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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 04/15/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain the kitchen in a sanitary manner resulting in the potential to spread foodborne illness to all residents that consume food from the kitchen.Findings Include: On 04/13/2026 9:31 a.m., the initial tour of the kitchen was conducted with Dietary Director L (DD L) and the following areas of concern were observed:A buildup of scaling was observed on both sides of the ice machine in the upper hinge area.A build-up of food debris was observed on multiple ready to use plastic bins. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. A drainpipe that connected a rinse sink and the high temp dish washing machine was observed to be without an air gap providing a space for backflow/overflow.According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention. (A) Except as specified in (B), (C), and (D) of this section, a direct connection may not exist between the SEWAGE system and a drain originating from EQUIPMENT in which FOOD, portable EQUIPMENT, or UTENSILS are placed.On 4/13/26 at approximately 10:01 a.m., the observed concerns were reviewed with DD L and they reported they would have to get the plastic bins cleaned of the food debris. DD L indicated they would have to see if a company could come out to install an air gap on the drainpipe leading into the floor from the rinse sink and dish machine and they would try to remove the additional scaling on the ice machine.

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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(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** Based on observation, interview, and record review the facility failed to prevent avoidable falls for one resident (R43) of one resident reviewed for falls, resulting in three avoidable falls. Findings include: On 4/13/26 at 9:22 AM, R43 was observed lying in their bed. The bed was in the lowest position with left side of the bed against the wall and a fall mat on the floor to the right side of the bed. On 4/14/2026 at 11:36 AM, a review of R43's facility provided Incident/Accident (I/A) reports were reviewed and revealed the following:An I/A for a fall on 10/10/25 that read, .Nursing Description: This writer was entering (room #) to check VS (vital signs) of the roommate, and writer observed (R43) sitting on the ground on his floor mat next to his bed with his CNA (Certified Nurse Aide) standing beside him. I asked what happened and CNA explained that after assisting resident to the edge of the bed to transfer to WC (wheelchair) he (the CNA) stepped away from the resident's side to grab the WC next to the dresser, in this moment resident slid onto the floor mat onto his butt .Investigative summary: r/t (related to) fall on 10/10/25 .Resident was assisted by aide to edge of bed to transfer into w/c when aide stepped aside to grab w/c next to dresser. Resident slid out of bed and onto fall mat .Root Cause: Resident is 2PA for transfer, non-ambulatory .Resident was being assisted into w/c from bed when resident slid off of bed and onto floor due to w/c not being beside bed at time of transfer .Intervention: Education provided by DON (Director of Nursing) .An I/A for the fall from a sit-to-stand on 11/9/25 was reviewed and read, .Nursing Description: Resident was being transferred by staff with sit to stand, when resident legs appeared to weaken .Predisposing Situation Factors .Mechanical Lift in Use .Other Infor: Staff was utilizing mechanical sit to stand to transfer resident when his legs became weak .Notes .Root Cause: Resident is a 2PA (2 person assist) with transfers, non-ambulatory .An I/A for a fall on 1/23/26 that read, Nursing Description: Resident observed sitting in w/c (wheelchair) attempting to stand up, as he was standing up w/c moved and resident slid out of w/c and onto floor, sitting on buttocks in Bistro, head against seat of w/c, legs outstretched in front of him. Upon assessment, left side wheelchair anti-rollback loose and flipped over .Other info: Anti-rollback device not functioning properly .ROOT CAUSE: Anti-rollback on left wide of w/c flipped over, unable to function properly, attempted to stand and w/c moved causing resident to slide out of w/c and onto buttocks on floor. INTERVENTION: Nurse adjusted anti-rollback, maintenance notified to assess both anti-rollback sides and adjust as necessary to ensure both are in proper working order . A review of R43's clinical record was conducted and revealed they most recently admitted to the facility on [DATE] with diagnoses that included: dementia, major depressive disorder, high blood pressure, neuromuscular dysfunction of the bladder, adjustment disorder, ataxia, falls, and traumatic brain injury. A review of R43's Minimum Data Set Assessments dating back to 8/8/25 were reviewed and revealed R43 was dependent on staff for sitting to standing and chair to bed transferring. R43's care plan for activities of daily living was reviewed and revealed an intervention initiated 11/9/23 that read, .Transfers x2PA . It was noted nowhere in R43's care plan mentioned indications for the use of a sit-to-stand lift. On 4/14/26 at 12:08 PM, an interview with the facility's Assistant Director of Nursing (ADON) 'G' was conducted regarding R43's falls. ADON 'G' indicated there was only one staff member present at the time of the of the transfer on 10/10/25 when CNA 'K' left the resident sitting on the side of the bed to retrieve the wheelchair. Next, ADON 'G' was asked about the fall from the sit-to-stand lift and indicated two staff were present, however; they admitted R43 had no orders, care plan, or indication they should have been transferred with a sit-to-stand lift. Finally, ADON 'G' indicated the fall on 1/23/26 was a result of an equipment malfunction and staff should be closely inspecting the appropriate function of safety-features such as anti-roll back devices and wheelchair brakes. A review of a facility provided policy titled, Falls-Clinical Protocol was reviewed and read, .Treatment/Management .1. Based on the preceding assessment, the staff and physician will identify (continued on next page)

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	235065	A. Building B. Wing	04/15/2026

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South Lyon Senior Care and Rehab Center	700 Reynolds Sweet Parkway South Lyon, MI 48178

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a laboratory diagnostics (labs) were completed for one resident (R19) of two residents reviewed for diagnostics.Findings include:On 4/14/26 the medical record for R19 was reviewed and revealed the following: R19 was initially admitted to the facility on [DATE] and had diagnoses including Type two diabetes mellitus, Hyperlipidemia and Acute cholecystitis.A Physician order dated 3/26/26 revealed the following: cbc (complete blood count) with diff (differential), cmp (comprehensive metabolic panel), hgba1c (hemoglobin A1C) on 2/27/26 <sic>A second Physician order dated 12/20/25 revealed the following: cbc with diff, cmp on monday 12/22/25A Physicians' evaluation dated 3/25/2026 revealed the following: Physician's note-note text: patient seen and examined in bed .a/p (assessment/plan) cognitive decline moderate pcm (protein calorie malnutrition) alb (albumin) 2.8 dietician to follow repeat albumin h/o (history of) cholycyctites .dm-2 (type-two diabetes) .A dietary weight change note dated 1/30/26 revealed the following: resident's weight stabilizing after triggering for significant loss no new labs to evaluate .monitor weekly weight, intake, labs .A Nurses note dated 12/20/25 revealed the following: resident has cbc w/diff & cmp scheduled for 12-22-25, order confirmed & entered to [lab company] for lab draw.A Physicians evaluation dated 12/19/2025 revealed the following: Physician's note-note text: patient seen and examined c/o (complaints of) rt (related to) upper quadrant pain . cellulitis around the drain site started on keflex muporocin <sic> to the insertion site labs ordered .Further review of R19's medical record revealed no laboratory results from the labs ordered on 12/20/25 or on 3/26/26.On 04/15/2026 at approximately 10:12 a.m., R19's medical record was reviewed with the ADON (Assistant Director of Nursing) regarding R19's missing lab results. the ADON indicated the facility has had problems with the contracted lab company coming out to do the lab draws. The lab was supposed to come on Mondays, Wednesdays and Fridays but have not been consistent and labs have been missed. The ADON was queried regarding the results from R19's labs that were ordered in December 2025 and in March 2026 and they indicated they were ordered but were never drawn and were not done. The ADON was queried regarding the process for following up on labs that were not being completed, and they indicated that when they noticed it, they had implemented a new system for responsibility to ensure the nursing staff were not missing any outstanding orders.A facility document titled Lab and Diagnostic Test Results was reviewed and revealed the following: 1. The physician will identify and order diagnostic and lab testing based on diagnostic and monitoring needs. 2. The staff will process test requisitions and arrange for tests. 3. The laboratory, diagnostic radiology provider, or other testing source will report test results to the facility. 1. A nurse will review all results. a. If the staff who first receive or review lab and diagnostic test results cannot follow the remainder of this procedure for reporting and documenting the results and their implications, another nurse in the facility (supervisor, charge nurse, etc.) should follow or coordinate the procedure. 2. The person who is to communicate results to a physician will review and be prepared to discuss the following (to the extent that such information is available): a. The individual's current condition and any recent changes in status, including vital signs and mental status. b. Major diagnoses, allergies, pertinent current medications, other recent pertinent lab work, actions already taken to address results and treat the resident, and pertinent aspects of advance directives (for example, limitations on testing and treatment). c. Why the tests were obtained. d. How test results might relate to the individual's current status, treatments, or medications. e. Any concerns or issues the physician will be expected to address upon receiving the results. 3. Before contacting the physician, the nurse will gather and organize the information listed above and coordinate any telephone communications with others who may also need to speak with the physician 1. Physicians or nurses who have concerns about how test results have been handled or reported should communicate such concerns to the DON and/or Medical Director. a. Such concerns or disagreements should not prevent timely, clinically (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate management of a current result or clinical situation .None of R19's lab results from 12/20/25 or on 3/26/26 were provided by the end of the survey.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement appropriate infection control practices during catheter site and wound site care for one resident, (R43) of one resident reviewed for catheter site and wound care, resulting in the potential for the spread of infection. Findings include: On 4/13/26 at 9:22 AM, a sign posted outside R43's room indicated they were on enhanced barrier precautions (an infection control strategy requiring an isolation gown and glove use during high-contact resident care to prevent Multidrug-Resistant Organism transmission). R43 was observed lying in bed. A urinary catheter drainage bag was clipped to the bed rail. R43 was asked about their catheter and voluntarily lifted their shirt to expose their abdomen revealing a suprapubic catheter (a tube inserted into the bladder through a small abdominal incision, rather than the urethra, to drain urine). On 4/14/26 at 11:10 AM, an observation of S/P (suprapubic) catheter site care and catheter site wound care was observed with Nurse 'I'. Nurse 'I' gathered the required supplies and entered the room. Nurse 'I' was not observed to don an isolation gown prior to entering the room. Nurse 'I' then donned a clean pair of gloves and set-up the supplies to provide the care. Once prepared, Nurse 'I' was observed to remove an occlusive dressing from the site and discard it in the trash. Nurse 'I' then cleansed the insertion site, a small area of reddened tissue and catheter tubing with wound cleanser. Nurse 'I' was not observed to perform hand hygiene or don a clean pair of gloves after removing the old dressing and cleansing the catheter and wound site. After cleansing, Nurse 'I' applied a small amount of antibiotic ointment to cotton swap and applied it to the reddened tissue. It was only after application of the ointment did Nurse 'I' discard their gloves, perform hand hygiene, and don a new pair. On 4/14/26 at 11:25 AM, an interview was conducted with Nurse 'I' regarding R43's status of being on enhanced barrier precautions. They were asked if they should have donned an isolation gown and said they should have. They were then asked about not changing their gloves and performing hand hygiene after removing the old dressing at the catheter insertion site prior to cleansing the area and applying the treatment and said they should have. On 4/14/26 at 3:12 PM, an interview was conducted with the facility's Infection Control Nurse 'A'. They agreed Nurse 'I' should have worn an isolation gown when performing care for R43 and also indicated hand hygiene and new gloves should be donned after removing an old dressing before cleaning the area and applying treatments. A review of the National Library of Medicine website at https://www.ncbi.nlm.nih.gov/books/NBK593201/#ch20woundcare.sec20.8 was conducted and read, .8. Expose the dressing. 9. Perform hand hygiene and apply nonsterile gloves. 10. Remove the outer dressing. 11. Remove the inner dressing.12. Remove gloves, perform hand hygiene, and put on new gloves.16. Cleanse the wound based on agency policy.17. Cleanse around the drain (if present).18. Remove gloves perform hand hygiene, and apply new gloves.