STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Parkridge	28 S Prospect Street Ypsilanti, MI 48198

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to address and prevent repeated intrusive behaviors by one resident toward another resident in one (Resident #11) out of three reviewed for resident rights. Findings include:Review of the medical record reflected R11 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included morbid obesity. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4-20-26, reflected R11 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the medical record reflected R12 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included dysphagia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5-20-26, reflected R12 scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 6/25/26 at 8:59 AM, Resident #11 (R11) was observed in bed. R11 was pleasant, conversant, and answered questioned appropriately. R11 shared that his neighbor, Resident #12, (R12) frequently enters his room, either through the shared bathroom or R11's main doorway. R11 reported that when R12 enters his room he at times will take food off of his meal tray, snacks, and personal belongings. R11 stated that R12's favorite item to take is his potato chips. R11 stated that it does bother him and at times startles him when R12 barges into his room, so he calls out for staff assistance to remove R12. R11 stated that the most upsetting behavior occurs when R12 repeatedly stands in the shared bathroom flushing the toilet over and over again, creating a noise disturbance throughout the day and the night. According to R11, staff have responded by locking the shared bathroom door on R12 room side, making it inaccessible to R12, but then R12 enters R11's room to access the bathroom. R11 reported bringing these concerns to staff several times but stated he was told to move rooms or to just deal with it. R11 expressed frustration and dissatisfaction with how his concerns are being addressed. In an interview on 6/25/26 at 9:55 am, Certified Nursing Assistant (CNA) J stated that R12 does enter R11's room through the connecting bathroom and removes food from his room. CNA J stated that R12 is not permitted to consume food by mouth and despite that being an order, R12 desires to consume food so to acquire the food, he will enter R11's room and remove food items from R11 to consume. CNA J confirmed that R12 does have a behavior of repeatedly flushing the toilet in the shared bathroom over and over again. CNA J stated that R11 will yell when these intrusive behaviors occur.In an interview on 6/25/26 at 10:26 am, social worker (SW) L reported not knowing about the concerns regarding the intrusive behaviors of R12. Review of R12's Care plan revealed a focus area which stated [R12] has a behavior problem spitting on the floor, removing incontinence pad, urinating on the floor, refusing care at times, refusing and removing abd (abdominal) binder and peg tube dressing, refusing bolus feeding at times, cursing staff, pushing staff, self-transferring, toileting without asking for assistance, ambulating without supervision. Physically aggression towards staff, wandering into resident's rooms.Resident raises bed to high position. Resident rummages through closet - removes and replacing items/ rearrangesitems. Refusing showers/ bathing. Eating food outside of diet (NPO). Removing previous trach site dressing. Wanders into other resident's rooms at times. Pulls PEG out at (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	times. Date Initiated: 02/17/2025. The listed interventions on the care plan did not address anything regarding wandering into other resident's rooms. In an interview on 6/25/26 at 12:36 pm, CNA I stated that R11 gets frustrated about R12 entering into his space and the repeated toilet flushing, which causes R11 to yell out in anger when it occurs. In an interview on 6/25/25 at 1:50 pm, Nursing home administrator (NHA) A stated that the facility was recently made aware with the concern regarding R11 and R12 and would develop and implement interventions to reduce the intrusive behaviors.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3039625 and 3039655 Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from physical abuse by a resident.Findings Include:Resident #1 (R1) Review of the face sheet reflected R1 was admitted to the facility on [DATE], with diagnoses that included auditory hallucinations, delusional disorders, adjustment disorder with anxiety, and paranoid schizophrenia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/25/26, reflected R1 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the face sheet reflected R2 was admitted to the facility on [DATE], with diagnoses that included dementia, post-traumatic stress disorder, and adjustment disorder with anxiety. On 6/25/26 at 10:11 AM, R1 was observed in his room. R1 declined an interview. Review of a Psychiatric follow up note dated 4/27/2026 at 7:13 PM, R1 was admitted on [DATE] following hospitalization for psychosis with paranoid delusions and a disorganized thought process .Patient was evaluated sitting on side of bed. He presents as anxious, cooperative, and pleasant. Patient is to be evaluated for paranoid schizophrenia, whichis [sic] ongoing. He denies any paranoia, delusions, and hallucinations .Patient has mild depression, which is ongoing. He reports feeling continued depression and sadness. He denies any crying or suicidal ideations .Patient has daily anxiety, which has increased. He denies any anxiety or agitation. Per chart notes: patient has episodes of agitation and nervousness. Staff denies any aggression or combativeness. Staff reports patient having increased episodes of agitation. Patient has nightly insomnia, which is ongoing. He reports that he has been sleeping well. Nursing staff denies any other behaviors . Review of an Interdisciplinary Team Note dated 5/23/26 at 7:23 am stated [R1] made allegation towards another resident. Resident appear to be safe in his environment .Review of a Five-day investigation summary submitted to the Michigan Facility Reported Incident system revealed On 5/23/2026 at approximately 4:15 AM, a certified nursing assistant heard loud voices followed by a smack sound. While going down the hall to investigate the CNA heard I asked you to close the door and heard another smack sound. The certified nursing assistant reported that R2 was standing by the door and she stood between both residents. R2 stated that he asked R1 to close the door and R1 called him a racial slur which led him to react. R1 admitted to calling R2 a racial slur but did not use the r so it's not racist, according to R1. The nurse and certified nursing assistant entered the room and R1 was removed from the room. The nurse was assessing R1who claimed R2 slapped him two times because he called him a racial slur. Neither resident complained of pain. R1 admitted that R2 made contact to his face and R1 admitted , but later stated he cannot recall hitting R2 as incident occurred very quickly. R2 further stated he also thought R1 was white. Both residents were educated about the incident. Verbal understanding received. R1 one was assessed with redness noted to the sides of R1's face.Review of R1's Care plan revealed the following R1 displays behavioral symptoms r/t (related to) attempts to sit on floor , increasing the risk of falls or injury, cursing others, expressing frustration, screaming others, agitated and anxious, refusing care, putting self on floor to [NAME] [sic] to the bathroom. Refuses showers. Resident make racial slurs towards others at times, auditory hallucinations. Date Initiated: 10/24/2025. An intervention included Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Date Initiated: 10/24/2025.On 6/24/26 at 11:15 am, R2 was observed lying in bed. When queried what occurred between him and the former roommate R2, R1 stated he called me a [racial slur] so I popped him. When questioned further, R2 stated that he hit R1 in the face with a fist two times. When asked why, R2 confirmed it was in response to being called a [racial slur]. The facility summary further indicated that while the facility substantiated physical contact did occur, they could not substantiate abuse due to the interaction not (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due to intentional harm.Per the State Operations Manual Appendix PP under F600 S483.12 Freedom from Abuse, Neglect, and Exploitation, Abuse, is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .The word willful means that the individual's action was deliberate (not inadvertent or accidental).Resident #4 (R4) Review of the face sheet reflected R4 was admitted to the facility on [DATE], with diagnoses that included adjustment disorder with anxiety, chronic pain syndrome, and abnormalities of gait and mobility. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/5/26, reflected R4 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the medical record reflected R3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Alzheimer's disease. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/11/26, reflected R3 scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 6/24/26 at 9:46 am, R3 was observed in room independently ambulating in and out of her room. R3 and R4 had rooms in close proximity of each other. On 6/24/26 at 12:10 pm, R4 was observed in bed. When queried about the incident that occurred between R3 and R4, R4 stated she hit me. She came in here and hit me in the leg with her fist and a comb. When asked if R4 had any further interactions with R3, R4 stated that R3 continues to wander in R4's room, stating she comes in almost daily, She was in here last night R4 said. When asked how she felt during the incident, R4 stated that she felt scared because she can't walk, she has to lay here and get hit. R4 stated that she is afraid every time R3 enters her room. Review of a summary submitted on the Michigan Facility Reported Incident, On 5/25/2026 [R4] reported to a certified nursing assistant that [R3] ambulated into her room and hit her on her left leg with her hand and her right leg with a comb while in bed.Review of R3's care plan revealed the following; [R3] has a behavior problem r/t entering others rooms, picking apart briefs. Resident refuses Bath/showers at times. Resident refuses meals at times. Resident goes into others room, wandering. Resident removes paper towel from out of her bathroom at times to play with it. Refuses weights. Refuses medications at times. Date Initiated: 04/05/2024. An intervention included Staff redirect resident from others rooms. Date Initiated: 12/23/2025. No further interventions were noted to ensure R3 did not continue to enter R4's room without permission. Per the State Operations Manual, Appendix PP, F600 S483.12 Freedom from Abuse, Neglect, and Exploitation, Abuse, is defined at S483.5 as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish .Willful, as defined at S483.5 in the definition of abuse, and means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Despite R4's credible report that R3 entered R4's space and intentionally struck her, the facility concluded that no intentional harm occurred and failed to implement further and lasting interventions to prevent the potential for a reoccurrence of resident-to-resident abuse.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and/or implement policies and procedures for ensuring the timely reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. Findings Include:Resident #1 (R1) Review of the face sheet reflected R1 was admitted to the facility on [DATE], with diagnoses that included auditory hallucinations, delusional disorders, adjustment disorder with anxiety, and paranoid schizophrenia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/25/26, reflected R1 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the face sheet reflected R2 was admitted to the facility on [DATE], with diagnoses that included dementia, post-traumatic stress disorder, and adjustment disorder with anxiety. On 6/25/26 at 10:11 AM, R1 was observed in his room. R1 declined an interview. Review of an Interdisciplinary Team Note dated 5/23/26 at 7:23 am stated [R1] made allegation towards another resident. Resident appear to be safe in his environment .Review of a Five-day investigation summary submitted to the Michigan Facility Reported Incident (MIFRI) system revealed On 5/23/2026 at approximately 4:15 AM, a certified nursing assistant heard loud voices followed by a smack sound. While going down the hall to investigate the CNA heard I asked you to close the door and heard another smack sound. The certified nursing assistant reported that R2 was standing by the door and she stood between both residents. R2 stated that he asked R1 to close the door and R1 called him a racial slur which led him to react. R1 admitted to calling R2 a racial slur but did not use the r so it's not racist, according to R1. The nurse and certified nursing assistant entered the room and R1 was removed from the room. The nurse was assessing R1who claimed R2 slapped him two times because he called him a racial slur. Neither resident complained of pain. R1 admitted that R2 made contact to his face and R1 admitted , but later stated he cannot recall hitting R2 as incident occurred very quickly. R2 further stated he also thought R1 was white. Both residents were educated about the incident. Verbal understanding received. R1 one was assessed with redness noted to the sides of R1's face.On 6/24/26 at 11:15 am, R2 was observed lying in bed. When queried what occurred between him and the former roommate R2, R1 stated he called me a [racial slur] so I popped him. When questioned further, R2 stated that he hit R1 in the face with a fist two times. When asked why, R2 confirmed it was in response to being called a [racial slur]. Review of the MIFRI submission record revealed that the incident between R1 and R2 occurred and was discovered on 5/23/26 at 4:30 AM. The abuse allegation was submitted to the MIFRI system on 5/23/26 at 7:11 am. In an interview on 6/25/26 at 2:20 PM, Nursing Home Administrator (NHA) A stated that the timeframe for reporting allegations of abuse to the State Agency was immediately but no later than two hours after the allegation is made. NHA A acknowledged the allegation was not reported within the two hour timeline. Resident #4 (R4) Review of the face sheet reflected R4 was admitted to the facility on [DATE], with diagnoses that included adjustment disorder with anxiety, chronic pain syndrome, and abnormalities of gait and mobility. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/5/26, reflected R4 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the medical record reflected R3 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Alzheimer's disease. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/11/26, reflected R3 scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 6/24/26 at 9:46 am, R3 was observed in room independently ambulating in and out of her room. R3 and R4 had rooms in close proximity of each other. On 6/24/26 at 12:10 pm, R4 was observed in bed. When queried about the incident that occurred between R3 and R4, R4 stated she hit me. She came in here and hit me in the leg with her fist and a comb. When asked if R4 had any further (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interactions with R3, R4 stated that R3 continues to wander in R4's room, stating she comes in almost daily, She was in here last night R4 said. When asked how she felt during the incident, R4 stated that she felt scared because she can't walk, she has to lay here and get hit. R4 stated that she is afraid every time R3 enters her room. Review of a summary submitted on the Michigan Facility Reported Incident, On 5/25/2026 [R4] reported to a certified nursing assistant that [R3] ambulated into her room and hit her on her left leg with her hand and her right leg with a comb while in bed.Review of the MIFRI submission record revealed that the incident between R3 and R4 occurred and was discovered on 5/25/26 at 7:25 AM. The abuse allegation was submitted to the MIFRI system on 5/25/26 at 11:37 am. In an interview on 6/25/26 at 2:20 PM, Nursing Home Administrator (NHA) A stated that the timeframe for reporting allegations of abuse to the State Agency was immediately but no later than two hours after the allegation is made. NHA A acknowledged the allegation was not reported within the two-hour timeline.

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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** Based on observation, interview, and record review the facility failed to identify, assess, document, and initiate appropriate treatment for a wound in one (Resident #11) out of three reviewed for wound care. Findings includeReview of the medical record reflected R11 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included morbid obesity. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4-20-26, reflected R11 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 6/25/26 at 8:59 AM, R11 was observed in his room laying on a standard mattress. R11 reported pain in both legs related to existing wounds but stated that the wounds on his lower extremities had been improving but recently had a new wound that was causing quite the setback. When queried about the wound, R11 used the trapeze bar to lift his upper body, exposing a reddened, open wound on his right scapula. The bedsheet was adhered to the wound, with copious amounts of malodorous, dark red-brown drainage on the sheet surrounding the wound. R11 stated that the wound had been present for approximately three weeks and was painful. R11 recalled multiple occasions that the sheet adhered to the wound. R11 stated that he has had to instruct the Certified Nursing Assistants to wet the sheet before pulling the sheet from the wound. R11 recalled a few times when the CNAs forget to wet the sheet and pulled the sheet from the wound, which resulted in a significant amount of pain and removal of tissue. R11 stated that the nurses do not do much about this wound and sometimes they might put cream on it or a pad. In an interview on 6/25/26 at 9:40 AM, Licensed Practical Nurse (LPN) D reported that she recently assumed the role as the facility Wound Care Nurse. When asked if LPN D had her wound care certification, LPN D stated that she did not. LPN D reported that every Monday the wound provider comes into the facility and does wound rounds to access the wounds in the facility. LPN D stated that the Nurse Practitioner (NP) observed R4's right axillary wound on Monday and ordered a cream and antibiotic. When queried regarding the wound on the right scapula/back area, LPN D did not have knowledge of that wound.After gaining consent to observe the right scapula wound from R11, a joint observation of the right scapular wound was completed with LPN D. R11 used his trapeze bar to lift and slightly rotate his upper body to the left. LPND attempted to visualize the wound, however, had to pause to obtain sterile saline to moisten the bedsheet and attempt to peel the sheet from the skin and wound. After the sheet was loosened, LPN D described the wound observation as an open spot with drainage and bleeding. Another observation of the wound was made, and an open area was observed with drainage, and an odor was noted. R11 stated that the pain was getting unbearable and the wound assessment was discontinued. After exiting the room, LPN D stated, that the area that we jointly observed was a new opening. LPN D stated that staff are expected to do head to toe skin checks twice a week on shower days. If R11 were to refuse a shower, the staff are expected to document any refusals. LPN D said that it is possible R11 refused his skin checks and turning and repositioning.Immediately following the joint observation, R11 was interviewed and denied refusing any skin assessments. He stated that staff turn him to do brief changes and there would be no reason they couldn't observe his skin during those moments. In an interview on 6/25/26 at 9:55 am, Certified Nursing Assistant (CNA) J stated that she knew about the open area on R11's right back/shoulder area. CNA J denied seeing a bandage on it and stated that occasionally R11 would use his back scratcher to scratch the wound. 5 other nursing staff telephone interviews were attempted; however, staff did not return any of the telephone calls. In an interview on 12:43 PM, Nurse Practitioner (NP) H reported that they were in the facility on 6/24/26 to observe R11's wounds. NP H denied knowledge of R11's right scapula wound. Review of skin assessment documentation dated 5/22/26, 5/25/26, 5/28/26, 6/1/26, 6/4/26, 6/15/26, 6/16/26, 6/18/26, and 6/22/26 revealed no documented refusals of the skin assessment and no documentation identifying an open area on the right scapula.Review of the Wound tab in the electronic medical record, last (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	updated on 5/22/26, identified active wounds on the bilateral lower extremities and the right axilla. The Wound tab reflected no measurements or imaging for the right scapula open area. In an interview on 6/25/26 at 2:11 pm, Director of Nursing (DON) B stated that the expectation was for staff to evaluate skin twice a week in conjunction with the resident's shower schedule. If a resident refuses a shower, the nursing staff are expected to attempt a skin assessment and document a refusal. DON B stated CNAs are expected to report any newly identified skin concerns to nursing for evaluation. DON B stated that she would be contacting the Physician promptly to have the open area assessed and have treatment order implemented.