STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235298	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Father Murray, A Villa Center	8444 Engleman Center Line, MI 48015

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 0684 Level of Harm - Minimal harm or potential for 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** This citation pertains to Intake 2609700.Based on observation, interview, and record review, the facility failed to schedule a follow up consultation appointment for one resident (R903) out one reviewed for appointments. Findings include:On 11/20/2025 at 10:38 AM, an interview was conducted with R903. R903 reported they have been trying to get to an appointment that they were referred to by their neurologist. R903 reported the follow up appointment was in their discharge paperwork from the hospital, as well as an order that was recently entered by the facility's Nurse Practitioner (NP). R903 reported they hadn't heard anything about the appointment and when they would be going, and they were starting to get worried.A review of the medical record revealed R903 admitted into the facility on 7/31/2025 with the following medical diagnoses, Spina Bifida and Presence of Cerebrospinal Fluid Drainage Device. A review of the most recent Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 15/15, which indicated intact cognition. R903 also required staff assistance with bed mobility and transfers.Further review of the medical record revealed the following neurology consultation note dated 8/30/2025, Per (neurologist) request plastics evaluation due to [R903's] chronic wound to the right temporoparietal (right side of the head) scalp. This evaluation can be done as an outpatient as well.A review of the hospital Discharge summary dated [DATE], revealed R903 was to follow up with the plastics physician within 1 to 2 weeks of discharge back to the facility.Further review of the physicians' orders revealed the following, Schedule Plastic Surgery [Physician Name and location]. Created 10/29/2025.On 11/20/2025 at 1:18 PM, an interview was conducted with R903. R903 reported they were asked about going to their plastic surgery appointment; however, they were trying to send them for their leg and not address their head. R903 reported they did not want a consultation for their leg but would go for the appointment recommended by their neurologist.On 11/20/2025 at 1:24 PM, an interview was conducted with Licensed Practical Nurse (LPN) B. LPN B reported they had asked R903 about going to a scheduled plastics appointment and they refused. LPN B reported they did tell R903 it was for their leg, because that's what they thought the appointment was for.On 11/20/2025 at 1:27 PM, LPN C asked R903 if they would like to be scheduled to go to plastics for their head. R903 stated, yes, I will go on that appointment.On 11/20/2025 at 1:32 PM, an interview was conducted with the Director of Nursing (DON). The DON stated R903 kept refusing the appointment from their understanding. The DON was informed that the only progress note related to refusing appointments referred to R903's wounds on their leg. The DON reported they would look further into refusals regarding their head wound and plastics appointment.On 11/20/2025 at 1:55 PM, an interview was conducted with the DON. The DON reported they went and spoke with the R903, and they reported they would go on the appointment if it was for their head, and not their leg. The DON reported they informed the scheduler to make the appointment and R903 would be attending it.On 11/20/2025 at 2:50 PM, an interview was conducted with Scheduler F. Scheduler F reported they were just informed about the appointment and would be getting with the facility NP to put in a new order and then would get the plastics appointment for R903's head scheduled.A review of a facility policy titled, Appointments revealed the following, It is the policy of this facility that the Nursing Department will communicate on a consistent basis with outside agencies consulted for (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ancillary services and/or medical appointments. Appointments include ancillary providers (such as dental, vision and audiology services) scheduled within the facility. Consultation appointments require a physician's order.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to 2598400 and 2609700. Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary environment in one of one bathroom on the 100 unit, and in two of four shower rooms. Findings include:On 11/20/25 at 9:20 AM, the shared bathroom between rooms [ROOM NUMBERS] was observed to have an area of built-up black soil, wall to wall on the floor behind the toilet. This had not been cleaned up prior to survey exit.On 11/20/25 at 9:40 AM and 1:04 PM, observation of the one south shower room revealed: The toilet had what looked like rust stains down from the lip of the bowl to the floor on the right side of toilet; black scratch marks also appeared on the rim of the toilet; The first stall to the left had two EKG (electrocardiogram) leads and a used Tegaderm (wound dressing) on the floor; The second stall had a soap bottle cap on the floor and the third stall had a (soap scum) soiled plastic bag attached to the left arm of the shower chair with a draw string; The shower bed in the main shower area had two pillows and a hospital style gown on the foot of the pad; The pad for the shower bed had a half dollar size dried brown substance in the center area; An approximate 1/2 to 3/4 inch cut was noted in the surface toward the foot of the pad; Black and tan soil was observed on the inside edges of the drain holes of the mat and under the mat, tan and brown soil (soap scum) rings and black soil (mildew) had formed around the drain holes; and all the drain holes for the white plastic bed surface were black with soil (mildew). The large shower chair with the brown mesh back had black soil (mildew) under the rim of the seat and around the joint connections. The shower chair with the blue mesh back had brown and black soil build up under the seat area. The white plastic shower chair had a buildup of tan, brown and black soil in the honeycomb of the back support and under the seat area. At 1:04 PM, the leads and dressing had been picked up. The rest of the items remained the same. The white plastic chair was wet, and it was noted that a resident had taken a shower.On 11/20/25 at 9:56 AM, loose dust buildup was observed in the corners behind the fire doors to one north.On 11/20/25 at 10:39 AM, a resident of the one north unit reported they did not believe the staff had any cleaner to clean the shower chairs. On 11/20/25 at 11:11 AM, the one north shower room felt stuffy and damp and had a lingering smell from the dampness (as when an area does not dry fully). A puddle of water around the size of a regulation basketball rim was observed in front of the third stall. The sink and the toilet had signs on them which stated they were out of order; The tub had mechanical items stored inside; A hospital style gown and a bath towel were on the floor next to the tub; The first stall to the left had hair left on the seat of the shower chair; The brown mesh back for the same shower chair had a buildup of tan soil (soap scum); Two razors were left on the stall divider - one had visible soil from shaving on the blades; a second and third razor were on the floor of the stall and in the hand sink respectively; The solid gray shower chair had a buildup of tan soil under the seat; The ceiling tile support grids above the shower stalls were rusted and/or separated in multiple areas over the three stalls. It appeared white spray paint had been used in places along the edges at the wall above the first stall. No cleaner was observed in the cabinets of the shower room.On 11/20/25 at 1:07 PM, a one south Certified Nursing Assistant, (CNA) D reported they had not used the shower bed in a week and was not aware of any resident who would use it to shower that day. CNA D further noted that while CNAs may sanitize the shower chairs, housekeeping would do any deep cleaning. On 11/20/25 at 1:18 PM, the one south shower room and shower chairs were observed with the housekeeping supervisor Staff G. Staff G reported the CNAs were responsible to clean the shower chairs after use and housekeeping was to do the walls and floors. On 11/20/25 at 1:26 PM, the Director of Nursing (DON) reported that after each shower the CNA was responsible for cleaning the shower rooms and chairs. This included the need to pick up trash, bag up dirty towels and clothes and put them in the soiled utility. The DON further reported they will have to find out where the disconnect between the housekeeping staff and the CNAs (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsibilities is. On 11/20/25 at 2:10 PM, the observed condition of the shower rooms was reviewed with the CNA supervisor Staff H. Staff H reported the CNAs are responsible to clean all sides and underneath the shower chairs and the shower bed. Staff H reported floor care was responsible for the floors in the shower rooms. The puddle on the floor remained. A review of the facility policy titled, Quality of Life - Homelike Environment date 02/06/01, revealed, Residents are provided with a safe, clean and comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.A review of the facility policy titled, Device Cleaning dated 05/08/20, revealed, .Examples of noncritical patient care items are Blood pressure cuffs/vital sign machines, mechanical lifts that touch the skin, shower chairs/gurney . At a minimum noncritical patient care devices are disinfected when visibly soiled and on a regular basis .