STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235701	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Willows at Okemos	4830 Central Park Drive Okemos, MI 48864

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 This Citation Pertains to Intake Number MI00152440. Based on observation, interview and record review, the facility failed to ensure Activities of Daily Living (ADL) and hygiene care were provided to one resident (Resident #704) of three residents reviewed. Findings include: Resident #704: On 5/6/25 at 12:15 PM, Resident #704 was observed sitting in a wheelchair at a table in the dining room of the facility. The Resident's fingernails were long. When asked questions, the Resident made eye contact but did not provide verbal responses. Record review revealed Resident #704 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses which included Alzheimer's disease, dementia with other behavioral disturbance, anxiety, right foot hallux rigidus (limited movement, stiffness, pain in the big toe joint), falls, and displaced fracture of the right and left femurs with surgical repair. Review of the Minimum Data Set (MDS) assessment, dated 4/15/25, revealed the Resident was severely cognitively impaired and required substantial to maximum assistance to complete Activities of Daily Living (ADL), and moderate assistance with transfers. On 5/7/25 at 8:30 AM, Resident #704 was observed sitting in a wheelchair in the dining room of the facility. The Resident's wheelchair was positioned far from the table, approximately one foot away. Resident #704 was observed lifting the plate of food to bring it closer to them. The Resident then picked up a fried egg with their finger and began to eat it. Resident #704's fingernails were long and uneven with a dark colored, unknown substance visible under their nails. When spoke to, Resident #704 made eye contact but did not provide meaningful responses to questions when asked. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Registered Nurse (RN) L on 5/7/25 at 8:40 AM. When queried regarding Resident #704, RN L stated, (Resident #704) is alert and oriented to self only. RN L further explained that the Resident was very confused and required assistance and cueing for all tasks including eating. RN L stated, (Resident #704) doesn't remember me from day to day. When queried regarding observation of the Resident picking up and eating their egg with their hands, RN L stated, (Resident #704) needs cueing and is independent for eating. RN L verbalized the Resident does better with finger foods. With further inquiry regarding the Resident's lack of meaningful communication but being more interactive today than yesterday, RN L indicated the Resident had a rough day yesterday and stated, (Resident #704) had a big BM (bowel movement) yesterday and is hands everywhere so they had their hands in the BM. When queried if the Resident is able to complete any of their own hygiene activity including washing their hands, RN L revealed the Resident requires assistance primarily due to loss of cognition. An observation of Resident #704 was completed in the dining room of the facility with Assisted Living Director B on 5/7/25 at 9:00 AM. Resident #704 was observed sitting in their wheelchair in the same place/position as prior observation. Director B was asked to look at Resident #704's fingernails, including the underside of the nails. When asked what they saw, Director B confirmed the Resident had a dark colored, unknown substance under their fingernails and verbalized they would address immediately. On 5/7/25 at 1:11 PM, an interview was completed with Family Member Witness M. When queried regarding the care Resident #704 receives at the facility, Witness M verbalized multiple concerns including ADL care and feeding assistance. When asked how often they visit the Resident, Witness M replied, I just went to their doctor appointment with them. When asked if they had any concerns regarding the hygiene care provided at the facility, Witness M verbalized concern regarding the Resident's fingernails. Witness M verbalized Resident #704's nails were very long and had not been maintained and/or cut. Witness M indicated a Certificated Nursing Assistant (CNA) had told them they would cut their nails when they asked, but it had not happened. Review of Resident #704's care plans revealed a care plan entitled, ADL's: Resident requires staff assistance to complete self-care and mobility functional tasks completely and safely (Start Date: 4/29/25). The care plan included the intervention, Provide nail care on shower days and PRN (as needed) (Start Date: 4/29/25). On 5/7/25 at 2:02 PM, an interview was conducted with Director B. Director B verbalized they spoke to the direct care staff regarding Resident #704's nails. A review of Resident #704's Electronic Medical Record (EMR) did not reveal specific documentation related to completion of nail care and/or hand hygiene. An interview was conducted with the facility Administrator and Director B on 5/7/25 at 4:52 PM. When queried regarding observation of Resident#704's fingernails while eating with their hands, the Administrator verbalized understanding of concern. No further explanation was provided. Review of facility policy/procedure entitled, Nursing ADL Documentation Guidelines (Dated: 5/10/16) did not include information pertaining the provision of ADL and/or hygiene care.

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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** 37668 This Citation Pertains to Intake Number MI00152440. Based on interview and record review, the facility failed to ensure adequate supervision, implementation of meaningful and resident-centered care plan interventions, and staff awareness of planned interventions for fall prevention for two residents (Resident #701 and Resident #704) of three residents reviewed, resulting in Residents with a known risk of falls experiencing falls with injury, including a fracture, necessitating emergency medical treatment and unnecessary pain and discomfort. Findings include: Review of intake documentation revealed Resident #701 fell out of their bed on [DATE]. Per the intake, the Resident was then made to sit in a chair in the hallway so that staff could keep an eye on them and proceeded to have a second fall at appropriately 4:15 AM on [DATE] which resulted in the Resident having an open laceration on their head, which required transfer to the hospital for treatment and sutures in the Emergency Department (ED). Resident #701: Record review revealed Resident #701 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included dementia without behavior disturbance, heart disease, kidney disease, irritable bowel syndrome with diarrhea, and falls. Review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed the Resident was moderately cognitively impaired, utilized a wheelchair for mobility, and required moderate assistance for transferring. Resident #701's Electronic Medical Record (EMR) revealed that the Resident was admitted to Hospice services on [DATE] and was discharged from the facility on [DATE]. Review of Resident #701's EMR revealed a care plan entitled, Resident is at risk for falling r/t (related to) dementia which could lead to poor safety awareness and choices, legally blind . (Start Date: [DATE]). The care plan included the interventions: - Provide non-skid footwear (Start Date: [DATE]) - Staff to assist resident with transfers as needed (Start Date: [DATE]) - Encourage resident to assume standing position slowly (Start Date: [DATE]) - Keep call light within reach (Start Date: [DATE]) - Offer restroom during rounds around 2a in an attempt to anticipate needs (Start Date: [DATE]) - Was started on trazadone for sleep on ,d+[DATE] for ,d+[DATE] observation on floor (Start Date: [DATE]) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- Dysem to be placed above and below the wheelchair cushion (Start Date: [DATE]) - Offer assistance with antislip footwear as resident allows at HS (bedtime) and throughout the night if removes them (Start Date: [DATE]) - Offer activities if awake at night (****activities that does not require seeing- such folding towels, listening to music) (Start Date: [DATE]) - Bolster mattress to help define space (hospice to provide) (Start Date: [DATE]) A second care plan entitled, Profile Care Guide (Start Date: [DATE]) in Resident #701's EMR revealed the following interventions pertaining to fall prevention: - Falls/Safety: keep frequently used items in reach (Start Date: [DATE]) - Transfers: two person assist/pivot, gait belt (Start Date: [DATE]) - Walking/Mobility Devices: wheelchair (Start Date: [DATE]) An interview was completed with Family Member Witness C on [DATE] at 12:50 PM. When queried regarding Resident #701, Witness C stated, (Resident #701) died yesterday. With further inquiry, Witness C revealed Resident #701 was transferred to an inpatient hospice center from the facility on [DATE] and they passed away at the inpatient hospice facility. Witness C was asked about the care Resident #701 had received at the facility and verbalized they had concerns with multiple aspects of the care provided. When queried if the Resident had fallen in the facility, Witness C responded they had. Witness C stated, We got a call that (Resident #701) fell out of their wheelchair at 4:30 in the morning and was going to the hospital. Witness C stated they asked the facility staff member who called them what happened and were told, I can't tell you because I don't want to implicate anybody. Witness C revealed they found out that Resident #701 had fallen earlier in the night in their room. When queried, Witness C stated, I was told (Resident #701) was naked in the corner of the room. When queried if they were provided any additional information as to how the Resident was found naked in the corner of their room, Witness C revealed they were not and did not know how the Resident had fallen. Witness C revealed they went there because they wouldn't tell me the CNA (Certified Nursing Assistant) who was working when (Resident #701) fell . Witness C revealed they wanted to know as they had concerns with specific CNA's not addressing the Resident's needs. Review of documentation from [DATE] in Resident #701's EMR revealed the Resident had two unwitnessed falls from their bed and two unwitnessed falls from their wheelchair. Documentation in Resident #701's EMR detailed the following: - [DATE] at 8:15 PM: Nursing . Incident Report . IDT note for fall event from [DATE]. Resident was observed in room in wc (wheelchair) then observed on floor by staff. Resident is legally blind has dementia . resident is on hospice care requires assistance to transfer . Dysem applied to top/bottom of wc cushion to prevent any sliding out of wc . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- [DATE] at 3:50 AM: Nursing . Incident Report . [DATE] at 3:00 AM . Fall . Resident room . Observed on the floor. Did resident hit head? Unknown . Indicate new measures taken to prevent reoccurrence.: Other hospice consult . - [DATE] at 7:09 AM [Recorded as Late Entry on [DATE] 07:09 PM]: IDT note for fall incident on ,d+[DATE] . Resident had fall in middle of night . blind and partly deaf uses hearing aides during day time. Resident is poor historian also has dementia was barefoot upon time of fall. Intervention- offer assistance with antislip footwear as resident allows at HS and throughout the night if removes them . - [DATE] 11:14 PM: Event . Date/Time of Incident: [DATE] 10:12 PM . Fall . Location: Resident Room . Witnessed: No . Injury . Laceration/Abrasion . Other: Bump on forehead . What was the resident doing prior to fall . In bed sleeping . What type of footwear did the resident have on? . Regular socks . - [DATE] at 11:38 PM: Nursing . Incident Report . What was date and time of occurrence? [DATE] 10:12 PM . Fall, Laceration/Abrasion . Resident room type of fall . Observed on the floor . Did resident hit head? Yes . exhibit or complain of any new pain? Yes . Forehead sore . Was resident sent to the hospital? No . new measures taken to prevent reoccurrence.: Bed in lowest position, Night light placed . immediate treatments were given? Cold packs. How many lacerations/abrasions? 2. Laceration/abrasion 1: Length: 1.5 cm (centimeter) . Width: 5.0 cm . Depth: 0.5 cm . location of the laceration/abrasion?: Right side of forehead . Laceration/abrasion 2: Length: 1 cm . Width: 1.5cm . Location of the laceration/abrasion?: Right eye brow . New measures taken to prevent reoccurrence.: Apply moisturizer to keep skin supple, Monitor for edema . - [DATE] at 11:46 PM: Incident Report . Resident's roommate came out of the room to report that resident had fallen out of bed. Writer and nursing assistant went to room and observed resident laying on the floor on right side. Neuro check initiated. Resident has abrasion on the right side of forehead and the right eye brow. Tender to touch. Resident assisted back to chair . - [DATE] 5:48 AM: Event . Date/Time of Incident: [DATE] 4:20 AM . fell out of wc . Fall . Skin tear . Hallway . Was incident witnessed? No . Injury . Skin tear . Was safety equipment in place and functioning at time of fall? None ordered . Indicate if any of the following factors are present? Cognitive or memory impairment . Difficulty understanding or following directions . Impaired vision . Requires assistance to transfer . Requires assistance to ambulate with or without assistive device . - [DATE] 4:40 AM [Recorded as Late Entry on [DATE] 05:24 PM]: Nursing . 4:40 AM: At approximately 0420 (AM) writer was leaving [NAME] Hallway and observed resident on the floor near [NAME] Hallway. While making my way to the resident I observed the other nurse on [NAME] Hallway and informed them of what had happened. Upon reaching the resident I observed (Resident #701) laying on left side in front of their wheelchair. Resident had a moderate amount of blood on head and on the floor around head. I cleaned away the blood as much as possible and observed a bump and laceration on the R side of resident's forehead. Laceration was still actively bleeding, light pressure was applied. Resident was repeating my leg, my leg but was not able to state which leg was bothering them or how they had ended up on the floor. EMS arrived approximately 0430 (AM) and took over care. Writer had last observed resident approximately 10 minutes prior sitting calmly in wheelchair . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- [DATE] at 4:40 AM: Nursing . Incident Report . At approx. 04:20 (AM), res. was observed on hard floor in common area in front of w/c (wheelchair). Res. was laying on left side with forehead against floor. Res. Had moderate amount of blood loss from skin tear on forehead with continued bleeding. Res. c/o (complain of) leg pain but would not specify which leg . last observed sitting in w/c by multiple staff members at approx. 04:15 (AM). - [DATE] at 4:52 AM: Res. had been up in chair since fall at beginning of shift. Res. up in w/c near nurse station, propelling self in w/c and conversing with staff. Res. was asked multiple times throughout the night if would like to go to bed and declined . Snacks and drinks offered and declined. - [DATE] at 5:06 AM: Telehealth - Asynchronous . Resident had another fall tonight but did hit head this time, RN (Registered Nurse) noted a pool a blood coming from a skin tear on forehead, they were able to get the bleeding to slow . sent to the hospital for further evaluation . - [DATE] at 7:34 AM: Another family member is present and whom called the police writer called DPOA (Durable Power of Attorney -Witness C) to inquire of an update of resident and advise that writer will be calling hospice to update . - [DATE] at 9:22AM: Nursing . Returned from ER per ambulance. Resident awake, answering questions. Drsg (Dressing) to head dry and intact . Bruise noted right knee . - [DATE] at 9:36 AM: Nursing: 6 sutures 1.5 cm long laceration surrounding skin is light pink abrasion, old bruise to R forearm anterior aspect, new right knee light green bruise, denies pain able to move leg . Small bruise (red in color) less than 0.5 cm to face near corner to skin of L eye Right eyebrow abrasion no scab formation no bleeding noted. some blood noted to be dried consistent with the bleeding from forehead laceration . - [DATE] at 9:47 AM: Skin Integrity Events . Description: Laceration to R side of forehead . Describe location of incision: right side forehead superior to eyebrow . Length . 1.2 cm (centimeters) . Width: 0.2 mm (millimeters) . Exudate . Scant . Sanguinous (bloody) . Wound approximated with? Staples (number) - 6 . - [DATE] at 9:50 AM: Incident Report . IDT note for incident event (fall) on [DATE]. Resident rolled out of bed, roommate said (Resident #701) was holding on and almost lowered self to floor but could not hold on and place on call light for staff to assist. Resident bed was in lowest position, call light was in reach although not on as resident did not put it on. resident had socks on while in bed. resident sustained a minor non-bleeding abrasion almost rug burn like appearance to forehead requiring no first aide or treatment will monitor open to air . INTERVENTION- Approach: bolster mattress to help define space (hospice notified of this and are going to provide). RAI -care guides updated. Goal is to remain free from falls . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- [DATE] at 9:55 AM: Incident Report . IDT note for incident event (fall) on [DATE]. BIMS is 9. resident is a poor historian and hx (history) of Alzheimer's dementia. Resident s/p (status post) second fall . was up with staff in wc as already rolled out of bed and seemed to be restless in bed, did better in wc . (CNA) advised to writer that resident made it clear all her needs were met prior to assisting another resident and told the resident she will be right back after helping someone else. resident was sitting upright in wc at 415 am last noted by (CNA). Upon the (CNA) being in another room, the floor nurse was passing medications to another resident on another floor at this very time. resident was then observed by the other nurse whom was not assigned to (Resident #701) from afar this was around 420am . Resident sustained abrasion to R forehead and was bleeding from a skin tear same location and pressure was applied but bleeding continued so on call provider ordered to send for eval and tx (treatment) . INTERVENTION- Send to ER for evaluate and tx. in addition will offer activities if awake at night (activities that do not require visualization such folding towels, listening to music) . Review of Resident #701's Hospice documentation revealed a note dated [DATE] which detailed, RN (Registered Nurse) . visit following (Resident #701's) return from ED related to fall. Spoke to (RN E), stated . (Resident #701) rolled out of bed at 10:00 PM on [DATE]. (Resident #701) ws brought out to a common area and self-propelling, then fell out of wheelchair on hard vinyl floor causing laceration to right forehead. Due to bleeding . was sent to ED . When (Resident #701) returned, family was unhappy with care, unsure of how (the Resident) fell and stated neglect . called 911, filed a police report and the facility is performing an investigation . (Resident #701) was put in wheelchair following fall out of bed as was awake and tends to be restless . completed assessment with (facility staff). Noted: Dry blood in hair, 1.5 inch laceration with 6 sutures to right forehead, small bruise to right side of right eye, abrasion above right eye/forehead, large bruise to right knee . (Resident #701) is alert, asking 'What do we do' and 'Help me' . confused at baseline . Hospice RN encouraged use of bolster mattress and to offer activity like folding towels or listening to music as (Resident) is blind to (Resident) when awake and not sleeping at night as new interventions, (facility nurse) entered into care plan. Hospice to order mattress . Discussed event with (Witness C) . extremely unhappy with care at facility, how the event happened and staffs lack of care and communication . listened and supported by active listening and validating concerns . An interview was completed with Registered Nurse (RN) D on [DATE] at 9:16 AM. When queried if they recalled Resident #701, RN D responded that they did. RN D was queried regarding the level of assistance Resident #701 required and replied, (Resident #701) was hard of hearing, couldn't see, had dementia very bad, and wouldn't follow directions. RN D revealed the Resident was a two-person pivot transfer. RN D continued, It was turning for a pivot transfer that seemed to cause (Resident #701) pain and indicated the Resident would become combative with care. When asked if the Resident became combative because they were in pain, RN D indicated it was possible or could have been because they couldn't hear or see and didn't understand what staff were asking them to do. RN D then stated, They were going to start (Resident #701) on Seroquel (antipsychotic medication with black box warning for use in elderly) just before (Resident #701) went on hospice but (Witness C) wanted (the Resident) put on Zoloft (antidepressant medication) instead. When queried why Seroquel was discussed, RN D replied, At night, (Resident #701) would yell out. RN D then stated, Zoloft was not really effective. It was like (the Resident) would get in a loop and ask the same thing it was like you had to be constantly engaged with them. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was completed with Confidential Witness F on [DATE] at 9:45 AM. When queried regarding Resident #701, Witness F stated, (Resident #701) did fine if someone sat with them and helped them. When queried if they were present when the Resident fell , Witness F indicated they were not but verbalized the Resident would become restless if left alone due to being blind and hard of hearing. An interview was completed with the facility Administrator on [DATE] at 1:50 PM. When queried if there was any additional facility investigation documentation pertaining to Resident #701's falls in [DATE], other than the event documentation, the Administrator stated, The investigation stuff was submitted with a five-day investigation that was closed for neglect. The Administrator was asked to review the investigation documentation and replied, The staff followed the fall care plan. The Administrator then stated, I will get (Assisted Living [AL] Director, Licensed Practical Nurse [LPN]) B. They can talk you through it. An interview was completed with AL Director B on [DATE] at 2:02 PM. When queried if staff involved in Resident #701's falls were interviewed, Director B indicated they were and provided Statement of Witness forms for RN I, CNA J, and RN K. All the Statement of Witness Forms specified the interviews were conducted by RN E. Review of the statements detailed: - RN I - Date of Interview: [DATE]: I called (Witness C) and spoke with them in regards to both falls including at 10ish PM. No injuries, just abrasion no bleeding to forehead. Aide (CNA) got (Resident #701) in WC, self-propelling around hall wall and nurse station. Offered snacks drinks and to lay down every so often, Res declined. (Resident) made it clear was happy and content in wc and needed nothing. Went to pass meds on (different facility hallway). Last seen in wc on hallway sitting upright . While on (different hallway), other nurse came and told me Resident had fall, I went to assess . - CNA J - Date of Interview: [DATE]: Did shift change at beginning of hallway. Call light was on mid-report. 2nd shift aide answered light. Observed on floor as I walked behind (Resident #701). I helped transfer to bed, appeared not tired to I transferred to wc. Nurse sat with resident in between call lights. Time passed. Toileted just after 3:00 AM. Went to toilet another resident on hallway and (RN K) observed Resident on floor. Last seen about 4:1AN, When came out of other resident room was on floor next to wc area/hard floor area before [NAME] ([NAME]). Hallway. Prior to going to other resident room (Resident #701) wasn't want to eating/drink/no pain/good position in wc. Needs appeared met . - RN K - Date of Interview: [DATE]: I was walking off [NAME] (hallway) and seen (Resident #701) from afar on the floor at edge/front of [NAME] (hallway) - not on carpeted area. Upon walking/hurrying to get (Resident #701), their nurse was on [NAME] (other hallway) told them of (Resident #701) on floor and placed towel to forehead was bleeding. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	When queried if they completed the interviews, Director B responded that RN E was the weekend supervisor and had completed the interviews with the staff who were working when the incident occurred. Director B was then asked about documentation from the fall on [DATE] detailing the Resident was wearing regular socks and not non-slip footwear, Director B confirmed the Resident had on regular socks per the documentation. When asked why Resident #701 did not have non-slip footwear in place as per the care plan intervention following their previous fall from bed, Director B was unable to provide further explanation. When queried what intervention the staff implemented following the Resident's first fall, Director B reviewed the Resident's care plan and indicated a bolster mattress. When queried if that intervention was immediately implemented, Director B confirmed it was not and revealed the Resident was put in a wheelchair to be within view of the nursing staff. When asked, Director B confirmed the Resident's second fall occurred when they were in the wheelchair. Director B was asked where facility staff were when the Resident fell and responded that the nurse was on a different hallway passing medications and the CNA was in a room providing care to another Resident. When queried regarding staffing assignments, Director B revealed nurses are assigned to two halls and there is one CNA per hallway. When asked if Resident #701 was incontinent when they fell from their wheelchair, as they were last toileting by the CNA around 3:00 AM, Director B revealed they were unsure as the fall documentation did not specify. When asked what the facility determined the Resident was attempting to do when they fell , Director B indicated the Resident was self-propelling in their wheelchair but was unable to provide further explanation. When asked why the Resident was left unattended and unsupervised after having been supervised by nurse, according to the notes, given the Resident was blind, hard of hearing, and had severe dementia/confusion, Director B indicated the CNA checked on the Resident before going to provide care to a different resident but did not provide further explanation. Resident #704: At 12:10 PM on [DATE], Resident #704 was not in their room. The room was located approximately midway down the hallway and not near the central area of the facility and/or nurses' station. No notable fall prevention interventions were present in the room. On [DATE] at 12:15 PM, Resident #704 was observed sitting in a wheelchair at a table in the dining room of the facility. The Resident's wheelchair had bilateral leg/footrests in place and the Resident's feet were positioned on the footrests. When asked questions, the Resident made eye contact but did not provide verbal responses. Review of the CMS-802 Form detailed Resident #704 had a fall with major injury. Record review revealed Resident #704 was originally admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia with other behavioral disturbance, anxiety, right foot hallux rigidus (limited movement, stiffness, pain in the big toe joint), falls, and displaced fracture of the right femur with surgical repair. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was severely cognitively impaired and required substantial to maximum assistance to complete Activities of Daily Living (ADL), moderate assistance with transfers, and had one sided lower extremity Range of Motion (ROM) impairment. Further review revealed Resident #704 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235701	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Willows at Okemos	4830 Central Park Drive Okemos, MI 48864

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 8:30 AM, Resident #704 was observed sitting in a wheelchair in the dining room of the facility. The Resident's wheelchair was positioned far from the table, approximately one foot away. Both of the Resident's feet were positioned on the leg/footrests of the wheelchair. Resident #704 was observed lifting the plate of food to bring it closer to them. The Resident then picked up a fried egg with their finger and began to eat it. When asked questions, Resident #704 made eye contact but did not provide meaningful responses. An interview was completed with Registered Nurse (RN) L on [DATE] at 8:40 AM. When queried regarding Resident #704, RN L stated, (Resident #704) is alert and oriented to self only. RN L further explained that the Resident was very confused and required assistance and cueing for all tasks including eating. RN L stated, (Resident #704) doesn't remember me from day to day. When asked how long the Resident had been at the facility, RN L stated, (Resident #704) went to the hospital and came to this side after. They fell and fractured their hip. With further inquiry, RN L explained the Resident was originally admitted to the 400-hall of the facility, they fell and were sent to the hospital where they had surgery due to fracturing their hip and were admitted to the 100-hallway when they returned to the facility. When queried, RN L revealed Resident #704 was originally admitted to the facility for therapy because they fell and fractured their right hip then they fell and fractured their left hip while at the facility. On [DATE] at 1:11 PM, an interview was completed with Family Member Witness M. When queried regarding Resident #704's stay in the facility and fall, Witness M stated, (Resident #704) went (to the facility) because they broke their right hip and then fell while there and broke their left hip. That kind of bothered me. When queried what bothered them, Witness M revealed what they were told by facility staff about what happened did not make sense. Witness M was asked what they were told and stated, The first call they said we found (Resident #704) in a corner and said (the Resident) took off all their clothes. Witness M revealed the staff told them Resident #704, Took the sheets off the bed and wrapped themselves in it and that they put (Resident #704) back in their bed. When asked if they were aware of a reason the Resident may have removed their clothes and if that was something the Resident had done previously, Witness M verbalized that was not normal for Resident #704. Witness M continued, Then they called me around 9:00 AM the next morning and said the Doctor was on their rounds, checked (Resident #704) out, and had a big bruise so they were going to send them out to the hospital. When asked what happened, Witness M stated, (Resident #704) went to the hospital and they said (the Resident) broke their left side (hip) too. Witness M declared, I never got the truth out of them (facility staff) of what actually happened. It doesn't make sense. When asked, Witness M revealed they did not understand how or why Resident was found in the corner and why staff were not monitoring them. When queried if Resident #704 was able to use the call light when they need assistance, Witness M replied, Won't call for help and indicated the Resident does not remember the call light or that they need assistance. Review of Resident #704's Electronic Medical Record (EMR) revealed a care plan entitled, Falls- Resident is at risk for falling r/t (related to) broken bones (Start Date: [DATE]). The care plan included the interventions: - Ensure the floor is free of liquids and foreign objects (Start Date: [DATE]) - Keep call light within reach (Start Date: [DATE]) - Staff to assist resident with transfers as needed (Start Date: [DATE]) (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- Encourage resident to assume standing position Slowly (Start Date: [DATE]) A second care plan entitled, ADL's: Profile Care Guide (Start Date: [DATE]) was also present in Resident #704's EMR. This care plan included the interventions: - Falls/Safety: high fall risk (Start Date: [DATE]) - Other: not oriented to name, place, time, or date (Start Date: [DATE]) - Transfers: two person assist, gait belt, no ambulating at this time per therapy, 2PA (Person Assist) with lower body dressing, transfers and bed mobility-reposition q (every)2 hr while in bed, 1PA for upper body dressing and hygiene wbat (weight bearing as tolerated) lle (left lower extremity) (Start Date: [DATE]) - Walking/Mobility Devices: unable to ambulate, 2PA for transfers/toileting WBAT to LLE, activity as tolerated total hip replacement protocol WITHOUT need to follow hip precautions (Start Date: [DATE]) Review of documentation in Resident #704's EMR revealed the following: - [DATE] at 1:32 PM: Admission Observation . Prior surgeries in last 100 days, describe - right hip . Foot Press Strength: Weak bilaterally . Baseline Care Plan Goal- Resident will have no negative outcomes related to vision, hearing, oral and dental status . Desired Approaches: Encourage Resident to wear eyeglasses and assist with keeping them clean. Offer and provide dental/oral care as needed. Ensure adequate lighting in room. Report any oral/dental issues to social services for referrals as needed. Orient to objects and layout of the room Assist with hearing aids as needed . Musculoskeletal . Left Lower extremity - weak . Right Lower extremity - weak . Assistive Devices: Wheelchair . Weight Bearing: Full . Safety: Falls Risk Review . Did the resident have a fall any time in the last month . Yes . Fall Risk Score: 22 Level: High . Baseline Care Plan Goal- Resident will remain safe and free of major injury related to falls . Desired Approaches: Encourage Resident to assume a standing position slowly. Therapy eval and treat as ordered. Call light within reach . Personal items within reach . Non-skid footwear Observe for signs of wandering or exit seeking and notify MD as needed. Assure floor is free of foreign objects . Fall history . desired approaches . PT/OT/ST eval and treat as ordered . 2 person assist until therapy evaluation. Assess Pain every shift. Proper fitting shoes . Bed Mobility: Extensive Assistance . Transfers: Extensive Assistance . Toileting: Extensive Assistance . - [DATE] at 8:50 PM [Recorded as Late Entry on [DATE] 12:15 PM]: Nursinng . Incident Report . This writer was notified by (Certified Nursing Assistant - CNA) that the resident was observed on the floor next to the bed in the resident's room. Upon entering the room the resident was observed to be without a gown or brief on. Resident had removed clothing items. Staff was attempting to provide care with the resident swatting and pulling at the staff. Resident was also observed to be verbalizing nonsensical word salad during observations. No visual signs of injury were observed, no bruising noted. Unable to perform range of motion due to the resident moving all four limbs while being combative with staff. Grip strength was unable to be determined due to resident's inability to follow directions. Neuro checks were initiated and found to be within normal for the resident. Resident appears to be within base line. On call provider called and no new orders were received and responsible party was notified . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	- [DATE] at 9:08 PM: Nursing . Incident Report . date and time of occurrence? [DATE] 8:45 PM . Fall . Resident room . Observed on the floor (Unwitnessed) . Did resident hit head? No . Does resident exhibit or complain of any new pain? No. Range of Motion: ROM x 4 without pain/limitations. Positioning of extremities: No rotation/deformity/shortening noted. Was resident sent to the hospital? No. Indicate new measures taken to prevent reoccurrence: Bed in lowest position, Monitor for pain . - [DATE] at 4:13 AM: IDT note for incident fall on ,d+[DATE]. Resident poor historian, BIMS 0 (severely cognitively impaired). Resident observed on floor by staff . no injuries post fall noted by nurse notes/fall event assessment by floor nurse. Fall protocol initiated . Neuro assessments at resident baseline. Nursing will continue fall protocol and perform neuros per orders and VS (Vital Sign) assessments, along with pain assessment. Intervention: Staff to assist Resident with transfers as needed. Keep call light in reach and clip to resident shirt/gown as allows to help remind to use. Winged mattress to help define space . - [DATE] at 6:45 AM: Nursing . This RN rounded on res. multiple times during shift and res. observed to be restless and anxious during rounds. During rounds this RN offered res. Prn (as needed) medications, water, and repositioning. Res. refused offers for care and treatments. Per (CNAs) when toileting res. was observed to be combative and yelling out. - [DATE] at 8:26 AM: Nursing . This nurse went into residents room to obtain vitals and admini [TRUNCATED]