STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	04/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd 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)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on interview and record review, the facility failed to notify the resident's guardian of changes of condition for one (R702) of two residents reviewed for notification of changes. Findings include: A complaint was filed with the State Agency (SA) on 3/14/24 that alleged in part, .no one called to tell me that (R702) had pulled his feeding tube out . found out when I was visiting him and happened to touch his stomach . (R702) had also been put on an IV (intravenous fluids) and I only found out because my friend was coming to visit him . Review of the closed record revealed R702 was admitted into the facility on [DATE] with diagnoses that included: diabetes, depression and stroke. According to the Minimum Data Set (MDS) assessment dated [DATE], R702 had severely impaired cognition and required the assistance of staff for activities of daily living (ADL's). Review of R702's January 2024 Medication Administration Record (MAR) revealed four Enteral Feed Orders (feeding through a tube into the gastrointestinal tract) that were all discontinued 1/22/24. Review of R702's progress notes revealed: A nursing note dated 1/23/24 at 5:26 PM that read in part, Remove suture from PEG (percutaneous endoscopic gastrostomy - enteral feeding tube) insertion site per physician order. Suture removed by writer . A physician note dated 2/5/24 at 11:02 AM read in part, .Pulled out PEG last month . Further review of R702's progress notes revealed: A nursing note dated 1/29/24 at 8:23 PM that read, hypodermacloysis [sic] (the infusion of fluids into subcutaneous tissue) started at 1900 (7:00 PM) A nursing note dated 1/30/24 at 10:08 PM read in part, .resident has hypodermoclysis to right abdomen running at 70cc/hr (cubic centimeters per hour) per 1L (liter) of NS (normal saline) 0.9% (percent) . (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Continued review of the clinical record revealed no documentation of how R702's PEG tube was removed, who removed the PEG tube, when the PEG tube was removed, or that R702's guardian was notified of the removal. There was also no documentation of R702's guardian was notified, or consented to R702 receiving fluids through hypodermoclysis. On 4/3/24 at 11:51 AM, the Director of Nursing (DON) was interviewed and asked if a resident's guardian should be notified when a PEG tube was removed or before hypodermoclysis was started. The DON agreed a guardian should be notified. When informed no documentation could be found regarding the removal of R702's PEG tube or hypodermoclysis, the DON explained she would look into it. On 4/3/24 at 2:24 PM, Licensed Practical Nurse (LPN) I was interviewed and asked about R702's PEG tube. LPN I explained when she had gone into R702's room, the PEG tube was lying on the table, R702's doctor was at the facility at the time and he said not to put it back in. LPN I was asked if she had documented about the PEG tube removal, or the doctor's orders to leave the PEG tube out. LPN I explained she had not. When asked if she had notified R702's guardian of the PEG tube's removal, LPN I explained she had not. No further information about R702's guardian being notified or giving consent for the hypodermoclysis was received prior to the end of the survey. Review of a facility policy titled, Notification of Change revised 2/14/24 read in part, .The facility must inform the resident; consult with the resident's practitioner; and notify, consistent with his or her authority, the resident representative(s) when there is a change in status . A change in status would include the following: . A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) .

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #MI00143505 Based on interview and record review, the facility failed to document and address resident grievances for one resident (R705) of one residents reviewed for grievance resolution, resulting in verbalized complaints and frustration. Findings include: On 4/2/24 a complaint submitted to the Stage Agency was reviewed which indicated R705 had been left wet and soiled and nobody from facility administration had followed up with R705's family pertaining to the verbalized concerns. On 4/2/24 at approximately 12:27 p.m., during a conversation with family member J (FM J), FM J reported that they had concerns about the care in the facility for R705 pertaining to being left wet and soiled for five hours of time and not being placed back into bed and being left in their wheelchair for hours. FM J reported that that they had discussed their concerns with Social Work Director K (SWD K) and that SWD K was going to let the Director of Nursing (DON) know about the concerns so that they could follow up with them regarding resolution. FM J reported they never heard back from any facility administration regarding their concerns that were discussed with SWD K. On 4/2/24 the medical record for R705 was reviewed and revealed the following: R705 was initially admitted on [DATE] and discharged on [DATE]. A review of R705's MDS (minimum data set) with an ARD (assessment reference date) of 3/7/24 revealed R705 had a BIMS score (brief interview for mental status) of 15 indicating intact cognition. R705 was documented as needing partial/moderate assistance with personal hygiene. On 4/3/24 at approximately 9:45 a.m., during a conversation with SWD K, SWD [NAME] queried if they had a conversation with R705's family member J pertaining to the Nursing concerns that included being left wet and soiled and they reported that they did but did not remember what date they had the conversation and would have to look in their documentation. At approximately 10:12 a.m., during a follow up conversation with SWD K, SWD K indicated that they did have a conversation with R705's family member and that they had brought the concerns verbally to the Director of Nursing but did now know if any follow-up had been done because the DON stopped working at the facility shortly afterwards. SWD K was queried if they had documented FM J's concerns down on the grievance/concern form per the facility policy and they indicated they had not. SWD K was queried on the process for concern/grievance resolution and was to document on the form for the appropriate documentation of concerns and facility follow-up and they indicated that it was and would be more diligent about putting concerns down on the grievance form in the future. On 4/3/24 at approximately 10:20 a.m., a request from the facility Administrator was made for any grievance/concern forms for R705 or their family members pertaining to the concerns of R705's care and had been discussed with SWD K. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/24 At approximately 10:43 a.m., The facility administrator indicated they did not have any grievance/concern forms for R705 and provided the policy/procedures on grievance documentation for review. On 4/3/24 a facility document titled Facility Compliance Program was reviewed and revealed the following: Facility Compliance Program-Purpose: The Compliance Program provides a mechanism for the facility to comply with applicable statutes and regulations and government and private pay healthcare programs, thereby significantly reducing the risk of unlawful or improper conduct. Matters reported to the Facility Compliance Officer (FCO) allege substantial violations of compliance policies Policy Statement or federal health care program statutes are regulations and should be documented and investigated promptly to determine their veracity. It is the policy of the facility to comply with all applicable Federal and State regulations. To help accomplish this goal and assist associates in providing the highest quality of care to its guests/ residents, the facility has implemented a Compliance Program. The Facility Compliance Officer will oversee and monitor the program .A. Reporting: 1. Upon discovering an issue, problem, or event where non-compliance is reasonably suspected, the individual must report such concern to the Facility Compliance Officer (FCO). Failure to report may result in progressive disciplinary action or termination .2. The concerns will be communicated as soon as discovered to the FCO for investigation .B. Tracking 1. The Facility Compliance Officer will track all concerns reported through the Compliance Program. 2. The Guest Satisfaction Concern/Suggestion Form .and the Guest/Resident Assistance Form - MI will be faxed to [NAME] after the investigation is completed to assist with tracking for reporting to the QAPI (Quality Assurance Process Improvement) Committee No documentation or investigations regarding family member J's care concerns pertaining to R705 were provided by the end of the survey.

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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** 49083 This citation pertains to Intake #MI00142508 and Intake #MI00142954 Based on interview and record review, the facility failed to accurately complete assessments for one resident (R703) of three reviewed for change in condition resulting in R703 developing intense pain from a blood clot requiring hospitalization . Findings include: A Clinical record review revealed R703 was admitted to the facility on [DATE] for rehabilitation from back surgery performed on 1/5/24. Medical history includes, chronic obstructive pulmonary disease (COPD), hypertension, diabetes, chronic pain, morbid obesity, and overactive bladder. Brief Interview of Mental Status (BIMS) score total is 15/15 indicating R703 was cognitively intact. On 4/2/24 at 9:38 AM, a telephone interview was conducted with R703 and they reported on 01/17/24 around 1:00-2:00 AM they woke up with severe intense pain, swelling, and warm sensation in the left leg. The call light was pressed, and nobody came in. R703 placed their self into the wheelchair and saw a staff member sitting at the desk and asked to please have someone help. R703 stated a Nurse came in and provided ordered pain medications. After receiving the pain medication, the Nurse was informed the medication was ineffective and the pain and swelling was increasing. R703 indicated that the nurse never pulled down the covers, never looked at my leg. The nurse then stated the doctor would assess the leg in the morning. R703 reported they insisted the Nurse to call Emergency Medical Service (EMS) and get them to the hospital. R703 was subsequently admitted to the hospital on 1/17/24 and was diagnosed with a blood clot in the left leg which required surgery to remove it. A clinical record review of the medication administration record (MAR) was conducted on 4/3/24 which revealed administration on 1/17/24 at 2:51 AM, and documented pain medication was ineffective. The Situation, Background, Appearance, and Review (SBAR) Evaluation from 1/17/24 at 3:08 AM, was reviewed and revealed that the change in condition was reported as follows: Change in skin color or condition. Skin Evaluation on evaluation was blank. The SBAR Evaluation form revealed no records specific to R703's leg pain, or assessment. Further review of the record indicated no further documentation of assessments, progress notes, or transfer via EMS to a hospital. An interview with the Administrator (NHA) and Interim Director of Nursing (DON) was requested. On 4/3/24 at 11:35 AM, an interview was conducted with the NHA and the DON. The NHA and DON were informed of attempt to contact LPN L for an interview and still had no return call. When asked how the facility conducts a pain assessment, the DON replied the number scale is used to rate the pain, the intensity, the description of the pain, and the area of the body where the pain is located should be assessed and documented. When informed of R703's claim of sudden, intense leg pain and swelling after a back operation, the DON replied that nursing should have assessed for a concern of a possible blood clot. On 4/3/24, The NHA confirmed there was no further documentation related to the above incident, no communication was noted between the Nurse, Physician, and EMS transfer. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 3:00PM, a clinical record review of requested hospital documentation revealed R703 had arrived at the Emergency Department (ED) on 1/17/24 at 4:30 AM. Per ED assessment, R703 stated the pain woke her up from her sleep. Stated it felt tight, swollen, and had a squeezing sensation. A consented photograph of the left leg was reviewed, and documentation read.Patient has purple discoloration of the skin extending proximally (closest) above the knee. Left lower leg swelling, and pain . Further review of the record revealed on 1/17/24 at 6:38 AM, A doppler (ultrasound of leg) diagnosed an extensive blood clot in the left leg. Heparin Medication (blood thinning medication) was started, and vascular surgery was consulted for an emergent thrombectomy (surgery to remove blood clot from the vein) and placement of an Inferior Vena Cava (IVC) Filter (filter placed into the body to stop blood clots from going up into the lungs). The facilities Pain Management Policy Origination 5/1/2010, Last Revised 4/11/2023, .The facility will evaluate and identify residents for pain, determine the type, location, and severity. Additionally, residents will be monitored for the presence of pain and evaluated when there is a change in condition and whenever new pain, or an exacerbation of pain is suspected .