STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235254	A. Building B. Wing	11/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Grande Villa	2251 Springport Road Jackson, MI 49202

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake #2622799Based on observations, interviews, and record review, the facility failed to protect the resident's right to be free from mental, verbal and physical abuse by staff, for one Resident #1, of three residents reviewed.Findings include:Resident 1 (R1) was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary disease,repeated falls and macular degeneration and was admitted for short term rehab after a fall from her walker while at home. Review of the Minimum Data Set (MDS)dated 9/11/25, revealed R1 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS). Review of the facility reported incident dated 09/08/2025 reveled R1 reported while toileting her on 09/07/25 Certified Nursing Assistant (CNA) E, CNA E kept demanding R1 lock the wheelchair, R1 stated she couldn't and CNA E huffed. R1 stated she had trouble pulling down her pants and CNA E finished pulling down her pants and made the comment These people need to learn to help themselves. and threw a clean brief at R1 and walked out. R1's statement reflected she was crying during the investigation. Further review of the facility's investigation included an interview with R1's roommate at the time (R4) who was discharged at the time of the State Agency's investigation and was not available for an interview. R4's clinical record revealed R4 scored 15 out of 15 on the BIMS dated 8/22/25. When queried about the incident that occurred with R1 and CNA E on 09/07/25 R4's statement revealed she too had an issue on or about 8/30/25 with CNA E, alleging CNA E was rude and stated Everyone around you don't understand why you can't get up and walk to the bathroom R4 statement further reflected she felt like she had to care for herself when CNA E was working. On 09/24/25 at 9:25 am, during a bedside interview with R1, she was observed resting in a recliner chair and observed frail. R1 stated she had the call light on because she needed to use the bathroom. R1 stated she has and uses both a wheelchair and a walker but felt weak on 09/07 and when entering the room CNA E told R1 to get up and get her walker, R1 said CNA E was irritated when R1 requested help to get into the wheelchair because she felt weak. R1 stated she was having trouble pulling her pants down and CNA E impatiently tugged them down, threw a clean brief at her and said something to the effect of being at the facility for rehab and needed to learn to help themselves. R1 stated after CNA E threw the brief at R1 she told her to get herself cleaned up and to let her know when she was done. R1 said she did her own peri care with no assistance and struggled to put the brief that was thrown at her on. R1 elaborated she was weak and scared to death that she was going to fall and stated she almost did fall. R1 elaborated that she cried after CNA E threw the brief at her. R1 says she plays the incident over and over in her mind and still cries about it. R1 stated this was the lowest point in her life due to health issues and nursing home placement and could not understand why or how anyone could be so cruel. Of note, R1 cried during interview with this surveyor. On 9/24/25 at 1:14pm during a phone interview with CNA E she reported she didn't know who R1 was or any incident regarding an abuse investigation. CNA E stated she was fired on 09/15/25 but wasn't sure why. CNA E then stated she did work 9/07/25 and they were very short staffed and that R1 must have her confused with a different CNA. On 09/24/25 at 2:21pm during an interview with CNA G, it was reported that she was assigned to R1 on 09/08/25 and R1 was tearful and didn't want help with anything but thanked CNA G for being kind. CNA G stated she could tell something was wrong and upon probing R1 became tearful and told her CNA E she was scared because the day before CNA E was mean and told her she could and should be doing things for herself. CNA G stated R4 chimed in stating CNA E was a mean. Review of the facility's Abuse, Neglect and Exploitation policy dated 11/15/23 page 6. defined Mental abuse Includes, but not limited to humiliation, harassments, threats of punishment or deprivation. Page 7 of the abuse policy defined Physical abuse Includes, but is not limited to hitting, punching, slapping, biting and kicking. It also includes controlling behavior through corporal punishment. Page 7. defined Verbal abuse as Means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance regardless of their age, ability to comprehend, or disability.On 09/24/25 at 1:07 PM, during an interview with NHA A he offered no explanation for CNA E's behavior and stated CNA E was terminated on 09/15/25 for customer service issues related to R1.

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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** This Citation Pertains to Intake #2624374Based on observation, interview and record review the facility failed to develop and implement a plan of care related to deep tissue injury for one resident (#2) of two reviewed for skin care plans. Review of the clinical record revealed Resident 2 (R2) was admitted to the facility on [DATE] for short term rehabilitation after a fall at home that resulted in a pelvic fracture. Review of R2's skin assessment dated [DATE] revealed R2 was admitted with a Deep Tissue Injury (DTI) on the sacrum that measured in length 0.6 centimeters, a width of 0.5 centimeters. R2 scored a 15 indicating she was at risk for skin breakdown on the Braden Scale dated 9/16/25. Review of the nursing admission progress note reflected R2 was alert and oriented x 4. R2's Minimum Data Set had not yet been completed. On 09/24/25 at 9:39 am, during a bedside interview, R2 was observed resting in her recliner, R2 reported she fell at home on fractured her pelvis and sustained a bruise on her tailbone because of the fall. When queried what was being done for the bruise R2 reported the nurses put some sort of cream on it daily. R2 reported being significantly less mobile since the fall with fracture and was at the facility for short term therapy. R2 reported pain with movement and repositioning. Review of R2's care plans revealed that there was no care plan in place regarding R2's DTI. There were no interventions for prevention of further skin breakdown, nor were there any interventions for treatment to promote healing of R2's DTI. On 09/24/25 at 1:55 pm, during an interview with the facility's Wound Nurse & Unit Manager /Registered Nurse (RN) C she reported being the facility's wound nurse and reported there was a DTI on R2's sacrum it was not opened. RN C stated R2 received a foam dressing to the sacrum, had a specialty bed, was provided a cushion, and should be repositioned frequently. RN C stated R2 can reposition self but would cause shearing and should be helped by staff for repositioning. Review of R2's care plans was done with RN C who agreed there was nothing in place to promote the healing of the DTI or prevent further pressure ulcers from developing.