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	02/13/2025

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

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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 46954 This citation pertains to Intake MI00146710 Based on interview and record review, the facility failed to address and respond to a repeated concerns related to food palatability, satisfactory resolutions to grievances, being offered and provided an evening snack, and call light response, brought forth by Resident Council. Findings include: Review of the Resident Council Minutes, dated 2/2024 through 12/2024, reflected ongoing concerns with food palatability and call light response times, mainly during the afternoon and night shifts. During a confidential resident group meeting on 02/12/25 10:08 AM, 7 out of 8 residents reported they had discussed food taste concerns and afternoon/night shift staffing concerns with no changes to correct addressed concerns. The Resident Council group reported long waits for call light response from 45 minutes to 60 minutes, mainly during the afternoon and night shift. One of eight confidential residents reported staff is often heard chatting at the nurse's station at night for several hours while his call light is on. 3 of eight residents stated that snacks are not offered to them and if they are brought up to the floor for distribution, staff will often consume the snacks. 4 of eight reported unsatisfactory resolution to grievances and concerns brought forth from resident council. During an interview on 02/13/25 01:53 PM, Nursing Home Administrator (NHA) A reported that she was aware of the food and staffing concerns, and recently implemented a new process for tracking the concern to identify a resolution.

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: 235503	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/13/2025
NAME OF PROVIDER OR SUPPLIER: The Villa at Parkridge		STREET ADDRESS, CITY, STATE, ZIP CODE: 28 S Prospect St 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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 This citation pertains to Intake MI00146710 Based on observation, interview, and record review, the facility failed to make prompt efforts to resolve grievances for one (R88) of 2 reviewed. Findings include: Review of the medical record revealed R88 was admitted to the facility on [DATE] with diagnoses that included adjustment disorder with depressed mood and Alzheimer's Disease. Review of the Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/14/24 revealed R88 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 02/10/25 at 11:59 AM, R88 was observed sitting on the edge of their bed in their room. R88 reported they were missing a couple sweatshirts, half a dozen pair of pants (jeans and lighter pants), cotton t-shirts, and a green plaid jacket. R88 reported their clothing items go to laundry and don't come back. R88 reported their clothing items were labeled with their name and had been missing awhile. R88 reported they have told staff about the missing items and staff have told R88 they cannot find the clothing. R88 reported they were not sure if anyone filled out a missing items/grievance form for them. On 02/11/25 at 11:37 AM, R88's grievances and missing items forms for the last 12 months were requested from Nursing Home Administrator (NHA) A. R88 had one grievance dated 10/3/24 pertaining to meal alternatives and preferences. In an interview on 02/11/25 at 1:59 PM, Certified Nursing Assistant (CNA) X reported approximately two weeks ago, R88 reported that they were missing a pair of jeans and a plaid jacket. CNA X reported they went to the laundry room numerous times and have not been able to locate the items. CNA X reported they verbally told laundry staff about the missing items, but did not fill out a grievance form. In an interview on 02/12/25 at 9:54 AM, Environmental Services Director (ESD) Y reported all missing clothing items should go through the grievance process. When asked if they were aware of R88 missing clothing, ESD Y reported they thought we did a follow-up with [R88] but would have to double check. On 02/12/25 at 10:02 AM, NHA A reported R88 did not have any further grievances and nothing pertaining to missing items.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on observation, interview and record review, the facility failed to assess bed bolsters as potential restraints for two (Resident #25 and #63) of three reviewed. Findings include: Resident #63 (R63) Review of the medical record reflected R63 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included schizoaffective disorder and unspecified dementia. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/24, reflected R63 was rarely/never understood and had short-term and long-term memory impairments. Section P of the MDS, pertaining to Restraints and Alarms, did not reflect coding for restraint use. According to MDS question P0100. Physical Restraints, Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. On 02/10/25 at 9:20 AM, R63 was observed in bed, with the head of the bed elevated, watching TV. The sides of the mattress were noted to be elevated. A black strap was observed hanging from each side of the mattress. R63 did not verbally respond when spoken to but was noted to verbalize, unrelated to being spoken to. On 02/10/25 at 10:22 AM, R63 was observed self-propelling their wheelchair in the hallway, using their arms and legs. On 02/12/25 at 9:12 AM, R63 was observed in bed, with the head of the bed elevated. Each side of the mattress was noted to be elevated, under the fitted bed sheet. R63's Falls Care Plan reflected bolsters were added to both sides of the bed on 10/14/24. During an interview on 02/12/25 at 9:14 AM, Registered Nurse (RN) C reported bolsters were used on R63's bed because R63 got up independently and was unable to walk or independently transfer into their chair. RN C reported R63 could roll out of bed without the bolsters in place. In an interview on 02/12/25 at 9:38 AM, Certified Nurse Aide (CNA) E reported R63 would attempt to transfer independently, and since having bed bolsters, they no longer attempted as often. CNA E reported R63 did not walk but could stand for short periods of time and transfer with the assistance of one person and a gait belt. They reported the bolsters prevented R63 from getting up independently. (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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/13/25 at 12:25 PM, RN/MDS Coordinator N reported bolsters were on R63's bed to prevent them from rolling out of bed and falling. RN/MDS Coordinator N reported the facility had restraint assessments, but R63's medical record did not contain one. They reported R63 could remove the bolsters from their bed but could not be asked to do so consistently due to cognitive deficits. RN/MDS Coordinator N reported the floor nurses would assess for potential restraints. R63's medical record did not reflect whether the use of bed bolsters were evaluated as a potential restraint. During an interview on 02/13/25 at 2:23 PM, Director of Nursing (DON) B reported a restraint would restrict movement. According to DON B, if bed bolsters were used for fall prevention, they would not want the resident to be able to remove the bolsters, as they could fall and get injured. DON B reported R63's bed bolsters were for fall prevention. DON B reported if a resident had the ability to stand up and move, and bolsters were placed, that was a restraint. DON B reviewed R63's medical record and reported they did not see any type of restraint assessment. 46954 Review of the medical record reflected R25 was admitted to the facility on [DATE], with diagnoses that included history of falling, anoxic brain damage, and dementia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/13/25, reflected R25 did not meet the requirements for a Brief Interview for Mental status score due to rarely/never being understood. According to MDS question P0100. Physical Restraints, Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. On 2/10/25 at 10:27 AM, R25 was observed in bed. A fall mat was observed on the floor adjacent to the bed. The left side of the bed was up against the wall with a bolster placed underneath the fitted sheet. The right side of the bed had a triangle, hard foam positioning wedge underneath the fitted sheet which was strapped to the bed frame. While speaking to R25, he attempted to wiggle himself off of the bed but was unsuccessful due to the implemented barriers. R25's soft touch call light was observed at the foot of the bed, out of reach. On 2/11/25 at 12:50 PM, R25 was observed in bed. The positioning wedge and bolster remained in the same spot as the previous observation the previous day. R25's call light remained at the foot of the bed, out of reach. On 2/12/25 at 8:40 AM. R25 was observed in bed with the positioning wedge and bolster in the same spot as the previous observations. Review of R25's Fall Care plan revealed an intervention dated 3/22/22 which stated ensure bolsters are in place and well connected. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/12/25 at 8:55 AM Certified Nursing Assistant (CNA) K stated that R25 had some falls out of bed previously. CNA K stated that R25 was strong on his right side so the staff had placed the bolster and positioning wedge to ensure that he stays in bed and doesn't fall out. CNA K stated that it seems to work because R25 is unable to get himself out of bed. On 2/12/25 at 9:11 AM Licensed Practical Nurse (LPN) H reported that R25 had some falls out of bed in the past. LPN H confirmed that the positioning wedge and bolster were to prevent R25 from falling out of bed because it stops him from scooting out. In an interview on 02/13/25 at 12:25 PM, RN/MDS Coordinator N reported bolsters were on R25's bed to prevent them from rolling out of bed and falling. RN/MDS Coordinator N reported the facility had restraint assessments, but R25's medical record did not contain one. RN/MDS Coordinator N reported the floor nurses would assess for potential restraints. R25's medical record did not reflect whether the use of bed bolsters were evaluated as a potential restraint. During an interview on 02/13/25 at 2:23 PM, Director of Nursing (DON) B reported a restraint would restrict movement. According to DON B, if bed bolsters were used for fall prevention, they would not want the resident to be able to remove the bolsters, as they could fall and get injured. DON B reported R25's bed bolsters were for fall prevention. DON B reviewed R25's medical record and reported they did not see any type of restraint assessment.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to complete a significant change Minimum Data Set (MDS) assessment timely for one (R68) of 25 reviewed. Findings include: Review of the medical record revealed R68 was admitted to the facility on [DATE] with diagnoses that included dementia. The census tab in the medical record revealed R68 began hospice services on 11/1/24 and ended hospice services on 1/21/25. Review of R68's MDS assessments, revealed a Significant Change MDS with an Assessment Reference Date of 1/27/25 that was still in progress as of 2/10/25. The Significant Change Assessment was completed on 2/11/25. In an interview on 02/13/25 at 12:25 PM, MDS Coordinator N reported a Significant Change Assessment had to be completed within 14 days. MDS Coordinator N agreed R68's Significant Change Assessment was completed late. According to the Resident Assessment Instrument (RAI) Manual, a Significant Change in Status Assessment must be completed within 14 days of the determination that a significant change in a resident's condition has occurred.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set (MDS) Assessments were completed accurately for six (R25, R39, R48, R63, R103, and R374) of 25 reviewed. Findings include: Resident #48 (R48) Review of the medical record revealed R48 was admitted to the facility on [DATE]. The MDS with an Assessment Reference Date (ARD) of 1/11/25 revealed R48 had severely impaired cognitive skills for daily decision making and that their pneumococcal vaccination was not up to date but was offered and declined. Review of the Vaccine Consent and Administration Form revealed R48's Durable Power of Attorney for Healthcare gave consent on 4/17/24 for R48 to receive the pneumococcal vaccination. R48 did not receive the vaccination. In an interview on 02/13/25 at 12:25 PM, MDS Coordinator N reported when completing MDS Assessments, the vaccination information was obtained from the immunization tab in the medical record. MDS Coordinator N reported they do not review the consents/declinations when completing a MDS Assessment. Resident #103 (R103) Review of the medical record revealed R103 was admitted to the facility on [DATE] with diagnoses that included borderline personality disorder, anxiety disorder, and major depressive disorder. The MDS with an ARD of 1/4/25 revealed R103 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the medical record revealed a Gradual Dose Reduction was documented as clinically contraindicated on 8/14/24. A GDR was not attempted. The MDS with an ARD of 9/18/24 was coded that a GDR was not documented as clinically contraindicated. The MDS with an ARD of 1/4/25 was coded that a GDR was attempted on 8/14/24 and was also documented as clinically contraindicated on 8/14/24. In an interview on 02/13/25 at 12:25 PM, MDS Coordinator N reported R103's GDR was documented as clinically contraindicated on 8/14/24. MDS Coordinator N reported R103 did not have a GDR attempted. MDS Coordinator N agreed the MDS Assessments with ARDs of 9/18/24 and 1/4/25 were coded incorrectly. 27306 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #374 (R374) Review of the clinical record, including the Minimum Data Set (MDS) with an assessment reference dated of 7/29/24 reflected Resident # 374 was admitted to the facility on [DATE] with a readmitted [DATE], diagnoses that included nontraumatic intracerebral hemorrhage, multiple localized, muscle wasting and atrophy, anxiety, major depression. Of note, R374 was transferred to the hospital on 9/11/24 and did not return to the facility. Review of R374's weight record revealed R374 weighed 105.6 pounds on 7/23/2024. On 6/11/24 R374 weighed 117.4 pounds revealing an 11.7% weight loss in one month. Review of R374's 7/29/24 MDS section K queried for weight if there was a 5% or more in the last month or loss of 10% or more in 6 months. This question was coded as 0 meaning No or unknown. On 02/13/2025 at 10:33 am, during an interview with the facility's Registered Dietician (RD) M reported she worked at the facility for approximately one month and was not familiar with R374. Review of R374s weights was completed with RD M who agreed section K weight loss question was inaccurate. On 02/13/2025 at 12:45 pm during an interview with MDS Nurse N she reported she did not complete R374's section K of the MDS dated [DATE] but did state section K was coded incorrectly for weight loss. 38383 Resident #63 (R63) Review of the medical record reflected R63 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included schizoaffective disorder and unspecified dementia. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/14/24, reflected R63 was rarely/never understood and had short-term and long-term memory impairments. Section P of the MDS, pertaining to Restraints and Alarms, did not reflect coding for restraint use. According to MDS question P0100. Physical Restraints, Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. On 02/10/25 at 9:20 AM, R63 was observed in bed, with the head of the bed elevated, watching TV. The sides of the mattress were noted to be elevated. A black strap was observed hanging from each side of the mattress. R63 did not verbally respond when spoken to but was noted to verbalize, unrelated to being spoken to. On 02/10/25 at 10:22 AM, R63 was observed self-propelling their wheelchair in the hallway, using their arms and legs. R63's Falls Care Plan reflected bolsters were added to both sides of the bed on 10/14/24. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 02/12/25 at 9:38 AM, Certified Nurse Aide (CNA) E reported R63 would attempt to transfer independently, and since having bed bolsters, they no longer attempted as often. CNA E reported R63 did not walk but could stand for short periods of time and transfer with the assistance of one person and a gait belt. They reported the bolsters prevented R63 from getting up independently. In an interview on 02/13/25 at 12:25 PM, RN/MDS Coordinator N reported bolsters were on R63's bed to prevent them from rolling out of bed and falling. They reported R63 could remove the bolsters from their bed but could not be asked to do so consistently due to cognitive deficits. RN/MDS Coordinator N reported they were taught that the only restraints the facility had were wanderguard devices. During an interview on 02/13/25 at 2:23 PM, Director of Nursing (DON) B reported R63's bed bolsters were for fall prevention. DON B reported if a resident had the ability to stand up and move, and bolsters were placed, that was a restraint. 45135 Resident #39 (R39) Review of the medical record reflected R39 was an initial admission to the facility on [DATE]. Diagnoses of Acute and Chronic Respiratory Failure with Hypoxia (impairment of gas exchange between the lungs and the blood), Bronchiectasis with lower respiratory infection (condition characterized by the widening and damage of the airways, making it difficult to clear mucus and leading to frequent infections), Chronic Obstructive Pulmonary Disease (COPD)(a lung condition caused by damage to the airways that limit airflow), Chronic Atrial Fibrillation (abnormal heart rhythm characterized by rapid and irregular beating of the atrial chambers of the heart), Muscle weakness, History of Falls, Chronic Pain Syndrome, Chronic Kidney Disease (condition characterized by a gradual loss of kidney function), Dementia without behavioral disturbance , mood disturbance and anxiety, and Chronic Pain Syndrome. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/13/2024, revealed R39 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section GG0100, Activities of Daily Living (ADL) Assistance reveals R39 was dependent on showers, toileting, dressing lower body, minimal assist with setting up for meals and oral care. During an interview on 02/13/25 at 12:06 PM, MDS Nurse N, stated R39's sepsis diagnosis was put in last March by her boss, other one was put in by the prior to this MDS nurse. MDS Nurse N stated they had to remove these diagnosis's manually from the system as they do not fall off. Writer asked MDS Nurse N if this diagnosis should have been removed. MDS Nurse N stated she is looking that up now. MDS Nurse N also stated R39 was the hospital for some reason, he was on contact precautions. R39 went to the hospital on 11/11/24 and came back to the facility on [DATE]. MDS Nurse N stated she went off the hospital diagnosis of aspiration pneumonia and sepsis with hypotension from 11/14/24. MDS Nurse N also added he had a new quarterly, 5-day PPS on 11/19/24 and quarterly on 12/13/24. Writer asked if he was still being treated for these 2 diagnoses on 12/13/24. She was looking in her computer at electronic medical record Point Click Care (PCC). MDS Nurse N stated R39 tapered dose of prednisone, nothing else indicating he was being treated. MDS Nurse N stated his sepsis resolved as of 12/06/24. Pneumonia was resolved as of 12/06/24. SMDS Nurse N stated they should have been taken off and they were not. Stated she just removed them as we spoke. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	46954 Resident #25 (R25) Review of the medical record reflected R25 was admitted to the facility on [DATE], with diagnoses that included history of falling, anoxic brain damage, and dementia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/13/25, reflected R25 did not meet the requirements for a Brief Interview for Mental status score due to rarely/never being understood. According to MDS question P0100. Physical Restraints, Physical restraints are any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. On 2/10/25 at 10:27 AM, R25 was observed in bed. A fall mat was observed on the floor adjacent to the bed. The left side of the bed was up against the wall with a bolster placed underneath the fitted sheet. The right side of the bed had a triangle, hard foam positioning wedge underneath the fitted sheet which was strapped to the bed frame. While speaking to R25, he attempted to wiggle himself off of the bed but was unsuccessful due to the implemented barriers. R25's soft touch call light was observed at the foot of the bed, out of reach. On 2/11/25 at 12:50 PM, R25 was observed in bed. The positioning wedge and bolster remained in the same spot as the previous observation the previous day. R25's call light remained at the foot of the bed, out of reach. On 2/12/25 at 8:40 AM. R25 was observed in bed with the positioning wedge and bolster in the same spot as the previous observations. Review of R25's Fall Care plan revealed an intervention dated 3/22/22 which stated ensure bolsters are in place and well connected. On 2/12/25 at 8:55 AM Certified Nursing Assistant (CNA) K stated that R25 had some falls out of bed previously. CNA K stated that R25 was strong on his right side so the staff had placed the bolster and positioning wedge to ensure that he stays in bed and doesn't fall out. CNA K stated that it seems to work because R25 is unable to get himself out of bed. On 2/12/25 at 9:11 AM Licensed Practical Nurse (LPN) H reported that R25 had some falls out of bed in the past. LPN H confirmed that the positioning wedge and bolster were to prevent R25 from falling out of bed because it stops him from scooting out. In an interview on 02/13/25 at 12:25 PM, RN/MDS Coordinator N reported bolsters were on R25's bed to prevent them from rolling out of bed and falling. RN/MDS Coordinator N reported the facility had restraint assessments, but R25's medical record did not contain one. RN/MDS Coordinator N reported the floor nurses would assess for potential restraints. R25's medical record did not reflect whether the use of bed bolsters were evaluated as a potential restraint. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 02/13/25 at 2:23 PM, Director of Nursing (DON) B reported a restraint would restrict movement. According to DON B, if bed bolsters were used for fall prevention, they would not want the resident to be able to remove the bolsters, as they could fall and get injured. DON B reported R25's bed bolsters were for fall prevention. DON B reviewed R25's medical record and reported they did not see any type of restraint assessment.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans for four (R25, R48, R75, and R109) of 25 reviewed. Findings include: Resident #48 (R48) Review of the medical record revealed R48 was admitted to the facility on [DATE] with diagnoses that included bullous pemphigoid (a skin condition that causes large, fluid-filled blisters on the skin and mucous membranes). The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/11/25 revealed R48 had severely impaired cognitive skills for daily decision making. Review of the Physician's Order dated 7/25/24 revealed an order to monitor the alternating pressure mattress (APM), rotation on 2. Review of R48's Potential for Impairment to Skin Integrity care plan revealed an intervention of an air mattress dated 10/14/24. On 02/10/25 at 4:10 PM, R48 was observed in bed. The alternating pressure mattress was off. On 02/11/25 at 9:10 AM, R48 was observed in bed. The alternation pressure mattress was off. On 02/11/25 at 1:43 PM, R48 was observed asleep in bed. The alternating pressure mattress was off. In an interview on 02/11/25 at 1:59 PM, Licensed Practical Nurse (LPN) R reported R48's alternating pressure mattress should be on. LPN R entered R48's room and agreed the mattress was plugged in, but not functioning. LPN R called in another staff member to trouble shoot the mattress. It was determined the plug on the side of the machine was not plugged in all the way. 38383 Resident #75 (R75) Review of the medical record reflected R75 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included end stage renal disease and dependence on renal dialysis. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/24/25, reflected R75 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 02/11/25 at 8:59 AM, R75 was observed lying in bed. They reported going to dialysis three times per week, on Tuesday, Thursday and Saturday. R75 reported their dialysis access site was in their left arm and denied that the nursing staff were monitoring the site routinely. R75 reported they were not to have blood draws or blood pressures taken from their left arm. (continued on next page)

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

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F 0656

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

The Special Instructions section of the main page of R75's Electronic Medical Record (EMR) reflected they were not to have blood pressures on their right arm.

R75's Kardex (Certified Nurse Aide (CNA) Care Guide) was not reflective of R75 being on dialysis, nor the location of their access site or any care considerations pertaining to.

According to the medical record, R75's Nutrition Care Plan was not created/initiated until 10/16/24, which was approximately six months after admission to the facility.

During an interview on 02/13/25 at 1:25 PM, CNA P reported they had worked at the facility for three years but did not work on R75's floor often. CNA P reported the Care Plan and Kardex were used to identify care needs of the residents. CNA P believed R75's dialysis access site was in their left arm but reported they did not know that for sure.

During an interview on 02/13/25 at 2:23 PM, when asked how CNAs would know the location of the dialysis access site and care considerations pertaining to, Director of Nursing (DON) B reported it should have been on the Kardex. DON B confirmed that R75's Nutrition Care Plan was not initiated until 10/2024.

Resident #109 (R109)

Review of the medical record reflected R109 admitted to the facility on [DATE], with diagnoses that included generalized anxiety disorder, vascular dementia, non-suicidal self-harm, major depressive disorder, insomnia and adjustment disorder. The quarterly MDS, with an ARD of 1/2/25, reflected R109 scored 14 out of 15 (cognitively intact) on the BIMS.

Psychiatric Services visit notes for 8/5/24, 9/3/24 and 12/23/24 reflected the benefits of R109's antipsychotic regimen, which was controlling their agitation, aggressive behaviors and distressing delusions outweighed the risk.

In an interview on 02/12/25 at 10:20 AM, Licensed Practical Nurse (LPN) H reported R109 had times when they became frustrated and loud but were easily redirected. LPN H reported changing the conversation and talking about R109's mother and family made them happy. LPN H stated the Care Plan would reflect how to care for a resident, including any behavioral interventions.

R109's Care Plan did not reflect behavioral interventions pertaining to changing the conversation topic or talking about R109's mother or family, as described by LPN H.

In an interview on 02/13/25 at 2:23 PM, DON B reported their expectation was for the behavioral interventions, described by LPN H, to be on R109's Care Plan.

46954

Resident #25 (R25)

(continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record reflected R25 was admitted to the facility on [DATE], with diagnoses that included history of falling, anoxic brain damage, and dementia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/13/25, reflected R25 did not meet the requirements for a Brief Interview for Mental status score due to rarely/never being understood. On 2/10/25 at 10:27 AM, R25 was observed in bed. A fall mat was observed on the floor adjacent to the bed. The left side of the bed was up against the wall with a bolster placed underneath the fitted sheet. R25's soft touch call light was observed at the foot of the bed, out of reach. On 2/11/25 at 12:50 PM, R25 was observed in bed. The positioning wedge and bolster remained in the same spot as the previous observation the previous day. R25's call light remained at the foot of the bed, out of reach. Review of R25's Fall Care plan revealed an intervention dated 4/27/22 which stated ensure the resident's call light is within reach. On 2/12/25 at 8:55 AM Certified Nursing Assistant (CNA) K stated that R25 had some falls out of bed previously. CNA K stated that R25 was strong on his right side so the staff had placed the bolster and positioning wedge to ensure that he stays in bed and doesn't fall out. CNA K stated that it seems to work because R25 is unable to get himself out of bed. CNA K stated that R25 was able to make his needs know and would answer some questions with one word responses. CNA K reported that R25 was able to use his call light if it was placed near his hand and providing R25 with his call light was a fall intervention.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 This citation pertains to Intakes MI00146664, MI00146710 Based on observation, interview, and record review the facility failed to provide necessary care to assist two of five residents reviewed for grooming (R#29 and R#49) with necessary activities of daily living (ADLs), resulting in these residents not receiving the care needed to maintain their highest practicable well-being and potential for embarrassment and humiliation of residents. Findings Include: Resident #29 (R29) Review of the medical record reflected R29 was an initial admission to the facility on [DATE] and readmitted on [DATE]. Diagnoses of Acute and Chronic Respiratory Failure (a short term and long-term condition that is treated as an emergency and requires long term treatment), Type 2 Diabetes Mellitus, Cerebral Infarction (stroke), Chronic Obstructive Pulmonary Disease (COPD)(a lung condition caused by damage to the airways that limit airflow), Other Idiopathic Peripheral Autonomic Neuropathy (nerve damage with unknown cause), Acute on Chronic Combined Systolic and Diastolic Heart Failure (a condition where a patient experiences an acute exacerbation of heart failure that has both systolic (reduced ejection fraction) and diastolic (preserved ejection fraction) components), Chronic Pain Syndrome (characterized by pain that lasts beyond the expected healing time), Anxiety and Depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/2024, revealed R29 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section GG0100, Activities of Daily Living (ADL) Assistance reveals R29 was dependent on all care and requires minimal/moderate assist with setting up for meals. During an interview on 02/10/25 at 10:47 AM, R29 stated she would like to go play Bingo, but the staff do not get her up out of bed until late afternoon and she misses Bingo. R29 also stated there are not many activities for her to do, but she would like to go to bingo. Record review revealed of R29's care plan: The resident needs reminders of time and location of activities and assistance to and from activities. Date Initiated: 01/28/2024 Resident will attend appropriate activities of choice through the review date. Provide large group activities. Date Initiated: 01/28/2024. Activities Provide resident with afternoon activities. Date Initiated: 01/28/2024 Activities Provide resident with morning activities. Date Initiated: 01/28/2024. Activities Provide resident with small group activities. Date Initiated: 01/28/2024 Activities Invite/encourage the resident's family members to attend activities with resident to support participation. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/11/25 at 2:00 PM, residents were lining up to play bingo outside of the dining room at the end of hall 200. Some staff would wheel residents down in their wheelchairs and some residents could wheel themselves down to bingo. Observation of R29 still in bed with her nightgown/hospital gown on. Writer did not observe a staff member go into R29's room to ask if she would like to join in on bingo. During an interview on 02/11/25 at 2:20 PM, Certified Nursing Assistant (CNA) U stated they had to help residents get up to participate in activities. Writer asked CNA U how they would know who to get up? CNA U stated they would ask residents if they wanted to get up and attend the activity. Writer asked CNA U if they asked R29 if she wanted to get up, CNA U stated she was new here and doesn't usually work on this floor. During an interview on 02/11/25 at 3:27 PM, Activity Director T stated they do one on one activities with residents such as sensory stuff, different smells, music, visits, color books, try to engage the resident. Activity Director T also stated they will go into their room and ask residents if they want to go to an activity, and then they left the CNA know, so they can have them up. Activity Director T stated it would take longer to get her up since she is a 2 person and mechanical lift, and it takes time to get everyone down there. Activity Director T stated she would talk to this resident and staff so they can have her up for bingo. Activity Director T stated there were times R29 wanted to get up, so they got her up in her wheelchair for a while and then she wanted to go back to bed because her back was hurting. Writer asked Activity Director T if R29 would want to be up out of bed now and then. Activity Director T stated yes, but she likes to stay in bed. Record review revealed R29 did not have any planned activities for the last 30 days. R29 did not have any daily activities. The task record showed R29 did not have any interactions with activities at all during the last 30 days. The staff documented R29 watched TV every day. During an interview on 02/13/25 at 1:00 PM, with Director of Nursing (DON) B and Licensed Nursing Home Administrator (LNA) A writer asked to see what activities R29 had participated in during the last 30 days. DON B was looking through the task completed in R29's electronic medical record. DON B stated there wasn't anything documented for the last 30 days. DON B stated that activities had documented the involvement with residents but could not find were R29 had any activities in her room or else where during the last 30 days. Resident #49 (R49) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record reflected R49 was an initial admission to the facility on [DATE] and readmitted on [DATE]. Diagnoses of Cerebral Infarction (Stroke), Nontraumatic Subarachnoid Hemorrhage (bleeding of the brain), Chronic Respiratory Failure, Unspecified whether with Hypoxia or Hypercapnia (when you cannot get enough oxygen into the blood or eliminate enough carbon dioxide), Cognitive Social or Emotional Deficit following Cerebral Infarction, Flaccid Hemiplegia Affecting Right Dominate Side (paralysis on the right side of the body due to damage in the brain or spinal cord), Muscle Wasting and Atrophy not Elsewhere Classified (Loss of muscle mass and strength), Cognition Communication Deficit (deficits in communication skills that occur) Vascular Dementia, Unspecified Severity without Behavior Disturbance (brain damage from impaired blood flow to the brain), without Psychotic Disturbance, Mood Disturbance and Anxiety, End Stage Renal Disease (final stage of chronic kidney disease where the kidney function has deteriorated to the point that the kidneys and no longer effectively filter waste products from the blood) and Adjustment Disorder with Mixed Anxiety and Depressed Mood (excessive reactions to stress). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/04/2024, revealed R49 had a Brief Interview of Mental Status (BIMS) of 03 (Severe Cognitive Impairment) out of 15. Under section GG0100, Activities of Daily Living (ADL) Assistance reveals R49 was dependent on all care and requires minimal/moderate assist with setting up for meals. During an interview on 02/10/25 at 9:47 AM, R49 stated she had not had a shower in a long time. R49 stated she received 4 bed baths during the last month but did not have her hair washed during that time. R49 stated she wanted a shower, not all bed baths. During an interview and observation on 02/11/25 at 1:22 PM, Licensed Practical Nurse (LPN) R was asked to see shower schedule for days residents get a bath/shower by this writer. Observed a paper with resident's name on it to receive a shower/bath 2 times a week. Writer asked if they got a shower or bath, LPN R stated she wasn't sure, but she would find out and let me know. LPN R reported back to this writer a short time following the inquiry, stating the CNA's ask the residents which one they would like a shower or a bed bath. LPN R also stated that the CNA's use a shampoo cap to wash the hair on residents that get a bed bath. During an interview on 02/11/25 at 1:45 PM, Registered Nurse (RN) Manager AA stated the CNA's ask the resident if they would like a bath or shower. If they want a bed bath, they can wash their hair with a shampoo cap. During an interview on 02/11/25 at 2:30 PM, CNA Q, stated he did give R49 a bath today. Writer asked if he gave her a bed bath or a shower. CNA Q stated he gave her a bed bath. Writer asked CNA Q if he offered her a shower instead of the bed bath. CNA Q stated he couldn't give her a shower because the shower bench is broken, the wheel was broken. Writer asked how long the shower bench had been broken. CNA Q stated for a few days. During an interview on 02/11/25 at 3:59, CNA Q stated the shower bench had been broken for a few days, stated it was reported to maintenance and just waiting now for it to be fixed. During an interview on 02/12/25 at 10:50 AM, Regional Maintenance Director S stated he was not personally aware of the broken shower bench, but he would check and see if a work order was put in. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/12/25 at 11:538 AM, Regional Maintenance Director S came back to conference room to report the maintenance guy noticed this was broke yesterday when he was touring the building with the sanitarian. Regional Maintenance Director S stated it would be fixed today. Record review revealed R49 had a bed bath on 01/17/25, 01/21/25, 01/24/25, 01/28/25, 01/31/25, 02/04/25, 02/06/25, 02/08/25 and 02/11/25. R49 did not get a shower for the last 30 days as preferred. Record review also revealed R49 received oral care in the middle of the night while sleeping on 01/17/25 at 5:10 AM, on 01/22/25 at 1:10 AM, on 01/23/25 at 3:51 AM, on 01/24/25 at 4:12 AM, on 01/30/25 at 5:49 AM, on 01/31/25 at 4:39 AM, on 02/02/25 at 4:10 AM, on 02/04/25 at 2:05 AM, on 02/05/25 at 4:26 AM, on 02/11/25 at 3:10 AM. Record review also revealed that R49 was in her wheelchair and wheeled herself 150 feet during the middle of the night, on 01/17/25 at 5:10 AM, on 01/22/25 at 1:10 AM, on 01/24/25 at 1:13 AM, on 01/30/25 at 5:49 AM, on 01/31/25 at 4:39 AM, on 02/02/25 at 4:10 AM, on 02/05/25 at 4:26 AM. Record review of the MDS assessment dated [DATE], section GG0170- self care revealed R49 is dependent on all care. Including the assessment that stated R49 is not able to wheel herself 150 feet in her manual wheelchair as documented above. R49 did not receive activities of daily living (ADL's) that was conducive to her preferences or during waking hours.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45135 Based on observation, interview and record review, the facility failed to provide meaningful, individualized activities to one resident (#29) of two reviewed for activities, from a total sample of 25 residents, resulting in the potential for depression, boredom and feelings of lack of self-worth. Findings include: Resident #29 (R29) Review of the medical record reflected R29 was an initial admission to the facility on [DATE] and readmitted on [DATE]. Diagnoses of Acute and Chronic Respiratory Failure (a short term and long-term condition that is treated as an emergency and requires long term treatment), Type 2 Diabetes Mellitus, Cerebral Infarction (stroke), Chronic Obstructive Pulmonary Disease (COPD)(a lung condition caused by damage to the airways that limit airflow), Other Idiopathic Peripheral Autonomic Neuropathy (nerve damage with unknown cause), Acute on Chronic Combined Systolic and Diastolic Heart Failure (a condition where a patient experiences an acute exacerbation of heart failure that has both systolic (reduced ejection fraction) and diastolic (preserved ejection fraction) components), Chronic Pain Syndrome (characterized by pain that lasts beyond the expected healing time), Anxiety and Depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/30/2024, revealed R29 had a Brief Interview of Mental Status (BIMS) of 15 (cognitively intact) out of 15. Under section GG0100, Activities of Daily Living (ADL) Assistance reveals R29 was dependent on all care and requires minimal/moderate assist with setting up for meals. During an interview on 02/10/25 at 10:47 AM, R29 stated she would like to go play Bingo, but the staff do not get her up out of bed until late afternoon and she misses Bingo. R29 also stated there are not many activities for her to do, but she would like to go to bingo. Record review revealed of R29's care plan: The resident needs reminders of time and location of activities and assistance to and from activities. Date Initiated: 01/28/2024 Resident will attend appropriate activities of choice through the review date. Provide large group activities Date Initiated: 01/28/2024. Activities Provide resident with afternoon activities. Date Initiated: 01/28/2024 Activities Provide resident with morning activities. Date Initiated: 01/28/2024. Activities Provide resident with small group activities Date Initiated: 01/28/2024 Activities Invite/encourage the resident's family members to attend activities with resident to support participation. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 02/11/25 at 2:00 PM, residents were lining up to play bingo outside of the dining room at the end of hall 200. Some staff would wheel residents down in their wheelchairs and some residents could wheel themselves down to bingo. Observation of R29 still in bed with her nightgown/hospital gown on. Writer did not observe a staff member go into R29's room to ask if she would like to join in on bingo. During an interview on 02/11/25 at 2:20 PM, Certified Nursing Assistant (CNA) U stated they had to help residents get up to participate in activities. Writer asked CNA U how they would know who to get up? CNA U stated they would ask residents if they wanted to get up and attend the activity. Writer asked CNA U if they asked R29 if she wanted to get up, CNA U stated she was new here and doesn't usually work on this floor. During an interview on 02/11/25 at 3:27 PM, Activity Director T stated they do one on one activities with residents such as sensory stuff, different smells, music, visits, color books, try to engage the resident. Activity Director T also stated they will go into their room and ask residents if they want to go to an activity, and then they left the CNA know, so they can have them up. Activity Director T stated it would take longer to get her up since she is a 2 person and mechanical lift, and it takes time to get everyone down there. Activity Director T stated she would talk to this resident and staff so they can have her up for bingo. Activity Director T stated there were times R29 wanted to get up, so they got her up in her wheelchair for a while and then she wanted to go back to bed because her back was hurting. Writer asked Activity Director T if R29 would want to be up out of bed now and then. Activity Director T stated yes, but she likes to stay in bed. Record review revealed R29 did not have any planned activities for the last 30 days. R29 did not have any daily activities. The task record showed R29 did not have any interactions with activities at all during the last 30 days. The staff documented R29 watched TV every day. During an interview on 02/13/25 at 1:00 PM, with Director of Nursing (DON) B and Licensed Nursing Home Administrator (LNA) A writer asked to see what activities R29 had participated in during the last 30 days. DON B was looking through the task completed in R29's electronic medical record. DON B stated there wasn't anything documented for the last 30 days. DON B stated that activities had documented the involvement with residents but could not find were R29 had any activities in her room or else where during the last 30 days.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 This citation pertains to Intake MI00146664. Based on observation, interview and record review, the facility failed to honor preferences for weight management for one (Resident #79) and prevent weight loss for one (Resident #374) of six reviewed. Findings include: Resident #79 (R79) Review of the medical record reflected R79 admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis following cerebral infarction, unspecified protein-calorie malnutrition and gastrostomy status (artificial, external opening into the stomach, which can be used for nutritional support). The Admission/5-day Medicare Part A Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/1/24, and the Quarterly MDS, with an ARD of 11/1/24, reflected R79 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and received 51 percent or more of their total calories via tube feeding. On 02/10/25 at 11:43 AM, R79 was observed in bed and reported being told they had gained 20 pounds. R79 reported they ate breakfast and also consumed pudding and applesauce at lunch and dinner. R79 reported their tube feeding had not been adjusted, although they had been gaining weight. On 02/12/25 at 10:03 AM, R79 was observed lying in bed. Osmolite 1.5 Cal tube feeding formula was infusing at a rate of 50 milliliters (mL) per hour. R79 reported they ate one meal per day and consumed yogurt and two bowls of oatmeal that morning. The Quarterly Nutrition Assessment, dated 10/28/24, reflected R79 received a pureed texture diet and enteral feeding (tube feeding). According to the assessment, R79's ideal body weight was 120 pounds, and they weighed 144 pounds on 10/23/24. According to the assessment, there was a slight uptrend in weight but no significant weight changes in 90 days. The assessment reflected the Registered Dietitian (RD) would continue to monitor weight trends and adjust the enteral nutrition regimen if needed. The Quarterly Nutrition Assessment, dated 2/3/25, reflected R79 received a pureed diet texture and enteral feeding. According to the assessment, R79's ideal body weight was 120 pounds, and they weighed 161.6 pounds on 2/3/25. The assessment reflected R79 had a significant weight gain of 8.2 percent, compared to their weight on 11/15/24. According to the assessment, R79 had a significant weight gain of 14.1 percent, compared to their weight on 8/6/24. The assessment reflected the Physician had not been consulted about R79's weight gain. There was notation that the accuracy of R79's weights was questioned, and R79 refused to be re-weighed. According to the assessment, the RD attempted to call R79's Responsible Party multiple times about R79's weight status but did not receive a response. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the medical record, R79's weight history (not all-inclusive) reflected they weighed 137.2 pounds on 7/26/24, 148.4 pounds on 11/15/24, 151.8 pounds on 12/12/24 and 161.6 pounds on 2/3/25. During an interview on 02/13/25 at 10:55 AM, RD M reported R79 triggered for weight gain and had a Body Mass Index (BMI) of 27.7, which was overweight. According to RD M, R79's preference was to eat breakfast, consisting of two bowls of oatmeal, and to receive tube feeding other than that. RD M reported R79 did not want to gain weight and desired weight loss and weight maintenance. RD M reported R79 did not walk and spent their time in bed. In an interview on 02/13/25 at 1:55 PM, RD M reported R79 had a stage four pressure ulcer (full-thickness skin and tissue loss), and in order to receive the recommended calories and protein, their diet order needed to remain the same. The medical record did not indicate that the risks and/or benefits of weight gain/loss and continuation of the current diet orders were discussed with the responsible party and the resident. 27306 Resident #374 Review of the clinical record, including the Minimum Data Set (MDS) with an assessment reference dated of 7/29/24 reflected Resident # 374 was admitted to the facility on [DATE] with a readmitted [DATE], diagnoses that included nontraumatic intracerebral hemorrhage, multiple localized, muscle wasting and atrophy, anxiety, major depression. Of note, R374 was transferred to the hospital on 9/11/24 and did not return to the facility. Review of R374's weight record revealed R374 weighed 105.6 pounds on 7/23/2024. On 6/11/24 R374 weighed 117.4 pounds revealing an 11.7% weight loss in one month. Review of R374's 7/29/24 MDS section K queried for weight if there was a 5% or more in the last month or loss of 10% or more in 6 months. This question was coded as 0 meaning No or unknown. Further review of the MDS revealed R374 scored 2 out of 15 (severe cognitive impairment). R374 was further coded as rarely/never able to make self understood and was rarely/never able to understand others. Review of R374's nutritional care plan dated 4/15/24 revealed R374 was at risk for malnutrition related to their medical condition. Revisions were made to the care plan on 6/05/24 which included allow sufficient time to eat, monitor and report signs and symptoms of pocketing food, choking, refusal to eat. Obtain and monitor blood work, provide regular diet with regular texture and provide assistance with meals as needed. There was no further revisions or added interventions made to R374's care plan after a significant weight loss of 11. 7 % in July 2024. Review of facility Nutritional progress notes dated 4/15/2024 reflected R374 received tube feeding to meet nutritional needs. Nutritional progress note dated 5/6/24 reflected R374 oral intake had improved to approximately 50% and tube feeding was recommended to be trialed nocturnally to promote oral intake. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nutritional progress notes dated 5/9/24 reflected R374 was eating well and consumed 100% of her dinner meal on 5/8/2024 tube feeding rate was slowed and held during the day related to improved oral intake. Nutritional progress notes dated 5/17/24 reflected R374 had varied intake at meals and refusals of meals, recommendations were to continue diet as ordered and staff to provide encouragement and supervision at meals. Readmission Nutritional progress note dated 6/5/24 revealed R374 had a 5.1 % unplanned weight loss over a 30 day period and R374 was interviewed on food preferences. Recommendations were 1. Continue current diet order as tolerated. 2. Osmolite 1.5 calorie for 1500 calories starting at 8:00 pm with stop when 1000 milliliters infused. 3. Provide assistance with meals. 4. Encourage tube feedings. 5. Monitor weight with goal of no significant weight changes, weight gain planned favorable. Review of Nutritional progress notes dated 6/14/24 reveled R374 current body weight was 117.4 and R374 continued to trigger for significant unplanned weight loss and continued to refused artificial nutrition. Recommendations were to 1. continue with liberalized diet, 2. Encourage tube feeding as tolerated. 3. Continue 8. ounce nutritional shakes, 4. Continue multivitamin. 5. Additional high calorie snacks and finger foods added to meal ticket. 6. Encourage family to bring in foods/snacks. 7. Staff to continue fluid intake. 8. Monitor weekly weights. None of the 8 recommendations listed in the Nutritional progress notes were reflected on R374's nutritional care plan or the Kardex (a guide used by the certified nursing assistants on how to care for their resident). Readmission Nutritional progress note dated 7/23/24 revealed R374 weight at this time was 105.6 and had a Body Mass Index (BMI) of 17.6. (underweight) the note reflected R374 had poor intake at meals, severe fat and muscle loss, tube feeding was no longer in place, nutritional supplements continued, high protein and caloric foods, supervision with meals, weekly weights and multivitamin. The Nutritional assessment dated [DATE] reflected R374's meal ticket was up to date with likes and dislikes but nowhere in the medical record R374's likes or dislikes were documented. The recommended interventions documented in the 7/23/24 Nutritional notes and assessment were the same as the 6/14/24 Nutritional progress notes, but none of the interventions/recommendations were implemented according to the care plan and kardex. There was no evidence any new or additional preventive measures were implemented to prevent weight loss. Review of the Nutritional progress notes dated 9/11/2024 revealed R374 weighed 99 pounds and BMI of 16. 6. The nutritional progress note did not include any new recommendations or interventions to prevent R374's continued weight loss. On 02/13/2025 at 10:33 am, during an interview with the facility's Registered Dietician (RD) M reported she worked at the facility for approximately one month and was not familiar with R374. RD M stated the Dietician at the time of R374's stay at the facility was no longer employed by the facility. R374's medical record was reviewed with RD M who offered no explanation R374's continued weight loss without the former RD's recommendations fully implemented or why there was not any new/added interventions to prevent R374's continued weight loss.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on observation, interview and record review, the facility failed to ensure assessment and monitoring of a dialysis access site and updated Care Plans for one (Resident #75) of one reviewed. Findings include: Review of the medical record reflected Resident #75 (R75) admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included end stage renal disease and dependence on renal dialysis. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/24/25, reflected R75 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 02/11/25 at 8:59 AM, R75 was observed lying in bed. They reported going to dialysis three times per week, on Tuesday, Thursday and Saturday. R75 reported their dialysis access site was in their left arm and denied that the nursing staff were monitoring the site routinely. R75 reported they were not to have blood draws or blood pressures taken from their left arm. R75 reported being on a fluid restriction. R75's Kardex (Certified Nurse Aide (CNA) Care Guide) was not reflective of R75 being on dialysis, nor the location of their access site or any care considerations pertaining to. The Special Instructions section of the main page of R75's Electronic Medical Record (EMR) reflected they were on a fluid restriction and were not to have blood pressures on their right arm. R75's medical record did not include an active Physician's Order for a fluid restriction. R75's January 2025 Medication Administration Record (MAR) reflected an order to check for a bruit/thrill (bruit-sound heard over dialysis fistula/thrill-palpable vibration felt over dialysis fistula) every shift, which was discontinued 1/16/25. The same MAR reflected an order for no blood pressure, lab draws or intravenous therapy on upper extremities, which was discontinued 1/16/25. R75's February 2025 MAR was not reflective of orders pertaining to monitoring or assessment of their dialysis access site or any care considerations pertaining to. During an interview on 02/13/25 at 1:25 PM, CNA P reported they had worked at the facility for three years but did not work on R75's floor often. CNA P reported the Care Plan and Kardex were used to identify care needs of the residents. CNA P reported R75 was on a fluid restriction, which could have been identified by the color of their name tag on the outside of their room. CNA P reported the fluid restriction amounts should have been in the Care Plan, and they could also ask the nurse. CNA P believed R75's dialysis access site was in their left arm but reported they did not know that for sure. In an interview on 02/13/25 at 1:55 PM, Registered Dietitian (RD) M reported R75 was not on a fluid restriction. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/13/25 at 2:11 PM, Registered Nurse (RN) C reported R75's dialysis fistula (access site) was in their left arm. According to RN C, daily monitoring of the fistula was on the MAR and included listening for a bruit and ensuring the fistula was not open or hurting. During the interview, RN C was unable to locate the orders for monitoring and assessing R75's dialysis access site. RN C stated R75 was on a fluid restriction and only took sips of water with medication. RN C stated there would typically be an order for a fluid restriction, but they did not locate one in the medical record. During an interview on 02/13/25 at 2:23 PM, Director of Nursing (DON) B reported the expectation was for daily monitoring of a dialysis access site, which included checking for a bruit and thrill and assessing for bleeding. DON B reported there should have been orders in place for the monitoring, and the nurses should have been documenting in the Progress Notes. When asked how CNAs would know the location of the dialysis access site and care considerations pertaining to, DON B reported it should have been on the Kardex. DON B reported R75 went to the hospital on 1/16/25, and their orders were discontinued and not reimplemented upon return to the facility.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 This citation pertains to Intakes MI00146664, MI000146710 Based on observation, interview, and record review the facility failed to maintain sufficient staff to meet residents' needs timely for three (R41, R65, R109) and Resident Council of ten reviewed for staffing. Findings include: Review of the Resident Council Minutes, dated 2/2024 through 12/2024, reflected ongoing concerns with call light response times, mainly during the afternoon and night shifts. During a confidential resident group meeting on 02/12/25 10:08 AM, 7 out of 8 residents reported they had discussed afternoon/night shift staffing concerns with no changes to correct addressed concerns. The Resident Council group reported long waits for call light response from 45 minutes to 60 minutes. One of eight confidential residents reported staff is often heard chatting at the nurse's station at night for several hours while his call light is on. Resident #41 (R41) Review of the medical record reflected R41 was admitted to the facility on [DATE], with diagnoses that included respiratory failure. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 8/3/2024, reflected R41 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 2/10/25 at 11:49 AM, R41 was observed in bed. R41 reported that call light responses times were unreasonably long during the afternoon and midnight shifts. R41 stated that the employees play the light game. When asked for clarification, R41 stated that the staff will come in and shut off the call light without providing the requested service, and not return. On 2/13/25 at 10:59 AM, R41's call light was observed on. R41 stated light had been on for a while, over 20 minutes, however, this is the second time his light had been on for the same need. R41 stated that his brief hasn't been changed since 3:00 AM and needed a brief change. R41 stated he told staff however they shut the light off and exited the room without returning. R41 stated after waiting for some time, he reactivated his light. Moments later, Staff member O staff entered the room and shut R41's light turned off, stating that his certified nursing assistant knew he needed something and would be there to assist in a few minutes. When asked if R41's light had already been on, Staff Member O confirmed that the certified nursing assistant had bene in earlier and shut off R41's light without providing the requested service. In an interview on 2/13/25 at 1:53 PM, Nursing Home Administrator (NHA) A stated that staff should not be shutting the call light off until care is rendered. 32064 (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #65 (R65) Review of the medical record revealed R65 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke). The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/24 revealed R65 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), was always incontinent of urine, and frequently incontinent of bowel. Review of the Activities of Daily Living (ADL) care plan revealed R65 required two people for care. On 02/10/25 at 10:54 AM, R65 was observed in bed. R65 reported the facility did not have enough staff after 11:00 PM. R65 reported when they used their call light at night to be changed, it takes hours for someone to come. R65 reported staff come into their room, say they will be right back and then never come back. R65 stated It's like the aliens came in and took them. In an interview on 02/13/25 at 2:16 PM, director of Nursing (DON) B reported call lights have been a concern and that the facility was working on the issue in Quality Assurance and Performance Improvement (QAPI). DON B reported the expectation is that the call light is not turned off until the resident's need is met. 38383 Resident #109 (R109) On 02/10/25 at 12:08 PM, R109 reported facility staffing levels were poor to fair. R109 reported it sometimes took 30 to 45 minutes for their call light to be answered, and call light response times were extended around meal times and shift changes. Although it did not happen often, R109 reported they had urinated in their bed and soiled themselves due to waiting too long for staff assistance to the bathroom.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review the facility failed to provide medically related Social Services for one resident (#375) of two reviewed for Social Services. Findings include: Resident #375 (R375) Review of the medical record reflected R375 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction. A Brief Interview for Mental Status had not been completed due to R375's refusal to participate in the assessment. On 02/10/25 at 12:02 PM, R375 was observed in bed. R375 was wearing a sweatshirt which had food debris on the front of it. R375 actively listened to questions, participated in the interview, and appropriately answered questions. R375 was able to accurately answer questions about who he was, his personal information, where he was currently located, the current date, his medical history, what facility he previously resided at, and who his guardian was. It was clear that R375 was cognitively intact. R375 stated extreme frustration with his situation stating that he currently had a legal guardian in place, did not want a legal guardian, and absolutely did not want to be at the facility. R375 shared that back in October, he had suffered a stroke and was admitted to the hospital. R375 stated that at the time of his stroke and hospitalization , he was out of it which led to the hospital pursuing legal guardianship for R375 due to his acute medical condition that resulted in the temporary confusion. R375 stated since then, his confusion had resolved and R375 felt that he no longer required a guardian. R375 was extremely frustrated with the fact that he was admitted to the facility, had not received his clothing, shoes or any personal supplies such as a razor, and despite being a cigarette smoker for years, had not been provided cigarettes. R375 stated that he had requested to speak to his guardian multiple times and requested these items several times, however, had not heard from his guardian. R375 stated that he had stated these same concerns to the facility social workers and nursing staff several times, however, no one had done anything. R375 felt completely helpless because he could not make his own decisions and felt very strongly that he had no one to advocate for him or provide him with the basic supplies. R375 stated that he had none of his personal clothing or shoes, stating that they had been left at his previous facility. R375 stated that he would like to go out and smoke a cigarette however, not having shoes, socks, and clothing prevented him from being able to go outside. R375 stated that he did not have a wheelchair due to staff removing it from his room to provide to another resident. R375 stated that he was stuck in bed. A wheelchair was not observed in R375's room. Review of a Psychosocial Note dated 1/31/2025 2:12 PM revealed SS (social services) met resident at bedside regarding psychosocial support. SS greeted the resident by name and he responded appropriate. Resident acknowledge refusing meals, showers, therapy and meds. Resident stated that he does not want to be here at the facility. Resident is aware that he has a guardian. Resident guardian is aware of his behaviors. Resident will continue to be followed by psych. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Social Services note dated 1/31/2025 at 4:20 PM revealed SS spoken to resident at bedside regarding therapy. SS greeted the resident by name and he responded appropriate. Resident acknowledged his behavior refusing therapy, refusing meds (medications), refusing to eat. Resident express that he does not care. He wants to discharge. SS contacted resident guardian regarding resident behavior's. Guardian encourage resident to do his therapy and to eat his food. Resident told guardian no. However, guardian express that she is in the process of finding placement for resident. Resident guardian is aware of behaviors. Review of a Health Status Note dated 1/31/2025 9:42 PM revealed resident complained he want \s [sic] his guardian called and he wants to leave this facility. guardian was called at 21:25pm and she stated that she is still in the process of getting another facility for him and writer should let resident know about this . Review of a Physician Progress note dated 2/7/2025 at 1:33 PM stated Patient lying in bed alert verbal and no s/s (signs/symptoms) of distress noted .Patient continues to refuse care and treatment, refuses medications, refuses physical therapy and at times refuses to eat. Patient's guardian was called and she states she cannot help him at this time. Review of an Alert Note dated 2/10/2025 at 2:07 PM revealed Behavior was observed- at baseline. Guardian contacted and stated that she is working into providing the items that he requested. Review of a Social Services Note dated 2/10/2025 6:22 PM stated Social services met with resident regarding refusal of meals. Social services greeted resident by name and resident responded appropriately. Resident stated that he would like to discharge from the facility. Guardian is aware of the resident wanting to discharge and is working on placement. Review of a Behavioral Solutions Note dated 2/3/25 revealed Patient evaluated at bedside. He presents as calm, cooperative, and pleasant. Social worker requested patient to be evaluated for bipolar disorder, depressive type, which is ongoing. He denies any hallucinations, delusions, or paranoia .Per chart notes: few days ago, patient refusing physical therapy, refusing meds, and refusing to eat because he wanted to go home. Patient has been compliant lately. He reports feeling depressed and sad. In an interview on 02/12/25 at 11:23 AM, Social Worker (SW) I stated that the typical process for residents with a guardian that do not wish to have one anymore would be to perform a competency evaluation and take the concern to the judge for guidance and a decision. SW I stated that she was aware that R375 has a guardian, however, does not want a guardian. SW I explained that the guardianship had been in place when R375 admitted to the facility. SW I stated that R375 was refusing care because he was adamant about not wanting to be at the facility. R375 stated that she was aware that R375 was refusing medications, food and therapy because R375 was not happy here, not happy with having a guardian, not happy about not having his clothing and stated his clothing was still at the other facility . SW I stated that despite these concerns, no one felt that R375 should be reevaluated for guardianship because of his care refusals, despite R375 having the mental capacity to make his own decisions. SW I was also aware that R375 had expressed concerns about not having clothing or cigarettes but believed that those items had been provided to R375 by the guardian. SW I stated that the facility gives the guardian a week or two to provide resident requests. (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 02/12/25 at 11:45 AM, Social Worker (SW) J stated that she has been discussing concerns with R375, however, he is reluctant to have a conversation with social work unless it is regarding how he can be discharged from the facility. SW J stated that she was aware of R375's dissatisfaction regarding not having his clothing, shoes or cigarettes. SW J stated that she was unaware of R375's Brief Interview for Mental Status score because he had refused the assessment, however, did no other attempts to determine mental capacity were attempted. SW J was unable to determine why a guardian was in place for R375, stating, he admitted to the facility with one so he must have required a guardian for some reason. On 2/12/25 at 11:55 AM, R375 was observed in bed wearing the same clothing as the last observation. Food debris were observed on the resident's sweatshirt. R375 confirmed that social services had not spoke with him regarding the guardianship, that he still had not received his basic supplies and requests from his guardian, despite being in the facility for nearly a month, and now had suicidal ideation with a plan. Review of a Social Services Note dated 2/12/2025 at 12:16 PM revealed Social services spoke with the guardian r/t (related to) suicidal ideation's. Social services informed the guardian that the resident will be getting petitioned out. Per guardian, she was heading to the facility to bring the resident cigarettes and will attempt to get to the (name of previous facility) facility to pick up the residents clothing. Per the guardian, she is fine with the resident being sent out and will get the resident his items and meet with the resident at the hospital .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45135 Based on observation, interview, and record review, the facility failed to ensure safe storage and administration of medications, in one of five residents (R#5) reviewed for sample of 25 resulting in unsafe medication administration, unsafe medication access, and the potential for lost medications/medication errors. Findings include: Resident #5 (R5) During medication administration on 02/12/25 at 8:20 AM, Registered Nurse (RN) C was observed removing a pre-filled med cup from the top drawer of her medication cart. RN C had filled it prior to this time with the 8:00 AM medications and set in the top drawer of medication cart. RN C pulled the medication cup out of the top drawer and began to pour a glass of water to give these medications to R5. This writer stopped RN C and asked her to identify every medication she was administering to R5 from that med cup. RN C recalled the medications she put in the cup; however, RN C did not have R5's Lithium Carbonate Oral Capsule 150mg tablet in the medication cup. Resident did not receive this morning dose of Lithium, resulting in a medication error. During an interview on 02/13/25 at 1:00 PM, with Director of Nursing (DON) B and Licensed Nursing Home Administrator (LNA) A writer asked DON B what her expectations would be when nurses are administering medications. DON B stated the expectation would be to pull the medications out when they are due from the bubble pack and goes directly in the medication cup, and it is administered at that time and they would be signed out.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22050 This citation pertains to intakes MI00148581, MI00147352. Based on observations, interviews, record reviews, 7 of 8 from the confidential group meeting, 3 (#65, #94, #103) of 25 sampled residents, and 1 (#105) non-sampled resident, the facility failed to provide palatable food products effecting 125 residents, resulting in the increased likelihood for decreased resident food acceptance and nutritional decline. Findings include: On 02/10/25 at 01:35 P.M., An interview was conducted with Resident #94 regarding facility food products. Resident #94 stated: The food could be better. Resident #94 also stated: They could do better than just hamburgers and hot dogs. Resident #94 was also queried regarding gluten free facility food products. Resident #94 stated: I receive gluten free food for the most part. On 02/10/25 at 01:45 P.M., An interview was conducted with Resident #105 regarding facility food products. Resident #105 stated: I want to eat specific vegetables that are nutritious (Zucchini, Asparagus, [NAME] Beans, (Grilled Onion and Bell Pepper), and fresh white rice. Resident #105 also stated: I've spit out their green beans more times than not. Resident #105 additionally stated: The rice is usually tough and congealed. Resident #105 further stated: The [NAME] beans served are generally very sour. On 02/11/25 at 10:58 A.M., An interview was conducted with Resident #103 regarding facility food products. Resident #103 stated: The food products don't taste good. and The salad cheese is wilted together and slimy. Resident #103 also stated: The breakfast food (scrambled eggs, sausage links, pancakes, French toast, etc.) is always cold. Resident #103 additionally stated: I prefer to buy my own food, because the facility food is generally cold, tastes bad, and is poor quality food. On 02/11/25 at 11:10 A.M., Resident #103's personal food products (One 32-ounce container of Cottage Cheese (one-eighth full), Two 6-ounce containers of Yoplait Yogurt, 1 medium Pizza, two small containers of Ranch Dressing, and six containers of soda pop) were observed resting directly upon the resident room windowsill, adjacent to the radiant heating unit. The window sash was also observed cracked open approximately 2-3 inches to supply limited refrigeration for the personal food products. On 02/11/25 at 11:13 A.M., Resident #103 was interviewed regarding how long the personal food products had been stored on the windowsill. Resident #103 stated: The pizza has been here for three days. Resident #103 further stated: The cottage cheese, yogurt, and ranch dressings have been here for two days. The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 C (41 F) or less. (continued on next page)

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

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The 2022 FDA Model Food Code section 3-501.17 states: (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. On 02/11/25 at 11:16 A.M., An interview was conducted with Resident #65 regarding facility food products. Resident #65 stated: They make the world's worst grilled cheese. Resident #65 also stated: The hot dogs are burnt. and The hamburgers are tough and very dry. Resident #65 additionally stated: You can't talk to the Dietician or [NAME] or anybody. Resident #65 further stated: The pizza is very tough. and You could tile a house with the pizza. On 02/11/25 at 11:56 A.M., Resident lunch meal food trays (25) were observed leaving the food production kitchen, within a stainless-steel non-insulated transport cart. On 02/11/25 at 11:59 A.M., Resident lunch meal food trays (25) were observed arriving to second floor north, within a stainless-steel non-insulated transport cart. On 02/11/25 at 12:07 P.M., Resident lunch meal food trays (18) were observed leaving the food production kitchen, within a stainless-steel non-insulated transport cart. On 02/11/25 at 12:08 P.M., Resident lunch meal food trays (18) were observed arriving to second floor south, within a stainless steel non-insulated transport cart. On 02/11/25 at 12:15 P.M., Food product temperatures were monitored utilizing a ThermoWorks Super-Fast Thermapen model CR2032 digital thermometer. The following food product temperatures were recorded for Resident #65's lunch meal food tray: Pork Loin - 132.4* Au-gratin Potatoes - 141.5 Green Beans - 133.4* Pineapple Tidbits - 42.6* Beverage (Lemonade) - 43.8* Dannon Yogurt - 43.4* (*) The 2022 FDA Model Food Code section 3-501.16 states: (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57oC (135oF) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; or (2) At 5 C (41 F) or less. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/11/25 at 12:20 P.M., A lunch meal food product palatability test was conducted by this surveyor. The following items and comments were noted: Pork Loin - The pork loin was observed to be moist and tender. Au-gratin Potatoes - The potatoes were observed to be bland, grainy, and starchy. Green Beans - The [NAME] beans were observed to be bland and tender. Pineapple Tidbits - The pineapple was observed to be tender and flavorful. Dannon Yogurt (Strawberry) - The yogurt was observed to be fresh and flavorful. Beverage (Sugar Free Lemonade) - The sugar free lemonade was observed to be cold, refreshing, and reflecting weak lemon flavor. On 02/11/25 at 01:02 P.M., A lunch meal food product palatability test was conducted by this surveyor. The following (Always Available Alternate Menu Option) item was noted: Hot Dog - The hot dog was observed to be discolored, starchy, grainy, reflecting a distinct aftertaste. On 02/11/25 at 02:35 P.M., An interview was conducted with Regional Dietary Director V regarding a specific Policy/Procedure for resident personal refrigerators. Regional Dietary Director V stated: We don't provide personal refrigerators for residents. Regional Dietary Director V also stated: We have a refrigerator in the Activity Room for resident specific food items. On 02/13/25 at 09:30 A.M., Record review of the Policy/Procedure entitled: Meal Distribution dated 09-01-2021 revealed under Standard: Meals are transported to the dining locations in a manner that ensures proper temperature maintenance, protects against contamination, and are delivered in a timely and accurate manner. Record review of the Policy/Procedure entitled: Meal Distribution dated 09-01-2021 further revealed under Guidelines: (4) The nursing staff will be responsible for verifying meal accuracy and the timely delivery of meals to residents/patients. (5) For point-of-service dining, the Dining Services department staff, under the supervision of the licensed nurse, will assemble the meal in accordance with the individual meal card and present it to the resident/patient or care staff for delivery to the resident/patient. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/13/25 at 10:00 A.M., Record review of the Policy/Procedure entitled: Safe Storage & Handling of Outside Food dated (no date) revealed under Can I Bring Food for Patients and Residents: Food can be brought into the facility as long as the food is safe. There can be a risk of foodborne illness when food is not properly prepared, transported, or stored. This can have serious consequences for the resident. Record review of the Policy/Procedure entitled: Safe Storage & Handling of Outside Food dated (no date) further revealed under Food Receiving and Safe Food Storage: You must check in at the nurse's station when you bring food in for a resident. Any food which is not going to be consumed immediately must be covered and labeled with the resident's name, and date the food the day the food was brought into the facility and placed into the unit refrigerator. Labels and the location of the refrigerator are available at the nurse's station as well as in the pantry area. All food that is stored in the refrigerator and not consumed within 3 days will be discarded by facility staff daily. Signage regarding this process is displayed on all fridges. Any food without the correct labeling will also be discarded. 32064 Resident #65 (R65) Review of the medical record revealed R65 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke) and diabetes. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 11/20/24 revealed R65 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 02/10/25 at 10:49 AM, R65 was observed in bed. R65 reported the facility's food was lousy, it's absolutely terrible. R65 reported he was often served grilled cheese sandwiches after telling the facility to quit giving them grilled cheese sandwiches. R65 reported the grilled cheese was awful. R65 reported they ate in their room and the food was always cold like it just came out of the refrigerator. R65 reported the meat was like rubber. 46954

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review, the facility failed to accurately honor food preferences for one resident (#94) of six resident reviewed for food preferences. Findings include: Review of the medical record reflected R94 was admitted to the facility on [DATE], with diagnoses that included celiac's disease (gluten intolerance). The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/4/24, reflected R94 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 2/10/25 at 12:21 PM, R94 was observed in bed. R94 was on an air mattress and had her heels floated. R94 explained that she had several pressure ulcers that she admitted with. R94 expressed her frustration with the meals that the facility had been providing her. R94 stated that she had a gluten free diet order and required extra protein due to her pressure ulcers. R94 stated that the dietician visited with her when she admitted to the facility in November and had not since visited her since despite her weight trending down. R94 stated that the kitchen is substituting her meals with hot dogs and hamburgers nearly daily, and at times, the bun is sent. R94 denied double portions, denied disliking anything however, had to avoid gluten. R94 stated that she loves fish, chicken, and pork but for unknown reasons, the kitchen regularly substitutes the meat of the day with a hot dog or hamburger. Review of the Physician Orders revealed an active order which stated Regular diet, Regular texture, Thin consistency GLUTEN FREE. for GLUTEN FREE. In an interview on 2/12/25 at 9:16 AM, Certified Nursing Assistant (CNA) CC stated that she was familiar with R94. CNA CC stated that R94 usually gets sent a hot dog or hamburger. CNA CC stated that R94 is getting tired of the hamburger and hot dogs In an interview on 2/13/25 at 10:34 AM Registered Dietician (RD) M stated that meat should not be substituted for residents with a gluten free diet.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on observation, interview and record review, the facility failed to ensure collaboration of care and communication with the hospice provider for one (Resident #112) of one reviewed. Findings include: Review of the medical record reflected Resident #112 (R112) admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included neuromyelitis optica and cerebral infarction. The Significant Change in Status Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/19/25, reflected R112 scored nine out of 15 on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and received hospice services. On 02/13/25 at 1:06 PM, R112 was observed lying in bed. A staff member was present in the room, providing feeding assistance. A Physician's Order, with a revision date of 1/13/25, reflected R112 was admitted to hospice services. In an interview on 02/12/25 at 11:01 AM, Social Services Director (SSD) I reported they helped coordinate hospice services within the facility. According to SSD I, R112 received hospice services that included a Certified Nurse Aide (CNA), nurse, talk therapy and Social Worker. Review of R112's Hospice Binder, which was located at the nurse's station on 02/13/25 at 1:10 PM, reflected a hospice visit calendar, dated for 1/26/25 through 4/12/25. For the dates of 1/26/15 through 2/13/25, there were to be 14 scheduled visits from hospice staff. A Registered Nurse was to visit weekly, a CNA was to visit twice weekly, a Social Worker was to visit weekly and a Chaplain was to visit every other week. The Hospice Staff Collaboration Log, located in R112's hospice binder on 02/13/25 at 1:10 PM, reflected notation of four visits from hospice staff. The Hospice Binder was not noted to include any Progress Notes pertaining to hospice visits. Review of R112's Electronic Medical Record (EMR) reflected it was lacking documentation of their hospice services visits. Additionally, R112's Care Plan was not reflective of the hospice disciplines that were involved in their care. On 02/13/25 at 1:21 PM, an email was sent to Nursing Home Administrator (NHA) A to request R112's Hospice Visit Calendar for January through April (2025), as well as the Hospice Communication Log. The Hospice Communication Log was not provided prior to the exit of the survey. During an interview on 02/13/25 at 2:23 PM, Director of Nursing (DON) B reported hospice visit notes should have been in the Hospice Binder on the unit, as well as scanned into the EMR. DON B reported staff should have had hospice visit notes available to them.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32064 Based on interview and record review, the facility failed to administer a pneumococcal immunization per consent for one (R48) of five reviewed. Findings include: Review of the medical record revealed R48 was admitted to the facility on [DATE]. The MDS with an Assessment Reference Date (ARD) of 1/11/25 revealed R48 had severely impaired cognitive skills for daily decision making and that their pneumococcal immunization was not up to date but was offered and declined. Review of the Vaccine Consent and Administration Form revealed R48's Durable Power of Attorney (DPOA) for Healthcare gave consent on 4/17/24 for R48 to receive the pneumococcal immunization. R48 did not receive the pneumococcal immunization. In an interview on 02/12/25 at 10:33 AM, Assistant Director of Nursing (ADON)/Infection Preventionist (IP) Z agreed R48's DPOA consented to the pneumococcal immunization on 4/17/24. ADON/IP Z was not sure why R48 had not received the pneumococcal immunization after consent was given.