STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235182	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lynwood Manor Healthcare Center	730 Kimole Lane Adrian, MI 49221

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 intake 2747712Based on observation, interview, and record review the facility failed to implement interventions to prevent accidents for one resident (#1) of three resident reviewed for accidents.Findings Included: Resident #1 (R1)Review of the medical record demonstrated that R1 was admitted [DATE] with diagnoses that included pain left knee, diverticulosis (the formation of small bulging pouches in the lining of the colon), disorder of bone density, epilepsy (chronic neurological disorder), hyperlipidemia (high fat content in blood), hypertension, type 2 diabetes, weakness, difficulty walking, lack of coordination, and fracture of the sacrum. Review of the most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/12/2026, revealed a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15.Review R1's medical record revealed that 01/30/2026 she was discharged from the facility because of an incident that occurred while being transported back to the facility from an appointment. R1's medical record also revealed that she was readmitted on [DATE] with new diagnoses that included distal femur fracture, fibula fracture, and bimalleolar ankle fracture.Review of a facility investigation file provided revealed that on 01/30/2026 at approximately 04:00 p.m. R1 was picked up by [NAME] Manor Driver C, to return to the facility from the outside appointment. At approximately 04:49 p.m., while being transported back the facility, [NAME] Manor Driver C was required to make a sudden stop. As a result of this sudden stop, R1 came out of her wheelchair and landed on the floor of the facility van. R1 was transported to the local emergency department by an area ambulance. Review of the facility investigation file [NAME] Manor Driver C had not applied the van seat belt to R1 prior to returning to the facility.On 02/20/2026 at 09:56 a.m., during an interview, [NAME] Manor Driver (LMD) C explained that on 01/20/2026 at approximately 04:00 p.m. he arrived with the facility van to transport R1 from an appointment back to the facility. LMD C explained that he placed R1 into the van and anchored her wheelchair to the floor of the van using the appropriate strap devices. LMD C explained that he could not recall if he had placed the van seatbelt around R1. LMD C explained that while driving back to the facility, he had encountered a location on the road which contained backed up traffic. LMD C explained that this occurred as the facility van was going around a corner with a significant blind spot. LMD C explained that it was necessary for him to apply the van brakes in a hard manner. LMD C explained that when this occurred R1 came out of her wheelchair and landed on the van floor. LMD C explained that he pulled into an area business parking lot and assessed R1. LMD C explained that he could not move R1 and contacted the facility and the was directed to contact 911. LMD C explained that R1 was transported to the area hospital by an ambulance. LMD C was asked why the van seat belt had not been applied to R1 prior to transportation. LMD C explained that he had thought the seat belt had been applied but apparently, he had forgotten to apply the seat belt. LMD C explained that he had received education on the use of an updated Transportation Driver Check List for Wheelchair Transport document on (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	01/30/2026, after the incident and again on 02/02/2026. On 02/20/2026 at 10:37 a.m. during and interview Nursing Home Administrator (NHA) A explained that on 01/30/2026 at approx. 04:30 p.m. she was notified of the above incident with R1. NHA A explained that an investigation was initiated immediately on 01/30/2026. NHA A explained that as a result of the investigation it was determined that [NAME] Manor Driver C had failed to apply the seat belt to R1 upon transportation. NHA A explained that following actions were initiated:A new form entitled Transport Driver Checklist for Wheelchair transport was developed and initiated. The new checklist included- wheelchair properly placed, wheelchair secured/brakes locked, 4-point anchors, seatbelt secured properly. Check list was to be completed on each transport.All Van Drivers were re-educated by 02/03/2026 for safety training and use of the new Transportation Driver Checklist for Wheelchair transport.An Ad Hoc Quality Improvement Council Meeting was conducted on 02/02/2026.Visual Audits will be completed no less than 2x per week for 4 weeks of driver securing passenger in van, and then weekly x 4 weeks. Audits will be done by NHA or designee. Audit reviews of the document Transport Driver Checklist for Wheelchair transport will be completed weekly for 4 weeks. During an interview on 02/20/2026 at 11:10 a.m. R1 was observed lying down in bed and it was observed that her left leg was elevated and covered by bedding. R1 explained that on 01/20/2026 that she had gone to an appointment outside of the building. R1 explained that once the appointment was completed her sister had called the facility requesting transportation to return. R1 explained that when the facility van arrived, she was assisted into the van by the driver. R1 explained that the van driver secured the wheelchair to the floor of the van but did not place a seat belt around her. R1 explained as the van was returning to the facility the van driver stopped suddenly at which time she was thrown out of her wheelchair and landed onto the floor. R1 explained that she was then transported to the hospital by an ambulance. R1 explained that she had broken her left leg and broken her left ankle. R1 explained that both fractures required surgery. R1 explained that her pain had not increased due to the fractures and her level of function for activities of daily living had not changed due to the new fractures. R1 explained that she was originally admitted after a fractured pelvis so the pain was no different and that her level of function for activities of daily living had not changed because of the new fractures to her left leg and ankle.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:A new form entitled Transport Driver Checklist for Wheelchair transport was developed and initiated. The new checklist included- wheelchair properly placed, wheelchair secured/brakes locked, 4-point anchors, seatbelt secured properly. Check list was to be completed on each transport.All Van Drivers were re-educated by 02/03/2026 for safety training and use of the new Transportation Driver Checklist for Wheelchair transport.An Ad Hoc Quality Improvement Council Meeting was conducted on 02/02/2026.Visual Audits will be completed no less than 2x per week for 4 weeks of driver securing passenger in van, and then weekly x 4 weeks. Audits will be done by NHA or designee. Audit reviews of the document Transport Driver Checklist for Wheelchair transport will be completed weekly for 4 weeks.The facility was able to demonstrate monitoring of the corrective action and maintained compliance.