STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235599	A. Building B. Wing	04/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carriage House Nursing and Rehabilitation	2394 Midland Road Bay City, MI 48706

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** Based on interview and record review, the facility failed to ensure appropriate supervision for one resident (Resident #1) of three residents reviewed for falls, resulting in three unwitnessed falls causing an elbow skin tear and a hand laceration, resulting in a hospital visit for sutures. Finding include:Resident #1:On 4/6/2026, at 12:10 PM, a record review of Resident #1's electronic medical record revealed an admission on [DATE] with diagnoses that included Wedge compression fracture of T7-T8 Vertebra, fracture of first thoracic vertebrae, Vascular Dementia and Anxiety. Resident #1 had a Brief Interview for Mental status (BIM) assessment on 3/26/2026 which resulted the resident had severely impaired cognition. Resident #1 required extensive assistance with Activities of Daily Living (ADL's).A review of the Fall Assessment Date: 3/30/2026 . revealed the resident was High Risk for falls.A review of the I am at risk for falls care plan related to: Vascular Dementia, history of falls with injuries prior to admission, history of CVA (stroke), new to surroundings and potential medical side. Resident self transferring in deconditioned state. Date Initiated: 03/19/2026 Revision on: 03/27/2026 My Interventions will minimize my risk of serious injury related to falls. Date Initiated: 03/19/2026 Interventions Have commonly used articles within easy reach Date Initiated: 03/19/2026 Hip protectors on at all times as I will allow. Date Initiated: 03/30/2026 RESOLVED: Keep resident within sight of staff while awake and in wheelchair Date Initiated: 03/20/2026 Revision on: 03/30/2026 Maintain bed at transfer height as resident will tolerate. Date Initiated: 03/19/2026 Observe for signs and symptoms of medication side effects and report to Physician as needed. Date Initiated: 03/19/2026 Reinforce the need to call for assistance Date Initiated: 03/19/2026 RESOLVED: staff to offer bathroom assist in restroom q (every) two hours and PRN (as needed) When resident is up in his chair, as him to come out for an activity or where staff can visualize him. Date Initiated: 03/21/2026 Revision on: 03/30/2026 Resolved Date: 03/30/2026. A review of Resident #1's Incident reports, while in the facility, revealed the following falls: Fall Date: 3/20/2026 14:45 (2:45 PM) Incident Location: Resident's Room . Called to residents' room where staff had observed resident to be on the floor by his bathroom in his room. Resident Description: Resident unable to describe what happen .Was this incident witnessed: N (no) Description: Resident assessed and assisted into bed to complete skin assessment by writer and 2 staff members. See notes for injuries. Root cause: Resident is newly admitted and confused . Immediate Intervention: When resident is up in chair offer activities and encourage and request resident to come out to an activity and/or come to an area where he can be more closely visualized . Injury Type Bruise . Left elbow Skin Tear . Right elbow . Mental Status Orientated to Person . was the only box checked. Predisposing Physiological Factors Confused Impaired Memory were check marked. Fall Date: 3/26/2026 15:45 (3:45 PM) Incident Location: Resident's Room . Resident observed laying on floor near his dresser head towards sink. Back brace and c-Colloar on. Right palm had a deep jagged cut. Minimal bleeding. Resident had no complaints of pain or discomfort. On call md notified, orders to send to ER for evaluation and treatment . Resident unable to give Description Was this incident witnessed: N (no) Immediate Action Taken . palm wound cleansed and ABD with kerlix applied (bandage with wrapping). Root Cause: (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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(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	Confusion Self transferring. Immediate Description: Sent to ER for eval and treat and treat r/t cut on hand. Remove foot pedals on w/c when in room . Injury Type Laceration Right hand (palm) . Fall Date: 3/30/3036 08:45 (am) Incident Location: Resident's room . Nurse was sitting at desk and heard a loud crash. Went down the hallway and found resident on the floor. His head was towards door. Feet towards bed. He was lying next to the bathroom door. He was wearing nonskid socks and c-Collar and brace were on. Resident was able to move all extremities on his own and did not complain of any pain. He did not appear in any distress. Resident Description: resident stated he fell, he was unable to give any further description Was this incident witnessed: N (no) . Resident assessed for injuries, none noted at this time. MD (physician) notified, UCN notified, Spouse was also notified. Root Cause: confusion/Dementia. Immediate interventions: hip protectors for safety. No injuries observed at time of incident . A review of the AFTER VISIT SUMMARY 3/26/2026 revealed 2 sutures have been placed in your hand . Review the attached information Fall Prevention . A review of the progress notes revealed the resident discharged to ER on [DATE] for their Covid-19 symptoms and did not return to the facility. On 4/6/26, at 12:30 PM, the Director of Nursing (DON) was interviewed regarding Resident #1's falls while they were in the facility. The DON offered that all three falls were unwitnessed and in the resident's room. The DON was asked what interventions the facility put in place to ensure the resident's safety for each fall and the DON explained:For the 3/20/2026 fall, the intervention was for the resident to go to activities and to sit at the desk when up. For the 3/26/2026 fall, the DON explained they removed the foot pedals from the residents wheelchair and the resident was sent to the ER for the cut on his hand.For the 3/30/2026 fall, the DON explained the resident was in transmission based precautions for Covid-19 infection and was isolated to their room. They couldn't bring the resident to the nursing desk anymore so the hip protectors were placed. The DON was asked if they were aware Resident #1 had a risk of falls and the DON offered, the resident had a fall at his assisted living, yes. The DON was asked if the facility provided more supervision such as a someone sitting at their bedside keeping a close eye on the resident and the DON stated, if they had that availability they would but they did increase visualization and going in his room more often. The DON was asked if the resident admitted with the back fractures from falls and the DON offered, yes.