STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235139	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avista Nursing and Rehabilitation	2901 Galaxy Drive Saginaw, MI 48601

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** based on interview and record review, the facility staff failed to follow and update timely a fall care plan for one resident (Resident #101) resulting in missed interventions necessary for care and services not being care planned with a likelihood of unmet care needs. Findings include: Resident #101:Record review of Resident #101's fall incident report dated 4/2/2026 at 6:00AM revealed that the aide requested nursing assistance in the weight room across from the therapy office. Upon arrival the writer noticed resident alert and oriented laying up against the wall in the weight room. Aide reported resident lost his footing on the weight scale as resident was assisted back to his wheelchair. Aide stated resident did not (hit) his head. This writer assessed resident for bruising & injuries, none noted. Resident reported he lost his step on his weaker side as the aide was assisting him back in his wheelchair. There was no mention of resident footwear at the time of the incident. Incident report noted no witness statements found.In an interview on 4/15/2026 at 2:30PM with the Director of Nursing (DON) related to Resident #101's fall on 4/2/2026 at 6:00AM, the DON stated that the facility did not wake up residents at that time just for weights. The DON stated that she talked to the nurse and investigated the incident, no notes or witness statements were made, we followed the plan of care. It was not a huge investigation. The resident had no appointments that day. Record review of resident weight log revealed weight at 5:51 Am and as a standing weight. Why was this aide to get the weight at that time of the morning? The DON stated that the facility has staff that do weights, so that it is consistent, weights can be done anytime. Daily weights we do them in the morning depending usually on day shift which is 6am to 6pm. He has history of left foot drop and left side weakness to left leg/arm. The resident was just mad that the nurse left the Certified Nurse Assistant (CNA) and him in the weight room. He said that his knees gave out. No, I did not talk to the CNA or resident, just the nurse.Record review of Resident #101's medical record revealed admission on [DATE] from the hospital setting. Medical diagnoses included: heart disease, occlusion and stenosis of right carotid artery, hemiplegia and hemiparesis post intracerebral hemorrhage affecting the left non-dominant side, diabetes, depression, anxiety disorder, hypothyroidism, orthostatic hypotension, anemia, moderate protein-calorie malnutrition, mitral valve insufficiency, tricuspid valve insufficiency, and cardiomyopathy.Record review of Resident #101's care plans page 1 through 27, revealed the resident needed assistance with ambulation per one person with 2 wheeled walker and left foot orthosis, received physical therapy for gait training and neuro-muscular re-education. Transfer: Resident requires assistance by one staff to move between surfaces, allow increased time secondary to dizziness at times. Record review of Fall care plan dated 3/3/2026 related to recurrent falls, history of left hip fracture, debility, cardiovascular accident (CVA) with left hemiplegia, diabetes, anemia, dizziness, fatigue, orthostatic hypotension, and potential medication side effects. Interventions included: Transfer and change positions slowly, left side of bed at wall. On 4/6/2026 new intervention of: Use seated scale when obtaining weights, was added 4 days post fall.Record review of the facility 'Care Plans- Baseline' policy dated 9/2025 was the only care plan policy received when requested, revealed a baseline plan of care to meet the resident's immediate health and safety needs is (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	developed for each resident within forty-eight (48) hours of admission. the baseline care plan includes instructions needed to provide effective, person-centered care of the resident the meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident

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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 a fall/accident and ensure that a left foot Ankle Foot Orthosis (AFO) device and gait belt were applied prior to standing for one resident (Resident #101) of 4 sampled residents, resulting a fall with likelihood for repeat falls, pain and serious injury. Findings include: Resident #101:Record review of Resident #101's fall incident report dated 4/2/2026 at 6:00AM revealed that the aide requested nurse assistance in the weight room across from the therapy office. Upon arrival the writer (Nurse) noticed resident #101 was alert and oriented laying up against the wall in the weight room. Aide reported resident lost his footing on the weight scale as resident was assisted back to his wheelchair. Aide stated resident did not (hit) his head. This writer assessed resident for bruising & injuries, none noted. Resident reported he lost his step on his weaker side as the aide was assisting him back in his wheelchair. There was no mention of resident footwear at the time of the incident. Incident report noted no witness statements found.In an interview on 4/15/2026 at 2:30PM with the Director of Nursing (DON) related to Resident #101's fall on 4/2/2026 at 6:00AM, the DON stated that the facility did not wake up residents at that time just for weights. The DON stated that she talked to the nurse and investigated the incident, no notes or witness statements were made, we followed the plan of care. It was not a huge investigation. The resident had no appointments that day. Record review of resident weight log revealed weight at 5:51 AM and as a standing weight. The surveyor asked why was this aide to get the weight at that time of the morning? The DON stated that the facility has staff that do weights, so that it is consistent, weights can be done anytime. Daily weights we do them in the morning depending usually on day shift which is 6am to 6pm. He has history of left foot drop and left side weakness to left leg/arm. The resident was just mad that the nurse left the Certified Nurse Assistant (CNA) and him in the weight room. He said that his knees gave out. No, I did not talk to the CNA or resident, just the nurse.Record review of Resident #101's medical record revealed admission on [DATE] from the hospital setting. Medical diagnoses included: heart disease, occlusion and stenosis of right carotid artery, hemiplegia and hemiparesis post intracerebral hemorrhage affecting the left non-dominant side, diabetes, depression, anxiety disorder, hypothyroidism, orthostatic hypotension, anemia, moderate protein-calorie malnutrition, mitral valve insufficiency, tricuspid valve insufficiency, and cardiomyopathy.Record review of Resident #101's care plans page 1 through 27, revealed the resident needed assistance with ambulation per one person with 2 wheeled walker and left foot orthosis, received physical therapy for gait training and neuro-muscular re-education. Transfer: Resident requires assistance by one staff to move between surfaces, allow increased time secondary to dizziness at times. Record review of Fall care plan dated 3/3/2026 related to recurrent falls, history of left hip fracture, debility, cardiovascular accident (CVA) with left hemiplegia, diabetes, anemia, dizziness, fatigue, orthostatic hypotension, and potential medication side effects. Interventions included: Transfer and change positions slowly, left side of bed at wall. On 4/6/2026 new intervention of: Use seated scale when obtaining weights, was added 4 days post fall.Observation and interview on 4/15/2026 at 8:20AM of Resident #101 while lying in bed with no covers on, the resident was awake. Resident #101 stated that his left foot is getting better, he has a calf/leg/shoe device (AFO-Ankle Foot Orthosis) that helps his leg, and he stated when asked about his right foot that it was fine and had no injury or pain. Observation of residents' bare feet bilaterally noted no bruising, sore or skin injuries noted, to the feet while in the bed. He stated that he is doing therapy services and that he is getting more strength and feels like he is making progress. Observation on 4/15/2026 at 10:25AM of Resident #101 was seated up in wheelchair in therapy session, with right ankle weight on and exercises in progress, right arm 3 lb. weight for arm strengthen. Resident #101 stated that he had a massive stroke and had left side weakness and foot (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	drop. The surveyor Observed left leg/foot Ankle Foot Orthosis (AFO) in place to left shoe. Resident #101 did state that he had a lidocaine patch to his left knee for pain. In an interview on 4/15/2026 at 11:20AM with Resident #101 revealed he had left foot drop and the splint thing (AFO) to stand/walk. On that night (4/2/2026) at 4AM in the morning 2 nurses came into his room to weigh him. They got him up at 4:00AM, and he refused. Resident #101 stated that he was sat up and he told them that he needed to sit for 10 minutes or so or his blood pressure would drop. It was a big-sized nurse, she was wide and a skinny young girl that was told to get me up to be weighed. The big-sized girl was snotty and picked me up under my arm pits and put me in the wheelchair. The skinny girl took me to the weight room across from the therapy. Resident #101 stated that he usually goes to the chair weight scale on the other end of the hallway. They (staff) had no gait belt on him and he was barefoot, he did not have any socks on, they just got him out of bed. The skinny girl stood the resident up and he started to black out and went down. The resident #101 stated that there was only one handrail in the room, it was on the back of the scale. He fell backwards and landed on his left foot/leg and hurt his knee. The skinny aide was only about 90 pounds, and she went to get the big-sized girl. Resident #101 stated that his left big toe was bleeding. The large-sized girl didn't do anything. Resident #101 stated that he had a fall at home and broke his hip in December/January. Resident #101 stated that his toe healed up and there's nothing to look at there. Resident #101 stated that he usually gets weighed on the sitting chair scale and for some reason that night they changed to a wheelchair scale but made him stand up, he knows the wheelchair weighs 27 pounds and they subtract that from the total weight. Observation on 4/15/2026 at 11:35AM Observation of the weight room/closet across from the therapy office, revealed a white room with tiled walls, with a wheelchair platform scale with one handrail and scale head plugged in to the wall. There were no other handrails noted in the room. Observation on 4/15/2026 at 11:38AM on Unit 2 revealed a Chair scale with black plastic seat with bilateral arm rest with scale head noted located in the courtyard entry way. In a phone interview on 4/15/2026 at 12:27PM with Certified Nurse Assistant (CNA) J revealed that the Licensed Practical Nurse (LPN) I asked her to get a weight on resident #101 so she went to his room and asked him to get up, she stated that it was like 4:00AM in the morning and she had to wake him up. CNA J stated that she felt bad about waking him, but the nurse told her to get his weight. The resident stated that he was tired and did not want to get up, so we moved slowly, he sat up at the edge of the bed and got in the wheelchair eventually. CNA J stated she took the resident to the weight room across from the therapy office and had him stand up to get weighed. The resident was very upset he had to get weighed at 4AM. We had to get him up just for the weight. CNA J stated that she works 3rd shift and that was the first resident weight she had gotten since she was hired in October 2025, because it's her first CNA job. The resident #101 started to fall backwards against the wall. CNA J could not lift the resident herself, while the resident was on the floor, she had to go get the nurse LPN I to help get the resident up into the wheelchair. When asked the CNA J stated that the resident did not have socks on and she did not put his leg splint (AFO) or used a gait belt on the resident. Record review of Resident #101's Occupational and physical Therapy notes dated 3/3/2026 through 4/1/2026 noted hemiplegia and hemiparesis affecting the left side, orthostatic hypotension and muscle weakness generalized and diagnoses for therapy. In an interview on 4/15/2026 at 12:40pm with Physical Therapy Assistant (PTA) M revealed the PTA worked with the resident #101 most days. PTA M revealed that Resident #101 had left foot drop on admission and left leg AFO/splint and needed the left leg AFO/splint to stand and a gait belt. In a phone interview on 4/15/2026 at 1:01PM with Licensed Practical Nurse (LPN) I recalled the event of Resident #101's fall int the weight room on 4/2/2026. LPN I stated that Resident #101 fell in the weight room on the edge of the scale because he missed placed his footing and fell. He was weak on standing, he said he could stand. After he fell, she recommended that he use the weight chair scale instead. The surveyor asked why was the weight done so early in the morning? LPN I stated the resident needs daily weights. He needed to be weighed that morning. He didn't want to get up out of bed, and she stated that she explained that he (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would end up back in the hospital and the severity of not getting weighed. LPN I stated the Resident #101 slipped on the scale, and the CNA J came and got her. Resident #101 was on the floor, and she did an assessment, Vital signs, and skin assessment, the resident had no complaints of pain. Left knee pain? No, he did not say anything about left knee pain. When we were in his room I educated him and he sat up on the edge of the bed and I went back out of the room to the CNA, and she went into the resident's room and got him up and weighed him. He had yellow gripper socks on I believe, our practice is to have gripped socks or shoes on when weighing. Record review of Resident #101's left knee x-ray dated 4/4/2026 revealed clinical information of pain with 2 views. Impression: Mild osteoarthritis of the knee joint.Record review of the facility ?Fall and Fall Risk Management' policy dated 11/2025, revealed based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. A fall is defined as unintentionally coming to rest on the ground, floor or other lower level. Medical factors that contribute to the risk of falls include Arthritis, heart failure, anemia, neurological disorders and balance and gait disorders.