STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235052	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aberdeen Rehabilitation and Skilled Nursing Center	5500 Fort St Trenton, MI 48183

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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 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. Based on observation, interview, and record review, the facility failed to: 1. Properly date-label food in the walk-in cooler and walk-in freezer; 2. Adequately clean surfaces in the kitchen; 3. Consistently ensure the dish machine was operating properly; and 4. Maintain cleanable wall surfaces near the dish machine. These deficient practices had the potential to affect all the residents who consumed from the kitchen resulting in the potential for food-borne illness. Findings include: During tours of the kitchen beginning on 9/9/25 at 8:30 AM with Dietary Manager (DM) G the following was observed: Inside the walk-in cooler a plastic container of feta cheese was dated 8/9/25. DM G stated the opened cheese should be thrown out in seven days. There was an open and undated bag of cinnamon raisin bread. Inside of the walk-in freezer the following items were opened and undated: a bag containing four individual size cheese pizzas and a bag of sausage patties. The stove drip tray was soiled with dried and burnt food debris. DM G said the drip tray was supposed to be cleaned on Sunday. DM G added, I doubt that it was cleaned (yesterday). DM G indicated the dish machine used sodium hypochlorite (a bleach used as a disinfectant) to sanitize dishware and other kitchenware processed through the dishwashing unit. DM G said they use a chlorine test strip to test the dish machine for proper sanitization of the dishware once a week. When the dish machine sanitizing log was requested, none was available. Sections of the walls surrounding the dish machine were observed to be missing tiles. The exposed surfaces were not smooth. Approximately ten square wall tiles, measuring approximately 4 x 4 each, were missing. On 9/10/25 at 3:36 PM, Certified Dietary Manager (CDM) I, who worked at another building but oversees the kitchen operation of the facility being surveyed, incorrectly stated that the facility's dish machine used quaternary ammonium to sanitize dishware. CDM I confirmed and agreed with DM G that the dish machine was tested for proper sanitization once weekly. CDM I stated that if the dish machine was not tested prior to each use that we don't have a guarantee that it was properly sanitizing the dishware. CDM I acknowledged that the walls with missing tiles were not easily cleanable. On 9/11/25 at 11:42 AM, the Regional Director of Operations said opened food items should be dated. According to the 2013 FDA Food Code:Section 3-101.11, Safe, Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under S 3-601.12, honestly presented. Section 4-204.117 Warewashing Machines, Automatic Dispensing of Detergents and Sanitizers. (B) Incorporate a visual means to verify that detergents and sanitizers are delivered.Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (C) nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. Section 4-602.13, Nonfood-Contact Surfaces, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. Section 6-201.11 Floors, Walls, and Ceilings. Except as specified under S 6-201.14 and except for antislip floor coverings or applications that may be used for safety reasons, floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable.

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 0839 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ staff that are licensed, certified, or registered in accordance with state laws. Based on interview and record review, the facility failed to ensure proper use of the legally protected professional designation of Registered Dietitian. Findings include:On 9/9/25 at 3:00 PM, the facility provided survey prep book was examined and revealed that dietitian H was listed as the Registered Dietitian (RD) that worked at the facility. However, the RD credentials available in the survey prep book were for RD J. On 9/9/25 beginning at 3:49 PM the Regional Director of Operations (RDO) D was interviewed about dietitian H. RDO D acknowledged that dietitian H was not a Registered Dietitian, but RD J, who worked at another building, was a Registered Dietitian and supervised dietitian H. RDO D added that RD J does not have to be physically in the building and It has never been a problem before. On 9/9/25 at 4:05 PM during an interview, Human Resources (HR) K said that dietitian H completed a Coordinated Undergraduate Program at a local university September 2018 but had not obtained Registered Dietitian status. HR K stated, 100% I would know if she obtained a RD status. On 9/10/25 at 4:08 PM during an interview, RD J said Registered Dietitians are certified through the Commission on Dietetic Registration (CDR). RD J said she oversees the work that dietitian H performs at the facility. RD J said dietitian H completed a dietetic program, but she had not been certified as a registered dietitian. RD J said she was aware that dietitian H was using RD credentials but did not have the authority to use them. RD J acknowledged that she cannot impart her credentials on anyone and that the CDR was the organization that grants permission for an individual to use RD credentials. On 9/11/25 at 8:33 AM, dietitian H said she was eligible to become a RD and has been using RD credentials for six years but never put thought into if this was a concern. On 9/11/25 at 11:37 AM, RDO D said dietitian H was put into the electronic health record (EHR) computer system as a RD, but that designation was in the process of being corrected. The following dietary progress notes, designated with an electronic signature of RD H (signifying a legally recognized confirmation of accountability), for the following residents were reviewed on 9/9/25 at 3:30 PM:- R8. Dietary note written on 9/2/25.- R17. Dietary note written on 2/13/25- R22. Dietary note written on 9/2/25.- R43. Dietary note written on 8/1/25. On 9/11/25 at 1:10 PM, the electronic signature for the dietary notes referenced above had been changed to RD-EC for dietitian H. On 9/11/25 at 1:26 PM, dietitian H reported that RD-EC refers to Registered Dietitian-Exam Candidate. On 9/11/25 at 1:30 PM, Representative L from the CDR reported that Registered Dietitian-EC was not a standard, recognized credential by the CDR. The RD credential stands alone for those who earned it and cannot be modified or used for those who have not earned it. Representative L provided the following link related to misuse of RD credentials: https://www.cdrnet.org/use-misuse. The CDR affirmed that only individuals who have met the academic and professional requirements, completed supervised practice, and passed the national registration examination administered by the Commission on Dietetic Registration (CDR) can use the Registered Dietitian (RD/RDN) credentials. These credentials are legally protected designations, meaning they cannot be used by anyone without meeting the specific standards set by the CDR.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure consistent proper working order of the walk-in freezer and that the drain line from the commercial ice machine was protected against contamination from sewage or other sources of contamination. These deficient practices had the potential to affect all residents that eat from the kitchen. Findings include:During the initial tour of the kitchen on 9/9/25 at 8:30 AM with Dietary Manager (DM) G the following was observed:- The internal temperature of the walk-in freezer was 11 F (Fahrenheit). The temperature documented on the freezer temperature log, obtained earlier in the day, was 5 F. A four-ounce cup of ice-cream stored in the freezer was observed soft, not frozen solid. DM G said the temperature in the freezer should be zero or below. DM G added that there was a leak in the freon line, and they have been refilling it.- The drain line from the commercial ice machine was observed to not have an airgap (an unobstructed vertical space between the end of the ice machine drain line and the flood rim of the floor drain). DM G said if water backed up from the floor drain, the water could contaminate the ice machine. On 9/11/25 at 11:42 AM, the Regional Director of Operations said kitchen staff should have notified maintenance if the freezer was not operating correctly, and acknowledge a deficiency with the air gap. A review of the 2013 FDA Food Code revealed the following:- Section 3-501.11. Stored frozen foods shall be maintained frozen.- Section 5-402.11. Backflow prevention. Except as specified in paragraph (B), (C), and (D) of this section, a direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to transmit Minimum Data Set (MDS) assessments for three (R15, R17, and R29) of six residents reviewed for resident assessments in a timely manner. Findings include: On 9/10/25 at 3:05 P.M. Registered Nurse (RN)/ MDS Coordinator M, was queried regarding the MDS submissions to CMS. RN M said that she completes the MDS assessments and then puts them in a 'batch' to be sent to MDS. RN M said that she has to obtain a code from the Corporate Director of Operations, RN D. RN M said the following resident's MDS assessments are completed but in batched status and had not been sent or accepted by CMS at this time. We usually send them all at the same time to CMS. Usually twice a month. 1. R15's quarterly MDS assessment dated [DATE] was in 'batch status', due for submission on 8/21/25 but had not been submitted. 2. R17's quarterly MDS was dated 8/9/25 was in 'batch status', due for submission on 8/23/25 but had not been submitted. 3. R29's quarterly MDS was dated 8/7/25 was in 'batch status', due for submission on 8/21/25 but had not been submitted. On 9/11/25 at approximately 12:00 PM, RN D said that RN M could obtain their own code to submit MDS assessments to CMS and was unsure why that had not been done. RN D said it was the facility's expectation that MDS assessments be submitted timely and in accordance with CMS regulations.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review the facility failed to follow the standard of practice for transcribing physician's orders for one (R47) of seven residents reviewed for medication administration resulting in R47 missing nine doses of a multivitamin. Findings include:During observation of medication administration for R47 on 9/10/25 at 8:37 AM with Registered Nurse (RN) C, R47 did not receive a Multi-Vitamin (MVI) with minerals. According to R47's Electronic Health Record (EHR) the physician ordered MVI with minerals once a day on 8/18/25. A review of the R47's Medication Administration Record (MAR) for 9/2025 revealed the order for 'MVI with minerals once a day', did not get transcribed on the September 2025 MAR. On 9/10/25 at 9:56 AM, the Director of Nursing (DON) reviewed R47's EHR and confirmed that R47 and was supposed to get MVI w minerals once a day as of 8/18/25. The DON said the resident had not received the MVI with minerals since 8/31/25 because that order (MVI with minerals once a day) did not get transcribed onto 9/2025 MAR. The DON said the physician's prescription order was accidentally placed under the wrong category in 9/2025 and did not get transcribed on R47's MAR. The DON confirmed that R47 had missed 9 days of the MVI with minerals: 9/1/2025 - 9/09/2025. According to the facility's undated Medication Administration policy: Procedure:3. Medications must be administered in accordance with the orders, including any required time frame.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the facility failed to have a medication error rate below 5%.During the medication administration task three errors were observed from 28 opportunities and subsequently a 10.4% medication error rate. #1. On 9/10/25 at 9:19 AM, Registered Nurse (RN) C was observed to administer R28 medications at the bedside. RN C proceeded to sign out all the medications that were administered. R28 did not receive Ozempic 2 milligram (mg)/3 milliliter (ml)give 0.5 ml subcutaneous injection. Upon inquiry RN C confirmed all the resident's medications were given. R28's Medication Administration Record (MAR) was reviewed with RN C, and they were asked about the Ozempic prescription. RN C said, Oh, was that supposed to be given today? Yes, I should have given that. Its every Wednesday. Today is Wednesday. According to R28's Electronic Health Record (EHR) on 3/5/25 the physician prescribed Ozempic (2mg/3 ml) administer 0.5 ml subcutaneous once a day on Wednesdays. R28's MAR accurately documented the physician's order for the Ozempic every Wednesday.#2. On 9/10/25 at 8:10 AM Registered Nurse (RN) B was observed to administer R47 medications at the bedside. RN B proceeded to sign out all the medications that were administered. R47 did not receive Eliquis 5 milligrams (mg). Upon inquiry RN B confirmed all the resident's medications were given. R47's Medication Administration Record (MAR) was reviewed with RN B, and they were asked about the Eliquis prescription. RN B said, Yes, that should have been given. It wasn't in the medication cart at the time I was passing meds. According to R47's Electronic Health Record (EHR) on 8/24/25 the physician prescribed Eliquis 5 mg twice a day 9:00 AM and 9:00 PM. R47's MAR accurately documented the physician's order for the Eliquis 5 mg twice a day. #3. During reconciliation of R47's Medication Administration it was determined the resident had not received a multi-vitamin with minerals since 8/31/25. According to R47's Electronic Health Record (EHR) the physician ordered MVI with minerals once a day on 8/18/25. A review of the R47's Medication Administration Record (MAR) for 9/2025 revealed the order for 'MVI with minerals once a day', did not get transcribed on the September 2025 MAR. R47 had not received the multi-vitamin since 8/31/25 and missed 9 doses. On 9/10/25 at 9:56 AM the Director of Nursing (DON) reviewed R47's EHR and confirmed that R47 and was supposed to get MVI w minerals once a day as of 8/18/25. The DON said the resident had not received the MVI with minerals since 8/31/25 because that order (MVI with minerals once a day) did not get transcribed onto 9/2025 MAR. The DON said the physician's prescription order was accidentally placed under the wrong category in 9/2025 and did not get transcribed on R47's MAR. The DON confirmed that R47 had missed 9 doses of the MVI with minerals: 9/1/2025 - 9/9/2025. Procedure:3. Medications must be administered in accordance with the orders, including any required time frame.