. R6 said he used to go to the dining room for meals, but he now eats in his room because there are not enough staff in the dining room to help him get back to his room when he is finished eating. R6 was alert and oriented and responded appropriately to questioning. R6 scored 12 of 15 on a BIMS examination on 2/29/24 indicating R6 had moderately impaired cognition. Confidential Resident #7 (R7) was interviewed on 5/8/24 at 8:27 a.m. R7 said he had Parkinson's disease (a chronic and progressive disease that causes problems with movement). R7 said, We always have to wait for a very long time to get any help. R7 said he attended Resident Council and concerns including short staffing were conveyed by residents on numerous occasions, but the issues persisted. R7 was alert and oriented and scored 15 of 15 on a BIMS examination on 4/15/24 indicating R7 was cognitively intact. The Resident Council Meeting minutes for February 2024 documented resident concerns including slow call light response time, staff not checking residents for incontinence care/brief check during the night, and lack of staff in the dining room during meals. A question on the form read Do you get help and care you need without waiting a long time? The response included No as an answer. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Council Meeting minutes for March 2024 documented the same concerns as the previous month including but not limited to slow call light response time, staff not checking residents for incontinence care/brief check during the night, and lack of staff in the dining room during meals. The question Do you get help and care you need without waiting a long time? The recorded response included No. The first page for Resident Council Meeting minutes for April 2024 was blank and did not document any Old Business or New Business. The question Do you get help and care you need without waiting a long time? had a handwritten response that read, No. Everyone complained that sometimes the wait is 1-3 hours. The meeting minutes had attached pages documenting residents' statements in quotation marks. The statements included but were not limited to: I ask many times just to get help from dining room to my room and sometimes I have to wait 3 hours [sic]. I don't leave my room as much as I would like because I can't ever get help getting back . I wish call lights would remain on until I have been helped. Nobody checks on us during the night, sometimes I don't even see the night staff at all. The hand-written documentation noted, Everyone . does not like that the dining room is left unattended . The Nursing Home Administrator (NHA) was interviewed on 5/7/24 at 8:47 a.m. The NHA said the facility staffing is based on census and budgeted PPD (Per Patient Day). The Facility Assessment (FA), dated 3/24/24, did not include the numbers of staff needed to ensure sufficient staff are available to meet each resident's needs. The FA documented staffing needs based on the facility budgeted PPD (Per Patient Day, a metric used to calculate the number of hours of care per resident per day). The FA documented 2.05 hours PPD of CNAs were required meet the needs of the facility population. A review of the actual CNA PPD from 4/24/24 through 5/6/24 revealed actual working PPD of CNAs as follows: 4/24/24 (1.94 PPD), 4/25/24 (1.98 PPD), 4/26/24 (2.04 PPD), 4/27/24 (1.61 PPD), 4/28/24 (1.73 PPD), 4/29/24 (1.84 PPD), 4/30/24 (2.15 PPD), 5/1/24 (1.88 PPD), 5/2/24 (2.02 PPD), 5/3/24 (1.74 PPD), 5/4/24 (1.27 PPD), 5/5/24 (1.54 PPD), 5/6/24 (0.96 PPD).