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	05/13/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2984138.Based on observations, interviews, and record reviews, the facility failed to ensure care plans and/or fall interventions were timely implemented, reviewed, and/or revised. The facility also failed to follow its fall management policy by ensuring all falls were reviewed by the interdisciplinary team and that fall risk assessments were completed in accordance with the facility policy. Findings include:A review of a complaint submitted to the SA (State Agency) reported the facility neglected to address issues regarding resident falls.On 5/13/26 an onsite investigation was conducted.R202A review of the R202's medical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: Alzheimer's disease and chronic obstructive pulmonary disease (COPD) and history of falls. A Minimum Data Set (MDS) assessment dated [DATE], noted a Brief Interview for Mental Status (BIMS) score of 10 (which indicated moderately impaired cognition).On 5/13/26 at approximately 12:00 noon an attempt to observe and interview the resident was unsuccessful. The resident was out of the building at an appointment.A review of an Incident Note dated 2/21/26 at 6:41 PM, documented Resident noted to get up and walk in room and lost balance and fell and hit head on wheelchair. Resident has stated that she doesn't have much pain except in back and on head, head has small scrape and is bruised. Resident stated that she wanted to go to the ER (emergency room) to get checked out due to past falls where she has had a fracture or a sprain. On call called and notified, DPOA (durable power of attorney) called and notified, and on call manager called and notified. Resident awaiting non-emergent EMS (emergency medical services) transport to (hospital name)A review of a Physician consult dated 2/23/26, documented in part . Follow-up fall, ER visit. rib cage pain and multiple bruises following a fall. Patient sustained a fall resulting in rib cage pain and multiple bruises on the face, left arm, right arm, and humerus. Physical examination revealed significant bruising on extremities and face, with a large bruise noted on the humerus. Given the mechanism of injury location of pain, there is concern for possible rib fracture that may have not been adequately evaluated with initial imaging. Plan: Order ribs x-ray to rule out rib fractures, - Apply lidocaine patch to affected area for pain management.A review of the care plan revealed no modifications completed to the Risk for falls (dated 1/8/26) care plan after the resident's fall.A review of the medical record revealed no documentation of the interdisciplinary team to reviewed R202's fall and fall interventions. On 5/13/26 at 12:35 PM, the Administrator was asked to provide the fall incident reports for R202 from January 2026 to current.On 5/13/26 at 1:42 PM, the Administrator replied they had no fall incident reports for the resident.A review of a facility policy titled Falls Risk Management (no date noted) documented in part, . Purpose: Prevent falls and promote safety. If a fall occurs, an investigation is immediately initiated. A fall huddle is conducted, and witness statements obtained. A preliminary. is completed at the time of the fall and nursing interventions will be initiated. An usual occurrence form is completed at the time of the fall. is completed and reviewed by the interdisciplinary team within 24-72 hours of the fall. R203On 5/13/26 at 11:39 AM, R203 was observed sitting up in bed sipping on water. A brief interview was conducted with the resident at that time.A review of the medical record revealed R203 was (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted to the facility with diagnoses that included: acute respiratory failure with hypoxia and orthostatic hypotension.A review of a Nursing note dated 4/16/26 at 7:08 PM, .During dinner resident was sitting in wheelchair and writer was informed that resident had fall in dining room , observed resident on floor, resident stated she was not in any pain and was able to move her extremities, patient did hit her head she stated redness was observed on front of forehead.A review of an occurrence report for the 4/16/26 fall provided by the Administrator documented in part, . Follow up. Education, Care Plan updated, Care Plan generated, Referred to therapy for screen. CNA's (certified nursing aides) to offer to resident to assist her into bed to rest when tired, frequent rest periods.A review of the care plans revealed a care plan titled The resident has had an actual fall with. Poor Balance, Unsteady gait initiated on 3/4/26. This care plan noted no interventions implemented until 4/21/26, five days after the residents 4/16/26 fall.A review of the progress notes and incident reports provided revealed the resident had additional falls on - 1/1/26, 2/15/26, 3/4/26, and 3/25/26.Further review of the care plans revealed a care plan titled . is at risk for falls r/t weakness. initiated on 2/6/26. All interventions on the care plan were also initiated on 2/6/26, more than a month after the residents 1/1/26 fall.A review of a fall risk assessment completed on 12/31/25, noted the resident to be Moderate Risk with a score of 10 and noted to have a history of falls in the last three months.A review of the medical record revealed no fall care plans implemented prior to 2/6/26, despite the resident's fall risk score and history of falls.Further review of the facility policy titled Falls Risk Management documented in part, . all residents are assessed for fall risk by completing a Fall Risk Assessment. Depending on risk level, appropriate interventions will be initiated. A Fall Risk Assessment is to be completed by the restorative nurse or designee for the following. Post Fall.A review of the resident's fall risk assessments revealed no post fall risk assessments completed for the 1/1/26, 2/15/26, 3/4/26 and 4/16/26 falls.R204On 5/13/26 at 11:42 AM, R204 was observed lying on their back in bed. Two grey mats were observed on each side of the bed. A brief interview was conducted with the resident at that time.Review of a Nursing note dated 2/19/26 at 8:16 AM, documented in part . a loud noise was heard coming from resident's direction. Nurse writer went to room and observed resident on floor in front of wheelchair, laying on his Left side, head on bedside mat. Nurse writer asked what happened. Resident state <sic> I was trying to plug my phone in. Non skid footwear on. Call light laying across bed. Small skin tear to L elbow. Area cleansed and treatment applied. Resident denies pain at this time .A review of the resident's fall risk assessments revealed no post fall risk assessment completed for the 2/19/26 fall.On 5/13/26 at 2:48 PM, Nurse A (who was acting as the Director of Nursing (DON) and Assistant Director of Nursing (ADON) in their absences during the survey) was interviewed and asked if an occurrence (incident) form is completed for every fall. Nurse A reported that the unusual occurrence paperwork is completed for every fall and reviewed by the interdisciplinary team (IDT). Nurse A reported the IDT team reviews the occurrence and fall interventions. Nurse A reported the facility's Quality Assurance committee also reviews the occurrence fall report. When asked if an occurrence report was not made for a fall, if it was safe to say that the IDT team and Quality Assurance committee did not review the fall and interventions for that particular fall and Nurse A replied that to be true. Nurse A was asked when staff are expected to complete the residents' fall risk assessments and Nurse A replied they would look into it and follow back up. Nurse A was then asked about R202 fall on 2/21/26 that required a transfer to the hospital. Nurse A was asked why an occurrence form was not completed for the fall and why there were no documentation in the medical record of the residents fall care plan to have been reviewed and modified after the 2/21/26 fall. Nurse A was also asked why fall interventions and/or care plans were not timely implemented to prevent falls for R203, despite multiple falls documented. Nurse A was also asked about the fall risk assessments for R's 203 & 204 to not have been completed post fall per the facility's policy. Nurse A stated they would look into it and follow back up. At 3:54 PM, Nurse A returned with the facility's Fall Coordinator (FC) B. Nurse A confirmed they looked into all of the concerns and were unable to find additional information to provide for review.