STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235489	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Villa at Green Lake Estates	6470 Alden Dr Orchard Lake, MI 48324

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** 40330 This citation pertains to Intake #MI00149522. Based on observation, interview, and record review, the facility failed to prevent a fall with injury for one Resident (R701) of three residents reviewed for falls and accidents, resulting in actual harm, when R701 required stitches to their shoulder after falling out of bed. Findings include: On 2/04/25 at 12:25 p.m., R701 was observed in their bed positioned on their back, wearing a hospital gown. R701's left arm was observed flexed at the elbow, with a clenched fist. On 2/04/25 at 12:27 p.m., R701 reported they sustained a fall recently when they rolled off their bed onto the floor. R701 stated, My aide was changing me and (they) stepped out and left me unattended. I rolled out of bed. (They) work the night shift, and it happened on the night shift. I fell over there . R701 pointed to the right side of their hospital bed, to the floor. R701 continued, I didn't have pain, just a cut, and pointed to their left arm, at the shoulder. R701 reported they required 11 stitches, and this made them feel upset, as they did not understand why their aide placed them on their side unsupported and left the room. R701 explained they yelled for help before falling. R701 described they fell off the right side of their bed, between their bed and the wall, onto the floor heating vent, which had a nail sticking out and cut them. R701 reported staff put a bedrail on the right side of the bed up after the fall out of bed. R701 described they also hit their forehead when they fell out of bed when they injured their arm. R701 denied significant pain when the incident occurred. R701 stated they did not want to work with them again, as they believed the aide was still worked at the facility. R701 was alert and fully oriented during the interview. On 2/04/25 at approximately 12:33 p.m., R701's left shoulder was observed and showed a closed red scar, approximately two inches long, with a small circle scab, located just below the shoulder joint. R701's hospital bed was observed positioned at least 18 inches from the wall. A baseboard heating vent was observed running along the base of the floor under the floor window. There were on obvious nails or sharp edges observed. Enabler mobility bedrails were observed on both sides of R701's bed. (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	Review of R701's Minimum Data Set (MDS) assessment, dated 10/04/24, revealed R701 was admitted to the facility on [DATE], with diagnoses including stroke, heart failure, arthritis, anxiety, and depression. The assessment revealed R701 required maximal assistance with bed mobility, including rolling, maximal assistance with toileting and hygiene, was incontinent of bladder and bowel, and was dependent for transfers. The behavioral assessment showed no behaviors. The range of motion assessment showed range of motion impairment on one of the upper extremities, and both lower extremities. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R701 was cognitively intact. Review of R701's profile revealed R701 was their own responsible party and made their own care decisions. On 2/04/25 at 2:10 p.m., Certified Nurse Aide (CNA) C was asked during a phone interview regarding R701's fall out of bed on 1/01/25. CNA C reported they worked by themselves that night covering the hall, due to a staff member calling in, and reported they only had one day of training on the hall. CNA C stated they received in report R701 was a one person assist, and was told R701 could hold their weight. CNA C explained they left R701 unattended to gather their supplies, and said to R701, I am going to be right back, and by the time I turned around after leaving (R701) screamed. R701 reported when they returned R701 was already on the floor. CNA C stated, I believe (R701) fell by the windowsill. I am grateful (R701) was ok .I think (R701) cut (their) arm on the nail in the vent .I wasn't in the room (when the incident occurred), and the nurse was doing wound care with R701's roommate. I honestly think it was a miscommunication between me and (R701), as (R701) holds onto (their) remote (bed control) . When asked how the bed was positioned, CNA C reported the bed was flat and at mid-height (transfer height), not lowered to the ground, and it was locked. CNA C explained when they were short staffed, they meant they went from being assigned 14 residents care to about 24 residents that night. CNA C continued, I don't like working that way, as something could go wrong .I was overwhelmed. R701 reported they were only told the level of assistance of this resident and had not looked at R701's care plan, Kardex, or any care designation guide. CNA C clarified they were unfamiliar with R701, as they had been recently hired. CNA C reported there was no intention of any injury, and the incident was an accident. CNA C stated they no longer worked at the facility. Review of R701's nursing progress note, dated 1/01/25 at 8:15 a.m., revealed, Resident (701) was receiving care from CENA (aide) while writer (nurse) was doing wound care for (roommate) and heard a loud noise. Resident (701) was then observed on the floor, on (their) left side between (their) bed and the wall at 623 (a.m.) . Noted scant amount of blood on (their) torso .Noted deep laceration to (their) left upper arm and a small cut to (their) right lower back but resident denies pain .911 (emergency services) called at 648 (a.m.), arrived to facility and transported resident (R701) out on stretcher at 655 (a.m.) to (name of) hospital . Review of R701's SBAR (Situation, Background, Assessment, Recommendation)- Fall report, dated 1/01/25, revealed, (R701) was receiving care from Cena (aide) while writer was doing wound care for 215 C (R701's roommate) and heard a loud noise. (R701) was then observed on the floor, on (their) left side, between (their) bed and the wall at 623 (6:23 a.m.) .Deep laceration to left upper arm. Small cut to right lower back . Call ER and explain why resident is being sent to ER .CT of head and laceration repair . The report revealed R701 was on a blood thinner (increasing bleeding risk) at the time of the fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R701's post fall evaluation, dated 1/10/25 at 6:23 (a.m.), revealed a score of 16, which showed R701 was at high risk for falls. A score above 5 was noted as a fall risk. The evaluation also showed R701 was receiving anti-coagulant medication (blood thinner). The new intervention revealed, Do not leave resident (701) unattended during care . Review of R701's emergency room report, dated 1/01/25, revealed a complex laceration, with no medication changes. Their CT scan of their head, spine, and x-rays including left shoulder, pelvis, spine, and chest were negative for any fractures, dislocations, or acute changes. Review of R701's progress note, dated 1/01/25 at 13:53 (1:53 p.m.), revealed upon return from the hospital, . A/o (alert and oriented) x 3 (person, place, time), able to make needs known .Resident (701) have (sic) 11 stiches in (their) upper left arm . Review of R701's tasks for bed mobility for the last 30 days showed R701 was dependent for bed mobility 36 times, and substantial/maximal assistance seven times, across various shifts. Review of R701's Care Plan, accessed 2/04/25, revealed R701 required, assistance by staff to turn and reposition in bed . and showed R701 was dependent on a full mechanical lift for transfers. Review of R701's Accident and Incident report, dates 1/01/25 at 6:23 a.m., revealed, .Resident (701) was receiving care from Cena (aide) while writing was doing wound care for (R701's roommate) and heard a loud noise. Resident was then observed on the floor, on his left side, between (their) bed and the (sic) wall .Other info: Cena (aide) stepped away to grab a pad (for bed) while Resident (701) was turned on (their) right-side during patient care . Review of R701's Incident Investigation file, provided on 2/04/25 upon request, revealed, Employee Coaching Form. Employee Name: (CNA C). Date of Hire: 12/17/24. Date 1/02/25 .Details: .Make sure to gather all items needed prior to entering the (resident) room. Always turn residents toward you and not away from you. If you have to step away from resident during care, be sure to place resident in safe position and lower bed to safe height . The Coaching form was signed by CNA C and dated 1/02/25. Review of R701's physical therapy notes, from 1/03/25 through 1/31/25, revealed R701 required maximal assistance for bed mobility (rolling) as their prior level of function, was dependent upon evaluation on 1/03/25, and required substantial/maximal assistance of one-person on 1/31/25. Review of the policy, Fall Evaluation Safety Guideline, dated 11/26/17, revealed, .The intent of this guideline is the (sic) ensure this facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident as identified through the following process: I. Identification of hazards and risks. II. Evaluation. III. Implementation. IV. Monitoring. V. Analysis. Fall evaluation: Fall evaluation is used to identify individuals who have predicting factors for falls Fall prevention is achieved through and IDT (Interdisciplinary Team) approach of managing predicting factors and implementing appropriate intervention to reduce risk for falls .