STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235052	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aberdeen Rehabilitation and Skilled Nursing Center	5500 Fort St Trenton, MI 48183

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 2794609. Based on interview and record review, the facility failed to provide proper transfer assistance for one resident (R106) out of three residents reviewed for falls, resulting in a fall. Findings include: A review of the clinical record for R106 documented an admission date of 1/16/26 and discharge date of 2/24/26. R106's diagnoses included congestive heart failure, chronic obstructive pulmonary disease, type 2 diabetes mellitus, peripheral vascular disease, and morbid obesity. A Minimum Data Set assessment dated [DATE] documented moderate cognitive impairment and dependence upon staff for transfer assistance. Additional record review documented in part the following progress notes, orders, and care plans: 1. 2/18/26 at 1:36 PM nursing progress note: Resident stated (they) slid to the floor from (their) wheelchair onto (their) back, mild pain noted. Assessed and no injury noted. Witnessed. 2. 2/18/26 at 2:29 PM nursing progress note: Resident c/o (complained of) low back pain r/t (related to) fall. PA (Physician Assistant) contacted, new order received for lumbar x-ray. All Stat (immediately). Portable called verbal order given. 3. 2/18/26 at 7:58 PM PA note (note entered 2/22/26 at 8:00 PM): Subjective: Patient seen and examined at bedside. Patient had been reported to have slid out of wheel chair. Did have some low back pain. No head trauma reported. Fall. Slid out of wheel chair, lumbar pain reported. Obtain x-ray imaging. Pain management. Supportive care. Patient education. Fall precautions. Monitor for changes. 4. Review of facility document titled, Event Report for R106 documented in part the following:Safety Event - FallEvent Date: 2/18/26 at 1:31 PMDescription: FallLocation of Fall: Resident RoomWhat was resident doing just prior to fall? Resident states she slid from wheelchair onto back.Was Fall Witnessed? Yes 5. Review of facility document titled, Fall Assessment for R106, dated 2/18/26 documented in part the following: What is the resident's current transfer status? 2 Person Assist. 6. 2/19/26 at 4:07 PM nursing progress note: Resident c/o lower back pain and pain in hands and feet which resident states is chronic and more of a neuropathy pain level is an 8. Writer administered pain med per (resident) request. Pillows requested and arms placed on pillows - resident stated hour post medication that pain in back is gone but arms and hands still aching 7. Physician order dated 1/19/26: Transfers: (Mechanical lift) with two persons assist. 8. Care plan problem: I need help with transfers, bed mobility, locomotion and range of motion due to my diagnosis of muscle weakness. Approach: Supervise, cue, and encourage me as needed to participate in my mobility. Transfers: two person assist, (mechanical) lift. Dated 1/17/26. 9. Care plan problem: I am at risk for falls and injury r/t my impaired balance, muscle weakness, and history of falls. Approach: Please assist me with all transfers as needed. Dated 1/16/26. On 4/9/26 at 3:35 PM, the Director of Nursing (DON) identified Certified Nurse Aide (CNA) E as the person who witnessed R106's fall on 2/18/26. The DON indicated CNA E was alone when a mechanical lift was used to transfer R106 into their wheelchair. The DON identified this transfer was unsafe and indicated this was the reason CNA E received disciplinary action. A review of a facility document titled, Corrective Action Form dated 2/18/26 revealed in part the following: (CNA E) transferred resident via (mechanical lift) without assistance. Resident's transfer order reads, Transfers: (Mechanical) lift with two persons assist. A review of a facility policy (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	titled, Hoyer Lift, dated September 2018, documented in part the following: A Hoyer Lift transfer requires a minimum of two nursing employees in attendance to provide resident safety. On 4/9/26 at 4:30 PM, the DON and Regional Director of Operations did not offer additional documentation or information pertaining to this concern when asked.