STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235728	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Michigan Veterans Home of Chesterfield Township	47901 Sugarbush Road Chesterfield Township, MI 48047

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2747949.Based on observation, interview, and record review, the facility failed to provide prompt care and services to one resident (R901) of three reviewed for quality of care. Findings include: On 03/03/26 at 8:50 AM, R901 was observed seated in their wheelchair, dressed interacting with a staff member who was working on the computer. At 2:54 PM, R901 was seated in an armchair with a walker toward the left of the chair, and a Certified Nurse Assistant (CNA) to their right. R901 stood independently from the chair and staff queried R901 on their needs providing a confused response and did not immediately sit back down.A review of R901's progress notes revealed R901 had a fall to the floor on 02/06/26 at 7:16 PM.Member decided to get up from chair and sit on the floor . A note at 11:21 PM documented R901 had one shoe on, and one non-slip sock on at the time of the fall. On 03/03/26 at 10:22 AM, Nurse A reported the care plan and the Kardex (care guide) are used for interventions to work through R901's behaviors. It was noted R901 had a history of falls, self-transfer, urinating, and disrobing in the common areas.On 03/03/26 at 10:30 AM, CNA B reported R901 was a fall risk who needed daily intermittent redirection related to standing, disrobing, public urination, and other inappropriate behaviors. CNA B reported specific care needs were noted on the Kardex.On 03/03/26 at 12:03 PM, Licensed Practical Nurse (LPN) C was asked about R901's fall to the floor on 02/06/26. LPN C reported R901 had been busy their whole shift that day and they often had to redirect R901 when the resident attempted to sit on the ground or sit in a chair that was not there. LPN C noted the fall occurred during the evening shift change between 7:00 PM and 7:30 PM. LPN C reported they heard CNA F say (R901) is on the floor. LPN C reported they turned around and observed R901 to be the floor playing with their feet and felt R901 was safe and continued to work on their documentation on the computer. LPN C indicated two nurses were at the nurse station and reacted in a similar way. LPN C then reported after a few minutes CNA F said they could not get R901 up off the floor.LPN C went on to say on review of the video R901 had been transferring themself back and forth between different chairs in the common area with CNA F in attendance monitoring and at one-point R901 missed the arm of the chair and went to the ground. CNA F was not able to be contacted for comment.On 03/03/25 at 1:20 PM, CNA E reported they had been working on R901's unit at the time of the fall but did not see the fall. CNA E reported R901 normally wanders and goes from chair to chair and when R901 winds down may be found asleep in one of the chairs for a while. CNA E reported CNA F tried to get R901 up but R901 was resisting and told the nurses to call for two male staff to help get (R901) up and they just looked at CNA F. CNA E reported after some time passed and no one came the nurses went over to help get R901 up. On 03/03/26 at 3:23 PM, the administrator reported all falls are reviewed and upon review of the video for R901's fall the CNA was seen to call in the direction of the nurse station and the nurses did not immediately get up to go and assess R901. The administrator commented they expected to see the nurses respond immediately and it was not acceptable to not assess the resident immediately. The administrator noted about 15 minutes had elapsed between the time of the resident's fall and the nurse's response. A review of the record for R901 revealed R901 was admitted into the facility on [DATE]. Diagnoses included Dementia, Adjustment Disorder with Anxiety and Depressed Mood, and Vitreous Opacities (Impaired (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235728	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Michigan Veterans Home of Chesterfield Township	47901 Sugarbush Road Chesterfield Township, MI 48047

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vision). A progress note dated 02/23/26 documented the Brief Interview for Mental Status (BIMS) score to be 3/15 which indicated severely impaired cognition. A review of the care plan: (R901) is at risk for falls (related to) r/t Alzheimer's, impaired safety awareness, arthritis, high blood pressure, and a history of stroke revealed: (R901) often refuses to wear a gait belt while ambulating despite safety education. (R901) often bends down to pick stuff up off the floor, (R901) bends down to (their) hands and knees to pick stuff up. Date Initiated: 08/03/2023 Revised 02/16/26; Assist (R901) to the floor if (R901) asks to sit onto the floor. Date Initiated: 02/10/2026 Revision on: 03/02/2026. If a fall occurs, follow facility protocol for post-fall. Review and document with the IDT to identify root cause and factors contributing to the fall. Date Initiated: 08/10/2023 . The Kardex (CNA care guide) documented, when (R901) is demonstrating less ability to walk use wheelchair .A review of the facility policy titled, Fall and Fall Risk, managing with review date of 05/05/25, revealed, .A fall is defined as (according to the MDS): unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., a resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred. Challenging a resident?s balance and training him/her to recover from loss of balance is an intentional therapeuticintervention. The losses of balance that occur during supervised therapeutic interventions are not considered a fall .A review of the facility policy titled, Accident/Incidents, Investigation and Reporting with review date of 07/10/25, revealed, .6. In the event of an incident or accident, immediate assistance will be provided, or securement of the area will be initiated unless it places one at risk of harm. 7. Any injuries will be assessed by the licensed nurse or practitioner, and the affected individual will not be moved until safe to do so. First aid will be given for minor injuries such as cuts or abrasions. 8. The supervisor or other designee will be notified of the incident/accident. If necessary, law enforcement may be contacted for specific events .