STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235481	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Orion Nursing Center	585 East Flint Street Lake Orion, MI 48362

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2546912Based on observation, interview and record review, the facility failed to provide an environment that promoted and enhanced residents' dignity for three (R402, R404 and R405) of three residents reviewed for dignity. Findings include: R404 On 12/23/25 at 11:58 a.m., R404 was observed in their room dressed and seated on the edge of their bed. R404 stated two to three days prior an aide (Certified Nurse Aide S) rushed them off the toilet when they were trying to have a bowel movement. R404 reported they typically needed one-person assistance to get off their commode. R404 explained CNA S was mean to them when they kept telling them to get off the toilet over and over in a raised voice and then made them get off the commode. R404 further described CNA S and said they were going to report them to their supervisor to come down and see what they caused (which was unclear to them). R404 said this made them feel terrible, belittled.I am scared of (CNA S) now. R404 clarified CNA S had not cared for them since the incident, and they would not allow them to care for them every again and told their nurse (unnamed) about their concerns. R404 said, Give (CNA S) more training. I said something to (CNA S) about her manner and I said, You don't talk to people like that as you don't know why they are here (in the facility). R404 added, She (CNA S) needs extra help with her personality, and I hope (management) can work on her. I hope I don't see her back here. I am fine as long as I don't see her. R404 reported no one had followed up with them about the incident afterwards. R404 denied abuse and described this as undignified conduct with a (negative) attitude and called them aggressive. R404 said they were fine now and had no lasting effect, other than they will not let them work with them. R404 was alert and oriented to herself, time, situation and place. Review of R404's Care Plan, accessed 12/23/25, showed R404 was a [AGE] year-old patient who required one-person assistance with toileting and transfers. They were admitted to the facility on [DATE] with diagnoses including frequent falls, anxiety, heart failure, and late onset Alzheimer's disease. Review of R404's Brief Interview for Mental Status, dated 11/14/25, showed a score of 15/15, which revealed they were cognitively intact. Review of R404's progress notes confirmed there was no nursing, social services, or staff documentation or follow-up about this employee to resident incident, as described by R404. On 12/23/25 at 4:42 p.m., the scheduler, Staff P confirmed they had not been made aware of any incident between R404 and CNA S, and had not removed them from the schedule, and would follow up with management. Staff P confirmed CNA S worked with R404 on 12/21/25, and recently. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/23/25 at approximately 5:00 p.m., the Human Resources Consultant, Staff Q, reviewed CNA S's employee file with this Surveyor. The file review confirmed CNA S had received abuse training and had no current or recent disciplinary action since two unprofessional conduct concerns in 2023. Staff Q reported they had not been made aware of the incident and said they would typically be a part of any disciplinary action. No recent competencies were found for CNA S since 2023. On 12/23/25 at approximately 5:15 p.m., R404's concerns regarding this incident and CNA S were reviewed with the Nursing Home Administrator (NHA) and Director of Nursing (DON). Both reported they had not been made aware of the incident and acknowledged the dignity concerns. The DON reported they were considering disciplinary action and would refer CNA S to the [NAME] (Employee Assistance Program). Since both denied being made aware of the incident, they confirmed CNA S had not been removed from working with R404 and ensure this would occur going forward. The DON acknowledged CNA S had abuse and behavioral training however it appeared there were no recent competencies in their employee file. The NHA reported their staff had completed a competency fair with all staff this year, however no documentation of such was received by survey exit upon request, so it was unclear if CNA S had updated competencies. The NHA and DON both reported they would follow up, do retraining, up to disciplinary action, and ensure there were no other resident outcomes for facility residents. R405 On 12/23/25 at 4:18 p.m., R405 was observed laying in their bed with a long brace on their left leg. Their bed was observed by the room door. R405 agreed to be interviewed and reported they were going home tomorrow. A curtain was observed on the right side of their bed. On 12/23/25 at 4:20 p.m., R405 was asked their care at the facility. R405 stated they had a concern the other night (about two days ago) when they were talking with their sister on the phone and their sister asked them a question about a nurse. R405 reported CNA S all of a sudden came around from behind that curtain (on their right side), and I said, Excuse me, and (CNA S) said, I will not be taking care of you anymore tonight, rudely, and said, I am going to get the nurse.(CNA S) told them (their nurse) I was talking about them (R405 confirmed she was not). R405 reported two nurses came in and said, Did something just happen?. R405 said they responded, I don't understand what I did wrong, and began to cry as they felt upset. R405 said the nurses apologized and said CNA S reported their HIPPA (privacy rights) was violated. R405 said CNA S was mixing things up and then told they told their sister to pick them up as they wanted to immediately leave the facility and go home. R405 said the nurses apologized to them, planned to follow-up with CNA S, and talked them into staying. R405 decided to stay after talking with nursing management, as they were told they would have been leaving AMA (Against Medical Advice), and CNA S was immediately relieved from their care. R405 reported their sister came to the facility and stayed with them until 1:00 a.m R405 said, I am ok now, and said they never wanted CNA S to ever care for them again. R405 reported CNA S had not worked with them again since the incident. It was noted R405 was alert and oriented to person, place, time, and situation. On 12/23/25 at approximately 5:30 p.m., the NHA and DON reported they had been made aware of this incident between CNA S and R405, and nursing management had been involved as described. Both confirmed CNA S had not worked with R405 since the incidents. Both reported they understood the undignified care concerns and planned to follow up .including up to disciplinary action and ensuring CNA S would not be working with either R404 or R405 and ensured their safety. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Policy, Policy on Dignified Care, undated, received from the NHA, revealed, Purpose: To ensure all residents receive care that preserves dignity, respect, individuality, and autonomy, and promotes quality of life in accordance with ethical standards and regulatory requirements. Policy Statement: The facility is committed to providing dignified, person-centered care to every resident. All residents shall be treated with respect, compassion, and consideration for their physical, emotional, cultural, psychosocial , and spiritual needs.Principles of Dignified care: Be treated with courtesy, respect, and kindness.Care Practices: Staff shall: Knock, introduce themselves, and explain care before initiating any interaction.Use appropriate draping and close doors or curtains during care.Communicate in a clear, respectful, and age-appropriate manner. Staff responsibility and accountability: Staff are responsible for upholding this policy and reporting concerns related to undignified care, abuse, neglect, or disrespect through appropriate channels. Failure to comply with this policy may result in corrective action. R402 A complaint was filed with the State Agency (SA) that alleged in part, .on 10/16 [2025]. an administrator was also yelling at [R402] to stop crying. were screaming at her and asking if she wanted to go to the hospital and get placed in a psychiatric unit. On 12/23/25 at 8:45 AM, R402 was observed lying in her bed. R402 was asked about what happened on 10/16/25. R402 explained Supervisor 'C' rushed into her room and told her she had C. diff [Clostridioides difficile – a contagious infection of the colon]. she did not know what that was. the staff told her they had to move her to a different room. she did not want to move. she started crying. the Administrator got in her face and told her if she did not stop crying she was going to send her to the psych ward. they moved her in the bed to the elevator to go to another floor, all the staff was standing at the nurse station and they were staring at her, she felt like an animal on display. she could not stop crying. put her in a room with another resident who they said had the same infection. her new roommate was allowed to leave the room, go downstairs to activities, but she was told she could not leave the room. R402 was asked what would have made it easier for her to be moved to another room. R402 explained the staff needed to treat people with respect and dignity. Review of the clinical record revealed R402 was admitted into the facility on 8/4/21 and readmitted on [DATE] with diagnoses including: anxiety disorder, diabetes and spinal stenosis. According to the Minimum Data Set [MDS] assessment dated [DATE], R402 was cognitively intact. Review of R402's Psychosocial Well-Being care plan revealed an approach edited 9/28/25 that read in part, 1. Continue to promote a relationship of mutual trust and respect. 2. Offer choices daily and encourage simple decision making. 4. Provide active listening, validation, and reassurance as needed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/23/25 at 12:28 PM, Licensed Practical Nurse [LPN] 'B' was interviewed and asked about what she observed with R402 on 10/16/25. LPN 'B' explained she was R402's assigned nurse that day, she told R402 that she had C. diff, she said she did not want to move to another room. she told Supervisor 'C' and the Administrator that R402 did not want to move to another room. they said she had to move and then they took over. they told her she had to move, she was yelling and crying, she did not want to move, they moved her anyway. LPN 'B' was asked if she had heard any staff member tell R402 they were going to send her to the psych ward. LPN 'B' explained she had not heard anyone say that, but R402 had told her after that the Administrator had told her that. LPN 'B' was asked if Social Work had been asked to talk to R402 before the move. LPN 'B' explained she did not remember either Social Worker talking to R402 before they moved her. On 12/23/25 at 1:12 PM, former Supervisor 'C' was interviewed by phone and asked what had occurred with R402 on 10/16/25. Supervisor 'C' explained R402 was upset and crying that she had to move. the Administrator told R402 she did not have a choice about moving. R402 said she did not want him in her room so he left and let the Administrator handle the situation because sometimes a change of face will help. they moved her to the other room, she was crying the whole way. On 12/23/25 at 1:25 PM, Social Worker [SW] 'D' was interviewed and asked if she had been involved with moving R402 to another room on 10/16/25. SW 'D' explained she did not know anything about what had happened until after R402 was moved to another room. SW 'D' was asked if she was ever requested to help out if a resident was upset. SW 'D' explained she would have expected staff to get her if a resident was that upset. On 12/23/25 at 1:55 PM, the Administrator was interviewed and asked to describe what happened on 10/16/25 with R402. The Administrator explained R402's nurse came and told her R402 did not want to change rooms and was positive for C. diff. she went and talked to R402 who said she did not want to go by wheelchair. told R402 they could move her in the bed. got two maintenance men and they pushed the bed and she went with them to the new room. The Administrator was asked if R402 was yelling and crying when they were moving the bed. The Administrator explained R402 was not crying or making any noise, she just kept her arms folded across her chest and had her eyes tightly shut the whole way. When asked if anyone had told R402 she was going to be sent to the psych ward if she did not stop crying, the Administrator said no. The Administrator was asked why Social Work had not been asked to talk to R402 before being moved. The Administrator explained Social Work had already talked to the resident before she had. On 12/23/25 at 2:01 PM, SW 'F' was interviewed and asked if she had talked to R402 before being moved to a different room on 10/16/25. SW 'F' explained she had only found out about what happened after R402 was in the new room. On 12/23/25 at 2:05 PM, Maintenance Worker [MW] 'G' was interviewed and asked if he had helped move R402 on 10/15/25. MW 'G' explained they usually do not move beds, and hardly never with a resident in the bed. we were told she had to be moved per physician orders. she did not want to be moved, she was upset and crying. everyone could hear her and were looking at her. it was an uncomfortable position for us to be in. the Administrator told us we had to move her. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/23/25 at 2:18 PM, former Infection Control Nurse [ICN] 'E' was interviewed by phone and asked about R402 having to move rooms on 10/16/25. ICN 'E' explained she had not been working that day, and if she had been, the entire situation would have been handled differently. R402 should not have been moved to a different room, R402's roommate should have been moved. the room was already contaminated, so R402 should have stayed in the room and her roommate moved out. she made it abundantly clear that in the future the uncontaminated person is the one who should be moved, not the one with the infection. ICN 'E' was asked if R402's new roommate had been allowed to leave the room. ICN 'E' explained the new roommate was just finishing her isolation for C. diff when they moved R402 into her room. should not have moved R402 into that room, R402 could have reinfected her. ICN 'E' was asked if she had seen R402 when she was in the new room. ICN 'E' explained R402 remained very upset the whole time she was in that room until she was allowed to go back to her original room. Review of R402's census record revealed R402 was moved from her room on 10/16/24 to a room on a different floor, and moved back to her previous room on 10/28/25. On 12/23/25 at 3:15 PM, MW 'H' was interviewed and asked if he had helped move R402 on 10/16/25. MW 'H' explained the Administrator came and got them and told them they had to move a resident per doctor's orders. thought it was an infection control issue. R402 was not happy, she was yelling and crying the whole way. everyone could hear her. he felt bad for her, she did not want to move.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intake 2645567. Based on observation, interview, and record review, the facility failed to provide adequate staffing for two residents, R403 and R404, which had the potential to affect all facility residents. Findings include: Review of an anonymous complaint received by the State Agency on 10/01/25 revealed an allegation when R403 was not assisted with timely toileting on 9/29/25 from 11:00 p.m. to 7:00 a.m. due to short staffing. The complainant alleged, I was speaking with a coherent resident (R403) who stated she sat on the toilet for one hour and 45 minutes and she turned the call light on and no one came to assist for an hour. She (R403) had to use her cell phone to call the facility downstairs and have them send help. After using her own cell phone to call for help it was another 45 minutes before someone came to help her off the toilet, in which she told me she had to scream, 'help, help'. The building is always short staffed . The complainant alleged nursing management did not come in to assist so that the residents get the proper care. The complaint described, .Working (the) midnight shift aides with one person for 40 people is unacceptable. On 12/23/25 at 10:35 a.m., R403 had left the facility with their family. On 12/23/25 at approximately 10:37 a.m., R403's room was observed to have a wide bedside commode adjacent to their bed. On 12/23/25 at approximately 10:38 a.m., Licensed Practical Nurse (LPN) J, was asked about staffing. LPN J reported they had 24 residents including new rehabilitation residents assigned to them on 3 North on this date, which included higher acuity residents who needed wound care, peg tube care, medications passed, extra pain medications, and rehab residents including admissions who may have had more acute treatment needs. LPN J reported when they worked on the [NAME] Hall they had up to 26 residents. LPN J acknowledged at times this could make the medications and treatments late, and the residents became upset sometimes. LPN J reported they did not understand why the other 3 floor nurse had only about 13 residents. LPN J reported they had brought this to management's attention but the situation had not changed. LPN J stated they believed staffing was more number than acuity based, and they wished resident acuity was taken into account more. LPN J reported the aides had anywhere from 15 to 16 residents each on their unit, so they needed to help with transfers and patient care at times as well, and they were concerned they could make a mistake in providing care with such high acuity and residents. LPN J confirmed this had not occurred but they felt there needed to be a solution. LPN J stated they did not understand why the second floor always had three nurses and the 3rd floor had only two nurses assigned. LPN J said the facility had recently hired new nursing management and unit managers assisted at times with the medication pass, but concerns remained as they needed more assistance for resident care needs to be met timely and without being rushed with the current resident census. On 12/23/25 at 11:22 a.m., CNA J was asked about resident care on the 3rd floor, as they were assigned there. CNA J reported they had too many residents and not enough assistance, with up to 15 residents on the day shift. CNA J clarified they could meet the residents' care needs but they were late, which frustrated the residents. CNA J explained it was difficult to check and change residents every two hours so sometimes residents had to wait longer, which concerned them and some of the residents. CNA J said the nurses were understaffed as residents were sometimes getting their medications late as the residents yelled at them about getting late medications. CNA J stated when there were only two nurses up here they had up to 30 residents each and said they watched the nurses' scramble. CNA J explained there was a new rule about two weeks ago that no other staff could help them (the aides) answer call lights. CNA J said the housekeeping staff used to answer call lights to assist with tray or water pass, and other lighter non-certified needs. CNA J was unsure why this rule had been changed but said now they had more duties on them and the nurses, including non-care needs. CNA J said the nurses could not help the aides much as they had pain medications, IV's (intravenous liquids/medications), tube feedings, colostomy bags and other high acuity needs on the 3rd floor.On 12/23/25 at 11:34 a.m., CNA K was asked about caring for residents on the 3rd floor. CNA K confirmed R403 told them of an incident when they were left on their bedside commode too long, which upset them, but said they did not have the details. CNA K reported the 3rd floor residents had higher acuity needs, so with 3 aides or less they struggled. CNA K explained some of the residents were frequently incontinent, needing to be turned, required mechanical lifts, and had frequent toileting needs, so it was difficult getting their care needs met timely, and stated their second schedules check and changes may be late or were not able to be completed. CNA K said some of the residents complained about waiting for care. CNA K said yesterday they had about seven residents who