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	04/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at the Bay	1500 Spring Street 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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. This citation pertains to intake #2991669.Based on interview and record review the facility failed to provide timely pharmaceutical services, for one Resident (#40) of three sampled residents reviewed for pharmacy services. Findings include:Resident #40 (R40)On 4/22/2026, the State Agency (SA) received a complaint which read in part, Complainant states that she is prescribed Zubsolv. Complainant states that the medication is for opioid dependence . Complainant states that she runs out of the medication often and the staff have to go to a local pharmacy to locate the medication. Complainant states that she starts to have withdrawals when she is not on it, which includes sweating, nausea, anxiety, and diarrhea.The medical record for R40 indicated an admission date of 9/25/25 with diagnoses of pain in right ankle and joints of right foot, major depressive disorder, and chronic pain syndrome. Physician orders on 10/27/25 included Zubsolv Sublingual Tablet 5.7-1.4 MG (milligrams). Give 1 tablet sublingually three times a day for pain dissolve under tongue.The medical record also included a nurses progress note on 4/1/26 at 11:35 (AM) which read, . Zubsolv . awaiting delivery from pharmacy. An additional nurse progress note dated 4/12/26 at 12:09 (PM), read . Zubsolv . On order from pharmacy.During a phone interview on 4/28/26 at 3:17 PM, Pharmacist I stated the medication Zubsolv for R40 had to be pulled from the pharmacy back up on 4/1/26 and 4/12/26 and sent to the facility. Usually, they will pick it up.During an interview on 4/28/26 at 4:42 PM, the medication administration record was reviewed with the Director of Nursing (DON) and the Nursing Home Administrator (NHA). The Zubsolv medication was observed scheduled for 8:00 AM, 1:00 PM and 8:00 PM each day. Zubsolv was signed as not available on 4/1/26 at 8:00 AM and on 4/12/26 at 8:00 AM. The DON presented records indicating a facility staff member picked up the medication Zubsolv from the local pharmacy on 4/1/26 at 4:18 PM, and it was given as the 1 PM dose. On 4/12/26 at 3:15 PM the facility personnel again picked up the Zubsolv from the local pharmacy and it was administered at approximately 3:30 PM as the 1 PM dose. The medication was unavailable at 8 AM on both 4/1/26 and 4/12/26.The facility pharmacy policy titled, Medication Administration - General Guidelines read in part, Medications are administered as prescribed in accordance with good nursing principles and practices.Medications are administered within 60 minutes of scheduled time.

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

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	04/28/2026

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. This citation pertains to intake #2991669.Based on observation, interview, and record review, the facility failed to follow menus prepared in advance for six Residents (#41, 47, 48, 49, 50 & 51) of six residents prescribed a pureed diet.Findings include:On 4/22/2026, the State Agency (SA) received a complaint which read in part, Complainant states that (Resident #41 [R41]) is on a puree diet and the staff have given him mashed potatoes for two meals per day for a year. Complainant states that (R41) has asked for a different meal option, but they haven't given him anything else to eat. Complainant states that (R41) chooses not to eat the mashed potatoes because they make him sick to his stomach because he has had them for too long.On 4/28/26 at 12:44 PM, R41 was in the north dining room waiting for lunch. R41 stated the food was getting better but he still got a lot of mashed potatoes.During a tour of the south dining room on 4/28/26 at 12:50 PM, R47 and R48 were observed to be eating a pureed diet. R47 was being assisted with her meal and did not voice any comments. R48 was not happy with her meal. She pointed to her plate (a puree diet) and said, It is all mush. The same mush every day. I can chew. The plate contained pureed peas, pureed mashed potatoes, and pureed chicken.On 4/28/26 at 12:55 PM, R41 had received his pureed lunch in the north dining room and it included pureed peas, pureed mashed potatoes, pureed chicken and ice cream as a dessert. The other residents in the dining room received chicken soft tacos, refried beans, and corn and a dessert of churros.During an interview on 4/28/26 at 2:45 PM, the Dietary Manager (DM) F presented the planned menus titled, Week At a Glance as well as the pureed diet extension for the meal. The pureed diet was listed as pureed chicken soft tacos, pureed refried beans, pureed chef choice vegetable (not corn) and pureed churros. DM F was asked why the menu did not include what was planned and he replied that the cook had not followed the menu. DM F said, Instead of pureed refried beans he made mashed potatoes.During an interview on 4/28/26 at 2:50 PM, Dietary Staff H was asked what was prepared and served for the pureed lunch meal. Staff H described the meal preparation. The cook had pureed chicken, but he had not followed the pureed chicken soft tacos recipe. Staff H had not prepared pureed refried beans but made mashed potatoes. Staff H had pureed peas for the chef choice of vegetable. It was also confirmed those residents prescribed a puree diet including Resident #49, Resident #50 and Resident #51, did not get the planned pureed churros dessert but an ice cream cup.The menu prepared by a Registered Dietitian included a variety for the pureed diets and included corresponding recipes for each pureed item. The menu and recipes were reviewed with DM F and it was agreed the menu and recipes for the residents on a pureed diet had not been followed.