STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235289	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Borgess Place	3057 Gull Road Kalamazoo, MI 49048

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2795029.Based on interview and record review the facility failed to implement an effective discharge planning process to ensure a safe and orderly discharge for 1 resident (Resident #103) of 3 residents reviewed for discharge process, resulting in lack of a capable caregiver in place and the necessary durable medical equipment available prior to discharge to the community.Findings include: Review of an admission Record revealed Resident #103 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: aftercare following joint replacement surgery, artificial left knee joint, and hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (inability to move one side of the body due to brain damage from a blood clot).Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 2/11/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #103 was cognitively intact. Review of Resident #103's Discharge Care Plan revealed, .has care needs that presently requires the support and services of the skilled rehabilitation care setting. Discharge potential and discharge planning needs have been assessed by the interdisciplinary team (IDT). Discharge potential is good, and the stay is presently identified as short-term. I intend to work with my social worker on discharge planning to the community and d/c (discharge) to the community when I am clinically cleared to be able to do so. Date initiated: 1/12/26. Goal: Resident will work to regain strength and abilities and discharge to the community when clinically cleared to be able to do so, by next review. Target date: 4/12/26. Interventions: .Arrange for a physician's order for discharge. be sure to include any necessary recommendations as made by the IDT .Coordinate, communicate, and confirm all discharge arrangements such as home health, outpatient, physician appointments, and equipment needs. D/C Planning: Evaluate discharge potential including medication compliance, independence, self-care/hygiene, ADL (activities of daily living) deficits and self-management skills as indicated, initiate assistance with discharge planning as necessary. It is important that any discharge be to a safe environment where the resident will receive on-going medical and mental health services. Discuss resident strengths and abilities with the therapy team. Recognize that multiple co-morbidities will impact discharge planning. Document, explain/teach follow up care techniques as required and provide written instructions to both resident and healthcare representative. Help the resident and support system identify a post-discharge care plan that will provide necessary services and minimize future hospitalizations which may include in-home caregivers. If DME (durable medical equipment) is needed, Please assist resident with gathering the necessary paperwork from their physician .Meet with resident and their family/representative to discuss plans for discharge. Discuss expectations and resources necessary for their return home .In an interview on 3/24/26 at 1:36 PM, Licensed Practical Nurse (LPN) C reported that she had taken over care for Resident #103 about 2 hours before her shift was over (4:00 PM) on 2/23/26 and was told that the resident was all packed and ready to discharge and his paperwork was on the counter. LPN C reported that Social Services (SS) S told her that Resident #103's family member (FM U) had been in the facility earlier that day and then left upset (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about the resident having to discharge but was going home to prepare the house and arrange for transportation. LPN C reported that she did not have any discharge conversations with Resident #103 or FM U and was not aware that Resident #103 had been picked up by the ambulance until a Certified Nursing Assistant (CNA) notified her that the resident had left.Review of Resident #103's Nurse's Note by LPN C created on 2/27/26 at 1:24 PM, effective date 2/23/26 at 5:15 PM revealed, Received report that resident was awaiting a ride for discharge, assisted resident with packing his room, assisted aide with toileting resident. Went to check on resident during report resident was out of room, ride for pick up did not get D/C (discharge) paperwork that had been printed and was ready for resident upon pick up.In an interview on 3/24/26 at 11:32 AM, Business Office Manager (BOM) V reported that Resident #103 was served a notification on 2/20/26 stating that his last covered service day was 2/22/26. BOM V reported that on 2/23/26, FM U told her that she had appealed the insurance denial of coverage but BOM V had not receive a notification that an appeal was started therefore informed FM U of the cash cost per day. BOM V reported that normally while an appeal was pending the resident would be allowed to continue services in the facility but since there was no pending appeal on record, the resident would have to discharged or pay cash. BOM V reported that she was not involved in the actual discharge planning or insurance appeals process but did discuss costs with residents if they wanted to stay and pay cash. BOM V reported that she had told FM U what the cost would be to pay cash and FM U decided to bring Resident #103 home. BOM V reported that she found out later that FM U had called the wrong phone number to request an appeal for Resident #103 to remain in the facility.In an interview on 3/24/26 at 12:14 PM, FM U reported that Resident #103 had called her from the facility on 2/20/26 after 5:00 PM and told her that the social worker had given him a notice that he would have to discharge on [DATE] but that he had signed a paper to appeal the decision. FM U reported that she had not heard anything more about a discharge until 2/23/26 at 10:10 AM when she received a call from the facility informing her that Resident #103 would be discharging at 11:00 AM that day. FM U reported that she realized that when Resident #103 had signed the form, it was not considered appealing the decision; FM U called the insurance company right away and left a message. FM U drove to the facility and spoke with SS S to tell her that they were appealing the notification to discharge and was waiting to hear back from the insurance. SS S told FM U that Resident #103 would have to discharge that day or pay cash but did not offer assistance with understanding the appeal process. FM U expressed her anxiety about not being able to take care of Resident #103 at home and asked to borrow a wheelchair, but when she was denied any assistance from the facility, she packed Resident #103's belongings, called an ambulance to pick up the resident, and went home to prepare the house; FM U contacted neighbors to be present to help her with Resident #103 when the ambulance arrived. FM U reported that she did not have any discharge planning discussions with the facility, she did not get any caregiver instructions or education, the facility did not assist with a referral for outpatient therapy services, home health services or durable medical equipment. FM U reported that it took about a week to get a wheelchair and hospital bed donated and delivered to their house, but until then Resident #103 laid in bed. FM U reported that after Resident #103 discharged , FM U had called the facility multiple times trying to get discharge paperwork and finally had to ask the ombudsman for assistance to get the paperwork. Review of Resident #103's Notice of Medicare Non-Coverage revealed, .The effective date coverage of your current services will end: 2/22/26. The notice was signed by Resident #103 on 2/20/26.Review of Resident #103's Social Services Note written by SS S dated 2/23/26 at 10:24 AM revealed, Spoke with resident's wife regarding discharge today. Resident has filed an appeal with the insurance company and awaiting answer. Wife expressed anxiety with today's discharge and states that she does not have transportation scheduled at this time, but she will coordinate after speaking with insurance. There were no other notes related to discharge communication with resident and family.In an interview on 3/26/26 at 10:48 AM, SS S reported that she was very new to the facility and the social services role on 2/20/26 and had only a few days of training. SS S reported that she (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	packet scanned into his record after it was reviewed and signed by the resident, but there was no packet scanned into his record. MDS-C K reported that she was on the email thread on Friday 2/20/26 that indicated Resident #103's last covered day was 2/22/26 and needed to be served a notification of his insurance benefits ending. MDS-C K reported she realized at 4:10 PM on 2/20/26 that the new social services staff SS S was not included on the email thread, so she forwarded it to her so that Resident #103 could be notified and file for an appeal if desired.Review of Resident #103's Discharge Packet that was discovered in a shred box by MDS-C K on 3/26/26 at approximately 3:30 PM, included Resident #103's medication orders, care plan, and a discharge document. The discharge document My Transition Home-Discharge was dated 2/23/26 at 9:44 AM revealed, .Post-discharge resources: Home health care, physical therapy, occupational therapy. Home health Agency (name omitted) (no addresses or phone numbers entered in document blanks), Post-Discharge Equipment/Supplies Needed: Wheelchair, Ambulation: Needs physical assistance: extensive assist with transfer. discharge date : [DATE]. Method of transportation for discharge: (question not completed). Discharge Instructions reviewed with: (question not completed). Signatures: signature confirming you have reviewed this document and acknowledge a copy is being given to resident and/or resident representative. Resident or Resident Representative: (No signatures entered) Date: (no date entered). Printed name of staff member: (no name entered).Review of the facility policy Transfer and Discharge Guidelines dated 5/5/2025 revealed, .The facility will work with the physician to obtain adequate documentation about the reason to discharge the resident. The facility will provide preparation and orientation to the resident, family and receiving facility prior to discharge . The facility may not transfer or discharge a resident while the appeal process is pending . Notifications: The interdisciplinary team designee will meet with the resident and resident representative as applicable to review the discharge/transfer notice and its contents . Appealing the notice: The interdisciplinary team designee will meet with the resident to review and explain the notice to the resident and their representative and discuss the resident's right to appeal the discharge. a. If the resident wishes to appeal the social worker will provide information and assistance to obtain, complete, and submit the appeal request. b. During the appeal process, the resident will not be discharged . D. Documentation of notification: a. The resident's physician and facility staff will document in the resident's record: The resident's health status at the time of notice. Reason the services provided by the facility are no longer needed, document discharge needs and discharge plan . Date when staff reviewed the notice and its contents with the resident and resident representative. Date of formal discharge planning meeting and appeal rights. b. Documentation will include the basis for the transfer and the services to be provided by the receiving health care provider that will meet the resident's needs . F. Orientation for transfer/discharge: a. The facility will provide the resident with sufficient preparation and orientation to the upcoming discharge to ensure that the discharge is safe and orderly. The orientation will be provided to the resident and resident representative in a form and manner that can be understood .f. The facility will provide the appropriate education related to medication, treatments, medical care and services, psychosocial needs, care interventions and approaches and other applicable approaches for a safe care transition . Documentation: a. The resident needs and discharge plan must be documented in the medical record. If a discharge to the community is determined to not be feasible, document who made the determination and reason. b. The resident and resident representative will be informed of the final discharge plan . c. An evaluation of the resident's discharge needs will be documented in the resident record on a timely basis. The results of this evaluation will be discussed with the resident or resident representative .

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2799926.Based on interview and record review, the facility failed to develop a baseline care plan related to high risk for falls in 1 resident (Resident #101) of 3 residents reviewed for falls, resulting in an unwitnessed fall with major injury.Findings include: Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: sepsis (life threatening condition cause by an infection), weakness, cognitive deficit (impaired mental processes), insomnia (unable to sleep) and repeated falls. Review of Resident #101's Social Services Note dated 1/16/26 indicated, a Brief Interview for Mental Status (BIMS) score of 4, out of a total possible score of 15, which indicated Resident #101 had severe cognitive impairment.Review of Resident #101's Fall Assessment dated 1/15/26 at 2:02 PM revealed, High Fall Risk. Score: 24.3 or more falls in past 3 months, intermittent confusion, Ambulation/elimination status: ambulatory/continent.hospitalization history in the last 30 days, Mobility: Is resident able to walk with or without assistance and/or device? NO. If the resident is unable to walk, describe the resident's mobility in wheelchair: Confined in a wheelchair and disoriented. A score of 10 or higher indicates the resident is at high risk of fall. It was noted that the mobility status assessment was not an accurate reflection of Resident #101's status.Review of Resident #101's Fall Prevention Care Plan revealed no care plan developed related to fall prevention and/or the resident being at high risk for falls until 1/20/26, after resident #101 fell and discharged to the hospital. Review of Resident #101's ADL (activities of daily living) Care Plan revealed, Resident requires assist with daily care needs r/t (related to) general weakness/debility. Date initiated: 1/16/26. Interventions: Dining: Resident with direct feeding assistance for po (by mouth) intake.Date initiated: 1/16/26. The remainder of the interventions were created 1/19/26 after Resident #101 fell and discharged to the hospital. The record did not indicate if the resident was continent or incontinent and/or if there was a toileting program.Review of Resident #101's Incident Report-Fall Unwitnessed dated 1/19/26 at 6:00 AM revealed, .Resident had an unwitnessed fall. Aide walked into resident's room and observed resident sitting on the floor in front of the toilet, resident was sitting on her bottom with legs crisscross, blood trail from room to bathroom, resident had an episode of emesis (vomiting). Resident bleeding from right side of head, resident unable to describe what she was doing at the time of fall, nurse asked resident if she was in pain, resident stated yes but could not describe pain or describe location. Nurse manager agreed with nurse to send resident out after observing resident's head.In an interview on 3/25/26 at 2:29 PM, Registered Nurse Manager (RNM) F reported that Resident #101 was not safe to ambulate on her own, she was very weak, a new admit, and required at least 1 person to assist with transfers and ambulation. RNM F reported that Resident #101 had a baseline care plan developed within 24 hours of admission, but it did not include being at high risk for falls, fall prevention interventions or the level of assistance that she needed for transfers and ambulation. RNM F reported that after Resident #101's fall on 1/19/26 the care plans for high risk for falls, actual fall, skin, and pain were created and the ADL care plan was updated to reflect that she needed 1 person assistance. RNM F reported that having at least the transfer needs on the baseline care plan is important so that direct care staff know how to care for the resident.In an interview on 3/25/26 at 4:55 PM, Certified Nursing Assistant (CNA) M reported that she had worked with Resident #101 once before the day of the fall, and the resident was able to get out of bed and walk on her own, but she was unsteady. CNA M reported that she did not think Resident #101 was a major risk for falling because normally when a resident is at high risk for falling there are signs up in the room, a cushion on the floor by the bed, and we know to check on them frequently, but Resident #101 did not have those things.In an interview on 3/26/26 at 8:47 AM, CNA J reported that she was working with Resident #101 on 1/19/26 but had left the facility at 6:00 AM. CNA J reported that she heard that (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #101 had fallen and was sent to the hospital. CNA J reported that she had only worked with Resident #101 one other time and other staff had told her that the resident liked to walk around her room and do her own thing. CNA J reported that she did not know if Resident #101 was continent or incontinent, and the resident could not communicate toileting needs. CNA J reported that Resident #101's door was closed all night. CNA J reported that the last time she checked on Resident #101 was before 4:00 AM. CNA J reported that she would refer to the Kardex (care guide for CNA's) if she needed to find transfer and ambulation status.In an interview on 3/26/26 at 9:19 AM, Director of Nursing (DON) B reported that Resident #101 was assessed by nursing to be at high risk for falls upon admission and was evaluated by therapy and determined to require at least 1 assist for transfers and ambulation. DON B reported that the nurse managers should enter that information into the care plan. DON B reported that Resident #101 did not have a fall care plan and/or her transfer status documented in her care plan or Kardex until after she had fallen which was 4 days after admission. DON B reported the care plan carries over direct care needs to the Kardex. DON B reported that the CNA's are expected to refer to the information in the Kardex to determine the resident's needs; Resident #101 was at high risk for falls and she should have had frequent checks and should not have been ambulating on her own. DON B reported that she was not aware that Resident #101's care plan/kardex was missing the information until talking to this surveyor.In an interview on 3/26/26 at 11:25 AM, Occupational Therapist (OT) R reported that Resident #101 could not follow commands, did not use her call light, got up and walked on her own, but required assistance of at least one person to be safe. OT R reported that Resident #101 was evaluated and then discharged before treatment started.

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F 0658 Level of Harm - Minimal harm or potential for 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** This citation pertains to Intake #2791318.Based on interview and record review the facility failed to ensure residents received care in accordance with professional standards and per physician orders for 1 resident (Resident #104) of 3 residents reviewed for quality of care, when nursing staff failed to administer medications per physician order and resident request.Findings include: Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: chronic bronchitis (a long-term type of COPD (chronic obstructive pulmonary disease that makes breathing difficult) characterized by a persistent, mucus-producing cough). Review of Resident #104's Brief Interview for Mental Status (BIMS) dated 2/23/26 revealed, a score of 15, out of a total possible score of 15, which indicated Resident #104 was cognitively intact.Review of Resident #104's Care Plan revealed no documentation of chronic bronchitis, COPD, and/or cough. No documentation related to physician ordered medications.In a phone interview on 3/24/26 at 9:45 AM, Resident #104 reported that he was in the facility recovering from influenza and when he tried to rest or lay down, he would cough a lot. Resident #104 reported that he was prescribed Tessalon [NAME] (medication for cough) at the hospital because nothing else seemed to be effective. Resident #104 reported that there were multiple days between 2/15/26 and 2/19/26 that he asked repeatedly for the Tessalon [NAME] and was told that he could not have them. Resident #104 reported that he became angry with Registered Nurse (RN) D because he was coughing and could not sleep; Resident #104 reported that RN D got very defensive and refused to give him the medication. Resident #104 reported that RN D started offering cough syrup but refused to give him the Tessalon [NAME].Review of Resident #104's Physician Orders revealed, Benzonatate (cough suppressant) oral capsule (common name Tessalon [NAME]) give 1 capsule by mouth every 8 hours as needed for cough. Start date 2/9/26. DC (discontinue) date 2/13/26. The medication was administered 5 times over 4 days but not at all on 2/11/26.Review of Resident #104's Physician Orders revealed, Benzonatate oral capsule give 1 capsule by mouth every 8 hours as needed for cough for 10 days. Start date 2/13/26. DC date 2/23/26. The medication was administered 13 times over 11 days but not at all on 2/15/26, 2/17/26, 2/18/26 or 2/19/26. RN D's initials were NOT listed on any of the doses that were administered.Review of Resident #104's Physician Orders revealed, Guaifenesin (cough suppressant) oral syrup.give 10 ml by mouth every 4 hours as needed for cough. Start date: 2/17/26. There were 3 doses administered on 3 separate days, 2/17/26, 2/18/26 and 2/19/26. All doses were initialed by RN D.In an interview on 3/25/26 at 10:43 AM, Licensed Practical Nurse (LPN) X reported that Resident #104 had a persistent cough and regularly requested the Tessalon [NAME]. LPN X reported that the medication was stored in the medication cart and she did not remember a time that it was unavailable.In an interview on 3/25/26 at 10:56 AM, Certified Nurses Assistant (CNA) Y reported that Resident #104 would frequently get upset about not receiving his medications on time.In a phone interview on 3/26/26 at 8:05 AM, RN D reported that Resident #104 was insistent on getting the Tessalon [NAME] for his cough and he frequently asked for the medication. RN D reported that Resident #104 did not have an order for that medication, so she was not able to administer it. RN D reported that she did not notify the physician and she did not remember ever administering a cough syrup.In an interview on 3/26/26 at 3:25 PM, Nurse Manager (NM) F reported that there was an issue involving Registered Nurse (RN) D not honoring Resident #104's request for his cough medication. NM F reported that Resident #104 had brought it to the attention of NM F and RN D had no good explanation for why the resident did not receive his medication. NM F reported that Resident #104 had the physician's order for Tessalon [NAME] and the medication was available and should have been administered.Review of Resident #104's Provider Visit Note dated 2/20/26 revealed, .He has a multitude of complaints about some medications, timing of the medications. Recently had influenza A and was treated with Tessalon [NAME] and Tamiflu and (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	apparently significant improvement. He also has a history of COPD, was an ex-smoker.He still has some intermittent cough which is mostly dry.He has a multitude of mostly administrative complaints regarding his medication timing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235289	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Borgess Place	3057 Gull Road Kalamazoo, MI 49048

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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 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** This citation pertains to Intake #2799926.Based on interview, and record review, the facility failed to ensure that interventions for increased supervision and assistance were implemented for residents at high risk for falls for 1 resident (Resident #101) of 3 residents reviewed for fall prevention, resulting in an unwitnessed fall with laceration to the head and subsequent hospitalization for SAH (subarachnoid hemorrhage) and SDH (subdural hematoma). Findings include:Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: sepsis (life threatening condition cause by an infection), weakness, cognitive deficit (impaired mental processes), insomnia (unable to sleep) and repeated falls. Review of Resident #101's Social Services Note dated 1/16/26 indicated, a Brief Interview for Mental Status (BIMS) score of 4, out of a total possible score of 15, which indicated Resident #101 had severe cognitive impairment. Review of Resident #101's Fall Assessment dated 1/15/26 at 2:02 PM revealed, High Fall Risk. Score: 24.3 or more falls in past 3 months, intermittent confusion, Ambulation/elimination status: ambulatory/continent.hospitalization history in the last 30 days, Mobility: Is resident able to walk with or without assistance and/or device? NO. If the resident is unable to walk, describe the resident's mobility in wheelchair: Confined in a wheelchair and disoriented. A score of 10 or higher indicates the resident is at high risk of fall. It was noted that the mobility status assessment was not an accurate reflection of Resident #101's status.Review of Resident #101's Fall Prevention Care Plan revealed no care plan developed related to fall prevention and/or the resident being at high risk for falls until 1/20/26, after resident #101 fell and discharged to the hospital. Review of Resident #101's ADL (activities of daily living) Care Plan revealed, Resident requires assist with daily care needs r/t (related to) general weakness/debility. Date initiated: 1/16/26. Interventions: Dining: Resident with direct feeding assistance for po (by mouth) intake.Date initiated: 1/16/26. The remainder of the interventions were created 1/19/26 after Resident #101 fell and discharged to the hospital. The record did not indicate if the resident was continent or incontinent and/or if there was a toileting program.Review of Resident #101's Incident Report-Fall Unwitnessed dated 1/19/26 at 6:00 AM revealed, .Resident had an unwitnessed fall. Aide walked into resident's room and observed resident sitting on the floor in front of the toilet, resident was sitting on her bottom with legs crisscross, blood trail from room to bathroom, resident had an episode of emesis (vomiting) . Resident bleeding from right side of head, resident unable to describe what she was doing at the time of fall, nurse asked resident if she was in pain, resident stated yes but could not describe pain or describe location. Nurse manager agreed with nurse to send resident out after observing resident's head. Resident was assisted off floor by aid and nurse manager into shower chair and transferred from shower chair to stretcher by EMS (emergency medical services) .Review of Resident #101's Hospital Records dated 1/19/26 revealed, .presenting after being found down at her nursing home. Patient not able to answer questions for me or follow commands. laceration to R (right scalp).Impression and Plan: .presenting with SAH (subarachnoid hemorrhage) and SDH (subdural hematoma) (these are both serious forms of brain bleeding) after being found down at her nursing home.Neurosurgery recommending MMA (middle meningeal artery) embolization (a procedure to block the flow of blood that is causing the brain bleed).In an interview on 3/25/26 at 9:07 AM, Family Member (FM) T reported that Resident #101 had fallen in the facility on 1/19/26 and was hospitalized due to head injury and brain bleed; Resident #101 transitioned to hospice and recently passed away. FM T reported that Resident #101 had fallen multiple times at home prior to admitting to the facility and did not understand that she was not safe to walk on her own.In an interview on 3/25/26 at 9:26 AM, Licensed Practical Nurse (LPN) E reported that she was notified shortly after 6:00 AM on 1/19/26 that Resident #101 had been found on the floor in her bathroom and there was a large amount (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	of blood on the floor around her and a trail of blood from her bed to the bathroom. LPN E reported that the blood was coming from Resident #101's head but her hair was saturated and matted, so the actual laceration was not observed. LPN E reported that she called 911 right away and then notified the provider and the nurse manager. LPN E reported that Registered Nurse Manager (RNM) F assessed Resident #101 and agreed that the resident needed to be sent to the hospital.In an interview on 3/25/26 at 2:29 PM, RNM F reported that he had assessed Resident #101's head to determine where the blood was coming from and found a laceration on the back of her head. RNM F reported that Resident #101 could not verbalize what had happened. RNM F reported that Resident #101 was not safe to ambulate on her own, she was very weak, a new admit, and required at least 1 person to assist with transfers and ambulation. RNM F reported that Resident #101 had a baseline care plan developed within 24 hours of admission, but it did not include being at high risk for falls, fall prevention interventions or the level of assistance that she needed for transfers and ambulation. RNM F reported that after Resident #101's fall on 1/19/26 the care plans for high risk for falls, actual fall, skin, and pain were created and the ADL care plan was updated to reflect that she needed 1 person assistance. RNM F reported that having at least the transfer needs on the baseline care plan is important so that direct care staff know how to care for the resident.In an interview on 3/25/26 at 4:55 PM, Certified Nursing Assistant (CNA) M reported that during her initial rounds on 1/19/26 approximately 6:00 AM, Resident #101's door was closed and when she opened the door she noticed a lot of blood on the floor of the bedroom, leading into the bathroom. CNA M reported that she immediately alerted LPN E and then opened the bathroom door, finding Resident #101 sitting in a puddle of blood and vomit, with a large amount of blood in her hair. CNA M reported that she had worked with Resident #101 once before that day and the resident was able to get out of bed and walk on her own, but she was unsteady. CNA M reported that she did not think Resident #101 was a major risk for falling because normally when a resident is at high risk for falling there are signs up in the room, a cushion on the floor by the bed, and we know to check on them frequently, but Resident #101 did not have those things.In an interview on 3/26/26 at 8:47 AM, CNA J reported that she was working with Resident #101 on 1/19/26 but had left the facility at 6:00 AM. CNA J reported that she heard that Resident #101 had fallen and was sent to the hospital. CNA J reported that she had only worked with Resident #101 one other time and other staff had told her that the resident liked to walk around her room and do her own thing. CNA J reported that she did not know if Resident #101 was continent or incontinent, and the resident could not communicate toileting needs. CNA J reported that Resident #101's door was closed all night. CNA J reported that the last time she checked on Resident #101 was before 4:00 AM because after that time she was in a different resident's room until 6:00 AM because he had fallen, stating, that night was crazy. CNA J reported that she would refer to the Kardex (care guide for CNA's) if she needed to find transfer and ambulation status.In an interview on 3/26/26 at 9:19 AM, Director of Nursing (DON) B reported that Resident #101 was assessed by nursing to be at high risk for falls upon admission and was evaluated by therapy and determined to require at least 1 assist for transfers and ambulation. DON B reported that the nurse managers should enter that information into the care plan. DON B reported that Resident #101 did not have a fall care plan and/or her transfer status documented in her care plan or Kardex until after she had fallen which was 4 days after admission. DON B reported the care plan carries over direct care needs to the Kardex. DON B reported that the CNA's are expected to refer to the information in the Kardex to determine the resident's needs; Resident #101 was at high risk for falls and she should have had frequent checks and should not have been ambulating on her own. DON B reported that she was not aware that Resident #101's care plan/kardex was missing the information until talking to this surveyor.In an interview on 3/26/26 at 11:25 AM, Occupational Therapist (OT) R reported that Resident #101 could not follow commands, did not use her call light, got up and walked on her own, but required assistance of at least one person to be safe. OT R reported that Resident #101 was evaluated and then discharged before treatment started.Review of Resident #101's Occupational (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Therapy Evaluation dated 1/16/26 revealed, .Functional Skills Assessment-Functional Mobility: .Transfers: toilet transfer: partial/moderate assistance.Cognition/Communication Assessment: . Safety awareness: Impaired.Assessment Summary: .requires min a (minimal assistance) for ADLs.Review of Resident #101's Physical Therapy Evaluation dated 1/16/26 revealed, .Functional Mobility Assessment: .Transfers: .Partial/moderate assistance. Ambulation: Partial/moderate assistance. Assessment Summary: .Cognition: decision making ability for routine activities: severely impaired.Review of the facility policy Fall Evaluation Safety Guideline dated 11/28/17 revealed, Purpose: To consistently identify and evaluate residents at risk for falls and those who have fallen to treat or refer for treatment appropriately and develop an organization-wide ownership for fall prevention to: .prevent or reduce injuries related to falls. 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.Procedure: 1. Fall Risk Evaluation will be completed. 2. If evaluation finds the resident at risk, implement resident specific interventions/precautions. 3. Initiate, review and revise the fall care plan as appropriate, with new or discontinued interventions. Falls Prevention: environmental evaluation, individual risk factors, rounding, applied appropriate supervision, footwear, medication regimen review, management of incontinence/toileting program, evaluation for pain, evaluation of mental status, strength and balance, exercise programs, education.