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	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Parkridge	28 S Prospect Street 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. Based on interview and record review, the facility failed to address and resolve grievances reported in Resident Council Meetings as stated during a confidential Resident Council meeting resulting in unresolved concerns, unmet resident needs and frustration. Findings include:During an interview on 3/09/2026 at 11:45 AM, Activity Manager Q verified Resident Council President and reported plant to gather residents for Confidential Resident Council Meeting at 3:00 p.m. Requested six months of minutes for review and Activity Manager reported after each meeting concern forms are completed for reported concerns and department managers are responsible for addressing concerns and verified follow up information with be proved with requested minutes. During a Confidential Resident Council Meeting on 3/09/2026 at 3:14 PM there were 12 residents present with 8 residents who actively participated and appeared to be alert and oriented. When asked if staff respond to call light timely, 8 of 8 resident reported ongoing issue with slow response to call lights. Residents reported discussed at every Resident Council Meeting for months with no improvements and management staff say they are working on it. Residents gave examples of call light response times greater than one hour on night shift and then when staff arrive residents were not treated with dignity and resident told, I am busy, we are short staffed, what do you need. Another confidential resident reported always told by staff short staffed after waiting for call light to be answered and stated, That is not our problem when we have to ask for assistance with basic care like going to the bathroom. Another resident who attends monthly verified call lights discussed every month with no improvements. Eight of eight confidential residents were not aware where to locate or how to complete a grievance form or how the process worked.Review of Resident Council Meeting minutes, dated 9/23/25 through 3/8/26, provided by Nursing Home Administrator (NHA) A. Continued review of minutes revealed resident complaints of long call light response times on 5 of 6 months of council meetings. The facility responses were all that staff was re-educated on call light answering. (for past 6 months same facility response to re-educate staff with continued complaints of current call light response times appears not effective.)

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

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review, the facility failed to notify residents of where to find grievance forms and how to file a grievance as stated during a confidential Resident Council meeting resulting in unresolved concerns, unmet resident needs and frustration. Findings include:During a Confidential Resident Council Meeting on 3/09/2026 at 3:14 PM there were 12 residents present with 8 residents who actively participated and appeared to be alert and oriented. When asked if staff respond to call light timely, 8 of 8 resident reported ongoing issue with slow response to call lights. Residents reported discussed at every Resident Council Meeting for months with no improvements and management staff say they are working on it. Residents gave examples of call light response times greater than one hour on night shift and then when staff arrive residents were not treated with dignity and resident told, I am busy, we are short staffed, what do you need. Resident reported made them feel like they were a bother to staff because they had to ask for assistance. Another confidential resident reported always told by staff facility was short staffed after waiting for call light to be answered and stated, That is not our problem when we have to ask for assistance with basic care like going to the bathroom. Another resident who attends monthly verified call lights discussed every month with no improvements. Eight of eight confidential residents were not aware where to locate or how to complete a grievance form or how the process worked.

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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** Based on observation, interview and record review, the facility failed to provide adequate nursing staff to ensure that the needs of their residents were met for 11 residents (R7, R41, and R64) and 8 residents identified through confidential group interviews, resulting in insufficient and unmet resident care needs, feelings of frustration, and complaints about not enough staff. Findings includeR7 Review of the clinical record revealed R7 was admitted into the facility on 1/11/2026 with diagnoses that included: paraplegia, neurogenic bowel (loss of normal bowel control caused by nerve damage), and sarcoidosis (an inflammatory disease where the immune system overreacts, causing tiny, swollen lumps to form in organs). According to the Minimum Data Set (MDS) assessment dated [DATE], R7 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). On 3/8/26 at 1:13 PM, R7 was observed lying in bed on his back with a personal video game set up for his use. R7 reported that he has waited as long as 3 hours for his call light to be answered and that his roommate is like his legs and will go to the nurses station if R7's call light is on for too long. R7 further reported that when his roommate goes to the nurses station he reports back that the staff are just sitting at the nurses station talking and that it routinely takes an hour plus for staff to respond to his call light. During a Confidential Resident Council Meeting on 3/09/2026 at 3:14 PM there were 12 residents present with 8 residents who actively participated and appeared to be alert and oriented. When asked if staff respond to call light timely, 8 of 8 resident reported ongoing issue with slow response to call lights. Residents reported discussed at every Resident Council Meeting for months with no improvements and management staff say they are working on it. Residents gave examples of call light response times greater than one hour on night shift and then when staff arrive residents were not treated with dignity and resident told, I am busy, we are short staffed, what do you need. Another confidential resident reported always told by staff short staffed after waiting for call light to be answered and stated, That is not our problem when we have to ask for assistance with basic care like going to the bathroom. Another resident who attends monthly verified call lights discussed every month with no improvements. Eight of eight confidential residents were not aware where to locate or how to complete a grievance form or how the process worked. On 03/09/2026 at 2:26 PM three activated call lights were observed on the 300 hall. Two nurses were seated at the nurse's station chatting to each other. On 03/09/2026 at 2:31 PM, R41 was heard screaming I need a nurse from her room. Her family member was observed exiting the room shortly after and proceeded to the nurse's station. On 03/09/2026 at 2:32 PM, the family member returned to R41's room. R41 stated, what did she say. The family member said, she said okay. On 03/09/2026 at 2:39 PM, R41 was heard screaming, I need a nurse, someone help. The family member stated I don't know where they are at, yes i told them you needed help. This is unreal. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/09/2026 at 2:41 PM, another call light was activated. Meanwhile, the two nurses remained seated at the nurses' station. On 03/09/2026 at 2:45 PM, a confidential Certified Nursing Assistant entered R41's room. R41 screamed at the CNA stating, I have to go to the bathroom so bad, my call light has been on for over an hour, this is insane. R41's family member said, she's been waiting a very long time. On 03/09/2026 2:48 PM, the confidential CNA was visibly frustrated, stated that there are two nurses, the two at nurses' station that could help with answering call lights, the CNA has had no break, and had 17 residents assigned to her today. On 3/9/26 at 2:50 pm, I inquired with R64 as to why he had his call light activated, as R64 was one of the four. R64 stated that he had his call light activated since after he finished his lunch. R64 stated that his brief was digging into his skin and causing him pain. In an interview on 03/10/2026 at 12:41 PM, Director of Nursing (DON) B stated that all staff are responsible for answering call lights and ignoring call lights is not acceptable.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat all residents with dignity for one (Resident #7) of two reviewed.Findings include:Review of the clinical record revealed R7 was admitted into the facility on 1/11/26 with diagnoses that included: paraplegia, neurogenic bowel (loss of normal bowel control caused by nerve damage), and sarcoidosis (an inflammatory disease where the immune system overreacts, causing tiny, swollen lumps to form in organs). According to the Minimum Data Set (MDS) assessment dated [DATE], R7 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).On 3/8/26 at 1:13 PM, R7 was observed lying in bed on his back with a personal video game set up for his use. R7 reported that the staff are rude and that he had enough. R7 reported that staff do not explain what they are doing prior to performing care and often leave him exposed during wound care and pericare. R7 specifically mentioned wound care that was performed recently, R7 stated that his privacy curtain had not been pulled and he wasn't covered up, R7 could see his roommate ambulating within their room and when R7 looked down he realized his genitals were also exposed. R7's roommates are both ambulatory and that staff routinely do not pull his privacy curtain while providing care. R7 further stated that he just wanted basic common courtesy. On 3/8/26 at 1:51 PM, LPN R was observed entering R7's room without knocking. Upon entering the room during my interview, LPN R stated that she sort of knocked, had her phone in her hand and that she was looking for the bladder scanner. LPN R did not knock until she had already opened the door, stuck her head inside and saw I was in the middle of an interview. R7 reported that staff rarely knock before entering their closed door. On 3/10/26 at 2:21 PM, during an interview with Director of Nursing (DON), it was reported that the expectation for staff is that they knock on the door, introduce themselves and wait for an answer prior to entering resident rooms and staff should always pull privacy curtains when performing resident care.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident had a call system adapted to their physical limitations in one (Resident #98) out of two reviewed for accommodation of needs. Findings include: Review of the medical record reflected R98 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included apraxia following cerebral infarction (inability to make voluntary movements or gestures even though you have the physical ability and understanding to do so), dysarthria (motor speech disorder where damage to your nervous system causes the muscles that produce speech to become paralyzed or weakened) and weakness/paralysis affecting the right dominant side following a stroke. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/16/26, reflected R98 was rarely or never understood. On 03/08/2026 at 10:28 AM, Resident #98 (R98) was observed in his room wearing only an adult brief, lying flat on his back, heels not elevated off the mattress. R98's room was very warm. R98 had a Styrofoam cup on his bedside table with a handwritten date of 3/6/26 PM that contained about 1/4 of water. R98 had an unpleasant body odor coming from him that indicated that he had not been bathed in quite some time. He has a very unkempt appearance. R98's lips appeared very dry and chapped. R98's toenails were very overgrown. R98's push button call light was clipped to his curtain on his right side and out of reach. I introduced myself to R98 and explained the purpose of my visit, however, R98 did not verbally respond. I continued to make conversation and discovered that R98 understood what I was saying but could not verbalize back to me but could answer by nodding yes or shaking his head no. R98 could answer questions appropriately. When asked about details such as the surroundings or details such as the colors of the clothing I was wearing, R98 answered the questions appropriately. I inquired if R98 was warm and he nodded his head yes. When asked if he had been receiving showers, he shook his head and stated no no no. When asked if he would like a shower, he nodded yes. When asked if he would like to have his face shaved and a haircut, he nodded yes. When asked if he was thirsty, he enthusiastically nodded his head yes. When asked if he could hold a cup and give himself drinks of water, he stated, no no no and raised and lowered his left arm. I observed his left hand and R98's fingers were on a fixed, fanned out position. When asked if he required assistance with eating and drinking, he nodded yes. When inquired how he requested assistance from staff, he shrugged his shoulders. When asked how he communicated his needs to staff, he shrugged his shoulders again. When asked if he used a communication board with pictures, he stated 'no, no, no. When I attempted to leave the room, R98 appeared frantic and looked at the empty Styrofoam cup of water on the bedside table and stated no no no. I asked him if he was thirsty and he nodded yes. I provided him with staff assistance. Review of a Psychiatric note dated 11/10/25 revealed that R98 was able to shake his head to answer simple questions. On 03/09/2026 2:56 PM, R98 was observed in bed in the exact same position. R98's push button call light was positioned on his chest. I inquired if R98 could demonstrate using his call light. R98 looked at me and again showed me that he could only raise and lower his left arm, and his fingers were fixed in a fanned-out position. On 03/10/2026 at 7:57 AM, R98 was observed in his room. R98 was lying flat on his back with his heels not floated. LPN J entered the room and stated that it was hot in the room. A full, room temperature Styrofoam cup of water dated 3/10 22:00 (10:00 pm) was observed on his bedside table with no straw in it. On 03/09/2026 at 3:02 PM, Certified Nursing Assistant (CNA) G stated she is not sure how he communicates his needs and she is not sure if he can use his call light but it is clipped on to him. On 03/10/2026 at 9:58 AM, CNA O stated that R98 cannot use the call light.On 03/10/2026 at 11:23 AM, Unit Manager (UM) I stated that R98 communicates by nodding yes or no or by using the communication board. When queried where the communication board currently was in R98's room, UM I informed me that it was not in his room. R98's call light was observed clipped to the top of his mattress on the right side (his affected side) during the interview. I inquired how R98 notifies staff if (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he requires assistance. UM I proceeded to unclip the out of reach call light and place it in R98's hand. I asked R98 to demonstrate using the call light. R98 looked at me and again, raised and lowered his arm stating no no no. I asked R98 if he could use the call light and he shook his head to indicate that he was unable to use the push button call light which was obvious due to his left sided functional limitations. When asked how the facility monitors hydration statuses and ensures that R98 is being offered fluids, UM I stated that staff document fluid intake and offer fluids. I held up the full, room temperature water that contained no straw dated 3/10 22:00 and asked R98 if that was his water from last night. R98 nodded yes. I asked R98 if he had anything to drink last night. R98 nodded no. I asked if R98 was thirsty and he indicated that he was thirsty. In an interview on 3/10/26 at 11:26 PM, Director of Nursing B stated a soft touch or pancake call light would be more fitting for R98.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a safe, clean, comfortable and homelike environment for one (Resident #72) of two reviewed.Findings include:Review of the clinical record revealed R72 was admitted into the facility on 5/19/25 with diagnoses that included: pancytopenia (blood counts-red blood cells, white blood cells and platelets are lower than normal), immunodeficiency due to drugs, asthma, paraplegia, depression and anxiety. According to the Minimum Data Set (MDS) assessment dated [DATE], R72 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).On 3/10/26 at 9:31 AM a sign was observed to see staff prior to entering resident room, record review confirmed that R72 was in reverse isolation. Upon entering room, R72 was observed laying on her back in bed, the room was dark with light coming in from the bathroom, the bathroom door was open and a large hole was observed where the wall and ceiling meet in the shower. The exposed wall was observed to have dark, rust colored debris and 2 pipes were exposed. The approximate size of the hole was 6 inches wide by 6 inches long. The ceiling had a replacement piece covering what appeared to be damage to the ceiling. The tub was covered with a board and R72 reported that it had not been usable. There was a brown substance noted in a splatter pattern on the tub exterior, close to the floor. Additionally, there was a white substance noted on the mirror in a vertical streaking pattern. R72 reported that the wall/shower area had been in that condition for an extended period of time and was noted to be worse in the past. A review of R72's physician orders revealed: Reverse isolation (neutropenic precautions), every shift for immunosuppressive long term linezolid use, with a start date of 5/19/25 and no specified end date. On 3/10/26 at 1:16 PM, during an interview with Regional Director of Maintenance (RDM) S and Maintenance Director (MD) T, it was reported that they were aware of need for repair in R72's bathroom and the original problem was a leak in a pipe back in mid-November of 2025 that required repair. Repairs had been made and the holes in the walls/ceiling had been previously repaired, however it was discovered the materials that were used were not fireproof and needed to be replaced again. RDM S agreed that in the current condition it was not homelike.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect for one (R135) of four reviewed.Findings Include: Review of the medical record revealed R135 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes. Review of the Social Services Comprehensive Evaluation dated 3/4/26 revealed R135 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Physician's Order dated 3/3/26 revealed Wound Care (L [left] posterior leg): cleanse [with] normal saline, apply Medihoney (Activon) to wound bed, cover with foam dressing. The wound care was ordered to be completed every evening shift, every other day. On 03/08/2026 at 10:13 AM, R135 was observed sitting on the edge of his bed. R135 reported he had a wound on the back of his left calf, but the facility had not changed the dressing since 3/2/26 or 3/3/26. R135 pulled up his pant leg and a dressing dated 3/3/26 was observed on his left calf. R135 reported he had his own wound care supplies from the hospital, but the facility removed the supplies from his room when he was admitted . On 03/09/2026 at 1:38 PM R135 was observed self-ambulating in the hallway. R135 reported his wound care still had not been completed. On 03/09/2026 at 1:47 PM, R135's left calf dressing was observed to be the same dressing dated 3/3/26. Review of Treatment Administration Record (TAR) revealed R135's wound care was checked off and signed out as completed on 3/4/26 by Licensed Practical Nurse (LPN) L, on 3/6/26 by LPN M, and on 3/8/26 by LPN N. In an interview on 03/09/2026 at 2:13 PM, Registered Nurse (RN)/Unit Manager (UM) I reported R135 had a wound on his left calf which was caused by his walking boot. UM I reported she monitored if wound care was completed as ordered by reviewing the TAR and progress notes. UM I reviewed R135's TAR and reported the check mark with initials indicated the wound care was completed. UM I reported if the wound care was not completed, the TAR would reflect a code 9 and then have a coordinating progress note. On 03/09/2026 at 2:17 PM, with UM I, R135 was observed in bed. R135's bandage was observed with the date of 3/3/26. UM I agreed R135's dressing was dated 3/3/26 and therefore had not been changed since then. On 03/09/2026 at 2:49 PM, UM I changed R135's dressing to which he responded, It's about time. R135's wound was observed as an open area with a red wound bed and drainage on the removed dressing. In a telephone interview on 03/09/2026 at 1:56 PM, LPN N reported she worked with R135 last night (3/8/26). LPN N reported R135 did have ordered wound care, but she could not recall if she completed the wound care on 3/8/26. When asked why it was checked off and signed off as completed on the TAR, LPN L then reported she did the wound care. When informed that R135's dressing was dated 3/3/26, LPN N then reported she knows she did a dressing last night but could not recall if it was for R135. LPN N reported she did not know why the wound care was signed out as completed but not done. In a telephone interview on 03/10/2026 at 11:14 AM, LPN L reported they worked on 3/4/26, but could not recall R135. When asked if she performed any wound care that day, LPN L reported she changed a dressing on another resident's heel. When asked if she performed any wound care/changed a dressing on the back of a resident's calf, LPN L stated, No. When asked what a check mark and their initials reflected on the TAR, LPN L reported that indicated the wound care was done. LPN L reported if the wound care was not done, the TAR would indicate a special code and then she would make a progress note. When asked why the TAR reflected R135's wound care was completed when it was not, LPN L stated, maybe I checked it off. Review of R135's progress notes revealed no indication as to why wound care was not completed on 3/4/26, 3/6/26, or 3/8/26. In an interview on 03/10/2026 at 10:54 AM, Director of Nursing (DON) B reported LPN L, LPN M, and LPN N did not follow the physician's orders for R135's wound care. DON B reported there was no reason as to why the wound care should be signed out as completed but not done. DON B reported she was in the process of educating the nursing staff related to this concern. In an interview on 03/10/26 at (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:02 AM, LPN M reported she was not sure if R135 had any ordered wound care. LPN M reported if the TAR showed a check mark and her initials, then she would assume the wound care was completed. When she was informed that R135's dressing was dated 3/3/26, LPN M reported R135 mentioned that to her yesterday. LPN M reported since R135's dressing was dated 3/3/26, she probably did not do his wound care on 3/6/26. Review of the personnel files revealed on 1/20/25, LPN N received an Employee Discipline Form for documenting that a catheter change was performed, but it was not completed. On 10/20/23, LPN L received an Employee Discipline Form for not completing skin evaluations and falsified documentation. On 3/9/26, LPN M received a Corrective Action for Minor Offenses for documenting wound care as completed but not dated for that day (3/6/26).

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to prevent misappropriation of resident property for one (Resident #34) of one reviewed.Findings include:Review of the clinical record revealed R34 was admitted into the facility on 2/10/26 with diagnoses that included: difficulty in walking and partial intestinal obstruction. According to the Minimum Data Set (MDS) assessment dated [DATE], R34 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).On 3/8/26 at 12:24 PM, R34 was observed sitting at the edge of the bed, eating lunch. R34 reported that a staff member entered his room that morning while he was asleep, stated she needed to use his phone charger, removed R34's phone from his charger and plugged her phone in and left it at his bedside. A pink, iPhone was observed to be plugged in and charging at R34's bedside. R34 described the staff member, and it was determined the phone belonged to CNA U. On 3/8/26 at 12:55 PM, during an interview with Unit Manager (UM) V, it was reported that it would not be appropriate for staff to have their cellphones in resident rooms or to charge their personal cellphones in resident rooms, using residents' personal property. On 3/8/26 at 1257 PM, UM V entered R34's room and discussed the staff members phone being charged in his room. UM V removed the iPhone and reported that she would address the concern.

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The Villa at Parkridge	28 S Prospect Street Ypsilanti, MI 48198

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview, and record review the facility failed to ensure comprehensive care plans were developed and implemented for three out of 24 residents (Resident #'s 12, 41, & 98). Findings Included: Resident #12: Per the facility face sheet R12 was admitted to the facility on [DATE]. Record review of R12's care plans revealed an active care plan that was in place with a Focus of .antidepressant medication r/t (related to) bipolar, depression. There was an intervention on R12's care plan to, Monitor/document/report PRN (as needed) adverse reactions to ANTIDEPRESSANT therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt (weight) loss, n/v (nausea/vomiting), dry mouth, dry eyes Dated 6/20/2025. There was no documentation of monitoring R12's antidepressant medication for any of the care planned adverse reactions. RR of the care plan revealed a. Focus that R12 had a .mood problem r/t dx (diagnosis) of generalized anxiety disorder, post-traumatic disorder, chronic, vascular dementia, mild, with anxiety, major depressive disorder, recurrent, moderate., dated 6/8/2025. The intervention on the care plan was to, Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills Date Initiated: 06/08/2025, and Monitor/record/report to MD (Medical Doctor) prn mood patterns s/sx (signs/signs and symptoms) of depression, anxiety, sad mood as per facility behaviour (sic) monitoring protocols. dated 6/8/2025. Another intervention revealed to, Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behaviour (sic) monitoring protocols. Date Initiated: 06/08/2025 Upon review of R12's electronic medical record (EMR) no documentation of monitoring of R12's mood for signs and symptoms, feelings, mood patterns, depression, anxiety, sadness, etc ., was found. In an interview on 3/10/2026 at 9:31 AM, Director of Nursing (DON) B stated there was no documentation for monitoring R12's antidepressant medication, which was Lexapro, as she was not able to find any documentation upon review of R12's EMR. DON B stated that the nurses were responsible to document on the care plan interventions of signs and symptoms and mood for the monitoring of. DON B stated that the information would be reviewed and discussed in an Interdisciplinary (IDT) meeting for Psychology follow-up if needed. During the same interview DON B stated that there was no documentation of monitoring of R12's mood per the care plan intervention to, Monitor/record/report to MD prn acute episode feelings or sadness; loss of pleasure and interest in activities; feelings of worthlessness or guilt; change in (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appetite/ eating habits; change in sleep patterns; diminished ability to concentrate; change in psychomotor skills Date Initiated: 06/08/2025, or Monitor/record/report to MD prn mood patterns s/sx of depression, anxiety, sad mood as per facility behaviour (sic) monitoring protocols. Date Initiated: 06/08/2025 In an interview on 3/10/2026 at 9:43 AM Social Worker (SW) S stated nursing would document the monitoring of the changes in R12's mood, and the monitoring for signs and symptoms of antidepressant use. SW S said when there was a concern, she would see it pop up on the clinical alert in the EMR system. SW S was not able to locate any documentation of monitoring of R12's mood or signs and symptoms related to antidepressant use in R12's EMR. SW S stated that it was a concern for her because she was not able to follow up with the resident and do a three day psychosocial evaluation when the documentation was not in a resident's EMR and she was not alerted to it. SW S said it was her expectation that the monitoring be documented because that is the only way she was going to know what is going on with a resident. Review of the medical record reflected R98 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included apraxia following cerebral infarction (inability to make voluntary movements or gestures even though you have the physical ability and understanding to do so), dysarthria (motor speech disorder where damage to your nervous system causes the muscles that produce speech to become paralyzed or weakened) and weakness/paralysis affecting the right dominant side following a stroke. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/16/26, reflected R98 was rarely or never understood. On 03/08/2026 at 10:28 AM, Resident #98 (R98) was observed in his room wearing only an adult brief, lying flat on his back, heels not elevated off the mattress. R98's room was very warm. R98 had a Styrofoam cup on his bedside table with a handwritten date of 3/6/26 PM that contained about 1/4 of water. R98 had an unpleasant body odor coming from him that indicated that he had not been bathed in quite some time. He has a very unkempt appearance. R98's lips appeared very dry and chapped. R98's toenails were very overgrown. R98's push button call light was clipped to his curtain on his right side and out of reach. I introduced myself to R98 and explained the purpose of my visit, however, R98 did not verbally respond. I continued to make conversation and discovered that R98 understood what I was saying but could not verbalize back to me but could answer by nodding yes or shaking his head no. R98 could answer questions appropriately. When asked about details such as the surroundings or details such as the colors of the clothing I was wearing, R98 answered the questions appropriately. I inquired if R98 was warm and he nodded his head yes. When asked if he had been receiving showers, he shook his head and stated no no no. When asked if he would like a shower, he nodded yes. When asked if he would like to have his face shaved and a haircut, he nodded yes. When asked if he was thirsty, he enthusiastically nodded his head yes. When asked if he could hold a cup and give himself drinks of water, he stated, no no no and raised and lowered his left arm. I observed his left hand and R98's fingers were on a fixed, fanned out position. When asked if he required assistance with eating and drinking, he nodded yes. When inquired how he requested assistance from staff, he shrugged his shoulders. When asked how he communicated his needs to staff, he shrugged his shoulders again. When asked if he used a communication board with pictures, he stated 'no, no, no. When I attempted to leave the room, R98 appeared frantic and looked at the empty Styrofoam cup of water on the bedside table and stated no no no. I asked him if he was thirsty and he nodded yes. I provided him with staff assistance. Review of a Psychiatric note dated 11/10/25 revealed that R98 was able to shake his head to answer (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	simple questions. On 03/09/2026 2:56 PM, R98 was observed in bed in the exact same position. On 03/10/2026 at 7:57 AM, R98 was observed in his room. R98 was lying flat on his back with his heels not floated. On 03/10/2026 at 11:23 AM, R98 was observed flat on his back with his heels on the mattress. Review of the Face Sheet and Minimum Data Set (MDS) with a Assessment Reference Date (ARD) of 1/26/26, reflected R41 was a [AGE] year-old female admitted to the facility on [DATE], with recent re-admission 1/9/26 related to acute on chronic respiratory failure with hypoxia and hypercapnia, CO2 narcosis (dangerous, altered mental state caused by severe accumulation of carbon dioxide in the blood) and sleep apnea. R41 had other diagnoses that included morbid obesity, chronic obstructive pulmonary disease, respiratory failure with hypoxia dependent on oxygen, anxiety, and depression. The MDS reflected that R41 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact. Review of R41 History and Physical, dated 1/4/26, reflected that R41 had been transferred to the hospital from the facility with diagnosis that included community acquired pneumonia. Continued review reflected R41 had diagnosis that included obesity hypoventilation syndrome ([NAME]). During an observation and interview on 3/08/2026 at 10:00 AM, R41 was lying in bed in hospital gown with oxygen via nasal canula in place. R41 appeared depressed and repeated several times, I do not know how much longer I can stand this. When asked what she meant by that R41 reported was very unhappy with her stay at the facility including care and current guardianship issues. R41 son was at the bedside and appeared to be supportive to R41. R41 reported had lived at the facility for about six months after a very long hospital stay related to decline in health. R41 reported had two recent hospital transfers related to pneumonia and respiratory failure in January, and hospital had discharged her with orders to continue to use Bi-level Positive Airway Pressure (BIPAP) machine and had not used since January because staff to do not assist her with it. Verified machine was located in R41's closet. R41 reported to facility staff and provider that BIPAP needed to be used at night but continues to not use. R41 reported was aware of risks of not using ordered BIPAP and reported labs had been abnormal related to not BIPAP and reported was worried health would decline again and would never be able to discharge from facility. Review of the Electronic Medical Record (EMR) reflected R41 was transferred to the hospital on 1/4/26 and returned to the facility on 1/5/26 with diagnosis of pneumonia. Continued review reflected R41 transferred back to the hospital on 1/6/26 related to acute on chronic respiratory failure with hypoxia and hypercapnia and CO2 narcosis and returned to the facility on 1/9/26. Review of R41 Care Plans, dated 10/23/25, reflected, Resident has potential for difficulty in breathing r/t [related to] CHF [chronic heart failure], COPD, chronic respiratory failure, OSA [obstructive sleep apnea] and requires use of BiPAP.Interventions BiPAP per MD [medical doctor] order. During an interview on 3/10/2026 at 11:36 AM, Assistant Director of Nursing (ADON) C verified R41 was admitted to the hospital on [DATE] and 1/6/26 related to pneumonia and respiratory issues and verified R41 had history of COPD with use of BIPAP. ADON C reported R41 had Physician orders for BIPAP prior to 1/4/26 transfer to the hospital with hospital discharge orders to continue use and (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported appeared R41 BIPAP was not re-ordered when re-admitted on [DATE] and should have been. ADON C verified R41 did not have a physician order for BIPAP after 1/5/26 and 1/9/26 hospital admission, however, was on R41 Care Plan, dated prior to 1/4/26 transfer to the hospital and would expect staff to follow care plans.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an effective and consistent means of communication in one (Resident #98) out of two reviewed. Findings include. Review of the medical record reflected R98 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included apraxia following cerebral infarction (inability to make voluntary movements or gestures even though you have the physical ability and understanding to do so), dysarthria (motor speech disorder where damage to your nervous system causes the muscles that produce speech to become paralyzed or weakened) and weakness/paralysis affecting the right dominant side following a stroke. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/16/26, reflected R98 was rarely or never understood. On 03/08/2026 at 10:28 AM, Resident #98 (R98) was observed in his room wearing only an adult brief, lying flat on his back, heels not elevated off the mattress. R98's room was very warm. R98 had a Styrofoam cup on his bedside table with a handwritten date of 3/6/26 PM that contained about 1/4 of water. R98 had an unpleasant body odor coming from him that indicated that he had not been bathed in quite some time. He has a very unkempt appearance. R98's lips appeared very dry and chapped. R98's toenails were very overgrown. R98's push button call light was clipped to his curtain on his right side and out of reach. I introduced myself to R98 and explained the purpose of my visit, however, R98 did not verbally respond. I continued to make conversation and discovered that R98 understood what I was saying but could not verbalize back to me but could answer by nodding yes or shaking his head no. R98 could answer questions appropriately. When asked about details such as the surroundings or details such as the colors of the clothing I was wearing, R98 answered the questions appropriately. I inquired if R98 was warm and he nodded his head yes. When asked if he had been receiving showers, he shook his head and stated no no no. When asked if he would like a shower, he nodded yes. When asked if he would like to have his face shaved and a haircut, he nodded yes. When asked if he was thirsty, he enthusiastically nodded his head yes. When asked if he could hold a cup and give himself drinks of water, he stated, no no no and raised and lowered his left arm. I observed his left hand and R98's fingers were on a fixed, fanned out position. When asked if he required assistance with eating and drinking, he nodded yes. When inquired how he requested assistance from staff, he shrugged his shoulders. When asked how he communicated his needs to staff, he shrugged his shoulders again. When asked if he used a communication board with pictures, he stated 'no, no, no. When I attempted to leave the room, R98 appeared frantic and looked at the empty Styrofoam cup of water on the bedside table and stated no no no. I asked him if he was thirsty and he nodded yes. I provided him with staff assistance. Review of a Psychiatric note dated 11/10/25 revealed that R98 was able to shake his head to answer simple questions. On 3/8/26, a confidential staff member stated that they do not have a way to effectively communicate with R98, so they do their best to guess R98's needs. On 03/09/2026 2:56 PM, R98 was observed in bed in the exact same position. R98's push button call light was positioned on his chest. I inquired if R98 could demonstrate using his call light. R98 looked at me and again showed me that he could only raise and lower his left arm, and his fingers were fixed in a fanned-out position. On 03/09/2026 at 3:02 PM, Certified Nursing Assistant (CNA) G stated she does not have a way to communicate with R98. CNA G stated she is not sure if he can use his call light, but it is clipped on to him. On 03/10/2026 at 7:57 AM, R98 was observed in his room. R98 was lying flat on his back with his heels not floated. LPN J entered the room and stated that it was hot in the room. A full, room temperature Styrofoam cup of water dated 3/10 22:00 (10:00 pm) was observed on his bedside table with no straw in it. On 03/10/2026 at 11:23 AM, Unit Manager (UM) I stated that R98 communicates by nodding yes or no or by using the communication board. When queried where the communication board currently was in R98's room, UM I informed me that it was not in his room. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R98's call light was observed clipped to the top of his mattress on the right side (his affected side) during the interview. I inquired how R98 notifies staff if he requires assistance. UM I proceeded to unclip the out of reach call light and place it in R98's hand. I asked R98 to demonstrate using the call light. R98 looked at me and again, raised and lowered his arm stating no no no. I asked R98 if he could use the call light and he shook his head to indicate that he was unable to use the push button call light which was obvious due to his left sided functional limitations. When asked how the facility monitors hydration statuses and ensures that R98 is being offered fluids, UM I stated that staff document fluid intake and offer fluids. I held up the full, room temperature water that contained no straw dated 3/10 22:00 and asked R98 if that was his water from last night. R98 nodded yes. I asked R98 if he had anything to drink last night. R98 nodded no. I asked if R98 was thirsty and he indicated that he was thirsty. Review of R98's Care Plan revealed an intervention to encourage to point to make needs know however, no staff mentioned that as an option, nor would that be an applicable form of communication considering the very limited range of motion for R98's left arm.

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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** Based on observation, interview, and record review the facility failed to ensure activities of daily living, including showers, shaving, grooming, and nail care, were being completed in one (Resident #98) out of two residents reviewed for activities of daily living. Findings include. Review of the medical record reflected R98 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included apraxia following cerebral infarction (inability to make voluntary movements or gestures even though you have the physical ability and understanding to do so), dysarthria (motor speech disorder where damage to your nervous system causes the muscles that produce speech to become paralyzed or weakened) and weakness/paralysis affecting the right dominant side following a stroke. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/16/26, reflected R98 was rarely or never understood. On 03/08/2026 at 10:28 AM, Resident #98 (R98) was observed in his room wearing only an adult brief, lying flat on his back, heels not elevated off the mattress. R98's room was very warm. R98 had a Styrofoam cup on his bedside table with a handwritten date of 3/6/26 PM that contained about 1/4 of water. R98 had an unpleasant body odor coming from him that indicated that he had not been bathed in quite some time. He has a very unkempt appearance. R98's lips appeared very dry and chapped. R98's toenails were very overgrown. R98's push button call light was clipped to his curtain on his right side and out of reach. I introduced myself to R98 and explained the purpose of my visit, however, R98 did not verbally respond. I continued to make conversation and discovered that R98 understood what I was saying but could not verbalize back to me but could answer by nodding yes or shaking his head no. R98 could answer questions appropriately. When asked about details such as the surroundings or details such as the colors of the clothing I was wearing, R98 answered the questions appropriately. I inquired if R98 was warm and he nodded his head yes. When asked if he had been receiving showers, he shook his head and stated no no no. When asked if he would like a shower, he nodded yes. When asked if he would like to have his face shaved and a haircut, he nodded yes. When asked if he was thirsty, he enthusiastically nodded his head yes. When asked if he could hold a cup and give himself drinks of water, he stated, no no no and raised and lowered his left arm. I observed his left hand and R98's fingers were on a fixed, fanned out position. When asked if he required assistance with eating and drinking, he nodded yes. When inquired how he requested assistance from staff, he shrugged his shoulders. When asked how he communicated his needs to staff, he shrugged his shoulders again. When asked if he used a communication board with pictures, he stated 'no, no, no. When I attempted to leave the room, R98 appeared frantic and looked at the empty Styrofoam cup of water on the bedside table and stated no no no. I asked him if he was thirsty and he nodded yes. I provided him with staff assistance. Review of a Psychiatric note dated 11/10/25 revealed that R98 was able to shake his head to answer simple questions. Review of the Care Plan stated bathing: physical assist.Review of the MDS: Section GG Physical Abilities revealed R98 was dependent on bathingReview of the task list reflected that R98's shower days were scheduled for Wednesdays and Saturday. The past thirty days revealed that R98 had only received bed baths in the past 30 days and zero showers.On 03/10/2026 at 12:14 PM, Director of Nursing (DON) B stated that Activity of Daily living care should be being completed on residents. When queried on showers, DON B reviewed the documentation for R98's ADL'S and was unable to find any refusals. DON B attempted to locate a preference for bed baths vs. showers in the care plan but could not locate that in the care plan either.

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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** Based on observation, interview and record review the facility failed to ensure consistent availability of water at the bedside, failed to ensure hydration was offered, and failed to document fluid intake in one (resident 98) of 2 reviewed for hydration. Findings include.Review of the medical record reflected R98 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included apraxia following cerebral infarction (inability to make voluntary movements or gestures even though you have the physical ability and understanding to do so), dysarthria (motor speech disorder where damage to your nervous system causes the muscles that produce speech to become paralyzed or weakened) and weakness/paralysis affecting the right dominant side following a stroke. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/16/26, reflected R98 was rarely or never understood. On 03/08/2026 at 10:28 AM, Resident #98 (R98) was observed in his room wearing only an adult brief, lying flat on his back, heels not elevated off the mattress. R98's room was very warm. R98 had a Styrofoam cup on his bedside table with a handwritten date of 3/6/26 PM that contained about 1/4 of water. R98 had an unpleasant body odor coming from him that indicated that he had not been bathed in quite some time. He has a very unkempt appearance. R98's lips appeared very dry and chapped. R98's toenails were very overgrown. R98's push button call light was clipped to his curtain on his right side and out of reach. I introduced myself to R98 and explained the purpose of my visit, however, R98 did not verbally respond. I continued to make conversation and discovered that R98 understood what I was saying but could not verbalize back to me but could answer by nodding yes or shaking his head no. R98 could answer questions appropriately. When asked about details such as the surroundings or details such as the colors of the clothing I was wearing, R98 answered the questions appropriately. I inquired if R98 was warm and he nodded his head yes. When asked if he had been receiving showers, he shook his head and stated no no no. When asked if he would like a shower, he nodded yes. When asked if he would like to have his face shaved and a haircut, he nodded yes. When asked if he was thirsty, he enthusiastically nodded his head yes. When asked if he could hold a cup and give himself drinks of water, he stated, no no no and raised and lowered his left arm. I observed his left hand and R98's fingers were on a fixed, fanned out position. When asked if he required assistance with eating and drinking, he nodded yes. When inquired how he requested assistance from staff, he shrugged his shoulders. When asked how he communicated his needs to staff, he shrugged his shoulders again. When asked if he used a communication board with pictures, he stated 'no, no, no. When I attempted to leave the room, R98 appeared frantic and looked at the empty Styrofoam cup of water on the bedside table and stated no no no. I asked him if he was thirsty and he nodded yes. I provided him with staff assistance. Review of a Psychiatric note dated 11/10/25 revealed that R98 was able to shake his head to answer simple questions. On 03/09/2026 2:56 PM, R98 was observed in bed in the exact same position. R98's push button call light was positioned on his chest. I inquired if R98 could demonstrate using his call light. R98 looked at me and again showed me that he could only raise and lower his left arm, and his fingers were fixed in a fanned-out position. On 03/10/2026 at 7:57 AM, R98 was observed in his room. R98 was lying flat on his back with his heels not floated. LPN J entered the room and stated that it was hot in the room. A full, room temperature Styrofoam cup of water dated 3/10 22:00 (10:00 pm) was observed on his bedside table with no straw in it. On 03/09/2026 at 3:02 PM, Certified Nursing Assistant (CNA) G stated she is not sure if he can use his call light but it is clipped on to him. On 03/10/2026 at 9:58 AM, CNA stated that R98 cannot use the call light.Review of the MDS Section GG- Functional Abilities- revealed R98 was dependent on staff for bringing food or liquid to R98's mouth.Review of R98's Electronic Medical Record revealed no consistent documentation or monitoring for fluid intake.On 03/10/2026 at 11:23 AM, Unit Manager (UM) I stated that R98 communicates by nodding yes or no or by using the communication board. When queried where the communication board currently was in R98's room, UM (continued on next page)

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	235503	A. Building B. Wing	03/10/2026

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	I informed me that it was not in his room. R98's call light was observed clipped to the top of his mattress on the right side (his affected side) during the interview. I inquired how R98 notifies staff if he requires assistance. UM I proceeded to unclip the out of reach call light and place it in R98's hand. I asked R98 to demonstrate using the call light. R98 looked at me and again, raised and lowered his arm stating no no no. i asked R98 if he could use the call light and he shook his head to indicate that he was unable to use the push button call light which was obvious due to his left sided functional limitations. When asked how the facility monitors hydration statuses and ensures that R98 is being offered fluids, UM I stated that staff document fluid intake and offer fluids. I held up the full, room temperature water that contained no straw dated 3/10 22:00 and asked R98 if that was his water from last night. R98 nodded yes. I asked R98 if he had anything to drink last night. R98 nodded no. I asked if R98 was thirsty and he indicated that he was thirsty. In an interview on 03/10/2026 at 12:14 PM Director of Nursing (DON) B stated that the facility staff should be offering fluids to the dependent residents every two hours and documenting fluid intake in the medical record.The observed lack of consistent fresh water/full old water at the bedside and incomplete documentation of fluid intake limited the facilities ability to monitor R98's hydration status.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents receive necessary respiratory care and services that was in accordance with professional standards of practice for 1 (Resident #41) of 1 resident reviewed for respiratory care resulting in the potential for respiratory distress and exacerbation of respiratory conditions. Findings include: Review of the Face Sheet and Minimum Data Set (MDS) with a Assessment Reference Date(ARD) of 1/26/26, reflected R41 was a [AGE] year-old female admitted to the facility on [DATE], with recent re-admission 1/9/26 related to acute on chronic respiratory failure with hypoxia and hypercapnia, CO2 narcosis (dangerous, altered mental state caused by severe accumulation of carbon dioxide in the blood) and sleep apnea. R41 had other diagnoses that included morbid obesity, chronic obstructive pulmonary disease, respiratory failure with hypoxia dependent on oxygen, anxiety, and depression. The MDS reflected that R41 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact.Review of R41 History and Physical, dated 1/4/26, reflected that R41 had been transferred to the hospital from the facility with diagnosis that included community acquired pneumonia. Continued review reflected R41 had diagnosis that included obesity hypoventilation syndrome ([NAME]).During an observation and interview on 3/08/2026 at 10:00 AM, R41 was lying in bed in hospital gown with oxygen via nasal canula in place. R41 appeared depressed and repeated several times, I do not know how much longer I can stand this. When asked what she meant by that R41 reported was very unhappy with her stay at the facility including care and current guardianship issues. R41 son was at the bedside and appeared to be supportive to R41. R41 reported had lived at the facility for about six months after a very long hospital stay related to decline in health. R41 reported had two recent hospital transfers related to pneumonia and respiratory failure in January, and hospital had discharged her with orders to continue to use Bi-level Positive Airway Pressure (BIPAP) machine and had not used since January because staff to do not assist her with it. Verified machine was located in R41's closet. R41 reported to facility staff and provider that BIPAP needed to be used at night but continues to not use. R41 reported was aware of risks of not using ordered BIPAP and reported labs had been abnormal related to not BIPAP and reported was worried health would decline again and would never be able to discharge from facility. Review of the Electronic Medical Record (EMR) reflected R41 was transferred to the hospital on 1/4/26 and returned to the facility on 1/5/26 with diagnosis of pneumonia. Continued review reflected R41 transferred back to the hospital on 1/6/26 related to acute on chronic respiratory failure with hypoxia and hypercapnia and CO2 narcosis and returned to the facility on 1/9/26.Review of R41 Hospital After Visit Summary, dated 1/9/26, reflected, 71 y.o. [year old] cis-gender female admitted with Altered mental status, unspecified altered mental status type.This seems to be related to hypercapnia [excess of carbon dioxide]. This resolved with the BIPAP.It is stressed that the patient needs to have her BiPAP for when she sleeps and naps.Plan.Continue BiPAP when napping and sleeping. Review of the Hospital Labs, dated 1/6/26, reflected R41's venous CO2 was significantly elevated to 76 mmHg with normal range between 34-50 mmHg (indicating a potential emergency including respiratory failure.)Review of R41 Care Plans, dated 10/23/25, reflected, Resident has potential for difficulty in breathing r/t [related to] CHF [chronic heart failure], COPD, chronic respiratory failure, OSA [obstructive sleep apnea] and requires use of BiPAP.Interventions BiPAP per MD [medical doctor] order.Review of R41 Physician Orders, dated 10/23/25 through 1/5/26, reflected orders for BIPAP at bedtime on at night. Continued review of Physician orders with no evidence of orders for use of BIPAP after 1/9/26 return from the hospital to current (3/8/26). Review of the Medication Administration Record (MAR) and Treatment Administration Records (TAR), date 1/1/26 through 1/4/26, reflected R41 had orders for use of BIPAP every night. Continued review of the MAR and TAR, dated 1/9/26 to 3/8/26 reflected no evidence of BIPAP used for R41. (Two months without use of Physician ordered BIPAP). During an (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 3/10/2026 at 11:36 AM, Assistant Director of Nursing (ADON) C verified R41 was admitted to the hospital on [DATE] and 1/6/26 related to pneumonia and respiratory issues and verified R41 had history of COPD with use of BIPAP. ADON C reported R41 had Physician orders for BIPAP prior to 1/4/26 transfer to the hospital with hospital discharge orders to continue use and reported appeared R41 BIPAP was not re-ordered when re-admitted on [DATE] and should have been. ADON C verified R41 did not have a physician order for BIPAP after 1/9/26 hospital admission, however, was on R41 Care Plan, dated prior to 1/4/26 transfer to the hospital. ADON C reported was most likely a transcription error. During an interview on 3/10/2026 at 12:48 PM, ADON C reported located R41 BIPAP machine and supplies in the closet and was currently working on setting up equipment. During an interview on 3/10/2026 at 2:21 PM, ADON C reported would expect staff to recognize if R41 had prior order BIPAP when she returned to the facility from hospital to re-order and/or double check hospital discharge summary and Unit Managers expected to verify orders as well. ADON C reported and verified R41 use of BIPAP was now in place moving forward.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medical records were accurate and not falsified for one (R135) of 24. Findings include:Review of the medical record revealed R135 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes. Review of the Social Services Comprehensive Evaluation dated 3/4/26 revealed R135 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of the Physician's Order dated 3/3/26 revealed Wound Care (L [left] posterior leg): cleanse [with] normal saline, apply Medihoney (Activon) to wound bed, cover with foam dressing. The wound care was ordered to be completed every evening shift, every other day. On 03/08/2026 at 10:13 AM, R135 was observed sitting on the edge of his bed. R135 reported he had a wound on the back of his left calf, but the facility had not changed the dressing since 3/2/26 or 3/3/26. R135 pulled up his pant leg and a dressing dated 3/3/26 was observed on his left calf. R135 reported he had his own wound care supplies from the hospital, but the facility removed the supplies from his room when he was admitted . On 03/09/2026 at 1:38 PM R135 was observed self-ambulating in the hallway. R135 reported his wound care still had not been completed. On 03/09/2026 at 1:47 PM, R135's left calf dressing was observed to be the same dressing dated 3/3/26. Review of Treatment Administration Record (TAR) revealed R135's wound care was checked off and signed out as completed on 3/4/26 by Licensed Practical Nurse (LPN) L, on 3/6/26 by LPN M, and on 3/8/26 by LPN N. In an interview on 03/09/2026 at 2:13 PM, Registered Nurse (RN)/Unit Manager (UM) I reported R135 had a wound on his left calf which was caused by his walking boot. UM I reported she monitored if wound care was completed as ordered by reviewing the TAR and progress notes. UM I reviewed R135's TAR and reported the check mark with initials indicated the wound care was completed. UM I reported if the wound care was not completed, the TAR would reflect a code 9 and then have a coordinating progress note. On 03/09/2026 at 2:17 PM, with UM I, R135 was observed in bed. R135's bandage was observed with the date of 3/3/26. UM I agreed R135's dressing was dated 3/3/26 and therefore had not been changed since then. On 03/09/2026 at 2:49 PM, UM I changed R135's dressing to which he responded, It's about time. R135's wound was observed as an open area with a red wound bed and drainage on the removed dressing. In a telephone interview on 03/09/2026 at 1:56 PM, LPN N reported she worked with R135 last night (3/8/26). LPN N reported R135 did have ordered wound care, but she could not recall if she completed the wound care on 3/8/26. When asked why it was checked off and signed off as completed on the TAR, LPN L then reported she did the wound care. When informed that R135's dressing was dated 3/3/26, LPN N then reported she knows she did a dressing last night but could not recall if it was for R135. LPN N reported she did not know why the wound care was signed out as completed but not done. In a telephone interview on 03/10/2026 at 11:14 AM, LPN L reported they worked on 3/4/26, but could not recall R135. When asked if she performed any wound care that day, LPN L reported she changed a dressing on another resident's heel. When asked if she performed any wound care/changed a dressing on the back of a resident's calf, LPN L stated, No. When asked what a check mark and their initials reflected on the TAR, LPN L reported that indicated the wound care was done. LPN L reported if the wound care was not done, the TAR would indicate a special code and then she would make a progress note. When asked why the TAR reflected R135's wound care was completed when it was not, LPN L stated, maybe I checked it off. Review of R135's progress notes revealed no indication as to why wound care was not completed on 3/4/26, 3/6/26, or 3/8/26. In an interview on 03/10/2026 at 10:54 AM, Director of Nursing (DON) B reported LPN L, LPN M, and LPN N did not follow the physician's orders for R135's wound care. DON B reported there was no reason as to why the wound care should be signed out as completed but not done. DON B reported she was in the process of educating the nursing staff related to this concern. In an interview on 03/10/26 at (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11:02 AM, LPN M reported she was not sure if R135 had any ordered wound care. LPN M reported if the TAR showed a check mark and her initials, then she would assume the wound care was completed. When she was informed that R135's dressing was dated 3/3/26, LPN M reported R135 mentioned that to her yesterday. LPN M reported since R135's dressing was dated 3/3/26, she probably did not do his wound care on 3/6/26. Review of the personnel files revealed that previously each of the nurses LPN N, LPN M and LPN L had falsified medical records: LPN N received an Employee Discipline Form for documenting that a catheter change was performed, but it was not completed on 1-20-25. LPN L received an Employee Discipline Form for not completing skin evaluations and falsified documentation on 10/20/23. LPN M received a Corrective Action for Minor Offenses for documenting wound care as completed but not dated for 3/6/26.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to provide a functional window for one (Resident #98) out of 2 reviewed for environment. Findings include: Review of the medical record reflected R98 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included apraxia following cerebral infarction (inability to make voluntary movements or gestures even though you have the physical ability and understanding to do so), dysarthria (motor speech disorder where damage to your nervous system causes the muscles that produce speech to become paralyzed or weakened) and weakness/paralysis affecting the right dominant side following a stroke. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/16/26, reflected R98 was rarely or never understood. On 03/08/2026 at 10:28 AM, Resident #98 (R98) was observed in his room wearing only an adult brief, lying flat on his back, heels not elevated off the mattress. R98's room was very warm. R98 had a Styrofoam cup on his bedside table with a handwritten date of 3/6/26 PM that contained about 1/4 of water. R98 had an unpleasant body odor coming from him that indicated that he had not been bathed in quite some time. He has a very unkempt appearance. R98's lips appeared very dry and chapped. R98's toenails were very overgrown. R98's push button call light was clipped to his curtain on his right side and out of reach. I introduced myself to R98 and explained the purpose of my visit, however, R98 did not verbally respond. I continued to make conversation and discovered that R98 understood what I was saying but could not verbalize back to me but could answer by nodding yes or shaking his head no. R98 could answer questions appropriately. When asked about details such as the surroundings or details such as the colors of the clothing I was wearing, R98 answered the questions appropriately. I inquired if R98 was warm and he nodded his head yes. When asked if he had been receiving showers, he shook his head and stated no no no. When asked if he would like a shower, he nodded yes. When asked if he would like to have his face shaved and a haircut, he nodded yes. When asked if he was thirsty, he enthusiastically nodded his head yes. When asked if he could hold a cup and give himself drinks of water, he stated, no no no and raised and lowered his left arm. I observed his left hand and R98's fingers were on a fixed, fanned out position. When asked if he required assistance with eating and drinking, he nodded yes. When inquired how he requested assistance from staff, he shrugged his shoulders. When asked how he communicated his needs to staff, he shrugged his shoulders again. When asked if he used a communication board with pictures, he stated 'no, no, no. When I attempted to leave the room, R98 appeared frantic and looked at the empty Styrofoam cup of water on the bedside table and stated no no no. I asked him if he was thirsty and he nodded yes. I provided him with staff assistance. Review of a Psychiatric note dated 11/10/25 revealed that R98 was able to shake his head to answer simple questions. On 03/10/2026 at 7:57 AM, R98 was observed in his room. R98 was lying flat on his back with his heels not floated. LPN J entered the room and stated that it was hot in the room. A full, room temperature Styrofoam cup of water dated 3/10 22:00 (10:00 pm) was observed on his bedside table with no straw in it. On 03/08/2026 at 10:28 AM duct tape was observed applied on the perimeter of the window preventing it from being opened or cracked, effectively sealing it shut. The room continued to feel room very warm. I asked R98 if he was warm and he nodded his head, yes. On 03/10/2026 at 9:20 AM, eight months of requested work order requests forR98's room revealed no work order pertaining to the window. On 03/10/2026 at 9:34 AM, Maintenance P Stated that the purpose of the duct tape on the window was to because when the temperatures were low, the window was drafty causing the cold to come in. Maintenance P stated that the facility intended to get some window people out to repair the windows. Of note, on 3/9/26 the high temperature was 72 degrees. It is reasonable to believe that R98 would have enjoyed being able to crack the window to enjoy cooler room temperatures and fresh air.