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	06/22/2026

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 0689 Level of Harm - 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 #3030201.Based on observation, interview and record review, the facility failed to ensure their transfer status was accurately following resident's plan of care to prevent fall to occur for one resident (R#2) of 3 sampled residents sustaining a fall resulting in a hospital transfer and admitted for Right Rib Fractures 5-10, Right Forehead Hematoma, Right non-displaced Humeral Fracture, and Right Superior Pubic Rami Fracture and pain.Findings include: The facility incident report was reviewed on 6/22/26 at 1:30 PM. It revealed that Resident#2 (R#2) had a Fall on 5/26/26, while being assisted by CNA A to the bathroom. The Certified Nursing Assistant (CNA A) assisted R#2 to ambulate from the wheelchair to the bathroom using a walker without a gait belt. R#2 was at High Risk for falling, and the plan for R#2's transfer status is to use a lift. Meanwhile, during this transfer, CNA A stepped away from R#2 to put her gloves on for care, and CNA A heard R#2 saying I am falling and suddenly fell. CNA A immediately called for help, and the nurse went to assess R#2.R2 was transferred to the Acute care hospital on 5/26/26 and was admitted . Upon return from the hospital on 6/2/26, hospital records noted the following added diagnoses resulting from a fall that occurred on 5/26/26: Fall resulting in a hospital transfer for Right Rib Fractures 5-10, Right Forehead Hematoma, Right non-displaced Humeral Fracture, and Right Superior Pubic Rami Fracture and pain.The facility terminated CNA A, on 5/29/26 who was the only witness during R#2's fall, and admitted ambulating R#2 using a walker and did not follow R#2's Kardex and Care Plan instructions.Resident #2 (R#2)According to the resident's face sheet and facility record, R#2 was originally admitted to the facility 10/30/2024, with diagnoses of Nutritional Deficiency, Allergic Rhinitis, Muscle Wasting and Atrophy, Dysphagia and Gastroesophageal Reflux Disease (or GERD), Dementia, Adjustment Disorder, Depression, Neurofibromatosis, and Retention of Urine in addition to other diagnoses. R#2's Face Sheet noted no diagnosis of Osteoarthritis or Osteoporosis found in her Face Sheet dated 6/10/1026. However, according to the facility, R #2's Brief Interview of Mental Status (BIMS) Score assessed on 5/1/2026 was 12/15. A BIMS Score of 12 indicates a moderate cognitive impairment.Fall risk assessment scored a High Risk for falling, and the current plan for R#2's transfer status is to use a Sara Steady lift and ambulate with one assist/Gait Belt and Rolling Walker.An interview with CNA A by telephone was conducted on 6/22/26 at 1:05 PM. CNA A revealed she worked at the facility for 3 years and often worked at the hall with R#2. She stated: They don't update residents' kardexes. They changed her Care Plan and Kardex without letting us know. I am assigned to R#2. I was not aware that she needed a sit-to-stand lift for transfers. No update on the Kardex, and no transfer (gait) belts were available at the facility. It takes a long time to find one, and residents need to go when they press the light. That is why R#2 did not have one on her. CNA A continued to explain that R#2 was assisted to the bathroom, ambulating with a walker, and her foot got caught, and she fell down. No changes on her transfer status were communicated. Nothing was changed in the Kardex, not at the point of care. That's where we look. She has always been a transfer using a walker.An attempt was made to call Nurse B on 6/22/26 at 1:15 PM, but Nurse B did not pick up the phone. A message was left on voicemail requesting a callback, but no reply was received.A review of Nurse B Witness (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
	235287	A. Building B. Wing	06/22/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Statement dated 5/26/26 revealed Resident (R#2) was lying down positioned between the 2 rooms in the bathroom but into the neighboring room. (Shoulder up was in room [ROOM NUMBER]). R#2 was asked whether she had hit her head and was observed to have a bump on her right eyebrow . The Unit Manager came into the room to assist, and the NP said to send her to the hospital. Nurse B took R #2's vitals, and her BP was high. R#2 complained of pain in her right arm. Staff got her on the toilet, and R#2 used the restroom, then we cleaned her up. R#2 then started to complain of pain in her right leg and was grabbing with her left arm. Staff used steady and got her onto the stretcher .The Facility AVHS.NSG-Resident Lift Assessment-Vs for R#2, Effective Date 4/26/2026 revealed:A. Resident can reliably stand and pivot with only contact guard or stand by assistance from staff with minimal risk of falling/ Answer: No.B. Resident is able to pull self into standing position AND weighs less than 265 pounds AND has reliable trunk stability? Answer: Yes, Use Sit to Stand Lift C. Resident can reliably bear weight on at least one leg AND reliably able to follow simple instructions AND reliably able to grip with at least one hand AND has reliable trunk stability? Answer: Yes, Use Sit to Stand Lift.A review of R#2 Care plan was conducted on 6/22/26 at 2:00 PM. It indicated:Care Plan 1. R#2 has ADL self-care performance deficit r/t/ T12 burst fracture, Neurofibromatosis, dementia. Date initiated: 10/24/24. Intervention: Toilet use: R#2 requires extensive assistance with toileting needs. R#2 utilizes the (Manufacturer's name mentioned) Lift (a sit-to-stand lift) for toilet needs and may require assistance with brief changes at times. (Date created/initiated: 02/11/2025).Care Plan 2. R#2 has limited physical Mobility r/t/ T12 Fracture, Neurofibromatosis, OA. Intervention: TRANSFER: Sara Steady. Date created and initiated 10/24/24.Care Plan 3. R#2 at risk for falls r/t Alzheimer's, history of falls at home, OA, glaucoma, visual impairment, urinary retention, IFG, and T12 burst fracture. GOAL: Will remain FREE from fall-related injury through the review date. Interventions: Provide Assistance as needed for mobility tasks and ensure the use of appropriate devices. Refer to ADL/Mobility plans of care. Report any changes. (Date created/initiated: 10/24/24.)R#2 Kardex (A quick reference nursing system that provides a concise, at-a-glance overview of a patient's current care needs.) dated as of 5/26/25, indicated in Transferring: Transfer status: Sara Steady (is a manual, non-powered sit-to-stand patient transfer aid).Resident Nurse's Notes dated 5/26/26 at 11:36 AM noted, Per CNA interview, resident was ambulating with 2WW to the restroom with CNA supervision. Once in the bathroom, the resident's foot appeared to twist, or to come partially out of the shoe, causing the resident to fall to the floor. Resident landed partially through the adjoining door to next room . Resident complained of pain to head, large hematoma developing. Neuro assessment at baseline; vitals WNL (within normal limits); ROM reveals pain in the right arm/shoulder. NP in facility and immediately responded to fall; new order to send to emergency department for evaluation .Transported via EMS on stretcher. First Emergency contact (Name mentioned) called, and VM left to call facility. Signed by the nurse on 4/26/26.CNA A employee file was reviewed, and on 5/29/26, CNA was terminated under Category 3 #58: Employees may not disregard the resident's care plan related to repositioning, transfers, and/or lifting. It was further described what happened: CNA (A) did not follow the resident's care plan regarding the resident's transfer status, which required the use of a mechanical lift. CNA performed an inappropriate transfer and also did not use a gait belt. Resident fell during this transfer and as a result sustained significant injuries. Corrective action needed: Termination.On 6/22/26 at 3:15 PM, a tour observation was conducted with the In-service Director/Infection Control Nurse C. Both the surveyor and the in-service director C observed that the entire B Hall lacked gait belts, contrary to the in-service director's expectation that they would be in place after the education and purchasing the belts. None of the random rooms the surveyor and in-service director visited had a gait belt for access. The in-service director was surprised because she had placed them herself for staff to use a week ago for fall-prevention intervention. She did not find them in the rooms we randomly checked in Hall A and Hall C. Only one staff member was carrying her gait belt with her and was wearing it as her belt, but the in-service director stated that that is the belt that is made of cloth and is not appropriate for cleaning and disinfecting. The In-service Nurse C (continued on next page)

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	06/22/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	has been getting 36 pieces every week to replace the cloth gait belts. The Inservice director said that staff received training that 2 belts (if 2 residents per room) are made accessible in each room for staff to use on residents. But none were found behind the door with the hooks.An interview with the Administrator on 6/22/26 at 3:30 PM was conducted, and she stated that they have kept the belts in the corridor closet. The administrator went to a closet in Hall B and showed the surveyor where the CNAs can find the gait belts where it was stored. There was a small box containing 4 gait belts. When asked if the in-service director knows where they are kept? The administrator had no response. Fall Policy dated 7/11/2018 indicated, It is the policy of this facility to evaluate the extent of injury after a fall, prevent complications, and to provide emergency care.