STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235380	A. Building B. Wing	10/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Rose City	517 W Page St Rose City, MI 48654

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	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** 39059 This Citation pertains to Intake Number MI00147582. Based on observation, interview and record review, the facility failed to provide appropriate supervision, follow and implementtimely interventions for three residents (Resident #1,Resident #2 and Resident #3) of three residents reviewed for falls, resulting in repeated unwitnessed falls, an eyebrow laceration, right hip and left hip fractures with the likelihood of further falls and/or injuries. Findings include: Resident #1: On 10/23/2024, at 10:00 AM, Resident #1 was resting in a reclined geri-chair in the therapy room with the speech therapist. On 10/23/24, at 10:10 AM, a record review of Resident #1's electronic medical record revealed an admission on 9/6/24 with diagnoses that included intellectual disability, repeated falls and Dementia. Resident #1 had severely impaired cognition and required assistance with all Activities of Daily Living. A review of the Fall Risk Evaluation Admission 9/6/2024 revealed total score is 16 Total score of 5 or above is HIGH RISK. A review of the Physical Therapy PT Evaluation & Plan of Treatment Start of Care: 9/8/2024 revealed . Ambulation Walk 10 feet = Supervision or touching assistance . A review of the Fall - Unwitnessed . 09/13/2024 11:00 . This nurse called to nursing station, observed staff hoyering res into w/c. Res had fallen and obtained laceration to left brow. Res was assessed by DON, no further injuries noted. Resident unable to give description . Res assessed and received laceration to left brow, area cleansed, Res sent to ER for eval for need of stitches. Confused Gait Imbalance Impaired Memory Balance Problem were all check marked. (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 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the corresponding IDT progress note revealed IDT met to discuss resident fall. Root cause determined to be poor safety awareness d/t dementia diagnosis, has history of falls. Intervention for resident to be supervised with ambulation. Care plan reviewed and updated. A review of the Fall - Unwitnessed . 10/9/2024 1350 (1:50 PM) . CNA went to get resident up to take to lunch and when she went in room resident was sitting in wheelchair and said that she fell . Resident had no c/p at this time Resident stated she fell . After lunch RN attempted to get resident out of wheelchair. Resident was able to stand but unable to walk, right leg would give out. (physician) notified and Xray ordered . Injury location Right trochanter (hip) . Confused Gait Imbalance Weakness/Fainted Balance Problem were all check marked. A review of the progress notes revealed: 9/23/2024 . Sutures removed from left eyebrow . 10/7/2024 12:30 . Resident has been becoming increasingly restless. She is pacing and wandering into others rooms . 10/9/2024 14:14 Resident stated she fell in room prior to lunch. No injuries noted or c/o of pain at that time. After lunch resident returned to unit and was unable to walk. Resident could stand but when attempt to walk right leg would give out. Resident would grab right leg as if it was painful. Xray ordered. No visible injuries noted. 10/9/2024 17:30 . X-ray came out Right Hip fx (fracture) present notified DON and (physician) resident sent to hospital via (ambulance). 10/15/2024 11:34 IDT met to discuss resident fall. Root cause determined to be poor safety awareness r/t dementia, and unsteady gait. Intervention for lipped mattress to be placed in bed. Resident had Xray ordered immediately, with results of fracture, send to ED for further eval/treatment. Care plan reviewed and updated accordingly. 10/13/2024 14:59 Resident readmitted from (hospital), assisted from gurney to bed to recliner chair due to restlessness . 10/15/2024 17:50 Late Entry: Admission visit for right hip pain status post ORIF (open reduction internal fixation) . Open reduction internal fixation is a surgical repair of the hip fracture. A review of the facility provided Investigation Form 10/11/2024 revealed CONTRIBUTING FACTORS AND INTERVENTIONS . Resident with multiple falls prior to admission . A review of the care plan revealed Focus Fall Risk: (resident) is high risk for falls r/t weakness, incontinence, poor safety awareness Date Initiated: 09/06/2024 . Interventions Anticipate and meet the resident's needs. Date Initiated: 09/06/2024 Environment: Keep my room free of potential fall hazards - clutter, spills, tripping hazards, poor lighting, etc. Date Initiated: 09/10/2024 Follow facility fall protocol. Date Initiated: 09/10/2024 Gripper socks to be utilized unless wearing hard/rubber soled shoes Date Initiated: 09/10/2024 Ortho B/P's x 2 days Date Initiated: 09/13/2024 PT to evaluate and treat as ordered or PRN. Date Initiated: 09/10/2024 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Focus The resident has had an actual fall with injury Date Initiated: 09/13/2024 . Interventions Date and description of other interventions put in place after a fall: 9/13/24-Supervised when awake while in common areas, sent to ED for stitches to L eyebrow 10/9/24-Xray ordered, New med order rec'd, Lipped mattress, floor mat in place. Date Initiated: 09/13/2024 Resident #2: On 10/23/24, at 11:35 AM, Resident #2 was in their room in their wheelchair. Their family was present. Resident #2 denied they fell and hurt themselves and their family reminded them they fell and broke their hip. A review of Resident #2's electronic medical record revealed an admission on 09/26/2024 with diagnoses of Chronic obstructive pulmonary disease, Dementia and repeated falls. Resident #2 had severely impaired cognition and required assistance with Activities of Daily Living. A review of the Fall Risk Evaluation Admission 9/26/2024 revealed total score is 18 Total score of 5 or above is HIGH RISK. A review of the Fall-Unwitnessed . 10/2/2024 21:00 . CNA going to answer call light on C-Hall, when she swa resident seated on floor, called for nurse assistance. This nurse entered room and observed resident lying on her L side, in between her w/c and bed. Legs outstretched, w/no immediate injuries observed. States I tried going by myself but I'm too weak. Unable to state if she was attempting to transfer to bed or bathroom . Confused was check marked. A review of Fall-Unwitnessed . 10/5/2024 09:23 . Resident from across hall called out to writer, Writer observed (resident) laying on the floor, on her right side, with her food tray across the front of her, bed table on it's side, (resident) stretched out towards the bathroom door, hold her left hip complaining of pain . Stated she did not remember than stated she was trying to go to the bathroom . assessed resident for injury, neuros started, lifted with mechanical lift back in to bed. Attempted to assess for injury to left hip but will not allow writer to straighten legs. Once in bed straighten legs, complaining of pain, grabbing hip . Impaired Memory was check marked. A review of the SBAR-Fall . 10/05/2025 . Resident attempted to self transfer to restroom falling on to the floor unwitnessed. Feet close to bed body extend toward restroom door, Resident laying on right side when observed by writer, bed side table tipped over food tray above head . A review of the Fall-Unwitnessed . 10/12/2024 . Staff entered room alerted by resident yelling out. Resident [NAME] on floor on abdomen next to bed in lowest position on mat next to bed with head toward window. Resident incontinent at time of fall. Resident c/o left hip pain. Resident description I was going to the bathroom . immediate action take . new intervention to toilet before breakfast and have resident up in w/c for breakfast. Obtaining x-ray left hip per order . Injury Location Left trochanter (hip) . Confused Impaired Memory were check marked. A review of the Radiology Report Date of Service 10/12/2024 3:07 PM revealed Results: there is an intertrochanteric fracture at the hip. Conclusion: Fractured hip . A review of the progress revealed 10/16/2024 16:18 . Resident returned from hospital via ambulance. Assisted into bed. No c/o pain, staples to left leg have dry dressing covering . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the care plan revealed Focus The resident is at risk for falls r/t impaired cognition, deconditioning Date Initiated: 09/26/2024 Goal The resident will be free of minor injury through the review date. Date Initiated: 09/26/2024 Interventions Anti roll backs in wheelchair Date Initiated: 10/23/2024 Anticipate and meet (resident) [NAME] to deter attempting to self transfer Date Initiated: 09/26/2024 Environment: keep my room free of potential fall hazards - clutter, spills, tripping hazards, poor lighting, etc. Date Initiated: 09/27/2024 Follow facility fall protocol. Date Initiated: 09/27/2024 Gripper Socks to be utilized unless wearing hard/rubber soled shoes Date Initiated: 09/27/2024 keep bed in lowest position while I am resting Date Initiated: 09/27/2024 Padded floor mat to exposed side/sides of bed when resting Date Initiated: 09/27/2024 . Focus The resident has had an actual fall with no injury, fall with major injury 10/1/2024 Date Initiated:10/02/2024 Goal The resident will resume usual activities without further incident through the review date. Date Initiated: 10/02/2024 Interventions Date and description of other intervention put in place after a fall: 10/2/24-Bed moved against wall on right side. Resident to transfer with left side which is her strong side. 10/5/24-Resident to be offered to eat at the nurses station or dining room [ROOM NUMBER]/12/24-Xray; up for all meals, toileted before meals, bed flipped against the wall. Will be moved closer to the nurses station when bed becomes available. Grab bars added per family request as well. Date Initiated: 10/14/2024 Resident #3: On 10/23/24, at 9:30 AM, Resident #3 was resting in their low bed. There was a mat to the floor on the right side of the bed. The left side of the bed was pushed against the wall. On 10/23/24, at 10:30 AM, a record review of Resident #3's electronic medical record revealed an admission on 07/16/2024 with diagnoses that included Dementia, Diabetes and recent subdural hematoma. Resident #3 had severely impaired cognition and required assistance with Activities of Daily Living. A review of the Fall Risk Evaluation Admission 7/16/2024 revealed total score is 9 Total score of 5 or above is HIGH RISK. A review of Fall - Unwitnessed . 8/5/2024 . Call light activated. CNA entered room and immediately called for nurse assistance. Resident lying on floor next to bed, w/his head in between bed and nightstand. He's alert, taking, w/no obvious s/s of injury. Resident unable to give Description . Confused Gait Imbalance Impaired Memory were all check marked. A review of the SBAR-Fall Effective Date: 8/05/2024 . Call light activated, CNA entered room and immediately called for nurse assistance. Resident lying on floor next to bed, w/ his head in between bed and nightstand. He's alert, talking, w/no obvious s/s of injury. Unable to state what occurred. ROM and neuro-checks WNL. Refusing full set of vitals at the time d/t confusion. Full skin assessment completed, some redness to L ear observed, skin intact . A review of Fall-Unwitnessed . 8/6/2024 19:00 . CNA walking passed resident room and notified nurse of incident. Entered room and observed resident lying on floor next to bed, on his L side. He's alert and talking w/ no obvious injuries observed. Resident unable to give description . Immediate action taken . Non-compliant w/ wearing grippy socks, confused . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of Fall-Witnessed . 8/17/2024 20:20 . This nurse head others calling out for help and observed resident laying on his back near nurses station. CNA who was sitting at nurses station stated she observed him falling backwards from standing and fell mostly on his back. Resident unable to give account of events r/t dementia . Resident assisted to bed with use of Hoyer lift . Impaired Memory was check marked. A review of the SBAR-Fall . 8/17/2024 . Resident was observed getting up from seated area and observed slipping and falling backwards. Resident was barefoot at time of fall . A review of Fall-Unwitnessed . 8/18/2024 22:50 . Nursing staff entered room to provide care for resident he was noted to be laying on mat next to bed with head toward door. Resident unable to give description . Immediate action taken . Brief was soiled w/ urine and feces . Confused Gait Imbalance Impaired Memory were check marked. A review of Fall-Unwitnessed . 9/1/2024 19:05 . A review of the SBAR-Fall . 09/01/2024 . At 1845 CNA was walking down C hall and called for nurse assistance. Entered resident's room, observed him seated on floor mat next to bed, alert w/no immediate injuries observed. Unable to state what occurred. ROM, neuro-checks and vitals all WNL. Brief was soiled w/urine and feces. Assisted into bed to provided personal hygiene. No injuries observed to skin and no s/s of pain . A review of the focus (resident) is high-risk for falls r/t poor safety awareness: confusion Date Initiated: 07/16/2024 . Interventions Non-slip material to wheelchair cushion. Date Initiated: 10/01/2024 Anticipate and meet the resident's needs. Date Initiated: 07/16/2024 Assist with routine toileting and PRN to help prevent self-transfers Date Initiated: 07/16/2024 Environment: keep room free of potential fall hazards - clutter, spills, tripping hazards, poor lighting, etc Date Initiated: 07/16/2024 Follow facility fall protocol. Date Initiated: 07/16/2024 Gripper socks to be utilized unless wearing hard/rubber soled shoes Date Initiated: 07/16/2024 If resident becomes restless/agitated, bring res into communal area for increased supervision. If resident refuses, remain with resident until directed by nurse Date Initiated: 07/16/2024 PT evaluate and treat as ordered or PRN. Date Initiated: 07/16/2024 The resident needs activities that minimize the potential for falls while providing diversion and distraction. Date Initiated: 07/16/2024 On 10/23/24, at 11:30 AM, Resident #3 remained in the same position. On 10/23/24, at 11:55 AM, CNA C and CNA E in to assist Resident #3 with incontinent care. CNA E offered that Resident #2 ate breakfast in bed and remained in bed since. On 10/23/24, at 1:00 PM, the Director of Nursing (DON) was interviewed regarding the sampled residents and their multiple falls. The DON was asked if there was anything else the facility could have done to prevent the unwitnessed falls and DON responded, well, I cant have one to one while they are in their rooms. Prior to exit, the DON was asked to provide the day of the most recent unwitnessed fall in the facility and the DON, stated, yesterday. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the facility provided Fall Evaluation Safety Guideline Effective Date: 11.28.17 revealed . A fall evaluation is used to identify individuals who have predicting factors for falls . Involve interdisciplinary (IDT) on: Individualized assessment for safety Identification of Hazards Need for Supervision Development and implementation of interventions to reduce accidents . Guideline for Evaluation May include: . Fall history . Impaired mobility/functional status Incontinence Cognitive status Mood or behavior indicators . If the evaluation finds the resident at risk, implement resident specific interventions/precautions .