STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235360	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Manor Care Center	151 2nd Street Spring Arbor, MI 49283

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a homelike environment for up to 84 residents residing at the facility, resulting in residents being subjected to numerous loud overhead paging throughout the day. Findings: During an observation on 3/3/25 at 8:31 AM on North 2 unit, during initial resident screening heard very loud overhead speaker announcement made through facility, [named staff] to dietary. During an observation on 3/3/25 at 8:41 AM, overheard very loud overhead announcement, Maintenance to back hall for delivery. During an observation on 3/03/25 at 9:12 AM, overheard very loud overhead announcement throughout facility. During an observation on 3/03/25 9:at 21 AM , overheard very loud overhead announcement throughout facility, Wander risk front lobby. During an observation on 3/03/25 at 9:34 AM, resident # 35 granted permission to enter room and reported door was closed because overhead paging was so loud and was annoying to her. During an observation on 3/03/25 at 9:39 AM, overheard very loud overhead announcement throughout facility, [name] to front office. During an observation on 3/03/25 at 9:45 AM, overheard very loud overhead announcement throughout facility. During an observation on 3/03/25 at 10:02 AM, overheard very loud overhead announcement throughout facility, Doctor call . During an observation on 3/03/25 at 12:12 PM, overheard very loud overhead announcement throughout facility, beep noise, followed by sound of phone hanging up. During an interview on 3/03/25 at 12:52 PM, R20 family reported visits facility often and reported have observed R20 startled by overhead announcement because they are so loud. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 3/03/25 at 1:07 PM, overheard very loud overhead announcement throughout facility. During an observation on 3/03/25 at 1:57 PM, overheard very loud overhead announcement throughout facility. During an observation on 3/03/25 at 2:02 PM, overheard very loud overhead announcement throughout facility. During observations on 3/4/25, overheard several overhead announcements. During an observation on 3/05/25 at 9:09 AM, overheard very loud overhead announcement throughout facility, [stated name] to front office. Review of the, Phone extentions for ., provided to survey team 3/3/25, also included staff contact information. The Document indicated in bold, red print, TO PAGE OVERHEAD - DIAL *460 . During an interview on 3/05/25 at 9:30 AM, Nursing Home Administrator (NHA) A reported reviewed General Maintenance Policy yesterday that spoke about, Homelike Environment that included limiting overhead announcements and verified facility paged too frequently overhead and should limit to emergencies only. NHA A reported planned to limit overhead announcements starting today (3/5/25). NHA A reported he had just tuned out noise but agreed that frequent overhead paging was not homelike.

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of transfer/discharge for one (R92) of two reviewed. Findings include: Review of the medical record revealed R92 was admitted to the facility on [DATE] with diagnoses that included dementia, anxiety, and multiple rib fractures. Review of the Health Status Note dated 12/31/24 revealed R92 was transferred to the emergency room for evaluation due to behaviors and refusals of care. R92 did not return to the facility. Review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/24 revealed R92 had an unplanned discharge with return not anticipated. The medical record did not indicate a written notice of transfer/discharge was provided. In an interview on 03/05/25 at 10:20 AM, Director of Nursing (DON) B reported they were not able to locate a written notice of transfer/discharge for R92.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written notice of bed hold policy upon transfer for one (R92) of two reviewed. Findings include: Review of the medical record revealed R92 was admitted to the facility on [DATE] with diagnoses that included dementia, anxiety, and multiple rib fractures. Review of the Health Status Note dated 12/31/24 revealed R92 was transferred to the emergency room for evaluation due to behaviors and refusals of care. R92 did not return to the facility. Review of the Discharge Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/31/24 revealed R92 had an unplanned discharge with return not anticipated. The medical record did not indicate a written notice of bed hold policy was provided upon transfer. In an interview on 03/05/25 at 10:20 AM, Director of Nursing (DON) B reported they were not able to locate a written notice of bed hold policy upon transfer for R92.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure enteral nutrition was administered as ordered and weights were monitored for two (R33 and R41) of four reviewed. Findings include Resident #33 (R33) Review of the medical record revealed R33 was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing) and dementia. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/3/24 revealed R33 scored 3 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of Physician's Order dated 11/27/24 revealed an order for Jevity 1.5 cal (tube feeding formula) run at 55 milliliters (mL) per hour continuous via PEG tube (percutaneous endoscopic gastrostomy/feeding tube) for total of 1320 mL of formula per day. On 03/03/25 at 09:27 AM, R33 was observed lying in bed. An empty bottle of Jevity 1.5 cal was hanging from the tube feeding pump. The pump was off. At 9:43 AM, a new bottle of Jevity 1.5 cal was observed sitting on R33's nightstand. The empty bottle had been discarded. R33 did not have the tube feed formula running as ordered. At 10:23 AM, the new bottle was still on the nightstand and R33 did not have the tube feed formula running as ordered. On 03/03/25 at 11:41 AM, R33's Jevity 1.5 cal was started after not receiving the tube feed for over 2 hours. Review of the Weight Change Note dated 2/28/25 revealed R33's weight was 150.5 pounds which was a significant weight gain and was over R33's usual body weight of approximately 140 pounds. The note revealed new weight to be obtained for confirmation .Possible need for reduction to total formula pending confirmation of weight gain .Will reassess for quarterly next week and make updates. R33 did not have another weight obtained to confirm the significant weight gain. In an interview on 03/05/25 at 10:32 AM, Registered Dietitian (RD) E reported R33 receives enteral nutrition continuously and they were not aware of any reason as to why R33 would have not received their nutrition for over two hours on 3/3/25. RD E reported R33's last weight obtained was on 2/27/25. RD E reported they asked for a re-weigh which they would have expected to be obtained by now. RD E reported they were completing R33's quarterly evaluation today and would ask staff to weigh R33. In an interview on 03/05/25 at 11:22 AM, Director of Nursing (DON) B reported re-weights should be completed the same day or next day. Resident #41 (R41) Review of the medical record revealed R41 admitted to the facility on [DATE] and readmitted [DATE] with diagnoses that included dysphagia and moderate protein-calorie malnutrition. The Minimum Data Set (MDS) with an Assessment Reference date (ARD) of 11/23/24 revealed R41 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and had a feeding tube. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Physician's Order dated 10/8/24 revealed an order for monthly weights. R41's last documented weight was on 1/6/25 at 123.5 pounds. Review of the Physician's Order dated 12/31/24 revealed an order to run Jevity 1.5 cal at 70 mL per hour continuous for 16 hours for a total of 1120 mL of formula daily. The tube feeding was scheduled to begin each day at 6:00 PM and end at 10:00 AM. On 03/03/25 at 09:46 AM, R41 was observed in bed with a 1000 mL bottle of Jevity 1.5 cal hanging and running at 70 mL per hour. The bottle was not dated or timed. On 03/03/25 at 10:27 AM, R41's tube feeding pump indicated they had received 930 mL total of Jevity 1.5 cal. On 03/03/25 at 11:38 AM, R41 was observed awake in bed. The tube feeding was turned off. At this point, R41 would have received approximately 1010 mL of Jevity 1.5 cal which was not the ordered 1120 mL . On 03/04/25 at 09:23 AM, R41 was observed asleep in bed with a 1000 mL bottle of Jevity 1.5 cal running at 70 mL per hour. The bottle was dated 3/3/25 at 6:00 PM. The tube feeding pump reflected a total amount fed as 1820 mL, indicating the pump most likely was not reset when the tube feeding was started on 3/3/25 at 6:00 PM In an interview on 03/04/25 at 09:43 AM, Licensed Practical Nurse (LPN) F reported R41 started their tube feeding each day at 6:00 PM and then stopped the tube feeding the next morning at 10:00 AM. When asked about the total amount administered during that time, LPN F calculated the total to be 880 mL. When asked if the pump indicated the total milliliters administered, LPN F stated I don't think so. LPN F then entered R41's room to observe the pump. LPN F reported the pump indicated R41 had received 1858 mL and reported the pump must not have been reset when the tube feeding was started the prior evening. LPN F reported R41 was due to come off the tube feeding at this time. LPN F reported it appeared R41 had received approximately 820 mL because there was a little less than 200 mL left in the bottle that was dated 3/3/25 at 6:00 PM. LPN F reported R41 usually only received one bottle of Jevity 1.5, but they usually had to discard some when the tube feeding was disconnected each day at 10:00 AM. On 03/04/25 at 10:32 AM, LPN F reported R41 was taken off the tube feed already. LPN F reported they left the bottle hanging on R41's pump. The 1000 mL bottle of Jevity 1.5 cal was observed with approximately 180 mL left in the bottle. On 3/4/25 at 12:58 PM, R41's tube feeding bottle was still hanging with approximately 180 mL of formula left in the bottle. R41 did not receive the ordered 1120 mL of feeding formula. On 03/05/25 at 09:15 AM, R41 was observed asleep in bed. R41's tube feed was observed as a Jevity 1.5 cal 1000 mL bottle (33.8 ounces/1.05 quarts/1 liter) dated 3/4/25 at 6:00 PM. The tube feed was running at 70 mL/hour. According to the pump, the total administered at that time was 815 mL. In an interview on 03/05/25 at 09:17 AM, LPN F reported they usually turned off R41's tube feeding between 9:45 AM and 10:00 AM. LPN F reported at that time, R41 would have received just under 880 mL of tube feeding formula, which is what LPN F calculated as being needed. On 03/05/25 at 09:53 AM, LPN F reported they hung R41's tube feed formula on 3/4/25 at 6:00 PM and cleared the pump to zero. LPN F reported the tube feeding formula bottle hanging was the one that they personally hung on (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/4/25 at 6:00 PM. LPN F was observed turning off R41's tube feeding as scheduled for 10:00 AM. The pump was observed to have administered 861 mL of feeding formula. The feeding formula bottle had approximately 200-250 mL of formula remaining in the bottle. R41 did not receive the ordered 1120 mL of feeding formula. In an interview on 03/05/25 at 10:32 AM, RD E reported R41 should be weighed monthly and agreed the last documented weight for R41 was 1/6/25 at 123.5 pounds. RD E reported R41 was ordered to receive a total of 1120 mL of Jevity 1.5 cal over a period of 16 hours. RD E reported the facility previously had 1500 mL bottles of Jevity 1.5 cal, but if they were currently using the 1000 mL bottles, R41 would require a second bottle to receive the ordered total of 1120 mL. RD E went to R41's room and confirmed there was still approximately 200-250 mL of formula remaining in the bottle. On 03/05/25 at 10:44 AM, Jevity 1.5 cal was observed in the medication room. There were 1000 mL bottles available. LPN F reported they did not have 1500 mL bottles in the medication room.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure monitoring of psychotropic medications was completed as ordered for one (Resident #74) of five reviewed. Findings include: Review of the medical record reflected Resident #74 (R74) admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included bipolar disorder, schizophrenia, anxiety disorder, other recurrent depressive disorders and bipolar type schizoaffective disorder. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/9/25, reflected R74 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). A Physician's Order, dated 4/10/24, reflected orthostatic blood pressures (monitoring for blood pressure changes that occur when transitioning from lying down to standing) were to be obtained monthly for psychotropic medication monitoring. Further review of Physician's Orders reflected R74 routinely received Buspirone (medication used to treat anxiety), Venlafaxine (antidepressant medication) and Risperidone (antipsychotic medication). A Progress Note for 10/11/24 reflected R74's blood pressure was obtained while lying down, sitting and standing. A Progress Note for 12/11/25 reflected R74's blood pressures were obtained while lying down and after standing for one minute and two minutes. A Progress Note for 2/11/25 reflected R74's blood pressures were obtained while sitting down and while standing. The medical record was not reflective of orthostatic blood monitoring for 11/2024 or 1/2025. On 03/05/25 at 1:39 PM, a request was made for R74's orthostatic blood pressures for the previous six months. During an interview on 03/05/25 at 1:55 PM, Director of Nursing (DON) B reported there was documentation of R74's blood pressures but not while lying, sitting and standing. DON B reported R74 was able to stand, but it was possible they were refusing to stand (for blood pressures). DON B stated there was no documentation of refusals. On 03/05/25 at 2:10 PM, DON B reported they located orthostatic blood pressures for 10/11/24 and 12/11/24 but were not able to locate any additional. DON B reported the purpose of orthostatic blood pressures was for medication monitoring.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based observation, interview, and record review the facility failed to ensure proper storage of medication in one of three medication carts and one medication room of three reviewed for medication storage. Findings include: During an observation and interview on 3/04/25 at 12:32 PM, Licensed Practical Nurse(LPN) R unlocked the South 1 medication cart. Located in the medication cart was an open resident Albuterol 90mcg, dated on box 2/21/24. LPN R verified date and inhaler was open and reported should have been discarded 12 months after open date. LPN R verified the LOT#(batch number) on the inhaler and the box were not the same and reported should match. Observed open bottle of Timolol Mateate eye drops with no open date. LPN R verified eye drops open and should have been labeled with open date. Observed Glucose Gel in cart with manufacturer expiration date of 7/2024. LPN R reported planned to discard. During an interview on 3/05/25 at 11:45 AM, Director of Nursing (DON) B reported would expect nursing staff to date medications when opened. DON B reported Pharmacy and Unit Managers routinely check medications carts for outdated items. During an observation and interview on 3/05/25 at 1:27 PM, Registered Nurse (RN) S unlocked the South 2 medication room. Several (more than 20) yellow Heparin 100units/1 ml syringes were observed in bin with manufacturer expiration date of 6/30/23. RN S reported was unsure what they were used for and reported plan to dispose. Unit Manager T arrived and verified Heparin syringes should have been discarded according to manufacture date 6/30/23.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment effecting 84 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage. Findings include: On 03/03/25 at 07:30 A.M., An initial tour of the food service was conducted with Dietary Aide C. The following items were noted: Ice [NAME] were observed protruding from the Walk-In Freezer Freon refrigerant inlet supply lines. The Walk-In Freezer ceiling surface was also observed with accumulated ice droplets, adjacent to the refrigeration fan unit. The Can Opener Assembly was observed soiled with accumulated and encrusted food residue. The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. The Microwave Oven door face plate was observed (etched, scored, particulate, corroded). The damaged face plate surface measured approximately 0.5 - inches-wide by 4-6 inches-long. The 2022 FDA Model Food Code section 4-501.11 states: (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate FOOD when the container is opened. On 03/03/25 at 08:35 A.M., An initial tour of the food service was continued with Director of Food Services D. The following items were noted: The three-compartment sink rinse and sanitizer basin faucet assembly was observed leaking water from the chemical diversion valve. Director of Food Services D indicated he would contact Ecolab for necessary repairs as soon as possible. The 2022 FDA Model Food Code section 5-205.15 states: A plumbing system shall be: (A) Repaired according to LAW; and (B) Maintained in good repair. One of two Dish Machine Room overhead spray arm valve assemblies were observed soiled with accumulated and encrusted food residue. Director of Food Services D indicated he would have dietary staff thoroughly clean and sanitize the soiled spray arm valve assembly as soon as possible. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	West Wing Dining Room: The microwave oven interior and exterior surfaces were observed soiled with accumulated and encrusted food residue. Director of Food Services D indicated he would have dietary staff thoroughly clean and sanitize the soiled microwave oven as soon as possible. The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. On 03/05/25 at 08:30 A.M., Record review of the Policy/Procedure entitled: Equipment dated 5/2014 revealed under Policy Statement: It is the center policy that all food service equipment is clean, sanitary, and in proper working order. Record review of the Policy/Procedure entitled: Equipment dated 5/2014 further revealed under Action Steps: (1) The Food Services Director will ensure that all equipment is routinely cleaned and maintained in accordance with manufacturer directions and training materials. (4) The Food Services Director ensures that all non-food contact equipment is clean. On 03/05/25 at 08:45 A.M., Record review of the Policy/Procedure entitled: Environment dated 5/2014 revealed under Policy: It is the center policy that all food preparation areas, food services areas, and dining areas will be maintained in a clean and sanitary condition. Record review of the Policy/Procedure entitled: Environment dated 5/2014 further revealed under Action Steps: (1) The Food Service Director will ensure that the physical plant is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation.

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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** Based on observation, interview and record review, the facility failed to maintain complete and accurate medical records for one (Resident #90) of 18 reviewed. Findings include: Review of the medical record reflected Resident #90 (R90) was admitted to the facility on [DATE], with diagnoses that included atrial fibrillation, retention of urine and urinary tract infection. R90's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/4/25, was in progress (not complete). On 03/03/25 at 9:56 AM, R90 was observed seated in a recliner, in their room. R90 reported they had open areas on their buttocks, since admitting to the facility. R90 believed cream and a bandage were being applied to the open areas. A Progress Note for 2/26/25 at 5:54 PM reflected R90 admitted from the hospital following a urinary tract infection and atrial fibrillation. Open areas were noted to R90's bilateral (both sides) buttocks, according to the note. The admission skin assessment for 2/26/25 reflected R90 had pressure ulcers to their bilateral buttocks. There was no further documentation pertaining to the pressure ulcers, including wound measurements, wound staging or wound characteristics. A Physician's Order with a start date of 2/26/25 reflected the open area on the bilateral buttocks was to be cleansed with normal saline and patted dry. Barrier cream was to be applied, then covered with a sacral dressing, every shift and as needed. In an interview on 03/04/25 at 3:52 PM, Licensed Practical Nurse (LPN) N reported being unsure of the appearance of R90's pressure ulcers, stating R90's treatment was not scheduled on their shift. Upon review of the treatment order, LPN N reported R90's treatment was for cream only. LPN N then identified the treatment order included application of a dressing. LPN N stated they had not yet performed R90's treatment that day. The March 2025 Treatment Administration Record (TAR) reflected R90's bilateral buttocks treatment was signed out as completed for the 6 AM to 6 PM shift on 3/4/25 by LPN N. The Medication Administration Audit Report reflected LPN N signed the treatment out as being completed on 3/4/25 at 8:24 AM. During an interview on 03/05/25 at 10:45 AM, Unit Manager (UM) P reported assessing R90's skin upon admission to the facility. UM P stated R90's pressure ulcer presented as a stage two (partial-thickness loss of skin, presenting as a shallow open ulcer) upon admission. UM P reported they assessed R90's pressure ulcer on 3/4/25, and it was healed. UM P reported when completing their weekly wound assessments, they compared their assessment from the week prior. A late entry Progress Note for 2/26/25, entered by UM P on 3/4/2025 reflected R90's buttocks was assessed upon admission to the facility. The note reflected there were peeling areas, open areas and several scattered, small open areas, which were in different stages of healing. According to the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235360	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arbor Manor Care Center	151 2nd Street Spring Arbor, MI 49283

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note, stage two pressure ulcers were present upon admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235360	A. Building B. Wing	03/05/2025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During an observation and interview on 3/04/25 at 11:51 AM, Licensed Practical Nurse (LPN) F was preparing medications for resident on North 1 unit. LPN F reported plan to administer insulin via insulin pen. LPN F removed the cap from the Humalog insulin pen and twisted needle on the end of the pen without cleaning rubber tip first with alcohol wipe. During an interview on 3/05/25 at 11:45 AM, Director of Nursing (DON) B reported would expect nurse to clean tip of insulin pen prior to attaching new needle every time. Based on observation, interview and record review, the facility failed to ensure appropriate use of Personal Protective Equipment (PPE-protective garments or equipment designed to protect the wearer from injury or infection) and hand hygiene for Transmission-Based Precautions (TBP-used for patients known or suspected to be infected or colonized with infectious agents) for one (Resident #4) of two reviewed. Findings include: Review of the medical record reflected Resident #4 (R4) admitted to the facility on [DATE], with diagnoses that included congestive heart failure and carrier of Carbapenem-resistant Acinetobacter baumannii (a multi-drug resistant bacteria). The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/9/24, reflected R4 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). A Physician's Order, dated 12/5/24, reflected R4 was on Contact Precautions (a type of TBP) for a multi-drug resistant organism (MDRO). According to the Centers for Disease Control and Prevention (CDC), .Use Contact Precautions for patients with known or suspected infections that represent an increased risk for contact transmission .Use personal protective equipment (PPE) appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning [putting on] PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens . (https://www.cdc.gov/infection-control/hcp/basics/transmission-based-precautions.html) On 03/03/25 at 9:34 AM, PPE was observed hanging on the exterior of R4's room door. A sign for Contact Precautions was posted on the exterior of the door, which reflected two STOP signs and notation of, CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit . On 03/03/25 at 9:34 AM, Licensed Practical Nurse (LPN) I reported R4 was on Contact Precautions for methicillin-resistant Staphylococcus aureus (MRSA-an infection caused by a type of staph bacteria that is resistant to many antibiotics) in their urine, and a gown and gloves were to be worn into R4's room. During an observation on 03/03/25 at 12:02 PM, Certified Nurse Aide (CNA) J entered R4's room with (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235360	A. Building B. Wing	03/05/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a lunch tray. CNA J did not wear PPE into the room and closed the door behind them. CNA J exited the room at 12:02 PM and proceeded to the meal cart in the hallway. On 03/03/25 at 12:04 PM, CNA J reported they would wear gloves when going into R4's room and would wear a gown and gloves if doing perineal care for R4 or anything related to toileting. CNA J stated they were supposed to wear gloves to pass the room tray due to an MDRO in R4's urine. CNA J indicated they forgot to put PPE on prior to passing R4's lunch tray. CNA J also reported they did not perform hand hygiene upon exiting R4's room. On 03/03/25 at 2:30 PM, R4 was observed seated in a recliner, in their room. R4 stated staff only wore a gown and gloves when assisting them in the bathroom. A box of empty pop cans was observed on the lid of the trash can, near the inside of R4's room door, which was designated for disposal of PPE. In an interview on 03/05/25 at 9:36 AM, Director of Nursing (DON) B reported if a resident was on Contact Precautions, a gown and gloves should have been worn any time someone entered the resident's room. In an interview on 03/05/25 at 11:21 AM, Unit Manager (UM) Q reported R4 had a history of an MDRO in their urine, for which staff was to wear a gown and gloves for any care. UM Q indicated they were attempting to determine if R4 was to be on Enhanced Barrier Precautions (EBP-use of gowns and gloves during high-contact resident care activities for residents known to be colonized or infected with a MDRO and/or residents at an increased risk of acquiring an MDRO).