STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235463	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at the Park	111 Ford Ave Highland Park, MI 48203

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956 This citation pertains to Intake MI00146498. Based on observation, interview, and record review, the facility failed to provide an appropriate sized bed for one (R255) of five residents reviewed for accommodation of needs. Findings include: On 08/27/24 at 10:21 AM, R255 was observed laying in bed. Their left heel was resting on top of the footboard of the bed and the right leg was bent at the knee and resting over the left leg. Review of the facility record for R255 revealed an admitted [DATE] with diagnoses that included Parkinson's Disease and Dementia. The resident's height was documented to be six feet, four inches. On 08/28/24 at 10:23 AM, R255 was observed laying in bed. Their head was near the top of the mattress and their feet were resting on top of the footboard of the bed. R255 was asked if their feet resting on the footboard was uncomfortable and they stated yes. When asked if they would prefer a bed that accommodates their height R255 stated That would be nice. R255 expressed they were only able to fit on the matress by bending their legs. On 08/28/24 at 02:19 PM, R255 was observed laying in bed. The head of the bed was raised to approximately 70 degrees and the resident had slid down far enough in the bed that their legs were hanging over the end of the bed from the knees down. R255 was asked about their positioning and they stated I need some help. It was observed the bed adjustments were manual and did not have a remote control. R255 was not able to adjust themselves up in the bed independently. On 08/29/24 at 09:24 AM, R255 was observed laying in bed. The resident was positioned with their head near the head of the bed and their feet were resting on the footboard. On 08/29/24 at 10:26 AM, the facility Assistant Director of Nursing (ADON) reported their expectation is that residents should have a bed that fits their body and residents feet/legs should not be resting on the footboard. The ADON reported a bed extension can be added or a larger bed can be ordered and direct care staff would have identified that the bed was too small and addressed the issue. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy Accommodation of Needs and Preferences and Homelike Environment Guideline dated 11/28/17 included the following entries: Purpose: It is the practice of this facility to identify and provide reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. The objective of the accommodation of resident needs and preferences is to create an individualized, home-like environment to maintain and/or achieve independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own needs and preference. Reasonable accommodation of resident needs and preferences means the facility's efforts to individualize the resident's physical environment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34851 This citation pertains to Intake MI00146593. Based on observation, interview, and record review, the facility failed to prevent resident to resident and staff to resident abuse for two residents (R24 and R40) of three reviewed for abuse, resulting in a broken leg and verbal abuse. Findings include: R24 On 8/28/24 at 3:20 PM, during an interview with an anonymous resident they reported they didn't understand why R38 was allowed back to the facility after they assaulted another resident. The anonymous resident explained R24 was pulled out of their wheelchair to the ground a couple of days ago by R38, R38 then was on top of R24 which broke their leg. The anonymous resident stated R24 is a small person and was sent out to the hospital. On 8/28/24 at 8:46 AM, Registered Nurse (RN M) was asked the reason R24 was in the hospital. RN M explained R24 reported pain in their leg that weekend, an x-ray was ordered with the findings of an acute proximal left tibula/fibula fracture. RN M stated, Resident [R38] tripped and fell on [R24]. RN M stated, R38 was being aggressive towards staff when this happened and later R38 was petitioned out to the hospital for a psychological intervention. A review of R24's Minimum Data Set (MDS) assessment noted, Quarterly dated 8/6/24, impaired cognition, Functional Limitation in Range of Motion: Upper extremity (shoulder, elbow, wrist, hand) 0. no impairment. Lower extremity (hip, knee, ankle, foot) No impairment. A review of R24's progress notes revealed, 8/23/2024 13:41 (1:41 PM) Health Status Note: Resident received in back day room. Resident told writer that [R24] is experiencing pain in [their] leg and around [their] ankle. Medications administered as ordered. Supervisor notified about pain in leg. X-rays ordered . Further review of R24's progress notes revealed: 8/23/2024 14:41 (2:41 PM) Health Status Note Late Entry: Resident MD (medical doctor) ordered an X-Ray to left leg. 8/24/2024 01:14 (AM) Health Status Note: [R24] in bed with HOB (head of bed) elevated . no s/s (signs symptoms) of distress some discomfort awaiting for leg x-ray . 8/24/2024 15:17 (3:17 PM) Health Status Note: Resident received alert and verbally responsive. Able to make needs known. Noted resident left leg swelling and resident c/o pain to left leg. Pain meds given as ordered. X-ray done. Awaiting for result . 8/25/2024 07:21 (AM) Health Status Note: Received X-ray results displaced Fx (fracture) Rt. (right) Tibia. [physician] called. Transfer to Hospital. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	8/25/2024 07:55 (AM) Health Status Note: Transfer complete to (local) hospital. 8/25/2024 07:41 (AM) Transfer to Hospital or other Facility .Reason for Transfer: Displaced Fracture of the Proximity Rt. Tibia . On 8/28/24 at approximately 9:30 AM, RN M provided an incident and accident report noting, Date: 8/24/24 14:33 (2:33 PM) Incident Description: This writer was informed by [R24] that another resident fell on [their] leg when the resident was being aggressive towards the staff. Was this incident witnessed: Resident [R24] c/o (complained of) pain to left leg this writer asked was it a new onset resident stated another resident fell on [R24] leg when [R38] was trying to throw [R38's] walker. Immediate Action taken. Description: Resident MD (medical doctor) notified that the resident c/o pain to [R24's] left leg a order was given to administered Tylenol 325mg (milligrams) two tabs times one now and PRN (as needed) for pain and a X-ray ordered. Statements: No Statements found . On 8/28/24 at 10:37 AM, the Assistant Director of Nursing (ADON) was asked to review and provide the date the incident and accident report was completed. A review of the ADON's computer revealed the incident and accident report was not signed/completed and had been revised on 8/28/24 at 9:33 AM. The document did not have the statement section completed. The ADON was asked the procedure for completing the incident and accident report and explained the report is to be fully complete with statements and signatures. The ADON was asked for a policy regarding incident and accident report documentation. The policy was not provided by the end of the survey. A review of R24's hospital record documentation revealed, History and Physical: Date of service: 8/25/24. Chief Complaint: Arrive date/time 8/25/24 13:27:00 Nursing Home. Ambulance EMS. Service: trauma: Trauma Code Level: Trauma Evaluation. Chief Complaint: Fall. Site of Injury: residential. History of Present Illness. [R24] . with a hx (history) of a stroke who presented to (local hospital) from nursing home after a fall from a wheelchair. Patient reports that she was at her nursing home when one of the fell ow nursing home residents pushed her out the wheelchair . Left tib/fib (tibla/fibula) xray showed acute proximal left tib/fib fracture . A review of R24's hospital Physical Therapy (PT) eval revealed, PT Initial Evaluation Acute Care Entered On: 8/27/24 . General Info. Reason for Referral to Physical Therapy: Decreased mobility . Past Medical & Surgical History: pt (patient) admit s/p (status post) being pushed out of w/c (wheelchair) at NH (nursing home) by another resident Left tib/fib fx now s/p ORIF (Open reduction and internal fixation (ORIF) is a type of surgery used to stabilize and heal a broken bone). PMHx: BLE (bilateral lower extermies) weakness . On 8/29/24 at 11:23 AM, R24 was observed lying in bed and was asked about their leg. R24 stated, [R38] knocked me out of my wheelchair. [R38] has to come downstairs because [R38] starts trouble. R24 stated, [R38] pulled me out of the wheelchair. I can't do anything to fight back, I don't know why [R38] is back (at the facility). R38 On 8/27/24 at 9:35 AM, R38 was observed lying in bed wearing green disposable scrubs. R38 had recently been readmitted from the hospital. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	A review of R38's medical record noted, R38 was admitted on [DATE] with diagnosis of Dementia. A review of R38's annual MDS dated [DATE] revealed, moderate cognitive impairment and mobility devices walker. A review of R38's care plan did not reveal a care plan to address abusive behavior. A review of R38's progress notes reveled, a pattern of aggressive behavior. 6/1/2024 16:34 (4:34 PM) Behavior Narrative Text: Resident rode the elevator by [R38's self] without assistance. Resident became agitated and verbally aggressive with staff. Redirection unsuccessful . 6/12/2024 20:22 (8:22 PM) Behavior Narrative Note: Resident verbally aggressive and combative with staff unprovoked . 6/13/2024 22:46 (8:46 PM) Behavior Narrative Note: Res (resident) continues with aggressive behavior towards staff. Res lashed out at undersign when trying to redirect res away from female bathroom. Res yelled out obscenities to undersign and was redirected back to [R38's] room by other staff members . 6/14/2024 22:22 (8:22 PM) Behavior Narrative Note: Res continues with aggressive behavior towards staff . 7/17/2024 20:33 (8:33 PM) Behavior Narrative Note: Resident verbally and physically aggressive with other residents unprovoked. Refused afternoon shower. Redirected several times unsuccessfully . 7/27/2024 17:56 (5:56 PM) Health Status Note: Periods of verbal/physical aggression with staff and other residents. Refuses meds and lab draws. No changes in baseline. 8/14/2024 10:17 (AM) Behavior Narrative Note: [R38] is in a bad mood he refused breakfast and was verbally and physically aggressive towards staff and residents . 8/21/2024 15:29 (3:29 PM) Behavior Narrative Note: Resident being disruptive to other residents during activity time. Verbally and physically aggressive unprovoked. Attempts to use [R38's] walker as a defensive tool. Redirected x2. 8/23/2024 11:42 (AM) Transfer to Hospital or other Facility Note: .Key clinical Information: Violent towards staff and other residents, sister notified .doctor informed . 8/23/2024 12:02 (AM) Health Status Note: Resident was picked up by [local] police to go to crises center officer will call back with location of center. On 8/29/24 at 3:37 PM, the Nursing Home Administrator (NHA) was asked about the incident. The NHA administrator explained R38 is shaky on their walker and they bumped R24's wheelchair and R38 fell on top of R24. The NHA could not explain if R38 bummped into R24's wheelchair or if R38 pulled or pushed R24 from the wheelchair. 50223 R40 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/27/24 at 2:33 PM, during an interview R40 described an incident with Licensed Practical Nurse (LPN) C and Certified Nurse Assistant (CNA) F. R40 stated LPN C choked them. R40 stated CNA E took a picture of R40's neck after the incident and reported the incident to the Director of Nursing (DON). R40 stated LPN C still worked at the facility and CNA F is on a leave. A review of R40's medical record revealed they were admitted to the facility on [DATE] with the following diagnoses: Chronic obstructive pulmonary disease, senile degeneration of brain, and muscle weakness. A review of R40's Minimum Data Set revealed a brief interview for mental status score of 10 indicating cognitive impairment. On 8/28/24 at 1:20 PM, during an interview, LPN C was asked about the incident involving R40. LPN C explained there was an altercation with another staff member in front of the nursing station and said R40 and the other staff member were getting closer to each other and were both agitated. LPN C explained they tried to diffuse the situation but R40 Got up out of (their) wheelchair and tried to jump at LPN C and the other staff member pushed (R40) back into their chair. LPN C confirmed the incident was reported to Registered Nurse (RN) D and CNA F no longer worked at the facility. On 8/28/24 at 1:49 PM, during an interview, the nursing home administrator (NHA) was asked if they recalled an incident involving R40. The NHA stated CNA 'F' is not here anymore. Yeah (they) probably did get into it with R40. The NHA was asked to provide the incident report. The NHA explained they would have to find it. On 8/28/24 at 3:16 PM a voicemail was left for RN D with a request for a return call. A call was not returned by the completion of the survey. On 8/28/24 at 3:36 PM, during an interview, CNA E was asked if they recalled an incident involving R40. CNA E explained R40 told them CNA F and LPN C choked them. CNA E confirmed (R40's) neck did look red. CNA E explained they took a picture of R40's neck and reported it to RN D. On 8/29/24 at 9:06 AM, LPN C was observed to be working on the unit in which R40 resides. R40 was asked if they felt safe with LPN C working on their unit. R40 stated, I don't know why (they) still work here. On 8/29/24 at 8:19 AM, during an interview, the Assistant Director of Nursing (ADON) was asked to describe what should happen if there is an altercation between two residents or between a resident and a staff member. The ADON stated If it's only a verbal altercation involving residents we separate or redirect, same with staff but we would also reassign the staff member. If its physical, then an incident report is filled out and we notify the administrator, and an investigation is started. The staff member is suspended until the investigation is completed. The ADON was informed of the allegations made by R40 and was asked to provide the documentation of the alleged incident. The ADON was observed looking through R40's medical record and explained they could not find a record of the incident or investigation. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 8/29/24 at 9:31 AM, a review of CNA F's employee file revealed a discipline form that stated: Description of policy, procedure, rules or requirements violated: Verbal altercation with resident. Factual basis for the discipline, including prior counseling: Employees are not allowed to engage into any altercation with a resident this violates company policy. Level of discipline: indefinite suspension pending investigation. A review of the facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property stated the following: The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements immediately .C. PREVENTION ABUSE POLICY REQUIREMENTS: It is the policy of this facility to prevent abuse by providing residents, families and staff information and education on how and to whom to report concerns, incidents and grievances without the fear of reprisal or retribution. The facility will provide feedback regarding complaints and concerns. The facility leadership will assess the needs of the residents in the facility to be able to identify concerns in order to prevent potential abuse .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 This citation pertains to Intake MI00146593. Based on Interview and record review the facility failed to investigate a physical altercation between staff to resident and between resident to resident for two residents (R24 and R40) out of three residents reviewed for abuse. Findings include: R24 On 8/28/24 at 3:20 PM, during an interview with an anonymous resident they reported they didn't understand why R38 was allowed back to the facility after they assaulted another resident. The anonymous resident explained R24 was pulled out of their wheelchair to the ground a couple of days ago by R38, R38 then was on top of R24 which broke their leg. The anonymous resident stated R24 is a small person and was sent out to the hospital. On 8/28/24 at 8:46 AM, Registered Nurse (RN M) was asked the reason R24 was in the hospital. RN M explained R24 reported pain in their leg that weekend, an x-ray was ordered with the findings of an acute proximal left tibula/fibula fracture. RN M stated, Resident [R38] tripped and fell on [R24]. RN M stated, R38 was being aggressive towards staff when this happened and later R38 was petitioned out to the hospital for a psychological intervention. A review of R24's Minimum Data Set (MDS) assessment noted, Quarterly dated 8/6/24, impaired cognition, Functional Limitation in Range of Motion: Lower extremity (hip, knee, ankle, foot) No impairment. On 8/28/24 at approximately 9:30 AM, RN M provided an incident and accident report noting, Date: 8/24/24 14:33 (2:33 PM) Incident Description: This writer was informed by [R24] that another resident fell on [their] leg when the resident was being aggressive towards the staff. Was this incident witnessed: Resident [R24] c/o (complained of) pain to left leg this writer asked was it a new onset resident stated another resident fell on [R24] leg when [R38] was trying to throw [R38's] walker. Immediate Action taken. Description: Resident MD (medical doctor) notified that the resident c/o pain to [R24's] left leg a order was given to administered Tylenol 325mg (milligrams) two tabs times one now and PRN (as needed) for pain and a X-ray ordered. Statements: No Statements found . A review of R24's hospital record documentation revealed, History and Physical: Date of service: 8/25/24. Chief Complaint: Arrive date/time 8/25/24 13:27:00 Nursing Home. Ambulance EMS. Service: trauma: Trauma Code Level: Trauma Evaluation. Chief Complaint: Fall. Site of Injury: residential. History of Present Illness. [R24] . with a hx (history) of a stroke who presented to (local hospital) from nursing home after a fall from a wheelchair. Patient reports that she was at her nursing home when one of the fell ow nursing home residents pushed her out the wheelchair . Left tib/fib (tibla/fibula) xray showed acute proximal left tib/fib fracture . R38 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R38's medical record noted, R38 was admitted on [DATE] with diagnosis of Dementia. A review of R38's annual MDS dated [DATE] revealed, moderate cognitive impairment and mobility devices walker. 8/21/2024 15:29 (3:29 PM) Behavior Narrative Note: Resident being disruptive to other residents during activity time. Verbally and physically aggressive unprovoked. Attempts to use [R38's] walker as a defensive tool. Redirected x2. 8/23/2024 11:42 (AM) Transfer to Hospital or other Facility Note: .Key clinical Information: Violent towards staff and other residents, sister notified .doctor informed . 8/23/2024 12:02 (AM) Health Status Note: Resident was picked up by [local] police to go to crises center officer will call back with location of center. On 8/29/24 at 3:37 PM, the Nursing Home Administrator (NHA) was asked about the incident. The NHA administrator explained R38 is shaky on their walker and they bumped R24's wheelchair and R38 fell on top of R24. The NHA could not explain if R38 bumped into R24's wheelchair or if R38 pulled or pushed R24 from the wheelchair because an investigation was not done. R40 On 8/27/24 at 2:33 PM, during an interview R40 described an incident with Licensed Practical Nurse (LPN) C and Certified Nurse Assistant (CNA) F. R40 stated LPN C choked them. R40 stated CNA E took a picture of R40's neck after the incident and reported the incident to the Director of Nursing (DON). R40 stated LPN C still worked at the facility and CNA F is on a leave. A review of R40's medical record revealed they were admitted to the facility on [DATE] with the following diagnoses: Chronic obstructive pulmonary disease, senile degeneration of brain, and muscle weakness. A review of R40's Minimum Data Set revealed a brief interview for mental status score of 10 indicating cognitive impairment. On 8/28/24 at 1:20 PM, during an interview, LPN C was asked about the incident involving R40. LPN C explained there was an altercation with another staff member in front of the nursing station and said R40 and the other staff member were getting closer to each other and were both agitated. LPN C explained they tried to diffuse the situation but R40 Got up out of (their) wheelchair and tried to jump at LPN C and the other staff member pushed (R40) back into their chair. LPN C confirmed the incident was reported to Registered Nurse (RN) D and CNA F no longer worked at the facility. On 8/28/24 at 1:49 PM, during an interview, the nursing home administrator (NHA) was asked if they recalled an incident involving R40. The NHA stated CNA 'F' is not here anymore. Yeah (they) probably did get into it with R40. On 8/28/24 at 3:36 PM, during an interview, CNA E was asked if they recalled an incident involving R40. CNA E explained R40 told them CNA F and LPN C choked them. CNA E confirmed (R40's) neck did look red. CNA E explained they took a picture of R40's neck and reported it to RN D. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 9:31 AM, a review of CNA F's employee file revealed a discipline form that stated: Description of policy, procedure, rules or requirements violated: Verbal altercation with resident. Factual basis for the discipline, including prior counseling: Employees are not allowed to engage into any altercation with a resident this violates company policy. Level of discipline: indefinite suspension pending investigation. On 8/29/24 at 10:02 AM, during an interview with the Nursing Home Administrator (NHA) they stated I have been looking for the incident report and I can't find anything. The NHA was asked to provide the reference number for the facility reported incident. The NHA stated We didn't call it in. I've been looking for the investigation and can't find it. The CNA was suspended. The NHA was asked if CNA F was suspended in response to the incident. The NHA stated yes. The NHA was asked if the incident should be documented in R40s medical record. The AD responded, Yeah, there should be something. They usually put it in the chart. The NHA was asked if they reported the incidents to the State of Michigan and complete a 5-day investigative follow-up. The NHA stated, I didn't think we had to. A review of the facility policy titled Abuse, Neglect, Exploitation, Mistreatment and Misappropriation of Resident Property stated the following: The Nursing Home Administrator or designee will report abuse to the state agency per State and Federal requirements immediately . E. INVESTIGATION ABUSE POLICY REQUIREMENTS: It is the policy of this facility that reports of abuse (mistreatment, neglect, or abuse, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. PROCEDURE: The investigation is the process used to try to determine what happened. The designated facility personnel will begin the investigation immediately. A root cause investigation and analysis will be completed. The information gathered is given to administration. a. Investigation of abuse: When an incident or suspected incident of abuse is reported, the Administrator or designee will investigate the incident with the assistance of appropriate personnel. The investigation will include:i. Who was involved ii. Residents' statements a. For non-verbal residents, cognitively impaired residents or residents who refuse to be interviewed, attempt to interview resident first. If unable, observe resident, complete an evaluation of resident behavior, affect and response to interaction, and document findings. iii. Resident's roommate statements (if applicable) iv. Involved staff and witness statements of events v. A description of the resident's behavior and environment at the time of the incident vi. Injuries present including a resident assessment vii. Observation of resident and staff behaviors during the investigation

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34851 Based on observation, interview, and record review the facility failed to develop a comprehensive care plan to address aggressive behaviors, for one sampled resident (R38) of a total sample of 21 residents reviewed for care plans. Findings include: On 8/29/24 at 11:23 AM, R24 was observed lying in bed and was asked about their leg. R24 stated, [R38] knocked me out of my wheelchair. [R38] has to come downstairs because [R38] starts trouble. R24 was asked how did R38 knock them out of their wheelchair. R24 was observed to motion with their arms in a pulling motion. R24 stated, [R38] pulled me out of the wheelchair. I can't do anything to fight back, I don't know why he's back. A review of R38's progress notes revealed, the following patterns of aggressive behavior. 6/1/2024 16:34 (4:34 PM) Behavior Narrative Text: Resident rode the elevator by [R38's self] without assistance. Reorientated resident of facility policy and safety concerns. Resident became agitated and verbally aggressive with staff. Redirection unsuccessful. Safety maintained. 6/12/2024 20:22 (8:22 PM) Behavior Narrative Note: Resident verbally aggressive and combative with staff unprovoked. Repeatedly gives roommate drinks despite being asked not to r/t (related to) roommates fluid restriction. Requires constant redirection. Safety maintained. 6/13/2024 22:46 (8:46 PM) Behavior Narrative Note: Res (resident) continues with aggressive behavior towards staff. Res lashed out at undersign when trying to redirect res away from female bathroom. Res yelled out obscenities to undersign and was redirected back to [R38's] room by other staff members. Will monitor. 6/14/2024 22:22 (8:22 PM) Behavior Narrative Note: Res continues with aggressive behavior towards staff. Res also continues to give [R38's] roommate items after staff has told [R38] on several occasions not to do this. Res yells obscenities when staff reminds him. Will continue to monitor behaviors. 7/17/2024 20:33 (8:33 PM) Behavior Narrative Note: Resident verbally and physically aggressive with other residents unprovoked. Refused afternoon shower. Redirected several times unsuccessfully. Removed from area. Safety maintained. 7/27/2024 17:56 (5:56 PM) Health Status Note: MONTHLY SUMMARY Resident remains alert. Able to make needs known . Remains a safe smoker with staff supervision. Periods of verbal/physical aggression with staff and other residents. Refuses meds and lab draws. No changes in baseline. 8/14/2024 10:17 (AM) Behavior Narrative Note: [R38] is in a bad mood he refused breakfast and was verbally and physically aggressive towards staff and residents. Redirected several times with success. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/21/2024 15:29 (3:29 PM) Behavior Narrative Note: Resident being disruptive to other residents during activity time. Verbally and physically aggressive unprovoked. Attempts to use [R38's] walker as a defensive tool. Redirected x2. Safety maintained. 8/23/2024 11:42 (AM) Transfer to Hospital or other Facility Note Text: Most Recent Admission: 07/25/2022 11:48. Key clinical Information: VIOLENT TOWARDS STAFF AND OTHER RESIDENTS SISTER NOTIFIED . Dr . informed. Reason for Transfer: VIOLENT TOWARDS RESIDENTS AND STAFF . 8/23/2024 12:02 (AM) Health Status Note: Resident was picked up by [local] Police to go to crises center officer will call back with location of center. A review of R38's medical record noted, R38 was admitted on [DATE] with diagnosis of Dementia. A review of R38's annual Minimum Data Set Assessment (MDS) dated [DATE] revealed, moderate cognitive impairment and mobility devices walker. A review of R38's care plan did not reveal resident does not have a care plan regarding abusive behavior. On 8/29/24 at 3:26 PM, the Assistant Director of Nursing (ADON) was asked about R38's care plan for interventions regarding R38's aggressive behavior. The ADON was observed to look at the medical chart and explained that R38 should have one because R38 has a history of aggressive behavior but was unable to locate a care plan that addressed R38's aggressive behavior.

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F 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28776 Based on interview, and record review, the facility failed to obtain and assess the blood pressure (B/P) and administer blood pressure medication based on that assessment for one sampled resident (R104) of one reviewed for monitoring, resulting in a significant low blood pressure and hospitalization . Findings include: A review of R104's closed record revealed they were admitted to the facility on [DATE] with a diagnosis of Hidradenitis suppurativa (chronic skin condition featuring lumps in armpits and groin) and hypertension (high blood pressure). A review of R104's Minimum Data Set assessment revealed R104 had a death within the facility. A review of R104's orders revealed the following orders: -Carvedilol (a medication that lowers B/P) oral tablet 3.125 MG (milligrams) Give 1 tablet by mouth two times a day for hypertension. -Spironolactone (a medication for fluid retention which can also lower the B/P)) oral tablet 25 MG give 1 tablet by mouth one time a day for diuretics. Vital signs every shift. On [DATE] at 1:39 PM, on admission into the facility R104's blood pressure was documented as ,d+[DATE] (normal blood pressure ,d+[DATE]). A review of R104's Medication Administration Record (MAR) revealed on [DATE] at 5:00PM, Carvedilol was administered without the blood pressure being documented as being obtained prior to medication administration. The next blood pressure that was documented was on [DATE] at 6:15 AM which noted B/P - ,d+[DATE]. A review of the MAR revealed on [DATE] at 9:00AM, Spironolactone was administered by Licensed Practical Nurse (LPN) C. Carvedilol was not administered at this time with a notation stating, Vitals outside of parameters for administration. There was no blood pressure documented at that time. The medical record did not reveal a progress note that indicated the physician was contacted. Further record review revealed a physician progress note dated [DATE] at 8:47 PM, Restart B/P meds with hold parameters (a pre-determined parameter to guide the nursing staff when to give and when to hold the medication). MAR revealed on [DATE] at 9:00 AM, Spironolactone and Carvedilol were both administered by LPN C. R104's blood pressure at that time was documented as ,d+[DATE] on the MAR. There were no hold parameters noted on the MAR. The medical did not reveal a progress note that indicated the physician was notified of the low blood pressure. (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	R104's MAR revealed on [DATE] at 5:00 PM, Carvedilol was administered, no B/P was documented. Further record review revealed a progress note dated [DATE] at 11:08 PM, R104 was transferred to the hospital for a Change in condition; B/P reading ,d+[DATE]. On [DATE] at 11:25 AM, during an interview, the Assistant Director Of Nursing (ADON) was asked about the status of R104 and if they expired in the facility or if they were transferred to the hospital. The ADON requested an update from the admissions coordinator. On [DATE] at 12:57 PM the ADON provided a list of discharged residents and explained R104 was transferred to the hospital on [DATE] and is now deceased . The ADON explained the MDS is correct in listing R104 as a death within the facility due to the resident expiring within 24 hours of transfer to the hospital. On [DATE] at 11:55 AM during an interview with Licensed Practical Nurse (LPN) B was asked if orders for blood pressure medications include holding parameters. LPN B explained the majority of the orders for B/P meds do include hold parameters that usually say to hold if the systolic (top number) B/P is less than 130 or if the diastolic (bottom number) B/P is less than 60 but some orders do not. LPN B stated if there were no parameters, I'd use my nursing judgement. If someone's B/P is ,d+[DATE] I'm not gonna give them a pill to drop it lower. I would also call the doctor. On [DATE] at 2:45 PM, during an interview LPN C was asked if orders for blood pressure medications include holding parameters and stated Some do, some don't have hold parameters but if the blood pressure is too low, I would hold it and put in a note why it was held. Most of the blood pressure medications ask you for a blood pressure on the Medication Administration Record (MAR). LPN C was asked to review the blood pressure and medication administration record for R104 on [DATE]. LPN C verified their initials on the MAR for the Spironolactone and Carvedilol indicating they administered the medications. LPN C stated I don't remember. It should not have been given. On [DATE] at 3:04 PM, during an interview the ADON was asked to review R104's record. The ADON confirmed that R104 had a low B/P documented on [DATE] at 9:00 AM and the medications (Spironolactone and Carvedilol) were administered. The ADON was asked to review the administration of blood pressure medications on [DATE] at 5:00PM and confirmed no B/P results were present. The ADON was asked if it was concerning that R104's blood pressure meds were given with a low blood pressure and without it being reevaluated. The ADON stated Yes. They should not have been given and (name of LPN C) should have called the physician. A medication administration policy was requested and not returned by the conclusion of the survey.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 Based on observation, interview, and record review, the facility failed to provide proper oral care for one (R83) out of five residents reviewed for actvities of daily living (ADLs). Findings include: On 8/27/24 at 9:01 AM and 11:19 AM, R83 was observed lying in bed. R83's mouth was observed to be dry and R83's teeth were observed to be coated with a noticeable layer of white residue, particularly accumulating between the teeth and around the gum line. On 8/27/24 at 2:31 PM, R83 was observed in their room sitting in their gerichair (medical recliner). R83's mouth appears unchanged from the previous observations. On 8/28/24 at 9:56 AM, R83 was observed lying in bed. R83's mouth remained unchanged from the previous observations. R83 was asked if the staff helps them brush their teeth. R83 explained they needed help to brush their teeth and sometimes the aide helps them. R83 was asked how long it had been since they brushed their teeth. R83 stated About 4 or 5 days. A toothbrush and tooth paste were observed to be covered with other belongings and papers in the night stand drawer. On 8/28/24 at 12:24 PM, R83 was observed sleeping in bed with their mouth open. The white substance was still observed in R83's mouth and on their teeth. On 8/28/24 at 1:34 PM, R83 was observed sitting in their chair. R83's mouth appeared unchanged from previous observations. R83 was asked if anyone helped them brush their teeth or clean their mouth yet. R83 stated No. They haven't. On 8/29/24 at 8:57 AM, R83 was observed lying in bed. R83's mouth was observed to be unchanged from previous observations. A review of R83's record revealed they were admitted to the facility on [DATE] with the following diagnoses: bacterial meningitis and aphasia (difficulty swallowing). A review of R83's Minimum Data Set (MDS) revealed a brief interview for mental status score of 8 indicating cognitive impairment. Further review of R83's MDS revealed the Functional Abilities Assessment stated the following: Dependent with dressing and hygiene including oral care. A review of R83's care plan revealed the following: (R83) has actual/potential for an ADL self-care performance deficit r/t (related to) disease process. On 8/28/24 at 12:33 PM, during an interview, Licensed Practical Nurse (LPN) N was asked if R83 was able to perform any of their own oral hygiene care. LPN N confirmed R83 needs assistance and encouragement with oral care. On 8/29/24 at 9:13 AM, during an interview, Certified Nurse Assistant (CNA) O explained R83 requires help with hygiene and oral care. CNA O stated R83 receives oral care every day when I (am assigned to them), otherwise, I'm not sure. CNA O stated Yes. I brush my teeth every day so the residents should too. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/29/24 at 11:34 AM, during an interview, the Assistant Director Of Nursing (ADON) explained the CNA is responsible for the residents ADLS (activities of daily living) but the nurse is responsible to ensure it was performed. The ADON stated, If a resident is dependent, they should receive it every day. The ADON stated If R83 refuses, it should be documented. It is expected for them to receive oral hygiene every day. A facility policy on ADL care was requested and was not provided by the completion of the survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 Based on observation, interview, and record review, the facility failed to treat a wound for one resdent (R3) of one reviewed for skin conditions. Findings include: On 8/27/24 at 9:29 AM, R3 was observed lying in bed. A wound was noted on the third toe of their right foot with a bandage partially stuck to the wound and partially hanging off. R3 was asked how long the bandage had been there. R3 stated too long. On 8/27/24 at 10:41 AM, R3 was observed in the hallway reclined in a gerichair (medical recliner) wearing a sock on their left foot. Their right foot was bare, and the same bandage was observed to be unchanged from the previous observation. On 8/27/24 at 11:16 AM, R3 was observed still in the gerichair in the hallway. An unnamed Certified Nurse Assistant (CNA) was observed putting a sock on R3's right foot over the wound and the bandage was unchanged from the previous observations. On 8/28/24 at 3:54, PM R3 was observed lying in bed with socks on both feet. The sock was removed from R3's right foot and the wound on the third toe was observed to still have the same bandage stuck to it. On 8/29/24 at 9:13 AM, R3 was observed lying in bed. The same bandage was observed to still be partially stuck to the wound and partially hanging off R3's toe as previously observed. A review of R3's medical record revealed, that they were admitted to the facility on [DATE] with a diagnosis of epilepsy, unspecified. A review of R3's Minimum Data Set assessment revealed a brief interview for mental status score of 5 indicating cognitive impairment. Further review of R3's record revealed the following orders: Paint digits of bilat (both) feet with Betadine (iodine solution), no drsg (dressing). every day shift for -Skin Irritation; Soak Right foot for 20 minutes then apply triple Antibiotic with dry dressing to right toes digit 3 and 4 two times a day every other day for Wound. On 8/28/24 at 4:00 PM, during an interview, wound care nurse Licensed Practical Nurse (LPN) C was asked if R3 had any wounds. LPN C stated No. R3 does not have any wounds right now but sometimes (they) have issues with their feet so I watch them every day. On 8/29/24 at 9:14 AM, during an interview, LPN C was asked why R3 had a bandage on their toe to which they replied, That's the area that keeps breaking down. LPN C stated, The treatment is supposed to be every day but I only do it as needed. LPN C stated, We can soak them in the whirlpool. During the survey an observation was made of the whirlpool tub to be unusable and filled with bags of linen and other belongings. On 8/29/24 at 11:40 AM, during an interview, the Assistant Director Of Nursing (ADON) was asked to review R3's wound care orders and was asked if the orders should be implemented. The ADON stated, Yes if it was ordered by the physician the order should be carried out. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A wound care policy was requested and not returned by the conclusion of the survey.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **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 food service equipment effecting 104 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased illumination. Findings include: On 08/27/24 at 08:53 A.M., An initial tour of the food service was conducted with Dietary Manager H and Dietary Support G. The following items were noted: The [NAME] 2-door reach-in cooler door gaskets and upper door ledge were observed soiled with accumulated and encrusted food residue. 12 of 12 overhead plastic light lens covers were observed soiled with accumulated and encrusted dust, dirt, and food residue. Dietary Manager H indicated she would have staff thoroughly clean and sanitize the door gaskets and light lens covers as soon as possible. The 2017 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. The [NAME] 2-door reach-in cooler door gaskets were observed worn and torn. The damaged gasket surfaces measured approximately 12-inches-long and 8-inches-long respectively. Dietary Manager H indicated she would have maintenance replace the worn and torn door gaskets as soon as possible. The 2017 FDA Model Food Code section 4-501.11 states: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened. On 08/29/24 at 01:50 P.M., Record review of the Policy/Procedure entitled: Kitchen Equipment dated 9-1-21 revealed under Standard: All food service equipment will be clean, sanitary, and in proper working order. Record review of the Policy/Procedure entitled: Kitchen Equipment dated 9-1-21 further revealed under Guidelines: (1) All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 22050 Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the outdoor waste and cardboard recycling receptacles effecting 104 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and pest attraction/harborage. Findings include: On 08/28/24 at 09:00 A.M., An environmental tour of the outdoor waste receptacle cement pad area was conducted with Regional Director of Dietary Services I. The following items were noted: The cardboard waste receptacle was observed missing 1 of 2 plastic lids. The metal mounting rod was also observed bent and convoluted. The drain plug was further observed missing from the cardboard waste receptacle port. The solid waste receptacle was observed with offset plastic lids. The metal mounting rod was also observed bent and convoluted. The rear metal brace bars were further observed bent, unattached, and convoluted. Regional Director of Dietary Services I indicated she would contact the waste removal contractual service for necessary repairs as soon as possible. The cement pad surface was observed heavily soiled with accumulated and encrusted dirt and debris. One large plastic container with wheel castors was also observed full of water. Two wooden containers were further observed resting on the cement pad near the rear fence line. The waste grease container was additionally observed with rancid and malodorous used grease product. One large wooden skid was further observed resting against the waste grease container. On 08/29/24 at 02:00 P.M., Record review of the Policy/Procedure entitled: Dispose of Garbage and Refuse dated 09/01/2021 revealed under Standard: All garbage and refuse will be collected and disposed of in a safe and efficient manner. Record review of the Policy/Procedure entitled: Dispose of Garbage and Refuse dated 09/01/2021 further revealed under Guideline: (1) The Dining Services Director coordinates with the Director of Maintenance to ensure that the area surrounding the exterior dumpster area is maintained in a manner free of rubbish or other debris. (3) Appropriate lids are provided for all containers.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46956 Based on observation, interview, and record review, the facility failed to date and store oxygen tubing for one (R64) of five residents reviewed and failed to complete proper hand hygiene for four of four staff members (Staff member's #1, #2, #3, and CNA O) . Findings include: Review of the facility record for R64 revealed an admitted [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disease and Acute Respiratory Failure. R64's record included active physician orders for supplemental oxygen use. On 08/27/24 at 11:00 AM, R64 was using oxygen that was connected to the room condenser and the tubing was not dated. Extra oxygen tubing was laying on the floor and was not in a bag or dated. The oxygen tubing connected to R64's portable condenser on the wheelchair was not dated or bagged. Two flies were observed on and around R64 during the interview. On 08/28/24 at 10:30 AM, R64's oxygen tubing attached to the large condenser was not dated or bagged. Additional tubing was laying on the bed and was not dated or bagged and the tubing on the portable condenser the resident was using at the time was not dated. On 08/29/24 at 09:33 AM, R64's oxygen tubing being used from the room condenser was not dated. The tubing connected to the portable condenser was not dated or bagged. On 08/29/24 at 10:20 AM, the facility Assistant Director of Nursing (ADON) reported the expectation is oxygen tubing should be dated. The ADON reported that oxygen tubing not in use should be stored in a bag and should not be on the floor. A facility policy addressing maintenance of oxygen tubing was requested however the policy provided only addressed storage and safety as it related to oxygen cylinders or tanks. 50223 On 8/27/24 at approximately 9:00 AM, a hand sanitizer dispenser mounted in the hallway on the 2nd floor west wing was noted to be empty. The other hand sanitizer dispensers on the 2nd floor west wing were all tested and were all found to be empty. On 8/27/24 at 10:46 AM, an unidentified staff member #1 was observed to enter room [ROOM NUMBER] and to pick up dirty laundry from the floor next to the bed. The staff member carried the laundry without bagging it, across the hall into the soiled utility room. The staff member immediately walked out of the soiled utility room and into another resident's room without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 10:44 AM, an unidentified staff member #2 was observed performing a blood draw on a resident in room [ROOM NUMBER]. On 8/27/24 at 10:48 AM, the staff member finished the blood draw and removed their gloves, threw them away and walked out of room [ROOM NUMBER] while placing the specimens into the bag hanging over their shoulder. The staff member then walked directly into another residents room without performing hand hygiene. The staff member then applied gloves and performed a lab draw without performing hand hygiene. On 8/27/24 at 10:53 AM, the staff member then removed their gloves and left the room carrying the specimen without performing hand hygiene. On 8/27/24 at 10:55 AM, an unidentified staff member #3 was observed removing the linen from room [ROOM NUMBER] bed, linens was observed to have a brown substance on it. The staff member was observed to not be wearing gloves and carried the bed linens without being bagged across the hall to the soiled utility room and immediately left the soiled utility room and walked down the hall past the nurse's station without washing their hands. On 8/27/24 at 11:16 AM, Certified Nurse Assistant (CNA) O was observed putting a sock on a residents foot that had an uncovered wound on it. CNA O was observed to not perform hand hygiene before or after putting the sock on. On 8/28/24 at approximately 11:00 AM during an interview the Assistant Director of Nursing (ADON) was asked to describe the facility's hand hygiene practices. The ADON explained they use hand sanitizer which is maintained by housekeeping and does hand washing audits and education. The ADON provided hand hygiene education and a check off skills hand wash observation form instead of audits. The skills check off provided were not completed and lacked signatures. The ADON explained the hand sanitizer in the hallways is sometimes removed because the residents will eat it. The ADON explained there should be sanitizer at the nurse's station and all staff should use the sanitizer before and after coming out of resident rooms or providing care to the residents. A facility policy on hand hygiene and copies of the hand hygiene education was requested but not returned by the completion of the survey.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 Based on interview, and record review, the facility failed to document or offer the influenza or pneumonia vaccine for two residents (R23 and R305) out of five reviewed for vaccinations. Findings include: On 8/28/24 at approximately 11:00 AM, during an interview, the Assistant Director Of Nursing (ADON) was asked to review the vaccination status of R23 and R305. During the review, R23's medical record revealed R23 was admitted to the facility on [DATE]. A review of R23's record revealed a brief interview for mental status score of 15 indicating intact cognition. Review of R23's vaccination status revealed there were no vaccine consents, and no vaccines were offered or provided. The ADON explained they're not sure how that got missed. A review of R305's medical record revealed a consent signed by R305's guardian for the influenza and the pneumonia vaccine. The vaccinations were documented as resident refused. A progress note indicated the resident was educated on the vaccines. No note indicating the guardian was notified the resident refused the vaccines.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50223 Based on Interview, and record review, the facility failed to offer and document the Covid vaccine for one residents (R23) out of five reviewed for Covid vaccinations. Findings include: On 8/28/24 at approximately 11:00 AM during an interview the ADON was asked to review R23's Covid vaccination status. During the review, R23's medical record revealed R23 was admitted to the facility on [DATE]. A review of R23's record revealed a brief interview for mental status score of 15 indicating intact cognition. A review of R23's vaccination status revealed there were no Covid vaccine consents, and no vaccines were offered or provided. The ADON explained that they are not sure how that got missed.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 22050 Based on observations, interviews, and record reviews, the facility failed to provide 80 square feet of living space per bed within multiple resident rooms in 21 (#'s 102, 103, 104, 105, 106, 107, 108, 112, 115, 119, 201, 202, 203, 204, 207, 209, 211, 212, 214, 218, 219) of 36 rooms, resulting in the increased likelihood for resident dissatisfaction and psychosocial impairment. Findings include: On 08/28/24 at 01:20 P.M., An environmental tour of resident room minimum square footage requirements (80 square feet per bed) was conducted by this surveyor. The following resident rooms were noted: 102: 3 bed ward (216 square feet) 103: 2 bed ward (155 square feet) 104: 2 bed ward (149 square feet) 105: 4 bed ward (291 square feet) 106: 4 bed ward (289 square feet) 107: 4 bed ward (291 square feet) 108: 4 bed ward (288 square feet) 112: 4 bed ward (282 square feet) 115: 4 bed ward (283 square feet) 119: 4 bed ward (288 square feet) 201: 3 bed ward (220 square feet) 202: 3 bed ward (219 square feet) 203: 2 bed ward (155 square feet) 204: 2 bed ward (152 square feet) 207: 4 bed ward (291 square feet) 209: 4 bed ward (291 square feet) 211: 4 bed ward (288 square feet) (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Many	212: 4 bed ward (294 square feet) 214: 4 bed ward (289 square feet) 218: 4 bed ward (272 square feet) 219: 4 bed ward (287 square feet) Note: Queries were made of residents available for interview in the affected rooms. The residents verbalized they were not affected by the current room size. On 08/29/24 at 02:40 P.M., Record review of the Policy/Procedure entitled: Resident Rights dated 11/28/17 revealed under Purpose: It is the practice of this facility to provide for an environment in which residents may exercise their rights, each day. Our residents have certain rights and protections under federal law. Our facility meets and provides these rights through care and related services at all times . Safe Environment: The right to a safe, clean, comfortable, and homelike environment that allows independence as possible.

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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 104 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and decreased air quality. Findings include: On 08/27/24 at 10:05 A.M., A common area environmental tour was conducted by this surveyor. The following items were noted: Staff Break Room (Basement): The microwave oven was observed (etched, scored, particulate, corroded). The building rear exterior entrance metal door sweep was observed corroded and broken, allowing a significant air gap between the door slab and metal threshold plate. The significant air gap created an increased likelihood for pest entrance into the building. 1st Floor Back Dining Room: The wall mounted [NAME] air conditioner filters and intake grills were observed heavily soiled with accumulated and encrusted dust/dirt deposits. The two window tracks were also observed soiled with accumulated dust and dirt deposits. The window curtains were additionally observed worn, threadbare, and torn. 1st Floor Front Dining Room: The American Standard air conditioning unit intake grills were observed heavily soiled with dust and dirt deposits. The activity storage room was also observed in complete disarray. Holiday decorations and activity items were observed stacked on top of each other, within the storage room. The flooring surface was observed heavily soiled with accumulated and encrusted dirt/grime, and black from accumulated and encrusted dirt/grime deposits. 1st Floor West Soiled Utility Room: The liquid waste hopper interior was observed heavily soiled with accumulated and encrusted soil residue. The return-air-exhaust ventilation was observed non-functional. The ambient air was further observed extremely malodorous. Men's Restroom: Four of four commode base stalls were observed partially or completely plugged with human waste. One of four commode base stalls were also observed with human waste resting directly upon the flooring surface. One of four hand sink faucet assemblies were additionally observed missing both the hot and cold-water control handles. The four-hand sink basin countertop surface was further observed warped and sunken. The countertop front lip was also observed separated from the laminate surface, exposing the porous particle board subsurface. Storage Room: Four of four wooden shelving units were observed (etched, scored, particulate), exposing the porous particle board subsurface. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nurses Station: The restroom hand sink faucet assembly was observed loose-to-mount. The wall mounted radiator cover was also observed loose-to-mount, within the nurse station cubicle. The cubicle flooring surface was further observed soiled with accumulated and encrusted dirt/grime. The nurse station desk laminate surface was also observed (etched, scored, particulate, missing). The wall/floor junctures were further observed heavily soiled with accumulated and encrusted dirt/grime. Two bedside tables were observed (etched, scored, particulate), adjacent to the Nurses Station. Occupational/Physical Therapy: The rolling stool seat cushion was observed (etched, scored, particulate), exposing the inner Styrofoam padding. The Sharp Carousel microwave oven interior was observed (etched, scored, particulate). The black refrigerator exterior and interior was also observed soiled with accumulated and encrusted food residue. Oxygen Storage Room: The flooring surface was observed soiled with accumulated dust and dirt deposits. Paper tags were also observed resting upon the flooring surface. Bathing Room: The body wash and skin protectant dispenser exteriors were observed soiled with accumulated dust and dirt deposits. 1st Floor East Shower Room: Three anti-skid strips were observed (etched, peeling, missing), within the shower stall. The atmospheric vacuum breaker was also observed missing on the shower wand assembly. The shower wand assembly control head chrome plated surface was further observed etched and peeling. Women's Restroom: The commode base grab bar was observed loose-to-mount. Mop Closet: The mop sink basin was observed soiled with accumulated and encrusted dirt/grime. The flooring surface was also observed with two wire hangers, two plastic milk crates, and a severely soiled mop bucket. Staff Restroom: The return-air-exhaust ventilation grill was observed heavily soiled with dust and dirt deposits. The hand sink basin was also observed loose-to-mount. Nurses Station: The laminate countertop surface was observed (etched, scored, particulate, missing). The damaged laminate surface edge measured approximately 2-feet-long and 6-feet-long respectively. The upper laminate countertop surface corner edge was also observed completely missing. The damaged upper laminate countertop surface edge measured approximately 18-inches-long. 2nd Floor East The Sanyo wall mounted air-conditioning unit filters (4) were observed heavily soiled with accumulated dust and dirt deposits. Restroom: 1 of 4 hand sink basin faucet assemblies were observed missing the handle extensions. 2 of 2 overhead light plastic lens covers were also observed soiled with accumulated dust, dirt, and insect carcasses. The overhead light switch cover was further observed soiled with accumulated soil residue. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Nurses Station: The desktop laminate surface was observed (etched, scored, missing), creating a non-cleanable and non-sanitizable surface. The medication refrigerator was also observed unsecured. One Healthy Choice Pineapple Chicken meal and a bottle of drinking water was further observed stored within the medication refrigerator. The medication refrigerator ambient temperature was also observed to read 55.8 degrees Fahrenheit. The medication refrigerator was further observed with accumulated ice [NAME] resting upon the refrigeration coil plate. The restroom hand sink basin faucet assembly was additionally observed leaking water, was loose-to-mount and separated from the wall surface. The return-air-exhaust ventilation grill was also observed heavily soiled with accumulated dust and dirt deposits. 2nd Floor Back Dining Room: The [NAME] Electronic Air Cleaner intake grill was observed heavily soiled with accumulated dust and dirt deposits. The Blueridge wall mounted air-conditioning unit was also observed soiled with accumulated dust and dirt deposits. Previous moisture discoloration was further observed on the wall surface, adjacent to the Blueridge air-conditioning unit. 2nd Floor Front Dining Room: 8 of 8 return-air-exhaust ventilation grills were observed heavily soiled with accumulated and encrusted dust/dirt deposits. The Activity Storage Room was also observed in disarray. Activity items were further observed stacked upon each other. The drywall surface was also observed unfinished on the central column pillar. The unfinished drywall surface measured approximately 5-feet-wide by 6-feet-long times two. The wall/floor vinyl coving strip was further observed missing around the column pillar perimeter. 2nd Floor West Bathing Room: The return-air-exhaust ventilation grill was observed heavily soiled with accumulated and encrusted dust/dirt deposits. The commode base grab bar was also observed loose-to-mount. The oxygen storage room was further observed in disarray. Two wire hangers and paper tags were also observed resting upon the flooring surface. Nurses Station: The oscillating desk fan was observed heavily soiled with accumulated dust and dirt deposits. The desktop laminate surface was observed loose-to-mount in various locations. One small cockroach nymph was observed moving across the upper desktop laminate surface. One adult cockroach was also observed above the restroom entrance door. On 08/28/24 at 10:50 A.M., An environmental tour of the facility Laundry Service was conducted with Director of Housekeeping and Laundry Services K. The following items were noted: Clean Laundry Room: The large floor fan (36-inches-wide) was observed soiled with accumulated dust and dirt deposits. The wall surface, adjacent to the waste receptacle, was also observed soiled with dust, dirt, and debris. The flooring surface was further observed soiled with accumulated dust and dirt deposits, directly behind the three commercial driers. Soiled Laundry Room: The flooring surface was observed soiled with accumulated dust and dirt deposits. The corners and wall/floor junctures were also observed soiled with accumulated and encrusted dust/dirt deposits. The return-air-exhaust ventilation grill plate and interior plenum were additionally observed soiled with accumulated and encrusted dust/dirt deposits. The mop sink basin interior and backsplash faucet countertop were further observed heavily soiled with accumulated and encrusted soil residue. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Washing Machine Room: The flooring surface, located between and directly behind the two commercial washers, was observed heavily soiled with accumulated and encrusted dust/dirt deposits. On 08/28/24 at 11:05 A.M., An interview was conducted with Regional Director of Maintenance L regarding the facility maintenance work order system. Regional Director of Maintenance L stated: We have the TELS system. On 08/29/24 at 09:20 A.M., An environmental tour of sampled resident rooms was conducted with Director of Maintenance J and Director of Housekeeping and Laundry Services K. The following items were noted: 102: The window tracks were observed soiled with accumulated and encrusted dust/dirt deposits. One pest control monitoring glue board was also observed with numerous dead adult cockroaches, adjacent to the room entrance door. 104: The hand sink basin was observed loose-to-mount. One pest control monitoring glue board was also observed with numerous dead adult and nymph cockroaches resting upon the surface. The glue board was additionally observed resting on the flooring surface, directly behind the wooden wardrobe. The window tracks were further observed soiled with accumulated and encrusted dust/dirt deposits. The wall/floor vinyl coving strip was also observed missing throughout the entire room perimeter. 106: The window tracks were observed soiled with accumulated and encrusted dust/dirt deposits. The radiator metal cover upper ledge was also observed soiled with accumulated and encrusted dust/dirt deposits. 108: The hand sink faucet assembly was observed loose-to-mount. The wall/floor vinyl coving strip was also observed missing throughout the entire room perimeter. 110: The wall/floor vinyl coving strip was observed missing throughout the entire room perimeter. The radiator metal cover was also observed loose-to-mount, adjacent to the corner surface. The window tracks were additionally observed soiled with accumulated and encrusted dust/dirt deposits. 111: The wall/floor vinyl coving strip was observed missing throughout the entire room perimeter. The window tracks were also observed with accumulated and encrusted dust/dirt deposits. The flooring surface wall/floor edge was additionally observed heavily soiled with accumulated and encrusted dust/dirt deposits. 113: The wall/floor vinyl coving strip was observed missing throughout the entire room perimeter. The window tracks were also observed soiled with accumulated and encrusted dust/dirt deposits. 115: The wall/floor vinyl coving strip was observed missing throughout the entire room perimeter. The radiator metal cover upper ledge was also observed soiled with accumulated dust, dirt, and debris. The window tracks were additionally observed soiled with accumulated and encrusted dust/dirt deposits. The window shade was further observed soiled with dust, dirt, and food residue. 202: The electrical cover plate was observed loose-to-mount, adjacent to the wooden wardrobe next to the room entrance door. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	203: The oscillating wall fan was observed heavily soiled with accumulated and encrusted dust/dirt deposits. 207: The window tracks were observed soiled with accumulated and encrusted dust/dirt deposits. The radiator metal cover plate upper ledge was also observed soiled with accumulated and encrusted dust/dirt deposits. 208: The window tracks were observed soiled with accumulated and encrusted dust/dirt deposits. The flooring surface wall/floor vinyl coving strip was also observed missing throughout the entire room perimeter. 210: The hand sink basin was observed loose-to-mount. The window tracks were also observed soiled with accumulated and encrusted dust/dirt deposits. 211: The wall/floor vinyl coving strip was observed missing throughout the entire room perimeter. The radiator metal cover plate upper ledge was also observed soiled with accumulated and encrusted dust/dirt deposits. The window tracks were additionally observed soiled with accumulated and encrusted dust/dirt deposits. 212: The window tracks were observed soiled with accumulated and encrusted dust/dirt deposits. The wall/floor vinyl coving strip was also observed missing throughout the entire room perimeter. 215: The box fan was observed heavily soiled with accumulated and encrusted dust/dirt deposits. The flooring surface wall/floor edge was also observed heavily soiled with accumulated and encrusted dust/dirt deposits. The window tracks were additionally observed soiled with accumulated and encrusted dust/dirt deposits. 218: The window tracks were observed soiled with accumulated and encrusted dust/dirt deposits. On 08/29/24 at 02:15 P.M., Record review of the Policy/Procedure entitled: Daily Cleaning Procedures dated (no date) revealed under Procedures: (4) High Dust. Work your way clockwise around the room (starting at the door and finishing at the door) and dust all high surfaces. This includes, but is not limited to: pictures/prints, televisions, over-the-bed lights, blinds, vents, and all corners. (5) Disinfect. Work your way clockwise around the room (starting at the door and finishing at the door) and disinfect flat surfaces and high-touch items. This includes, but is not limited to: doorknobs, light switches, call lights, TV remotes, bed siderails, bed frame, footboard and headboard, bedside tables, closet handles, windowsills, chairs, heating unit, and any flat surfaces. If the resident has a fan in his/her room, check and clean routinely to avoid buildup of dust. (7) Clean Restroom. Complete the following steps in the restroom: (a) Restock all supplies - paper towel, toilet paper, soap, etc. (b) Empty trash (follow step 2 above). (c) High dust - lights, vents. (d) Disinfect sink area. (e) Disinfect toilet area - including handrails, call lights, and tub/shower. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/29/24 at 02:25 P.M., Record review of the Policy/Procedure entitled: Preventative Maintenance (TELS) and Inspections dated (no date) revealed under I. Policy Guidelines: It is the policy of (facility name) that in order to provide a safe environment for residents, employees, and visitors, a preventative maintenance program (TELS) has been implemented to promote the maintenance of equipment in a state of good repair and condition. Record review of the Policy/Procedure entitled: Preventative Maintenance (TELS) and Inspections dated (no date) further 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 08/29/24 at 02:35 P.M., Record review of the Direct Supply TELS Work Orders for the last 60 days revealed no specific entries related to the aforementioned maintenance concerns.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 22050 Based on observations, interviews, and record reviews, the facility failed to effectively provide pest control services effecting 104 residents, resulting in the increased likelihood for pest attraction and harborage. Findings include: On 08/27/24 at 10:05 A.M., The rear building exterior entrance door sweep was observed (corroded, loose, broken), creating a significant air gap between the door slab and metal threshold plate. The significant air gap created an increased likelihood for pest entrance into the building. On 08/27/24 at 10:20 A.M., One lone cockroach was observed on the flooring surface, near the 1st floor Back Dining Room entrance door. On 08/27/24 at 11:15 A.M., One small cockroach nymph was observed moving across the upper desktop laminate surface of the 2nd Floor [NAME] Nurses Station. One adult cockroach was also observed above the 2nd Floor [NAME] Nurses Station restroom entrance door. On 08/28/24 at 10:17 A.M., The facility Pest Control Program was reviewed with Director of Maintenance J and Regional Director of Maintenance L. On 08/28/24 at 10:30 A.M., Record review of the facility Pest Control Contract revealed the following treatment categories and frequencies: Crawling Insects & Mice - Interior serviced twice per month. (24/year) Exterior Treatment - May thru October treat for crawling insects and spiders. (6/year) Fall Invader Treatment - Fall time treat exterior for fall invaders. (1/year) ILT (Insect Light Traps) Service - Install 2 units service April thru October. (8/year) Rodent Control - 10 exterior bait stations serviced and cleaned monthly. (12/year) Supplemental Fly Control - Fly control large and small April thru November. (8/year) On 08/28/24 at 10:35 A.M., Record review of the Pest Control Technician Treatment Invoices for the last 12 months revealed no specific treatment for targeted pests only general treatment for pests. On 08/28/24 at 04:10 P.M., One housefly was observed flying throughout the facility Administrator's Office, during our day 2 team meeting. On 08/29/24 at 09:20 A.M., An environmental tour of sampled resident rooms was conducted with Director of Maintenance J and Director of Housekeeping and Laundry Services K. The following items were noted: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235463	A. Building B. Wing	08/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at the Park	111 Ford Ave Highland Park, MI 48203

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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	102: One pest control monitoring glue board was observed with numerous dead adult cockroaches resting upon the surface. The glue board was also observed resting on the flooring surface, adjacent to the room entrance door. 104: One pest control monitoring glue board was observed with numerous dead adult and small nymph cockroaches resting upon the surface. The glue board was also observed resting on the flooring surface, directly behind the wooden wardrobe. On 08/29/24 at 09:40 A.M., An interview was conducted with Resident #51 regarding cockroach activity. Resident #51 was asked: Have you seen any cockroaches in your room? Resident #51 stated: Yes. I have seen them around.