STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 30337 Based on interview and record review, the facility failed to complete a significant change in status assessment in 2 of 30 residents reviewed for Minimum Data Set assessments (Resident #63 & #111), resulting in the comprehensive assessment not competed timely. Findings include: Resident #63 (R63): In review of R63's Minimum Data Set (MDS), she was admitted to the facility on [DATE]. R63's significant change in Status Assessment (SCSA) with an assessment reference date (ARD), the specific end point for the look-back period) of 1/06/22 was not completed until 1/24/22. 38383 Resident #111 (R111): Review of the medical record reflected R111 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included displaced intertrochanteric fracture of the left femur, intraarticular fracture of lower end of left radius, chronic obstructive pulmonary disease, muscle weakness and unspecified dementia without behavioral disturbance. The Significant Change in Status/Medicare 5 day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/13/21, reflected R111's cognition, memory, mood and potential indicators of psychosis were not assessed. The same MDS reflected R111 did not walk and required supervision to total assistance of one to two or more people for activities of daily living. The Significant Change in Status MDS, with an ARD of 12/13/21, reflected R111 was not assessed for the following sections: Section C (cognitive patterns): C0100-Should Brief Interview for Mental Status (C0200-C0500) be conducted C0200-Repetition of Three Words C0300-Temporal Orientation (orientation to year, month and day) C0400-Recall (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	C0500-BIMS Summary Score C0600-Should the Staff Assessment for Mental Status (C0700-C1000) be Conducted? C0700-Short-term Memory OK C0800-Long-term Memory OK C0900-Memory/Recall Ability C1000-Cognitive Skills for Daily Decision Making C1310-Signs and Symptoms of Delirium Section D (mood) D0100-Should Resident Mood Interview be Conducted? D0200-Resident Mood Interview (PHQ-9) D0300-Total Severity Score D0500-Staff Assessment of Resident Mood (PHQ-9-OV) D0600-Total Severity Score Section E (behavior): E0100-Potential indicators of Psychosis E0500-Impact on Resident E0600-Impact on Others E1100-Change in Behavior or Other Symptoms R111's Physician's Orders reflected they were admitted to hospice services on 1/4/22. According to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2019, .The SCSA [Significant Change in Status Assessment] is a comprehensive assessment for a resident that must be completed when the IDT [interdisciplinary Team] has determined that a resident meets the significant change guidelines for either major improvement or decline .An SCSA is required to be performed when a terminally ill resident enrolls in a hospice program (Medicare-certified or State-licensed hospice provider) or changes hospice providers and remains a resident at the nursing home. The ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than). An SCSA must be performed regardless of whether an assessment was recently conducted on the resident. This is to ensure a coordinated plan of care between the hospice and nursing home is in place . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R111's MDS history on 1/27/22 at 2:33 PM, reflected a Significant Change in Status MDS, with an ARD of 1/11/22, which had a status of In Progress. Review of R111's MDS history on 2/1/22 at 11:50 AM, reflected R111's Significant Change in Status MDS, with an ARD of 1/11/22, was completed, locked and accepted on 1/31/22. During an interview on 2/1/22 at 3:41 PM, MDS Coordinator HH reported when they started their employment with the facility, the MDS department was behind. Social Work was not completing their sections. MDS Coordinator HH reported Significant Change in Status MDS assessments were to be completed by day 14. They then had seven days after completing the comprehensive MDS to complete the Care Plans. MDS Coordinator HH reported they were not always meeting that timeframe. MDS Coordinator HH acknowledged that the Care Plan process relied on the MDS. According to the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated October 2019, a Significant Change in Status MDS ARD was to be no later than the 14th calendar day after determination that a significant change in the resident's status occurred (determination date plus 14 calendar days). The Significant Change in Status MDS was to be completed no later than the 14th calendar day after determination that a significant change in the resident's status occurred (determination date plus 14 calendar days).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 This citation pertains to intake MI00125658. Based on observation, interview, and record review the facility failed to update and implement comprehensive person-centered care plans for nine (Resident #'s 38, 42, 43, 61, 94, 81, 111, 214 and 264) of 30 reviewed for care plans, resulting in the potential for unmet care needs and goals. Findings include: Resident #81 According to the clinical record, including the Minimum Data Set (MDS) with an ARD of 10/31/2021 reflected Resident # 81 (R81) was a [AGE] year old male, admitted to the facility on [DATE] with diagnoses that included anoxic brain damage, paranoid schizophrenia, depression, anxiety and Covid 19. The MDS reflected R81 had long and short term memory impairment and severely impaired decision making skills. The MDS, with an ARD of 10/31/21, was completed, locked and accepted on 11/18/21. Review of 81's electronic medical record (emr) revealed R81 was admitted to hospice care 7/23/2019 and was admitted to the facility with hospice care, further review of the emr revealed the facility did not incorporate care plans that pertained to hospice care. Review of a hospice binder located at the Nurses station did entail a hospice care plan that was written in 08/31/2019 and had never been updated or revised. On 01/25/22 09:54 AM, during an interview with facility Social Worker Z she acknowledged there was no updates or changes made to the hospice care plan located in the binder at the Nurses station in 3 years. Social Worker Z further stated she was recently employed at the facility and could not speak to why R81's hospice care plan was not updated. 27446 Resident #61 (R61) Per the facility face sheet R61 was admitted to the facility on [DATE]. In an observation and interview on 1/13/2022, at 1:58 PM, R61 stated that he did not know what his plan of care was. R61 stated that he did not sit in the wheelchair that was observed to be in his room, which was a regular low back wheelchair, because it hurts his back to sit in it and he needed a high back wheelchair. R61 stated that he was currently receiving therapy services. In an interview on 1/25/2022, at 9:21 AM, Certified Nurse Aid (CAN) M stated that several different wheelchairs had been trialed for R61's use but stated R61 would only gets up for a few minutes then would want to go back to bed due to pain in his lower back. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 1/25/2022, at 9:31 AM, Physical Therapy Director (PT) N stated that R61 was currently on therapy services and is not receiving restorative services. Record review of a Physical Therapy Evaluation & Plan of Treatment, dated 1/15/2022, revealed R61 was referred to therapy due to weakness reported during quarterly screening. The evaluation revealed R61 was certified for therapy treatment from 1/15/2022 through 2/15/2022. Per record review of physical therapy Service Matrix Log for the month of January 2022 revealed R61 had received therapy on 1/15, 1/19, 1/20, and 1/25/2021 for a total of 240 minutes. In an interview on 1/26/2022, at 11:12 AM, Licensed Practical Nurse (LPN) O, who was the Unit Manager of the third floor, stated that R61 was not receiving restorative services. LPN O said she did not know what the process was for resident care plans to be updated, and further stated that she was not responsible for that. Record review of a care plan in place, titled, Restorative: Resident is at risk for decline in ROM (range of motion). Will have RNP (Restorative Nursing Program) for BUE AROM (bilateral upper extremities assist range of motion). 3 X 15 reps (repetitions) 3 X weekly. The care plan was initiated on 8/4/2021 and revised on 1/19/2022. The care plan was active and had not been canceled or resolved. Review of another care plan titled, The resident has limited physical mobility, dated 6/12/2021, and revised on 10/28/2021, revealed an intervention in place that R61, Uses High back w/c (wheelchair) for mobility and uses lateral support for positioning . The intervention was initiated on 11/6/2020. Resident #214 (R214): Per the facility Electronic Medical Record (EMR) R214 was admitted to the facility on [DATE]. Diagnosis included a cognitive communication deficit. In an attempted interview on 1/13/2022, at 3:24 PM, R214 attempted to ask a question, however R214 was not able to be understood due to speaking in a different language. In an observation on 1/19/2022, at 10:00 AM, staff were observed speaking with R214 in the hallway using a device that translated R214's language to English and vice versa. Record review of a care plan in place for R214 titled, The resident (R2140 has a communication problem r/t (related to) language barrier. Resident's dominant language is mandarin. The care plan was initiated on 11/19/2021, however under the interventions section the care plan was blank, and did not have R214's need for the use of a communication device listed. 30337 Resident #42 (R42) R42's history and physical dated 6/20/21 at 10:12 PM revealed he was admitted to the facility after a 17-day hospital stay for acute metabolic encephalopathy (chemical imbalance in blood affecting the brain) and gastrointestinal (GI) bleeding. R42 had a history of high blood pressure and dementia. The same note indicated with was alert and oriented to person only and was somewhat ornery. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician Progress Note dated 7/06/21 at 7:27 PM indicated R42 was alert and orientated to person only and was unable to hold a conversation. Social Service note dated 6/22/21 at 3:54 PM indicated the social worker spoke to R42's son, informed R42 was unable to give verification as to whether he wanted his son to continue coordinating his affairs and conveyed R42 lacked a power of attorney (POA). The same note indicated R42's son was encouraged to speak to an elder law attorney and social services would follow and provide support to R42 and family as needed. Physician Progress Note dated 10/21/21 at 8:04 PM revealed R42 was seen for a medical evaluation and was alert and orientated to person only. Interdisciplinary Progress Note dated 10/27/21 at 3:15 PM revealed R42 had wandering behaviors and was to be seen by psychiatry for competency. A psychiatric consult dated 11/09/21 indicated the reason for R42's referral was to assess his current mental status and ability to make independent decisions. Following a neurobehavioral status exam and other tests, R42 was found to have severe dementia and a severe intellectual impairment. The same consult indicated R42 was incompetent in making independent decisions. Social Worker (SW) Z was interviewed on 1/26/22 at 11:27 AM and stated R42 was a full code by default. SW Z stated she had talked to R42's son last week and he was upset that his father had not received the COVID-19 vaccine. SW Z stated she explained to R42's son that he did not receive the vaccine because he did not have a guardian in place. SW Z stated the facility had not pursued guardianship and will do so in 2 weeks if the son did not initiate himself. In review of R42's care plans, there were no goals for establishing a POA. In review of R42's physician progress notes dated 1/21/22 10:13 PM, seen for follow-up for covid infection R42 tested positive for covid 1/10/22. Physician progress notes dated 1/23/22 6:47 PM indicated R42 had a lack of appetite, had a fall with no injury, had COVID fatigue. Plan for COVID positive was to add Vitamin C and Vitamin D supplementation and advised if symptoms worsen with decline in function, transfer resident to the emergency room immediately. In review of R42's care plans on 1/26/22, there were no revisions related to COVID fatigue. Resident #94 (R94) On 1/19/22 at 1:47 PM R94 door was closed, and yelling could be heard. R94 observed lying in bed, her gown off, and her call light was placed over the top of the light fixture over the bed. R94 was unable to articulate any need. Psychiatric consult dated 5/31/21 revealed R94 was admitted to the facility on [DATE] following hospitalization for failure to thrive and increased behaviors. R94 previously resided in a group home, they were not sure if they could continue to meet her needs. R94 had a diagnosis of down syndrome. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per chart notes: R94 had episodes of yelling, refusing showers, crawling out of bed, shouting, and resistant to care. R94 stated during visit I want to go home. Ativan (anti-anxiety) medication 0.5 milligrams (mg) was ordered every 8 hours as needed. The same consult instructed to continue to monitor for agitation, anxiety, behaviors, and document. Psychiatric consult dated 9/30/21 revealed R94 was seen for follow-up. The same consult indicated R94 would spit out oral tablet of Ativan 0.5mg every 8 hours as needed; and was changed to Ativan gel 1 mg twice a day due to yelling out behaviors. Social Worker Z was interviewed on 2/01/22 at 2:21 PM indicated R94 still continued with yelling out behavior. SW Z was not aware if a gradual dose reduction was attempted. R94's behavior care plan dated 5/09/21 indicated her goal was to have fewer episodes by review date. R94's behaviors continued with Ativan medication. Resident #264 (R264) On 1/21/22 at 9:45 AM R264 was observed lying in bed with his eyes closed. R264 stated was very sleepy and was unable to keep eyes his open. Hospital visit summary dated 1/01/22 instructed to start anti-psychotic medication Seroquel, 12.5 milligrams (mg) at night as needed for agitation and to decrease Depakote (anticonvulsant). R264's progress notes dated 1/01/22 at 5:24 PM, he was admitted to the facility following a hospital stay. Physician Admission History and Physical dated 1/02/22 at 1:30 PM, revealed R264's chief complaint was altered mental status and weakness. R264 had a history of stroke, seizure disorder on Depakote, thrombocytopenia (low platelet level), and was transferred from the hospital after evaluated for concerns of seizures as well as behavioral disturbances worrisome for encephalopathy (altered brain function) although no definite evidence of encephalopathy was found. It is thought that it is from dementia with intermittent behavioral disturbances. They recommended continuing Seroquel at night. The Depakote dose was reduced to 750 mg daily from twice a day as apparently level was high. R264's wife had been unable to care for him, he was transferred the nursing home for subacute rehabilitation and consideration of long-term care. The same note indicated R264 was alert and oriented to person and place. R264's January 2022 Medication Administration Record (MAR) indicated Seroquel 25 mg was ordered daily at 7:00 AM for agitation. There was no rational in R264's medical record as why the dose was doubled from the hospital order or why the medication was scheduled at 7:00 AM. According to Web MD, at https://www.webmd.com, side effects of Seroquel included drowsiness and tiredness. Dizziness or lightheadedness may occur especially when medication was intricate or increase the dose of this drug and can increase the risk of falling. In review of R264's care plan, there was no mention of Seroquel medication or to monitor for side effects of the medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Social Worker (SW) Z was interviewed on 2/01/22 at 2:21 PM and stated she did not recall what behaviors R264 had or what the supporting diagnosis was for Seroquel. Social Worker Z stated she had not attended any behavior management meetings. SW Z stated there had not been a discussion for a gradual dose reduction and did not know the rationale for timing Seroquel at 7:00 AM versus at night. On 2/01/22 at 2:45 PM Assistant Director of Nursing (ADON) C stated she was not sure the rationale for the timing of R264's and did not provide additional information prior to exit. Resident #43 (R43) R43's quarterly 12/30/21 MDS assessment indicated he was admitted to the facility on [DATE] and his family and guardian did not participate in the assessment. R43's care plans last review date, as of 1/19/22, was on 8/11/21; over 5 months since his care plans were last reviewed. 38383 Resident #38 (R38): Review of the medical record reflected R38 was admitted to the facility on [DATE], with diagnoses that included fibromyalgia, malignant neoplasm of unspecified part of bronchus or lung, personality disorder, attention deficit hyperactivity disorder and adult failure to thrive. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/21, reflected R38's cognition was not fully assessed. The same MDS reflected R38 required limited to extensive assistance of one person for activities of daily living. R38's Admission MDS, with an ARD of 9/21/21, was completed, locked and accepted on 10/13/21. On 1/20/22 at 2:26 PM, R38 was observed lying in bed. Their bed was in a low position, and an over-bed table was near the right bedside. R38 was observed to have one bare foot and a sock on their other foot. Review of R38's Activities of Daily Living (ADL) Care Plan reflected it was initiated on 9/14/21. The focus area reflected, The resident has potential for an ADL self-care performance deficit r/t [related to] fibromyalgia & malignant neoplasm. Interventions included: -Encourage the resident to use bell to call for assistance (initiated 9/14/21) -Monitor/document/report PRN [as needed] any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function (initiated 9/14/21) -BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse (initiated 9/22/21) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The same Care Plan had one intervention dated for 11/1/21 and all additional interventions were dated for 12/13/21. It was not until 12/13/21 that R38's Care Plan reflected how they performed tasks such as dressing, eating, oral care, personal hygiene and toilet use. R38's medical record reflected they were on hospice as of 9/15/21, however, a hospice Care Plan was not initiated until 10/25/21. The Care Plan did not reflect the services being provided by hospice, the hospice disciplines that were involved in R38's care or the frequency/schedule of hospice visits. During an interview on 1/27/22 at 3:00 PM, Certified Nurse Aide (CNA) CC reported they did not know when hospice was coming. Sometimes hospice staff introduced themselves and stated what they were there for. The day prior, someone from hospice came, and the CNA and nurse did not know it was, according to CNA CC. During an interview on 1/27/22 at 3:38 PM, Unit Manager (UM) D reported hospice used to provide a calendar of when they were coming for the week. Resident #111 (R111): Review of the medical record reflected R111 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included displaced intertrochanteric fracture of the left femur, intraarticular fracture of lower end of left radius, chronic obstructive pulmonary disease, muscle weakness and unspecified dementia without behavioral disturbance. The Significant Change in Status/Medicare 5 day MDS, with an ARD of 12/13/21, reflected R111's cognition, memory, mood and potential indicators of psychosis were not assessed. The same MDS reflected R111 did not walk and required supervision to total assistance of one to two or more people for activities of daily living. On 1/20/22 at 11:02 AM, R111 was observed lying in bed with their eyes closed. Oxygen via nasal cannula was in place and running at 2 liters per minute. R111's bed was in a low position, and a fall mat was observed on the floor at the right bedside. R111's call light was clipped to their blankets. On 1/27/22 at 12:15 PM, R111 was observed in bed with their eyes closed. Their bed was in a low position, and their call light was in reach. An over-bed table with a beverage cup was at the right bedside. R111's Physician's Orders reflected they signed on with hospice on 1/4/22. During an interview on 1/27/22 at 2:51 PM, Licensed Practical Nurse (LPN) FF reported they did not know which hospice company R111 was signed on with. LPN FF reported there was supposed to be a binder behind the nursing desk for hospice residents. LPN FF was not sure which disciplines came from hospice for R111, but that information was in the hospice binder. In regard to if there was a schedule for when hospice would be coming, LPN FF reported they could not depend on that. If a resident needed care, the facility did it. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/22 at 3:30 PM, R111's hospice binder was reviewed. It included a contact number for hospice, and a Registered Nurse (RN) Case manager card was on the cover of the binder. The binder included Hospice Care RN Notes for 1/13/22, 1/20/22 and 1/24/22. The back pocket of the binder had consents. There were also pages for Nursing, Social Work, Spiritual Care and Home Health, none of which had documentation with them. There was no schedule of hospice visits to be provided. R111's hospice Care Plan was initiated on 1/12/22 and was not reflective of the services being provided by hospice, the hospice disciplines that were involved in R111's care or the frequency/schedule of hospice visits. During an interview on 1/27/22 at 3:38 PM, UM D reported they had not talked to R111's hospice much and assumed hospice spoke to the nurse or the Social Worker. When asked how they knew the frequency of hospice visits and the disciplines involved, UM D reported there may have been something in R111's chart. UM D looked in R111's hospice binder and reported they did not know (the hospice visit schedule) but would find out. During an interview on 2/1/22 at 4:56 PM, UM D reported they wrote R111's hospice schedule on a piece of paper after speaking to hospice about the schedule (after the Surveyor inquiry).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0661 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 This citation pertains to intake MI00123905. Based on interview and record review, the facility failed to provide a discharge charge summary that included a recapitulation of the resident's stay in 1 of 1 reviewed for discharge to community (Resident #115), resulting in the potential of information not communicated to home health services for continued care. Findings include: Resident #115 (R115) Physician Progress Note dated 12/08/21 at 4:50 PM indicated R115 was admitted to the facility on [DATE] and discharged home on 12/10/21. R115's diagnoses included Diabetic foot infection right foot that was resolved, diabetes mellitus, obesity, and chronic pain. In review of R115's electronic medical record on 2/01/22 at 1:46 PM, the recapitulation of stay document, dated 12/05/21, indicated it was not completed and in progress. On 2/01/22 at 5:45 PM Director of Nursing (DON) B and Licensed Practical Nurse (LPN)/Unit Manager D were interviewed and stated residents were not discharged with their recapitulation of stay.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 This citation pertains to MI00124642. Based on observation, interview and record review, the facility failed to, 1) perform skin assessments and administer treatments as ordered for four (Resident #6, #15, #23 and #111) of six reviewed for skin conditions; and 2) ensure timely administration of medications for one (Resident #117) of two reviewed for timely medication administration, resulting in skin assessments and treatments not being performed as ordered, medications not being administered within acceptable timeframe's and the potential for unrecognized and/or worsening skin impairments and adverse events. Findings include: Resident #6 (R6): Review of the medical record reflected R6 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included peripheral vascular disease, hypertension, diabetes, non-pressure chronic ulcer of other part of left foot with fat layer exposed and seborrheic keratosis. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/2/21, reflected R6 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The same MDS reflected R6 did not walk and required extensive assistance of one to two or more people for activities of daily living. On 1/20/22 at approximately 3:35 PM, R6 was observed seated in a high-back wheelchair in their room, watching TV. R6's feet were observed to be bare with pillow boots in place and resting on the footrests of the wheelchair. R6 stated they had sores on their feet since they came up here. R6 denied having any dressings or bandages in place. An air mattress pump was observed resting on the floor at the foot of the bed. Review of the Evaluations tab of R6's Electronic Medical Record (EMR) reflected that their last weekly Skin Observation was 12/28/21 and reflected bilateral lower extremity vascular dermatitis. R6's December 2021 Treatment Administration Record (TAR) reflected an order dated 11/22/21 for, WOUND CARE: cleanse BLE [bilateral lower extremities (both legs)] with soap and water, apply Ammonium lactate 12% to bilateral lower extremities with 4x4 gauze, leave OTA [open to air] two times a day for wound care. The treatment was not signed out as complete four times in December. R6's December 2021 TAR reflected an order dated 11/22/21 for, Apply skin prep to bilateral heels, medial, and lateral feet every shift for protection. The treatment was not signed out as complete seven times in December. R6's December 2021 TAR reflected an order dated 11/22/21 for, Cleanse bilateral buttocks, apply Dermaseptine [sic], leave OTA every shift for protection. Apply Q [every] shift and w/ [with] each incontinence episode. The treatment was not signed out as complete eight times in December. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R6's December 2021 TAR reflected an order dated 11/1/21 for, Ensure bilateral boots are in place every shift for skin integrity. The order was not signed out as complete seven times in December. R6's January 2022 TAR reflected an order for, WOUND CARE: cleanse BLE with soap and water, apply Ammonium lactate 12% to bilateral lower extremities with 4x4 gauze, leave OTA two times a day for wound care. The treatment was not signed out as complete eight times from 1/1/22 through 1/24/22, when the order was discontinued. R6's January 2022 TAR reflected an order dated 11/22/21 for, Apply skin prep to bilateral heels, medial, and lateral feet every shift for protection. The treatment was not signed out as complete 18 times from 1/1/22 through 1/26/22. R6's January 2022 TAR reflected an order dated 11/22/21 for, Cleanse bilateral buttocks, apply Dermaseptine [sic], leave OTA every shift for protection. Apply Q shift and w/ each incontinence episode. The treatment was not signed out as complete 16 times from 1/1/22 through 1/26/22. R6's January 2022 TAR reflected an order dated 11/1/21 and discontinued 1/25/22 for, Ensure bilateral boots are in place every shift for skin integrity. The order was not signed out as complete 17 times. Resident #15 (R15): Review of the medical record reflected R15 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included diabetes, chronic obstructive pulmonary disease and hypertension. The Quarterly MDS, with an ARD of 12/9/21, did not reflect cognition screening. The same MDS reflected R15 did not walk and required extensive to total assistance of one to two or more people for activities of daily living. On 1/20/22 at 2:07 PM, R15 was observed in bed with the head of the bed elevated. R15 stated they had a rash on their buttocks for about one month. R15 reported cream had been applied, but the rash was burning. According to R15, they often laid on their back, were unable to turn themselves independently, and staff did not assist to turn them. On 1/27/22 at 9:32 AM, R15 was observed in bed with their eyes closed and the head and foot of their bed elevated. R15's Care Plan, with a revision date of 12/7/21, reflected they had actual impaired skin integrity to the bilateral buttocks with moisture-associated skin damage (MASD) and an abrasion to the right buttock, related to incontinence and impaired mobility. R15's Care Plan, with a revision date of 12/7/21, reflected they had the potential for impaired skin integrity related to incontinence, limited mobility, morbid obesity and diabetes. R15's Quarterly MDS, with an ARD of 12/9/21, was coded for MASD. R15's medical record reflected their last weekly Skin Observation was documented on 12/28/21, which reflected MASD to the bilateral buttocks with abrasions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's December 2021 TAR reflected an order dated 11/4/21 for, monitor bilateral buttock MASD for s/s [signs/symptoms] of infection/worsening every shift for monitoring. The treatment was not signed out as complete ten times in December. R15's December TAR reflected an order dated 12/6/21 through 12/18/21 for, WOUND CARE: cleanse bilateral buttocks MASD, apply Dermaseptine [sic]. Cover/ensure placement R [right] buttock MASD abrasions w/ foam dressing every shift for wound care. The treatment was not signed out as complete six times in December. R15's December 2021 TAR reflected an order dated 12/18/21 through 12/22/21 for, WOUND CARE: cleanse bilateral buttocks MASD, apply Dermaseptine [sic]. Cover/ensure placement bilateral buttock MASD abrasions w/ foam dressing every shift for wound care. The treatment was not signed out as complete two times in December. R15's January 2022 TAR reflected an order dated 5/26/21 for, monitor bilateral buttock for s/s infection every evening shift for monitoring. The order was not signed out as complete six times from 1/1/22 through 1/26/22. R15's January 2022 TAR reflected an order dated 12/22/21 and discontinued 1/14/22 for, WOUND CARE: cleanse bilateral buttocks MASD, apply Dermaseptine [sic], cover each buttock with border foam every day shift for wound care. The treatment was not signed out as complete three times in January. R15's January 2022 TAR reflected an order dated 11/4/21 for, monitor bilateral buttock MASD for s/s of infection/worsening every shift for monitoring. The order was not signed out as complete 18 times from 1/1/22 through 1/26/22. R15's January 2022 TAR reflected an order dated 1/20/22 for, WOUND CARE: cleanse bilateral buttocks MASD, apply Dermafungal, leave OTA every shift for wound care. The treatment was not signed out as complete seven times from 1/1/22 through 1/26/22. Resident #23 (R23): Review of the medical record reflected R23 was admitted to the facility on [DATE] and was readmitted [DATE], with diagnoses that included unspecified bacterial pneumonia, chronic obstructive pulmonary disease, chronic kidney disease, dementia and paranoid schizophrenia. The Quarterly MDS, with an ARD of 12/9/21, reflected R23 scored 12 out of 15 (moderately impaired) on the BIMS. The same MDS reflected R23 required limited to total assistance of one to two or more people for activities of daily living. On 1/21/22 at 9:44 AM, R23 was observed seated in a wheelchair in their room. R23 reported they sometimes got sores on their buttocks that hurt. R23 reported staff were supposed to put cream on them in the morning and at night, but staff was not doing it unless they asked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/26/22 at 10:43 AM, R23 was observed seated in their wheelchair, in the hallway. A seating cushion and footrests were in place on R23's wheelchair. The air mattress pump on the foot of R23's bariatric bed was set at a patient weight of less than or equal to 250 pounds and a cycle time of 15 minutes. The pump weight range was less than or equal to 250 and up to a range of [PHONE NUMBER] pounds. The cycle time (in minutes) had settings for 15, 20, 25 and 30. The pump setting reflected static (versus alternating). On 1/27/22 at 9:30 AM, R23 was observed seated in their wheelchair, in their room. Their air mattress pump reflected settings of a weight less than or equal to 250 pounds and a 15 minute interval cycle. R23's Care Plan reflected they had potential for impairment to skin integrity related to limited mobility, recurring pressure area to the coccyx and recurring moisture-associated skin damage (MASD) to the buttocks/scrotum. The Care Plan focus area was revised 12/7/21 and included an intervention for an alternating pressure mattress with settings of 400 pounds and a cycle time of 20 minutes. The intervention was initiated on 10/18/21. During an interview on 1/27/22 at 9:44 AM, Registered Nurse (RN) BB reported R23 had an air mattress with settings of 400 pounds and a cycle time of 20 minutes. RN BB reported they tried to check the mattress settings when they were in the room and tried to round to ensure mattresses were on the proper settings. Review of R23's EMR, on 1/26/22, reflected their most recent weekly Skin Observation in the Evaluations tab was for 12/27/21. The document reflected that no skin issues were observed. R23's December 2021 TAR reflected an order for, Apply Miconazole powder to affected areas including groin, abdominal folds/areas of moisture every shift for protection, dated 11/19/21 and discontinued 12/22/21. The treatment was not signed out as complete eight times. R23's December 2021 TAR reflected an order for, Apply Miconazole powder to affected areas including groin, abdominal folds/areas of moisture every shift for protection, dated 12/22/21. The treatment was not signed out as complete four times. R23's December 2021 TAR reflected an order for, Cleanse bilateral buttock/thigh back, apply dermaseptine [sic] ointment, leave OTA Q shift and w/ incontinence episodes/brief changes every shift for protection, dated 11/19/21 and discontinued 12/22/21. The treatment was not signed out as complete seven times. R23's December 2021 TAR reflected an order for, Cleanse bilateral buttock/ thigh back, apply dermaseptine [sic] ointment, leave OTA Q shift and w/ incontinence episodes/brief changes every shift for protection, dated 12/22/21. The treatment was not signed out as complete three times. R23's January 2022 TAR reflected an order for, Cleanse bilateral buttock/thigh back, apply dermaseptine [sic] ointment, leave OTA Q shift and w/ incontinence episodes/brief changes every shift for protection, dated 12/22/21 to 1/25/22. The treatment was not signed out as complete 15 times from 1/1/22 through 1/25/22. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R23's January 2022 TAR reflected an order for, Apply Miconazole powder to affected areas including groin, abdominal folds/areas of moisture every shift for protection, dated 12/22/21. The treatment was not signed out as complete 17 times from 1/1/22 through 1/26/22. Resident #111 (R111): Review of the medical record reflected R111 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included displaced intertrochanteric fracture of the left femur, intraarticular fracture of lower end of left radius, chronic obstructive pulmonary disease, muscle weakness and unspecified dementia without behavioral disturbance. The Significant Change in Status/Medicare 5 day MDS, with an ARD of 12/13/21, reflected R111's cognition, memory, mood and potential indicators of psychosis were not assessed. The same MDS reflected R111 did not walk and required supervision to total assistance of one to two or more people for activities of daily living. On 1/27/22 at 12:15 PM, R111 was observed in bed with their eyes closed. Their bed was in a low position, and their call light was within reach. R111's January 2022 TAR reflected an order dated 1/17/22 for, WOUND CARE: cleanse sacrum, apply Dermaseptin to sacrum/bilateral buttocks, leave OTA [open to air] every shift for wound care. The treatment was not signed as completed 12 times from 1/17/22 to 1/27/22. R111's January 2022 TAR reflected an order dated 1/5/22 for, monitor sacrum for s/s [signs/symptoms] of infection every day shift for monitoring. The order was not signed out as complete three times from 1/6/22 to 1/27/22. Review of R111's Evaluations tab of the EMR, on 1/28/22 at 12:06 PM, reflected their last weekly Skin Observation was dated for 12/28/21. During an interview on 1/27/22 at 9:44 AM, Registered Nurse (RN) BB reported the Skin Observation in the Evaluations tab of the EMR was conducted weekly. RN BB reported they were not documented anywhere else besides the Evaluations tab of the EMR. Certified Nurse Aides (CNAs) were to check and chart on skin daily, and the nurse was to do weekly skin observations. Review of the facility policy, titled, Skin Protection Guideline, with an effective date of 7/7/21, reflected, . Monitoring of Skin Integrity .Skin will be observed daily during care by the nursing assistants .Weekly skin observation by a licensed nurse .This may be completed during a scheduled shower or bath day and/or as determined by preference through the care planning process . Resident #117 (R117): Review of the medical record reflected R117 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included rheumatoid arthritis, chronic obstructive pulmonary disease, hypertension and diabetes. The Admission MDS, with an ARD of 11/8/21, reflected R117 scored 13 out of 15 (cognitively intact) on the BIMS. The same MDS reflected R117 was coded for supervision level with physical assistance of one to two or more people for activities of daily living. R117's bathing was coded for total dependence of one person assist. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record reflected R117 was discharged from the facility on 11/29/21, with a return anticipated. R117's Medication Administration Audit Report for 11/1/21 through 11/30/21 reflected medications that were administered more than one hour late, daily, between 11/5/21 and 11/29/21 (25 days). The medications, dates and times included but were not limited to the following: -On 11/5/21, R117's Ferrous Sulfate (supplement that was to be given with breakfast) was scheduled to be administered at 7:00 AM and was administered at 3:38 PM. -On 11/5/21, R117's Omeprazole (for acid reflux) was scheduled to be administered at 7:00 AM and was documented as being administered at 3:38 PM. -On 11/6/21, R117's Ferrous Sulfate and Omeprazole, scheduled for 7:00 AM, were administered at 3:48 PM. -On 11/7/21, R117's Ferrous Sulfate and Omeprazole, scheduled for 7:00 AM, were administered at 3:57 PM. -On 11/9/21, R117's Ferrous Sulfate and Omeprazole, scheduled for 7:00 AM, were administered at 4:08 PM. -On 11/25/21, R117's Ferrous Sulfate and Omeprazole, scheduled for 7:00 AM, were administered at 1:54 PM. -On 11/26/21, R117's Ferrous Sulfate and Omeprazole, scheduled for 7:00 AM, were administered at 2:17 PM. -On 11/29/21, R117's Ferrous Sulfate and Omeprazole, scheduled for 7:00 AM, were administered at 2:32 PM. -R117's 8:30 AM scheduled medications, which included but were not limited to: Metformin (for diabetes), Apixaban (for deep vein thrombosis/blood clot prevention), Ipratropium-Albuterol Solution (used to treat and prevent lung disease symptoms), Losartan Potassium (for high blood pressure), Singulair (for asthma), Carafate (to treat and prevent ulcers), Advair Diskus inhaler (for asthma) and Spiriva (medication used to treat lung diseases) were administered on the following dates/times, including but not limited to: -10:25 AM and 10:26 AM on 11/7/21 -11:26 AM and 11:27 AM on 11/10/21 -10:48 AM to 10:52 AM on 11/13/21 -10:34 AM to 10:37 AM on 11/14/21 -1:20 PM to 1:21 PM on 11/18/21 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-11:56 AM to 11:57 AM on 11/19/21 -1:08 PM to 1:10 PM PM on 11/22/21 -1:19 PM to 1:20 PM on 11/23/21 -12:29 PM to 12:32 PM on 11/25/21 -12:29 PM to 12:30 PM on 11/26/21 -1:05 PM to 1:07 PM on 11/27/21 -1:44 PM to 1:45 PM on 11/28/21 -12:10 PM to 12:12 PM on 11/29/21 -On 11/18/21, R117's Carafate (1 gram by mouth four times daily for ulcers) was signed out for the scheduled 8:30 AM and 12:30 PM doses both being administered at 1:21 PM. -On 11/22/21, R117's Carafate was signed out for the scheduled 8:30 AM and 12:30 PM doses both being administered at 1:09 PM. -On 11/23/21, R117's Carafate was signed out for the scheduled 8:30 AM and 12:30 PM doses both being administered at 1:19 PM. -On 11/24/21, R117's Carafate was signed out for the scheduled 8:30 AM and 12:30 PM doses both being administered at 12:05 PM. -On 11/25/21, R117's Carafate was signed out for the scheduled 8:30 AM dose being administered at 12:32 PM and the scheduled 12:30 PM dose being administered at 12:31 PM. -On 11/26/21, R117's Carafate was signed out for the scheduled 8:30 AM dose being administered at 12:30 PM and the 12:30 PM scheduled dose being administered at 12:31 PM. -On 11/27/21, R117's Carafate was signed out for the scheduled 8:30 AM and 12:30 PM doses both being administered at 1:07 PM. -On 11/28/21, R117's Carafate was signed out for the scheduled 8:30 AM dose being administered at 1:45 PM and the 12:30 PM scheduled dose being administered at 1:48 PM -On 11/29/21, R117's Carafate was signed out for the scheduled 8:30 AM and 12:30 PM doses both being administered at 12:11 PM -On 11/18/21, R117's Ipratropium-Albuterol Solution, with instructions to inhale orally four times a day for asthma, was signed out for the scheduled 8:30 AM and 12:30 PM doses both being administered at 1:21 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 11/22/21, R117's Ipratropium-Albuterol Solution was signed out for the scheduled 8:30 AM and 12:30 PM doses both being administered at 1:09 PM. -On 11/23/21, R117's Ipratropium-Albuterol Solution was signed out for the scheduled 8:30 AM dose being administered at 1:19 PM and the scheduled 12:30 PM dose being administered at 1:22 PM. -On 11/25/21, R117's Ipratropium-Albuterol Solution was signed out for the scheduled 8:30 AM dose being administered at 12:30 PM and the 12:30 PM scheduled dose being administered at 12:31 PM. -On 11/26/21, R117's Ipratropium-Albuterol Solution was signed out for the scheduled 8:30 AM dose being administered at 12:29 PM and the 12:30 PM scheduled dose being administered at 12:30 PM. -On 11/27/21, R117's Ipratropium-Albuterol Solution was signed out for the scheduled 8:30 AM dose being administered at 1:05 PM and the 12:30 PM scheduled dose being administered at 1:07 PM. -On 11/28/21, R117's Ipratropium-Albuterol Solution was signed out for the scheduled 8:30 AM dose being administered at 1:44 PM and the 12:30 PM scheduled dose being administered at 1:45 PM. On 11/29/21, R117's Ipratropium-Albuterol Solution was signed out for the scheduled 8:30 AM dose being administered at 12:10 PM and the 12:30 PM scheduled dose being administered at 12:11 PM. During an interview with Director of Nursing (DON) B and Unit Manager (UM) D on 2/1/22 at 4:56 PM, it was reported that scheduled medications could be given one hour before or one hour after they were due. Neither DON B or UM D were aware of concerns pertaining to medication administration timeliness for R117.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45038 This citation pertains to Intake MI000123574 and MI000123659. Based on observation, interview, and record review the facility failed provide necessary treatment and services, consistent with professional standards of practice to promote healing for two residents (#7, #109) of six resulting in the potential delay of healing of pressure ulcers. Findings Included: Resident #7 (R7) Review of the medical record revealed R7 was admitted to the facility on [DATE] with diagnoses of paraplegia (paralysis of legs and lower body), chronic obstructive pulmonary disease, iron deficiency anemia secondary to blood loss, stage 4 pressure ulcer to left hip, stage 4 pressure ulcer to right buttock, stage 4 pressure ulcer to right hip, thrombocytopenia (low platelets in blood), injury at T-2 to T-6 level of thoracic spinal cord, abnormal posture, muscle wasting atrophy, muscle weakness, protein-calorie malnutrition, peripheral vascular disease, hypertension (high blood pressure), major depressive disorder, neuralgia (pain along nerves) and neuritis (inflammation of peripheral nerves causing pain), gastro-esophageal reflux (heart burn), flaccid neuropathic bladder, peripheral vascular disease, acute hepatitis C, and neuromuscular dysfunction of the bladder. R7's most recent Minimum Data Set (MDS) with the Assessment Review Date (ARD) of 12/25/2021 was not assessed. During observation and interview on 01/20/2022 at 03:03 p.m. R7 was laying in bed. R7 was alert to time, place, and person. R7 explained that the facility staff do not complete her wound care as the physician has ordered and sometimes it does not get completed at all. Review the medical record revealed R7 currently has one stage 4 pressure ulcer on her coccyx, one stage 4 pressure ulcer on her left ischial tuberosity, one stage 4 pressure ulcer on her left trochanter, and one stage 4 pressure ulcer on her right trochanter. Review of R7's physician treatment orders for the right Trochanter pressure ulcer revealed the following: Apply PICO (Negative Pressure Wound Therapy) dressing to right trochanter/hip, place white foam into deeper areas prior to placing PICO to be done every day shift on Tuesday and Friday. This order was initiated on 08/04/2021, rewritten to remain unchanged 10/14/2021, rewritten to remain unchanged 11/06/2021, and discontinued on 1/4/2022. Physician treatment order for right trochanter was changed on 01/04/2022 to cleanse right trochanter with 1/4 strength Dakins, apply 1/4 inch Iodoform packing strips into wound leaving a tail outside of wound, cover with foam dressing to be completed two times per day. Review of R7's physician treatment orders for the left ischial tuberosity pressure ulcer revealed the following: Cleanse Left ischial/lower buttock, apply skin prep, cover with foam dressing every day. This order was written 08/04/2021 and discontinued 01/05/2022. Physician treatment order for the left ischial tuberosity pressure ulcer was changed on 1/5/2022 to cleanse Left ischial/lower buttock with soap and water, pat dry, leave to open air, to be done every day shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R7's physician treatment orders for the left trochanter pressure ulcer revealed the following: Cleanse left trochanter/hip pack with 1/4 inch iodoform packing strips (leave tail outside of wound) cover with foam dressing to be done every day shift. This order was initiated on 08/04/2021 and discontinued on 1/26/2022. Physician treatment order for the left trochanter pressure ulcer pressure ulcer was changed 1/26/202 to cleanse Left ischial/lower buttock with soap and water, pat dry, leave to open air, to be done every day shift. Review of R7's physician treatment orders for the coccyx pressure ulcer revealed the following: cleanse sacrum, apply skin prep, cover with foam dressing every day shift. This order was initiated 08/04/2021 and remained unchanged at time of survey ext. Review of R7's treatment administration records (TAR) revealed the dressing changes for the left ischial tuberosity pressure ulcer were not completed on 10/04/2021, 10/18/2021,10/27/2021,10/29/2021,10/30/2021, 11/04/2021,11/20/2021,11/22/2021,11/29/2021,12/01/21, 12/25/2021,12/26/2021,01/02/2022, 01/05/22, 01/07/2022, 01/10/2022, and 01/14/2022. No justification was provided in the medical record as to why the dressing changes were not completed. Review of R7's TAR revealed the dressing changes for the left trochanter pressure ulcer were not completed on 10/14/2021, 10/18/2021, 10/27/2021, 10/29/2021, 10/30/2021, 11/04/2021, 11/20/2021, 11/29/2021, 12/1/2021, 12/25/2021, 12/26/2021, 01/02/2022, 01/07/2022, 1/10/2022, 1/14/2022, and 01/17/2022. No justification was provided in the medical record as to why the dressing changes were not completed. Review of R7's TAR revealed the dressing changes for the ulcer on the coccyx pressure ulcer were not completed on 10/04/2021, 10/18/2021, 10/27/2021, 10/29/2021, 10/30/2021, 11/4/2021, 11/20/2021, 11/22/2021, 11/29/2021, 12/01,2021, 12/25/2021, 01/02/2022, 1/14/2022, and 1/17/2022. No justification was provided in the medical record as to why the dressing changes were not completed. Resident #109 (R109) Review of the medical record revealed Resident #109 (R109) was admitted to the facility 06/02/2020 with diagnoses of cellulitis of left upper limb, rhabdomyolysis (muscle breakdown as a result of protein into the blood), chronic pain, polyneuropathy (malfunction of peripheral nerves), anxiety, hyperlipidemia (excessive fats in blood), alcohol dependence, major depression, abnormal weight loss, pressure ulcer of right heel, contracture of right knee, muscle wasting, insomnia, and history of falls. R109 most recent Minimum Data Set (MDS) with the Assessment Review Date (ARD) of 11/20/2021 revealed a Brief Interview for Mental Status (BIMS) of 13 (intact cognitive response) out of 15. R109 was transferred to the hospital on 12/27/2021. Review the medical record revealed R109 has one stage 4 pressure ulcer on his right heel. Review of R109's physician treatment orders for the right heel pressure ulcer revealed an order to cleanse right heel, apply collagen to wound bed (Collogen must be moistened) cover with border gauze every day shift. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R109's treatment administration records (TAR) revealed the dressing changes for the right heel pressure ulcers were not completed on 12/01/2021, 12/05/2021, 12/15/2021, 12/24/2021, 121/25/2021, and 12/26/2021. No justification was provided in the medical record as to why the dressing changes were not completed. In an interview on 01/27/22 09:54 a.m. with Registered Nurse (RN) BB was asked if she had knowledge that all R7's treatments were not being completed as ordered? RN BB explained that she is not aware of specific days treatments were not completed. RN BB further explained that she only knows of percentage of treatments not completed facility wide, which is reported through Point Click Care (facility electronic medical record system) dashboard. RN BB offered no explanation as to why treatments would not have been done as ordered. No further information was provided by time of survey exit. In an interview on 02/01/2022 at 02:58 p.m. Nurse Manager O was asked to review R109's medication administration record. Nurse Manager O confirmed that treatments were completed certain specific days. Nurse Manager O could not answer why treatments would not have been completed. No further information was provided by time of survey exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 This citation pertains to MI00124642. Based on observation, interview and record review, the facility failed to 1) formulate effective interventions to prevent falls for three (Resident #38, #111 and #117) of 13 reviewed for accidents; and 2) perform smoking assessments for two (Resident #7 and #62) of 13 reviewed for accidents, resulting in the potential for continued falls, major injury, unsafe smoking practices and smoking hazards. Findings include: Resident #38 (R38): Review of the medical record reflected R38 was admitted to the facility on [DATE], with diagnoses that included fibromyalgia, malignant neoplasm of unspecified part of bronchus or lung, personality disorder, attention deficit hyperactivity disorder and adult failure to thrive. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/21, reflected R38's cognition was not fully assessed. The same MDS reflected R38 required limited to extensive assistance of one person for activities of daily living. The Quarterly MDS, with an ARD of 12/22/21, reflected short-term and long-term memory were not assessed, and the Brief Interview for Mental Status (BIMS- a cognitive screening tool) score was 99 (unable to complete the interview). On 1/20/22 at 2:26 PM, R38 was observed lying in bed. Their bed was in a low position, and an over-bed table was near the right bedside. R38 was observed to have one bare foot and a sock on their other foot. Review of R38's Activities of Daily Living (ADL) Care Plan reflected it was initiated on 9/14/21. The focus area reflected, The resident has potential for an ADL self-care performance deficit r/t [related to] fibromyalgia & malignant neoplasm. Interventions included: -Encourage the resident to use bell to call for assistance (initiated 9/14/21) -Monitor/document/report PRN [as needed] any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function (initiated 9/14/21) -BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse (initiated 9/22/21) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	The same Care Plan had one intervention dated for 11/1/21 and all additional interventions were dated for 12/13/21. It was not until 12/13/21 that R38's Care Plan reflected how they performed tasks such as dressing, eating, oral care, personal hygiene and toilet use. R38's Fall Risk Evaluation, dated 9/14/21, reflected a score of 14, which indicated a high risk for falls. R38's Care Plans reflected a potential risk for falls related to medications and chronic disease processes. The Care Plan was initiated 9/14/21, however, their only interventions until 10/22/21 reflected: -Anticipate and meet the resident's needs (initiated 9/14/21) -Ensure footwear fits properly (initiated 9/22/21) An Incident report for 10/22/21 at 2:15 PM reflected R38 had a fall outside while smoking when supervised. R38 caught themselves on a fence to prevent the fall. The report reflected shoes were in place, and there were no injuries. R38 was re-educated to use their walker when going to activities. The report reflected R38 was oriented x3 before and after incident. The report section titled, Investigate did not include any documentation. The report reflected there were no investigative statements or staff interviews. R38's Care Plan intervention, dated 10/22/21, reflected R38 was educated to use their walker when out on activities. An Incident Report for 10/27/21 at 9:30 AM reflected R38 fell while ambulating (walking) in the bathroom. R38 was last observed at 9:00 AM, positioned correctly, sitting in bed. The report reflected the fall was witnessed, and R38 sat on the floor in the bathroom. According to the report, R38 had non-skid footwear was in place, R38's bed was in a low position, and their call light was in reach. There were no injuries. The report reflected R38 had poor safety awareness and was oriented x2 before and after the incident. The report section titled, Investigate did not include any documentation. The report reflected there were no investigative statements or staff interviews. R38's Care Plan intervention, dated 10/27/21, reflected they were re-educated on the use of their call light for assistance. An Incident report for 11/28/21 at 4:31 PM reflected R38 had an unwitnessed fall while ambulating in their room. R38 was last observed at 4:00 PM, sitting on their bed, positioned correctly, with their call light in reach. R38 was found sitting on the floor, next to their roommates bed. R38 had non-skids socks on, their call light was in reach and their bed was in a low position. There were no injuries. The report reflected R38 was oriented x1 before and after the incident. The report reflected the intervention was to re-educate the resident on call light use. The report section titled, Investigate did not include any documentation. The report reflected there were no investigative statements or staff interviews. R38's Care Plan intervention, dated 11/28/21, reflected re-education on the use of a walker and asking for assistance. A resolved intervention, dated 11/28/21, reflected re-education to use the call light and ask for assistance. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	An Incident Report for 12/10/21 at 9:36 PM reflected R38 had an unwitnessed fall while ambulating in the corridor/hallway. R38 was last observed at 9:00 PM and was in bed, positioned correctly with the call light in reach. R38 was observed sitting on the floor in the hallway with non-skid socks on. There were no injuries. The report reflected the intervention was to continue to encourage the resident to ask for assistance. The report reflected R38 was oriented x1 before and after the incident. The report section titled, Investigate did not include any documentation. The report reflected there were no investigative statements or staff interviews. R38's Care Plan intervention, dated 12/10/21, reflected to continue to encourage R38 to ask for assistance. An Incident Report for 12/18/21 at 9:19 PM reflected R38 had a witnessed fall while ambulating in the hallway/corridor. The report reflected the resident was last observed at 8:30 PM, resting in bed, positioned correctly, with call light in reach. R38 was observed sitting on the floor in the hallway with non-skid socks on. There were no injuries. The report reflected an intervention to re-educate on the use of a walker and asking for staff assistance. The report reflected R38 was oriented x3 before and after the incident. The report section titled, Investigate did not include any documentation. The report reflected there were no investigative statements or staff interviews. R38's Care Plan was not reflective of a new intervention. An Incident Report for 12/31/21 at 10:30 AM reflected R38 had an unwitnessed fall while ambulating their room. R38 was last observed at 10:30 AM, lying in bed, positioned correctly, with the call light in reach and the bed in a low position. R38 was observed lying on the floor, on their right side, by their bed, wearing non-skid socks on. There were no injuries. The report reflected the intervention was to educate the resident to use a wheelchair for ambulation. The report reflected R38 was oriented x1 before and after the incident. The report section titled, Investigate reflected, .Administrator review, nursing assessments, care plan updated, [Director of Nursing], Physician and family notified. The report reflected there were no investigative statements or staff interviews. R38's Care Plan intervention, dated 12/31/21, reflected re-education on the use of a wheelchair for ambulation. An Incident Report for 1/14/21 at 7:30 PM reflected R38 fell while ambulating in their room. The fall was witnessed by R38's roommate. R38 was last observed at 6:15 PM, lying in bed, positioned correctly, with the call light in reach. R38 was observed sitting on the floor near their bed, with non-skid socks in place. There were no injuries. The report reflected an intervention to monitor for safety and continue to reeducate. The report reflected R38 was oriented X2 before and after the incident. The report section titled, Investigate reflected R38 was non-compliant with interventions for safety. There were no investigative statements. A staff interview reflected an interview with R38's roommate, where it was reported that R38 got up and was told by their roommate to sit back down or they would fall. R38 sat down on the floor, and their roommate called for the nurse. R38's Care Plan did not reflect a new intervention. During an interview with Director of Nursing (DON) B and Unit Manager (UM) D on 2/1/22 at 4:56 PM, it was reported that R38 had several falls and was very determined to do things on their own. It was reported they continued to educate R38. In addition, R38 had been changed from a wheelchair to a walker, had a low bed and floor mats at the bedside. When asked if education was effective for R38, DON B reported R38 had a BIMS of 15 (cognitively intact), but it had recently changed. DON B stated the best they could do was place floor mats to prevent injury. When asked where a root cause analysis could be located, DON B stated it was sometimes in the incident report and in the medical record. A root cause would be at the end of the incident report, under the conclusion for the investigative section. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #111 (R111): Review of the medical record reflected R111 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included displaced intertrochanteric fracture of the left femur, intraarticular fracture of lower end of left radius, chronic obstructive pulmonary disease, muscle weakness and unspecified dementia without behavioral disturbance. The Significant Change in Status/Medicare 5 day MDS, with an ARD of 12/13/21, reflected R111's cognition, memory, mood and potential indicators of psychosis were not assessed. The same MDS reflected R111 did not walk and required supervision to total assistance of one to two or more people for activities of daily living. On 1/20/22 at 11:02 AM, R111 was observed lying in bed with their eyes closed. Oxygen via nasal cannula was in place and running at 2 liters per minute. R111's bed was in a low position, and a fall mat was observed on the floor at the right bedside. R111's call light was clipped to their blankets. On 1/27/22 at 12:15 PM, R111 was observed in bed with their eyes closed. Their bed was in a low position, and their call light was in reach. An over-bed table with a beverage cup was at the right bedside. A Progress Note for 9/27/21 at 6:47 PM reflected R111 had right orbital (area around the eye) bruising and bruising to the bridge of the nose. R111 stated they fell on the floor the night prior. A Progress Note for 9/28/21 at 12:36 PM reflected R111 had right eye bruising and stated they fell but did not tell anyone. An Incident Report for 9/27/21 at 6:00 PM reflected that R111 had an unwitnessed fall in their room during a transfer. According to the report, R111 was last observed at 5:30 PM. The fall was documented as self-reported, and R111 got back in bed independently. R111 sustained a bruise to their right eye. The staff interview section of the report reflected R111's roommate reported R111 rolled out of bed and got up independently. The report reflected R111's cognition prior to and after the incident was oriented x2. R111's Care Plan intervention, dated 9/27/21, reflected a mat was placed at the bedside. A Progress Note for 12/5/21 at 8:24 AM reflected R111 was observed lying on their right side, on the floor of their room. R111's Progress Notes reflected a fall on 12/5/21 with complaints of left hip pain and wrist pain. R111 was sent to the emergency room (ER). A Physician's Progress Note for 12/10/21 at 7:45 AM, reflected, .transferred back from [Hospital] after she was evaluated for left hip pain after she sustained a fall. She was found to have left intertrochanteric fracture. She underwent left cephalmedullary nail .on 12/5/21 .She also had distal radius fracture on the left. She underwent closed reduction in the emergency department with immobilization and sugar tong splint . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	An Incident report for 12/5/21 at 6:45 AM reflected R111 had an unwitnessed fall while ambulating in their room. R111 was last observed and checked and changed at 6:00 AM. They were resting in bed, positioned correctly, with their call light in reach. R111 was observed lying on their right side, next to the window. Their bed was in the low position, non-skid socks were in place, the call light was in reach, and a fall mat was on the floor. The report reflected R111's cognition prior to and after the incident was oriented x1. R111 was admitted to the hospital and sustained fractures of the left hip and left wrist. Fall was behavioral. Will readmit to a room closer to the nurses station and have therapy eval [evaluate]. This was an unpredicted fall. resident [sic] has not had a fall related to getting up from bed and falling while ambulating in the past. Will re-eval [re-evaluate] after readmission . R111's Care Plan interventions, dated 12/6/21, reflected to move their room closer to the nurses station upon readmission and for therapy to re-evaluate. During an interview on 1/27/22 at 3:00 PM, Certified Nurse Aide (CNA) CC reported R111 had a mat on the side of the bed and a low bed. CNA CC reported not knowing which side of the bed R111's floor mat was to be on. CNA CC stated they changed the floor mat to the side of the bed that R111 was laying on. R111 did not use their call light and hollered out, according to CNA CC. During a phone interview on 2/1/22 at 12:46 PM, Licensed Practical Nurse (LPN) GG reported R111's fall happened at shift change. R111 had slept all night, and there were no problems on their shift. LPN GG stated R111 was getting up or whatever they were doing and fell in their room. R111 typically walked around independently but was not allowed to do so. If staff saw R111 up, they would put them back to bed. In regards to determining interventions after falls, LPN GG reported for most residents, they made sure the bed was in the lowest position and a floor mat was at the bedside. If a resident moved around by themselves most of the time, they made sure the bed was in a low position/close to the floor. When asked if they attempted to determine why a resident was up or what they were trying to so, LPN GG stated residents always wanted to get up, even though you tell them they should go back to bed. Residents just wanted to get up and move around, even though staff tried to redirect them. Resident #117 (R117): Review of the medical record reflected R117 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included rheumatoid arthritis, chronic obstructive pulmonary disease, hypertension and diabetes. The Admission MDS, with an ARD of 11/8/21, reflected R117 scored 13 out of 15 (cognitively intact) on the BIMS. The same MDS reflected R117 was coded for supervision level with physical assistance of one to two or more people for activities of daily living. R117's bathing was coded for total dependence of one person assist. Review of the medical record reflected R117 was discharged from the facility on 11/29/21, with a return anticipated. R117's Fall Risk Evaluation, dated 11/4/21 and locked on 11/30/21, reflected a score of 18, which indicated a high risk for falls. A Progress Note for 11/4/21 at 5:39 PM reflected R117 had limited upper extremity (arm) mobility, lower extremity (leg) weakness and was legally blind. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	A Progress Note for 11/4/2021 at 11:01 PM reflected R117 had highly impaired vision, near blindness and wore glasses. R117's Care Plans did not include an ADL Care Plan or R117's fall risk upon admission. R117's Care Plan with a focus area of being at risk for falls related to weakness was initiated on 11/30/21, after R117 had a fall and was discharged to the hospital. The care planned intervention, dated 11/30/21, reflected to anticipate and meet the resident's needs. A Progress Note for 11/29/21 at 4:10 PM reflected R117 was found lying on the ground in the hallway at 3:30 PM. R117 reported falling hard on their head and having a lot of head and back pain. R117 requested to go to the hospital. R117 left for the hospital at 4:10 PM. An Incident Report for 11/29/21 at 3:30 PM reflected an unwitnessed fall in the hallway/corridor while ambulating. R117's cognition prior to and after the incident was oriented x3. The report reflected R117 was last observed at 2:00 PM, sitting on the edge of the bed, with their call light in reach. The fall type reflected, Fall caused by patient intent or behavior. According to the report, R117 had non-skid socks, their bed was in the lowest position and their call light was in reach. The report section titled, Investigate did not include any documentation. The report reflected there were no investigative statements or staff interviews. There was no documentation pertaining to root cause analysis During an interview with DON B and UM D on 2/1/22 at 4:56 PM, it was reported if a resident was assessed to be a high fall risk upon admission, they automatically used a low bed, they were oriented to the room and call light, personal items were in reach, and they were provided with non-skid socks. DON B reported those items were generally care planned but was unsure why they had not been for R117. DON B reported they normally conducted a root cause analysis, but R117 discharged to the hospital and never returned, so they did not have the opportunity. The facility policy titled, Fall Evaluation Safety Guideline, with an effective date of 11/28/17, reflected, .A fall evaluation is used to identify individuals who have predicting factors for falls .Fall prevention is achieved through an IDT [interdisciplinary team] . approach of managing predicting factors and implementing appropriate interventions to reduce risk for falls .Understanding contributing and predicting factors that present will assist with determining individualized care approaches .Residents who are evaluated as being at risk for falls will be identified and individualized fall precautions will be developed for each resident. Preventative measures shall be taken to decrease the number of falls whenever possible .A Fall Risk Evaluation will be completed .If the evaluation finds the resident at risk, implement resident specific interventions/precautions .Initiate, review and revise the fall care plan as appropriate, with new or discontinued interventions .The Interdisciplinary team (IDT) will evaluate the resident's fall risk in conjunction with the care plan to develop, review and revise at a minimum quarterly with increased frequency as needed to reduce resident falls .The IDT will evaluate the effectiveness of the individualized interventions .All residents identified as at risk for falls will be reviewed for individualized interventions .Post Fall Action .Root Cause Analysis-Determine causal factors of fall .Evaluate effectiveness of interventions . 45038 Resident #7 (R7) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the medical record revealed R7 was admitted to the facility on [DATE] with diagnoses of paraplegia (paralysis of legs and lower body), chronic obstructive pulmonary disease, iron deficiency anemia secondary to blood loss, stage 4 pressure ulcer to left hip, stage 4 pressure ulcer to right buttock, stage 4 pressure ulcer to right hip, thrombocytopenia (low platelets in blood), injury at T-2 to T-6 level of thoracic spinal cord, abnormal posture, muscle wasting atrophy, muscle weakness, protein-calorie malnutrition, peripheral vascular disease, hypertension (high blood pressure), major depressive disorder, neuralgia (pain along nerves) and neuritis (inflammation of peripheral nerves causing pain), gastro-esophageal reflux (heart burn), flaccid neuropathic bladder, peripheral vascular disease, acute hepatitis C, and neuromuscular dysfunction of the bladder. R7's most recent Minimum Data Set (MDS) with the Assessment Review Date (ARD) of 12/25/2021 was not assessed. During observation and interview on 01/20/2022 at 02:34 p.m. R7 was laying in bed. R7 was alert to time, place, and person. R7 explained that she did smoke but only five or six times per month. She also explained that she performs her own ADLS. Review of the medical record revealed that R7 was an independent smoker as identified in her plan of care focus statement (revised 01/08/2022). The medical record further revealed that the facility completed R7's smoking assessment on 04/1/2021 and 09/15/2021. Both smoking assessments identified R7 to have an assessment score of 0.0, which delineated her as a safe independent smoker. Resident #62 (R62) Review of the medical record revealed R62 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis, bipolar disorder, unsteadiness on feet, weakness, muscle weakness, hypokalemia (below normal potassium in blood), attention deficit hyperactivity disorder, tremors, and schizophrenia. During observation and interview on 01/20/2022 at 12:33 p.m. R62 was laying in bed and pleasant during conversation. R62 explained that he smoked and would go outside independently. Review of the medical record revealed that R62 was an independent smoker as identified in his plan of care focus statement (revised 1/26/2022). The medical record further revealed that the facility completed R62's smoking assessments on 01/28/2021, 04/28/2021, 09/15/2021, and 09/30/202. The smoking assessments completed on 04/28/2021 and 09/15/2021 identified R62 to have an assessment score of 2.0 (unsafe to smoke independently). The smoking assessments completed on 1/28/2021 and 09/30/2021 identified R62 to have an assessment score of 0.0, which delineated him as a safe independent smoker. Document review of the facility provided policy Smoking Guideline (effective date 11/28/2017) revealed that procedure number two states: The evaluation is to be used at the time of admission, annually, with quarterly review, and with change of condition. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 01/26/2021 at 01:10 p.m. the Director of Nursing (DON) B was questioned what the policy was concerning resident smoking assessment and the time that those assessments were to be completed. DON B explained that it was policy that resident smoking assessments be completed on admission, every quarter, and if there is a change in the resident's condition. DON B also explained that she had identified this issue through a Quality Assurance process earlier in the year. When this surveyor identified that R7 and R62 did not have current quarterly resident smoking assessments completed DON B confirmed that the smoking assessments for R7 and R62 had not been complete. When questioned if the facility was compliant with the current policy DON B explained that the facility was not currently compliant.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 This citation pertains to MI00124642. Based on interview and record review, the facility failed to ensure ileostomy (a surgical opening that connects the small intestines to the abdominal wall) monitoring for one (Resident #117) of one reviewed for ileostomy care, resulting in the potential for skin impairment and infections. Findings include: Review of the medical record reflected R117 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included rheumatoid arthritis, chronic obstructive pulmonary disease, hypertension and diabetes. The Admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/8/21, reflected R117 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The same MDS reflected R117 was coded for supervision level with physical assistance of one to two or more people for activities of daily living. R117's bathing was coded for total dependence of one person assist. Review of the medical record reflected R117 was discharged from the facility on 11/29/21, with a return anticipated. R117's Admission MDS, with an ARD of 11/8/21, reflected coding for an ostomy [a surgical opening that allows stool or urine to leave the body]. The MDS was completed, locked and accepted on 12/14/21 (after R117 discharged from the facility). A Progress Note for 11/4/2021 at 11:01 PM reflected R117 had ostomy skin irritation. R117's Admission Skin Assessment, dated 11/4/21, reflected an ostomy to the right lower quadrant of the abdomen. There were no weekly skin observations documented for R117. During an interview on 1/27/22 at 9:44 AM, Registered Nurse (RN) BB reported the Skin Observation in the Evaluations tab of the EMR was conducted weekly. RN BB reported they were not documented anywhere else besides the Evaluations tab of the EMR. Certified Nurse Aides (CNAs) were to check and chart on skin daily, and the nurse was to do weekly skin observations. Review of the facility policy, titled, Skin Protection Guideline, with an effective date of 7/7/21, reflected, . Monitoring of Skin Integrity .Skin will be observed daily during care by the nursing assistants .Weekly skin observation by a licensed nurse .This may be completed during a scheduled shower or bath day and/or as determined by preference through the care planning process . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician Progress Note for 11/5/21 at 7:07 AM reflected R117 had been in the hospital after presenting to the emergency room due to difficulty with ileostomy treatment.She has had several parastomal skin changes and irritations. She reports that in the last 24 hours she has changed her stoma six times and she was admitted to the hospital for further care .Ostomy care. She will need followup with the wound care team here to see that this is make sure [sic] that is healing. She did have some minor erythema [redness], but it is now healing and there is no drainage noted . A Progress Note for 11/5/21 at 3:00 PM reflected that R117 would not be followed by the wound team. A Progress Note for 11/8/21 at 12:48 PM reflected R117 was admitted to the facility following hospitalization related to ostomy concerns. A Nurse Practitioner Note for 11/9/21 at 7:38 PM reflected, .Patient recently discharge [sic] from hospital due to difficulty with ileostomy treatment and concern for personal safety at home. Patient states she has had her ostomy for about 40+ years and is able to care for it on her own . A State Agency document reflected there had been times that R117's ileostomy leaked, and they sat in feces and fluids for hours. R117's Care Plan with a focus of, The resident has an ostomy to RLQ [right lower quadrant] was initiated 11/4/21. The Care Plan included one intervention, which was dated 11/4/21, to monitor for signs or symptoms of pain with ostomy or stools and notify the physician as needed. R117's Care Plans were not reflective of an ADL Care Plan. R117's Kardex [CNA care guide] was not reflective of ADL care or their ileostomy status/care. R117's Physician's Orders were not reflective of ileostomy care. A Physician's Order, dated 11/4/21, reflected, Wound Care Nurse may evaluate and treat. Has RLQ ostomy. Per [hospital] was treating area with miconazole upon dressing changes. Also has non-pressure related scab on R [right] buttock. R117's medical record did not reflect ileostomy care on their Medication Administration Record (MAR) or Treatment Administration Record (TAR). There were no provisions for changing the appliance, monitoring of the stoma (a surgical opening in the skin) or surrounding skin or emptying the ileostomy bag/pouch. Director of Nursing (DON) B and Unit Manager (UM) D were queried on ileostomy care standards during an interview on 2/1/22 at 4:56 PM. UM D reported the CNAs would clean the ileostomy bag if it was full. If it needed to be changed, the nurse would do that. UM D then reported R117 was big on changing their own ileostomy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled, Colostomy, Urostomy or Ileostomy Care, with an effective date of 6/29/21, reflected, . Purpose: To ensure residents who require colostomy, urostomy or ileostomy services receive care consistent with professional standards of practice and person-centered goals and preferences .A resident that does not have the ability secondary to cognitive or functional deficits should have a plan of care developed for the evaluated determined support and assistance .Change the ostomy pouches when they are 1/3 - 1/2 full to avoid leakage, which can lead to chemical or enzymatic injury to the skin .Observe pouch for leakage and length of time in place .pouch should be changed every 3 to 7 days .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30337 This citation pertains to intake MI00123957. Based on observation, interview, and record review, the facility failed to provide accurate reconciliation and accounting for all controlled medication and disposition of medications, in 3 of 30 reviewed for medications (Resident #24, #53 and #110), resulting in the potential for adverse consequences, unmet needs and medication errors. Findings include: Resident #53 (R53) During an observation and interview on 1/13/22 at 2:40 PM R53 stated he was concerned he did not always receive his medications as ordered. R53's 12/13/21 Minimum Data Set (MDS) indicated he was admitted to the facility on [DATE] and had a Brief Interview for Mental Status (BIMS), a short performance-based cognitive screener for nursing home (NH) residents, score of 11 (Scale: 08-12 Moderate Impairment). R53 was admitted to the facility with prescriptions from the hospital for Gabapentin 300 milligrams (mg), 2 tabs (600 mg) three times a day (nerve pain), Ativan 0.5 mg three times a day as needed for anxiety, and Oxycodone-Acetaminophen 10-325 mg every 6 hours as needed for pain. In review of R53's October 2021 Medication Administration Record (MAR) Gabapentin was transcribed as 300 mg three times a day, and Ativan 0.5 mg was transcribed as three times daily, not as needed. During an interview on 1/26/22 at 3:24 PM Director of Nursing (DON) B stated there were no medication error reports for R53 during his nursing home stay. DON B was interviewed on and was unable to provide an documentation as why R53's orders for Gabapentin and Ativan were changed upon admission. Pharmacy Packing Slip indicated on 10/17/21 the following medications were delivered for R53: 6 tablets of Ativan 0.5 mg, 8 tablets of Oxycodone-Acetaminophen 10-325 mg, 14 tablets of Gabapentin 300 mg, and 6 tablets of Methadone. R53's Medication Monitoring/Control Record's were requested beginning on 10/17/21, there was no control records for Ativan, Gabapentin, Methadone, or Oxycodone-Acetaminophen from the 10/17/21 pharmacy delivery. In review of R53's October 2021 Medication Administration Record (MAR) Gabapentin was increased to 600 mg three times a day. There was no rationale in the record as to why Gabapentin was increased. Pharmacy Packing Slip dated 10/20/21 indicated 45 tablets of Gabapentin was received for R53. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R53's Medication Monitoring/Control Record for Gabapentin, dated 10/20/21, quantity 30, medication was first signed out at 9:00 PM. The same record indicated R53's 6:00 AM dose of Gabapentin was not documented on the record. The same record indicated R53 received one 300 mg tablet of Gabapentin, instead of 600 mg as ordered on: 10/21/21 at 9:23 PM, 10/23/21 at 2:00 PM, 10/24/21 at 2:00 PM and 9:00 PM, 10/26/21 at 1:00 PM. R53's Medication Monitoring/Control Record for Gabapentin, dated 10/20/21, quantity 15, reflected 12 of the 15 tablets were signed out, there were two tablets left on the record, however the two tablets were unaccounted for. During an interview on 1/27/22 at 9:49 AM DON B stated she wasn't aware of the disposition of the two Gabapentin tablets, but they were likely administered to R53. Pharmacy Packing Slip indicated on 10/30/21, 90 tablets of Gabapentin was received for R53. Review of R53's Medication Monitoring/Control Records indicated only 60 of the 90 tablets of Gabapentin were accounted for. Pharmacy Packing Slip indicated on 10/17/21 6 tablets of Lorazepam 0.5 mg, were delivered for R53. The facility did not have any Medication/Control Records for the six Lorazepam tablets. R53's October 2021 MAR reflected Lorazepam 0.5 mg was ordered at 8:30 AM, 2:00 PM and 8:00 PM. In review of R53's Medication Monitoring/Control Record for Lorazepam 0.5 mg, Lorazepam was signed out on 10/22/21 at 7:00 AM, 8:30 AM, 2:00 PM, and 8:00 PM; the 7:00 AM dose was not documented on R53's MAR or anywhere else in his medical record. 10/24/21 Lorazepam was signed out on the Medication Monitoring/Control Record at 7:00 AM, no time documented with one dose signed out, 2:00 PM and 9:00 PM; the 7:00 AM dose was not recorded on R53's MAR. 10/25/21 Lorazepam was signed out on the Medication Monitoring/Control Record at 6:00 AM; the 6:00 AM dose was not recorded on R53's MAR. R53's MAR on 10/25/21 at 8:30 AM indicated the dose was not administered, and to see nurses notes; there was no nursing notes found on 10/25/21. On 10/29/21, 10/30/21, and 10/31/21 Lorazepam was signed out on the Medication Monitoring/Control Record at 6:00 AM, 8:30 AM, 2:00 PM, and 8:00 PM; the 6:00 AM dose was not recorded on R53's MAR. On 11/03/21, 11/05/21, 11/07/21, 11/08/21, 11/13/21, and 11/19/21 Lorazepam was signed out on the Medication Monitoring/Control Record at 6:00 AM and was not documented on R53's MAR. On 11/29/21 Lorazepam was signed out twice at 9:00 PM on the Medication Monitoring/Control Record and was not documented on R53's MAR. R53's Medication Monitoring/Control Record on 12/06/21 indicated Lorazepam was signed out at 6:00 AM, 8:26 AM, 2:00 PM and 9:30 PM. The 6:00 AM dose was not documented on R53's MAR or on any documentation in his medical record to account for the Lorazepam dose removed at 6:00 AM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Medication Monitoring/Control Record indicated R53's Lorazepam on 12/15/21 at 7:30 PM, there were 26 tablets remaining. The next 2 doses removed on the same record was left blank under name of person giving, and R53 was left with 24 tablets. On 12/19/21 Lorazepam was signed out at 6:00 AM, 7:48 AM, 1:00 PM and 9:00 PM; the 6:00 AM dose was not documented on R53's MAR or anywhere else in his EMR to account for the Lorazepam dose removed at 6:00 AM. On 12/20/21 at 6:00 AM, Lorazepam was signed out at 6:00 AM, and there was no documentation anywhere else in R53's record to account for the administration of the medication. Licensed Practical Nurse (LPN) TT was interviewed on 1/27/22 at 3:18 PM and stated she would normally follow whatever the physician's order was at time and would document right away if medication was removed on the controlled record and MAR. LPN TT did not have an explanation why she signed out Lorazepam at 6:00 AM or 7:00 AM on the control record but not on the MAR, when Lorazepam was ordered at 8:30 AM on: 10/22/21, 10/23/21, 10/24/21, 10/30/21, 11/05/21, 11/07/21, 11/13/21, 11/19/21, 12/06/21 and on 12/19/21. DON B was interviewed on 1/27/22 at 10:15 AM and stated they had a meeting with LPN TT and LPN TT reported that she gave the Lorazepam medication on the dates/times in question to R53 because he was requesting it at 6:00 AM or 7:00 AM and did not document that she administered the medication. On 1/28/22 at 10:50 AM during an interview with R53, he stated did not receive Lorazepam at 6:00 AM or 7:00 AM; and stated he received Lorazepam at 8:30 AM, 2:00 PM, and 8:00 PM. R53 denied he asked for extra Lorazepam, and was more concerned he didn't receive Gabapentin as ordered. Pharmacy Packing Slip indicated on 10/17/2, 8 tablets of Oxycodone-Acetaminophen 10-325 mg were delivered to the facility for R53. R53's Medication Monitoring/Control Record's were requested beginning on 10/17/21, there were no control records for Oxycodone-Acetaminophen from the 10/17/21 pharmacy delivery. R53's October 2021 MAR revealed 4 doses of Oxycodone-Acetaminophen were administered (between 10/17/21 and 10/20/21 prior to 9:00 PM): 10/17/21 at 8:38 PM, 10/19/21 at 1:04 PM, 10/20/21 at 5:59 AM, and 10/20/21 at 12:16 PM. Emergency Drug Kit Slip dated 10/17/21 indicated on dose of Oxycodone-Acetaminophen was removed from the back-up box for R53. A total of 5 doses of Oxycodone-Acetaminophen was unaccounted for between 10/17/21 and 10/20/21. Pharmacy Packing Slip indicated on 10/20/21, 30 tablets of Oxycodone-Acetaminophen 10-325 mg were delivered for R53. R53's Medication Monitoring/Control Record's, that the facility was able to locate, for Oxycodone-Acetaminophen started on 10/20/21 at 9:00 PM. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Oxycodone-Acetaminophen was signed out on R53's Medication Monitoring/Control Record 30 times beginning on 10/20/21 at 9:00 PM and ending on 10/30/21 at 9:00 PM, however was not documented on the October 2021 MAR for 12 doses. In November 2021, Oxycodone-Acetaminophen was signed out on R53's Medication Monitoring/Control Record, but not documented on the November 2021 [DATE] times. Physician Progress Notes dated 11/29/21 10:35 PM revealed R53 was seen for medication refill, he was alert and orientated to person, place and time. R53 reported pain as 8 out of 10 (0 to 10 scale, with 0 being no pain and 10 worst pain) at his stump site that was usually relieved with his ordered pain medications. R53 reported he was upset on that morning because he did not receive some of his medications as ordered. The same not indicated it was explained to R53 that his medications were being refilled and he should get all his medications as ordered. LPN Unit manager (UM) PP was interviewed on 1/27/22 at 2:00 PM, and stated he had only been in the unit manager role for 22 days, prior to his position he worked midnights. UM PP stated he was not aware of medication discrepancies for R53 until this same day due to survey requests. Resident #24 (R24) In review of R24's January 2022 MAR, Gabapentin 400 mg was ordered twice a day at 8:30 AM and 8:30 PM for neuropathy (nerve pain) related to diabetes mellitus. R24's Medication Monitoring/Control Record indicated on 1/22/22 Gabapentin was signed out by LPN S 3 times, at 10:00 AM, 2:00 PM, and 8:00 PM. In review of R24's nurses notes, there was no explanation of why three doses of Gabapentin was signed out instead of two doses that was ordered. LPN S was interviewed on 1/28/22 at 1:22 PM and did not recall why Gabapentin was signed out 3 times on 1/22/22, she stated she had worked a double shift that day. LPN/Unit manager O was interviewed on 1/28/22 at 1:25 PM and stated she was not sure why R24's Gabapentin was signed out 3 times instead of two times on 1/22/22. 32064 Resident #110 (R110) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/27/22 at 2:11 PM, Licensed Practical Nurse (LPN) Q prepared medications to administer to R110. The medications included Gabapentin 600 milligrams (mg) (a controlled substance) and two tablets of 500 mg acetaminophen. It was then determined that R110 was not in the building. LPN Q asked Unit Manager (UM) O to waste medications with her. It was observed that LPN Q and UM O both signed for the wasting of the controlled substance (Gabapentin) and then all three pills were placed in the sharps container which located on the side of the medication cart. When asked about the destruction/wasting of medications, UM O reported medications were wasted in the sharps container. When asked if the facility had a drug buster available, UM O stated, No. In an interview on 1/28/22 at 10:52 AM, Registered Nurse (RN) R reported medications, including controlled substances were wasted by placing the medications inside the sharps container. In an interview on 1/28/22 at 10:08 AM, Director of Nursing (DON) B reported all three medications rooms had a drug buster solution and that's where the medications should be wasted. Review of the facility's Controlled Substance Accountability Guide (undated) revealed For routine destruction, [corporate name] facilities are required to utilize a chemical dissolution drug disposal system, (Rx Destroyer) which is safe and minimizes environmental impact. Review of the facility's Discarding and Destroying Medications Policy revised 10/2014 revealed Destruction of a controlled substance must render it non-retrievable, meaning that the process permanently alters the physical or chemical properties of the substance so that it is no longer available or usable, and cannot be illegally diverted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27306 This Citation Pertains to Intake MI00124964 Based on observation, interview and record review, the facility failed to ensure proper communication/documentation of Hospice services provided for three (Residents #'s 38, 81 and 111) of three residents reviewed for hospice services, resulting in lack of coordination of comprehensive services and care provided. Findings include: Resident #81 According to the clinical record, including the Minimum Data Set (MDS) with an Assessment Reference Date ARD of 10/31/2021 reflected Resident # 81 (R81) was admitted to the facility on [DATE] under hospice care with diagnoses that included, anoxic brain damage, paranoid schizophrenia, depression, anxiety and Covid 19. The MDS reflected R81 had long and short term memory impairment and severely impaired decision making skills. The MDS, with an ARD of 10/31/21, was completed, locked and accepted on 11/18/21. Review of 81's electronic medical record (EMR) revealed R81 was admitted to hospice care 7/23/2019 and was admitted to the facility with hospice care, further review of the EMR revealed the facility did not incorporate care plans that pertained to hospice, and there was no documentation located from any discipline from hospice in R81's EMR. On 01/25/22 at 12:59 PM, Licensed Practical Nurse /Unit Manager (LPN- UM) D was interviewed and reported hospice records, progress notes were all kept in a hospice binder located at the nurses station. Review of the hospice binder located at the nurses station was completed at that time and reflected the last notation from hospice was 12/7/21 which indicated a bed bath was given. The most recent Social Work note from Hospice was dated 10/28/2021, most recent Nursing note was dated 10/26/21. The hospice sign in sheet reflected the last time the Nurse from hospice visited Resident # 81 was 12/30/21, and the most recent Social Work was 12/14/21. There were no progress notes from any discipline from hospice staff in the EMR or the hospice binder. The hospice binder did not provide any type of schedule of when hospice was planning to see R81 or what specific disciplines and services R81 received. LPN- UM D reported there was no schedule or calendar of who was providing what type of hospice service, what days the Nurse or aide from hospice came, if a chaplain or volunteer was involved. LPN-UM D stated the hospice Nurse would check in with her when they visited, (per LPN-UM D no other discipline from hospice sought her out or provided any type of update) LPN -UM D stated she felt comfortable with the process since the Hospice Nurse would check in. When queried how the remaining facility staff including afternoon and midnight staff became updated and informed hospice care and any changes that pertained to R81 and his care, LPN-UM D offered no explanation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/25/22 at 1:15 PM during an interview with Certified Nursing Assistant (CNA) KK she reported she was an agency staff person but worked frequently at the facility, she further reported she was familiar with R81 but was not aware he was a hospice resident. On 02/01/22 at 05:44 PM, during an interview with Director Of Nursing (DON) B lack of coordination of hospice care was discussed , DON B was queried what the expectation with Hospice and coordination of care was, DON B did not respond. 38383 Resident #38 (R38): Review of the medical record reflected R38 was admitted to the facility on [DATE], with diagnoses that included fibromyalgia, malignant neoplasm of unspecified part of bronchus or lung, personality disorder, attention deficit hyperactivity disorder and adult failure to thrive. The Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/22/21, reflected R38's cognition was not fully assessed. The same MDS reflected R38 required limited to extensive assistance of one person for activities of daily living. The Quarterly MDS, with an ARD of 12/22/21, reflected short-term and long-term memory were not assessed, and the BIMS score was 99 (unable to complete the interview). On 1/20/22 at 2:26 PM, R38 was observed lying in bed. Their bed was in a low position, and an over-bed table was near the right bedside. R38 was observed to have one bare foot and a sock on their other foot. R38's medical record reflected they were on hospice as of 9/15/21, however, a hospice Care Plan was not initiated until 10/25/21. The Care Plan did not reflect the services being provided by hospice, the hospice disciplines that were involved in R38's care or the frequency/schedule of hospice visits. During an interview on 1/27/22 at 3:00 PM, Certified Nurse Aide (CNA) CC reported they did not know when hospice was coming. Sometimes hospice staff introduced themselves and stated what they were there for. The day prior, someone from hospice came, and the CNA and nurse did not know it was, according to CNA CC. Review of R38's Hospice Care Coordination Notes reflected a signature line for, Collaborate with Facility Staff Name(s). There was no documentation on that line for Hospice visits on 10/29/21, 10/30/21, 10/31/21, 11/26/21, 12/15/21, 12/22/21 and 1/7/22. During an interview on 1/27/22 at 3:38 PM, Unit Manager (UM) D reported R38's hospice used to provide a calendar of when they were coming for the week. According to UM D the hospice nurse and CNA always checked in with her. If she was not there, they checked in with the floor nurse and provided a paper to report off. Resident #111 (R111): (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medical record reflected R111 was admitted to the facility on [DATE] and was readmitted on [DATE], with diagnoses that included displaced intertrochanteric fracture of the left femur, intraarticular fracture of lower end of left radius, chronic obstructive pulmonary disease, muscle weakness and unspecified dementia without behavioral disturbance. The Significant Change in Status/Medicare 5 day MDS, with an ARD of 12/13/21, reflected R111's cognition, memory, mood and potential indicators of psychosis were not assessed. The same MDS reflected R111 did not walk and required supervision to total assistance of one to two or more people for activities of daily living. On 1/20/22 at 11:02 AM, R111 was observed lying in bed with their eyes closed. Oxygen via nasal cannula was in place and running at 2 liters per minute. R111's bed was in a low position, and a fall mat was observed on the floor at the right bedside. R111's call light was clipped to their blankets. On 1/27/22 at 12:15 PM, R111 was observed in bed with their eyes closed. Their bed was in a low position, and their call light was in reach. An over-bed table with a beverage cup was at the right bedside. R111's Physician's Orders reflected they signed on with hospice on 1/4/22. During an interview on 1/27/22 at 2:51 PM, Licensed Practical Nurse (LPN) FF reported they did not know which hospice company R111 was signed on with. LPN FF reported there was supposed to be a binder behind the nursing desk for hospice residents. LPN FF was not sure which disciplines came from hospice for R111, but that information was in the hospice binder. In regard to if there was a schedule for when hospice would be coming, LPN FF reported they could not depend on that. If a resident needed care, the facility did it. On 1/27/22 at 3:30 PM, R111's hospice binder was reviewed. It included a contact number for hospice, and a Registered Nurse (RN) Case manager card was on the cover of the binder. The binder included Hospice Care RN Notes for 1/13/22, 1/20/22 and 1/24/22. The back pocket of the binder had consents. There were also pages for Nursing, Social Work, Spiritual Care and Home Health, none of which had documentation with them. There was no schedule of hospice visits to be provided. R111's hospice Care Plan was initiated on 1/12/22 and was not reflective of the services being provided by hospice, the hospice disciplines that were involved in R111's care or the frequency/schedule of hospice visits. During an interview on 1/27/22 at 3:38 PM, UM D reported they had not talked to R111's hospice much and assumed hospice spoke to the nurse or the Social Worker. When asked how they knew the frequency of hospice visits and the disciplines involved, UM D reported there may have been something in R111's chart. UM D looked in R111's hospice binder and reported they did not know (the hospice visit schedule) but would find out. During an interview on 2/1/22 at 4:56 PM, UM D reported they wrote R111's hospice schedule on a piece of paper after speaking to hospice about the schedule (after the Surveyor inquiry).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27446 This citation includes to intake MI00123905. Based on observation, interview, and record review the facility failed to properly prevent and contain Covid 19 infections for 39 residents (Resident #94, 100, 20, 75, 64, 266, 101, 22, 90, 41, 56, 84, 42, 43, 34, 2, 106, 87, 55, 81, 32, 416, 417, 36, 10, 85, 112, 11, 102, 31, 5, 70, 418, 264, 48, 104, 17, 38, 96) out of 114 residents, resulting in Immediate Jeopardy when the facility failed to appropriately implement infection control and prevention measures to control the spread of Covid 19, failed to properly cohort and isolate Covid 19 positive residents from Covid 19 negative residents (Resident #63, 414, 49) and 39 residents were identified to have tested positive for Covid 19 between the dates of 1/3/2022 and 1/21/2022 leading to Immediate Jeopardy. Findings Include: In an interview on 1/12/2022, at 1:38 PM, Infection Control Preventionist (ICP) C stated that she used a tracking tool to track Covid 19 residents and staff. ICP C stated she did not have any documentation of any audits, nor had identified the root cause for the recent spread of covid 19 infections in the facility. ICP C said she did perform donning and doffing (placing on and off respectively) of personal protective equipment (PPE) observations of the facility staff however, ICP C stated she did not have any documentation of those audits. ICP C said the only things she had implemented to stop the spread of the current Covid 19 outbreak was staff education and monitoring of resident vital signs and respiratory assessments. In another interview on 1/13/2022, at 10:58 AM, ICP C stated that when residents were tested for Covid 19 she was required to read the Covid 19 test results, but another nurse would document the results on a document that was then given to her and placed on her desk. S ICP C as not able to provide information or documentation of actions put into place for residents and/or staff who tested positive for Covid 19. ICP C stated that she referred to the Centers for Disease and Prevention (CDC) for the policies and procedures (PP) for Covid 19. Record review of the facility's Policy/Prodedure for Covid 19, titled Infection Prevention and Control Interim Guideline for Suspected or Confirmed Coronavirus (COVID-19), dated 3/26/2020 and revised on 12/27/2021, revealed under, Monitoring Activities and Surveillance, The following activities should be completed by the IP/designee (ICP): Record-keeping of the above activities to include mapping the area in the facility where symptoms are being identified, Review of PPE equipment that is currently available, with reordering items as necessary (eye/face shields, gowns, gloves, masks), Random observations of hand hygiene by staff to ensure appropriate technique is used, Random observations of staff donning/doffing appropriate PPE (standard, contact, and/or droplet),Random observations of environmental cleaning with approved EPA products of the high-touch areas (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In an observation on 1/26/2022, at 9:12 AM, Maintenance Assistant (MA) I was observed arriving at room [ROOM NUMBER] with a bed mattress on a wooden cart that also had a sheet on it. MA I was observed to place the mattress on its side onto the floor in the doorway of room [ROOM NUMBER] with no protective barrier between the mattress and the floor. room [ROOM NUMBER] was observed to be an isolation room that also had an over the door hanging pockets that contained PPE, including gloves and gowns. MA I was observed to enter room [ROOM NUMBER] with only an N95 mask and googles on. MA I did not put gloves or a gown on prior to entering room [ROOM NUMBER]. MA I was then observed to spray a cleaner onto the top of the mattress that was on a bed in room [ROOM NUMBER] next to the door were a resident had resided that tested positive for Covid 19 and had been recently moved to the fourth floor. MA I was then observed to remove the mattress from the bed, leave the room, did not wash, or sanitize his hands and placed the mattress on the wooden cart. MA I did not clean the sides or the bottom of the mattress and did not clean or sanitize the bed frame or anything else in the area of the bed situated by the room door. MA I was then observed to pick up the mattress that was on the floor, and re-enter room [ROOM NUMBER], again without donning a gown or gloves, and place the mattress on the bed, then exit room [ROOM NUMBER] without washing or sanitizing his hands. The sheet on the mattress MA I placed on the bed was observation to have dirt from the floor all over the side it. In an observation on 1/26/2022, at 9:21 AM, Certified Nurse Aid (CNA) J was observed to enter room [ROOM NUMBER] to retrieve breakfast trays from two residents who resided in that room. CNA J entered room [ROOM NUMBER] with only an N95 face mask and googles on. CNA J did not don gloves nor a gown prior to entering room [ROOM NUMBER]. CNA J stated that it was his second day back to work in the last two months, and stated that he was instructed by a nurse, who's name he could not recall, on Friday 1/21/2022, that if he was just to delivering food trays into the isolation rooms he only needed to wear goggles/face shields, and an N95 but did not need to don a gown or gloves, because putting gowns on took too long in between each isolation resident room, and the resident's food were getting cold before the trays were delivered. Of note, the observation made was of CNA J removing food trays from room [ROOM NUMBER] at the end of the meal, and not delivering them. CNA J was not observed to have washed or sanitized his hands upon entering or exiting room [ROOM NUMBER]. On 1/13/2022, at 12:19 PM, the Administrator was notified of the Immediate Jeopardy, that was identified on 1/13/2022 and determined beginning on 1/3/2022, when the facility failed to appropriately implement infection control and prevention measures to control the spread of Covid 19, failed to properly cohort and isolated Covid 19 positive residents from Covid 19 negative residents, and 31 residents were identified to have tested positive for Covid 19 between the dates of 1/3/2022 and 1/13/2022. On 1/19/2022 the facility provided an acceptable plan to remove the Immediate Jeopardy as follows: 1). On 01/13/2022 the 7 identified Covid negative residents were moved from the 4th floor and relocated to the non-covid units to prevent the spread of COVID -19 infection. 2). On 01/13/2022 the 14 identified unvaccinated residents who were exposed to positive residents and staff members have been placed under transmission-based droplet precautions. 3). All residents residing in the facility are at potential risk for the spread of infection related to improper PPE utilization. 4). All 113 residents were audited on 01/13/2022 by the Facility Management Team. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	a. The audit consisted of the Management Team assessing all COVID-19 positive and exposed resident as far back as 01/01/2022 when the first staff person was positive for COVID-19. On 01/13/2022 the 85 negative residents were tested for COVID-19. Of the 85 residents tested , 5 residents were positive. 3 of the new positive residents were already on the COVID-19 unit and in droplet precaution related to previous exposure. The 3 remained on the COVID-19 Unit to isolate in place. The other 2 new positive residents were from the second floor and already in droplet precautions related to previous exposure. The 2 residents were moved to the COVID-19 unit to isolate in place per CDC guidelines. 1 roommate on 2nd floor was exposed, but already on droplet precautions and will remain on droplet precautions per the CDC guidelines. 5). All 113 residents were audited by the Facility Management Team. b. The audit consisted of the Management Team reviewing the 14 unvaccinated residents who had exposure to positive COVID-19 residents and staff members as dating back to 01/01/2022 when the first staff person was positive to ensure that proper transmission-based precautions were implemented. 6). An audit of all 45 present employees was completed by 01/13/2022 by the Facility Management Team. c. The audit consisted of the Management Team assessing all facility staff to ensure they were appropriately donning and doffing gowns, and properly using face shields, goggles, and N95 to further prevent the spread of COVID-19 per CDC Guidelines. 7). All residents currently residing in the facility were audited on 01/13/2022 for infection surveillance to identify possible COVID-19 disease before the spread to others in the center. On 01/13/2022 in-service education was initiated for proper PPE utilization, surveillance, mapping and tracking for COVID-19 per CDC guidelines for Villa 107 building staff, including contracted therapy, contracted housekeeping/laundry, and contracted agency members. In-service's education ongoing. 8). On 01/13/2022 the Regional [NAME] President of Clinical Services educated the DON on appropriately cohorting COVID-19 positive and exposed residents per CDC guidelines. 9). On 01/13/2022 the Regional [NAME] President of Clinical Services educated the DON on system surveillance to identify possible COVID-19 disease and infections before they spread to others in the facility, line listing, mapping and tracking. 10). On 01/13/2022 the Regional [NAME] President of Clinical Services educated the DON on properly implementing transmission-based precautions on unvaccinated residents potentially exposed to positive employees and enforce the proper PPE utilization, surveillance, mapping and tracking for COVID-19 per CDC guidelines. 11). On 01/13/2022 the DON immediately in-serviced the ADON/Infection Preventionist on appropriately cohorting COVID-19 positive and exposed residents per CDC Guidelines. 12). On 01/13/2022 the DON immediately in-serviced the ADON/Infection Preventionist on system surveillance to identify possible COVID-19 disease and infections before they spread to others in the facility, line listing, mapping, and tracking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	13). On 01/13/2022 the DON immediately in-serviced the ADON/Infection Preventionist on properly implementing transmission-based precautions for unvaccinated residents exposed to positive employees per CDC Guidelines. 14). In-servicing for all staff was started on 01/13/2022 by the DON/Designee on appropriate use of gowns, goggles, face shields, and N95s. At this point 45 out of 107 have been in-serviced. Facility staff will not be able to work on the units until they have been in-serviced. 15). All new hires will receive training on the facilities practice on Transmission-Based Precautions and the proper use of PPE. 16). Daily monitoring is ongoing for residents and staff related to COVID-19 and testing per CDC guidelines. Although the Immediate Jeopardy was removed on 1/28/22 the facility remained out of compliance at a scope of isolated that is no actual harm with potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance had not been verified by the State Agency. 30337 In an interview on 1/12/2022 at 12:55 PM, Infection Control Preventionist (ICP) C stated Registered Nurse (RN) R called the facility on 1/01/22, reported symptoms of headache and sore throat that began in the morning on 1/01/22, and had tested positive for COVID-19. RN R had last worked at the facility on 12/31/21 and worked on the fourth floor. ICP C reported Resident #36 (R36) had symptoms of shortness of breath, tested positive for COVID-19 on 1/03/22, was transferred to the hospital and returned on 1/05/22; R36 resided on the fourth floor, had two roommates (Resident #10 & #85) that also tested positive for COVID-19 on 1/03/22. ICP C stated there were residents in rooms 406, 407, 410 and 412 that were COVID-19 positive, as of 1/10/22 and sharing the same room with residents negative for COVID-19; and planned to move the negative residents to different rooms on the same date of the interview. Residents in room [ROOM NUMBER] included Resident #22, that tested positive for COVID-19 on 1/10/22 and Resident #63, who was negative for COVID-19. Residents in room [ROOM NUMBER] were Resident #90, that tested positive for COVID-19 on 1/13/22; Resident #42 that tested positive for COVID-19 on 1/10/22; and Resident #264 that tested positive for COVID-19 on 1/18/22. Residents in room [ROOM NUMBER] included Resident #22 that tested positive for COVID-19 on 1/10/22 and Resident #414 that was negative for COVID-19. Residents in room [ROOM NUMBER] included Resident #96 that tested positive for COVID-19 on 1/10/22, Resident #84 that tested positive for COVID-19 on 1/11/22, and Resident #49 that was negative for COVID-19. According to lists provided during survey, the following additional residents tested positive for COVID-19 on 1/03/22: Resident #94, 64, 55, 81, 32, 416, 417, 85, 112, 11, 102, 31, 5, 70, and 418. The following additional residents tested positive for COVID-19 on 1/05/22: #266, 106, and 87. The following additional residents tested positive for COVID-19 on 1/10/22: Resident #101, 20, 75, 42, and 2. The following residents tested positive for COVID-19 on 1/11/22: Resident #41, 56, 84, 43, and 34. Additional Residents tested positive for COVID-19 on 1/13/22: Resident #43, 100, and 104. The following residents tested positive for COVID-19 on 1/18/22: Resident #63 and 17. Residents tested positive for COVID-19 on 1/21/22 were resident #38 and 48. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	In review of Resident #90's medical record, they tested positive for COVID-19 on 1/13/22, a care plan regarding COVID-19 positive status was not initiated until 1/18/22 and a physician's order for droplet precautions on 1/19/22. On 1/20/22 at 11:00 AM Licensed Practical Nurse (LPN) RR was observed standing in the doorway of room [ROOM NUMBER], talking to two residents that had tested positive for COVID-19. LPN RR was observed with her mask down under her nose. LPN RR' was interviewed on the same date and time and stated she used same mask and shield without cleaning when going into a resident's room that had not tested positive for COVID-19/status not confirmed, after providing care for COVID-19 positive residents. 1/20/22 at approximately 11:10 AM Certified Nurse Assistant (CNA) UU was observed donning a gown in the hallway and touched gown on floor when donning, continued to don, tied ties around neck, placed over head and then put arms through the sleeves, then tied around waist. CNA UU was observed wearing an N95 mask and face mask on over top of the N95. In an interview, CNA UU stated staff were instructed to wear both masks. CNA UU stated they put their N95 mask into a brown bag to re-use for a week. Licensed Practical Nurse/Unit Manager PP was interviewed on 1/20/22 at 11:15 AM and stated he didn't instruct staff to clean face shields between caring for residents that do not have the same infection. On 1/21/22 at 12:03 PM, unknown housekeeping staff member was observed coming out of the staff break room with an N95 mask hanging around his neck. Housekeeper staff member donned the N95 mask on face, did not perform hand hygiene and proceeded to get on the elevator. 27306 On 01/12/2022 at 9:45 am during the entrance conference, with Nursing Home Administrator (NHA) A and Director of Nursing (DON) B, it was reported that the 4th floor of the facility was divided in 2 sections with fire doors separating the unit. DON B reported the South side of the 4th floor was where Covid positive residents were residing. On 01/12/22 at 10:35 AM upon exiting the elevator on the 4th floor Licensed Practical Nurse (LPN)RR was observed coming out of the closed fire doors LPN RR was not wearing a gown, proceeded to sit at the common nurses station without performing hand hygiene. When queried about the positive vs negative Covid side of the 4th floor, LPN RR Stated she thought the whole unit was positive for Covid. While standing at the 4th floor Nurses station, LPN/Unit Manager PP was observed entering a room without donning a gown and wearing a cloth mask. Unidentified Nurse on the North side of the 4th floor unit was observed at the medication cart and passed medications without donning a gown this too was observed by LPN/Unit Manager PP whom volunteered he would address Personal Protective Equipment (PPE) with the Nurse. LPN/Unit Manager PP was asked to clarify what NHA A and DON B had reported about the division of the hall which side was positive for Covid and what side was negative, LPN/Unit Manager PP reported the entire unit Pretty much was positive for Covid. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/13/2022 at 1:42pm, Resident #55 whom tested positive for Covid and resided on the 4th floor was observed exiting the service elevator on the main floor with an unidentified Dietary employee. R55 was observed to be barefoot and was not wearing a mask. At 1:50PM a female was observed in the 4th floor resident lounge, she was observed talking on a cell phone and had not donned any PPE including a mask, LPN PP reported the person in the resident lounge was a Certified Nursing Assistant (CNA) but she did not know her name. By 01/25/22 the facility had a N95 mask and face shield/goggles mandate in place for all care areas of the facility. At 12:49 pm Psychiatry group Social Worker X was observed on the second floor entering and exiting resident rooms without wearing a face shield or goggles. On 01/28/22 at 08:36 AM, LPN/Unit Manager PP and agency CNA JJ were observed sitting behind the 4th floor Nurses station, agency CNA OO was observed standing at the station, the 3 were carrying on a conversation for over 6 minutes with agency CNA OO 's mask being worn below her nose the entire time. 38383 During an interview on 1/12/22 at 12:55 PM, Infection Preventionist (IP) C reported Registered Nurse (RN) R called the facility on 1/1/22, reporting they had tested positive for COVID-19. RN R had last worked at the facility on 12/31/21. The facility's resident COVID-19 outbreak began on 1/3/22, with Resident #31 (R31). COVID-19 positive residents were moved to the fourth floor of the facility. At the time of the interview, IP C reported the facility had 28 residents in-house that were currently COVID-19 positive and an additional (29th) resident that had been sent to the hospital the day prior. IP C reported COVID-19 was spreading fast, and the entire fourth floor was under Transmission-Based Precautions (TBP) as of 1/10/22. According to IP C, a gown, N95 mask and face shield or goggles were required to enter rooms on the fourth floor. A N95 and face shield or goggles was required in the hallway of the fourth floor. During the interview on 1/12/22 at 12:55 PM, IP C did report there were four resident rooms that were housing both COVID-19 positive and COVID-19 negative residents in the room for the past two days, since the positive tests on 1/10/22. According to IP C, they made sure the residents were six feet apart and that the curtain was drawn until they could do room changes. IP C stated they were trying not to move anyone that had been exposed to COVID-19 to a different floor due to the rapid spread. According to IP C the Medical Director wanted them to keep the residents on one unit. IP C stated, It gets tight when we have to move anyone positive and exposed. IP C reported the Health Department encouraged them to move positive residents in with other positive residents and exposed residents in with other exposed residents. During an interview that began on 1/13/22 at 10:19 AM, IP C reported three residents had tested positive for COVID-19 on 1/11/22, but they had not been added to the facility line listing yet. IP C also reported that Nurse SS was not included on the staff line listing because they tested at home and not did not test at the facility. IP C was unsure of when Nurse SS had last worked at the facility or the date of their positive test. IP C stated Nurse SS worked on the third floor but wherever they were needed. IP C stated Nurse SS for sure worked on the third floor, but she would have to see where Nurse SS worked on other days (prior to their positive COVID-19 test). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	When asked what was implemented for residents after a staff member tested positive, IP C stated they checked residents for symptoms and tested them. When asked, IP C reported vaccination status was taken into consideration for the residents, however, unvaccinated residents were not placed in precautions after potential exposure to COVID-19 positive staff. When asked if there was a reason that unvaccinated residents were not placed in precautions after exposure to positive staff, IP C stated because there are no symptoms, and they monitored for symptoms. If a staff member tested positive, the facility reviewed where staff last worked and which staff and residents they worked with. IP C again denied that TBP were implemented for unvaccinated residents that were cared for by a staff member that had tested positive. She stated if a resident was exposed by another resident, they were put in precautions. IP C did not have an answer for the difference in those practices. She then stated that they put residents in precautions when they were exposed to their positive roommate because they shared the same room. When asked how close contact was defined, IP C reported 15 minutes of close contact, within six feet. IP C stated that was for one interaction that lasted 15 minutes. On 1/13/22 at 12:13 PM, IP C reported via email that Nurse SS last worked 1/2/22 on the third floor of the facility. Nurse SS's symptoms of dry cough, fever, muscle pain and fatigue began on 1/4/22, and they tested positive 1/5/22. According to the Centers for Disease Control and Prevention (CDC), Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [COVID-19] Spread in Nursing Homes .Manage Residents who had Close Contact with Someone with SARS-CoV-2 Infection .Residents who are not up to date with all recommended COVID-19 vaccine doses and who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine after their exposure, even if viral testing is negative. HCP [Healthcare Personnel] caring for them should use full PPE [Personal Protective Equipment] (gowns, gloves, eye protection, and N95 or higher-level respirator) . (https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html) According to CDC, .A close contact is someone who was less than 6 feet away from an infected person (laboratory-confirmed or a clinical diagnosis) for a cumulative total of 15 minutes or more over a 24-hour period. For example, three individual 5-minute exposures for a total of 15 minutes . (https://www.cdc.gov/coronavirus/2019-ncov/your-health/quarantine-isolation.html) On 1/19/22 at 3:42 PM, a staff member was observed at a medication cart on the second floor, with their N95 mask below their nostrils. On 1/25/22 at 12:49 PM, Social Worker (SW) X was observed in a resident room with the door open, wearing a KN95 mask and eyeglasses. The room door was observed to have a PPE hanger on the door and signage for droplet and contact precautions. SW X reported they were told to wear a mask and social distance when in the facility. No facility staff were observed to educate SW X on PPE use on the unit. According to the facility policy, titled, Infection Prevention and Control Interim Guideline for Suspected or Confirmed Coronavirus (COVID-19), revised 12/27/21, .For resident on Contact Precautions: staff don [put on] gloves and isolation gown before contact with resident and his/her environment .For resident on Droplet Precautions: staff don gloves, isolation gown, facemask, and eye protection . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a meal pass observation on 1/27/22 at 12:21 PM, Certified Nurse Aide (CNA) CC was observed to touch the outside of their eye protection goggles, the outside of their N95 mask, then touch beverage lids, open the meal cart and pull trays out for Resident #77 (R77) and #314 (R314). CNA CC then grabbed a beverage mug and condiments before taking the delivery cart with meal trays for R77 and R314 to their room. CNA CC did not perform hand hygiene between touching their eye protection goggles, their N95 and meal trays/items. On 1/27/22 at 12:37 PM, Laundry Aide (LA) EE was observed on the first floor of the facility, near the elevators, without a mask on. Business Office Director (BOD) DD stopped LA EE and told her she could not be in the building without a mask on. LA EE stated she was about to put it on, then pulled a mask out of her pocket. On 1/27/22 at 3:31 PM, a facility staff member was overheard telling someone on the second floor that they could not be on the unit without eye protection on. The individual was observed to be wearing an N95 mask and eyeglasses. 45038 On 01/20/22 at 10:27 a.m. upon entering the elevator on the 1st floor Licensed Practical Nurse (LPN) FF was observed exiting the elevator with her KN-95 mask down around her neck. Once LPN FF saw this surveyor she appeared to laugh and stated, I at least have it around my neck. LPN FF then was observed placing her KN-95 mask properly over her mouth and nose.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 114 residents, resulting in the increased likelihood for decreased illumination, cross-contamination, and bacterial harborage. Findings include: On 01/19/22 at 10:10 A.M., A common area environmental tour was conducted with Director of Maintenance F, District Manager (Contractual Company) H, and Director of Housekeeping and Laundry G. The following items were noted: Director of Housekeeping and Laundry G indicated he currently has 5 full time and 4 part time/contingent housekeeping staff. Director of Housekeeping and Laundry G also indicated he currently has 3 full time and 3 part time/contingent laundry staff. 4th Floor (Covid-19 Positive) Men's Restroom: The hand sink faucet aerator was observed obstructed with mineral (lime and calcium) deposits. Women's Restroom: The soap dispenser was observed broken, adjacent to the hand sink. Day Room: 2 of 6 overhead light lens covers were observed soiled with dust, dirt, and dead insect carcasses. Two 24-inch-wide by 24-inch-long acoustical ceiling tiles were also observed stained from previous moisture leaks. Nurses Station: One small pink desk fan was observed heavily soiled with dust and dirt accumulations. Staff Break Room: The hand sink basin was observed etched and worn, exposing the cast metal subsurface. The two worn areas measured approximately 1-inch-wide by 3-inches-long. The hand sink faucet assembly was also observed loose to mount. The microwave oven interior (ceiling and wall) surfaces were observed soiled with accumulated food debris. Director of Housekeeping and Laundry G indicated staff would thoroughly clean and sanitize the microwave oven interior as soon as possible. Tub Room: The wall mounted soap dispenser was observed broken, adjacent to the hand sink basin. Computer Room: The room was observed in disarray. Heavy dust deposits and paper products were also observed resting upon the flooring surface. The entrance door frame was additionally observed with heavy accumulations of dust and dirt between the metal frame and door surfaces. Clean Utility Room: Two of four overhead light assemblies were observed non-functional. One of two light lens covers were also observed soiled and stained from a previous moisture leak. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Janitor Closet: The flooring surface was observed soiled with dust, dirt, and grime. The wall/floor junctures and corners were also observed with accumulated and encrusted dust, dirt, and grime. The mop sink basin was additionally observed soiled with accumulated dirt and debris. Soiled Utility: The double sink basin was observed with no available water supply for hand washing. One soap dispenser and one paper towel dispenser were also observed full and ready-for-use, adjacent to the double sink basin. The Formica countertop edge was additionally observed loose and missing, exposing the wooden non-porous sub-surface. The effected countertop edge surface measured approximately 12-inches-long. Two of four overhead light assemblies were finally observed non-functional. Director of Maintenance F stated: I have not seen the water work since I have been here. and I have been here for two and one-half years. Shower Room: The shower stall overhead light was observed non-functional. The hand sink basin overhead light assembly was also observed non-functional. Hall Corridor: The overhead light lens cover was observed soiled with dust, dirt, and dead insect carcasses. The overhead light lens cover was located adjacent to resident room [ROOM NUMBER]. Dining Room: Two of six overhead light lens covers were observed soiled with dust, dirt, and dead insect carcasses. On 01/19/22 at 01:00 P.M., A common area environmental tour was continued with Director of Maintenance F, District Manager (Contractual Company) H, and Director of Housekeeping and Laundry G. The following items were noted: 3rd Floor Day Room: One of six overhead light assemblies were observed non-functional. Three of six side chairs were also observed with loose to mount arm rest assemblies. Nurse Station: One of four overhead light assemblies were observed non-functional. One 24-inch-wide by 24-inch-long acoustical ceiling tile was also observed stained from a previous moisture leak. Clean Linen Room: One of two 48-inch-long overhead fluorescent light bulbs were observed non-functional. Staff Break Room: The overhead light lens cover was observed soiled with dust and dirt deposits. Clean Utility Room: One of two 48-inch-long overhead fluorescent light bulbs were observed non-functional. Soiled Utility Room: One of two 48-inch-long overhead fluorescent light bulbs were observed non-functional. Shower Room: The ceiling plaster surface was observed (cracked, chipped, particulate), directly above the commode base. The effected ceiling surface area measured approximately 3-feet-wide by 6-feet-long. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dining Room: One of six overhead light assemblies were observed non-functional. The wheelchair scale platform was also observed soiled with accumulated and encrusted dust/dirt deposits. 2nd Floor Men's Restroom: The overhead light assembly protective glass globe was observed soiled with dust/dirt deposits and stained from a previous moisture leak. Day Room: The drywall surface was observed (etched, scored, particulate), adjacent to the table. The effected drywall surface measured approximately 3-feet-wide by 4-feet-long. Nurses Station: Ten of sixteen 48-inch-long overhead fluorescent light bulbs were observed non-functional. Clean Utility Room: One of two 48-inch-long overhead fluorescent light bulbs were observed non-functional. Staff Break Room: The microwave oven interior (ceiling and wall) surfaces were observed soiled with accumulated and encrusted food residue. Dining Room: One of three restroom hand sink basin overhead light bulbs were observed non-functional. The glass light lens protective panel was also observed soiled and spotted from previous moisture exposure. 1st Floor Occupational/Physical Therapy: Four of six chairs were observed (etched, scored, particulate), exposing the inner foam cushion lining. Time Clock Room: The emergency exit door interior surface was observed (etched, scored, particulate). One 12-inch-wide by 12-inch-long section was also observed severely worn, exposing the bare metal surface directly above the door handle release bar. On 01/25/22 at 09:30 A.M., An environmental tour of sampled resident rooms was conducted with Director of Maintenance F, District Manager (Contractual Company) H, and Director of Housekeeping and Laundry G. The following items were noted: 202: The wooden windowsill frame was observed (etched, scored, particulate). 205: The wooden windowsill frame was observed (etched, scored, particulate). 212: The overbed light assembly pull string extension was observed missing on Bed A and Bed C. 213: The wooden windowsill frame was observed (etched, scored, particulate). The restroom soap dispenser was also observed broken adjacent to the hand sink, not allowing soap to be dispensed for proper hand washing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	218: The wooden windowsill frame was observed (etched, scored, particulate). The overbed light assembly pull string extension was also observed missing on Bed A. The restroom hand sink was additionally observed draining slow. Director of Maintenance F indicated he would have staff complete necessary repairs as soon as possible. 226: The main overhead light assembly was observed missing 2 of 4 (48-inch-long) fluorescent light bulbs. The two wooden windowsill frames were also observed (etched, scored, particulate). The Bed A and Bed C cubicles were additionally observed with excessive personal items, creating a non-cleanable area for housekeeping services. One full box of Hostess Ho Ho's, one partial box of Hostess Twinkies, one soiled drinking cup, and one half-full 2-liter bottle of Pepsi were also observed resting directly on the Bed C cubicle flooring surface. The flooring surface was further observed heavily soiled with food residue and debris. The Bed C cubicle bedside table surface was additionally observed heavily soiled with accumulated food residue and debris. The Bed C cubicle white bed sheets were finally observed heavily soiled with fecal material, food residue, and debris. Director of Housekeeping and Laundry G indicated he would have staff thoroughly clean and sanitize the cubicle and launder the soiled bed sheets as soon as possible. 227: The Bed B overbed light assembly switch was observed broken. The pull string extension was also observed missing. The vinyl wall/floor coving strip was additionally observed loose to mount, adjacent to Bed A and directly behind the Bed A headboard. The two wooden windowsill frames were also observed (etched, scored, particulate). The drywall surface was further observed (etched, scored, particulate), directly behind the Bed C headboard. The damaged drywall area measured approximately 1-foot-wide by 4-feet-long. 301: The wooden windowsill frame was observed (etched, scored, particulate). 302: The wooden windowsill frame was observed (etched, scored, particulate). The oscillating wall fan was also observed heavily soiled with dust and dirt accumulations. 305: The wooden windowsill frame was observed (etched, scored, particulate). 313: The drywall surface was observed (etched, scored, particulate), adjacent to the bed nightstand. The damaged drywall area measured approximately 1-foot-wide by 4-feet-long. The wooden windowsill frame was also observed (etched, scored, particulate). The cork board was additionally observed missing from the wall surface, exposing the metal mounting clips. 1 of 2 call system light bulbs were finally observed non-functional, within the corridor ceiling mounted assembly. 317: The restroom call system light bulb was observed non-functional, within the corridor ceiling mounted assembly. 320: The wooden windowsill frame was observed (etched, scored, particulate). The Bed B overbed light assembly drywall surface perimeter was also observed chipped and particulate. The damaged drywall surface measured approximately 1-foot-wide by 5-feet-long. 324: The restroom commode support was observed loose to mount. The commode support could be moved from side to side approximately 1-4 inches, creating the increased likelihood for resident accidental falls and/or injury. One used plastic vinyl glove was also observed resting directly on the flooring surface, adjacent to Bed C. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	328: The wooden windowsill frame was observed (etched, scored, particulate). The Bed B overbed light assembly pull string extension was also observed missing. 401: The wooden windowsill frame was observed (etched, scored, particulate). The drywall surfaces were also observed soiled with accumulated and encrusted food residue, adjacent to the private bed. The bedside protective landing strip was additionally observed heavily soiled with accumulated and encrusted food residue and dirt. The restroom hand sink was also observed draining slow. 3 of 4 overhead restroom hand sink light bulbs were further observed non-functional. 407: The Bed A overbed light assembly switch was observed broken. The wooden windowsill frame was also observed (etched, scored, particulate). The Bed C overbed light assembly 48-inch fluorescent light bulb was additionally observed non-functional. The restroom vinyl wall/floor coving strip was further observed loose to mount. 408: The drywall surface was observed (etched, scored, particulate), adjacent to the entrance door. The damaged drywall surface measured approximately 1-foot-wide by 3-feet-long. 413: The overbed light assembly pull string extension was observed missing. The wooden windowsill frame was also observed (etched, scored, particulate). The drywall surface was additionally observed (etched, scored, particulate), directly behind the bed headboard. The damaged drywall surface measured approximately 3-feet-wide by 3-feet-long. The bed enable bar surface was also observed heavily soiled with accumulated and encrusted food residue and dirt deposits. The restroom commode support was finally observed loose to mount. The commode support could be moved from side to side approximately 1-4 inches, creating the increased likelihood for resident accidental falls and/or injury. 414: The wooden windowsill frame was observed (etched, scored, particulate). The drywall surface was also observed (etched, scored, particulate), adjacent to the bed headboard. The damaged drywall surface measured approximately 2-feet-wide by 4-feet-long. The oscillating wall fan was additionally observed heavily soiled with dust and dirt deposits. The overhead light lens protective cover was also observed soiled with dust, dirt, and dead insect carcasses. The restroom commode support was finally observed loose to mount. The commode support could be moved from side to side approximately 1-4 inches, creating the increased likelihood for resident accidental falls and/or injury. 417: The overbed light switch was observed broken. The pull string extension was also observed missing. The window was additionally observed partially open with a white bed sheet inserted into the opening, creating a potential cold air draft for the resident. The aluminum framed window was also observed jammed or broken, not allowing the window to completely close. The restroom hand sink faucet aerator was further observed obstructed with mineral (calcium and lime) deposits, impeding the water flow pattern. The restroom exterior metal door frame was finally observed (etched, scored, chipped). 419: The overhead light assembly protective lens cover was observed soiled with dust, dirt, and dead insect carcasses. The wooden windowsill frame was also observed (etched, scored, particulate). Paper products and one white plastic spoon were additionally observed resting directly on the flooring surface. The overbed light switch was further observed broken. The pull string extension was also observed missing. The restroom return air ventilation grill (baffles and plenum) were finally observed heavily soiled with accumulated and encrusted dust and dirt deposits. 420: The wooden windowsill frame was observed (etched, scored, particulate). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235503	A. Building B. Wing	02/01/2022

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	424: The Bed A, Bed B, and Bed C overbed light assembly pull string extensions were observed missing. The restroom radiator wooden cover housing was also observed loose to mount. The radiator wooden cover housing was additionally observed pulled away from the wall surface, exposing the metal radiator unit. The restroom commode base was further observed loose to mount. The commode base could be moved from side to side approximately 1-3 inches. 425: The overhead light protective lens cover was observed soiled with dust, dirt, and dead insect carcasses. The wooden windowsill frame was also observed (etched, scored, particulate). The radiator wooden cover housing was additionally observed loose to mount from the wall surface. The overbed light assembly was additionally observed without light bulbs within the fixture. The overbed light assembly switch was also observed broken. The overbed light assembly pull string extension was further observed missing. The restroom hand sink was finally observed draining slow. 426: One black plastic fork was observed resting directly on the flooring surface. One used plastic vinyl glove was also observed resting directly on the bedside table surface. The Bed C quilted comforter was additionally observed soiled with accumulated and encrusted food residue and debris. The wooden windowsill frame was further observed (etched, scored, particulate). 3 of 4 overhead restroom hand sink light bulbs were finally observed non-functional. 427: The wooden windowsill frame was observed (etched, scored, particulate). The Bed B overbed light assembly switch was also observed broken. The Bed B overbed light assembly pull string extension was additionally observed missing. The restroom hand sink soap dispenser was further observed broken, not allowing the soap to be dispensed for proper hand washing. On 01/25/22 at 03:50 P.M., Record review of the Policy/Procedure entitled: Preventative Maintenance (TELS) and Inspections dated (no date) revealed under III. Procedural Components (D.) Work Orders and Service Requests: (1) A system for electronic work orders is established in TELS among all staff, and maintenance personnel that provides rapid communication regarding equipment problems. (2) The system includes documentation of: (a) The problem, (b) Date the problem was identified, (c) Who was assigned, and (d) Location of the problem. On 01/25/22 at 4:00 P.M., Record review of the Direct Supply TELS Work Orders from 12/01/21 thru 01/20/22 revealed no specific entries related to the aforementioned maintenance concerns. 38383 Resident #4 (R4): During an observation on 1/20/22 at 2:02 PM, R4 was observed on their bed, with their eyes closed, their feet on the floor and their torso leaning to the right side. R4's room floor was observed with what appeared to be food and debris. The surface of R4's over-bed table was observed with dried substances on it.