

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER South Lyon Senior Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Reynolds Sweet Parkway South Lyon, MI 48178	
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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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. 3032954Based on observation, interview and record review, the facility failed to safeguard an appropriately sized wheelchair cushion for one (R702) of two residents reviewed for accidents resulting in R702 falling to the floor, that required hospitalization for treatment of a large laceration requiring 24 sutures and pain. Findings include.Clinical record review revealed R702 was admitted on [DATE]. R702 had Activity of Daily Living (ADL) deficits related to peripheral vascular disease, history of falls related stroke with left sided weakness, vertebral stenosis and vertebral bone spurs. According to the Minimum Data Set (MDS) assessment dated [DATE], R702 required transfer with one-person assist and utilized a wheelchair. The Brief Interview of Mental Status (BIMS) indicated R702 had no cognitive impairment.A record review of the care plans revealed no documentation of R702's use of a wheelchair cushion and no updates following the fall. The State Agency received an allegation the facility failed to provide adequate supervision to prevent an avoidable fall that resulted in multiple injuries and required hospitalization.On 6/15/26 at 12:48 PM, record review of the facility Form-802 identified R702 had a fall with injury. The Nursing Home Administrator (NHA) confirmed with MDS Registered Nurse (RN) F the injury occurred on 5/9/26.On 6/15/26 at 1:21 PM, R702 was observed with their spouse sitting in a wheelchair watching television. R702 was asked about their recent fall with injury and both responded that the aide was helping them reposition into their wheelchair and when they went to slip their hips back into the seat, they slid forward, fell, and their right arm was cut on the metal bed frame. R702 pointed to their right arm which was observed with a foam adhesive dressing dated 6/14 and said it was pretty bad but getting better. R702 said there was a lot of blood, and they had to go to the emergency room and had 24 stiches. The spouse showed a picture of the arm with sutures after the accident and remarked how bad it was. When asked to give details of the fall, they said there was a wheelchair cushion put on the seat that was too big and could not slide back. R702 was observed pointing to the cushion they were sitting on during the interview and said this was their correct cushion.Record review of the fall assessment investigation dated 5/9/26 at 9:15 AM documented, an aide was repositioning R702 in the wheelchair with the brakes locked, when the resident fell forward out of the wheelchair. The investigation identified the wheelchair cushion was not well fitted for the resident's specific wheelchair and read .cushion assessed by therapy director, removed and replaced with better fitted cushion.On 6/15/26 at 1:45 PM, Therapy Director (TD) E was interviewed and recalled the event as they were on the premises at time of the accident. It was determined that R702 was placed on the wrong sized cushion for their wheelchair. TD E reported the wrong cushion was on the wheelchair and their specific cushion was on their dresser and not used for whatever reason. TD E explained that the cushion in place at time of the accident hung three to four inches over the seat and when the resident tried to scoot back, they slid forward.On 6/15/26 at 1:53 PM, Certified Nursing Assistant (CNA) I was interviewed on site and recalled they overheard CNA C yelling for help and said R702 had fallen. CNA I said they did not witness the fall but was familiar with R702 who always has to scoot themselves into their wheelchair and was informed the cushion that was in place was not the usual cushion they (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
--	-------	-----------

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/15/2026
NAME OF PROVIDER OR SUPPLIER South Lyon Senior Care and Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 700 Reynolds Sweet Parkway South Lyon, MI 48178	
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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	sat on, heard it was too long, and fell. On 6/15/2026 at 2:22 PM, RN H was interviewed and confirmed they were R702's assigned nurse on 5/9/26 but did not witness the fall. It was explained that CNA C was assisting R702 to transfer and the resident was wearing a baggy shirt and shorts and had no transfer belt on. CNA C was helping R702 to scoot their hips back into the seat and while trying to move back, the resident slid off the chair, sliced their right forearm and there was a lot of blood. RN H said it was brought to their attention there was a longer sized wheelchair cushion on the seat and because it did not fit correctly, when R702 tried to scoot back it slipped out and the resident fell forward. On 6/15/26 at 2:36 PM, Medical Director (MD) J was interviewed recalled the phone call from 5/9/26 as there was a lot of panic because R702 was bleeding so bad. MD J was informed the aide could not grab R702, they had fallen and scrapped their arm on the bed. R702 was sent to the hospital and came back with a lot of sutures and said it was pretty bad. MD J remarked it was going to time to heal and mentioned R702 needed antibiotics shortly after as the incision became infected with cellulitis, green colored drainage, warmth and redness. On 6/15/26 at 2:47 PM, CNA I was interviewed and confirmed they were the CNA involved with R702 and the accident. Per CNA I they were behind R702 in the wheelchair and was trying to back R702 into the seat. I started to pull them back, they started to slide forward, so I grabbed their shirt and pants to protect their head from hitting the floor at which time they slid and cut their arm on the bed frame. Per CNA I the wheelchair cushion was hanging off the front of the chair. Clinical record review from the nursing skin assessment from 5/9/26 by Wound Care Nurse RN B documented the new skin issue as an in house acquired wound, right lower arm laceration closed with 24 sutures with burning pain. The length of the laceration was documented at 10.92 centimeters (cm) and the dressing was heavily saturated. On 6/15/26 at 2:56 PM, RN B was interviewed and confirmed they were R702's assigned nurse on 5/9/26 when they arrived back from the hospital and remarked it looked like a [NAME] bite. Per RN B R702 will always deny pain and act like a tough guy known to be stoic. RN B told R702 they were giving them acetaminophen (pain medication) anyways as it looked so painful, I can't imagine anyone sustaining that and not have pain. On 6/15/26 at approximately 4:00 PM, The NHA, Director of Nursing (DON), and Corporate Clinical (CC) A were interviewed. The DON confirmed they had prepared the investigation of the fall and the final root cause was the wheelchair cushion was not the correct fit. Which resulted in R702 leaning over to scoot backwards and the cushion slid off at which time R702 fell forward and sustained the right arm laceration. The NHA, DON, and CC A were asked if there were any further investigations, audits, or education they would like to provide prior to the exit and all concurred this was an isolated accident and there was nothing further to provide.		