

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

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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 07/28/2026
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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **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 the physical plant affecting 91 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage. Findings include: On 07/21/2026 at 2:00 P.M., A common area environmental tour was conducted with Housekeeping & Laundry Director (HLD) D. The following items were noted: On 07/21/2026 at 2:10 P.M., The following item was noted within the 2 East Unit: Soiled Utility Room: The return air exhaust ventilation grill was observed heavily soiled with accumulated dust/dirt deposits. (HLD) D indicated she would have housekeeping staff thoroughly clean and sanitize the ventilation grill assembly as soon as possible. On 07/21/2026 at 2:20 P.M., The following item was noted within the 2 [NAME] Unit: Soiled Utility Room: The return air exhaust ventilation grill was observed moderately soiled with accumulated dust/dirt deposits. (HLD) D indicated she would have housekeeping staff thoroughly clean and sanitize the ventilation grill assembly as soon as possible. On 07/21/2026 at 2:30 P.M., The following items were noted within the 3 [NAME] Unit: Janitor Closet: The perimeter wall/floor coving strip was observed missing. The missing coving strip measured approximately 4 feet long. The perimeter wall/floor coving strip was also observed loose to mount. (HLD) D indicated she would contact maintenance for necessary repairs as soon as possible. Soiled Utility Room: 1 of 2 overhead clear plastic light lens covers were observed cracked and broken. On 07/21/2026 at 2:47 P.M., An interview was conducted with Housekeeping & Laundry Director (HLD) D regarding the facility maintenance work order system. (HLD) D stated: We have the (name of the electronic maintenance monitoring) software system. On 07/21/2026 at 4:30 P.M., An environmental assessment of resident room [ROOM NUMBER] was conducted. The resident room was observed soiled and in disarray (paper wrappers, food residue, portable bedside commode with aromatic human liquid (urine) and solid (feces) waste within catch basin, etc.) The bed linen sheets (flat and fitted) were also observed soiled and stained with feces and urine. The restroom commode was additionally observed plugged and would not flush. The restroom hand sink basin was further observed draining slowly. The Portable Terminal Air Conditioning (PTAC) Unit was additionally observed non-functional. A temporary portable air conditioning unit was also observed functioning providing cool air to the room. On 07/22/2026 at 9:35 A.M., A common area environmental tour was conducted with Maintenance Director (MD) E. The following items were noted: On 07/22/2026 at 9:40 A.M., The following items were noted within the 1 East Unit: Dining Room: The one-half inch quarter round base shoe was observed loose-to-mount. The damaged quarter round base shoe measured approximately six feet long. (MD) E indicated he would perform necessary repairs as soon as possible. Occupational/Physical Therapy: The microwave oven interior surface was observed (pitted, stained, corroded, etched). The interior surface was also observed yellowed and darkened from (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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	extensive use. (MD) E stated: I will remove and replace the microwave today.On 07/22/2026 at 9:50 A.M., The following items were noted within the 2 [NAME] Unit:Shower Room: The shower stall ceramic tile flooring surface was observed missing 24 tiles. The damaged flooring surface measured approximately 3-inches-wide by 5-feet-long. (MD) E stated: Corporate told me the shower room is going to be completely remodeled soon.Oxygen Room: The flooring surface was observed to be soiled with dust/dirt deposits and debris (plastic port covers, paper tags, etc.).On 07/22/2026 at 10:00 A.M., The following items were noted within the 3 [NAME] Unit:Shower Room: The commode base was observed loose-to-mount. The commode support assembly and seat were also observed loose-to-mount. The commode support assembly could be moved from side to side approximately 4-6 inches. (MD) E indicated he would perform necessary repairs as soon as possible.Dining Room: Two 24-inch-wide by 24-inch-long acoustical ceiling tiles were observed stained and warped from previous moisture exposure. 2 of 2 return-air exhaust ventilation grills were also observed soiled with accumulated and encrusted dust/dirt deposits.Resident room [ROOM NUMBER] was observed in complete disarray. Paper candy wrappers and empty food cardboard boxes were observed resting directly on the flooring surface. The bed sheet (fitted) was observed threadbare and heavily soiled/stained with human waste and liquid urine. The bedside commode was further observed partially full of aromatic human solid (feces) and liquid (urine) waste.On 07/24/2026 at 10:00 A.M., Record review of the Policy/Procedure entitled: Maintenance Department dated 9/19/2024 revealed under Policy: To assure proper maintenance of the physical plant.On 07/24/2026 at 10:15 A.M., Record review of the Policy/Procedure entitled: Housekeeping Services dated 7/8/2025 revealed under Policy: To promote a sanitary environment: (II) Routine Cleaning of Horizontal Surfaces: (A) In resident care areas, cleaning of non-carpeted floors and other horizontal surfaces will be done daily and more frequently if spillage or visible soiling occurs.On 07/24/2026 at 10:30 A.M., Record review of the Electronic Maintenance Monitoring Software System work orders for the last 90 days revealed no specific entries related to the aforementioned maintenance concerns.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3047057. Based on observation, interview, and record review, the facility failed to provide bath/showers for one Residents (#2) of three Residents reviewed. and six out of seven residents during confidential group meeting reported not receiving regularly scheduled showers. Findings Included: Resident #2 (R2) Review of the medical record revealed R2 was admitted [DATE] with diagnoses that included thrombocytopenia (low blood platelet count), monoclonal gammopathy (blood disorder abnormal plasma cells), neuromuscular dysfunction (impairment of the peripheral nervous system), bladder dysfunction, visuospatial deficit (brain disorder affecting depth perception, spatial orientation, and object recognition), protein calorie malnutrition, muscle wasting, chronic obstructive pulmonary disease (COPD), aftercare following surgery on digestive system, chronic kidney disease, Neoplasm (abnormal growth) of ascending colon, congestive heart failure (CHF), and ventral hernia without obstruction or gangrene. Review of R2's most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/23/2026, revealed a Brief Interview for Mental Status (BIMS) of 8 (moderate cognitive impairment) out of 15. Section GG- Functional Abilities, of the MDS with the same ARD, revealed R2 is dependent on shower/bathing. During observation and interview on 07/23/2026 at 10:07 a.m. R2 was observed sitting in her wheelchair in her room. R2 explained that she was scheduled to receive showers on Sunday and Tuesday of each week. R2 explained that she has not been receiving her showers at least twice per week. R2 could not recall the last time that she had received a shower. Review of R2's medical record revealed Point Of Care task entitled Task; Shower/Bathing- Did the resident received a shower/bath/bed bath?. Review of task for the shower/bathing task revealed yes on 07/09/2026 and no on 07/02/2026. Other dates 06/25/2026, 06/29/2026, 07/13/2026, 07/20/2026 were documented as not applicable. No other dates were listed for shower/bathing. During an interview on 07/23/2026 at 10:13 a.m. Certified Nurse Aide (CNA) S explained that resident showers are performed on the days shift and the afternoon shift. CNA S explained that resident showers are listed in a notebook, which is located at the nurse's station. CNA S explained once a shower is completed staff would complete a document titled Skin Monitoring: CNA Shower Sheet. CNA S explained that the sheet would be delivered to the nurse when completed. CNA S also explained that shower/baths were to be documented in the resident's computerized chart, entitled POC- Plan Of Care Task. Certified Nurse Aide (CNA) S explained that she had been taught that not applicable was not to be charted. During an interview on 07/23/2026 at 10:24 a.m. Director of Nursing (DON) B explained that it was her expectation that residents received a shower/bath at least twice per week. DON B explained that Certified Nurse Aides (CNA) would review the shower book, which is located at the nurse's station. DON B explained that once a shower is given the CNA would complete a Skin Monitoring: CNA Shower (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Sheet and turn those sheets into the Nurse responsible for that resident. DON B explained that those sheets are then turned into herself. DON B could not answer if the showers were being monitored for completion. DON B explained that it was the expectation that the staff nurse would complete a progress note if a resident did not have a shower completed. DON B provided a shower notebook that list R2's was to have showers completed on the day shift Sunday and Tuesday. DON B reviewed R2's documented shower task and confirmed, during the last 30 days of documentation, R2 had only received two showers/baths in the 30-day period. DON B could not explain why R2 had not received showers/bathing at least twice per week. DON B explained that she would attempt to locate R2's Skin Monitoring: CNA Shower Sheet that should have been documented on shower/bath days. On 07/23/2026 at 10:55 a.m. Director of Nursing (DON) B provided one Skin Monitoring: CNA Shower Sheet, dated 07/02/2026. DON B was unable to provide any documentation as to why R2 had not received her shower/bath at least twice per week. During the confidential group meeting held on 7/22/26 at 1:00 PM 6 of 7 of the group participants reported they do not receive regularly scheduled showers. One resident reported they were to receive a shower and have their bed linen changed twice a week but would like to have this done three times a week. Other residents openly chuckled at this, stating they can't even get the two showers on a weekly basis let alone three times a week. The group participants reported this is not a new problem and despite complaints made they still can't get showered routinely. Residents did not understand why they were only allowed two showers a week. On 07/24/2026 at 10:21 AM during an interview with Activity Director N who assists in running the monthly Resident Council meetings, acknowledged the list of ongoing and unresolved concerns including residents not getting showers. Activity Director N stated this has been discussed on a routine basis. On 07/24/2026 at 10:50 AM, during an interview with Nursing Home Administrator (NHA) A she reported she had been the NHA since April of this year and could not account for any information prior to that and was working on things. On 07/24/2026 at 11:15 AM during an interview with the Director of Nursing (DON) B she reported being the DON for one week but was employed at the facility prior to becoming DON and was aware of the concerns brought forth by Resident Council members and reported a teaching session was done with staff in May 2026 on customer service. When queried if she was aware that this was still an issue, DON B stated yes.		

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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 professional standards for insulin administration for R76, during medication administration observation. Findings include: On 7/24/26 at 8:10 AM, LPN Y was observed preparing R76's insulin. LPN Y dialed the insulin pen to the prescribed 28 units without priming the insulin needle first. LPN Y verbally confirmed her action of dialing the insulin pen to 28 units and then was observed administering R76's insulin without priming the needle. On 7/24/26 at 8:23 AM, LPN Y was asked if the insulin pen needles should be primed before administering the prescribed dose to the resident, LPN Y was unsure what priming meant and stated she didn't think so. On 7/24/26 at 10:58 AM, during an interview with Director of Nursing (DON) B, she reported that the expectation for insulin administration with an insulin pen was that the needle be primed with 2 units prior to dialing up and administering the prescribed dose. According to The Cleveland Clinic website (https://my.clevelandclinic.org/health/treatments/17923-insulin-pen-injections), when using an insulin pen you should wipe the rubber stopper with an alcohol wipe. Attach a new pen needle to the insulin pen. Prime the insulin pen. Priming means removing air bubbles from the needle. It ensures that the needle is open and working. You must prime the pen before each injection. To prime the insulin pen, turn the dosage knob to the 2 units indicator. With the pen pointing upward, push the knob all the way. At least one drop of insulin should appear. You may need to repeat this step until a drop appears. Select the dose of insulin that has been prescribed for you by turning the dosage knob.		

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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. Based on observation, interview and record review the facility failed to follow infection control standards during medication administration observations. Findings include: On 7/24/26 at 8:08 AM LPN Y was observed exiting a resident room with a glucometer that she reported to have just used to test a resident's blood sugar. LPN Y was observed placing the used glucometer on the prep surface of the medication cart without disinfecting it first. When asked the typical process for disinfecting a glucometer, she reported they use a bleach wipe. LPN Y was then observed using a Super Sani-Cloth Germicidal Disposable Wipe to clean the glucometer, then wrapped the glucometer in the wipe, placed it in a plastic cup and placed it in the top drawer of the medication cart. LPN Y was then observed prepping an insulin pen for administration. Prior to screwing on the insulin pen needle, LPN Y failed to clean the tip of the pen where the needle connects to the insulin pen. LPN Y was asked if anything should have been done prior to attaching the needle to the pen. LPN Y then removed the first needle, discarded it, cleansed the tip with an alcohol pad and placed a new needle. On 7/24/26 at 10:58 AM, during an interview with Director of Nursing (DON) B, she reported that the expectation is for a used glucometer to be disinfected prior to placing it on the medication administration cart and that an insulin pen would be cleaned prior to placing the insulin needle. A review of the facilities policy titled Glucometer and PT/INR (Prothrombin Time/ International Normalized Ratio-blood tests for clotting) Decontamination updated 4/30/26, documented in part Since glucometers & PT/INRs may be contaminated with blood and body fluids as well as other pathogens, such as would be encountered in contact precautions, this facility has chosen a disinfectant wipe that is EPA (Environmental Protection Agency) registered as tuberculocidal; therefore, it is effective against HIV (human immunodeficiency virus), HBV (hepatitis B virus), and a broad spectrum of bacteria. The glucometer & PT/INR shall be decontaminated with the facility approved wipes following use on each resident. According to The Cleveland Clinic website (https://my.clevelandclinic.org/health/treatments/17923-insulin-pen-injections), when using an insulin pen you should wipe the rubber stopper with an alcohol wipe. Attach a new pen needle to the insulin pen.		