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	05/22/2024

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 This citation pertains to intake #'s MI00138702 and MI00144605. Based on observations, interviews and record review, the facility failed to protect the Resident's (R611) right to be free from neglect, including the provision of medical assistance, activities of daily living (ADL) assistance, medication administration and nursing supervision/monitoring for one of three reviewed for neglect, resulting in the resident to have been abandoned at a chemotherapy appointment, waiting approximately five hours for family to pick them up and having to pay for an overnight motel room until the resident was able to go to the hospital for medical care. Findings include: The immediate jeopardy (IJ) began on 5/17/24, it was identified by the survey team on 5/21/24 and the facility was notified of the IJ on 5/21/24, and a removal plan was requested. On 5/22/24, the State Agency completed onsite verification that the Immediate Jeopardy was removed on 5/22/24, however the facility remained out of compliance at a scope of isolated and severity of potential for more than minimal harm that is not Immediate Jeopardy due to sustained compliance that has not been verified by the State Agency. On 5/20/24 the State agency received a complaint in regard to R611 being abandoned at a chemo therapy appointment, not being accepted back into the facility and requiring hospitalization due to a lapse in nursing care. On 5/21/24 at 9:30AM, R611 was contacted via cell phone and asked how they were doing and where were they located, R611 responded that they were doing better and was at the hospital. R611 was then asked what happened on 5/17/24 the entire day, R611 stated that they went to their chemo appointment and when it was over they called the transportation company to come and get them and transportation stated we don't have an order to get you and hung up (the phone) on them. R611 continued and stated they then called the facility and asked them were they going to come and get them and the Nurse they spoke too stated that R611 had been discharged and couldn't come back there. R611 stated that they told the facility that they didn't have any clothes and all their items were in their room still and the nurse told R611 that they would have someone pack them up and someone could come and get it for them later. R611 then stated that they called their sister to help them, and R611's niece was then able to come and get them around 10 PM and they had to stay in a motel for the night because they had no where to go. R611 then asked could I call their sister so she could tell me the rest of what happened. (continued on next page)

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

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/21/24 at 10:00AM an interview with the Administrator was held and the Director of Nursing (DON) was present. The Administrator was asked how many residents the facility can hold and what is the current census, the Administrator stated they could hold 127 residents, and they were currently at 104. The Administrator was then asked how many beds they had available she stated about 23 or so and there was no female beds left and had about four male beds left the rest were Medicaid certified only. The Administrator was further questioned if someone was discharged could they take the resident back, the Administrator explained that they would not be able to take a female resident because they did not have any long term beds. The Administrator was asked why couldn't R611 come back to the facility after a chemo appointment and the Administrator, We don't have any female beds and she was discharged to the hospital. This Surveyor reviewed the progress note with the Administrator that stated that R611 was sent to a chemo appointment and would go to the hospital after the appointment. The admin stated, No, she was discharged to the hospital that morning due to aggressive behaviors and pain. The Administrator stated she would check with the admissions to see where R611 was and if they had been discharged (from the hospital) because that's how they had it in the system. The Administrator came back and stated that [Name of transport company] transportation was to take her to her chemo appointment and then was to take her to the hospital. The Administrator was informed that R611 stated that they were stranded at the chemo appointment and had no one to pick them up until 10PM that night because transportation stated they didn't have an order (to pick the resident back up from the chemo appointment). The Administrator then stated the transportation company should have picked them up and took them to the hospital and stated she would follow up. On 5/21/24 at 10:32AM, [Transportation company] was contacted and asked did R611 have any upcoming appointments scheduled, they replied, No. [Transportation company] was then asked can they look back and see what R611's route was for 5/17/24. FT replied that R611 had a round trip but on that morning, Nurse B called and canceled the return trip back to the facility. [Transportation company] was asked did Nurse B state why they canceled transportation, [Transportation company] stated, Because she said they were discharged . On 5/21/24 at 10:35 AM, the administrator was notified about the findings from [Transportation company] and stated she would follow up and see who that nurse was. This indicated the facility set up transportation for R611 to attend their scheduled chemotherapy appointment. The facility then canceled the return transportation and discharged the resident from the facility while they attended their chemotherapy appointment, leaving them stranded without transportation, shelter, or medical care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/21/24 at 11AM, during a telephone conversation with R611's Family Member C and D, they reported they were notified by R611 that the facility had discharged them and were not going to allow them to return after their Chemotherapy (chemo) appointment had concluded (. They reported that R611 was left outside of the Chemo center in their wheelchair for almost five hours without any food, drink, medication, or medical supervision after receiving chemotherapy. Family Member C indicated they had R611's niece (Family Member D)pick R611 up after driving out of state and took R611 to a motel. At that time, R611 had an episode of incontinence and was in severe pain. Family Member C reported that R611 was in extreme pain during the night at the motel and subsequently had to go to the emergency room due to their untreated pain and not being able to receive their anticoagulant medication and was scared they would have a stroke. Family member C also stated that after she had gotten off the phone with Nurse B the morning of 5/17/24 she (Nurse B) then called R611 and told them that they were being discharged from the facility and asked R611 if they wanted to go to the emergency department. R611 stated, No after my chemo, I just want to go back to the facility and lay down. Family member D stated that she was on her way out of town when they received a call to come and pick up R611 . Family member D stated she had to turn around and come back to get R611 around 10 PM. Family Member D took R611 to their daughter's house but the apartment could not accommodate R611 needs (because of the stairs) so she got a motel room for the night and R611 stayed in the motel room with their daughter until the next morning when R611 was in so much pain she had to take them to the emergency department. On 5/21/24 at 12:15 PM, the administrator was interviewed along with the Unit Manager (UM) and asked why R611 was not permitted back to the facility if they were transported to a scheduled doctors appointment, why was the transportation canceled for the resident to return to the facility, and how they expected the resident to get back to the facility or the emergency department if their means of transportation was canceled. The Administrator replied, She was supposed to go to the hospital and because we don't have any available beds, she couldn't return. This surveyor asked for the bed hold policy and if R611 was offered one, the Administrator stated they would follow up. On 5/21/24, a record review revealed that R611 was admitted into the facility on [DATE] with the diagnoses of Malignant neoplasm of breast, cerebrovascular disease and hemiplegia and hemiparesis of the right Side. According to the most recent Minimum Data Set (MDS) assessment, R611 had a Brief Interview for Mental Status score of 12, indicating moderate cognitive deficits. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/22/24 at 9:47AM, an interview with Nurse B was conducted. She was asked how long they had worked at the facility and what unit did she typically work on. Nurse B replied they had been at the facility for about three weeks and usually worked on unit 1 but was on unit 2 today. Nurse B stated she was contingent (works less that part time) stated she floats (moves from unit to unit). She was then asked about the incident with R611, Nurse B explained R611 had aggressive behaviors, was following her up and down the hallway and cursed me out stating they were in pain. I asked (R611) to go to their room because I was taking care of another resident at that time. Nurse B was asked who ordered R611 to be transported to the hospital? Nurse B replied their Doctor had ordered it, but R611 had left the facility for an appointment. When I called the Doctor to make him aware of their behaviors, the doctor stated (R611) could go to the hospital once they finished the chemo appointment. Nurse B stated she was not aware that R611 had an appointment so around the time she completed the e-transfer assessment the resident was already out of the facility and at their appointment. Nurse B was asked how she didn't know that R611 was out of the facility and that they had a chemotherapy appointment since they were assigned to care for R611. Nurse B replied, Morning activities came and took [R611] to the front of the building and there is a communication located in [Electronic Medical Record] called the dashboard where all appointments and important information can be found. Nurse B was asked if they reviewed the dashboard prior to the incident with R611 and Nurse B acknowledged they had not. Nurse B was asked if she communicated with the resident about the order to send them to the hospital, Nurse B replied, No, I spoke with the family to let them know I was sending them out. Nurse B was asked why transportation for back to the facility was canceled. Nurse B was informed at that time that [Transportation company] provided this Surveyor her name stated that Nurse B had canceled the ride. Nurse B replied, Then I guess I did if that is what they told you. Nurse B was asked did she receive an education, trainings or follow up from the Administration staff regarding the incident with R611 and Nurse B replied no. Nurse B was asked why they called the physician for orders to send R611 to the hospital and Nurse B explained it was because the resident was cursing at them because they wanted their pain medication. Nurse B was asked why they didn't administer R611's pain medication to them and Nurse B stated they were going to help another resident first. Nurse B was then asked why they called the physician to send R611 to the hospital if they were not a threat to themselves and/or others and was no longer in the building and on their way to their chemotherapy appointment, and Nurse B stated at the time, they didn't know that R611 had an appointment that morning. On 5/22/24 at 10:00AM, R611 was observed resting in their bed with their eyes closed. On 5/22/24 at 10:07AM, the Social Worker (SW) was interviewed and asked did she complete a petition for R611 to be sent to hospital for a psychiatric evaluation, SW stated no. The SW was then asked what she knew in regards to R611 on 5/17/24, and the SW stated there was a new nurse that approached her with Unit Manager stated that R611 was being verbally abusive and that sounds like a situation where the administration needs to be involved. The Admin was present and stated that she would handle the situation so I did not get involved further. The SW was then asked was she aware the return transportation was canceled for R611, and the SW replied no. The SW was then asked was this a usual or typical behavior for R611. The SW stated, No, I have never experienced that behavior but there was concerns that the cancer may have spread to their brain and other parts of the body. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/22/24 at 10:39AM The director of Nursing(DON) was interviewed and asked what happened with R611 and Nurse B. The DON replied, [Nurse B] came to me and stated that she did not like how [R611] was speaking to her and felt that [R611] was drug seeking and that it was too early for [R611] to receive their pain medication. I told [Nurse B] not to take it personal and when it was time to administer the medication to give it to [R611]. The DON was informed that after review of the medical record, it revealed that R611 was due for their pain medication. The DON was asked if R611 was in pain and wanted their pain medication before their chemotherapy appointment, why didn't the nurse administer it to deescalate the situation with R611 and the DON stated they were not aware that R611 could receive their pain medication because they were told by Nurse B that (R611) medication was not due yet. The DON was asked how the Administrator got involved, and explained that the nurse must have went to the Administrator after we had spoken.The DON stated they saw the Administrator was handling the situation and that there was no need for both of them to handle the situation. DON stated she did receive a call from staff on Saturday to see if they could accept R611 back from the hospital. The DON stated, I contacted the Administrator to see if we could accept the resident back and that's when the Administrator told me that we did not have any more female beds available. I called the nurse back and relayed the message.The DON was then asked how a resident that goes to their chemotherapy appointment gets discharged from the facility while at the appointment, who is not informed of the discharge and/or transfer by the facility staff, and who also had their return transportation canceled, no longer has their bed/room at the facility and the DON explained they were under the understanding that R611 had returned back to the facility after their chemotherapy appointment and was transferred to (hospital name) after their return from their chemotherapy appointment. On 5/22/24 at 11:04 AM, Unit Manager(UM) A was interviewed and asked about the incident that occurred with R611 and Nurse B, UMA explained that it started on Thursday 5/16/24 and that the resident was cursing the nurse out about receiving their medications and following Nurse B from room to room. UM A stated, [R611] began to curse me out and I went ahead and gave her the medications for Nurse B. I asked the SW to come out and assist and the Administrator ended up being present and they stated that they would handle it. On 5/22/24 at 3:20PM Nurse B was re-interviewed and asked for clarification on the date of the behavior incident that occurred with themselves and R611, and Nurse B stated, It happened Thursday 5/16/24. Nurse B was then asked actually happened the next day on 5/17/24 when they called the doctor to send the resident out to the hospital and Nurse B replied, [R611] was just cursing at them on 5/17/24. Nurse B was then asked if the incident happened on 5/16/24, why did they call the physician on 5/17/24 to obtain an order to send R611 to the hospital if R611 was not a treat to themselves and/or others on 5/17/24 the day of their chemotherapy appointment and Nurse B explained that R611 was still verbally aggressive. The Immediate Jeopardy that began on was removed on when the facility took the following actions to remove the immediacy. [Facility] submits the following Credible Allegation of Compliance outlining the measures it has completed to abate the findings of immediate jeopardy. [Facility] believes that as 5/21/24 at 5:30 pm the measures it has implemented demonstrate compliance. 1. Resident identified to be affected by the alleged deficient practice. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident # 611 is scheduled to return 5/21/24 at 5:30 pm. The Administrator has been suspended pending investigation. 2. Residents with the potential to be affected by the alleged deficient practice. The facility currently has 104 residents residing in the facility, the administrative nurses reviewed residents with scheduled appointments to ensure transportation was set/confirmed to ensure residents are returned back to the facility on 5.21.24. In addition, newly admitted residents or readmitted residents, will be reviewed M-F during the clinical meetings; to ensure residents who requires transportation to scheduled appointments are set/confirmed to ensure residents are being returned back to the facility safely. As well as, communicated on the dashboard. 3. Systematic Measures The License Professional Nurses education began on 5.21.24 at 4:14 pm and they were re-educated on the facility's Routine Resident Care Policy, Medication Administration Policy, and the Standard of Nursing Practice Policy to residents' needs are met. There are 44 Licensed Nurses who will be in-serviced on Routine Resident care Policy, Medication Administration Policy and Standards of Nursing Practice Policy. As of 5pm on 5/21/24, 40 nurses have been in-serviced and in-servicing continues. This will be on-going until all licensed nurses have been re-educated. The remaining nurses will receive education on the above policies on or before their next scheduled day. The Certified Nursing Assistances (CNA/CENA) education began on 5.21.24 at 4:14 pm and they were re-educated on the facility's Routine Resident Care Policy to ensure residents' needs are met. There are 46 CENA'S who will be in-serviced on the Routine Resident Care Policy. As of 5pm on 5/21/24, 38 CENA'S have been in-serviced and in-servicing continues. This will be on-going until all licensed nurses have been re-educated. The remaining CENA'S will receive education on the above policies on or before their next scheduled day. Scheduler, Receptionist, and Central Supply was educated on residents who have scheduled appointments will ensure transportation is set/confirmed to ensure residents are returned back to the facility. The DON/Admin Nurses reviewed the appointment book to ensure upcoming scheduled appointments, were confirmed for pick-up and return trip to the facility. Any areas of concern will be addressed. Finding will be taken to the monthly QAPI (quality assurance process improvement) meeting for further review and recommendations. The DON is responsible obtaining and maintaining compliance. DON will sustain and maintain compliance.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. 48680 Based on interview and record review, the facility failed to ensure two of six staff members reviewed for criminal background checks were screened for eligibility to work in a nursing home, resulting in the potential for abuse or neglect to occur. This has the potential to affect all residents who reside in the facility. Findings include: On 5/22/24 at 8:30AM the facility was asked to provide the personnel file, all educations, trainings. Disciplines and background checks for six employees. On5/22/24 at 10:10AM a follow up request was initiated for employee's information. On 5/22/24 at 12:32PM The facility provided the files with completed background checks, educations and trainings for all employees except for two. The facility provided a personnel file for Nurse H, this file was not requested, however was reviewed due to identification of a missing background check clearance. A third request for Nurse B's file was made to the Administration staff. Nurse H's file was reviewed and it was missing educations, training, a background check with finger print results. On 5/22/24 at 2:00PM the facility provided additional documentation for Nurse B and Nurse H personnel files however the fingerprint background results were not included. At this time the Administration and corporate personnel was asked to provide fingerprint results for both Nurse B and H. On 5/22/24 at 2:30PM the facility provided a background check for Nurse B that was dated 5/22/24 (the day of the request) and one for Nurse H dated 10/24/18. The facility was then asked to provide the Hire dates for these two nurses . The hire dates for both nurses needs to be documented in this paragraph. Also, It should be noted that Nurse B was allowed to work in the facility without the results of the background fingerprint check to have been obtained by the facility and without signing a conditional letter of employment document, pending the results of their fingerprint check. It should note that Nurse H was a former employee who had left the facility and was rehired on (date) and was allowed to work in the facility without a current fingerprint background check completed upon their rehire. The director of Nursing (DON) and Human Resources (HR) was then asked can a person work without having a clearance to work they responded no and stated the staff should have one completed before working their shifts. On 5/22/24 at 3:45PM a follow up explanation and/or documentation was made for background clearances and hire dates to the Administration and Corporate staff- Identifiers. The facility was not able to provide any further explanation or documentation. No additional information was received by the exit of survey.