STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235461	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Pine Place	4800 Clintonville Rd Clarkston, MI 48346

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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 relates to Intake #2571092. Based on observation, interview, and record review, the facility failed to prevent an avoidable fall out of bed for one Resident (R8) of five resident reviewed for falls, resulting in actual harm for R8, who sustained a femur fracture. Findings include: Review of a complaint received by the State Agency on 7/24/25 revealed an allegation that R8 fell out of bed while they were cleaned by nursing staff and rolled over onto the floor. The complaint alleged R8 had one person assisting them and said they were supposed to have two-person assistance. The concern further revealed that R8 was hospitalized and subsequently treated for a fractured right hip. Review of R8's investigation file, related to R8's fall with major injury on 7/23/25, revealed Certified Nurse Aide (CNA) AA was providing a bed bath (care) to R8 and rolled them on their side, and R8 continued to roll out of bed directly onto the floor. R8 was found to have two skin tears on their right knee, and complained of pain in both knees, both elbows, their right shoulder and right hip. The physician and R8's guardian were notified, and R8 was sent out to the hospital emergently. On 7/24/25 R8's guardian informed the facility R8 had sustained a fracture to their right hip. The file showed R8 was care planned to need 1-2-person assistance for bed mobility. The facility found the root cause of R8's fall was R8 needed two-person assistance with bed mobility, and was care planned for 1-2-person assistance (not always having two-person assistance). R8's care plan was updated by the facility after their fall to reflect two-person transfers after the incident. Review of CNA AA 's witness statement, dated 7/23/25, revealed (CNA AA) washed the front of (R8) and then rolled him on his side to wash the back of him. As (CNA AA) was washing (R8's) back he began to roll forward. (CNA AA) quickly attempted to grab him to pull him backwards and yelled for help, but (their) gloves were wet and (CNA AA) did not have a good grip on him. (R8) continued to roll forward out of the bed onto the floor. (Registered Nurse - RN D) heard (CNA AA) scream and quickly ran into to the room to help but (R8) was already on the floor. The statement confirmed CNA AA was providing one-person assistance to R8 with bed mobility and was behind him when he rolled off the bed (verses in front of him, per standards of practice). Review of RN D 's witness statement, dated 7/23/25, revealed RN D heard CNA AA telling R8 not to move forward, and then yelled R8 was on the floor. The report further described RN D went to R8's room and assessed R8, and found they had two skin tears on their right knee, and had pain in both knees, both elbows, their right shoulder, and right hip. RN D reportedly administered Tylenol, provided wound care, ordered x-rays, and then received orders to transfer R8 emergently to the hospital. On 8/19/25 at approximately 10:30 a.m., the Director of Nursing (DON) acknowledged with the Nursing Home Administrator (NHA) present CNA AA should have been in front of R8 while they were cleaning R8, not behind them, per standards of care. The DON confirmed if R8 had been positioned properly, R8 would have rolled towards CNA AA, and not onto the floor. The DON clarified R8's Care Plan should have designated R8 required either one-person or two-person assistance with bed mobility, as a CNA did not have the clinical expertise to make this decision. The DON reported the therapy staff made those decisions, and any facility residents who were care planned for 1-2-person assistance were changed to two-person assistance after R8's fall. The DON (continued on next page)

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	and NHA confirmed no abuse, or intent was suspected or found after their investigation. On 8/19/25 at 1:16 p.m., R8 was observed seated in their reclined manual wheelchair, sliding forward towards the edge of the wheelchair, with much of their weight on their back. Their bottom was sliding towards the edge of their wheelchair seat, with a full body Hoyer lift sling underneath them. R8 was pointing to their right hip, grimacing in pain, and said, Ouch, my hip, my hip, repetitively. R8 told Surveyor they needed to lay down. R8's call light was out of their reach, anchored to the wall. R8 explained they wanted to get into bed and said their right knee hurt also. On 8/19/25 at 1:17 p.m., it was observed there was no nurse on the unit hallway. On 8/19/25 at 1:18 p.m., CNA V arrived, and R8 said they wanted to go to bed. CNA V reported R8 just returned from in-house dialysis. CNA V was shown R8 had no call light, and their position. CNA V reported CNA W brought them back from dialysis, not them CNA V acknowledged R8 should have had their call light in reach. CNA V was shown R8 sliding out of their wheelchair, who stated there was a pommel cushion under their full body sling. which was supposed to prevent them from falling out of the chair, but it was under the padded sling. CNA V stated R8 had a new sling, but they were not certain how to transfer R8 and left the room. CNA W arrived shortly after, observed R8 grimacing in pain, and left the room to find CNA V. Both left the room while R8 was sliding out of their wheelchair and grimacing in pain, pointing to their right hip. On 8/19/25 at 1:34 p.m , the Rehabilitation Director, Physical Therapy Assistant, (PTA) Y , arrived, and educated the floor staff including CNA V and CNA W how to the use the full Hoyer Sling safely to transfer R8 back to bed, including which sling loop colors to use to attach to the lift anchor. Registered Nurse (RN) X, R8's nurse, was also present. On 8/19/25 at approximately 2:00 p.m., the Unit Manager, RN A , with RN X present, was asked how long R8 was using the full body lift for Hoyer transfers, since the floor staff reported did not know how to use the full body sling to transfer R8. RN A reported this was not in the medical record. RN A stated R8's guardian, Guardian Z, had declined surgery for R8's femur fracture, making Hoyer transfers difficult for them but necessary for dialysis. RN A was asked about R8's seating, sliding down the lift sling over the pommel cushion and had no explanation. Both RN A and RN X were asked about R8's call light being out of reach, given their pain and wanting to go back to bed. Both agreed R8 should have had their call light in their reach, as R8 had the potential to use their call light. On 8/19/25 at 4:30 p.m., Surveyor called R8's guardian, Guardian Z , who reported they were working the next two days, and could not be reached until 8/21/25. Review of R8's Care Plan, accessed 8/20/25, showed R8 needed two-person assistance for bed mobility as of 7/24/25 (after their fall with injury) and required 1-2-person assistance for bed mobility as of 5/28/25 (before their fall with injury). A separate care plan revision showed R8 required 2-person assistance also as of 5/28/25, revised on 7/24/25, appearing to be a discrepancy. The Care Plan showed R8 was care planned for the use of a mechanical list for two-person transfers on 8/08/25. The use of a full body sling was care planned on 8/19/25. It was noted R8's Care Plan showed the type of lift sling was not designated until after the staff education observed on 8/19/25. Review of R8's Minimum Data Set (MDS) assessment, dated 7/07/25, revealed R8 was admitted to the facility on [DATE], with diagnoses including stroke, anxiety, and depression. The assessment revealed R8 was dependent for all activities of daily living (care needs) including transfers and bed mobility. The sensory assessment revealed R8 was sometimes understood and was sometimes able to understand others and had adequate vision. The assessment further revealed that R8 had no pain and was on scheduled opioid (controlled substance) pain medication, and had no falls marked. On 8/20/25 at approximately 9:00 a.m., R8 was observed being transferred to their shower bed (a flat durable medical equipment bed for resident showers) by CNA F and another CNA. R8 grimaced in pain while being rolled to place the shower mesh sling underneath them. During the observation, CNA F was observed transferring R8 from their hospital bed to the shower bed, with two of the shower bed brakes unlocked. CNA F acknowledged afterwards they should have been locked the brakes while transferring R8 from their bed to the shower bed. On 8/20/25 at approximately 9:40 a.m., R8 was observed with the Director of Nursing (DON). R8 was in their hospital bed and had no call light near (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	them. The DON placed the call light in R8's hand, to see if they could operate their call light to call for assistance. R8 was able to operate their call light. The DON acknowledged afterwards they understood the concerns with R8 not having the call light near them. On 8/20/25 at 10:50 a.m., the DON was asked about the concerns observed during R8's transfers and positioning on 8/19/25 and 8/20/25. The DON reported CNA V should have known how to transfer R8 with a Hoyer lift and understood the seating and positioning concerns, causing R8 pain and discomfort. The DON confirmed R8's shower bed wheels should have been locked during the Hoyer transfer on 8/20/25. The DON acknowledged R8's call light should have been in their reach on 8/19/25 and 8/20/25. On 8/20/25 at 1:06 p.m., RN D confirmed R8's fall out of bed on 7/23/25 occurred as described. RN D reported R8's fall out of bed while receiving care from CNA AA was an accident, and no abuse or intent was suspected. RN D understood CNA AA should have been in front of R8 while cleaning them, which may have prevented the fall. RN D said R8 required 1-2-person assistance with bed mobility at the time of their fall and used a Hoyer lift for transfers. RN D confirmed R8 required a Hoyer lift and was dependent for all care prior to their fall on 7/23/25. On 8/20/25 at 1:37 p.m., CNA AA confirmed R8's fall out of bed while they were rolling him while cleaning him up occurred as described. CNA AA denied any intent, and confirmed the incident was an accident, when they were providing care and one-person assistance for bed mobility, as the Kardex (CNA care guide) showed R8 required 1-2-person assistance for bed mobility. CNA AA understood they should have been in front of R8 and rolled them towards them, instead of being behind them, cleaning them up. CNA AA reported R8 was in their bariatric bed, and they had not expected them to roll off the bed, as they had positioned R8 in the center of the bed. CNA AA reported they had tried to stop R8 from rolling out of their bed, but said their hands slipped. Review of R8's hospital internal medicine report, dated 8/04/25, revealed R8 sustained a right femur fracture with conservative management (no surgery) while being changed at the facility, and had sepsis (a severe infection), a urinary tract infection, end stage renal disease (kidney disease) and atrial fibrillation (a heart rhythm disorder). The report confirmed R8 was receiving Eliquis, a blood thinner, at the time of their fall at the facility, placing them at risk of bleeding. It was also noted that R8's right knee hardware appeared loosened on a hospital imaging report. Review of R8's hospital palliative care note, dated 8/04/25, revealed R8 was diagnosed with an acute right femur fracture in the ER (emergency room). It was noted R8 also presented to ER with a dislodged suprapubic catheter, which was replaced with a Foley catheter. The assessment showed uncontrolled pain during their hospitalization with repositioning and bowel movements, which was unresponsive to Norco, an opioid pain medication, and showed R8 reported ongoing pain during their hospital stay. The assessment showed non operative management of the hip fracture with a focus on pain control and rest. Review of R8's orthopedic provider progress note, dated 8/06/25, revealed, (R8) does not have absolute contraindication to Hoyer lift. (R8) is at high risk for displacement, skin compromise from intertrochanteric (region of bony protrusions) femur fracture, so recommend safe practices, frequent skin checks, and limited transfers to those absolutely necessary. Review of R8's hospice provider note, dated 8/09/25, showed R8 was placed on hospice care after their hospitalization (discharge) back to the facility on 8/08/25, as R8's guardian did not want to put R8 through any more treatments. The report confirmed R8's Guardian declined for R8 to have surgery. R8 was shown as alert and oriented x 3 spheres during this visit and reported they did not have pain at rest but had moderate to severe pain with movement. R8 was on Norco and Tramadol (a second narcotic pain medication) at that time. Review of R8's hospice provider note, dated 8/20/25, revealed R8 had been having high pain with transfers into the dialysis chair and was started on Morphine (an opioid controlled pain medicine for pain, often prescribed when other medications have not been successful) every four hours for pain and Ativan every six hours (to relieve anxiety).Review of R8's Physical Therapy (PT) Evaluation and Treatment, dated 8/07/25, showed a full body shower sling was recommended for bathing. The assessment revealed R8 did not need PT services, as they were at baseline (no change in their prior level of function while at the facility). The assessment revealed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the hospice recommendations for safe transfers and high risk for displacement. There was no documentation or plan to educate staff on transfers noted in their documentation provided by the facility. On 8/21/25 at 10:38 a.m., R8's guardian, Guardian Z, reported in a phone interview they had been made aware of R8's fall out of bed on 7/23/25, and the cause related to R8 needing 2-person assistance with bed mobility. Guardian Z clarified they did not suspect any abuse and understood R8 fell out of bed by accident when CNA AA rolled R8 out of bed during care. Guardian Z confirmed R8 was dependent on staff for all personal care and used a Hoyer lift for transfers prior to their fall. Guardian Z said they had observed staff transferring R8 in an unsafe manner with the Hoyer lift, with R8 nearly sliding out of the lift sling. Guardian Z reported they were concerned about R8's increased pain since their fall and had placed R8 on hospice care after their fall on 7/23/25, upon return to the facility on 8/07/25. Review of the fall reduction policy, dated 2/2025, revealed, Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize likelihood of falls.4. Standard Fall Risk Protocols: a. Implement universal environmental recommendations that decrease the risk of resident falling, including, but not limited to: .ii. Bed is locked.iii. Call light and frequently used items are within reach. Review of the policy, Safe Resident Handling/Transfers, dated 8/09/24, revealed, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable environment for the resident while keeping the employees safe in accordance with current standards and guidelines .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure appropriate infection control practices related to Enhanced Barrier Precautions (EBP) and hand hygiene for two residents (R#'s 58 and 65) of seven residents reviewed for infection control as well as ensure appropriate infection control practices in the facility laundry and with regards to staff fingernails. This deficient practice had the ability to affect all residents at the facility. Findings include: R58 Review of the clinical record revealed R58 was admitted into the facility on 7/8/25, discharged [DATE] and readmitted on [DATE] with diagnoses that included: acute gastric ulcer with perforation, pleural effusion, generalized acute peritonitis, atelectasis, extended spectrum beta lactamase (ESBL) resistance, fistula of intestine, candidal stomatitis, urinary tract infection, herpesviral cingivostomatitis (viral infection) and pharyngotonsillitis (an acute infection of the pharynx), acute peptic ulcer site unspecified with perforation, and peritoneal abscess. Review of the current physician orders included: “Maintain Enhanced barrier precautions for high contact resident care r/t (related to) PICC (Peripherally inserted central catheter) line/hx (history of) of MDRO (Multi-Drug Resistant Organism) every shift for PICC line/hx of MDRO”. On 8/20/25 at 9:00 AM Phlebotomist ‘U’ was observed at their cart with lab supplies in the hallway just outside R58’s room. The door to R58’s room was observed to have signage that identified anyone to lift the top sheet to review specific details about the resident. R58 was on enhanced barrier precautions (EBP). A Personal Protective Equipment (PPE) caddy was hung from the door and contained disposable gloves, masks, and gowns. At this time, Phlebotomist ‘U’ donned disposable gloves, retrieved lab supplies, then looked at the sign on the door to lift for review, but did not lift to read and proceeded to enter R58’s room and close the door. Less than a minute later, Phlebotomist ‘U’ exited the room using the same disposable gloves, touching the door handle, retrieved a bright orange band (tourniquet), then re-entered the room without changing gloves, using hand sanitizer, or donning a gown. At 9:03 AM, Phlebotomist ‘U’ was observed to not change gloves and was proceeding to push the cart to continue on. When asked to talk before they continued on, Phlebotomist ‘U’ was asked why they didn’t review the signage posted on the door to determine what type of precautions R58 was on and they stated, “They (facility) said I just left this up and nobody took this down (pointing to the bright orange sign on the door). I didn’t read cause I’ve read it before. I go by what the nurses show me, not what’s posted.” When asked if they routinely came to the facility, they reported “I’m not normally the one that comes here.” Phlebotomist ‘U’ proceeded to take their cart with lab supplies and go towards another hallway. At 9:09 AM, an interview was conducted with the Director of Nursing (DON). When asked about whether staff/visitors should be reviewing signage on doors to verify what they might need for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	precautions such as what PPE to don/doff, the DON reported everyone should be reviewing that. The DON further reported if signage was up, they were on precautions and they used a cover to maintain HIPAA (Health Insurance Portability and Accountability Act). The DON was informed of the observations of Phlebotomist ‘U’ and at the same time, Phlebotomist ‘U’ was observed in the hallway about to enter another resident’s room. The DON reported that should not have occurred and they would address it immediately. R65 On 8/19/25 at 10:00 AM, R65's room door was observed to have a sign to indicate they were on enhanced barrier precautions requiring the use of a gown and gloves for resident care activities. On 8/19/25 at 10:12 AM, Nurse 'S' was observed to enter R65's room with three wrapped packages of 4x4 gauze. Nurse 'S' was not observed to don an isolation gown prior to entering the room. On 8/19/25 at 10:15 AM, Nurse 'S' was observed to exit the room with an examination glove on their left hand carrying two wrapped packages of 4x4 gauze and the glove they removed from their right hand. Once in the hallway, Nurse 'S' removed the left glove and threw them in a housekeeping trash cart in the hallway. They were not observed to perform hand hygiene after removing the gloves in the hallway. After disposing the gloves, Nurse 'S' went to the treatment cart and placed the two wrapped packages of 4x4 gauze that had entered R65's room back into the treatment cart. After storing the gauze they proceeded to their medication cart where they were still not observed to perform hand hygiene and began preparing medications for administration to their next resident. On 8/19/25 at 10:17 AM, Nurse 'S' was asked what services they provided to R65 when they entered the room and reported they had changed the dressing to R65's tracheostomy opening. On 8/20/2025 at 3:43 PM, a review of R65's chart revealed an order dated 10/18/24 for them to be on enhanced barrier precautions related to presence of a feeding tube. Further review of the chart revealed an order to cover R65's trach opening with a dressing. On 8/21/25 at approximately 1:30 PM, an interview was conducted with the facility's Infection Control Preventionist and they acknowledged the concern with EBP and hand hygiene and indicated ongoing infection control education was being done. Laundry Service On 8/21/25 from 1:30 to 2:00 PM, an observation of the facility laundry room and service was conducted with Laundry Supervisor 'T'. They were asked if anyone routinely checked the concentration of their laundry soap/chemicals/bleach and said they recently switched laundry products and the company providing the new product did not routinely test but would come out if called. At that time, Supervisor 'T' said about a week ago they noticed the level of bleach in the bottle running to the washing machines hadn't moved in a few days. They said they called the company, and a representative came to the facility and fixed the problem but admitted several days of laundry were done without the use of bleach. Continued review of the laundry room revealed four clean laundry basket trunks equipped with spring lifts (a device to keep the laundry from sitting in the bottom of the cart) attached. Observation under the spring lifts in three of four of the clean basket trucks revealed copious amounts of lint, garbage (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	debris, food debris, peanut shells, examination gloves, and lancets for checking blood sugars. Supervisor 'T' said the clean laundry basket trunks should not have any debris underneath the spring lifts. A review of a facility provided policy titled, Enhanced Barrier Precautions was reviewed and read, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds .feeding tubes .b. PPE (personal protective equipment) for enhanced barrier precautions is only necessary when performing high-contact care activities .3. High-contact resident care activities include: .h. Wound care: any skin opening requiring a dressing . A review of Center for Disease Control Guidance titled, Clinical Safety: Hand Hygiene for Healthcare Workers | Clean Hands | CDC was reviewed and read, .Recommendations Know when to clean your hands .After touching a patient or patient's surroundings .Immediately after glove removal . A review of a facility provided policy titled, Handling Clean Linen was reviewed and read, It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection .3 Carts will be cleaned when visibly soiled, and routinely according to facility schedule. On 8/21/25 at 1:35 PM, CNA “L” was observed to have artificial fingernails approximately 1 inch in length that were [NAME]-encrusted with small to large jewels. CNA “L” was asked if she was currently providing patient care at the facility. CNA “L” explained she was working a double (two shifts, back to back) and had 12 residents on her set. On 8/21/25 at 2:36 PM, Registered Nurse (RN) “A”, who served as the Infection Preventionist, was interviewed and asked about staff having long, [NAME]-encrusted fingernails. RN “A” explained it was an infection control issue due to the inability to completely clean around the jewels, or under the artificial nails and the risk of the nails ripping the gloves. On 8/21/25 at 2:58 PM, the DON was asked if staff were allowed to have long [NAME]-encrusted nails. The DON explained staff were “forbidden” to have long nails. When informed of the observation of 1 inch [NAME]-encrusted fingernails, the DON acknowledged the concern. Review of a facility policy titled, “Dress & Personal Appearance” revised 7/11/23 read in part, “…Fingernails: …Fingernails should be at a moderate length when working in patient care areas. Artificial nails are not permitted on staff working in patient care areas (including Nursing, Recreation, and Food and Nutrition)…”

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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. This citation pertains to intake #1233191.Based on observation, interview, and record review the facility failed to ensure treatment in a dignified manner for five residents, (R20, R24, R43, R70, and R76) of six residents reviewed for dignity. Findings include:R#'s 24, 43, 70, and 20. On 8/19/25 at 9:39 AM, Certified Nurse Aide (CNA) 'M' was observed in R24's room providing one-to one feeding assistance. CNA 'M' was not observed to be seated while feeding R24, rather they were observed standing at the bedside over the resident while providing assistance. On 8/19/25 at 12:27 PM, R20 R43, and R70 were observed seated in the dining room at a table. CNA 'M' was observed to be standing at the table providing one-to-one feeding assistance alternating bites of food between R20 and R70. On 8/19/25 at 12:35 PM CNA 'M' was observed providing one-to-one feeding assistance to R20. Several times throughout the meal, CNA 'M' left the table in the middle of the meal to assist the other residents and returned to provide one-to-one feeding assistance to R20. On 8/19/25 at 12:40 PM, CNA 'M' is again observed standing at the table providing feeding assistance with alternate bites to R20 and R70. On 8/19/25 at 1:00 PM, CNA 'M' is observed in R24's room standing at the bedside attempting to provide one-to-one feeding assistance. R76 On 8/21/25 at 8:40 AM, R76 was observed near the nursing station overheard saying Isn't anyone going to help me?. At that time, R76 was asked what was going on and said they had requested pain medication, but their nurse told them they had to wait. They went on to say the nurse was sitting at the nursing station and didn't understand why they couldn't go get their pain medication for administration. On 8/21/25 at 8:43 AM, R76 was observed in the hallway near the nursing cart. Nurse 'E' was observed at the cart preparing medications for another resident on the hallway. R76 was pointing at Nurse 'E' and verbalizing complaints with the use of expletives of not receiving their pain medication and being told they, Had to wait, to Therapy Staff Member 'Q'. Staff member 'Q' was overheard to tell R76 they would be, taken care of and to stop swearing at people. Staff member 'Q' was then observed to leave the unit. Nurse 'E' did not acknowledge R76's complaints and Staff 'Q' did not inquire with Nurse 'E' why R76 had not received their pain medication. On 8/21/25 at 8:54 AM, an interview was conducted with Nurse 'E'. They were asked why R76 had not received their pain medication and said they had tried to give it earlier but R76 had gone outside. They were asked about the observed verbal exchange in the hallway with R76 complaining to Staff member 'Q' about not getting their pain medication. Nurse 'E' said, That's just how he gets. They were asked if at that time they could have acknowledged R76's complaints, as opposed to ignoring him and said they could have. On 8/21/25 10:30 AM, an interview was conducted with Therapy Staff 'Q' regarding R76's complaints (continued on next page)

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Villa at Pine Place	4800 Clintonville Rd Clarkston, MI 48346

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to them. Staff 'Q' said, He's bipolar and unpredictable. They were asked if they could have inquired with the nurse in the hallway about his medications and said they could have acknowledged. On 8/21/25 at 2:11 PM, an interview was conducted with the facility's Director of Nursing (DON). The witnessed incident between R76, Nurse 'E', and Staff 'Q' was discussed and the DON indicated staff could have addressed R76's needs in a more appropriate way. A review of a facility provided policy titled, Resident Rights was conducted and read, .The resident has a right to be treated with respect and dignity . On 8/19/2025 at 12:15 PM, an observation of main dining room revealed concerns with dignity during dining. At one table there were three residents seated and two of the residents already had their lunch meal served and were being assisted by staff. R70 was observed seated at the table and did not have a meal tray. At 12:30 PM, R70 still did not have their lunch served. At this time, staff were observed asking out loud to one another “So we need a tray for [name of R70]?” and several other staff asking about getting the resident a meal tray. Certified Nursing Assistant (CNA ‘M‘) (who was not wearing a name badge) was observed seated next to R70 assisting another resident at the table with their meal. CNA ‘M’ was then observed telling R70 “[name of R70] they’re getting your tray right now sweet pea.” At 12:32 PM, the Director of Nursing (DON) was observed telling R70, “At least you got your coffee right there.” R70 was observed to continue watching the other residents eat their lunch meal. At that time, CNA ‘M’ stated out loud, “She looking like where's my food at. Everyone else got theirs. At that time, Nurse ‘N’ stated out loud to R70, “I know it’s coming, you're looking at me like that. At 12:35 PM, Nurse ‘N’ delivered the meal tray to R70. Upon delivering the meal tray, CNA ‘M’ repeatedly referred to R70 as “Sweet Pea”. When R70 asked CNA ‘M’ what the ground up meat was, CNA ‘M’ stated to the resident, “I believe it's ribs but I don't want to lie to you, it's some beef. On 8/19/25 at 12:40 PM, an interview was conducted with the DON. When asked why R70 was not served at the same time as other residents at their table, the DON reported R70 ate later and the meal tray usually went to their room. When asked why the staff didn’t identify it upon serving the other residents at that time, the DON reported they were not sure. When asked about whether staff should be wearing name badges, the DON reported they should and was part of their uniform. At that time, CNA ‘M’ stated out loud from R70’s table, “I have one too (name badge), but it fell off.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation and interview, the facility failed to maintain a clean, comfortable, homelike environment for multiple residents, including R60. Findings include:Observations made during the recertification survey from 8/19/25 - 8/21/25 revealed concerns with flies observed in several resident rooms and throughout the hallways.Observations of the residents that attended smoking activities revealed the doors to the courtyard were kept open to allow the residents to exit the facility.On 8/19/25 at 9:58 AM, R60 was observed lying in bed with oxygen in place via nasal cannula. There was a small black portable fan on their table next to the bed that had a large build-up of dust that hung down off the front and back of the protective outer covering and fan blades. When asked about their room environment and if they had any concerns, R60 reported, I have such allergies and they don't clean that (black fan). R60 reported housekeeping swept and mopped the floors, but didn't dust.Additional observations on 8/19/25 and 8/20/25 revealed the fan remained with a heavy accumulation of dust.On 8/20/25 at 12:12 PM - An interview was conducted with the Administrator. When asked about who was responsible for cleaning the portable fans in resident rooms, the Administrator called the Maintenance Director (Staff ?O?) and asked over them if there was a formal log of cleaning personal fans and it was reported there was not and if staff sees a dirty one, they should clean it.On 8/20/25 at 1:12 PM, an interview was conducted with Staff ?O'. When asked about the facility's pest control, they provided the log which showed monthly visits and none identified concerns with flies. When asked about if flies were observed by staff, what should be done, Staff ?O' reported staff should log in binder or put into their electronic reporting system. Staff ?O' reported they thought flies might be getting in when residents went outside to smoke and the doors were left open to allow the residents to exit.On 8/20/25 at 1:20 PM, an observation of R60's room was conducted with Staff ?O?. They confirmed the same and reported they were not aware of the resident having a portable fan but if staff observed the fan with build-up, they should report that in their electronic reporting system so they knew it needed to be addressed.According to the facility's policy titled, Safe and Homelike Environment dated 4/2024: .Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. Based on observation, interview and record review, the facility failed to prevent staff from handling resident's money (cash and cards) to purchase smoking materials for 18 (6, 11, 14, 16, 26, 29, 30, 31, 37, 40, 42, 45, 47, 50, 55, 63, 64, and 67) of 18 residents reviewed for abuse, resulting in the potential for exploitation and misappropriation of the resident's property. Findings include:On 8/19/25 at 12:20 PM, a staff member (Driver/Certified Nursing Assistant - Staff ?P') was observed entering the main dining room with a gray plastic bag. Staff ?P' was then observed going up to a resident and placed a debit/credit card down on the table next to R37, then proceeded to go around to several other residents while they were eating their lunch. Staff ?P' was then observed to pull out a large wad of folded cash and then showed another resident a carton of cigarettes.On 8/19/25 at 12:26 PM, an interview was conducted with Staff ?P' upon exiting the main dining room. Staff ?P' reported they worked as the facility's driver and had been employed since February 28, 2025. When asked about the observation of them going to several residents, placing debit/credit cards, cash and showing cigarettes, Staff ?P' explained they went to the smoke store for them (residents). When asked how many residents they did that for, Staff ?P' stated Today was like five or six. When residents go out to smoke, whoever says something, I tap into each resident, take cash or card. I have clipboard all sign off on I keep in the van. Anyone knows if I mess up, it's all over. When asked if the Administration was aware this was occurring, Staff ?P' reported they did.On 8/19/25 at 4:04 PM, an interview was conducted with the Administrator who reported they began working at the facility since August 2024. When asked about whether staff should be handling any money i.e cash/cards from residents, the Administrator reported absolutely not and further reported that had been going on when they first came and they put a stop to that because there were so many concerns with misappropriation. The Administrator was informed of the observation and interview with Staff ?P' and they reported they were employed as a driver.The Administrator further reported they made it very clear when they started that no staff should be handling resident money. The Administrator was informed Staff ?P' reported there was a clipboard they maintained and was requested to provide any additional documentation for review.On 8/19/25 at 4:28 PM, the Administrator provided the log maintained by Staff ?P' and reported, Apparently, they took it upon themselves to come up with this. Review of the documentation included the logs which were from 7/15/25 - 8/19/25 of multiple residents. There was no documentation provided prior to 7/15/25. It should be noted that several residents identified by the facility following notification of this concern were not included in the log documentation, including R37 who Staff ?P' was observed placing the debit/credit card down in the dining room. The Administrator reported they would review the logs and follow up with the residents to make sure no one has any misappropriation concerns.On 8/20/25 at 10:00 AM, review of the additional documentation provided by the facility included:A facility audit which included 18 residents (R6, R11, R14, R16, R26, R29, R30, R31, R37, R40, R42, R45, R47, R50, R55, R63, R64, R67).Resident Council minutes from 1/27/25 that documented, in part: .Administrator talked to the Council about a New Policy in effect March 1st, 2025, = The Facility will no longer be able to go out and purchase their personal smoking items. Each resident would be responsible for supplying their own, they must contact their family and or Guardians to help them.A disciplinary action for Staff ?P' dated 8/19/25 which was a written counseling notice that read, .During annual on 8.19.25 a surveyor observed employee collecting money, debit cards to purchase tobacco items .Corrective Action Employee's <sic> cannot take resident's money/debit cards to purchase cigarettes. Money's <sic> must be handled by resident directly, families, guardians, etc .These guidelines were reviewed in resident council in February of 2025 .According to the facility's policy titled, Abuse, Neglect and Exploitation dated 6/2024: It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food preferences were honored for four residents (R1, R24, R43, and R70) of 10 residents reviewed for dining/nutrition. Finding include R1 On 08/20/2025 at approximately 1:20 p.m., a meal tray was observed for meal service for R1 which included R1's meal preference ticket that revealed the following standing orders for their lunch meal: Standing Orders: 1. 1/2 cup of applesauce (as available). 2. 1/2 cup mashed potatoes & gravy. 3. Yogurt, Yogurt At that time, R1's lunch meal tray was observed to not contain any of the standing order items that were supposed to be provided on the meal ticket. On 8/8/25 at approximately 1:25 p.m., The Dietary Manger J (DM J) was queried regarding the dietary process for ensuring the standing orders indicated on the meal tickets are provided to the residents when the meal is served. DM J reported that the process occurs in the kitchen during the tray pass in which one of the dietary aides is responsible for reading the ticket and placing the standard order items on the meal tray for service to their room. DM J was queried why none of the items were provided on R1's meal tray at time of service and they indicated that the dietary aide missed them. On 8/8/25 the medical record for R1 was reviewed and revealed the following: R1 was initially admitted to the facility on [DATE] and had diagnoses including Iron deficiently and Dysphagia. A review of R1's MDS (minimum data set) with an ARD (assessment reference date) of 6/20/25 revealed R1 needed assistance from facility staff with most of their activities of daily living. A dietary evaluation dated 7/17/25 revealed the following: RD following resident for wt (weight) status & new order of labs. CBW (current body weight) ~110# as of 7/16 w/ BMI (body mass index) 21.4--WNL. Wt (weight) hx shows a ~11.4# wt loss since 6/12 admission. Noted res states her UBW prior to admission ~115-120#. Wt loss likely d/t (due to) to PT/OT (physical therapy/occupational therapy) services w/fatigue, fluid shifts, hx of substance disorder, and/or acute disease processes. Previous 1200mL (militers) FR d/c (discontinued) 7/7. Current diet order in place: Gen/Reg (general/regular) x 3 w/ extra protein. Po (by mouth) intakes are 100% x 5d per FAR (food acceptance record). Noted resident on Megestrol Acetate for appetite stimulation. Food preferences discussed w/ resident & remain up to date. Resident noted to have protein drinks/nutritional supplements provided from family/friends at bedside. Supplements in place: Prostat QD ~30mL (~100kcal, 15g prot/serv) & Medpass 2.0 QD (every day) ~120mL (~240kcal, 11g prot/serv) for added nutritional support & promotion of wt stability. Tolerating per resident .Rec to cont (continue) w/ POC (plan of care). Will monitor wts as available, diet tolerance/appetite . R24 On 8/19/25 at 9:21 AM, R24's breakfast meal was compared to the items listed on their meal ticket. The meal tray contained a glass of water, two sausage links, two pancakes, syrup, and jelly. R24's meal ticket indicated standing orders for 8 ounces of coffee, a half a cup oatmeal with brown sugar and a half cup of fruited yogurt that were not observed on their breakfast tray. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/19/25 at 12:51 PM, R24's lunch meal was compared to the items listed on their meal ticket. It was noted R24 had standing orders for pink lemonade and a chef salad (if available) that were not served with the meal. It was observed on the facility's posted menu; a chef salad was an always available menu item. On 8/20/25 at 12:39 PM, R24's lunch meal was compared to the items on their meal ticket. It was noted R24 had a standing order for a chef salad (if available) that was not served with the meal. At that time, a resident at another table in the dining room was observed to be served a chef salad. On 8/21/25 at 8:42 AM, R24's breakfast meal was compared to the items listed on their meal ticket. It was noted they had an order for 8 ounces of coffee under their standing orders that was not provided with the meal. R#'s 20, 43, and 70 On 8/19/25 at 12:27 PM, a review of R#'s 20, 43, and 70's lunch meals were compared to the items listed on their meal tickets. It was noted R20 had a standing order for a health shake and a glass of milk that were not present on the tray, R43 had a standing order for a health shake that was not provided with the meal, and R70 had standing orders for applesauce, cottage cheese, and a health shake that were not provided with the meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure sanitary conditions were maintained in the kitchen and during food service for one resident (R70) and all residents that consume food from the kitchen. Findings include:On 8/20/2025 at approximately 8:37 a.m., a tour of the main kitchen was conducted with the Dietary Manager J and the following was observed: 1. A box of Taquitos was not secured/unsealed and when moved on the shelf, the individual taquitos fell out of the box. 2. The storage rack that keeps the metal pans was observed to contain stacks of pans that were not air dried and contained water droplets up and down the stack of pans. When the pans were raised, water poured out on the floor. 3. The kitchen light covers had dust and staining on them. 4. The ventilation covers had dust/debris spreading out from them onto the ceiling tiles. On 8/20/25 at approximately 9:01 a.m., Dietary Manager J was queried regarding the nesting process for the stacking of their metal pans, and they indicated that the pans should have been air dried before being stacked on top of each other. DM J was queried regarding the box of frozen taquitos that were unsealed, and they indicated that the flap on the box was weak so they would get something else to ensure it was sealed. DM J was queried regarding the cleanliness of the vents and light covers and they indicated that they would have to notify maintenance to clean them. A review of the United States Food and Drug Administration (FDA)-Food Code revealed the following: 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles. (A) Except as specified in ¶ (D) of this section, cleaned equipment and utensils, laundered linens, and single-service and single-use articles shall be stored: (1) In a clean, dry location; (2) Where they are not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor. (B) Clean equipment and utensils shall be stored as specified under ¶ (A) of this section and shall be stored: (1) In a self-draining position that allows air drying; and (2) Covered or inverted. On 8/19/25 at 12:37 PM, Certified Nurse Aide (CNA) 'M' was observed assisting R70 with setting up their lunch meal. CNA 'M' was observed to remove R70's dinner roll from their plate with their bare hand and spread butter on it. They then placed it back on R70's lunch plate. On 8/21/25 at approximately 1:30 PM, an interview was conducted with Nurse 'R', the facility's Infection Control Preventionist and they said staff should not be touching resident's food with their bare hands. A review of a facility provided policy titled, Dining Service revised 1/2025 was conducted and read, ' .10. Staff will be educated on hygienic practices such as: a. No bar hand to food contact .

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1233191.Based on interview and record review, the facility failed to promote the resident's right to be treated with dignity and respect for one (R49) of six residents reviewed for dignity, resulting in facility staff searching a resident's personal possessions without giving the resident the opportunity to decline, in absence of concern with illegal substances, and implementing smoking suspension for three days. Findings include:On 8/19/25 at 9:35 AM, an interview was conducted with R49. When asked about the facility's smoking practices, R49 reported they smoked cigarettes and had to maintain their smoking materials with staff but further reported they were one of the residents that could smoke independently.Review of the clinical record revealed R49 was admitted into the facility on 7/1/22 and readmitted on [DATE] with diagnoses that included: alcoholic hepatic failure without coma, alcoholic cirrhosis of liver with ascites, gout, unspecified protein-calorie malnutrition, anxiety disorder, major depressive disorder, recurrent mild, and traumatic subdural hemorrhage without loss of consciousness.According to the annual Minimum Data Set (MDS) assessment dated [DATE], R49 had intact cognition and had no behavior concerns.Further review of the clinical record included an entry on 4/22/25 at 4:10 PM by Social Worker (SW ?H?) that read, Writer observed resident smoking outside even though the cigarette was not given to her by activity staff. Writer requested for a room search and a couple of cigarettes were found in resident's room. Writer had a conversation with resident and reminded her the smoking policy. Resident voiced being aware and understands the consequences for violating the smoking policy. This is a second violation, and the consequences is a 3-day suspension. Resident shared that she understands the consequence and will be resuming smoking on Friday 04/25/2025 at 4:00 PM. Activity staff and management team was notified.Review of the facility's policy titled, Resident Smoking dated 2/2025 documented, in part: .Any resident who is deemed safe to smoke, with or without supervision, will be allowed to smoke in designated smoking areas (weather permitting), at designated times, and in accordance with his/her care plan.If a resident or family does not abide by the smoking policy or care plan (e.g. smoking materials are provided directly to the resident, smoking in non-smoking areas, does not wear protective gear), the plan of care may be revised to include additional safety measures.Smoking materials of residents requiring supervision with smoking will be maintained by nursing staff.If at any time the facility changes its policy to prohibit smoking.it will allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents. There was no documentation that allowed the facility to conduct a room search, or that the resident would be penalized (such as revoking their smoking rights) included in this policy.On 8/20/25 at 11:00 AM, an interview and record review was conducted with SW ?H' who reported they had been in their role as the sole Social Worker for the facility for about a year. When asked about R49's smoking evaluation, SW ?H' reported R49 had been assessed to be independent with smoking for a while now and further reported they had been re-evaluated for competency in April 2025.When asked about their documentation and to recall the events that occurred on 4/22/25, SW ?H' reported the resident was seen smoking and their room was searched and additional cigarettes were found. When asked who did the room search, SW ?H' reported they did. When asked if the resident was given the choice to conduct a room search, or were they told their room was going to be searched, SW ?H' reported R49 was told their room was going to be searched and further stated, We have to see if they have more cigarettes on themselves.When asked about the implementation of a 3-day smoking suspension, SW ?H' reported that was the facility's process and they have the residents sign as well. When asked regardless if the resident is signing a document, why were they implementing punitive measures, SW ?H' reported they felt that was a concern but was something Administration said they had to do.On 8/20/25 at 12:00 PM, an interview was conducted with the Administrator. When asked about the (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's process for smoking, the Administrator reported when they first started at the facility about a year ago, there were many issues with residents smoking or sharing cigarettes and they had implemented smoking agreements that were signed on admission and discussed disciplinary processes if the residents were found in violation.The Administrator was requested to review their smoking policy and acknowledged the one they referenced was an outdated policy and the current policy (referenced above) was the current policy and did not include punitive measures. When asked about the facility conducting room searches when there is no concerns with illegal substances, the Administrator acknowledged the recent regulatory language and recent State Agency/Provider training and stated they might not have been using the most updated policy and R49 was disciplined based on the former smoking policy (prior to 2/2025).

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure a pull cord for the overbed light was accessible to the resident for one (R60) of one resident reviewed for accommodation of needs. Findings include:On 8/19/25 at 9:58 AM, R60 was observed lying in bed with oxygen in place via nasal cannula. The overbed light on the wall above their bed was observed to have a pull string that was tied up and hung down approximately one foot and was not able to be reached when in bed. They reported they rarely left their room and preferred to stay in bed. When asked about their room environment and if they had any concerns, R60 discussed several concerns including the light above their bed. When asked to explain further, R60 stated, I can't reach my light to turn on cause they never brought me a longer cord.Additional observations on 8/20/25 and 8/21/25 revealed the cord remained tied up and not within reach.On 8/20/25 at 1:20 PM, an interview was conducted with the Maintenance Director (Staff ?O?) who reported they had worked at the facility for about 30 years. Staff ?O' was asked to observe R60's room and confirmed the short length of the overbed light and reported those had likely been like that since the rooms were renovated a while ago.According to the facility's policy titled, Safe and Homelike Environment dated 4/2024: .The facility will provide and maintain adequate and comfortable lighting levels in all areas.The Maintenance Director will perform periodic rounds to ensure functioning lights.

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	235461	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa at Pine Place	4800 Clintonville Rd Clarkston, MI 48346

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review the facility failed to protect resident privacy for one (R25) of two resident reviewed for privacy. Findings include:On 8/19/25 at 9:27 AM, R25 was observed lying in her bed which had a concave mattress (mattress with raised edges). R25 did not answer any questions asked. R25's bed was positioned to the left side directly against the wall to the hallway. The bed extended approximately 6 inches past the doorframe to the room. Upon attempting to close the door to R25's room, the door would hit the footboard of R25's bed and was not able to close. Review of the clinical record revealed R25 was admitted into the facility on 6/27/25 with diagnoses that included: dementia, diabetes and fracture of the left wrist and hand. According to a Brief Interview for Mental Status (BIMS) exam dated 8/6/25, R25 had severely impaired cognition.On 8/20/25 at 9:20 AM, Certified Nursing Assistant (CNA) F was interviewed and asked how staff closed R25's door as the bed extended past the doorframe. CNA F explained that was a bed Hospice had brought, it was longer than the facility's beds. if she needed to close the door, she would move the bed. On 8/20/25 at 11:46 AM, CNA G was interviewed and asked how staff closed R25's door. CNA G explained she guessed she would move the bed.On 8/20/25 at 1:32 PM, the Unit Manager (UM) for R25's Unit, UM A was interviewed and asked about R25's bed positioned against the wall so the end of the bed extended into the doorway. UM A explained R25's bed did not need to be against the wall due to there being a concave mattress. she had moved the bed several times, but the staff kept moving it against the wall, but the bed was too long to be against that wall.On 8/20/25 at 2:20 PM, the Director of Nursing (DON) was interviewed and asked about R25's bed blocking the door from being closed. The DON explained the bed did not need to be against the wall, and it should not block the door from being closed. When informed of the concern of R25's privacy, since her door could not be closed, the DON acknowledged the concern.Review of a facility policy titled, Resident Rights revised 2/2025 read in part, .Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups .

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from neglect, for one Resident (R10) of two residents reviewed for abuse, resulting in R10 being transferred from their wheelchair with a damaged Hoyer lift sling, hitting their head and causing pain, with the potential to affect 15 additional facility residents who used Hoyer lifts for transfers. Findings include: On 8/19/25 at 11:32 a.m., R10 was observed seated in their manual wheelchair, dressed and well-groomed, propelling their wheelchair around their room. Review of R10's nursing progress note, dated 8/19/25 at 3:29 p.m., revealed R10 had a fall out of the Hoyer lift. The note described, (R10) was in the room with two aides with Hoyer. (R10) was getting put to bed and was hooked up to the Hoyer and upon lifting (R10) was not positioned correctly and sling come loose (sic). (R10) hit head on (the) baseboard of bed when being lowered back to a sitting position in wheelchair. Review of R10's Care Plan, accessed 8/21/25, showed R10 required 2-person assistance with a Hoyer lift for transfers. The Care Plan showed no designation for the type of sling used or sling size. The Care Plan showed R10 had an increased risk for fractures related to a diagnosis of osteoporosis (weakened bones due to decreased bone density), and showed R10 was at increased risk for falls. Review of the Electronic Medical Record (EMR) showed R10 was their own responsible party. Review of R10's progress notes revealed R10 declined to be sent out emergently for a CT scan (diagnostic test) after the fall from the Hoyer lift on 8/19/25 and agreed to an x-ray. Review of R10's skull x-ray report, dated 8/20/25, showed no acute abnormalities or fractures. Review of R10's nursing assessment, dated 8/19/25 at 3:29 p.m., revealed R10 hit the back of their head on their bed involving a Hoyer lift and sling. Review of R10's pain assessment, dated 8/19/25 at 3:38 p.m., revealed R10 experienced, Moderate pain, 3 of 10 (with 10 the highest pain), after the transfer from bed. Review of R10's Minimum Data Set (MDS) assessment, dated 7/24/25, revealed R10 was admitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (brain metabolic disorder), anxiety, and depression. The assessment revealed R10 was dependent for transfers and was cognitively intact. On 8/21/25 at 9:23 a.m., the Unit Manager, Licensed Practical Nurse (LPN) EE, was asked what occurred when R10 fell out of the Hoyer lift on 8/19/25. LPN EE described two aides started to transfer R10, when the Hoyer lift sling ripped on one side, and the aides transferred R10 into the wheelchair. LPN EE was asked to provide the damaged sling for observation and reported it was thrown away. LPN EE stated R10 bumped their head and said there was no palpable or visible lump or bruise, and confirmed they ordered an x-ray. LPN EE clarified Certified Nurse Aide (CNA) F was transferring R10 when the incident occurred, and said CNA F had received an education to inspect the lift slings prior to transferring residents. On 8/21/25 at 9:35 a.m., CNA F was asked about R10's fall from the Hoyer lift on 8/19/25, and who was working with them. CNA F reported CNA CC was the other aide present when the fall occurred. CNA F reported R10 had the sling under them in their bed, which was placed and left there by the midnight shift nursing aide staff. CNA F reported CNA CC put the green loop on their side of the lift sling onto the lift anchor, and the sling broke on the top right corner, which caused R10 to hit their head on the top metal piece of the lift. CNA F said R10 stated, Do not move me; go get the nurse, and said they positioned the wheelchair under them. CNA F reported they had not seen any concerns with the sling. CNA F acknowledged given the sling was under R10 when they arrived to transfer them, they had not fully visualized the sling.On 8/21/25 at 9:50 a.m., CNA CC was asked during a phone interview what occurred when R10 fell out of the Hoyer lift sling. CNA CC stated R10 fell during the transfer to their wheelchair, when the top of what was connected to the sling broke off (the sling loop).The sling (loop) was tattered on the end.I saw the side (a loop of the sling) on my side was faulty, so I went to a different color (loop). There are three loops (which fasten the lift sling to the lift arm anchor). I want to say the green (loop) on my side was slit and broken open, so I went to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	another color. And it broke on the other side (CNA F's side). I didn't put her on that sling. It was already under (R10) . CNA CC was asked why they did not get a new sling, when they saw a broken sling loop. CNA CC responded, It was the first time I ever seen it (happen).I saw one of the rings was faulty, so I went to another color. When I saw it was messed up on my side, I said, ?This sling is faulty.'.Maybe (CNA F) overlooked it. And when I looked and (R10) had fallen, (I said), Oh, this is tattered already. I just looked at it and the way it was frayed and stuff. I knew it had to be frayed.before (CNA F) put her on there. It had to be in bad condition. CNA CC said they worked at the facility a month and a half (when the incident occurred). CNA CC was asked if they were trained to inspect the lift slings prior to transferring a resident, and responded, I can't recall. CNA CC said R10 reported they hit their head but clarified they did not see this occur. CNA CC explained when they saw the lift sling after it broke, they would have expected CNA F to have noticed the lift sling loop appeared to be damaged on their side of the sling. CNA CC did not verbalize any understanding when they moved to another sling anchoring loop (of three available) to secure the sling to the lift, that their side of the lift sling was damaged, rendering the lift sling unsafe for use prior to R10's transfer. It was clear CNA F and CNA CC had not fully inspected the lift sling prior to transferring R10, as both reported the sling was under R10 in bed. On 8/21/25 at 9:32 a.m., Surveyor asked to speak with R10 about the incident. R10 declined to speak with the Surveyor, and stated, I'm fine. Leave me alone. On 8/21/25 at 10:05 a.m., the Laundry Supervisor, Staff T, was asked about inspections of the facility lift slings. Staff T reported the slings were sent to laundry by nursing staff in the mornings when they needed to be laundered. Staff T clarified at the time of the interview there was no process in place to ensure each sling were regularly inspected, as only the slings which were dirty were inspected at the time the incident occurred. Record review of the sling inspection laundry logs for the past six months with Staff T confirmed the facility laundered one to three slings most days randomly, only those sent to be laundered when dirty. Staff T reported they removed any slings with faded words on the tags in circulation (current use) when the soiled slings were laundered. Staff T said they did an audit after the sling incident occurred on 8/19/25 and removed any slings from circulation which were damaged. On 8/21/25 at 10:20 a.m., the slings in circulation were observed with Staff T in a centrally located room adjacent to the nurse's station. Staff T reported this was the location of the facility slings in current circulation for the nursing staff to use. It was observed the padded blue full body Hoyer slings showed three loops on each side at the top of the sling, to anchor the sling to the Hoyer lift. The loops were three different colors, including green, orange, and red on one of the slings. Staff T removed four of the current full body slings in the supply room from circulation, three with faded worn tags, showing signs of wear, including one with faded colored loops, and one sling which appeared worn and faded. It was confirmed there were no other incidents with the slings by Staff T and nursing management. Staff T had no explanation why current slings with faded tags and signs of wear were found in current circulation. On 8/21/25 at 12:03 p.m., Registered Nurse (RN) DD confirmed they were R10's nurse when R10 fell from the sling on 8/19/25. RN DD reported they observed the Hoyer sling after the incident, when one of the sling loops ripped apart. RN DD described the material was frayed, and described R10 did not fall to the floor, but fell back into the wheelchair which supported them. RN DD stated R10 said they hit their head, however they could not be certain, as they did not palpate a bump, and said they provided ice for pain. Review of R10's physician visit note, dated 8/21/25 at 12:36 p.m., revealed R10 reported hitting their head on the footboard of their head when one side of the lift's screen (fabric) loosened. The note showed some tenderness reported by R10 upon palpation, with no neurological changes or change in status evident, and there was no lump or laceration. R10's physician recommended continued monitoring and educated staff on signs of head injury. Review of CNA F's employee file showed a date of hire of 10/11/23, no disciplinary action, current nurse aide registration, abuse and neglect training, and current competencies in the use of mechanical lifts. Review of CNA CC's employee file showed a date of hire as 6/09/25, no disciplinary action, current nurse aide registration, abuse and neglect training, and mechanical lift training in their orientation on (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/14/25. Review of the manufacturer's instructions for sling use, provided by the NHA, including in their staff education, showed, .Staff should always inspect slings prior to each use. Signs of rips, tears, or frays indicate sling wear which is unsafe and could result in injury. Signs (included) fading, bleached areas, or permanent wrinkles on the strap from improper laundering which is unsafe and could result in injury. Any slings with signs or wear or improper laundering should be immediately removed from use.Do not remove sling labels. If sling labels are removed or no longer legible, sling must be immediately removed from use. On 8/21/25 at approximately 1:16 p.m., the NHA and DON reported CNA CC declined to participate in R10's incident investigation (from 8/19/25), and they had been unable to reeducate CNA CC. Both reported they were pursuing disciplinary action, up to termination. On 8/21/25 at approximately 1:28 p.m., the NHA and DON acknowledged the concerns related to R10's sling being damaged when CNA F and CNA CC transferred R10 in the Hoyer lift on 8/19/25. The DON acknowledged the sling should not have been left under R10 by the midnight staff and understood the concern. The NHA reported they had ordered new slings and had provided each resident with their own Hoyer lift sling on 8/21/25, which would be their process going forward. Their immediate intervention was that staff could only transfer residents who used Hoyer lifts with therapy staff or a nurse present. The NHA and DON reported there were no other residents who had incidents with Hoyer lifts or slings. Both confirmed they had begun to provide staff education on safe Hoyer lift transfers and had removed any slings which were damaged after R10's fall on 8/19/25. The NHA and DON were made aware there were additional slings were found on 8/21/25 with signs of wear by Staff T, with Surveyor present, and observed the worn slings. Both reported they understood the concerns related to no routine inspection or process for each sling to be regularly inspected in the building and had been working through this concern. Both acknowledged the sling which broke apart during R10's Hoyer lift transfer on 8/21/25 had been discarded to ensure the sling was no longer available for use. Both confirmed the concern related to CNA CC transferring R10 with a damaged, frayed sling was incorrect and placed R10 at risk for injury. The NHA reported they had informed their Medical Director of the concerns who they included in an ad hoc QAPI meeting on 8/21/25. The NHA described they had added routine Hoyer sling inspections in their maintenance system and were including their therapy and nursing staff in floor staff education including observations of Hoyer lift transfers. Review of CNA F's, Total Mechanical Lift Competency Checklist re-education, dated 8/21/25, provided by the NHA, included the following directives for safe mechanical lift operation: Ensuring two caregivers were present, visually inspecting slings for signs of wear and tear, not using any sling which was visually damaged, positioning a resident on the appropriate sling and size, and removing the sling from under a resident, unless care planned otherwise. An additional Handwritten directive included: Notifying the NHA or DON immediately, if there was an incident or injury with the equipment, and defective equipment must be removed and turned into the NHA or Maintenance Director immediately, and noted, Do Not Discard. Review of laundry staff education, Hoyer Sling Education, dated 8/21/25, revealed, i. Always inspect slings prior to each wash. Signs of rips, tears, and frays indicate sling wear which is unsafe and could result in injury. Signs of color fading, bleached areas, or permanent wrinkles on the straps indicate improper laundering which is unsafe and could result in injury. ANY slings with signs of wear or improper laundering should be immediately removed from use. ii. Do not remove sling labels. If sling labels are removed or no longer legible, sling must be immediately removed from use. iii. Slings are to be washed on a cycle with NO BLEACH. Review of the policy, Safe Resident Handling Transfers, dated 8/09/24, revealed, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident while keeping the employees safe in accordance with current standards and guidelines. Policy explanation: Residents require safe handling when transferred to prevent or minimize the risk of injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts is a safer alternative (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and should be used in non-emergent situations. Compliance guidelines:.6. The staff will inspect the equipment prior to use to ensure functionality and will alert maintenance or other designee if the equipment is not functioning properly. 7. Damaged, broken, or improperly functioning lift equipment will not be used and tagged out according to facility procedures. 8. The facility will ensure that there are appropriate amounts of varying sized slings to accommodate residents per the manufacturer's instructions on proper sling sizing. 9. Ensure that the sling designed for the lift is utilized with that specific lift. 10. Two staff members must be utilized when transferring residents with a full body mechanical lift. 11. Staff will be educated on the use of safe handling/transfer practices, to include use of mechanical lift devices upon hire, annually and as the need arises or changes in equipment occur. 12. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment. 13. Resident lifting and transferring will be performed according to the resident's individual plan of care. 14. Staff will perform mechanical lifts/transfers according to manufacturers' instructions for use of the device. 15. Slings will be laundered according to the manufacturer's instructions and any damaged, broken, or unsafe slings will be removed from service and replaced. 16. Environmental services will maintain a Lift Inspection Log. a. Slings will be inspected during routine laundering. b. Slings will be assigned a number for tracking purposes. Slings will be physically labeled with their number. Review of the policy, Abuse, Neglect, and Exploitation, revised 6/24, revealed, It is the policy of this facility to provide protections to the health, welfare and rights of each resident by developing and implements written policies and procedures that prohibit and prevent abuse, neglect.Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.IV. Identification.Possible indicators of abuse include but are not limited to: .8. Failure to provide care needs such as comfort, safety.turning, and positioning.6. Taking all necessary actions as a result if the investigation, which may include, but are not limited to, the following: a. analyzing the occurrence(s) to determine why abuse, neglect.occurred and what changes are needed to prevent further occurrence, b. Defining how care provision will be changed and/or improved to protect residents receiving services. c. Training of staff on changes made and demonstration of staff competency after training is implemented. d. Identification of staff responsible for implementation of correction action. E. The expected date of implementation. f Identification of staff responsible for monitoring the implementation of plan.VIII. Coordination with QAPI. A. The facility will communicate and coordinate situations of abuse, neglect.with the facility QAPI committee.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide timely incontinence care for one (R60) of one resident reviewed for bladder and bowel incontinence. Findings include:On 8/19/25 at 9:58 AM, R60 was observed lying in bed with oxygen running via nasal cannula. When asked about how they felt the care was and whether there was enough staff to meet their care needs, R60 reported concerns with not having enough staff to change their briefs regularly. The resident further reported they wore disposable briefs and they also had a UTI (Urinary Tract Infection) and still has burning (common pain from a UTI) because they felt like the UTI was because they weren't getting changed frequently. When asked what they considered as frequent, R60 reported they were trying to get a change every three to four hours, but they often had to wait a long time. When asked when the last time they were changed, R60 reported the last time was at 5:00 AM. The resident also reported it (the delay in being changed) was worse on the weekends and evenings.Review of the clinical record revealed R60 was admitted into the facility on [DATE] with diagnoses that included: chronic obstructive pulmonary disease with acute exacerbation, mild intermittent asthma, fibromyalgia, and major depressive disorder recurrent.According to the Minimum Data Set (MDS) assessment dated [DATE], R60 had intact cognition, and requires substantial/maximal assistance with lower body dressing, toileting hygiene, and is always incontinent of bladder and bowel.Review of the care plans included:I have an ADL (activities of daily living) Self Care Performance Deficit r/t (related to) increased weakness due to hospitalization. Able to make needs known. Hearing is adequate, vision is highly impaired. Inc (Incontinent) of B (Bladder) & B (Bowel). This care plan was initiated on 10/7/21 and last reviewed on 7/22/25.Interventions included:TOILET USE: I am not toileted. Provide briefs for dignity and pericare after each incontinent episode. This intervention was initiated on 11/4/24.Review of the nursing documentation for when R60 had incontinence episodes in the task section of the clinical record for the past 30 days (maximum look back period available) revealed some days there was only documentation that incontinence care was done twice, sometimes three times, and one day four times in a 24-hour period. This documentation included the following times it was documented as being done:8/21/25 at 2:36 AM8/20/25 at 10:25 AM and 8:23 PM8/19/25 at 6:24 AM, 1:39 PM, 9:24 PM, 11:57 PM8/18/25 at 6:42 AM, 11:11 AM, 10:35 PM8/17/25 at 6:59 AM, 8:00 AM, 10:07 PM8/16/25 at 5:15 AM, 1:37 PM, 7:57 PM8/15/25 at 12:43 AM, 2:14 PM, 9:12 PM8/14/25 at 12:06 AM, 1:19 PM, 6:31 PM8/13/25 at 6:39 AM, 10:06 AM, 7:52 PM8/12/25 at 6:38 AM, 10:30 AM, 9:00 PM8/11/25 at 12:26 AM, 9:53 AM, 8:48 PM8/10/25 at 6:32 AM, 10:22 AM, 10:59 PM8/9/25 at 6:25 AM, 7:47 AM, 6:44 PM8/8/25 at 6:41 AM, 11:10 AM, 7:33 PM8/7/25 at 6:15 AM, 8 56 AM, 4:22 PM8/6/25 at 6:57 AM, 10:03 AM, 5:10 PM8/5/25 at 9:26 AM, 8:56 PM8/4/25 at 6:50 AM, 8:51 AM, 5:35 PM, 11:37 PM8/3/25 at 4:50 AM, 2:59 PM, 8:27 PM8/2/25 at 10:28 AM, 9:41 PM8/1/25 at 6:33 AM, 2:22 PM, 10:23 PM, 11:42 PM7/31/25 at 6:59 AM, 2:53 PM, 8:47 PM7/30/25 at 6:52 AM, 8:53 AM, 10:49 PM7/29/25 at 6:53 AM, 12:05 PM, 9:40 PM7/28/25 at 2:59 PM, 10:33 PM7/27/25 at 12:34 AM, 11:23 AM, 8:38 PM, 11:55 PM7/26/25 at 6:34 AM, 9:53 AM, 6:03 PM7/25/25 at 12:52 AM, 10:39 AM, 5:35 PM7/24/25 at 6:49 AM, 12:58 PM, 10:59 PM7/23/25 at 12:30 AM, 11:12 AM, 10:59 PMOn 8/21/25 at 12:25 PM, an interview was conducted with the Director of Nursing (DON). When asked what the facility's process was for incontinence care, the DON reported the CNAs (Certified Nursing Assistants) should be checking for incontinence throughout the shift. When asked how they should be documenting if incontinence care was provided, the DON reported typically they document in (name of electronic record) but a lot don't do it in real time, some document towards the end of the shift, and they liked them to chart as they go. The DON further reported the facility was aware of issues with call light response and more of issue with off-shifts like nights and weekends and were trying to hold staff accountable, but call-ins were the issue. The DON further acknowledged at times there might only be one CNA but even if they had two CNAs per hallway, the acuity was hard.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide snacks for a resident with low body weight for one (R54) of three residents reviewed for nutrition. Findings include: On 8/19/25 at 9:06 AM, R54 was observed lying in her bed. R54 appeared to be small and very thin and bilateral arm and hand contractures were observed. R54 was asked about care at the facility. R54 explained she did not get snacks in the evenings, she did not always like the food being served and she was hungry in the evenings and would like to get snacks. sometimes someone would give her something, but she needed assistance to eat and it was hard to get someone to assist her at snack time.Review of the clinical record revealed R54 was admitted into the facility on [DATE] with diagnoses that included: spastic quadriplegic cerebral palsy, moderate protein-calorie malnutrition and anxiety disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R54 was cognitively intact. The MDS assessment also indicated R54 was dependent on staff for eating.Review of R54's weights revealed the most recent weight dated 8/7/25 was 77.4 pounds.Review of R54's nutritional care plan revised 2/17/25 revealed no intervention for providing evening snacks.Review of a 30 Day Look Back of Certified Nursing Assistant (CNA) documentation for Snacks revealed no snacks documented as given or eaten.On 8/20/25 at 8:43 AM, observation of CNA F assisting R54 with breakfast revealed R54 was not able to open items on the tray and required the assistance of staff to eat.On 8/21/25 at 9:01 AM, the Dietary Manager (DM) was interviewed and asked how evening snacks were distributed. The DM explained there was a list of residents that they would prepare a snack for and their name would be put on the snack and it was distributed to the resident in the evening. The DM was asked if R54 was on the list for evening snacks. The DM explained he would check to see.On 8/21/25 at 9:15 AM, the DM provided a list of 45 residents who were provided evening snacks. R54 was not on the list. On 8/21/25 at 10:05 AM, Registered Dietician (RD) K was interviewed and asked why R54 was not provided evening snacks. RD K explained R54 had never asked for evening snacks. RD K was asked why evening snacks were not included in R54's nutritional interventions due to her only weighing 77.4 pounds. RD K acknowledged the concern and explained he would add R54 to the list for evening snacks.On 8/21/25 at 2:10 PM, the Director of Nursing (DON) was interviewed and asked about R54 not receiving evening snacks. The DON explained R54 had never asked for evening snacks, but thought it would be a good idea since R54 only weighed 77.4 pounds.Review of a facility policy titled, Weight Monitoring revised 1/2024 read in part, .Interventions will be identified, implemented, monitored and modified (as appropriate), consistent with the resident's assessed needs, choices, preferences, goals and current professional standards to maintain acceptable parameters of nutritional status.