STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235669	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Rehab Center of Novi Inc	31215 Novi Road Novi, MI 48377

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 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 implement an effective water management program, appropriately initiate Enhanced Barrier Precautions and provide infection control practices with medication administration, this had the ability to affect all the resident's residing in the facility including six [R27, R85, R86, R87, R88 and R89] residents identified. Findings include, On 04/27/2026 at 10:15 AM, during a building tour with Maintenance Technician (MT) S and Director of Maintenance (DM) F observed four hot water tanks with setting at 130 degrees F. At this time DM F indicated that mixing valves are on resident point-of-use fixtures and monitored and logged. MT S and DM F indicated flushing protocols for unoccupied rooms but do not document this and have not identified other potential areas of stagnation for flushing. When asked about any additional control measures DM F said that legionella testing is done annually. On 04/27/2026 a Record Review of Maple Manor Rehab and Neuro Center Water Management Program policy dated January 2026 and supplement Water Management Program: Water Management Team (no date) found the following: Facility policy states Water Management Team (WMT) shall include: building owner, administrator, Maintenance, Chief Nursing Officer, Infection Control Designee A risk assessment will be conducted by the water management team annually. No risk assessment was in the program documentation at time of review. Based on the risk assessment, control points will be identified and Control measures will be applied to address potential hazards at each control point. A variety of measures may be used, including physical controls, temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. The measures shall be specified in the water management program action plan. No control points have been identified, and no action plan was documented. When control limits are not maintained, corrective actions will be taken and documented accordingly. On 04/27/2026 a Record Review of Legionella Surveillance policy dated January 2024 found that facility Primary prevention strategies include: d. Temperature Controls: ii: Hot water shall be stored above 140 degrees F and circulated at a minimum return temperature of 124 degrees F. Included in the WMP documentation were annual legionella test results from the vendor laboratory, including the most recent results date reported 7/30/25 which included several sampled areas testing positive for Legionella pneumophila Group. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/27/2026 at 1:30 PM an interview with the Nursing Home Administrator Assistant (NHA-A) and DM F regarding the WMP and legionella testing results took place. When asked about WMT meetings, NHA-A said that DM F reports any water related concerns at Quality Assurance and Process Improvement (QAPI) meetings. DM F indicated he thought the last sampling results were acceptable based on the cover sheet from the vendor laboratory. NHA-A indicated that they thought if there was a problem, the health department would contact the facility. At this time, both confirmed that there is currently no action plan in the WMP and no response was taken after receiving the last annual test results. On 04/27/2026 at 2:00 PM an interview continued with NHA-A, DM F and MT S regarding the WMP. NHA-A provided a completed Risk Assessment checklist dated April 2026 at this time. DM F and MT S confirmed that the only monitoring currently documented is water temperatures. When asked about WMP training, DM F and MT S indicated they have not completed any specific training on the CDC WMP guidance. On 4/27/26 at 3:11 PM, Infection Preventionist [IFP] B was interviewed and asked if she was aware the facility had tested positive for Legionella. IFP B explained she was not aware, the Maintenance Director had reported to her and the DON that there were no issues and everything was fine. IFP B was asked if she attended the water management meetings. IFP B explained she did not. On 4/27/26 at 3:42 PM, the DON was interviewed and asked if she had attended the water management meetings. The DON explained they did not have water management meetings, that the Maintenance Director would just report to them that there were no issues. Review of the infection control line listings revealed: R86 had facility acquired pneumonia with an onset date of 6/30/25. R87 had facility acquired pneumonia with an onset date of 7/23/25. R88 had facility acquired pneumonia with an onset date of 8/22/25. R89 had facility acquired pneumonia with an onset date of 2/14/26. On 4/28/26 at 2:46 PM, IFP B was asked if R86, R87, R88 and R89 had acquired pneumonia while residing at the facility. IFP B confirmed all were facility acquired pneumonia. IFP B was asked if R86, R87, R88 or R89 had been tested for Legionella. IFP B explained they had not tested anyone for Legionella as they were unaware of the facility testing positive. When asked if these residents should have been tested, IFP B agreed they should have been tested. Review of a Quality, Safety and Oversight Group [QSO] memorandum QSO-17-30 revised 7/6/18 by Centers for Medicare & Medicaid Services [CMS] read in part, .Facilities must. Specifies testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained. Medication Administration Observation On 4/28/26 at 9:07 AM, Licensed Practical Nurse (LPN) A was observed preparing the morning medications for R85. After prepping multiple tablets in to the medication cup, LPN A was observed to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	have spilled all of the tablets on to the medication cart and multiple paper documents on top of the cart. LPN A was observed to have don on a glove and returned all the dropped tablets back into the medication cup. At 9:17 AM, LPN A administered the medications to R85. A review of the facility policy titled Medication Administration revised January 2026, documented in part . If a medication is dropped onto a clean, disinfected medication cart or tray during preparation or administration, it shall not be considered contaminated, provided the surface has been sanitized and the medication remains intact/dry and free from visible contamination. All medications designated for disposal such as dropped medication. must be placed in the approved drug buster waste container. On 4/28/26 at 11:46 AM, the Director of Nursing (DON) was interviewed regarding the spilled medications by LPN A. The DON confirmed that LPN A should have properly disposed of the medications and prepared new medications for the resident. Enhanced Barrier Precaution/EBP: R27 On 4/27/26 at 10:24 AM, R27 was observed seated in a wheelchair beside their bed, getting dressed. R27 reported they had a wound vac for a pressure ulcer on their bottom (sacrum) and when asked about treatments, reported they went to an outside wound clinic but if the wound vac needed to be resealed, the facility staff were able to reapply. There were no infection control precautions (such as EBP) implemented for R27. On 4/28/26 at 9:33 AM, R27 was still observed to have no EBP implemented. Review of the clinical record revealed R27 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: infection of amputation stump, right lower extremity, pressure ulcer of sacral region, stage 4 (full-thickness skin and tissue loss), paraplegia, acquired absence of right leg below knee, personal history of traumatic brain injury, and other motorcycle injured in unspecified nontraffic accident. Review of the resident's physician orders included: Start Date 4/15/26, monitor wound vac (Peel and Place) in place. Keep area clean and dry. Do not apply direct pressure to wound vac. Cannot be off more >2 hrs. call wound clinic for any issues with wound vac. patient must stay off sacrum/wound vac and switch positions q (every) 2 hrs (hours).Wound vac should be in place until follow up with (wound specialist) Every Shift Day Shift 07:00 - 19:00, Night Shift 19:00 - 07:00. Start Date 4/8/26, Monitor wound vac daily. Do not turn off or remove. If leakage occurs, reinforce dressing with clear tegaderm only. Every Shift Day Shift 07:00 - 19:00, Night Shift 19:00 - 07:00. There were no current orders for EBP. Review of the discontinued orders revealed EBP had been in place from 11/5/25 - 12/17/25. Further review of the clinical record revealed R27 had recently had a debridement and graft application to the sacral wound on 4/6/26 and following this had the current wound vac implemented. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/28/26 at 11:05 AM, an interview was conducted with the Infection Preventionist (IP 'B') and the Wound Care Nurse (Nurse 'C'). When asked about the facility's practices regarding implementation of EBP, IP 'B' reported EBP should be implemented for residents that had pressure ulcers, including those that used medical devices. When asked if a wound vac should've been considered as a medical device, IP 'B' reported it should have. Nurse 'C' reported the resident's EBP orders were discontinued a while back due to the wound was dry with no drainage. When asked why the facility had not re-implemented the EBP upon R27's wound changes and implementation of the wound vac on 4/6/26, IP 'B' and Nurse 'C' offered no further explanation. According to the facility's policy titled, Enhanced Barrier Precautions dated January 2026: .An order for enhanced barrier precautions will be obtained for residents with any of the following: e. Wounds (e.g., chronic wounds such as pressure ulcers .unhealed surgical wounds .

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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. This citation pertains to intake# 2788480 Based on observation, interview and record review, the facility failed to maintain a clean and homelike environment for two residents (R57 and R65) of five residents reviewed for environmental concerns, as well as the residents that utilized the central shower room, resulting in unclean floors and shower/resident rooms in disrepair. Findings include: On 04/27/2026 at approximately 10:33 a.m., R57 was observed in their room, laying in the bed. R57's floor was observed to have old food debris covering it. R57 was queried regarding their floor, and they reported that housekeeping was not doing a good job of moping the floor. At that time, R57's Baseboard by their hand sink was observed to be peeling away from the wall along with the corner drywall strips. On 04/27/2026 at approximately 11:08 a.m., R65 was observed in their room, up in their wheelchair. R65's floor was observed to be sticky with darkened dirt spots covering it. On 4/29/2026 at approximately 10:40 a.m., R57 was observed in their room, laying in their bed. R57's baseboard was still observed to be peeling away from the drywall. R57's drywall was reviewed with the Maintenance Director F (MD F). MD F indicated they were unaware of the need to repair R57's walls and that they would have to start on the repair. On 04/27/2026 at 10:25 AM on a building tour with Director of Maintenance (DM) F and Maintenance Technician (MT) S the following was observed in the central spa areas: blue shower mats worn/cracked and no longer smooth and cleanable in the 2nd floor north and 1st floor north shower rooms light bulb burned out in the 1st floor north showering area at the showering area perimeter at the floor/wall juncture caulk is missing and this area is soiled with black mold-like substance in the 2nd floor north and 1st floor north shower rooms a disinfectant unit/cart containing bleach product was stored next to the sink in the 2nd floor south shower room several bottles of personal care items (soaps and shampoos) stored on the sinks in all spa rooms At this time, these observations were also noted by DM F and MT S, and they indicated these items would be addressed. The disinfectant unit was relocated, and they would let an administrator know about shower mats needing replaced. A record review of Routine Cleaning and Disinfection policy dated January 2026 found that these guidelines do not address cleaning and disinfection of the central spa areas. A record review of Safe and Homelike Environment policy dated January 2026 found the following compliance guidelines:Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment.The facility will provide and maintain adequate and comfortable lighting levels in all areas.Report any furniture in disrepair to maintenance promptly.

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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 ensure professional standards of practice for medication administration for one resident (R83) of three residents reviewed for medication administration. Findings include:On 4/28/26 at 8:43 AM, Licensed Practical Nurse (LPN A) was observed preparing the morning medications for a resident. When asked the resident's name, LPN A replied with the resident's room number and bed. When asked for the resident's name that resided in that room number and bed, LPN A replied with the resident's first name and stated they were not sure of the last name. At 8:52 AM, LPN A was observed to have handed R83 their medications to consume. The nurse failed to properly identify the resident.A review of the facility policy titled Medication Administration revised January 2026, documented in part . Ensure that the six right of medication administration are followed. Right resident. with MAR (Medication Administration Record) to verify resident name.At 8:58 AM, LPN A asked R83 why they were not wearing their oxygen. R83 explained they had been off of the oxygen all day the day before and no longer needed the oxygen per the Physician. LPN A told R83 they would look into it.A review of the Medication and Treatment Administration Record for April 2026 revealed LPN A had already signed the oxygen order as administered for their shift without verifying the administration of the oxygen therapy.A review of the facility policy titled Oxygen Administration revised January 2026, documented in part . Oxygen is administered to residents who need it, consistent with professional standards of practice. Staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen.On 4/28/26 at 11:46 AM, the Director of Nursing (DON) was interviewed and asked about the professional standards, protocols and practices for the nursing staff when administering medications and oxygen to the residents. The DON acknowledged the resident should have been verified properly before medication administration and the oxygen administration should have been signed after assessing the resident and ensuring oxygen was administered. The DON said they would follow up and provide LPN A with additional education.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record reviews the facility failed to ensure preventive interventions were implemented as noted in the plan of care, for two residents at risk for development of pressure injuries (R's 3 & 65) of five residents reviewed for pressure injury. Findings include:R65 On 04/27/2026 at approximately 11:08 a.m., R65 was observed in their room, up in their wheelchair. R65 was observed to have their feet with bilateral ace bandages on. No PRAFO boots (boots used to relieve pressure and prevent contractions) were observed applied to their legs/feet. R65's heels were observed to be touching the pedals of the wheelchair. On 4/27/26 at approximately 3:31 p.m., R65 was observed in their room, laying in their bed. R65 was observed with their heels flushed to the mattress, without any protective boots providing relief from pressure. On 4/28/26 at approximately 11:32 a.m., R65 was observed in their room, sitting in their wheelchair. R65 was observed to be without any pressure relieving boots applied and their heel were flushed with the wheelchair pedals. On 4/28/26 at approximately 12:45 p.m., was observed in their room, still up in their wheelchair. R65's heels were observed to be flushed to the wheelchair pedals without any pressure reduction boots being applied. On 4/28/26 at approximately 1:42 p.m., R65 was observed in their room, lying in bed with Nurse L. R65 was observed to have their heels flushed to mattress without any pressure reduction boots applied. Nurse L was queried regarding R65's soft boots and their PRAFO boots not being applied when sitting in their wheelchair or in lying in their bed and they indicated they would get a CNA (Certified Nursing Assistant) to put them on. Nurse L was queried if R65 should have their boots applied per the orders and they reported they should. On 4/27/26 the medical record for R65 was reviewed and revealed the following: R65 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and [NAME] insufficiency. A review of R65's MDS (minimum data set) with an ARD (assessment reference date) of 2/11/26 revealed R65 needed assistance from facility staff with all of their activities of daily living. R65's BIMS score (brief interview for mental status) was zero indicating severely impaired cognition. A Physician's order dated 3/6/25 revealed the following: Bilateral soft heel protectors on at all times when in bed. A second Physician's order dated 3/6/25 revealed the following: SPLINTING: Apply [brand of pressure/contracture reduction boots] to bilateral ankles when up in the wheelchair. A Nurse Practitioner evaluation dated 4/22/26 revealed the following: .Impression/Plan: Skin Management-Continue air loss mattress and [brand of specialized cushion], Continue frequent turns Q2H (every two hours) per nursing protocol. Continue bilateral [pressure reduction boots] heel protectors in bed. Wound team . A review of R65's care plan revealed the following: Pressure Ulcer/Injury Resident is at risk for skin (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breakdown due to pressure ulcer hx (history) of coccygeal/ sacral area wound and impaired mobility .Approach-Keep resident clean, dry and off affected areas as possible . On 2/28/26 at approximately 3:00 p.m., during a conversation with the Director of Nursing (DON), the DON was informed of the observations of R65's heels being flushed to the pedals and the mattress and the indicated that the staff should be following the orders and the care plan regarding the application of the boots to reduce pressure points. On 4/27/26 at 10:11 AM, two aides were observed providing care to R3 in their room. R3 was observed in their wheelchair getting their hair braided by one of the aides. Two inflated green boots were observed in the chair by the window. R3 was observed with no socks on and their feet touching the footboards of their wheelchair. The aides were asked about the inflated green boots and responded that the resident wears the boots when they are in bed. A review of the medical record revealed R3 was admitted to the facility on [DATE] with a readmission date of 1/26/26 and diagnoses that included: quadriplegia and dependence on ventilator. R3 was dependent on staff for all Activities of Daily Living (ADLs). A review of a care plan titled . I am at risk of contracture, discomfort and skin breakdown necessitating splint or brace use. I wear (name of inflated boots) on both my feet when I'm up in my wheelchair. The goal of the care plan was documented as . Maintain or improve functional abilities, prevent contractures, enhance comfort and promote skin integrity. On 4/28/26 at 12:02 PM, the Director of Nursing (DON) was interviewed and asked about the observation with R3 and the two aides. The DON replied the aide assigned to that unit is normally assigned to another unit and may not be familiar with R3's plan of care. The DON said they would follow up and educate the aides.