

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235462	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2025
NAME OF PROVIDER OR SUPPLIER Ch Rehab & Nurs Cnt - Commons Farmington Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 21450 Archwood Circle Farmington Hills, MI 48336	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083</p> <p>This citation pertains to Intakes: MI00151714, MI00150739</p> <p>Based on observation and interview, the facility failed to maintain a safe, clean and comfortable environment, resulting in the potential to affect the entire resident population.</p> <p>Findings include:</p> <p>The State Agency received a complaint of an allegation the facility failed to maintain a comfortable clean, homelike environment</p> <p>On 4/2/25 at 8:42 AM, The Second-floor hallway was observed with scattered white colored straw wrappers, crumbs, and debris. The floors in rooms 255, 252, 253, and 250 were observed with straw wrappers, moderate amounts of debris, and scattered crumbs of food. Dried red food matter was noted on the wall in front of room [ROOM NUMBER]. Partition curtains in rooms [ROOM NUMBER] were all observed soiled and unkempt.</p> <p>On 4/2/25 at 9:25 AM, A cabinet in the residential dining room of Dayroom [ROOM NUMBER] was observed with a white clear bag containing red colored clothing and a red purse. RN A opened the bag which contained a red [NAME] Lemon Jacket and a red colored MCM purse. Certified Nurse Assistant (CNA) C walked over and claimed it was their belongings and was observed removing them off the unit. RN A confirmed staff should not be storing personal items amongst residential common areas.</p> <p>On 4/2/25 at 9:30 AM, The third-floor dining room was observed with three moderate sized circled patterned, dried food spillages on the carpet area adjacent to dining tables.</p> <p>The carpet was observed heavily soiled near medication cart in front of room R354.</p> <p>The entrance to room [ROOM NUMBER], had hardwood flooring observed with scattered debris, food crumbs, and straw wrappers.</p> <p>room [ROOM NUMBER], was observed with wrappers from plastic utensils and moderate amount of food crumbs noted on the floor.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The common hallway carpeting in front of room [ROOM NUMBER] was observed soiled with a large spill of liquid and brown liquid dripping on the wall was observed.</p> <p>The common hallway carpeting in front of room [ROOM NUMBER] was observed with old food matter and appeared to be run over by a wheel.</p> <p>On 4/2/25 at 12:53 PM, an interview and tour of the facility was conducted with Environmental Services Supervisor (ESS) D who was shown the flooring, walls, and curtains in rooms. ESS D acknowledged the areas of dried food on the carpet and dried spillage of food on the walls should have been identified and spot cleaned. The resident rooms were just vacuumed at the time of the tour with ESS D, who was informed based on earlier observations, the carpet in the residents' rooms and hallway appeared cluttered with various debris and not vacuumed for some time.</p> <p>The partition curtains in rooms [ROOM NUMBER], were also shown to ESS D who acknowledged they were soiled and should have been cleaned and/or replaced.</p> <p>The facility policy for environment and housekeeping was requested and was not available by time of exit.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568</p> <p>This citation pertains to Intake Number(s): MI00151450.</p> <p>Based on interview and record review, the facility failed to conduct accurate and thorough sepsis screening for one (R902) of one resident reviewed for a change in condition. Findings include:</p> <p>A review of R902's clinical record revealed admission to the facility on [DATE] and R902 was discharged to the hospital on 3/10/25. Diagnoses included: metastatic cancer (prostate and bone), chronic obstructive pulmonary disease (COPD), and chronic respiratory failure. A review of R902's Minimum Data Set (MDS) assessment dated [DATE] revealed R902 had moderately impaired cognition.</p> <p>A review of the Progress Notes for R902 revealed they tested positive for influenza A on 3/1/25.</p> <p>A review of the Physician's Orders revealed R902 was placed on droplet precautions (isolation precautions used to prevent the spread of respiratory illnesses transmitted via droplets) from 3/5/25 through 3/12/25. The physician's orders indicated R902 was prescribed Tamiflu (an antiviral medication) from 2/26/25 through 3/8/25.</p> <p>On 4/2/25 at approximately 1:00 PM, an interview was conducted with the facility's Infection Control Preventionist, Registered Nurse (RN) F. When queried about how the facility monitored residents for sepsis, RN 'F' explained residents were screened for seven days on admission and when a resident had an infection that was treated with an antibiotic or antiviral medication, they were screened for sepsis throughout the duration of the illness (end of antibiotic/antiviral and end of isolation precautions). RN 'F' reported residents were monitored for sepsis by completing the Severe Sepsis Screening Tool assessment which nurses were required to complete according to the instructions on the form.</p> <p>A review of the Severe Sepsis Screening Tool assessments for R902 from 3/1/25 through 3/8/25 (onset of influenza A though the end of isolation precautions/antiviral treatment) revealed the following:</p> <p>On 3/1/25 and 3/2/25, yes was documented in the sections that indicated whether or not the resident had a suspected or documented infection and antibiotic therapy, which according to the instructions on the form, the next section should have been completed to determine if there was evidence of SIRS - Systemic Inflammatory Response Syndrome developing, and based on those answers if there was Organ Dysfunction. Other than indicating R902 had an infection and was on an antibiotic, the rest of the form was left blank.</p> <p>On 3/3/25, it was documented R902 had a suspected or documented infection, and no was documented in the section that indicated whether the resident received antibiotic therapy (or antiviral therapy according to RN 'F'). The rest of the form was left blank and no further assessment was documented.</p> <p>On 3/4/25, 3/5/25, 3/6/25, 3/7/25, and 3/8/25, it was documented R902 did not have a suspected or documented infection and was not on antibiotic therapy.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the Infection Control surveillance information provided by the facility, revealed R902 was considered to have an active influenza infection as evidenced by a positive test, was receiving antiviral therapy, and was on isolation precautions.</p> <p>On 4/2/25 at 2:33 PM, an interview was conducted with the Director of Nursing (DON). The above record review was discussed and the DON did not offer a response.</p> <p>A review of a facility policy titled, Sepsis, dated 10/15/24, revealed, in part, the following, .All newly admitted , readmitted and with an infection must be monitored for signs/symptoms of sepsis .Monitoring period . Infections - length of antibiotic therapy .The nurse must .Complete a Severe Sepsis Screening Tool .Using the current shift complete vital signs .and renal output .</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568</p> <p>This citation pertains to Intake Number(s): MI00151450.</p> <p>Based on interview and record review, the facility failed to appropriately monitor the respiratory status of one (R902) of one resident reviewed for a change in condition. Findings include:</p> <p>A review of the clinical record revealed R902 was admitted into the facility on [DATE] and discharged to the hospital on 3/10/25. Diagnoses included: influenza A, chronic obstructive pulmonary disease (COPD), metastatic cancer of the prostate spread to the bone, obstructive sleep apnea, and chronic respiratory failure. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R902 had moderately impaired cognition and did not require oxygen therapy on admission.</p> <p>A review of the Progress Notes revealed R902 tested positive for influenza A on 3/1/25.</p> <p>A review of the results of a chest X-ray for R902, completed on 3/5/25 revealed, Mild prominent bilateral hilar (wedge shaped middle portion of lungs) markings (may indicate inflammation or congestion).</p> <p>A review of R902's Physician's Orders revealed an order dated 3/5/25 for Oxygen at 2 L (liters) PRN (as needed) for SOB (shortness of breath).</p> <p>A review of R902's Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed no order for the PRN oxygen and no place to document when the oxygen was administered.</p> <p>Further review of R902's progress notes from 3/5/25 through 3/10/25 revealed the following documentation:</p> <p>On 3/10/25 at 9:58 AM it was noted R902's oxygen saturation was 94 percent on two liters of oxygen via nasal cannula. There was no documentation noting what R902's oxygen saturation was prior to administering the oxygen.</p> <p>On 3/10/25 at 7:33 PM, it was noted R902 had labored breathing with wheezing and rales (fine high pitched crackling lung sounds). At that time it was documented R902's oxygen saturation was 91 percent on oxygen.</p> <p>There were no other progress notes that indicated R902 required PRN oxygen.</p> <p>A review of a change in condition progress note dated 3/10/25 at 5:55 AM noted R902's oxygen saturation was 95% with oxygen via nasal cannula on 3/10/25 at 6:02 AM. There were no notes documenting R902's oxygen saturation prior to applying the oxygen.</p> <p>A review of R902's O2 (oxygen) sats (saturation) Summary from 3/5/25 through 3/10/25 revealed R902's O2 sats were taken while receiving oxygen via Nasal Cannula) on the following dates and times:</p> <p>3/6/25 at 6:30 AM</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3/7/25 at 12:39 AM, 2:22 AM, and 10:12 AM</p> <p>3/8/25 at 9:56 AM and 6:34 PM</p> <p>3/9/25 at 6:14 AM, 10:09 AM, and 5:23 PM</p> <p>3/10/25 at 6:02 AM, 7:23 AM, 9:30 AM, 7:17 PM, and 9:20 PM.</p> <p>At 9:20 PM, R902's O2 sats were 85% while on oxygen therapy.</p> <p>There was no documentation of R902's oxygen saturation levels prior to the administration of oxygen.</p> <p>On 4/2/25 at 2:33 PM, an interview was conducted with the Director of Nursing (DON). When queried about where PRN oxygen administration was documented, the DON reported either on the MAR/TAR or in a progress note. The DON reported if PRN oxygen was required, the nurse should document what the oxygen level was prior to administration. R902's clinical record was reviewed with the DON who then reported she would look into it to see if R902's oxygen levels were documented somewhere else.</p> <p>On 4/2/25 at 4:01 PM, during a follow-up interview, the DON reported she was unable to find any further information or documentation regarding R902's oxygen monitoring.</p> <p>A policy regarding respiratory therapy was requested. However, it was reported the facility did not have a policy regarding monitoring resident's respiratory status for PRN oxygen.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083</p> <p>Based on observation and interview, the facility failed to ensure resident food items brought in from the outside were labeled and dated resulting in the potential of foodborne illness and had the potential to affect all residents who store and consume food from the 2107 Dayroom community residential refrigerator.</p> <p>Findings include:</p> <p>On 4/2/25 at 9:10 AM, The refrigerator in Dayroom [ROOM NUMBER] was opened and the following items were observed no resident identifier or dates:</p> <p>A brown paper bag from (fast food restaurant), a black three compartment container with a clear lid containing cornbread, and a small clear container containing what appeared to be a white dressing located in the door section.</p> <p>The left bottom crisper revealed a white Styrofoam cup/lid containing a brown colored liquid. The freezer was observed storing a container of vanilla ice cream and a Styrofoam cup/lid with an unidentified frozen substance.</p> <p>Review of the facility policy titled Food Brought in by Others for Residents dated 3/2018 documented.</p> <p>.Any food brought in for residents should be identified to the charge nurse .a label to mark the food item with the resident's name and the date it was brought into the facility .</p> <p>On 4/2/25 at 9:15 AM, Unit Manger Registered Nurse (RN) B was shown the observations and acknowledged the items should have been labeled with residential identifiers and dates.</p>		