Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235561	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2026
NAME OF PROVIDER OR SUPPLIER Aria Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 707 Armstrong Lansing, MI 48911	

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: 2717790Based on observation, interview and record review the facility failed to: 1.) ensure the safety, and 2.) implement care-planned interventions during staff assisted care in 1 of 3 sampled residents (Resident #102) reviewed for falls, resulting in R102 fall from elevated bed during care, where R102 required immediate transport to the hospital related to significant leg laceration, 24 sutures, and pain.Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R102 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included chronic heart failure, diabetes, morbid obesity, major depression and anxiety disorder. The MDS reflected R102 had a BIM (assessment tool) score of 11 which indicated her ability to make daily decisions was moderately impaired, and she was dependent on staff for toileting, dressing, bathing and rolling left and right in bed.During a telephone interview on 1/30/26 at 1:58 p.m., Certified Nurse Aid (CNA) C reported was working on 1/9/26 around 6:00 a.m. when R102 fell out of bed. CNA C reported was alerted that R102 had fallen out of bed by CNA D. CNA C reported arrived to R102 room and observed R102 face down next to elevated bed, about hip height, with right lower leg that appeared split open and bleeding. CNA C reported R102's leg wound was larger than size of open hand and R102 was complaining of back and leg pain. CNA C reported CNA D had told CNA C she was assisting R102 with incontinence care and R102 rolled out of bed during care. CNA C reported R102 was alert and oriented and able to make needs known. CNA C reported was unsure of R102 care needs at the time of the fall and reported was not assigned to R102 but reported staff are expected to follow the Kardex.Review of R102's Nursing Progress Note, dated 1/9/26 at 7:12 a.m., reflected, Nurse and CNA were in the dayroom when another CNA urgently asked for help. Upon arrival at resident's room, the resident observed lying face down on the floor to the left side of her bed with blood pooling under her right knee. 911 was called at 0605, Paramedics arrived at 0615, Patient rolled into Hoyer sling after initial first aid was performed by paramedics.Review of R102's Nurse Progress Note, dated 1/10/26 at 2:35 p.m., reflected, Resident was transferred to hospital following a fall from bed on 1/9/26, and returned on the afternoon of 1/9/25 following care for laceration of right leg sustained during the fall.Review of R102's Nurse Progress Note, dated 1/11/26 at 3:55 p.m., reflected, Hospital DC [discharge] instructions for care of right lower leg wound transcribed. DC instructions indicate that the resident has had drains placed inside the wound in order to prevent collection of fluid which could lead to infection. Clarification for removal of internal drains in wound will be addressed by the providers. Drains are not visible The laceration is located on the lateral aspect of the right lower leg from knee level to mid calf area, and measures 112 cm L x 0.2 cm W. There are 24 intact sutures present. Scant amount of serosanguineous drainage present during dressing change noted. Periwound intact with mild bruising present. The area is tender to touch.Review of R102's Nurse Progress Note, dated 1/27/26, reflected, Resident continue on Clindamycin HCl[antibiotic] Capsule 300 MG every 8 hours (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	for cellulitis[infection] for 10 Days.During an interview on 2/4/26 at 9:25 a.m. Nursing Home Administrator (NHA) A reported the facility completed a Facility Reported Incident for R102's fall on 1/9/26. This surveyor requested the complete investigation for review. During an interview and record review on 2/4/26 at 9:35 a.m. NHA A provided a folder and verified was the complete investigation for R102 fall on 1/9/26.Review of R102 Care Plans, dated 1/2/26, reflected, [named R102] has a functional ability deficit and requires assistance with self care/mobility R/T[related to]: morbid obesity, weakness with need for assist with safe transfers.BED MOBILITY: Resident is Dependent This is including rolling side to side, lying to sitting on side of bed and sitting to lying. 2 person assist.Review of R102 Medication Administration Record, dated 12/1/25 through current, reflected increased use of narcotic pain control and anxiety medications after R1/9/26 fall.During a telephone interview on 2/4/26 at 1:01 p.m., Certified Nurse Assistant (CNA) D reported R102 fell out of bed while she was assisting R102 with incontinence care. CNA D reported had rolled R102 away from her and R102 fell out of bed, that was between knee and hip height, and began screaming of pain in right leg. CNA D reported immediately alerted nurse and other staff of fall. CNA D reported completed written witness statement and received education to follow Kardex and to roll residents towards not away during care. CNA D reported R102 Kardex indicated one assist with hygiene prior to fall so thought R102 only required one assist. During an interview on 2/4/26 at 2:40 p.m., NHA A again verified facility had provided this surveyor with complete investigation of R102 fall on 1/9/26 and he did not have any written witness statements. Director of Nursing (DON) B was present and reported had additional documents and would provide. During an interview and record review on 2/4/26 at 2:48 p.m., DON B provided Past Non-Compliance binder for R102 fall with alleged compliance date of 2/6/26(after current date 2/4/26 with no time of compliance). DON B reported the facility failed to follow the Care Planned interventions that led to R102 fall with injury. DON B reported that was the complete investigation and verified did not include any written statements. During a telephone interview on 2/4/26 at 3:03 p.m., Licensed Practical Nurse (LPN) E reported was working morning of 1/9/26 when R102 had fallen from the bed but was working on a different unit. LPN E reported was alerted of R102 fall and entered R102 room and observed R102 face down on floor next to the bed that was about waist height. LPN E reported CNA D had reported R102 had fallen out of bed while providing care to R102 with one assist. LPN E reported CNA D had reported R102 was assist of one with bed mobility and reported did not verify. LPN E reported educated CNA D to always roll residents toward self and not away during care. LPN E reported observed blood on floor but was unsure where it was coming from and advised staff to make R102 comfortable on the floor and Emergency Services were called and arrived quickly. LPN E reported R102 was complaining of leg pain. During an observation and interview on 2/4/26 at 3:30 p.m., R102 was lying in bed with lights off and door partially open and appeared calm, pleasant and well groomed. R102 pleasantly declined to speak of fall and requested to allow her to rest. During an interview on 2/4/26 at 3:45 p.m., DON B reported would expect staff to follow Care Plans and Kardex. DON B reported R102 fall occurred on 1/9/26 and had intervention added to Care Plans 1/2/26 for two person assist with bed mobility because had increase difficulty with one person mobility in bed. DON B reported would expect staff to check prior to care and would also expect if providing care to residents in bed with one person assist would expect staff to roll residents towards them and not away.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2722185Based on observation, interview, and record review the facility failed to prevent significant medication errors for one resident (#101) out of three residents reviewed for medication errors. Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE], reflected R101 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included insulin dependent diabetes, anxiety and depression. The MDS reflected that R101 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact.Review of the complaint submitted to the State of Michigan, dated 1/21/26, reflected the facility allegedly failed to administer insulin according to the physician orders.Review of the Electronic Medical Record on 1/30/26 reflected that R101 was not currently at the facility and had been hospitalized .During a telephone interview on 1/30/26 at 3:58 PM, R101 daughter F reported was very unhappy with care at the facility and verified had received several calls from the facility including insulin medication error and several recent admissions to the hospital. R101 daughter F reported R101 was currently at admitted to hospital related to urinary tract infection. During a telephone interview on 1/30/26 at 4:25 PM, Registered Nurse (RN) G reported R101 did have insulin error and RN G reported had accidentally given fast acting insulin instead of long acting and reported to DON immediately. RN G reported received education after incident and R101 was transferred to the hospital with no negative outcome.Review of R101 Nurse Progress Note, dated 11/5/25 at 7:47 PM, reflected, Resident returned back to facility via stretcher and 2 EMS[Emergancy Medical Service] at 1935 [7:35 p.m.]. EMS reports resident blood glucose never dropped below 100 and was uneventful. Per paperwork no changes to medications or new orders. Resident request this RN report to daughter [named] that she had returned back to the facility. Resident is happy to be home.Review of R101 Physician Note, dated 11/6/25, reflected, Chief Complaint / Nature of Presenting Problem: DM [Diabetes Mellitus] Emergency department evaluation History of Present Illness: [AGE] year-old female with chronic medical conditions including obstructive sleep apnea, breast cancer, diabetes mellitus type 2, hypertension and cholecystitis who is here for long-term stay. Staff feels patient is overall stable.Staff notes patient is a baseline mentation. Patient feels good no complaints staff notes patient was transferred to the emergency department yesterday after mis-administration of 52 units short acting insulin.During an interview on 1/30/26 at around 5:00 p.m. Director of Nursing (DON) B reported R101 did not have any Incident accident reports and verified had a medication error recently and would follow up with surveyor.During a telephone interview on 1/30/26 at 5:15 p.m., R101 son H reported was currently in the hospital with R101 who was admitted for urinary tract infection with plans to discharge back to the facility with hospice services soon. R101 son H verified R101 had been transferred to hospital in November after large amount of fast acting insulin had been given to R101 instead of long-acting insulin. Review of R101 Medication and Treatment Errors and Omissions document, dated 11/5/25 at 10:00 a.m., provided 1/30/26 at 5:32 p.m., reflected R101 was administered wrong medication and wrong strength/quantity. The document reflected R101 was administered 52 units of Novolog insulin (short acting) instead of long-acting insulin.During an observation and interview on 2/4/26 at 1:45 p.m., R101 was lying in bed with R101 son H at bedside. R101 appeared non-verbal with eyes open but non-responsive to questions. R101 son H verified R101 now has hospice services. During an interview on 2/4/26 at 5:10 p.m., DON B reported R101 would expect staff to follow physician orders including medication orders. DON B reported if a medication error occurs would expect nurse notifies DON along with Physician immediately.