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	06/24/2026

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.

(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	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 Number 3032293. Based on interview and record review, the facility failed to ensure that facility employees did not falsify one resident's (Resident #26) medical records of one resident reviewed for professional standards, resulting in approximately 33 fallacious entries. Findings Include:On 6/14/2026 at approximately 1:00 PM, a review was conducted of Resident #26's medical records and it revealed he was admitted to the facility on [DATE] with diagnoses that included, Chronic Kidney Disease, Abdominal Aortic Aneurysm, Amnesia, Heart Disease, Chronic Obstructive Pulmonary Disease and Hypertension. Resident #26 has a guardian and was not allowed to leave facility premises without staff supervision. Review was conducted of the Resident Sign In & Out form that per facility management is used when residents go outside to smoke. Resident #26 signed out at 5:16 PM on 5/26/2026 and never signed back into the facility. On 6/15/2026 at 9:08 AM, Receptionist PP reported when Resident #26 signed out on 5/26/26 at about 5:20 PM, he reported that he was going to smoke. She provided him with his lighter and the one cigarette he had remaining. On 6/15/2026 at 10:30 AM, Resident #26 stated on the afternoon of 5/26/26 he made the decision he no longer wanted to be at the facility. He took his wallet, coat and a box of Kleenex when he left out. He walked to the Walgreens up the street and caught the bus with intentions of going to Mio/Fairview area. He did not realize the buses only routed around the city and would not take him out of town until a Police Office at the bus station informed him. The officer transported him to an overnight shelter where he remained until Noon on 5/27/26. The shelter releases everyone at Noon and they can return at 1:00 PM, Resident #26 stated there was no point in him returning and he hitchhiked to the Hill Rd area in Grand [NAME]. He stated he was on the highway for about 30 minutes trying to catch a ride when someone pulled up who was going to transport him. But at the same time a police officer arrived and began to question him and scared off his ride. Shortly after this staff from the facility observed him on the highway and he was transported back to the facility. The facility was unaware Resident #26 was missing for over 16 hours. In total he was unaccounted for approximately 20 hours. Review was conducted of charting completed on Resident #26 from 5/26/26 after 5:30 PM to 5/27/2026 at 2:15 PM when he was missing from the facility. There were 33 falsified entries during this timeframe related to medications administered, cares provided/observed, assessment and treatments. They are as follows:May 26, 2026:Atorvastatin Calcium Tablet 80 MG (milligrams) administered at 8:47 PM.Sertraline HCl Tablet 25 MG administered at 8:47 PMPain rated 0 at 8:47 PMSnack offered at 10:04 PMRefused to shower at 10:04 PMAte 51%-75% of his dinner at 7:10 PMDocumented Bed mobility status as independent at 7:10 PM.Documented Hygiene (Oral, Toileting, Personal) as independent at 7:10 PM.Documented Locomotion (Walk 10ft Wheel 150 ft) as independent at 7:10 PM.Documented Transfers as independent at 7:11 PM.Applied ointment at 7:11 PM.Documented No behaviors observed at 7:11 PM.Documented he voided and was continent at 7:11 PM.Documented resident did not have a bowel movement at 7:10 PMMay 27, 2026:Snack offered at 4:24 AMDocumented Bed mobility status as independent at 2:46 AM and 4:21 AM.Documented Hygiene (Oral, Toileting, Personal) as independent at 2:47 AM and 6:48 AMDocumented Locomotion (Walk 10ft Wheel 150 ft) as independent at 2:47 AM and 4:23 AM.Documented Transfers as independent at 2:47 AM and 4:23 AM.Applied (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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(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	ointment at 2:49 AM and 4:23 AM.Documented No behaviors observed at 2:49 AM and 4:23 AM.Documented he voided and at 2:49 AM and 4:24 AM.Documented he did not have a bowel movement at 2:49 AM.Documented he had a small bowel movement at 4:24 AM.Pressure relieving device was placed in chair at 2:49 AM.Offered and consumed 100% of snack at 2:49 AM On 6/16/2026 at 12:50 PM, an interview was conducted with the DON (Director of Nursing) regarding the falsification of Resident #26's record. She stated CNA NN was newer to the facility and still becoming acclimated. She thought who she saw and was charting on was Resident #26, but it wasn't him. CNA MM reported she documented all shift cares were completed for Resident #26 at the start of her shift. She stated she is not responsible for knowing the whereabouts of patients and that is the responsibility of the guardian and front desk. The CNA could not understand her culpability in the situation. The DON was queried regarding the midnight census that was completed. She reported it was completed for the 3rd floor and it indicated all residents were accounted for the night of 5/26/26 going into 5/27/26. The DON reported the facility staff that falsified documentation when Resident #26 was not in the facility was Nurse LL, CNA MM and CNA NN. On 6/16/2026 at 2:20 PM, an interview was conducted with Nurse OO regarding Resident #26. She stated she arrived at work at 7 AM on 5/27/2026 and received report from the night shift nurse. There was nothing communicated in report that was of concern and there was no mention that Resident #26 was missing. She went into Resident #26's room to administer his eye drops and he was not there, so she assumed he was outside smoking. About 20 minutes later Nurse OO circled back to his room and the resident was still not there and had not passed her in the hallway. The nurse asked his roommate who stated Resident #26 left yesterday around dinnertime and had not returned. Nurse OO stated once provided with that information she alerted management. They located him later in day by Hill Road in Grand [NAME]. Nurse OO shared prior to Resident #26's roommate informing her he had left, the facility was not aware he was unaccounted for. The midnight census is when they should make sure that everyone is back in the facility and properly accounted for. On 6/16/2026 at 2:40 PM, an interview was conducted with CNA NN regarding Resident #26's elopement and her inaccurate documentation. The CNA reported on 5/26/26 she worked 11 PM- 7 AM shift and report between the aides is sometimes walking rounds or verbal but she could not recall who she took report from that evening. When CNA NN went to Resident #26's room she did not see him and assumed he was outside smoking or in the common area. She stated she assumed he was in the facility but never laid eyes on him during her 8 hours shift nor did she alert her nurse that she had not observed Resident #26. CNA NN admitted to completing all the shift charting that triggered for Resident #26 in their system. She stated the tasks/cares she marked off as completed were erroneous as she had not Resident #26 the entire shift. CNA NN reported she understood that what she did was falsification of records. On 6/19/2026 at 12:45 PM, an interview was conducted with Agency Nurse LL regarding Resident #26. On 5/26/2026 she reported to work at 7:00 PM and could not gain access to their medical records system until around midnight (medication audit reports show invalidated this statement as untrue based on times medications were timed). Upon doing her medication pass she went into Resident #26's room and he was not there, she saw four gentlemen sitting outside (from the window) and assumed one of them was Resident #26. Nurse LL was asked if she ever went outside to verify that one of the men was Resident #26 and she stated she did not. She continued as she clearing the MAR she marked off Resident #26's medications as administered. She made a mental note to go back and strike it out as he does not take off his medications. Nurse LL was asked if at anytime during her shift she observed Resident #26 and she stated she did not. Review was conducted of facility witness statements obtained:Nurse LL completed on 5/27/26 at 9:59 AM, I popped his meds, I did sign out medications out like I gave them, but I have them in a cup. I was thinking that this was one of the patients that was already gone. CNA NN on 5/27/26 at 1:24 PM, .Last seen him in bed at the beginning of my shift approximately around 11:30p.He was laying in bed when I dropped off his water cup at around 11:30 PM. CNA MM on 5/27/26 at 1:40 PM, .I was assigned to him for the afternoon (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	shift on 5/26/26. I spoke to him about taking a shower, he walked past me and said he would take one later. I last seen him during dinner time. On 6/22/2026 at 1:10 PM, the Administrator was queried regarding the falsification of Resident #26's records by facility staff in his absence. The Administrator reported upon interviewing Nurse LL she stated she went in the room to administer medications and Resident #26 was not in his room and she never went back to follow up or look for him. When they initially called her she was panicking and repeating OMG (oh my god). She admitted to dispending his medications in a cup and signing them out but never administering them to him. Nurse LL did call management or alert the oncoming shift to Resident #26's absence. CNA MM completed charting for all her residents (including Resident #26) at the beginning of her shift. She began her shift at 3:00 PM and completed all shift charting at 5:00 PM. When the aide was asked about this, she stated she knows the residents and has been working with him for a long time and knows his routine. CNA MM could not understand the error with her actions. CNA NN was newly certified nurse aide and new to the facility. She shared she thought Resident #26 was a different resident and that is why her charting was inaccurate. Review was conducted of the facility, Code and Standards of Conduct. It stated .Negligence or any careless action which endangers the life or safety of another person.Dishonesty, falsification or alteration of facility's records or other documents. Falsification, alteration, destruction or other changes to resident charts, medical records or similar data.

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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 Number 3051417. Based on interview and record review, the facility failed to implement care plan interventions for one resident (Resident #2), complete a thorough investigation for an elopement for one resident (Resident #70), and ensure a safe transfer using a mechanical lift for one resident (Resident #20) of six residents reviewed for accidents, resulting in a fall with a fracture for Resident #2. Findings include: Resident 20 (R20): On 6/24/26 at 11:35 PM, an interview was conducted with Resident 20 who answered questions and engaged in conversation. The Resident was asked about any incidents that had happened recently with transfers. The Resident reported she had gotten hurt when she was getting from her bed into the shower bed in the hallway when the Hoyer lift (mechanical lift used to transfer a person with limited mobility from one location to another) tipped over on top of her. The Resident said she wanted to get into the shower bed from the side instead of the foot of the shower bed. The Resident reported the staff had not made a wide enough turn and had come up to the side of the bed, side by side, and when started to be lowered, she came down really fast and the Hoyer lift had fallen on top of her. The Resident reported having more than usual pain in her left shoulder and arm that had twisted when she dropped onto the bed. The Resident reported she had x-rays done, had to go to the hospital for more testing, was told there was a fracture, then told there was not a fracture but a torn ligament and stated, I don't know what is really going on. The Resident reported going to her own orthopedic specialist the next day, who had completed x-rays on that shoulder a couple months back and the physician will be able to compare the x-rays. The Resident reported that she has had more pain in her shoulder and arm since the incident occurred and stated, All I know is it hurts like crazy. The Resident indicated that a lot of stuff was in the hallway and the staff were unable to turn with enough room. The Resident reported stuff on both sides of the hallway An observation in the hallway near the resident's room revealed, a cart, mattress, Hoyer lift and shower bed. A review of R20's progress notes dated 6/17/26 revealed, Note Text: Res (Resident) arm injured during transfer into shower bed using hoyer lift while in hallway with two staff members. Unit manager, NP (Nurse Practitioner) notified, bilat arm xray ordered. No bruising noted at this time. Res pain 5 left shoulder right arm, states oxy that she received at 0910 is helping to dull the pain. Vitals wdl. Active rom (range of motion) in both extremities. A review of Resident 20's medical record revealed an admission into the facility on 6/30/21 with diagnoses that included morbid obesity, muscle weakness, difficulty in walking, pain in right elbow and left shoulder and anxiety disorder. A review of the Resident's Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 15/15 that indicated intact cognition and the Resident was dependent with tub/shower transfers. On 6/24/26 at 12:26 PM, a phone call was made to Nurse II regarding Resident 20's incident with transfer with the Hoyer lift. The Nurse reported that once they got the Resident from the bed in her room to the shower bed that was in the hallway, I was told by (CNA RR) that (Resident 20) wanted to go parallel to the shower bed. I was holding her under the sling. She was going to lower it and then we (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	went fast onto the shower bed. It happened really fast, when I looked up, she (resident) started to scream. I could see the Hoyer was tipped, my arms were under (Resident 20) and (CNA RR) was caught under the Hoyer. On 6/24/26 at 1:45 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident 20's incident on 6/17/26 with the transfer into the shower bed using the Hoyer lift. The DON reported that the issue was the staff came to the shower bed sideways and it had tipped over when getting the resident onto the shower bed. The DON reported that they could have come at it straight on, but the wall would have prevented the wheels from going far enough. They needed to go straight in from the head and then slide her down. The DON indicated the Resident had a preference; they did it her way and the Hoyer tipped over to the side. The DON reported that they should have done the transfer from the end of the bed and repositioned her once on the shower bed, and reported, they were trying to make the resident happy but that was not a safe way to transfer the resident. The DON reported education was given to the Nurse and CNA, education was started and we are still in the process of doing education for everyone, started the education but it is not complete. A review of the staff working on this day was compared to the education list provided and not all the staff working were educated. A review of the facility document Resident Transfer Incident Summary, for Resident 20, included the following: -Incident occurred on June 17, 2026, at approximately 10:00 AM during a Hoyer lift transfer to a shower bed. -Resident was being transferred by a Registered Nurse and CNA when the Hoyer lift became unbalanced and tilted toward the shower bed. -Resident lowered into the shower bed and subsequently reported right arm and left shoulder pain. -Diagnostic imaging was ordered on June 17, 2026, including bilateral shoulders and additional upper extremity studies. -Initial imaging suggested an appearing fracture involving the surgical neck and glenoid of the right shoulder/humerus. -Repeat imaging was obtained of the surgical neck and glenoid for clarification and ultimately showed no acute fracture of dislocation. NP informed, transfer to ER for recommended CT (cat scan) per the radiologist of the humerus. -The CNA reported that the resident preferred to be transferred parallel to the shower bed and that staff had educated the resident regarding the safety concerns of this method. -The assigned CNA who provided the resident's shower on June 13, 2026, was also interviewed and reported the resident had requested the same transfer method during that shower. -Investigation findings determined that staff deviation from established Hoyer lift transfer procedures to accommodate resident preference was the likely contributing factor. -Corrective action included staff re-education emphasizing proper Hoyer transfer and that resident (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	preference does not supersede safe transfer practices. Resident #70: On 6/15/2026, at 10:32 AM, Resident #70 was sitting on their bed and dressed for the day. Resident #70 stared at didn't answer any question. There was a staff member sitting in a chair inside the room. On 6/15/2026, at 1:39 PM, a record review of Resident #70's electronic medical record revealed an admission on [DATE] with diagnoses that included Disorganized Schizophrenia, altered mental status and hypoxic ischemic encephalopathy. Resident #70 required assistance with activities of daily living and had impaired cognition. A review of the progress notes revealed 5/31/2026 20:10 (8:10 PM) . Earlier in shift resident was found lying in bed with his wander guard off, when asked why it was off he seemed confused as to what it was, making statements that it's his mom necklace. Writer immediately placed wander guard back on and continued with current plan of care. Later in the day resident got past exit door while wander guard was in place and exited building via north stairwell. Resident was located by staff member walking into the parking lot coming from [NAME] st. Resident walked back to facility independently, front desk receptionist notified the floor for assistance, cena and nurse present at this time and returned resident to assigned floor. Code white called and elopement drill initiated. Resident safely walked himself back into the building and was met by staff and assisted back to the floor. Resident is at baseline and has been reoriented to facility and reeducated that he is not to go off the floor without staff, Administrator, DON, and management notified. On call provider and guardian also notified. Floor staff re-educated on protocol for when alarm goes off. Statements taken, resident wanderguard in place, working. Care plan reviewed, updated to increase monitoring. On 6/15/2026, at 1:45 PM, the Administrator was interviewed regarding Resident #70's elopement and if they had reported the incident. The Administrator stated, no. The administrator offered they had an investigation file on the elopement and would provide it. On 6/15/2026, at 3:08 PM, Unit Manager F was interviewed regarding Resident #70. UM Fprovided the resident was placed on one-to-one (staff observation) for safety. UM F provided that the resident did cut off his wander guard but then was placed right back on over that weekend. UM F was asked to explain the elopement and if Resident #70 did elope and UM F stated, Yes, from my understanding he didn't leave the parking lot. On 6/15/2026, at 4:20 PM, a record review of the elopement investigation revealed the following: 5/31/2026 18:50 (6:50 PM) Elopement . Resident exited building via north stairwell. Resident was located by staff member walking into the parking lot coming from [NAME] st. Resident walked back to facility independently, front desk receptionist notified floor for assistance, cena and nurse present at this time and returned resident to assigned floor . Immediate action taken . Code white called and elopement drill initiated. Resident safely walked himself back into the building and was met by staff and assisted back the floor. Resident is at baseline and has been reoriented to facility and reeducated that he is not to go off the floor without staff. Administrator, DON, and management notified. On call provider and guardian also notified. Floor staff reeducated on protocol for when alarm goes off. Statements taken. Resident wander guard in place, working. Care plan reviewed, updated to increase (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	monitoring . 5-31-2026 was doing my charting when I heard 414 bathroom light going off as I got up to answer the light I heard door alarm going off looked down toward the west wing seen (resident) coming from that direction I directed him to come back this way, went to answer the bathroom light as soon as I walked out the phone was ringing so I answered the phone and was ask to come down stairs, I went down stairs right away to find (resident) and staff trying to get him to come back up, I asked him to come back up and he got on the elevator and come up with me . (CNA J) . I was on my break sitting in my car, I looked up and (resident) coming down [NAME] Street towards the building. I saw resident stop near the entrance of the parking lot + began looking around + standing there. I blew my horn + resident began walking towards the building + goi inside . The facility was asked to provide a scanned copy of the file. On 6/15/2026, at 4:30 PM, a record review of Social Service Comprehensive evaluation . 5/08/2026 . Section C. BIMS score of 4 . Section F . Is the resident at risk to wander/elope . NO . was check marked. A review of the (resident) is an elopement risk/wander r/t (related to) poor impulse control, impaired cognition, Wandering F06F7E, expiration date 4/2028 Date Initiated: 05/12/2026 Goal The resident will not leave the facility unattended through the review date Date Initiated: 05/12/2026 Interventions Ensure that all staff are aware of resident's elopement/wandering risk Date Initiated: 05/12/2026 Ensure that exit and stairwell alarms are responded to in a timely manner Date Initiated: 05/12/2026 Ensure that facility check in/check out log is utilized appropriately Date Initiated: 05/12/2026 Ensure that resident's photo in on the wander/elopement list Date Initiated: 05/12/2026 Monitor resident frequently Date Initiated: 05/12/2026 Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes, Date Initiated: 05/12/2026 Use personal safety device (wander guard) to resident's, Ensure device is checked regularly, F06F7E, exp 4/2028 Date Initiated: 05/12/2026 A review of the Resident is at risk for elopement and requires monitoring for safety Date initiated: 05/07/2026 Goal Resident will remain free from elopement incidents. Date Initiated: 05/072026 Interventions Reorient Resident as needed to place, time, and situation if he shows exit seeking behavior. Date Initiated: 05/07/2026 On 6/16/2026, at 12:20 PM, an interview with Nurse W regarding Resident #70's elopement was conducted. Nurse W stated they were on break sitting in their car. When they entered the building, the resident was standing at the front desk. Nurse W offered, they understood that the housekeeper eric had observed the resident; I guess he walked from the back of the building, into the parking lot and back through the front door. Nurse W was asked what time this happened and Nurse W stated, about 6:10 PM. Nurse W offered, the alarm sounds in the whole building and they have to check the panel to find out what alarm is going off and have to double tap the alarm button to shut it off. On 6/16/2026, at 12:47 PM, CNA J was interviewed regarding Resident #70's elopement. CNA J explained they were charting and heard the door alarm going off. Resident #70 was near the west end door but did not leave through the doorway. CNA J offered, they shut the west end alarm off via the panel. CNA J provided that they instructed the resident to stay with them while they answered a bathroom light. CNA J provided that the resident stood outside the doorway, and they could see him but once CNA J exited the bathroom (was in the room approximately 5 minutes), the resident was gone out of view. CNA J heard the alarm and the phone ringing once they exited the room. CNA J stated, they answered the phone and the receptionist instructed them to come downstairs right away. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA J entered the elevator and went to the lobby where they found Resident #70. CNA J offered, the resident came back to the floor with them via the elevator with no difficulty. CNA J offered it was about 6:00 PM. CNA J was asked if the alarm was going off at north doorway and CNA J stated, I didn't hear it loudly. Call lights were going off and it wasn't high pitched. CNA J offered, there is no visual light for the stairwell doors. CNA J provided, they did have to put the code in the elevator to get the resident back upstairs so yes, he did have on the wander guard. On 6/16/2026, at 1:12 PM, the Director of Nursing (DON) was asked regarding Resident #70's elopement and if there was video of the elopement. The DON provided, the administrator did the full investigation. The DON was asked if the facility had a timeline of the event and exactly how long the resident was unaccounted for and the DON stated, there definitely should be a timeline, let me look. On 6/16/2026, at 2:00 PM, the Administrator was in their office and was asked how long Resident #70 was outside/unaccounted for and the Administrator stated, maybe 15 to 20 minutes but he never left the property. The Administrator was asked if they had video to prove that and the Administrator stated, I believe (Maintenance Director (MD) B) may have reviewed it. Corporate staff marcy quickly offered, we don't have the video. On 6/16/2026, at 3:28 PM, Maintenance Director (MD) B was interviewed regarding their part in Resident #70's elopement. MD B offered, they came to the facility to reset the alarms and they reviewed the video and that they observed Resident #70 go towards the north end stairwell and not return but was unable to see the resident exit the actual doorway due to the camera placement. MD B was asked to explain the sounds of wander guard alarm and MD B provided, the wander guard alarm is only at the elevator and the alarm going off was the fire egress door alarm. On 6/16/2026, at 3:30 PM, a record review of the facility provided video of Resident #70's elopement was conducted with MD B which revealed the following 17:09 . Resident #70 was observed in the hallway at the nurses station walking towards the north door stairwell. MD B stated, this is when he doesn't come back into view. At this time, MD B was asked to provide the video of the front entrance door/lobby camera starting at 17:09. The video played from 17:09 until 17:12 when Resident #70 was observed entering the building and stops at the front desk until 1713. The front desk has an opening that faces into the therapy hallway and into the front lobby. At 17:13, Resident #70 enters the therapy hallway and goes out of view until 1717:11 when they reenter the lobby near the elevators. At 1717:11, CNA J was observed exiting the elevator and immediately assisted Resident #70 onto the elevator. MD B was asked to provide the video surveillance of the therapy hallway starting at 1713. Resident #70 was not observed at any time on this camera angle. At this time, MD B was asked exactly what time the video footage was, and MD B stated, the time stamp is 1 hour off exactly. On 6/22/2026, at 12:29 PM, the Administrator was again asked if they reviewed the video footage of Resident #70's elopement and the Administrator stated, I did not. On 6/22/2026, at 1:00 PM, a record review of the summary of (Resident #70) incident: that revealed: . Around 6pm the housekeeper noted (the resident) was walking at the side of the building. He was redirected into the facility . There was no mention of exactly how long the resident was outside or unaccounted for. (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	06/24/2026

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident #2 (R2): R2 was admitted to the facility most recently on 03/24/26 with diagnoses that include left femur fracture, pneumonia and falls. R2 has a brief interview for mental status (BIMS) score of 14, indicating they are cognitively intact. On 06/16/2026 at 8:14AM, an interview was conducted with R2 about a fall that occurred in January 2026. R2 stated she was getting her brief changed by a certified nursing assistant (CNA). R2 stated the CNA was on my left side by the bed and rolled me up on my right side away from him. I told him I was slipping but he wasn't paying attention. The third time I mentioned that I was sliding off the bed, I hit the floor. R2 was asked if they were injured in the fall. R2 stated, yes, I broke a bone in my left leg and then I ended up having surgery on it. I was in the hospital for close to a week with the surgery. R2 was asked how many CNAs were present for the care at the time of the fall. R2 stated that it was just the one CNA that was providing care. On 06/16/2026 at 8:28AM, record review of a fall on 1/5/26 at 20:00pm revealed that R2 was observed on the floor next to her bed, face down on her stomach after rolling out of right side of the bed. R2 denies blocking head impact with hands. R2 stated, I was being changed by the CNA and was on my side, I started to roll and couldn't catch myself. Assessment completed, hoyered back into bed. Neuro checks initiated and skin assessments completed. Pain meds administered per orders. An x-ray was ordered for the left knee due to complaints of pain. R2 was taken to [NAME], returned to the facility on 1/9/26. On 06/16/2026 at 8:35AM, record review the bed mobility care plan revealed that R2 was an extensive two person assist for bed mobility at the time of the fall. There was one person assisting at the time of the fall. On 06/16/2026 at 8:55AM, record review of a progress note dated 1/6/2026 at 11:05AM, titled Nursing: Antigravity Team Note Date of Fall: 1/5/2026, Root Cause(s) of Fall: Non-adherence to the residents required 2-person assist during bed toileting and mobility. New Interventions: Resident care plan updated to specify 2-person assist with bed toileting and mobility. Resident/Resident Representative Notification: Resident is her own responsible party. Attendees: ID Team. On 06/16/2026 at 10:14AM, an interview was conducted with the Director of Nursing (DON). The DON was asked if the facility did an investigation for this fall. The DON stated, yes, we did an investigation. The DON was asked what was concluded from the investigation. The DON stated the root cause of the fall was the resident being pulled over too far to support herself. The Aide had one hand on her and was reaching for other supplies. The DON was asked what was R2's assistance level for bed mobility at the time of the fall. The DON stated at the time of the fall, R2 was a one assist for bed mobility and one assist for hygiene. The DON stated we reached out to our corporate staff, and they reviewed the fall as well and determined there was no deficient practice because R2 was a one assist for bed mobility at the time of the fall. This surveyor provided evidence that R2 was a two assist at the time for bed mobility. The DON was made aware of a progress note that the facility noted the root cause of the fall was staff not following the care plan for two person transfers. The DON was asked if staff should have used two staff members to assist R2 while turning in bed. The DON stated, yes, they should have used two people.

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	235363	A. Building B. Wing	06/24/2026

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Numbers 3051417 and 3052791. Based on observation, interview, and record review, the facility failed to maintain a clean sanitary environment by maintaining plumbing fixtures, dining rooms and the structural integrity of the facility. Findings include: On 6/16/26, at 2:00 PM, an observation of the 4th floor Dining Room revealed the doorway/door jamb into the dining area was marked up with black residue. There was paint chips noted. The right door to the credenza was broken and hung down. On 6/16/26, at 2:30 PM, an observation of the main Dining Room revealed the door and door jamb with gross amounts of black build up. There was paint scraped off. The floor was dirty with dusty dirt residue. The baseboard had a large area of chipped paint which revealed brown paint, yellow paint and also pink paint showing through. The floor air vents had large amounts of dusty build-up. There was a dining chair that faced the front window with a hand-written sign that read do not sit. The chair appeared to be broken. On 06/14/2026 at 8:53AM the floor was flooded, covered with a towel, and a wet ceiling tile was observed in the visitor's bathroom across from the rehab department. On 06/14/2026 at 9:04 AM, the tub in the bathroom in the unused room [ROOM NUMBER] was observed. The water continued to run with the hot water knob torn from the wall and the tub surface was discolored with a yellowish tint. On 06/14/2026 at 9:07AM a black substance was observed inside the toilet bowl in the unused room [ROOM NUMBER]. On 06/14/2026 at 9:12AM the warped floor near the tub was observed in the bathroom in the unused room [ROOM NUMBER]. In addition, a hole in the dry wall was observed directly above the tub. On 06/14/2026 at 9:14AM the tub in the bathroom in the unused room [ROOM NUMBER] was observed. The water continued to run and a green discoloration was observed on the tub surface and severe calcification buildup on the tub fixture. On 06/14/2026 at 9:45AM the floor was observed flooded throughout the bathroom to room [ROOM NUMBER]. A drip leak was observed from the hand sink drain line while the sink was turned off, and once the sink was turned on, water began to spew out from the drain line and onto the floor. In addition, the ceiling above the tub showed signs of a previous water leak and the ceiling was deteriorating. On 06/14/2026 at 10:36AM interviewed Certified Dietary Manager A on whether there was a previous leak in the dining room, and he stated there was a leak in the dining room a couple weeks ago, but the ceiling tile has since been replaced and the dining room was closed off during the leak. On 06/14/2026 at 1:01PM interviewed Maintenance Director B on the warped floor in room [ROOM NUMBER], and he stated there was a leak at one point in that bathroom which is why the floor is warped and a hole in the wall at the tub. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/14/2026 at 1:04PM interviewed Maintenance Director B on why the tubs in room [ROOM NUMBER] and room [ROOM NUMBER] are continuing to run, and he stated the hot water stem needs to be replaced to the tub in room [ROOM NUMBER], and there aren't any local shut off valves to the tubs, only the main shut off valve, so they would have to shut the water off to the whole building. On 06/15/2026 at 9:11AM wet ceiling tile was observed above the nurse's station on the 4th floor. On 06/15/2026 at 9:21AM interviewed Maintenance Director B on what was causing the leak on the fourth floor above the nurse's station, and he stated the roof leak just happened yesterday due to the rain and there were a couple cracks on the flat roof, which have been sealed this morning. Maintenance Director B stated this is the first time there has been a roof leak, and he described the flat roof as having a white sheet that can get rips in it. On 06/15/2026 at 9:35AM interviewed Maintenance Director B on the tub that continued to run in room [ROOM NUMBER], and he stated it was fixed and was the reason for the ceiling leak in the first-floor visitor's bathroom. On 06/16/2026 at 10:18AM interviewed Administrator on when the roof was installed and whether a roofing contractor has ever evaluated the roof, and she stated in the past year if there were any issues with the roof, maintenance would fix it, and it has been the same roof since Maintenance Director B has been working at the facility, which has been eight years. Record review of the facility's maintenance logs for room [ROOM NUMBER] with a creation date of 5/15 states Water running in bathtub for weeks. Need to be turned off with vice grips because its stripped to shut it off. The work order was updated on 6/15 and comments were noted, Main water of building had to be shut off to change tub hot water stem. Record review of the facility's maintenance logs for room [ROOM NUMBER] hand sink with a creation date of 6/15 states, Replace broken pipe under sink completed same day 6-14-26. The work order status was updated at the same time as the creation date. On 06/14/2026 at 8:35AM, observation revealed the visitor's restroom on the first floor had a wet towel on the floor. Upon opening the bathroom door water fell from the ceiling and the ceiling tile was wet. On 06/14/2026 at 8:45AM, observation revealed that the bathtub is running hot water in room [ROOM NUMBER] (this room is not in use) and leaking into the public restroom on the first floor. The handle is off the hot water faucet so it cannot be turned off. The sink is dripping as well. On 06/14/2026 at 9:50AM, observation revealed eight (8) oxygen tanks in the bathroom of room [ROOM NUMBER]. They are not in a cart and freestanding. Findings were verified with Unit Manager (UM) M.