

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: 235360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Arbor Manor Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 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 92 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and toxic chemical residue. Findings include: During an observation and interview on 5/05/2026 at 9:07 a.m., of initial kitchen tour, Food Service Manager (FSM) N reported had worked at facility about 10 months. FSM N directed this surveyor to single hand-washing sink located in kitchen with trash can located next to sink with unfunctional lid. After washing hands, foot pedal on trash can was not functioning properly, and lid had to be handled with clean hands to open, and observe several used paper towels in trash can. FSM N reported would replace trash can. Continued tour with staff observed using dish machine. FSM N reported dish machine was low temperature chemical machine and staff monitor temperatures daily and record on log and monitor chemical level in large buckets under the machine. FSM N reported would expect dish machine to be greater than 120 degrees Fahrenheit with cycle. Observed clipboard with dish-machine log hanging on the opposite wall as dish machine with last documented data from 5/1/26. Observed three cycles of dishes from dish machine with temperature gauge that indicated 100 degrees Fahrenheit and FSM N verified temperature and that is how machine is monitored, with no mention of testing chemicals. While the three wash cycles were running, FSM N was observed entering data on dish machine log for 5/2/26 through current date, 5/5/26. FSM N was queried what he was writing on log and stated was completing log with approximate reading for last few days and verified had not been completed since 5/1/26 and other log for monitoring chemical was blank with no entries for May 2026. FSM N placed a digital monitor though the dish machine. Observed digital monitor read 104.9 degrees Fahrenheit and reported was still too low and planned to follow up. Continued kitchen tour on 5/05/2026 at 9:29 a.m., moderate Ice [NAME] were observed protruding from the Walk-In Freezer supply lines. The Walk-In Freezer ceiling surface was also observed with accumulated ice droplets, adjacent to the refrigeration fan unit with two of three fans functioning. Significant amount of solid, pooled ice was noted on at least eight opened cardboard boxes of bread and large pooled area of solid ice was observed on floor about one inch thick and two foot by 4 foot area. FSM N reported had door seal replaced about one month prior and contracted refrigerator company was aware of ice buildup. FSM N reported water pours out of water lines during defrost for past two weeks. 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. During an observation on 5/06/2026 at 11:31 a.m., entered kitchen for lunch tray service. [NAME] T started to tray meal and this surveyor had asked if food temperatures had already been completed. [NAME] T stated, yes, however was unable to produce completed log. [NAME] T was unable to locate alcohol swab to clean thermometer and another staff member provided one alcohol swab and [NAME] T obtained food temperature for at least six menu (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	items and cleaned thermometer probe with original food caked one inch alcohol swab between items. Observed contracted refrigerator company staff in area of freezer during tray service.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure accurate advance directives (legal documents that allow a person to identify decisions about end-of-life care ahead of time) information was in place for two resident (#12, #78) of two residents reviewed for advance directives. Findings Included: Resident #12 (R12) Review of the medical record revealed R12 was admitted to the facility [DATE] with diagnoses that included Alzheimer's disease, vascular dementia, atrial fibrillation, venous insufficiency (when leg veins [NAME] efficiently return blood to the heart), polyosteoarthritis (a form of arthritis affecting five or more joints), asthma, hypertension, anxiety, hypothyroidism (low thyroid hormone), delusional disorders, and depression. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R12 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15. During an attempted interview [DATE] at 09:32 a.m., R12 was observed sitting up in the dining room. R12 was unable to answer verbal questions. Review of R12's medical record revealed a document entitled DO-NOT-RESUSCITATE ORDER which was signed by R12 on [DATE]. The section, of the document listed above, entitled Attestation of Witness revealed one witness signature dated [DATE] and the other witness signature dated [DATE]. Resident #78 (R78) Review of the medical record revealed R78 was admitted to the facility [DATE] with diagnoses that included heart disease, osteoarthritis (degenerative joint disease with breakdown of cartilage) of knee, type 2 diabetes, stage 3 kidney disease, atrial fibrillation, hyperlipidemia (high fat content in blood), anemia (low red blood cells), and hypertension. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of [DATE], revealed R78 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) out of 15. Review of R78's medical record revealed a document entitled DO-NOT-RESUSCITATE ORDER which was signed by R78 on [DATE]. The section, of the document listed above, entitled Attestation of Witness revealed one witness signature dated [DATE] and the other witness signature had no date. During an interview on [DATE] at 03:35 p.m., Social Worker (SW) E explained that a residents advance directive wishes were obtained upon admission. SW E explained that if the resident did not want to be revived if their heart were to stop, the resident would sign the document entitled DO-NOT-RESUSCITATE ORDER. SW E explained that the document would be signed and dated by two witnesses, which was witnessed at the time of the resident or resident responsible persons. SW E explained that once the DO-NOT-RESUSCITATE ORDER form is completed the attending physician would sign the document and a physician's order would be written. SW E reviewed R12's DO-NOT-RESUSCITATION ORDER, signed by R12 on [DATE], and confirmed the second witness signature of [DATE]. SW E could not explain why the witness date was after the resident signed the document. SW E reviewed R78's DO-NOT-RESUSCITATION ORDER, signed by R78 on [DATE], and confirmed that the second witness signature was not dated. SW E could not explain why the second witness did not date the signature. During an interview on [DATE] at 03:59 p.m., Director of Nursing (DON) B explained that the Nurse Managers were responsible for reviewing the documents entitled DO-NOT-RESUSCITATION ORDER. DON B explained that during the review, the Nurse Managers were to verify that all portions of the document were completed accurately. DON B reviewed R12's DO-NOT-RESUSCITATION ORDER, dated [DATE], and confirmed that the second witness signature was dated [DATE]. DON B could not explain why the signature was dated the day after R12's signature. DON B reviewed R78's DO-NOT-RESUSCITATION ORDER, signed by R78 on [DATE], and confirmed that the second witness signature was not dated. DON B could not explain why the second witness did not date the signature.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide Activities of Daily Living care (showering and shaving) for one dependent resident (#61) of two residents reviewed. Findings Included: Resident #61 (R61) Review of the medical record revealed R61 was admitted to the facility 08/26/2022 with diagnoses that included Alzheimer's Disease, dementia, polyarthritis (arthritis in five or more joints), insomnia, kidney disease, peripheral neuropathy (nerve damage in nerves), gout (high uric acid in joints), urinary retention, sleep apnea, gastro-esophageal reflux, and muscle weakness. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/09/2026, revealed R61 had a Brief Interview for Mental Status (BIMS) of 3 (severe cognitive impairment) out of 15. Section GG- Functional Abilities of MDS, with the same ARD, revealed R61 was dependent for shower/bathe self and dependent for personal hygiene. On 05/05/2026 at 09:12 a.m. during observation and interview, R61 was observed sitting in chair at the side of his bed. R61 was observed to have facial hair covering his face that was approximately 3 cm (centimeters) in length. When R61 was asked about his facial hair he was observed rubbing his face with his hand and explaining that he would like to be shaved. R61 could not recall the last time he had been shaved. Review of R61's Point of Care (POC) documentation (documentation demonstrating care provided by direct care staff) for showers stated: .Shower/Wednesday/Saturday 2nd shift. Review of that previously listed POC revealed shower, for the last 30 days, was completed 04/08/2026, 04/18/2026, 04/22/2026, 04/29/2026. The same POC revealed documentation as not applicable on 05/02/2026. R61's POC documentation and/or progress notes did not reveal that he had received a shower, in the last 30 days, on 04/11/2026 (Saturday), 04/15/2026 (Wednesday), and 04/25/2026 (Saturday). On 05/06/2026 at 08:13 a.m., during observation and interview, R61 was observed sitting in a chair at the side of his bed. R61 was again observed to have facial hair covering his face that was approximately 3-4 cm (centimeters) long. R61 explained that he still had not gotten shaved. On 05/06/2026 at 08:14 a.m., License Practical Nurse (LPN) I explained that residents at the facility received showers/baths two times per week. LPN I explained that showers/baths are usually conducted by the Certified Nurse Aides (CNA). LPN I explained that if a resident refused a shower/bath the CNAs would inform the nurses and then the nurses were expected to try and encourage the resident to take a shower/bath as scheduled. LPN I explained if the resident still had not wanted to take a shower/bath it was expected that the nurse would enter a progress note explaining refusal in the resident's medical record. On 05/06/2026 at 08:18 a.m., Certified Nursing Aide (CNA) J explained that R61 was to have a shower/bath completed twice per week. She explained that R61's shower/bath days were listed in his POC (Point of Care) documentation and then demonstrated a documented that revealed what showers where to be completed on what days and what shifts. CNA J explained that if the resident was male the staff was expected to ask the resident if he would like to be shaved on the days and shifts that the resident was to have a shower. On 05/06/2026 at 08:22 a.m. Director of Nursing (DON) B explained that it was her expectation that residents were to receive a shower/bath at least twice per week and/or according to their plan of care. DON B explained that if residents had facial hair, she expected that the person conducting the shower/bath would ask the resident if they would like to be shaved. DON B also explained that if residents had refused a shower/bath that the Certified Nurse Aides (CNA) would notify the nurse and then the nurse would attempt to have the resident to agree. DON B explained that if the resident still refused it would be documented refusal by the CNA and the nurse are expected to write a progress note in the resident's record. DON B confirmed that R61's Point of Care documentation revealed showers, for the last 30 days, were completed 04/08/2026, 04/18/2026, 04/22/2026, 04/29/2026. DON B could not explain why R61 had not received showers on 04/11/2026 (Saturday), 04/15/2026 (Wednesday), and 04/25/2026 (Saturday). DON B could not explain why staff had documented not applicable on 05/02/2026. DON B could not answer if R61 had been offered shaving on any of his shower/bath days.		

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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, record review and interview, the facility failed to ensure proper positioning was in place for one resident (resident #28) of two residents reviewed for positioning. Findings include: Review of the clinical record revealed Resident #28 (R28) was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included heart failure. Review of the Minimum Data Set (MDS) dated [DATE] revealed R28 scored 7 out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS) and was receiving hospice care. On 05/05/2026 at 9:56 AM, R28 was observed sitting in her room in high back wheelchair. The footrests were on the wheelchair but R28's feet do not touch and were observed dangling. R28 was observed to be sitting on a wheelchair pad, a pillow and the sling to a mechanical lift. R28 was observed in the dining room at the noon meal with her feet dangling from the wheelchair. Observations of R28 were made on 05/06/2026 at 9:35 AM in her room watching television, R28 was sitting in her wheelchair, no footrests in place with R28's feet dangling. R28 was observed again on 05/06/2026 at 11:31 AM sitting in her room visiting with son, the footrests to the wheelchair were on the floor near the bed. Resident #28 feet observed dangling. On 05/06/2026 at 2:41 PM Resident #28 observed in her room sitting in the wheelchair, the footrests were observed on floor not attached to chair, and R28's feet observed dangling. On 05/07/2026 at 8:50 AM R28 was observed in her room, sitting in a high back wheelchair, no footrests in place. R28's feet were pointed down and dangling, toes do not reach floor. On 05/07/2026 at 11:40 AM, during an interview with Director of Nursing (DON) B the above observations were shared. DON B reported due to R28 being under hospice care, hospice provided the wheelchair, DON B reported for comfort the footrests of R28's wheelchair should be in place and was not sure why this was not done or if the chair may be ill fitting as a whole and due to R28's hospice status therapy would not have evaluated R28 for wheelchair positioning.		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide range of motion (ROM) to one (R11) of two reviewed. Findings include: Review of the medical record revealed R11 was admitted to the facility on [DATE] with diagnoses that included heart failure and polyarthritis (arthritis affecting multiple joints). The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/28/26 revealed R11 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and had functional limitation in range of motion impairments both sides of the lower extremities. On 05/05/2026 at 1:57 PM, R11 was observed lying in bed. R11 reported she had previously received therapy services, but her insurance no longer covered therapy services. R11 reported during therapy, she did exercises with her arms and legs. R11 reported she knew what exercises she should perform, but reported since therapy services ended, staff did not assist her with any exercises or range of motion. Review of the Occupational Therapy (OT) Discharge Summary revealed R11 received OT services from 2/20/26 through 4/17/26. The discharge recommendations included a home exercise program. Review of the Physical Therapy (PT) Discharge Summary revealed R11 received PT services from 2/20/26 through 3/24/26. The Discharge Summary revealed Staff and patient have been educated on ROM exercises to incorporate into daily routines. Encourage [patient] to participate in ROM exercises daily when providing care. Review of R11's Kardex (nurse aide care guide) and care plan revealed an intervention initiated on 3/27/26 that read please offer to provide ROM of upper and lower extremities daily while providing care to maintain joint mobility, reduce risk of contractures, and reduce painful symptoms. Review of R11's medical record revealed no documentation that ROM was being completed with care. In an interview on 05/07/2026 at 9:16 AM, Occupational Therapist (OT) P reported R11's therapy goals were to sit up in a wheelchair or Broda chair and to gain strength. When asked about the home exercise program mentioned in her discharge summary, OT P reported she believed Physical Therapy set up a passive range of motion program in which staff were trained to provide. In an interview on 05/06/2026 at 10:10 AM, Director of Nursing (DON) B reported the facility did not have a restorative program, but instead Certified Nursing Assistants (CNAs) were to encourage residents to work with them during care. When asked if range of motion was documented, DON B reported it should be in the CNA documentation. DON B agree R11 was care planned to receive ROM but did not have any specific documentation that this task was completed.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that the attending physician documented his/her rationale for not changing medication as requested by the pharmacist for one resident (#6) of five residents pharmacy reviews. Findings Included: Resident #6 (R6) Review of the medical record revealed R6 was admitted [DATE] with diagnoses that included congestive heart failure (CHF), epilepsy (neurological disorder causing seizures), type 2 diabetes, morbid obesity, bladder dysfunction, heart disease, hypothyroidism (low thyroid hormone) atrial fibrillation, restless leg syndrome, insomnia, depression, gout (build-up of uric acid in bone joints), hypertension, and hyperlipidemia (high fat content in blood). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/27/2026, revealed R6 had a Brief Interview for Mental Status (BIMS) of 15 (cognitively intact) of 15. Review of R6's medical record revealed a Consultant Pharmacist Medication Regimen Review, dated 02/07/2026, which stated: Patient is currently taking Eliquis 2.5mg (milligrams) twice daily for atrial fibrillation. Patient is 74 yo (year old), serum creatinine is 1.41 mg/dl (milligrams/deciliter) and weight is 198.7 kg (kilograms). Based on this information, recommend increase to Eliquis 5mg twice daily. The same document revealed that they physician placed an x near the back of other and placed a response of continue and the other word was illegible. Review of R6's physician orders had not demonstrated that the Eliquis dosage was increased but had stayed the same. In an interview on 05/06/2026 at 11:07 a.m., Director of Nursing (DON) B explained that R6's Consultant Pharmacist Medication Regimen Review, dated 02/07/2026, was signed by the physician and was documented as, Continue same dose. DON B confirmed that the physician had decided not to change the medication dosage and had not documented her rationale in the resident's medical record. DON B could not provide an answer why the physician had chosen not to change the dose of Eliquis as the pharmacist had recommended. DON B confirmed that the same document had requested Provide a brief clinical rationale note if the physician disagreed with the pharmacist recommendations. In a telephone interview on 05/06/2026 at 11:16 a.m., attending Physician T explained that she had not followed the recommendations of the pharmacist on 02/07/2026 for R6's dosage of Eliquis because he had a history of urinary bleeding. She explained that it would have been recorded in R6's medical record someplace but she had not provided that rational on R6's Consultant Pharmacist Medication Regimen Review, dated 02/07/2026. Attending Physician T explained that she was not aware that the document Consultant Pharmacist Medication Regimen Review had requested to be Provide a brief clinical rational note if she had disagreed with the pharmacist recommendation.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% when 2 of 26 medications for two residents (R7 and R31) were not administered in accordance with physician's orders resulting in a medication error rate of 7.69%. Findings include: R7 Review of the medical record revealed R7 admitted to the facility on [DATE] with diagnoses that included dementia and congestive heart failure. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/27/26 revealed R7 scored 9 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). During an observation on 5/6/26 at 8:35 AM, Licensed Practical Nurse (LPN) I prepared medications for R7. LPN I reported R7 took his medications crushed. LPN I separated a few medications that were not allowed to be crushed. Amongst those medications was ferrous gluconate 324 milligrams (mg). LPN I then used a pill cutter to cut those medications in half, including the ferrous gluconate. In a telephone interview on 05/06/2026 at 9:04 AM, Pharmacist R, from the facility's pharmacy, reported most of the medications LPN I cut in half were allowed to be cut. Pharmacist R reported ferrous gluconate should not be cut or crushed. R7's medical record did not contain a Physician's Order or any instructions from the pharmacy that the ferrous gluconate was okay to cut. In an interview on 05/06/2026 at 10:10 AM, Director of Nursing (DON) B reported each medication cart had a reference sheet that included which medications could not be crushed. DON B reported the reference did not mention the cutting/splitting of pills. DON B reported in that case, staff should reach out to the pharmacy. R31 Review of the medical record revealed R31 admitted to the facility on [DATE] with diagnoses that included congestive heart failure, and hypertension. The MDS with an ARD of 3/3/26 revealed R31 scored 11 out of 15 (moderate cognitive impairment) on the BIMS. Review of the Physician's Order dated 3/11/26 revealed an order for Metolazone 2.5 mg one time per day for congestive heart failure/weight gain. The Physician's Order included the instructions to give the metolazone 30 minutes prior to the bumetanide. During an observation on 05/06/2026 at 8:14 AM, LPN S prepared medications for R31. Amongst those medications were metolazone 2.5 mg and bumetanide 1 mg. LPN S administered both medications at the same time. In an interview on 05/06/2026 at 9:57 AM, when asked about the bumetanide and metolazone being given to R31 at the same time, LPN S reviewed R31's medical record and agreed the order reflected to administer the metolazone 30 minutes prior to the bumetanide. LPN S agreed the metolazone was not administered per the Physician's Order.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain infection prevention and control practices during medication administration for one (R31) of two reviewed. Findings include: Review of the medical record revealed R31 admitted to the facility on [DATE] with diagnoses that included congestive heart failure and hypertension. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/3/26 revealed R31 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). During an observation on 05/06/2026 at 8:14 AM, Licensed Practical Nurse (LPN) S prepared medications for R31. LPN S dispensed 11 of R31's 14 medications into her bare hand and then placed each medication in the pill cup. The medications included hydralazine, metformin, bumetanide, colchicine, diltiazem, tamsulosin, duloxetine, eliquis, metolazone, metoprolol, and potassium chloride. LPN S then administered the medications to R31. In an interview on 05/06/2026 at 9:57 AM, LPN S reported she normally dispensed the pills/capsules into her hand before placing them into the medication cup. LPN S was not aware that she was not supposed to touch the medications with her bare hands. In an interview on 05/06/2026 at 10:10 AM, Director of Nursing (DON) B reported nurses should not handle medications with their bare hands and then administer the medications to residents.		

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: 235360	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Arbor Manor Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain documentation that pneumococcal immunization education was provided and whether consent or declination was received for one (R11) of five reviewed. Findings include: Review of the medical record revealed R11 admitted to the facility on [DATE] with diagnoses that included heart failure and atrial fibrillation. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 1/28/26 revealed R11 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and was offered and declined the pneumococcal immunization. Review of R11's medical revealed no documentation of pneumococcal immunization education, consent or declination. On 05/07/2026 at 10:56 AM, Nursing Home Administrator (NHA) A reported the facility was not able to locate a consent or declination for R11's pneumococcal immunization. In an interview on 05/07/2026 at 11:21 AM, Director of Nursing (DON) B reported she was the facility's Infection Preventionist. DON B reported the facility had documentation of R11's education and consent for the influenza immunization and declination of the COVID-19 immunization, but no documentation of education and consent or declination of the pneumococcal immunization.		