| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235224 | A. Building<br>B. Wing | 03/19/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Lenawee Medical Care Facility | 200 Sand Creek Highway<br>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 0948<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that paid feeding assistants have the training they need.<br><br>Based on interview and record review, the facility failed to maintain record of successful completion of a State-approved paid feeding assistant training course for 6 of 12 paid feeding assistants. Review of the lists provided by the facility, the facility had 12 staff who were Paid Feeding Assistants and 9 residents who were approved for the Paid Feeding Assistant program. In an interview on 03/19/26 at 12:55 PM, Director of Nursing (DON) B reported the facility was only able to locate the documentation of completion of a State-approved paid feeding assistant training course for 6 of the 12 staff who worked as Paid Feeding Assistants. DON B reported Life Enrichment Coordinator W, Dining Room Assistant (DRA) X, DRA Y, DRA Z, DRA AA, and DRA BB all completed the Paid Feeding Assistant training and had assisted with feeding, however the facility was unable to locate the documentation that the training had been completed. |

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 |
|---|---|---|
| | | |