STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235287	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adrian Bay Rehabilitation and Nursing Center	700 Lakeshire Trail 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2807029.Based on interview and record review, the facility failed to administer medications as ordered by the physician for one (R1) of three reviewed.Findings include: Review of the complaint received by the State Agency revealed Family was not notified that he [R1] had not received Paxlovid for COVID after it was prescribed until after inquiring about it. Family was not informed that the medication was not covered by insurance, nor were they given the option to obtain it privately. No additional treatment was initiated until he developed worsening shortness of breath requiring oxygen therapy. At that point, he was prescribed prednisone and nebulizer treatments. Review of the medical record revealed R1 was admitted to the facility on [DATE] with diagnoses that included sepsis, urinary tract infection, and cerebral infarction (a type of stroke). The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/25 revealed R1 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R1 had a legal guardian. R1 transferred to another facility on 1/15/26. Review of the General Progress Note dated 12/30/25 revealed COVID-19 test obtained .result returned positive. Resident currently symptomatic, presenting with congestion. Resident notified of test results. Family notified via telephone. Provider notified; new orders received for Paxlovid [antiviral medication] 300 mg [milligrams]/100 mg BID [twice per day] for 5 days. Droplet precautions initiated. Review of the Physician's Order dated 12/30/25 and given as a verbal order from Physician N (R1's primary physician) revealed an order for Paxlovid (300/100) give one tablet two times a day for COVID for 5 days. The order was scheduled to begin on 12/31/25. Review of the Medication Administration Record (MAR) revealed R1's Paxlovid was not given the morning of 12/31/25 and marked as 9=Other/See Nurse Note. Review of the Progress Notes revealed awaiting arrival from pharmacy. Medication order updated to reflect. The previous order for Paxlovid was discontinued and a new Physician's Order dated 12/31/25 revealed a verbal order from Physician N (R1's primary physician) for Paxlovid 300/100 give one tablet by mouth two times a day for COVID for 4 days and give one tablet by mouth two times a day for COVID for 1 day. This order was discontinued the same day (12/31/25). A third Physician's Order was given verbally by Physician N (R1's primary physician) on 12/31/25 for Paxlovid (300/100) one tablet two times a day for COVID for 5 days. The order was scheduled to begin on 1/1/26. Review of the MAR revealed R9's Paxlovid was marked as 9=Other/See Nurse Note on 1/1/26 morning, 1/2/26 evening, 1/3/26 evening, and 1/4/26 morning. R1's MAR did not have any documentation for the dose scheduled in the morning on 1/3/26. R1's Paxlovid was documented as administered on 1/1/26 evening and 1/2/26 morning. Review of the Progress Notes revealed on 1/1/26 at 4:31 AM, Paxlovid was not given because it was on order. The Progress Note dated 1/3/26 at 12:20 AM revealed Paxlovid was not given because it was on order. The Progress Note dated 1/3/26 at 9:59 PM revealed R1's Paxlovid was not given because medication on order. The Progress Note dated 1/4/26 at 9:26 AM revealed the Paxlovid was not given because Medication unavailable. Pharmacy notified and stated they received a high cost form back from facility stated to cancel the order. Review of R1's Physician's Orders revealed the Paxlovid order cancelled per [Nurse Practitioner] dt [due to] high-cost medication. In an interview on 4/22/26 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Adrian Bay Rehabilitation and Nursing Center	700 Lakeshire Trail Adrian, MI 49221

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 11:03 AM, Director of Nursing (DON) B reported she recalled that an on call physician ordered Paxlovid for residents during their COVID outbreak in January, but then the primary physician determined Paxlovid was only necessary for residents with severe symptoms. DON B reported if a medication flagged as a high-cost medication, the facility had three options which included to bill the facility, change the order, or cancel the order. On 4/22/26 at 12:30 PM, DON B reported she contacted the pharmacy and discovered that R1 never received Paxlovid at the facility; therefore, the two doses that were documented as administered was inaccurate. In a telephone interview on 4/22/26 at 12:20 PM, Pharmacy Representative (PR) M reported they did not have full access to R1's notes because the facility had changed pharmacy branches since then. PR M reported R1's Paxlovid was assigned for delivery to the facility on 1/2/26, but then the order was cancelled before it left the pharmacy; therefore, R1's Paxlovid was never delivered to the facility. Review of R1's General Progress Note dated 1/4/26 revealed Vitals obtained and resident [oxygen saturation] 88% [room air] and experiencing difficulty to [breathe]. Lung sounds clear. Resident [placed] on 2L [liters] NC [nasal cannula] O2 [oxygen] and O2 increased to 93%. Physician notified. Orders received to begin prednisone 20 mg 2 tabs at bedtime for 5 days. Ipratropium-albuterol treatment q6 [every 6] hours. STAT 2 view chest xray.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2807029.Based on interview and record review, the facility failed to ensure the accuracy of medical records for one (R1) of three reviewed. Findings include:Review of the medical record revealed R1 was admitted to the facility on [DATE] with diagnoses that included sepsis, urinary tract infection, and cerebral infarction (a type of stroke). The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/30/25 revealed R1 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R1 had a legal guardian. R1 transferred to another facility on 1/15/26. Review of the General Progress Note dated 12/30/25 revealed COVID-19 test obtained .result returned positive. Resident currently symptomatic, presenting with congestion. Resident notified of test results. Family notified via telephone. Provider notified; new orders received for Paxlovid [antiviral medication] 300 mg [milligrams]/100 mg BID [twice per day] for 5 days. Droplet precautions initiated. Review of the Physician's Order dated 12/30/25 and given as a verbal order from R1's primary physician revealed an order for Paxlovid (300/100) give one tablet two times a day for COVID for 5 days. The order was scheduled to begin on 12/31/25. Review of the Medication Administration Record (MAR) revealed R1's Paxlovid was not given the morning of 12/31/25 and marked as 9=Other/See Nurse Note. Review of the Progress Notes revealed awaiting arrival from pharmacy. Medication order updated to reflect. The previous order for Paxlovid was discontinued and a new Physician's Order dated 12/31/25 revealed an order for Paxlovid 300/100 give one tablet by mouth two times a day for COVID for 4 days and give one tablet by mouth two times a day for COVID for 1 day. This order was discontinued the same day (12/31/25). A third Physician's Order was given verbally by R1's primary physician on 12/31/25 for Paxlovid (300/100) one tablet two times a day for COVID for 5 days. The order was scheduled to begin on 1/1/26. Review of the MAR revealed R9's Paxlovid was marked as 9=Other/See Nurse Note on 1/1/26 morning, 1/2/26 evening, 1/3/26 evening, and 1/4/26 morning. R1's MAR did not have any documentation for the dose scheduled in the morning on 1/3/26. R1's Paxlovid was documented as administered on 1/1/26 evening and 1/2/26 morning by Registered Nurse (RN) E. Review of the Progress Notes revealed on 1/1/26 at 4:31 AM, Paxlovid was not given because it was on order. The Progress Note dated 1/3/26 at 12:20 AM revealed Paxlovid was not given because it was on order. The Progress Note dated 1/3/26 at 9:59 PM revealed R1's Paxlovid was not given because medication on order. The Progress Note dated 1/4/26 at 9:26 AM revealed the Paxlovid was not given because Medication unavailable. Pharmacy notified and stated they received a high cost form back from facility stated to cancel the order. Review of R1's Physician's Orders revealed the Paxlovid order cancelled per [Nurse Practitioner] dt [due to] high-cost medication. An attempt to contact RN E via telephone was made on 4/22/26 at 9:38 AM. RN E did not return the phone call. In an interview on 4/22/26 at 12:30 PM, Director of Nursing (DON) B reported she contacted the pharmacy and discovered that R1 never received Paxlovid at the facility; therefore, the two doses that were documented as administered was inaccurate. DON B reported RN E no longer worked at the facility. In a telephone interview on 4/22/26 at 12:20 PM, Pharmacy Representative (PR) M reported R1's Paxlovid was assigned for delivery to the facility on 1/2/26, but then the order was cancelled before it left the pharmacy; therefore, R1's Paxlovid was never delivered to the facility. Review of RN E's personnel file revealed a previous Disciplinary Action Report dated 11/18/25 for documenting a medication was given when the medication was not administered. There were no disciplinary actions related to the inaccurate documentation for R1's Paxlovid.