STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235596	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Willow Place	8380 Geddes Road Ypslianti, 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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment affecting 87 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage.Findings include:During an observation and interview during the initial kitchen tour on 2/10/2026 at 9:28 AM, Food Service Director (FSD) F reported had been in role for about four months. Entered walk-in freezer with FSD F and observed several areas of ice damns that appeared to be coming from unit on ceiling directly over several open and closed cardboard boxes of frozen food items including individual ice creams. Several ice cream containers had solid ice directly on packaging, ceiling had frozen condensation covering large area and solid area of ice located on floor just inside door. FSD F reported freezer had history of issues and maintenance staff monitor routinely. The 2022 FDA Model Food Code section 4-501.11 states: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications.During an interview on 2/13/2026 at 10:35 AM, Maintenance Director (MD) BB reported long history of ice buildup in kitchen walk-in freezer with about monthly ice buildup removal. MD BB reported at time of ownership change maintenance was completed on unit in freezer with improvements but continued ice damn buildups with possible cause that staff move curtains. During an observation and interview on 2/13/2026 at 11:15 AM, entered kitchen walk-in freezer with FSD F and observed continued ice buildup on individual ice cream containers (with thin paper top layer) and several boxes with frozen ice buildup located under freezer unit. FSD F reported notified maintenance after surveyor visit on 2/10/26 and some ice buildup removed. During an interview on 2/13/2026 11:20 AM, MD BB reported walk in freezer had been repaired 10/2025 prior to new company purchase.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident?s assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure timely completion of Quarterly Minimum Data Set (MDS) assessments for four (R8, R29, R34, R82) of 25 reviewed for MDS. Findings include: R8: Review of the medical record reflected R8 admitted to the facility on [DATE], with diagnoses that included Alzheimer's and contracture of the right hand. The Quarterly MDS, with an Assessment Reference Date (ARD) of 10/7/25, reflected a Brief Interview for Mental Status (BIMS-a cognitive screening tool) was not conducted due to R8 being coded as rarely/never understood. R8 was coded for upper extremity impairments on both sides (both arms) and for being dependent upon staff for activities of daily living (ADLs). The Quarterly MDS was completed on 10/23/25. On 02/10/2026 at 12:22 PM, R8 was observed seated in a Broda chair, in the dining room, receiving staff assistance to consume lunch. As of 02/11/2026 at 1:49 PM, R8's Quarterly MDS, with an ARD of 1/6/26, was In Progress (not completed). R29: Review of the medical record reflected R29 admitted to the facility on [DATE], with diagnoses that included dysarthria (speech disorder) following cerebral infarction (stroke). The Quarterly MDS, with an ARD of 12/24/25, was completed on 1/27/26. In an interview on 02/11/2026 at 2:15 PM, MDS Coordinator J reported being about one month behind on MDS assessments. MDS Coordinator J reported a Quarterly MDS was to be completed within 14 days of the ARD. According to the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2025, .Quarterly Assessment .The MDS completion date (item Z0500B) must be no later than 14 days after the ARD (ARD + 14 calendar days) . During an interview on 2/13/2026 at 12:04 PM, MDS Coordinator J reported had been in role for about two years. MDS Coordinator J reported had been behind in completing scheduled MDS assessments for past two months and several were incomplete. MDS Coordinator J reported R34 had a quarterly MDS assessment, dated 12/30/25 that should have been completed within 14 days and verified was not completed until 2/10/26. MDS Coordinator J reported R82 quarterly MDS assessment, dated 1/8/26, should have been completed 1/22/26 and verified was completed until 2/13/26. MDS Coordinator J reported both R34 and R82 MDS assessments were completed late.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to treat 2 residents (R7, R19) of 18 residents reviewed, with dignity and respect. Review of the Face Sheet and Minimum Data Set (MDS) with assessment reference date of 1/2/26, reflected R7 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included spastic quadriplegic cerebral palsy, dystonia(neuromuscular movement disorder), polydipsia(excessive, persistent thirst and consequently high fluid intake), bilateral hand contractures, and depression The MDS reflected R7 had a BIM (assessment tool) score of 14 which indicated his ability to make daily decisions was cognitively intact, and he was dependent on staff for hygiene, bathing, dressing, bed mobility, transfers and eating. During an observation and interview on 2/10/2026 at 12:00 PM, R7 was observed lying in bed, located against the wall. R7 appeared able to express needs and needed extra time to verbalize. R7 reported staff usually respond to call light if he can reach it and reported was unable to reach call light at the time. Observed R7 soft touch call light on floor between bed and wall out of reach. R7 appeared to have significant contractures to bilateral upper extremities with limited mobility. R7 reported often takes him a long time to verbalize needs to staff and some staff are not patient to listen to R7's needs and makes him frustrated at times. During an observation on 2/10/26 at about 12:40 pm, R7 was laying in bed with staff at bedside assisting with meal. R7 soft touch call light remained on floor between bed and wall, out of reach. R7 call light could be observed on the floor from the hallway door without entering room. During an observation on 2/10/2026 at 3:50 PM, R7 soft touch call light remains on floor out of reach. Observed R7 during lunch meal with staff at bedside assisting with meal and had exited room with call light out of reach. During an observation on 2/11/2026 at 8:41 AM, R7 soft touch call light remains on floor between bed and wall out of reach in same location as evening prior. Observed housekeeping in room at the time. Review of R7 Care Plan, dated 11/30/23, reflected, Be sure my call light is within reach and encourage me to use it for assistance as needed. I need prompt response to all requests for assistance. During an interview on 2/13/2026 at 2:08 PM, Director of Nursing (DON) B reported would expect call light to be in reach for R7 and staff to verify prior to leaving room. DON B verified R7 required one on one assistance with meals with frequent checks and would expect staff to verify call light was in R7 reach prior to leaving the room. R19 Review of the clinical record revealed R19 was admitted into the facility on [DATE] with diagnoses that included: cerebral infarction (stroke), polyneuropathy (numbness/tingling/weakness due to nerve damage), bladder disorder, anxiety and left side hemiplegia (severe or complete paralysis) and hemiparesis (partial muscle weakness). According to the Minimum Data Set (MDS) assessment dated (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE], R19 scored 14/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). On 2/10/26 at 12:25 PM during an observation and interview, R19 was observed sitting up in a manual wheelchair. R19 reported that the facility had ran out of his size of briefs (medium) and he had to wear size extra-large, which he reported were ill fitting and uncomfortable. In an interview on 2/13/26 at 10:22 AM, Certified Nursing Assistant (CNA) Z reported that the facility had ran out of resident supplies such as briefs and wipes. CNA Z further reported that when the facility ran out of a certain size of briefs residents would need to wear a different size, for example someone who requires a size medium could have needed to wear an extra-large.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to inform three residents (#4,#8,#20) of five residents reviewed of the benefits, risks, and alternatives for the prescribing of psychotropic medication. Findings Include: R8: Review of the medical record reflected R8 admitted to the facility on [DATE], with diagnoses that included Alzheimer's and contracture of the right hand. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/7/25, reflected a Brief Interview for Mental Status (BIMS-a cognitive screening tool) was not conducted due to R8 being coded as rarely/never understood. R8 was coded for upper extremity impairments on both sides (both arms) and for being dependent upon staff for activities of daily living (ADLs). On 02/10/2026 at 12:22 PM, R8 was observed seated in a Broda chair, in the dining room, receiving staff assistance to consume lunch. R8's medical record reflected Physician Orders for 25 milligrams (mg) of Seroquel (antipsychotic medication) twice daily and two mg of Lorazepam (medication to treat anxiety) twice daily. Consents for the use of Seroquel and Lorazepam were not noted in R8's medical record. In an interview on 02/13/2026 at 3:47 PM, Regional Director of Operations (RDO) L reported she did not look for the psychotropic medication consents for R8 personally but reported there were issues with the consent process. R20: Review of the medical record reflected R20 admitted to the facility on [DATE], with diagnoses that included Huntington's Disease, dementia and depression. The Annual MDS, with an ARD of 11/20/25, reflected R20 had short-term and long-term memory impairments and was coded as requiring substantial/maximal assistance to dependence on staff for ADLs. On 02/12/2026 at 2:20 PM, R20 was observed in bed, lying on their left side. R20's knees appeared flexed under their bed linens. R20's medical record included Physician Orders for 15 mg of Mirtazapine (antidepressant medication) at bedtime, one mg of Lorazepam (medication to treat anxiety) daily, two mg of Lorazepam at bedtime and 100 mg of Seroquel (antipsychotic medication) three times daily. Consents for the use of Mirtazapine, Lorazepam and Seroquel were not noted in R20's medical record. In an interview on 02/13/2026 at 12:53 PM, RDO L reported she did not see consents for the use of psychotropic medications in R20's medical record. On 02/13/2026 at 1:23 PM, Social Worker (SW) K confirmed there were no consents for psychotropic medications in R20's medical record. Resident #4 (R4) (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record demonstrated that R4 was admitted to the facility 02/26/2025 with diagnoses that included end stage renal disease, pain right and left foot, ascites (abnormal buildup of fluid in the abdomen), osteoarthritis (degenerative joint disease) of left knee and bilateral hips, paranoid schizophrenia, chronic constipation, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux, depression, schizoaffective disorder, dependence on dialysis, anemia (low red blood cells), insomnia (difficulty sleeping), cognitive decline, anxiety, gout (buildup of uric acid in joints), hypertension, and atrial fibrillation. Review of R4's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/09/2025, revealed R4 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. On 02/10/2026 at 02:13 p.m. during observation and interview R4 was observed lying in bed. When R4 was inquired as to his current mood, he explained that he currently had no concerns. Review of R4's medical record revealed antipsychotic medication orders, written 01/03/2026, Aripiprazole oral tablet 15 MG (milligrams). Give 1 tablet by mouth one time a day for schizoaffective disorder and Olanzapine oral tablet 15mg give 1 tablet by mouth one time a day for paranoid schizophrenia. There were no consents for the above medications in R4's medical record. Review of R4's medical record revealed antidepressant medication orders, written 01/02/2026, Sertraline HCL (hydrochloride) tablet 25 MG (milligrams) give 1 tablet by mouth at bedtime for depression and trazodone HCL oral tablet 100mg give 1 tablet by mouth at bedtime for sleep. There were no consents for the above medications in R4's medical record. In an interview on 02/13/2026 at 12:54 p.m. Regional Director of Operations (RDO) L explained that all residents receiving psychotropic medication required documented consent. RDO L could located consents for R4's psychotropic medication. Review of facility policy entitled Psychotropic Medication Guideline, effective date: 04/27/2027 and last revised: 05/30/2025, revealed 4. Residents who have admitted with or have changes to their psychotropic medication regime will have informed consent obtained. The resident and/or responsible party have the right to accept or decline the initiation of or increase in psychotropic medication.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review the facility failed to provide completed Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF-ABN) for three residents (R41, R45, R86) of three residents reviewed. Findings include:A review of the SNF-ABN's provided by the facility revealed:R41 Beginning on 12/12/25, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. The care(s) you have been receiving during the Inpatient Skilled Nursing Facility include:Physical Therapy, Daily Skilled Nursing Care, Occupational Therapy, Other-Room and Board.We estimate that these services will cost you $_____ per day/item or service.No dollar amount was included on the form to indicate the resident's cost of those items/services. R41 signed the form on 12/11/25.R45 Beginning on 1/12/26, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. The care(s) you have been receiving during the Inpatient Skilled Nursing Facility include:Physical Therapy, Daily Skilled Nursing Care, Occupational Therapy, Other-Room and Board.We estimate that these services will cost you $_____ per day/item or service.No dollar amount was included on the form to indicate the resident's cost of those items/services. R45 signed the form on 1/9/26.R86 Beginning on 1/27/26, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs. The care(s) you have been receiving during the Inpatient Skilled Nursing Facility include:Physical Therapy, Daily Skilled Nursing Care, Occupational Therapy, Other-Room and Board.We estimate that these services will cost you $_____ per day/item or service.No dollar amount was included on the form to indicate the resident's cost of those items/services. R86 signed the form on 1/22/26.In an interview on 2/13/26 at 2:37 PM Business Office Manager (BOM) Y explained that her process is to obtain a SNF-ABN after a resident has been cut from Medicare services and after being given a NOMNC (Notice of Medicare Non-Coverage). BOM Y further explained that the form should include the residents name, the date, last covered date and a daily rate if private pay or daily rate based on the resident's secondary insurance. BOM Y did not offer a rationale for why the 3 SNF-ABN's that were reviewed did not have the daily rate filled in but stated that information would be important for the resident to have to make a decision on if they continue services or not.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify the resident and/or resident's representative of the facility policy for bed hold and a written reason for the transfer, for two (R1 and R64) of four reviewed for hospitalization. Findings Include:Resident #1(R1)Review of the Face Sheet and Minimum Data Set (MDS) with assessment reference date of 1/21/26, reflected R1 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and vascular dementia. The MDS reflected R1 had a BIM (assessment tool) score indicated her ability to make daily decisions was severely impaired, and she was dependent on staff for dressing, mobility, transfers, hygiene, bathing, toileting, and oral hygiene.During a telephone interview on 2/11/26 at 11:49 a.m., R1 Responsible Party reported had concerns that the facility had not contacted her after transferring R1 to hospital.Review of R1 Electronic Medical Record (EMR), dated 1/11/26, reflected R1 was transferred to the hospital. Continued review of the EMR, reflected no evidence that the responsible party was provided written notification of bed hold policy and reason for transfer.Resident #64(R64)Review of the Face Sheet and Minimum Data Set (MDS) with assessment reference date of 12/11/25, reflected R64 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included dementia, urinary tract infection and spinal stenosis. The MDS reflected R64 had a BIM (assessment tool) score of 4 that indicated her ability to make daily decisions was severely impaired, and she required staff assistance with dressing, mobility, transfers, hygiene, bathing, and toileting.During an observation on 2/10/2026 at 10:45 a.m., R64 was observed in bed with two staff at bedside assisting with care. R64 appeared pleasantly confused and did not appear to be oriented.During a telephone interview on 2/11/2026 at 10:54 a.m., R64 responsible party reported R64 was transferred to the hospital prior to Christmas and was not notified by the facility until over 24 hours later.Review of R64 EMR, dated 12/14/25, reflected R64 was transferred to the hospital. Continued review of the EMR reflected no evidence that the responsible party was provided written notification of bed hold policy and reason for transfer.During an interview on 2/13/26 at 12:50 pm, Director of Nursing DON B reported expect staff to complete transfer notice, sbar and Progress Note for transfer to hospital. DON B reported staff send to documents to the hospital with resident, provided to Emergency Medical Staff. DON B reported did recall complaint from R1 responsible party that they were not notified of R1 hospital transfer. DON B reported unit manager had verified it had been documented and reported if it was documented it was done. DON B reported R64 had a Progress Note that family had been notified of hospital transfer. DON B was unable to provide evidence R1 or R64 responsible party was notified and received physical copy of R1 and R64 transfer notice and bed hold.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure timely completion of comprehensive Minimum Data Set (MDS) assessments for three (R50, R59 and R114) of 25 reviewed.Findings include:R114: Review of the medical record reflected R114 admitted to the facility on [DATE], with diagnoses that included ocular laceration of the left eye, diabetes, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The admission MDS, with an Assessment Reference Date (ARD) of 2/3/26, was in progress (not completed) as of 2/12/26 at 9:29 AM. On 02/10/2026 at 11:22 AM, R114 was observed lying in bed. In an interview on 02/11/2026 at 2:15 PM, MDS Coordinator J reported being about one month behind on MDS assessments. They reported an admission MDS was to be completed within 14 days of admission, with the date of admission being day one. According to the Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2025, .The admission assessment is a comprehensive assessment for a new resident and, under some circumstances, a returning resident that must be completed by the end of day 14, counting the date of admission to the nursing home as day 1 . The MDS completion date (item Z0500B) must be no later than day 14 . During an interview on 2/13/2026 at 12:04 PM, MDS Coordinator J reported had been in role for about two years. MDS Coordinator J reported had been behind in completing scheduled MDS assessments for past two months and several were incomplete. MDS Coordinator J reported had been no leave then holiday was busy and had not been able to catch up. MDS Coordinator J reported R50 had an annual comprehensive MDS assessment dated , 1/9/26, that should have been completed by 1/23/26 and verified was currently incomplete. MDS Coordinator J reported R59 had an annual comprehensive MDS assessment dated , 12/29/25, that should have been completed by 1/12/26 that currently incomplete.

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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** Based on interview and record review, the facility failed to ensure timely completion of comprehensive significant change Minimum Data Set (MDS) assessments for one (R7) of 25 reviewed. Findings Include: Review of the Face Sheet and Minimum Data Set (MDS) with assessment reference date of 1/2/26, reflected R7 was a [AGE] year old male admitted to the facility on [DATE], with diagnoses that included spastic quadriplegic cerebral palsy, dystonia(neuromuscular movement disorder), polydipsia(excessive, persistent thirst and consequently high fluid intake), bilateral hand contractures, and depression The MDS reflected R7 had a BIM (assessment tool) score of 14 which indicated his ability to make daily decisions was cognitively intact, and he was dependent on staff for hygiene, bathing, dressing, bed mobility, transfers and eating.Review of R7 Electronic Medical Record on 2/11/26 at 9:22 a.m., reflected R7 had a significant change MDS assessment, dated 1/2/26, that indicated in progress.(incomplete)During an interview on 2/11/26 at 2:25 p.m., MDS Coordinator J reported R7 MDS assessment, dated 1/2/26, should have been completed and within 14 days and was currently late. MDS Coordinator J reported had several late MDS assessments and was currently working on getting them up to date.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to formulate a Baseline Care Plan which included pertinent care needs for one (R114) of 18 reviewed.Findings include: Review of the medical record reflected R114 admitted to the facility on [DATE], with diagnoses that included ocular laceration of the left eye, diabetes, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/3/26, was in progress (not completed) as of 2/12/26. On 02/10/2026 at 11:22 AM, R114 was observed lying in bed. On 02/12/2026 at 10:35 AM, R114 was observed being propelled in the hallway, by staff, while seated in their wheelchair. R114's Care Plan reflected a focus area of, Resident requires assist with daily care needs r/t [related to] Date Initiated: 01/29/2026. The Care Plan goal was initiated on 1/29/26. Interventions were not added to the Care Plan until 2/11/26, which included R114 requiring assistance of two people for bathing, bed mobility, toileting and transfers and setup assistance with eating/meals. In an interview on 02/11/2026 at 3:39 PM, Director of Nursing (DON) B reported nurses did initial care planning, then nurse managers and the interdisciplinary team (IDT) reviewed them. According to DON B, MDS consulted in the Care Plan process to make them patient centered. DON B reported it was her expectation that activities of daily living (ADL) Care Plans included bathing/showering level of assistance, oral care, toileting, transfer status, bed mobility and eating.

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Villa at Willow Place	8380 Geddes Road Ypslianti, 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 develop and implement comprehensive care plans for three residents (#4,#43,#64) of 18 reviewed. Findings Included: Resident #4 (R4) Review of the medical record demonstrated that R4 was admitted to the facility 02/26/2025 with diagnoses that included end stage renal disease, pain right and left foot, ascites (abnormal build up of fluid in the abdomen), osteoarthritis (degenerative joint disease) of left knee and bilateral hips, paranoid schizophrenia, chronic constipation, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), gastro-esophageal reflux, depression, schizoaffective disorder, dependence on dialysis, anemia (low red blood cells), insomnia (difficulty sleeping), cognitive decline, anxiety, gout (build up of uric acid in joints), hypertension, and atrial fibrillation. Review of R4's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/09/2025, revealed R4 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. On 02/10/2026 at 02:13 p.m. during observation and interview R4 was observed lying in bed. R4 explained that he received dialysis, outside of the facility, 3 times per week. Review of R4's medical record revealed physician orders, dialysis pick up T(Tuesday)/TH(Thursday)/Sat(Saturday). one time per day every Tue, Thu (Thursday), Sat for dialysis. The above listed physician order was written 01/02/2026. Review of R4's medical record revealed a care plan problem that stated, I have renal insufficiency r/t(related to) ESRD (End Stage Renal Disease). R4's also revealed a care plan intervention that stated, Encourage me to go for the scheduled dialysis appointments. Resident Received dialysis on _____, _____, &_____. Resident leaves at _____ & returns at _____. Is transported by _____. The above care plan problem and intervention was initiated 05/31/2025. In an interview on 02/11/2026 at 03:38 p.m. Director of Nursing (DON) B explained that admission plans of care are initiated by the admitting Nursing staff when the resident is admitted to the facility. DON B explained that Nurse Managers then update the initial plans of care. DON B explained that the interdisciplinary team updates the complete plan of care as needed. DON B confirmed that R4 did not have a care plan intervention that was initiated on 05/31/2025. DON B could not explain why R4's dialysis care plan intervention remained blank, as of this date. R43: Review of the medical record reflected R43 admitted to the facility on [DATE], with diagnoses that included lumbar spinal stenosis. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/2/25, reflected R43 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/11/2026 at 10:39 AM, R43 was observed lying in bed. R43's Care Plan, with a focus area of, I have an ADL Self Care Performance Deficit r/t [related to] impaired mobility was initiated on 8/26/25. An intervention dated 8/26/25 reflected R43 wore glasses to aid their vision and to ensure they were clean and applied in the morning. An intervention dated 9/3/25 reflected to ensure the resident's feet were properly positioned on the footrest. An intervention dated 1/16/26 reflected R43 was non-compliant with ADL care and was educated on the risks versus benefits. The ADL Care Plan did not include any further interventions for R43's ADL care. In an interview on 02/11/2026 at 3:39 PM, Director of Nursing (DON) B reported nurses did initial care planning, then nurse managers and the interdisciplinary team (IDT) reviewed them. According to DON B, MDS consulted in the Care Plan process to make them patient centered. DON B reported it was her expectation that ADL Care Plans included bathing/showering level of assistance, oral care, toileting, transfer status, bed mobility and eating. DON B acknowledged R43's Care Plan was not comprehensive. Resident #64(R64) Review of the Face Sheet and Minimum Data Set (MDS) with assessment reference date of 12/11/25, reflected R64 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included dementia, urinary tract infection and spinal stenosis. The MDS reflected R64 had a BIM (assessment tool) score of 4 that indicated her ability to make daily decisions was severely impaired, and she required staff assistance with dressing, mobility, transfers, hygiene, bathing, and toileting. During an observation on 2/10/2026 at 10:45 a.m., R64 was observed in bed with two staff at bedside assisting with care. R64 appeared pleasantly confused and did not appear to be oriented. R64 had foley catheter in place with no catheter secure observed. During an interview on 2/10/2026 at 2:42 PM, Unit Manager (UM) AA reported R64 has had foley catheter since December. Review of R64 Care Plans, dated 2/10/26, reflected, FOLEY: Resident requires use of an indwelling catheter r/t Bladder Dysfunction. Continued review of R64 care plan reflected no evidence R64 catheter care had been added to care plan prior to 2/10/26. During an interview on 2/13/2026 at 10:18 AM, UM AA reported started UM role 1/12/26. UM AA reported R64 was discharged from the hospital on [DATE] with foley catheter. UM AA reported would expect R64's care plan to reflect foley catheter in place and appropriate interventions added timely and verified was not added until 2/10/26.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 1) follow Physician Orders for vital signs monitoring; and 2) assess and monitor respiratory status with administration of an as needed nebulizer treatment for one (R114) of 18 reviewed.Findings include: Review of the medical record reflected R114 admitted to the facility on [DATE], with diagnoses that included ocular laceration of the left eye, diabetes, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/3/26, was in progress (not completed) as of 2/12/26. On 02/10/2026 at 11:22 AM, R114 was observed lying in bed and reported since having a pacemaker implant, they used oxygen at night, as needed. R114 reported when notifying staff of shortness of breath, staff would check their oxygen saturation and say it was fine. R114 stated that morning (2/10/26), they became short of breath in the Therapy Gym and were told to return to their room and rest. On 02/11/2026 at 10:09 AM, R114 was observed lying in bed and reported that morning or the night prior, they felt short of breath and requested a breathing treatment, which was not provided to them. The February 2026 Medication Administration Record (MAR) reflected R114's vital signs were to be monitored twice daily and as needed. The order was signed out as being completed twice daily; however, vital signs information was not recorded. As of 2/12/26 at 10:42 AM, the vital signs section of R114's medical record reflected temperature, pulse, respiratory rate and oxygen saturation were recorded a total of four times (1/28/26, 1/30/26, 2/5/26 and 2/9/26). R114's blood pressure was documented a total of 15 times between 1/28/26 and 2/12/26 at 7:37 AM. The February 2026 MAR reflected an order for Albuterol Sulfate Inhalation Nebulization Solution (2.5 milligrams per 3 milliliters) 0.083% to be inhaled orally, via nebulizer, every six hours as needed, for shortness of breath. The MAR reflected the medication was administered on 2/6/26 at 8:33 PM and documented to be effective. R114's medical record did not reflect documentation of a respiratory assessment before or after administration of the medication. In an interview on 02/12/2026 at 10:49 AM, Licensed Practical Nurse (LPN) H reported if there was an order for monitoring vital signs every shift, the documentation would be on the MAR and in the vital signs tab of the medical record. Regarding assessment for administration of an as needed nebulizer treatment, LPN H reported they could obtain an oxygen saturation level and count the respiratory rate, then document in the vital signs tab and in a Progress Note for electronic MAR administration. In an interview on 02/12/2026 at 11:24 AM, Director of Nursing (DON) B reported vital signs were documented under the weights/vital signs section of the medical record. DON B reported their expectation for administering an as needed nebulizer treatment would be to obtain vital signs and assess lung sounds and oxygen saturation before and after administration of treatment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement interventions to prevent the development and/or worsening of contractures for one (R20) of three reviewed.Findings include: Review of the medical record reflected R20 admitted to the facility on [DATE], with diagnoses that included Huntington's Disease, dementia and depression. The Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/20/25, reflected R20 had short-term and long-term memory impairments and was coded as requiring substantial/maximal assistance to dependence on staff for activities of daily living (ADLs). The same MDS reflected R20 did not have any upper or lower extremity impairments that interfered with daily functions or placed them at risk for injury in the prior seven days. On 02/10/2026 at 10:54 AM, R20 was observed seated in a Broda chair, in their room, watching TV. A hoyer lift sling was observed beneath them. Both knees were in a flexed (bent) position. On 02/12/2026 at 11:18 AM, R20 was observed in an activity, seated in a Broda chair, with their eyes closed and their knees in a flexed position. On 02/12/2026 at 2:20 PM, R20 was observed in bed, lying on their left side, and appeared to have their knees in a flexed position, beneath bed linens. R20's medical record reflected a task, with a revision date of 12/17/25, reflecting they were to have active and passive range of motion (ROM) with ADL care. On 2/13/26, there was no documentation to reflect that R20 received ROM within the prior 30 days. R20's Kardex (Certified Nurse Aide/CNA care guide) reflected active and passive ROM was to be provided with ADL care. A Physician's Order, with a revision date of 1/5/26, reflected ROM was to be provided with ADL care. In an interview on 02/12/2026 at 2:03 PM, Licensed Practical Nurse (LPN) M reported the facility started a list of residents with contractures, to begin ROM on. LPN M reported R20 was on the list, and staff were to begin ROM exercises with R20 on 2/17/26. In an interview on 02/12/2026 at 2:23 PM, CNA W reported R20's lower extremities were contracted, and the contractures had worsened in the six months they had worked with him. CNA W reported R20 kept their knees in a flexed position throughout the day. They attempted to stretch R20's extremities when getting him dressed and asked him to stretch his legs out. CNA W denied a ROM program being in place for R20, which included repetition. CNA W reported only stretching of the extremities for dressing and care was performed. In an interview on 02/12/2026 at 3:19 PM, Director of Nursing (DON) B reported R20's arms and legs could not fully extend, and he needed passive ROM. When asked about their expectations for R20's task pertaining to active and passive ROM with ADL care, DON B reported the expectation would be for abduction, adduction and rotation of the extremities. They would also expect assessment and monitoring of R20's tolerance, as well as documentation in the task, and assessment by the Restorative Nurse in a Progress Note. DON B explained that ROM should include two rounds of 15 or 30 repetitions.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to consistently provide palatable food for one resident (R19) of 18 residents reviewed. Findings include:Review of the clinical record revealed R19 was admitted into the facility on [DATE] with diagnoses that included: cerebral infarction (stroke), polyneuropathy (numbness/tingling/weakness due to nerve damage), bladder disorder, anxiety and left side hemiplegia (severe or complete paralysis) and hemiparesis (partial muscle weakness). According to the Minimum Data Set (MDS) assessment dated [DATE], R19 scored 14/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).On 2/10/26 at 12:12 PM, R19 was observed sitting at the edge of his bed eating lunch. Lunch consisted of a corn dog, yellow squash and a cold pasta with elbow macaroni. R19 reported that they have been served corndogs twice in the same week, the squash was over cooked (resident was observed having difficultly picking it up with his fork) and that it should have been grilled because is it a vegetable that absorbs a lot of water. R19 reported having dietary/kitchen experience, the food lacks flavor and variety, and he is often not provided with condiments (no salt or pepper observed on resident's tray). R19 further reported that the food is delivered cold sometimes and late on the weekends. On 2/12/2026 at 11:49 AM, R19 was observed sitting at the edge of his bed eating lunch. Meal consisted of cheeseburger with cheese only, coleslaw and juice. R19 reported that the burgers use to be made to order so they could get additional toppings (like onions and tomatoes), he reported that was no longer offered. R19 reported that sometimes the hamburger and grilled cheese will give him diarrhea. No condiments were observed on the resident's tray except salt and pepper. R19 reported that he didn't eat the cole slaw because they were served the same thing with their dinner the night before. Review of the facilities grievance log (August 2025 through January 2026) revealed the following food related concerns:12/26/25 Cold food12/4/25 Paper plates, no desserts

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to properly dispose of waste and maintain dumpster area to mitigate the presence of pests, potentially affecting all residents in the facility. Findings include:During an observation and interview during the initial kitchen tour on 2/10/2026 at 9:28 AM, Food Service Director (FSD) F reported had been in role for about four months. Kitchen tour continued outside and observed four dumpsters labeled with two company names. FSD F reported facility recently changed ownership in November 2025(four months ago) and prior garbage company had not picked up the dumpsters yet. Observed several items outside and around new yellow trash dumpster including full bags of trash. FSD F reported maintenance department responsible for maintaining trash receptacles and reported all trash should be in dumpsters not on ground around them with lids closed.During an interview on 2/13/2026 at 10:35 AM, Maintenance Director (MD) BB reported MD BB reported since ownership changed facility had communicated with prior garbage company but have not removed two full dumpsters yet. MD BB reported when past company had left several items and including large furniture items outside dumpster during the heavy snow and they were working to clean up area.Review of provided communication with prior dumpster company with no follow up or communications noted between 12/3/25 and 2/10/26(survey entrance) related to need to remove prior company dumpsters form facility.

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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 accurate documentation for one (Resident #64) of 18 reviewed for accurate medical records. Resident #64(R64)Review of the Face Sheet and Minimum Data Set (MDS) with assessment reference date of 12/11/25, reflected R64 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included dementia, urinary tract infection and spinal stenosis. The MDS reflected R64 had a BIM (assessment tool) score of 4 that indicated her ability to make daily decisions was severely impaired, and she required staff assistance with dressing, mobility, transfers, hygiene, bathing, and toileting.During an observation on 2/10/2026 at 10:45 a.m., R64 was observed in bed with two staff at bedside assisting with care. R64 appeared pleasantly confused and did not appear to be oriented. This surveyor overheard Licensed Practical Nurse (LPN) CC talking to R64 about plan to change wound dressing. Observed wound supplies at bedside. LPN CC turned R64 side to side in bed and pulled brief down slightly in back and reported that wound must have healed because was unable to locate and exited R64 room with wound supplies. Review of R64 Medication Administration Record(MAR), dated 2/7/26 through 2/10/26, reflected physician order that included, Medihoney Wound/Burn Dressing Gel (Wound Dressings) Apply to coccyx topically every day shift for Wound Care Cleanse with Soap and H2O or wound cleanser. Apply thin layer to wound bed. Cover with Foam dressing-D/C Date-02/10/2026 1744[6:44pm]. Continued review of MAR reflected that LPN CC had signed wound care as completed as evidence by initials. Review of R64 Progress Notes with no linked notes related to MAR.Review of R64 Wound Care Specialists consult note, dated 2/9/26, reflected R64 had a facility acquire unstageable pressure wound to coccyx area that measured 2.3cm length x 7.5cm width. (one day prior).During an interview on 2/10/2026 at 2:40 PM, LPN CC reported when this surveyor had observed R64 care that morning about 10:45 a.m. LPN CC did not complete wound care because she was unable to located wound. LPN CC reported treatment order must have been an old orders and should have been removed from MAR because R64 no longer had a wound.During a telephone interview on 2/11/2026 at 10:52 AM, R64 responsible party reported had concerns that R64 pressure wound had not been improving. During an interview on 2/12/2026 at 9:20 AM Registered Nurse(RN) I reported R64 wound treatment had been completed on night shift at 3:15 am.During an interview on 2/12/2026 at 9:25 AM, Wound Nurse Q reported resident treatmentst are usually scheduled on night shift because resident get in bed at night and staff get residents up in mornings. Wound Nurse Q reported R64 wound was unstageable to coccyx and started on 1/28/26. Wound Nurse Q reported if Physician ordered treatment was not completed would expect staff to document that and not document that treatment was completed. Wound Nurse Q reported R64 definitely had wound on 2/10/26 when LPN CC reported no wound and documented treatment as completed.During an interview on 2/12/2026 at 9:52 AM, Director of Nursing (DON) B reported started employment at facility on 1/12/26. DON B reported would expect nurse staff to follow physician orders for medication and treatment orders. DON B reported would expect if treatment not completed that staff document treatment as not completed. DON B reported would not expect staff to document treatment completed if not done and reported that would be falsification of medical records.