

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: 235613	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/29/2026
NAME OF PROVIDER OR SUPPLIER Maple Manor Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3999 Venoy Road Wayne, MI 48184	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to ensure a registered nurse was designated to serve full-time as the Director of Nursing. Findings include: Upon entrance to the facility on 5/27/2026, the Director of Nursing (DON) said they had started in their role on 5/19/2026. On 5/28/2026 at approximately 12:00 PM, the DON and Registered Nurse (RN) D were interviewed regarding nurse staffing within the facility. RN D identified themselves as a Director of Nursing at another facility owned by the same company and was assisting the facility DON learn their new role. When asked who the DON prior to the current DON was, they responded that the prior DON was terminated from employment on May 1, 2026. When asked who the acting DON between 5/1/2026 and 5/19/2026 was, RN D said they were acting as the interim. RN D then confirmed that their nursing license was designated as the Director of Nursing at another facility. No response was provided when asked whose name and license number was communicated to the state agency notifying them of the change in Director of Nursing. On 5/28/2026 at approximately 12:40 PM, Registered Nurse C was queried as to who the DON was at the facility. RN C confirmed the correct name of the current DON. When asked who the DON was between 5/1/2026 and 5/19/2026, RN C said they were not sure - that sometimes it was RN D and sometimes it was another nurse in the facility. When asked who they would contact regarding clinical concerns, RN C said they would contact RN D (the Director of Nursing at another facility). At approximately 12:57 PM, the Nursing Home Administrator (NHA) and RN D returned to the surveyor. The NHA reported that a charge nurse in the facility was assigned as the interim DON. When asked if the required notification to the state agency regarding the change in the Director of Nursing was completed, the NHA said no. The NHA further said that he was the person responsible for notifying the state agency of any DON changes within the facility but did not do so. A policy titled, Nursing Services - Registered Nurse and Full Time Director of Nursing dated reviewed/revised 5/28/2026 was received and read in part, The facility will designate a Registered Nurse to serve as the Director of Nursing on a full-time basis.		

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	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 maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include: On 05/27/2026 at 8:49 AM in an interview regarding date marking, Dietary Manager (DM) E indicated every food item is dated the day opened, and is discarded within three days. On 05/27/2026 at 8:50 AM observed sliced cheese wrapped in plastic with a facility marked date of 5/18 in the walk in cooler. On 05/27/2026 at 9:05 AM observed the three compartment sink drain lines for the wash, rinse, and sanitize basins all connect to a common drain line and discharge to the floor with no air gap. On 05/27/2026 at 9:08 AM observed a piece of cloth wrapped around the rinse and sanitizer faucet base. An interview with DM E at this time found that the sink drips sometimes and they had reminded maintenance about it. On 05/27/2026 at 9:20 AM an interview with DM E found the ice scoop and ice scoop bucket are cleaned weekly. Observation found water pooled at the bottom of the ice scoop bucket and brown debris floating in the water. DM E indicated they would have someone clean it. On 05/27/2026 at 9:24 AM observed an opened two liter of diet coke in the 215 kitchenette refrigerator with a sticker and no date or label on the bottle. On 05/27/2026 at 9:29 AM observed orange juice with a manufacturer in date of 4/6 in the 315 kitchenette refrigerator. DM E indicated they did not know an expiration date was not on the container. Further observation found a container of sliced meats with a facility marked date of 5/22. DM E indicated they had not seen it before. Record review of the facility provided document titled Maple Manor Rehab and Neuro Center Use and Storage of Food Brought in by Family or Visitors last revised January 2026, states: All food items that are already prepared by the family or visitor brought in must be labeled with content and dated. The policy continues, The prepared food must be consumed by the resident within 3 days. If not consumed within 3 days, food will be thrown away by the facility staff. According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking, (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety. According to the 2022 FDA Food Code section 5-402.11 Backflow Prevention, (A) Except as specified in (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. According to the 2022 FDA Food Code section 5-205.15 System Maintained in Good Repair, A PLUMBING SYSTEM shall be: (A) Repaired (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	according to LAW; and (B) Maintained in good repair. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (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.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among all residents in the facility. Based on interview and record review, the facility failed to consistently implement a comprehensive infection control program that conducted proper facility surveillance and utilized maps or other processes to readily identify trends of infections, resulting in missed opportunities for corrective actions and the potential for spread of infectious organisms throughout the facility affecting the entire census of 36 residents. Based on observation, interview, and record review, the facility failed to ensure appropriate infection control practices were followed for one resident (R1) out of 4 residents reviewed for infection control and prevention, resulting in the potential for spread of infection among residents in the facility. Findings Include: On 05/27/2026 at 9:45 AM observed a hand sink with a plastic board covering the basin and the hot and cold water off in the emergency food and water storage room. On 05/27/2026 at 10:28 AM observed a residential washing machine with water lines intact and an out of order sign on the machine in the laundry room. In an interview at this time with Laundry Aid (LA) G when asked how long the washer had been out of order, LA G indicated one or two months. Further observation found a residential washing machine with a towel covering the surface. When asked if this machine was broken, LA G indicated it works, however, they do not like to use it. On 05/27/2026 at 10:35 AM observed a hopper with the hot water faucet off in the south hall soiled linen room indicating possible stagnant water in the line. A sign on the hopper stated do not use. Further observation found a nonfunctional hand sink with foot pedal attachments to control the flow of water, indicating possible stagnant water in the line. On 05/27/2026 at 10:40 AM observed the cold water off at the hand sink faucet in the south hall supply room. On 05/27/2026 at 10:46 AM observed discolored water coming from the hopper cold water faucet for a few seconds before running clear in the north hall soiled utility room. The spray hose attachment was observed off, when turned upside down some discolored water dripped from the hose. On 05/27/2026 at 10:49 AM observed a nonfunctional hand sink with an out of order sign in the north hall supply room. An interview with LA G at this time found they were unsure why the faucet was off. On 05/27/2026 at 1:34 PM an interview with Maintenance Supervisor (MS) F found they are on the water management team, and meet quarterly to discuss with the team. When asked about control measures to prevent the growth of legionella, MS F indicated they keep the boilers above 140 degrees F and test for legionella yearly. MS F indicated they ordered chlorine tests and will begin using those to test the chlorine residual. When asked about empty rooms, MS F indicated they flush rooms quarterly that are not in use. When asked if the hoppers on the floor are a part of flushing schedule, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	MD F indicated no. On 05/27/2026 beginning at 1:45 PM a facility tour was conducted with MS F. On 05/27/2026 at 1:47 PM observed a nonfunctional hand sink in the north hall soiled linen room. An interview with MS F at this time found it was clogged and needed to be snaked out. When asked how long it had been out of order MS F indicated two weeks. On 05/27/2026 at 1:51 PM observed a tub with supplies in the basin in the north hall shower room. Further observation found a second tub near the back of the room. In an interview at this time, when asked if the tubs are used, MS F indicated the tubs are not used. On 05/27/2026 at 1:58 PM observed a nonfunctional hand sink in the emergency food and water room. An interview with MS F at this time found they turned the hand sink off and the room is used as storage. On 05/27/2026 at 2:49 PM observed discolored water discharging for a few seconds before running clear from the bathroom hand sink in unoccupied room [ROOM NUMBER]. On 05/27/2026 at 2:51 PM observed the hand sink with an out of order sign dated 2/7/21 in unoccupied room [ROOM NUMBER]. The hand sink was observed to be nonfunctional when turned on indicating possible stagnant water. On 05/27/2026 at 3:00 PM an interview with MS F regarding flushing of unoccupied rooms found they flush the sink faucet, toilet and shower. When asked about the nonfunctional hand sink in room [ROOM NUMBER], MS F indicated they turned the water off to the sink because it was not being used. Record review of the facility provided document titled WATER MANAGEMENT PROGRAM lists the scope of the program, 3. Identification of potentially hazardous areas or devices where Legionella could grow and spread. 4. Establishment of control point, measures and limits for identified potentially hazardous areas or devices. A risk assessment of the building was completed on January 27, 2026. The risk assessment did not include hoppers and nonfunctional fixtures still connected to the water line. A flow diagram of the facility, controls and control limits were not identified in the program. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Flush low-flow piping runs and dead legs at least weekly. Flush infrequently used fixtures (e.g., eye wash stations, emergency showers) regularly as needed to maintain water quality parameters within control limits. Eliminate dead legs, which are sections of no- or low-water flow. On 5/29/26 at 10:40 AM, a meeting was held with Director of Nursing (DON) D and Licensed Practical Nurse/Infection Preventionist (LPN/IP) H, both of whom were employed at a sister facility. DON D said that the facility's regular Infection Preventionist was currently out of the country. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	to them. When asked if the CNA wore a gown, they said no. At approximately 11:17 AM, an interview was conducted with CNA A. When asked what care he provided to R1, CNA A replied that R1 had a bowel movement and so he went in to change their brief. When asked if he wore PPE during the care provided, CNA A said no, that he did not wear a gown but that he knew he should have worn one. When asked how he knows if PPE should be donned prior to providing care to a resident, CNA A pointed to the sign on R1's door and said he would look for the PPE signage. A record review was completed which revealed R1 admitted to the facility on [DATE] with diagnoses that included paraplegia, muscle weakness, neuromuscular dysfunction of bladder, retention of urine, urinary tract infection, pressure ulcer of the sacral region, and hypertension. Physician orders included the use of Enhanced Barrier Precautions initiated on 1/23/2026. Section C of the Minimum Data Set (MDS) with an Assessment Reference Date of 3/5/2026 indicated R1 scored a 13/15 on the Brief Interview for Mental Status questionnaire - indicative of no cognitive impairment. Section GG of the same MDS indicated the resident was dependent on staff for all activities of daily living. A review of R1's care plan did not indicate any interventions for the use of Enhanced Barrier Precautions. On 5/28/2026, at approximately 12:00 PM, an interview was requested with the facility Infection Preventionist, but they were not available. An interview was then conducted with the Director of Nursing. When queried as to their expectation of staff following infection control and prevention interventions such as Enhanced Barrier Precautions, they said it was their expectation that staff follow the signage so that they can stop the spread of infection among residents. A policy titled Enhanced Barrier Precautions last reviewed/revised January 2026 was provided by the facility and read in part, PPE for enhanced barrier precautions is only necessary when performing high-contact care activities., and high contact care activities include.changing briefs or assisting with toileting.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review the facility failed to maintain a continuous Antibiotic Stewardship Program that includes monitoring antibiotic usage, tracking resistance, preventing emergence of resistance, and following protocols for antibiotic use, which has the potential to affect all residents residing in the facility. Findings include: On 5/29/26 at 10:40 AM, a meeting was held with Director of Nursing (DON) D and Licensed Practical Nurse/Infection Preventionist (LPN/IP) H, both of whom were employed at a sister facility. DON D said that the facility's regular Infection Preventionist was currently out of the country. When asked for documentation regarding the facility's antibiotic stewardship program, DON D and LPN/IP H indicated that this information was not available for May 2025 to December 2025. On 5/29/26 at 1:30 PM, the facility's DON indicated that part of an effective infection control program included consistent proactive attention to prevent the spread of infections. A review of the facility policy titled, Antibiotic Stewardship Program, reviewed January 2026, documented in part the following: It is the policy of this facility to implement an Antibiotic Stewardship Program as part of the facility's overall infection prevention and control program. The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. On 5/29/26 at 2:30 PM during the exit conference, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey, and they reported there was not.		