

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/12/2026
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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2986758 Based on observation, interview, and record review, the facility failed to develop fall interventions and implement fall interventions for one (R30) out of three reviewed for fall care plans. Findings include: Review of the medical record reflected R30 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included muscle wasting and atrophy, Aspasia following cerebral infarction (stroke). The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/29/26, reflected R30 scored 6 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 6/10/26 at 12:51 pm, R30 was observed seated in a wheelchair in the dining room with both feet resting on the foot pedals. The wheelchair did not have anti-tippers in place. During an interview conducted at the same time, R30's Family Member J reported that R30 had experienced falls at the facility, including one that resulted in a bump to his forehead. Review of an incident report dated 3/22/26 revealed that R30 sustained a fall in the therapy room after pushing backward while seated in his wheelchair, causing the wheelchair to tip backward. The care planned intervention for this fall, per R30's Fall care plan stated, Anti tippers applied to wheelchair with an initiation date of 03/24/2026. In an observation on 6/11/26 at 8:05 am, R30 was observed in bed. R30's call light was draped over his bedside table, out of R30's reach. Review of R30's Fall care plan indicated the following; Put the call light within reach and encourage him to use it for assistance as needed with an initiation date of 03/13/2026. Review of an incident report dated 4/16/26 at 6:05 am revealed that R30 was found sitting on the floor beside the bed with a laceration above his lip. Review of R30's Fall care plan revealed no added intervention were implemented after the 4/16/26 fall. In an interview on 6/11/26 at 11:43 AM, Director of Nursing (DON) B reported that she had recently taken over the position of DON at the facility. DON B stated that the process for falls that she would be implementing would be for nursing staff to put in an immediate intervention after a resident sustains a fall, which is something she is providing ongoing education for. DON B stated that the expectation for care planned intervention would be that that staff follow the interventions that are put into place as stated on the care plan.		

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 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** Based on observation, interview, and record review the facility failed to timely obtain diagnostic imaging following a residents fall in one (Resident #50) out of 3 reviewed for falls resulting in the delay in treatment for a left wrist fracture, uncontrolled pain, and loss of function. Findings include: Review of the medical record reflected R50 was admitted to the facility on [DATE], with diagnoses that included repeated falls. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 5/27/26, reflected R50 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 6/10/26 at 11:18 AM, R50 was observed being wheeled out of her room by a Certified Nursing Assistant. R50 had a purple cast on her left arm. Review of a Nurses Note dated 5/21/2026 9:46 PM, CNA (certified nursing assistant) informed writer at 2015 (8:15 pm) that resident (R50) was observed on the floor of her room. Upon entering room, writer observed resident sitting on her buttocks in front of the closet. The bathroom door was open, and the resident's personal walker was in the bathroom. She had previously requested to use it and was notified that therapy needed to evaluate her first and to ask for assistance prior to transferring. Resident verbalized understanding of these instructions. Resident c/o (complaining of) pain in left wrist rated 9/10 using numeric scale. Left wrist is swollen, discolored, and noticeably misaligned. provider contacted, images of resident's wrist sent with incident details. Provider conducted video call, and sent orders for xray, and pain medication. The resident remains in the dayroom for close supervision. Review of a Provider note dated 5/21/26 at 9:01 PM revealed Nursing reports resident was ambulating without assist and fell causing pain and swelling to left wrist with decreased ROM (range of motion). Left wrist has obvious swelling/deformity noted. Nursing reports resident reports it is sore and hurts to move. She has tylenol scheduled TID (three times a day) but hasn't received tonight yet Ibuprofen 600mg PO Q6H x 2 days for pain/swelling. STAT XR Left hand/wrist/arm up to elbow. Review of Physician orders reveal an order dated 5/22/2026 at 00:47 x-ray of left hand, wrist, forearm up to elbow STAT for pain, swelling. The order for a stat x-ray was entered nearly four hours after the Physicians verbal order for the stat x-ray. Review of a Nurses Note dated 5/22/2026 at 07:02 stated at 6:30 am this writer telephoned [x-ray company] x-ray regarding x-ray dispatcher stated that tech would arrive at facility within 30 min, this writer went into resident's room to assess resident's wrist and hand (L) wrist swollen resident unable to move writst [sic] this writer telephoned Np (Nurse Practitioner) regarding time of x-ray and resident unable to move wrist new order received to transfer resident to hospital [sic]. On 6/11/26 at 8:18 am, R50 was observed in her room in room. R50 recalled the details of the fall stating that she was instructed to use her call light, however, took herself to the bathroom and sustained a fall on her way out of the bathroom. R50 confirmed that she received Tylenol for pain after the fall, however, did not get sent out to the hospital until the next morning and her arm hurt like hell all night. R50 confirmed that her left wrist was fractured as a result of the fall. In an interview on 6/11/26 at 12:00 PM, Director of Nursing (DON) B stated that the expectation for a stat x-ray would be to have it completed within 4 hours. DON B acknowledged that there was a delay in obtaining the x-ray and explained that the nurses did not communicate the need for a stat x-ray order during shift change. Both nurses received education relating to the expectation of communication during shift change.		