STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Beecher Place	G 3201 Beecher Rd Flint, MI 48532

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interviews and record review, the facility failed to ensure to protect the residents' right to a safe, organized environment for 41 residents residing on the 4th floor when the nurse abandoned her assignment, leaving 41 residents without licensed nursing staff supervision, medication administration, or an emergency care capability for a period of over 2 hours (4:19 AM- 6:30 AM), without notifying the nursing assistants on the 4th floor and properly endorsing the keys to the two (2) medication carts, the medication room and narcotic boxes to a licensed nurse placing all 41 residents on the 4th floor at risk for serious injury or harm.Findings include:A review of the Facility Incident report, dated 2/11/25, submitted to the State Agency, revealed that an RN staff member (Nurse MI) assigned to the 4th floor left the faciity on 2/11/26 at 4:19 AM and did not return. According to the resident census record, on 2/11/26, the 4th floor has 41 residents, with 1 licensed nurse and 2 Nursing assistants to accommodate, provide care, and meet the medical and emergency needs of every resident. The conclusion, after a 5-day investigation done by the abuse coordinator, was that: Abuse was not substantiated. Although the facility recognizes that the nurse had left her assigned duties and should have waited for relief from another nurse, the abuse coordinator does not believe that the nurse (Nurse MI) intended to harm residents, and no negative outcome occurred.The Director of Nursing (DON) in an interview on 3/11/26 at 2:00 PM,) revealed that at the conclusion of the 5-day investigation, Nurse MI was terminated on 2/16/26 after the 5-day investigation and suspension pending investigation. When asked why she was terminated? The DON stated the following reasons:1.) Nurse MI left the unit with 41 residents without a relief from any licensed nurse, without proper endorsement of the medication keys, and without passing the medications due at 6:00 AM, PRN (as needed) medications for pain, discomfort or for anxiety were not assessed and administered by a licensed nurse for all residents who needed them on the 4th floor.2.) The DON also emphasized that Nurse MI had left the unit unbeknownst to the two nursing assistants of her leaving and did not return for the rest of the shift. Nurse MI left approximately at 4 AM without a proper handoff, leaving the keys with a nurse instead of the receptionist. The receptionist told the DON that she had brought it upstairs to the 3rd floor nurse because the receptionist thought she should give the keys to a licensed staff member, but the nurse from the 3rd floor did not take the keys for the 4th floor and refused to take 41 more residents when she already had the heaviest set at 48 census on the 3rd floor. The 3rd-floor nurse justified that she felt it would be unsafe to accept the responsibility. For 48 residents and add 41 more from another floor. The DON admitted she was the on-call manager that evening, but did not receive the call or text in a timely manner because she was asleep. The DON admitted that she did not hear the phone ring or see the text from Nurse MI until later that day, when she was asleep.3.) All Medications, assessments, and treatments due at 6:00 AM that day (2/11/26) were not administered and provided to residentsAn interview with the 4th Floor Unit Manager Nurse Q on 3/11/16 at 2:22 PM, indicated she came in early, arriving at 6:30 AM on 2/11/2026, because the nurse from the 3rd floor called her at 6:06 AM that there was no nurse on the 4th floor since 4:00 AM and left the keys with the front receptionist. Nurse Q stated they have balanced the narcotic cart, and there was nothing missing. There were 41 residents on the 4th floor. No one was sent out to the (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hospital on 2/11/26. There was no licensed nurse on the 4th floor; only the 2 Certified Nursing Assistants (CNA TJ and CNA VS) were providing care when Nurse Q arrived at approximately 6:30 AM. Nurse Q was asked what happened. She indicated that Nurse MI clocked out at 4:19 am. At that time, the 4th floor was unattended from 4:19 to 630 PM. Nurse MI did not wait for her relief to arrive and turned in the nurse key to the receptionist. Unit Manager Nurse Q indicated that she did not come sooner because she did not get a call, as she was not on call. The receptionist reported that she felt she should not have the key and that a licensed staff member should have it in case residents need scheduled or as-needed (PRN) medications. The receptionist went to see the nurse on the 3rd Floor to turn in the key, but the nurse said she already has 48 residents and can't take any more, or the 3rd floor nurse will end up being responsible for 89 residents total. Nurse Q stated she came in because it was over 2 hours with no nurse on the 4th floor. 41 residents will need their medications due at 6:00 AM and may acutely need pain as-needed medication.A narcotic reconciliation was performed on 3/11/26 at 3:00 PM on the 2 medication carts (East Cart and the [NAME] Cart) that hold the controlled substances and narcotic s lock box on the 4th Floor. The surveyor reviewed the East Cart Controlled Substance Shift Inventory and confirmed with the Unit Manager Nurse Q that there was no entry line for the date 2/11/26 at the 7:00 AM shift. When the Unit Manager was asked what the policy is. She said it requires a 2-nurse signature to balance the narcotics every shift. 2 nurses signatures at the end of the shift. If it is not written, it did not happen. The (West Cart) Medication Cart Controlled Substance Shift Inventory was reviewed for the dates 2/1/26 to 2/15/26, revealing that only one nurse (Nurse SG) signed in the oncoming Nurse Signature section.A telephone interview with the Certified Nurse Aide, CNA TJ, was conducted on 3/11/26 at 4:19 PM. When asked about the Nurse MI, she confirmed she was leaving the facility that night, but they did not know she had until the morning nurse showed up for the day shift. She remembered that night was busy, but nothing extraordinary happened that would require the resident's hospitalization, nor were there any falls. She worked with the other (CNA VS). We did not know the nurse had left until the morning nurse showed up at around 6:30 AM.A telephone interview with a Certified Nursing Assistant CNA VS on 3/13/2026 at 8:42 AM, revealed that she was that day from 10:00 PM to 7:00 AM during the time the Nurse left and went home too busy and did not realize that Nurse MI had left until we saw a nurse at around 6:30 AM and told us that she was the relief nurse and that Nurse MI had left and gone home. Certified Nursing Assistant CNA VS stated that although we were busy with resident care between the hours of 4:00 AM and 6:00 AM, there were no falls or accidents, and no one was sent to the emergency room during the time we did not have a nurse. Nurse SG was interviewed on 3/11/26 at 3:22 PM. Nurse SG indicated that she was the oncoming nurse at 7 AM on 2/11/26. She revealed that it was the day when the nurse left the facility at 4 AM. No nurse attended to the residents for over 2 hours. Nurse SG started her shift at 7:00 PM on 2/11/26 and revealed that the 6:00 AM meds were not administered. Vitals due for medications were not done, and nebulizer treatments were not given. Nurse SG stated that the 8:00 AM due meds started right away. The Nurse manager arrived 30 minutes before me and helped me.A Nurse Practitioner was interviewed on 3/16/26 at 1:49 PM and indicated that he was at the facility on 2/11/26 and heard about the nurse leaving the residents. I was there after 12 noon and asked the nurses to assess. I did not see the residents; only the ones flagged in the entire building, not just the 4th floor. He confirmed that he was made aware of the 6:00 AM meds not given, but no reports of compromised residents were received.41 residents were reviewed for 6 AM Medication and PRN Meds on 3/16/26 at 11:00 AM. One of 41 reviewed was R6, who missed her albuterol nebulizer treatments at 12:00 midnight and 06:00 AM on 2/11/26. According to a Late entry nurse's notes dated 2/11/26 at 16:02 (4:02 PM), Resident was assessed. No signs or symptoms of pain or discomfort were noted. call light near bedside table with personal belongings nearby. Current plan of care continues. This nurse's notes were followed by another set of notes dated as Late Entry for 2/11/26 at 17:45 (5:45 PM). Noted: Resident returned to the facility from the hospital with no fluid restriction per her hospital paperwork . R6 was sent to the hospital on 2/11/26 for evaluation.Another resident (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5 required suctioning by mouth every3times a day to maintain a patent airway and as needed (PRN. The suctioning task was not done at 0600 AM on 2/11/26. R5 has a peg tube and his 6:00 AM medications due were not given including pain assessment and pain medication scheduled at 02:00 AM and at 6:00 AM via peg tube route for cancer pain to mandible/teeth/gums was not administered.On 3/16/26 at 12:00 PM, the Administrator was asked for a list of 4th-floor residents sent to the hospital on 2/11/26 and 2/12/26, and R6 was not on the list.A review of the Nurse MI employee record conducted on 3/11/26 at 3:30 PM revealed that Nurse MI left the faciity on 2/11/26 at exactly 4:19 AM. She was responsible for 41 residents that night, and her employment was terminated effective 2/16/26. The facility's termination was due to the investigation's findings and the violation of its policy. The details of the reason for Nurse MI termination were noted as: On 2/11/2026, you left your scheduled shift at approximately 4:19 am. Prior to leaving, the medication cart keys were provided to a non-licensed staff member rather than transferred directly to another licensed nurse as required by facility policy.The termination letter continued: As a licensed nurse, you are responsible for ensuring proper medication security and an appropriate licensed handoff before leaving your shift. The failure to transfer medication keys to licensed personnel and ensure appropriate nursing coverage resulted in the scheduled 6:00 am medication pass not completed as required.Residents Rights PolicyResident Rights policy was reviewed on 3/16/26 at 11:30 AM, and specified the purpose as: 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. Freedom from Abuse, Neglect, Misappropriation of Property and Exploitation The right to be free from verbal, sexual, physical, and mental abuse, involuntary seclusion, exploitation, and misappropriation of your property by anyone.The facility Employee Handbook(Section 3, page 28) was reviewed. This section, Employee Standards of Conduct, specifies examples of the types of behavior and conduct that are considered inappropriate and which will lead to disciplinary action up to and including immediate termination: . 21. Leaving work early before the end of the workday or not being ready to work at the start of a work day without approval of a supervisor; stopping work before the time specified for such purposes; failure to report an absence or late arrival; excessive absence or lateness or any absence without notice; punching in or out when not scheduled to work.23. Leaving an assigned workstation during work hours without the permission of a supervisor, except to use the restroom.

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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 Intake Numbers 2749071 and 2786475.Based on observation, interview and record review, the facility failed to permit readmission of a resident following a hospital evaluation and discharge, affecting one resident (Resident #101) of five residents reviewed for safe and appropriate discharge, resulting in Resident #101 lacking a safe discharge and being readmitted to the hospital pending a safe placement. Findings include: Resident #101 (R101):A review of R101's medical record revealed an admission into long term care at the facility on 09/06/25 with diagnoses that included aphasia (impairment of speech/communication), hemiplegia and hemiparesis (weakness and paralysis affecting the dominant right side) following a intracerebral hemorrhage (stroke), dementia with agitation, hallucinations, major depression, need assistance with personal care and a history of suicidal behavior. A record review of the Minimum Data Set (MDS) assessment on 12/13/2026 revealed a Brief Interview of Mental Status (BIMS) score of 11/15 that indicated moderate cognitive impairment.A record review of Intakes 2749071 & 2786475 was completed.According to a record review of R101's face sheet revealed: Listed under Miscellaneous information Date of discharge: [DATE] at 1800 (6PM) to Acute care hospital (name of hospital). On 03/11/2026 at10:54 AM, during an interview with Nurse D admitted having been familiar with R101 and that she had worked on R101's unit. Nurse D said she had worked at the facility for 5 years. When she was asked if she had knowledge about R101 having been sent to the hospital on [DATE] and 02/12/2026, she said yes. Nurse D said she was told ?it was for behaviors', however that she did know what behaviors. Nurse D said R101 was sent to the hospital on [DATE] and that on 02/12/2026, when R101 returned to the facility and was not allowed back. When asked why R101 was not allowed back when he returned from the hospital, she said that she had heard ?they did not really do anything or did not made any changes, so he was not allowed to return'. When Nurse D was queried, she said she could not recall whom she heard that from. Nurse D said that she thought that R101 was going to go to a different facility (named city) because family member F had come to the building and gathered R101's belongings. Nurse D said when they came to get R101's belongings that family member F said, ?the facility was making him leave' and that family member F expressed ?she was upset because he was going to be far away and she lives in this area'. Nurse D was queried if there were any other residents with similar behaviors of R101 that had lived in the facility, and she said yes. On 03/11/2026 at 11:33AM, During an interview with Nurse C she admitted having been familiar with R101 and that she had worked on R101's unit. Nurse C said she had worked at the facility since December of 2025. When asked about R101's demeanor she said R101 was combative at times, he would grunt loudly and that he got frustrated if he was not understood. Nurse C said that on 02/10/2026 she was called down to the dining room, she was told that R101 had kicked the conference room door where the upper management was having a meeting, shook his fists at other residents and yelled out while in the dining area. Nurse C said that the NHA said ?he can't be threatening other residents, and he needed to be sent out for a behavior evaluation'. Nurse C was asked what the threat was and said that R101 shook his fist at them. Nurse C was asked queried about R101's functional abilities, she said he was wheelchair bound for mobility. Nurse C said R101 was sent to the hospital, and that R101 returned to the facility later that evening (02/10/2026). When asked, Nurse C said she was aware that R101 was sent out to the hospital on [DATE], She said she did not know details, but she assumed for behaviors. Nurse C said that through word of mouth she was told ?management said if the ambulance comes to drop (R101) off we are not to accept him back'. When queried further she said Unit Manager (UM) B is who informed her of that.A record review of R101's Transfer to hospital or other facility assessment, dated 02/10/2026, revealed: Reason for transfer: increased behaviors with key clinical information: resident is refusing medication and having increased behaviors. Being physical with (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff, inconsolable and non-compliant. There was no Transfer to hospital or other facility assessment dated [DATE] to review.On 03/11/2026 at 12 noon, during an interview, UM B admitted having been familiar with R101 and that she was the UM on R101's unit. UM B said she had worked at the facility for 3 years. UM B was asked about R101's behavior on 02/10/2026, she said that he needed to go upstairs and he was upset, and he kicked the door to the conference room where the managers were in a meeting. When the morning meeting was finished, we (management) exited the room, R101 shook his fist at the staff and yelled. The UM B said that R101 was sent to the hospital to be evaluated and returned later that day (02/10/2026). UM B was asked if there were any concerns with R101's behavior when he returned, she said none that she was aware of.UM B was queried about the transfer to hospital assessment that she completed for R101 on 02/10/2026, where she referenced being physical with staff it was clarified that aside from the gesture of R101's shaken fist at the staff that there was no physical contact to the staff. The UM B was asked about R101's transfer to the hospital on [DATE], She said that R101 was in the dining area and was visibly upset yelling out (his niece's name). UM B said that the Regional Director of Clinical operations (RDC) A was on site and that the RDC A assessed R101. The UM B said that R101 calmed down from the interaction with RDC A. The UM B said that later that day (02/12/2026) that R101 was waiting for the elevator to return to his room and that when the door opened 2 residents exited, and that R101 punched one of the residents in the arm. When asked what happened with resident that R101 stuck, she said she was assessed and had no injuries. When asked about R101 she said that we got a petition for a full psychiatric evaluation by the medical director and R101 was sent out to the hospital. The UM B was asked if R101 returned to the facility and she said no. When she was asked if the hospital attempted to transfer R101 back she said, I believe so. The UM B admitted she was the facility's manager on call 02/12/2026 and that the hospital called her at 10 PM at night on 02/12/2026 to report that they were told the facility will not accept the resident back, UM B said she directed the hospital to her upper management, the DON and the NHA. UM B said she was not aware of the staff that was involved. When asked what happened after that she stated, I do not know it was 10 PM at night and the next day when I came in, he was not there. When she was asked why that happened UM B said that staff was aware per the NHA that R101 was not to return. When asked how staff knew, she said she could not recall how they were advised.On 03/11/2026 at 1:35PM, During an interview with NHA, he was asked about R101 transfer to the hospital on [DATE] and he said that the DON and the RDC A were overseeing it all as far as a timeline of events. The NHA said that the hospital has been in contact with the company and that RDC reported to him that ?as of 03/10/2026 the hospital had not done a psychiatric evaluation on R101'. The NHA stated the resident has the right to return we know that further saying that he has had incidents with residents and they were afraid to come out of their rooms because of R101. The NHA was queried about R101's care plan and what was done for his behavior past and present, his response was this incident was unprovoked and there were no triggers or warnings, so there was no way to predict it. The NHA admitted they have other residents with behaviors however said they were not a safety issue. The NHA was asked about the evaluation of the resident that was involved with R101 on 02/12/2026 and he said they were not physically injured. When NHA was asked: the location of R101 currently (03/11/2026), he said he is still at the hospital; If the facility had residents with similar behaviors, and he said yes; When asked how R10's behaviors differed, NHA said they were unpredictable.On 03/11/2026 at 1:47PM, during an interview RDC A was queried on R101's behaviors. She said that on 02/10/2026 R101 was sent out for behavioral evaluation related to an outburst in the dining room, that R101 had kicked a door and shook his fist at staff and other residents, and they were unable to redirect him. The RDC A said that R101 returned from the hospital the same day, when asked about his demeanor upon return she said he was calm, which was his baseline. The RDC A said that she met with him on the afternoon of 02/12/2026, he was in the dining room, he was calm and we colored together, we talked about his frustration with having limited verbal communication and he agreed. The RDC A said it was difficult to communicate (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/12/2026 revealed: Time incident occurred: 03:20PM according to the Incident summary. (R101) has been sent out to the local hospital where they have been asked to find placement.On 03/12/2026 at 10AM, during an interview, NHA was asked if the facility's intent was to permit R101 upon discharge from the hospital when he was sent to the hospital on [DATE] and he was asked to review his statement in the incident summary of 02/12/2026. After the NHA reviewed the statement out loud (R101) has been sent out to the local hospital where they have been asked to find placement. NHA then stated well, yes, we wanted them to find placement but if they couldn't we would take him back, if they wanted to do a proper discharge. When he was asked what was not proper from the hospital's discharge, he stated, we wanted a psychiatric evaluation done The NHA said he could see how it looked as if the facility would not take R101 back and then explained that we would if they couldn't find placement and he had an evaluation. The NHA was queried is he advised staff not to accept R101 back into the facility if he was discharged from the hospital and brought back to the facility by EMS/ambulance, and he said yes, he did not want R101 back without communication and I advised staff don't accept (R101) and call the DON or myself.The NHA was asked if there was a bed hold and he said he did not know. The NHA was asked if the ombudsman had been notified or if the family member F was given a right to appeal, he said SW will send that out. On 03/12/2026 at 12 Noon, during an interview with the DON, she was queried about the progress note placed by her in R101 chart that had an entry date of 02/16/2026 and was effective date 02/12/2026, and she said that it just took time to chart. The DON is asked to review the R101 chart and read the progress note from the nurse that was R101 on 02/12/2026, and she confirmed there was not one in the chart. The DON is asked to review R101's chart and read the physicians progress note that validated the reason for the resident petition that day on 02/12/2026 and or a discharge, and she confirmed neither was in the chart. The DON is asked if a bed hold was given for R101, and she said per policy yes. The DON was asked to review R101's chart and locate it, she confirmed there was not one in the chart. The DON said R101 is medically cleared, we wanted answers and directions on how to treat the residents' behaviors. The DON said that R101 is inpatient at the hospital and needed at psychiatric evaluation still. The DON was asked if she had any contact with the hospital and she said she attempted to call them on 02/13/2026 and did not hear back nor talk to anyone, and that the liaison follows up with the hospital, not her. The DON was queried about medication, and if they had residents that were on the medication Haldol (antipsychotic drug), after she reviewed a report, she said yes there were 4 residents in the facility on that medication. On 03/11/2026 at 1:21PM a phone call was made to SW G and a message was left. According to the hospital records review of R101 there was no petition for R101 in the medical records for either 02/10/2026 or 02/12/2026. A record review of the hospital records dated 02/10/2026 revealed that R101 had a Social work Psychiatric initial intake that revealed Since arrival in ED pt has been jovial and compliant; Pt denied SI/HI/AH/VH (suicidal idealization / homicidal idealization/ auditory hallucinations / visual hallucinations). with a Disposition: Return to (facility name).A record review of the hospital records dated 02/12/2026 at 1812 (6:12 PM) revealed that R101 Pt arrived calm and cooperative and Social worker notes revealed patient presents nonverbal but was able to provide his name by gesturing letters with his hands. Patient reports becoming upset with facility workers. Patient denies becoming physically aggressive and facility workers did not report to EMS any physical assault against residents/staff. Patient denies SI, HI, AH, VH. Patient calm and cooperative during assessment patient agreeable with plan of care to be transported back to mission point. Signed at 2031 (8:31PM).A record review of the hospital records dated 02/12/2026 revealed in ED to Hospital admission : Chief compliant : patient presents with at risk social status - patient from, patient was seen here discharged back to facility, facility refused to allow EMS to enter with the patient and sent back here, patient alert, resp (respiratory) easy and non-labored.A record review ED SW note dated 02/12/2026 at 2210 (1010PM) revealed: upon re- presentation to the ED, MSW attempted to make contact with (facility). However, was unsuccessful as the phone number listed did not ring. MSW made contact with the patient's daughter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	03/16/2026

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inquiring about a point of contact for collateral information and was provided with the (UM B) number. MSW made contact with (UM B) where she was unsupportive in resolving the issue and stated she was unaware why she was being contacted at 2210 (1010) when she was no longer at work period MSW notified manager about the current situation where the patient has represented to the emergency room after being refused to return to the facility. MSW requested an additional point of contact from (UM B) and was declined to provide MSW with collateral information on behalf of the patient or any additional contacts. Per note MSW submitted complaints to [NAME], and APS (adult protective services). ED medical decision making: recent ED note and other 100 notes have been reviewed. Patient was seen in the emergency department earlier today, felt safe for discharge back to his facility. His wounds were addressed here at that time period however the patient was not able to be allowed into the facility, so EMS brought him back here. Social work has been attempting to contact the facility throughout the night to arrange for him to be transported back to his facility. Patient is appropriate for discharge, when they are able to accept him. and due to patients' inability to return to his facility was subsequently admitted to further management care.A record review of the hospital records revealed a behavior medicine note revealed a Psychiatric consult was completed for R101 related to Adult medication management. behavior management. intermittent agitation. ParanoiaOn 03/11/2026 at 3:42PM, during a phone interview, SW G was asked if there was a petition for R101 that was sent from (the facility) and she said no there was not a petition sent. The SW G said that on 02/10/2026 R101 was seen, medical and psychiatrically evaluated and did not meet criteria for either to be hospitalized , R101 was discharged back to the facility without incident.The SW G said that on 02/12/2026 R101 was seen, medical and psychiatrically evaluated and did not meet criteria for either to be hospitalized , R101 was discharged back to the facility at 21:34 (9:34PM) by EMS where they were not permitted to enter the building with R101 and EMS returned to the hospital at 2248 (10:48PM) with the pt (R101). SW G said that the hospital called the facility to inquire and got no assistance. She said that she called the Liaison for the facility and said we have this resident here we did our psychiatric evaluation last night and we tried to return him to his facility, and they refused to take him back. SW G said that the Liaisons response was ?that the higher ups say that he cannot return to the facility because he is a danger to the other residents and the staff'. The SW G said that that had been the continued communication with the liaison at every communication. SW G said she has asked for an eviction from liaison since he has been medically cleared and the facility refused him to return, but none had been sent. SW G said she had been communicated with (R101's) family member F and she was upset and wanted (R101) close; we found a place in (city name) but placement has not been confirmed yet. When asked for dates SW G attempted to contact facilities,DON and NHA with no response she said 02/13/26, 02/16/2026, 02/18/2026 and 02/27/2026 and I have not called them back since then because we handed our documentation over to our attorney. According to a record review of the facilities Mood and Behavior Guideline: Guideline: It is the process of the facility that each resident must receive, and the facility must provide the necessary behavioral health care and services and medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment (483.20) and plan of care. For Emergent Changes; a. If resident displays behaviors or mood changes that are a potential danger to the safety, health or welfare of themselves or others, the interdisciplinary team will assess the resident's current status and in conjunction with the discharge guidelines make appropriate intervention or placement decisions. According to a record review of the facilities Transfer and Discharge Guideline: Purpose: It is the practice of this facility that each resident has the right to remain in the facility and not transfer or discharge a resident unless a transfer or discharge from the facility. and The resident and representative will receive timely notification, adequate preparation, orientation and information to make the transfer as orderly and safe as possible. The notice contains information about the transfer and information about the residents' appeal rights. The facility will assist the resident to obtain, complete and submit an appeal (continued on next page)

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	235363	A. Building B. Wing	03/16/2026

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	form at the resident's request. The resident will not be discharged during the appeal process. If the transfer is due to an emergency, the notice will be issued as soon as practicable. The facility forwards a copy all discharge notices to the Office of the State Long-Term Care Ombudsman and required state agencies as indicated. The objective of the transfer/discharge guideline is to ensure that the resident is informed of an impending discharge and their right to appeal the discharge. In addition, the intent of this guideline is to support each resident's right to voice concerns and refusal related to the impending discharge as well as notification of their appeal rights. The guideline provides guidance to facility practices for identifying specific circumstances that allow a resident's involuntary transfer/discharge and stipulates the information provided in the discharge notice, the documentation in the resident's medical record and the information shared with the respective State Agencies per requirement.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that a continuity of care was provided for 41 residents on the 4th floor and that the early morning medications and treatments were provided for 13 residents (R#2, R#3, R#4, R#5, R#6, R#7, R#8, R#9, R#11, R#12, R#13, R#14 and R#15) of 41 residents reviewed for medications and treatments not administered, when the licensed nurse left for over 2 hours without a nurse relief and without a licensed nursing staff to assess and respond to medical needs and emergencies.Findings include:A review of the Facility Incident report dated 2/11/25, submitted to the State Agency, revealed that an RN staff member (Nurse MI) assigned to the 4th floor left the faciity on 2/11/26 at 4:19 AM and did not return. According to the resident census record, on 2/11/26, the 4th floor has 41 residents, with one (1) licensed nurse and two (2) nursing assistants to accommodate, provide care, and meet the medical and emergency needs of every resident. The conclusion, after a 5-day investigation done by the abuse coordinator, was that: Abuse was not substantiated. Although the facility recognizes that the nurse had left her assigned duties and should have waited for relief from another nurse, the abuse coordinator does not believe that the nurse Nurse MI) intended to harm residents, and no negative outcome occurred.Between 4:19 AM-6:30 AM on 2/11/26, No licensed Nurse was in charged responsible on the 4th floor with 41 residents. No nurses on call responded for relief. There was no system in place that was effectively reached the Nurse Managers and informed of the situation when the keys were handed off to a receptionist at 4:19 AM. Both nurses assigned on other floors (2nd and 3rd Floor) that evening refused the extra tasks and responsibilities for the 4th floor. Tthe Manager on call for 2/11/26 was unavailable and did not respond to any text and call. According to the Director of Nursing (DON) in an interview on 3/11/26 at 2:00 PM,) revealed that at the conclusion of the 5 day investigation, Nurse MI was terminated on 2/16/26 after the 5-day investigation and suspension pending investigation. When asked for the reason/s for Nurse MI's termination, the DON stated the following reasons:1.) Nurse MI abandoned the unit with 41 residents without a relief from any licensed nurse, without proper endorsement of the medication keys, and without passing the medications due at 6:00 AM, PRN (as needed) medications for pain, discomfort or for anxiety were not assessed and administered by a licensed nurse for all residents who needed them on the 4th floor.2.) The DON also emphasized that Nurse MI had left the unit unbeknownst to the two nursing assistants of her leaving and did not return for the rest of the shift. Nurse MI left at approximately 4 AM without a proper handoff, leaving the keys with a nurse rather than the receptionist. The receptionist told the DON that she had brought it upstairs to the 3rd floor nurse because the receptionist thought she should give the keys to a licensed staff member, but the nurse from the 3rd floor did not take the keys for the 4th floor and refused to take 41 more residents when she already had the heaviest set at 48 census on the 3rd floor. The 3rd-floor nurse justified that she felt it would be unsafe to accept the responsibility. For 48 residents and add 41 more from another floor. The DON admitted she was the on-call manager that evening, but did not receive the call or text in a timely manner because she was asleep. The DON revealed that she fell asleep and did not hear the phone ring or see the text from Nurse MI or the facility.3.) All Medications, assessments, and treatments due at 6:00 AM that day (2/11/26) were not administered and provided to residents.The DON emphasized that they did not substantiate abuse because they did not think there was any intention of harm on the part of the nurse. There was no medical emergency or fall during the time she left until the day shift came.An interview with the 4th Floor Unit Manager Nurse Q on 3/11/16 at 2:22 PM, indicated she came in early, arriving at 6:30 AM on 2/11/2026, because the nurse from the 3rd floor called her at 6:06 AM that there was no nurse on the 4th floor since 4:00 AM and left the keys with the front receptionist. Nurse Q stated they have balanced the narcotic cart, and there was nothing missing. There were 41 residents on the 4th floor. No one was sent out to the hospital on 2/11/26. There was no licensed nurse on the 4th floor; only the 2 Certified Nursing (continued on next page)

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	235363	A. Building B. Wing	03/16/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistants (CNA TJ and CNA VS) were providing care when Nurse Q arrived at approximately 6:30 AM. Nurse Q was asked what happened. She indicated that Nurse MI clocked out at 4:19 am. At that time, the 4th floor was unattended from 4:19 to 630 PM. Nurse MI did not wait for her relief to arrive and turned in the nurse key to the receptionist. Unit Manager Nurse Q indicated that she did not come sooner because she did not get a call, as she was not on call. The receptionist reported that she felt she should not have the key and that a licensed staff member should have it in case residents need scheduled or as-needed (PRN) medications. The receptionist went to see the nurse on the 3rd Floor to turn in the key, but the nurse said she already has 48 residents and can't take any more, or the 3rd floor nurse will end up being responsible for 89 residents total. Nurse Q stated she came in because it was over 2 hours with no nurse on the 4th floor. 41 residents will need their medications due at 6:00 AM and may acutely need pain as-needed medication.A narcotic reconciliation was performed on 3/11/26 at 3:00 PM on the 2 medication carts (East Cart and the [NAME] Cart) that hold the controlled substances and narcotic s lock box on the 4th Floor. The surveyor reviewed the East Cart Controlled Substance Shift Inventory and confirmed with the Unit Manager Nurse Q that there was no entry line for the date 2/11/26 at the 7:00 AM shift. When the Unit Manager Nurse Q was asked what the policy is. She said it requires a 2-nurse signature to balance the narcotics every shift. 2 nurses signatures at the end of the shift. If it is not written, it did not happen. The (West Cart) Medication Cart Controlled Substance Shift Inventory was reviewed for the dates 2/1/26 to 2/15/26, revealing that only one nurse (Nurse SG) signed in the oncoming Nurse Signature section.On 3/16/26 at 11:00 AM, 41 residents were reviewed for Scheduled Medication, PRN (as needed) medication, and treatments, due early morning at 6:00 AM or during the night nurse shift:These are the following findings for residents reviewed on the 4th Floor:R#2: (R2)R2 was admitted to the facility on [DATE] with a diagnosis of Pain, Vascular Angioplasty, Malignant Neoplasm of Bone, and articular Cartilage Pressure Ulcer in addition to other diagnoses.According to the review of the Medication Administration Record dated February 2026, Supplements: Calcium Carbonate and Ferrous Sulfate, and morning scheduled medications such as Lasix 20 mg, 1 tab. At 0600 AM, Omeprazole tablets for indigestion scheduled for 0600 AM were not signed off; therefore, they were not administered as ordered. R2's as needed (PRN) Hydrocodone 5-325 mg 1 tablet give every 8 hours as needed for pain. was not assessed, nor was it given.R#3: (R3)R3 was admitted to the facility on [DATE], with a diagnosis of Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, nCOPD Chronic Pain Syndrome (Right and Left Leg Pain)According to the review of the Medication Administration Record dated February 2026, specifically on 2/11/26:Famotidine oral tab: 1 tablet in AM for cholesterol at 0600 AM was not given.Hydralazine HCl Oral Tabs 25 mg at 0500 AM. Give 1 tab by mouth every 8 hours for hypertension.Hydralazine HCL Oral Tab 50 mg . Give 1 tab by mouth every 8 hours, 0600, not given.Monitor BPA PRN (as needed) for chronic pain every 8 hoursand a PRN Hydrocodone 5-325 give 1 tab by mouth every 8 hours as needed. Last time given was 2/10/26 at 12:27 PM. R#4: (R4)R4 was admitted on [DATE], with the following diagnoses: COPD, Type 2 Diabetes Mellitus, Benign Neoplasm, Essential Hypertension, Heart Failure, and Acute Kidney Failure, in addition to other diagnoses.A review of R4 EMR of February 2026 revealed that on 2/11/26:Ipratoprium-Albuterol Solution 0.5-2.5 (3) mg/3ml. 3 ml Inhale orally every 6 hours for wheezing related to Chronic Obstructive Pulmonary Disease, due at 12:00 AM and 0600 AM; scheduled doses were not administered. R4 did not receive the ordered breathing treatment.ON 2/11/26.Pain Level was not assessed from 12 MN to 7:00 AM. An order for PRN Acetaminophen oral Tab 325 mg: may give 2 tablets by mouth every 4 hours, as needed for pain. The pain level assessment box was not checked or signed.Morphine sulfate Concentrate oral Solution was also available for pain as needed. Because there was no assessment for pain, this medication was not given at the midnight shift.A late entry note was entered on 2/24/26 at 12:59 PM for the date 2/11/26 notes. These notes were entered by the Director of Nursing (DON).R#5: (R5)According to the review of EMR, R5 was admitted on [DATE] with the diagnosis of malignant neoplasm of the Mandible, gastrostomy, essential hypertension, and (continued on next page)

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	235363	A. Building B. Wing	03/16/2026

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	type 2 diabetes mellitus in addition to other diagnoses.According to the review of the Medication Administration Record dated February 2026, specifically on 2/11/26:R5, required suctioning by mouth every 3 times a day to maintain a patent airway and as needed (PRN). The suctioning task is scheduled at 0600 AM on 2/11/26. but was not signed as done. R5 has a peg tube, and his 6:00 AM medications:Levothyroxine Sodium Tablet 125 mcg: Give 125 mcg by mouth in the AM for low thyroid hormone, scheduled at 0600 AM- not administered.Gabapentine Oral Tablet 100 mg. Give 1 tablet via PEG-tub 3 times a day for trigeminal neuralgia due at 0600 AM on 2/11/26. It was not signed off; therefore, it was not administered by the licensed staff member.Ondenestron HCL Tablet 4 mg. Give 1 tablet via PEG-Tube every 8 hours for nausea due on 2/11/26 at 1200 midnight was not administered/not given, including pain assessment and pain medication scheduled at 02:00 AM and at 6:00 AM via peg tube route for cancer pain to mandible/teeth/gums was not signed off; therefore, it was not administered. R#6: (R6)According to the review of Electronic Medical Record, R6 was admitted on [DATE] with the diagnosis of Acute Respiratory Failure with Hypoxia, Type 2 diabetes Mellitus with diabetic Neuropathy, and senile degeneration of the brain in addition to other diagnoses.One of 41 reviewed was R6, who missed her albuterol nebulizer treatments at 12:00 midnight and 06:00 AM on 2/11/26. According to the nurse's notes (late entry) dated 2/11/26 at 16:02 (4:02 PM), it was written: Resident was assessed. No signs or symptoms of pain or discomfort were noted. call light near bedside table with personal belongings nearby. Current plan of care continues. This nurse's notes entry was followed immediately by another nurse's notes dated 2/11/26 at 17:45 (5:45 PM). Also labeled as Late Entry, noted: Resident returned to the facility from the hospital with no fluid restriction per her hospital paperwork . R6 was sent to the hospital on 2/11/26 for evaluation due to a change in condition. R#7: (R7)R7 was admitted to the facility on [DATE] with the diagnosis of Type 2 Diabetes Mellitus, Vascular Dementia, and Cerebral Atherosclerosis in addition to other diagnoses. According to the review of the Medication Administration Record dated February 2026, specifically on 2/11/26:Lidocaine Patch 4% to the Left and Right Knee pain was a scheduled order due at 0600 AM, but was not signed as applied at 0600 AM. R# 8: (R8)R8 was admitted on [DATE] with the diagnosis of quadriplegia, chronic pain due to trauma, tracheostomy, and gastrostomy. According to the review of the Medication Administration Record dated February 2026, specifically on 2/11/26:Baclofen oral tablet: Give 1 tablet by mouth every 8 hours for chronic spasticity due on 2/11/26 at 0500 AM. This was not signed off, therefore was not given.Med Pass1 was scheduled four times a day to increase energy and/protein due 1200 midnight and 6:00 AM and was not given.Tizanidine HCL oral capsule 1 capsule by mouth was scheduled to be administered 4 times a day for muscle spasms due at 0300 AM, but was not signed.Turn and reposition every 2 hours. 12:00 MN, 0200, 0400, and 0600 AM were all left blank; therefore, it was not signed asA Late entry note was entered on 2/24/26 at 12:35 PM for 2/11/26 by the DON: Resident was assessed. No signs and no symptoms of pain or discomfort noted, able to make all needs known if need be.The Director of Nursing (DON) on 3/16/26 at 1:30 PM, was asked about the timeline for late documentation and why it took 2 weeks to document in the nurses' notes. How would the nurses know that the assessment was done or whether there were positive or negative changes if it was documented 2 weeks later? The DON did not reply.A Policy for charting and documentation was requested.R#9: (R9)R9 was admitted on [DATE] with the diagnosis of Type 2 diabetes mellitus with Chronic Kidney Disease (stage 5), diabetic neuropathy, and conversion disorder with seizures or convulsions. According to the review of the Medication Administration Record dated February 2026, specifically on 2/11/26:Insulin Glargine Solostar Subcutaneous Solution Pen injector 100 units/ml. Inject 15 units subcutaneously in AM for diabetes. This injection was due at 0600 AM, but was left blank in the MAR; therefore, it was not administered as ordered. R#11: (R11)R11 was admitted to the facility on [DATE], with the diagnosis of Type 2 Diabetes Mellitus, Polyneuropathy, Pain in the left and right foot, COPD, and Anxiety in addition to other diagnoses.According to the review of the Medication Administration Record dated February 2026, specifically on 2/11/26:Furosemide tablet 20 mg: Give 1 tablet by mouth every (continued on next page)

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	235363	A. Building B. Wing	03/16/2026

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	morning and at bedtime, due at 0600 am and at 4:00 PM. On 2/11/26, the 0600 was not signed as given.A Late Entry Notes 2/24/26 at 12:46 PM by DON to reflect as for 2/11/26 nurses notes: Resident was assessed. No signs and symptoms of Pain or discomfort noted. Able to make all needs known if need be. R#12: (R12)R12 was admitted to the facility on [DATE], with a diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting the Left Non-Dominant side, low back pain, Diabetic Mellitus with diabetic polyneuropathy, Essential Hypertension, and Bipolar Disorder in addition to other diagnoses.According to the review of the Medication Administration Record dated February 2026, specifically on 2/11/26:Omeprazole Tablet Delayed Release 20 mg. Give 20 mg by mouth once daily for GERD (Gastroesophageal Reflux Disease), scheduled for 0600 AM on 2/11/26, but was not signed; therefore, it was not given.Sertraline HCL Tablet 100 mg. Give 2 tablets by mouth in the morning for depression, total dose of 200 mg.on 2/11/26 at 0600 am, this medication was not given.Ventolin HFA 108 (90 Base) MCG/ACT Aerosol, solution, 2 puffs in each nostril every 6 hours related to chronic Obstructive Pulmonary Disease. Scheduled at 12:00 MN and 0600AM on 211/26, was not administered.R#13: (R13) R13 was admitted at the facility on 6/19/24 with the diagnosis of Alcoholic Cirrhosis of the liver, Type 2 DM, and Essential Hypertension in addition to other diagnoses. According to the review of the Medication Administration Record dated February 2026, specifically on 2/11/26:Ipratropin-Albuterol Solution 0.5-2.5 (3) mg/3ml inhale orally every 6 hours for dyspnea/shortness of breath due at 12:00 Midnight and at 0600 AM as ordered was not administered.O2 Saturation , breath sounds, and the minutes of the breathing treatment were not documented for the 12:00 Midnight and 0600 AM.R#14 : (R14)R14 was admitted to the facility on [DATE] with the diagnosis of Acute Respiratory Failure, Hepatic Encephalopathy, Type 2 Diabetes Mellitus, Epilepsy, and cerebral infarction in addition to other diagnoses. According to the review of the Medication Administration Record dated February 2026, specifically on 2/11/26:R14 has an order: Losartan Potassium Oral Tab 50 mg. Give 1 tablet by mouth in the morning for hypertension. Hold SBP< 110. Blood Pressure and pulse were not taken, and the BP Medication was not given at 6:00 AM as ordered.A Late entry was noted for 2/11/26. No MD was notified. No medication order to Hold the dose and no MD recommendations were noted for this missed medication.R#15: (R15)R15 was admitted to the facility on [DATE], with the diagnosis of Chronic Heart Failure, Depression, Generalized Anxiety Disorder, and Pain in the left and right legs, in addition to other diagnoses. According to the review of the Medication Administration Record dated February 2026, specifically on 2/11/26:R15 scheduled blood pressure (BP) monitoring every 8 hrs ordered was not performed on 2/11/26, BP, Pulse 6:00 AM.A Late Entry Notes by DON done on 2/24/26 at 12:20 PM was noted for 2/11/26.On 3/16/26 at 11:45, an email request was sent to the administrator of the following policies for review, but the administrator did not receive the copy in Egress:Medication Administration PolicySchedule of MedsNarcotic Count PolicyFloor Nurse Change of Shift Report & DutiesMissed Medication PoliciesOn 3/16/26 at 12:00 PM, the Administrator was asked for a list of 4th-floor residents sent to the hospital on 2/11/26 and 2/12/26, and R6 was not on the list.A copy of the Charting and Documentation was reviewed on 3/16/26 at 2:00 PM:Policy Title: Charting and Documentation (10/2014, rev 11/2020)Policy Statement: All services provided to the resident, progress toward the careplan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's electronic medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235363	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Beecher Place	G 3201 Beecher Rd Flint, MI 48532

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that controlled medications were reconciled in each medication cart on the 4th Floor (East and West) when the nurse left the facility unauthorized on 2/11/26 at 4:19 AM and did not return.Findings include: During the narcotic count/reconciliation observation conducted on 3/11/25 at 3:00 PM, the Unit Manager of the 4th Floor Nurse Q explained that the 2 medication carts located on the 4th floor that carry 2 narcotic boxes, one from each Medication Cart. During this observation, the Unit Manager Nurse Q confirmed that a resident's Lorazepam (controlled substance) in a blister package had an inaccurate count. After we double-checked, the number of tablets was off by 2 and did not match the writteninventory record, there should have been 7 tablets, but only 5 were present.According to the Mayo Clinic (2026, https://www.mayoclinic.org/drugs), Lorazepam is used to treat anxiety disorders. It is also used for short-term relief of the symptoms of anxiety or anxiety caused by depression. Lorazepam is a benzodiazepine that works in the brain to relieve symptoms of anxiety. Benzodiazepines are central nervous system (CNS) depressants, which are medicines that slow down the nervous system.Incorrect/Inconsistent Narcotic Count Observed on 3/11/26::On 3/11/26 at 3:00 PM, A narcotic reconciliation count on the fourth floor was performed with the Unit Manager (Nurse Q). It was observed that one of the blister packs in the 4th Floor East Cart containing Lorazepam tablet 0.5 mg, 5 tabs left out of 30 in a pack, did not match the number on the narcotic count sheet. The order for this specific resident is to give a Lorazepam 0.5 mg tablet every 4 hours as needed for anxiety. The resident's narcotic sign-off sheet on 3/10/26 has 7 on hand. However, the actual count on the blister pack was 5, not 7 as recorded on the count sheet. The Unit Manager Q confirmed this observation and made copies of the count sheet and the blister pack discrepancy. The nurse assigned to the resident, when queried about the discrepancy, stated on 3/11/26 at 3:10 PM, She was planning to document them. The Unit Manager Nurse Q was asked what the policy was on documenting medication administration. Nurse Q said, Nurses should sign it as soon as it is administered. WEST Med Cart (4th Floor) Review:A review of the narcotic count sheet for February 2026 was conducted on 3/11/26 at 3:00 PM on the 4th floor (West) Medication Cart. Nurse SG confirmed that only one nurse signed the count sheet on 2/11/26 during the AM Shift. There should be 2 nurses' signatures. Nurse SG explained that the 2 signatures are from the Midnight (outgoing) and day shift (incoming) nurses. When asked what happened on 2/11/26 and why there was only one signature, the nurse SG confirmed that it was her signature on the inventory of the west cart, Controlled Substance Inventory, dated 2/11/26 at 7:00 AM, but there was no second nurse who verified and signed the count. She recalled coming in that day on 2/11/26, when they told her that the midnight nurse had left the building at 4 AM and had not returned. She recalled counting but did not know with whom she counted the narcotics. Nurse SG confirmed that on 2/11/26, there was no second nurse's signature found in the west med cart.EAST Med Cart (4th Floor) Review:The 4th Floor Unit Manager Q confirmed that the February 2026 reconciliation form entitled Controlled Substance Shift Inventory for the 4th Floor East Med Cart did not have an entry on [DATE], in the morning (7:00 AM) change of shift. Review of the Controlled Substance Sheet, specific to the date of 2/11/26, revealed that no narcotic/ controlled substance count was performed in the EAST med cart during the morning shift nurse-to-nurse handoff at 7:00 AM of 2/11/26, and there was only 1 nurse, as opposed to 2 nurses in the WEST Med cart.A review of the Nurse MI employee record conducted on 3/11/26 at 3:30 PM revealed that Nurse MI left the faciity on 2/11/26 at exactly 4:19 AM. She was responsible for 41 residents that night, and her employment was terminated effective 2/16/26. The facility's termination was due to the results of the investigation and to the violation of its policy. The details of the reason for Nurse MI termination were noted as: On 2/11/2026, you left your scheduled shift at approximately 4:19 am. Prior to leaving, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the medication cart keys were provided to a non-licensed staff member rather than transferred directly to another licensed nurse as required by facility policy.The termination letter continued: As a licensed nurse, you are responsible for ensuring proper medication security and an appropriate licensed handoff before leaving your shift. The failure to transfer medication keys to licensed personnel and ensure appropriate nursing coverage resulted in the scheduled 6:00 am medication pass not completed as required.