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	10/01/2024

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 0684 Level of Harm - 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** 41415 This citation pertains to intake: MI00146970. Based on interview and record review, the facility failed to continuously ensure orders were implemented for supplemental oxygen and for a CPAP (continuous positive airway pressure) machine, failed to implement care plans for chronic hypoxic and hypercapnic respiratory failure, failed to implement interventions for supplemental oxygen and the use of a CPAP machine, failed to provide the correct settings for the non-invasive ventilation as ordered by the Pulmonologist, failed to administer antibiotics as prescribed, and failed to provide the necessary CPAP/BiPAP (bilevel positive airway pressure) ventilation as needed for one R707 of two residents reviewed for falls, resulting in multiple incidents of respiratory distress and a change of condition that resulted in a fall, an acute corner fracture of the C5 vertebral body anteriorly and inferiorly, ultimately resulting in the residents death. Findings include: Review of a complaint submitted to the State Agency documented concerns of the care the facility provided to the resident (R707) who had a fall, fractured their back and ultimately died from their injuries. A review of the medical record revealed R707 was admitted to the facility on [DATE] with an admitting diagnosis of acute and chronic respiratory failure and additional diagnoses of chronic obstructive pulmonary disease (COPD) and asthma. Review of the hospital referral provided to the facility upon R707's admission included the following: A Pulmonary consultation dated [DATE] at 9:42 AM, . Acute on chronic hypoxic and hypercapnic respiratory failure . Acute exacerbation of COPD . At discharge can resume home ICS (inhaled corticosteroids)/[NAME] (long-acting beta agonists)/[NAME] (long-acting muscarinic antagonist) . Would benefit from home NIV (non-invasive ventilation) given severe chronic hypercapnia. Recommend continued to use QHS (every hour of sleep) & naps . Wean fio2 (fraction of inspired oxygen) for goal SPO2 (saturation of peripheral oxygen) , d+[DATE]%. Currently on his baseline 3L (liters) nc (nasal cannula) . appears high risk for recurrent exacerbations given severe disease at baseline . continue all aggressive care at this time . A review of the hospital After Visit Summary (dated [DATE]) provided to the facility at R707's admission documented the following: (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	. New Pap Machine & Supplies. Follow up with CPAP facility and pulmonology. Estimated Length of Need: Lifetime . Type of machine: CPAP, Heated Humidifier?: Yes, Type of Mask: Full Face Mask 1 per 3 months. CPAP 5 cm (centimeters), Tidal volume 480, rate 18, inspiratory time 1.2, max (maximum) pressure 37, min (minimal) pressure 7 . SPECIAL DISCHARGE INSTRUCTIONS . Very important to make sure you wear CPAP during sleep and with naps. Maintain nasal cannula throughout the rest of the day . A review of the Nursing admission note dated [DATE] at 6:55 PM, documented in part . Resident arrived to the facility via ambulance . With 02 at 3 L/m (liters/minute), at 91% saturation . Resident has CPA machine brought in by RT (Respiratory Therapist) but verbalized refusal to use it . Review of the medical record revealed no documentation of a physician order for the use of a CPAP as recommended by the hospital and no orders for oxygen administration. A review of a Nursing note dated [DATE] at 7:55 PM, documented in part . RT arrived with resident's CPAP. RT verbalized that she is unable to reach prescribed IPAP calibration of 37 but put it at 30. RT verbalized that 30 is the maximum calibration and that he would need a non invasive ventilator for the prescribed CPAP dosing which would be harder to acquire. Resident however declined to use CPAP and verbalized that he does not want to use it as it is uncomfortable for him and has caused bruising and abrasion on his nose. Review of the medical record revealed no notification to the Physician or interdisciplinary team to inform them of the CPAP machine settings concern and no notification of R707's refusal to wear the CPAP. Further review revealed no documentation of discussions for interventions to help prevent the CPAP nasal discomfort and no documentation of potential alternative methods and/or treatments. There was also no documentation of education provided to the resident regarding the refusal of the CPAP as ordered by the Pulmonologist. A review of the medical record revealed no documented assessment or evaluation completed by the RT that delivered the CPAP machine. Further review of the medical record revealed no implementation of care plans/interventions for R707's CPAP machine or Oxygen administration. Review of a Nursing note dated [DATE] at 5:51 AM, documented R707 had a change of condition Respiratory Arrest and was transferred to the hospital. Review of the hospital records for [DATE] to [DATE] hospitalization revealed the following: An Internal Medicine consult dated [DATE] at 1:33 PM, documented in part . PMHX (primary history) COPD on 3L NC (nasal cannula) at baseline . presented . for hypoxia. Patient was noted to have SpO2 saturations at 60% on 10L NC, patient was then placed on a non-rebreather en route with improvement to SpO2 100%. Patient noted to initially be in respiratory distress upon arrival. Initially in ED (emergency department), patient minimally responsive, not responding to questions or commands . Active Hospital Problems . AMS (altered mental status) secondary to hypercapnia, Acute on Chronic hypoxic respiratory failure with hypercapnia, Severe emphysema/COPD . The resident was admitted to the Intensive Care Unit (ICU). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a Pulmonary & Critical Care Specialists consult dated [DATE] at 8:57 AM, documented in part . presented . with a complaint of hypoxia, noted as low as 60s% . has end stage COPD, recently admitted to the ICU for a severe exacerbation, requiring many days of near-total BIPAP dependence . He is conversationally dyspneic and difficult to hear while on BIPAP. He is complaining of being thirsty. Per ED/IM (emergency department/internal medicine) notes he was saturating adequately on NRB (non-rebreather) but still felt dyspneic and asked to be placed on PAP which some improvement after this . ASSESSMENT AND PLAN: Acute on chronic hypoxic and hypercapnic respiratory failure, mostly chronic but very severe COPD . Recommendations: Will need maximal nebulized bronchodilator support (schedule Xopenex+Atrovent (respiratory medications) q4 (every four hours) along with Pulmicort (respiratory medication). Needs to be maintained on triple therapy [NAME]/[NAME]/ICS in outpatient if he can ever be stable enough to be maintained there. Would continue home azithro (azithromycin- antibiotic) MWF (Monday, Wednesday, Friday) along with singular (respiratory medications). Continue NIPPV (noninvasive positive pressure ventilation) (AVAPS- average volume-assured pressure support) qHS (every hour of sleep) and with naps- need to ensure long enough breaks to avoid worsening skin breakdown on nose . Only managed to reside outside of hospital environment for 3 days, he is very dependent on NIPPV . A review of an Internal Medicine consult dated [DATE] at 10:56 AM, documented in part . showing some improvement of his condition. He is more alert. Able to answer questions although does seem weak and fatigued. He has been transitioned to nasal cannula. Continue to wear BiPAP at night as he has high propensity for CO2 (Carbon Dioxide) retention and narcosis . Review of a hospital Pulmonary Teaching Service Progress Note dated [DATE] at 8:08 AM, documented in part . Patient seen and examined . Doing fairly on 3L (3 liters of oxygen) . arrangements made for SAR (Sub Acute Rehab) at 1pm today . Recommendations . Continue home azithro (antibiotic) MWF along with singular, Continue NIPPV (AVAPS) qHS and with naps- need to ensure long enough breaks to avoid worsening skin breakdown on nose - if AVAPS not available at facility and patient still wanting to try BIPAP usage can be put on ,d+[DATE] IPAP/EPAP (otherwise if transitioning into Hospice then patient can be given nasal cannula and dyspnea can be treated with morphine primarily rather than PAP . he is very dependent of NIPPV; agree with palliative care following case given recurrence admissions with end stage disease burden, agree with taking some palliative steps such as adding morphine for air hunger. Current plan is that patient would like to try going back to SAR 1 more time, but if failing again then he would like to go to a hospice facility . instead of coming back to hospital . Overall they feel patient is reaching a better/more realistic understanding of his poor prognosis . Review of an Internal Medicine consult dated [DATE] at 9:30 AM, documented in part . awake and resting comfortably in bed on 3 L of oxygen through nasal cannula. He is aware of discharge . Patient with end-stage emphysema and would be hospice appropriate however he is not ready to partake of hospice services . We are moving him to subacute rehabilitation today . He is leaving in improved condition. A review of a Nursing note dated [DATE] at 2:22 PM, documented in part . Nurse received resident in room by 2 ems (emergency medical services) drivers from (hospital initials) . RESIDENT A&OX3 (alert and oriented times three) . Resident is total dependent 2 person assist with all adl care . Resident is a fall risk due to overseeing limits and weakness . Resident lung sounds show expiratory wheezing in bilat (bilateral) anterior and posterior lungs . Resident in room resting eyes closed with no s/s (signs/symptoms) of distress at this time . This note was documented by Registered Nurse (RN) E. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the referral packet provided to the facility on [DATE] at 10:30 AM, contained the pulmonologist consult that documented the recommendations of . Continue NIPPV (AVAPS) qHS (hour of sleep) and with naps - need to ensure long enough breaks to avoid worsening skin breakdown on nose . The referral also contained the Internal Medicine consult that documented in part . remains on BiPAP mask . Patient with end-stage emphysema and continues to have oxygenation issues including CO2 retention and hypoxia . Review of the medical record revealed no documentation of the recommended CPAP or BIPAP applied while the resident was resting as documented above. Further review of the medical record revealed no physician orders for a CPAP, BiPAP or oxygen administration via NC ordered for R707. Review of the [DATE] Medication and Treatment Administration Record (MAR/TAR) revealed on [DATE] at 12:56 PM, a nebulizer treatment was provided to R707 for copd/sob (shortness of breath). Further review of the [DATE] MAR/TAR revealed the facility staff failed to administer the resident's antibiotic (Azithromycin 250 mg- milligrams) on [DATE] and [DATE], as prescribed by the physician. Review of the hospital discharge documents provided to the facility on [DATE] documented in part . Azithromycin 250 mg (milligram) . take 1 tablet . 3 times per week Monday, Wednesday Friday for COPD . Last time this was given: 500 mg on [DATE] - 4:28 PM . A review of a Physician note dated [DATE] at 3:00 PM, documented in part . hospitalized at (hospital name) from [DATE] through [DATE] . The patient is status post-hospitalization for hypoxia and respiratory failure. He was noted to by hypoxic on 60% on 10 liters. The patient had a previous hospitalization from [DATE] to [DATE] for chronic obstructive pulmonary disease exacerbation and atrial fibrillation with rapid ventricular response. The patient has recurrent hypercapnia. The patient requires BiPAP and he is noncompliant . He is awake. He is alert. He is oriented x3. Insight and judgment is intact . Continue supplemental oxygen . Continue BiPAP at h.s . Azithromycin every Monday, Wednesday, and Friday . Review of the medical record revealed no ordered supplemental oxygen or an order for the BiPAP and/or CPAP to be provided. Further review of the medical record revealed no documentation of noncompliance with the CPAP or BiPAP for the second inpatient readmission. All documentation of noncompliance was identified for the residents first admission into the facility on [DATE]. The resident was sent out to the hospital on [DATE] and educated by the hospital providers on the need for the CPAP and/or BiPAP when asleep at night and for naps. The facility failed to provide these services and care as directed. A review of a Nursing note dated [DATE] at 5:51 AM, documented in part . 95%NC (oxygen saturation level via nasal cannula). Pt has a severe case of anxiety which causes him to mouth breath more frequently. No other concerns at this time . It is unknown as to the liters of oxygen that was provided to the resident on [DATE], as there was no order implemented for the supplemental oxygen. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a Nursing note dated [DATE] at 12:40 PM, documented in part . Writer called to room by therapy. Writer entered room and noted resident appeared short of breath and lethargic O,d+[DATE]% via nasal cannula. Writer contacted primary physician . ordered to place resident on bipap and monitor for any additional changes. Once bipap was placed resident appeared less lethargic . Further review of the record revealed no documentation of the liters of oxygen that was provided via nasal cannula and no documentation of a bipap to have been delivered to the facility and no documentation of the settings the bipap and/or CPAP was set to. The medical record revealed no order for the BiPAP/CPAP or settings for either machine. A review of a note documented a few hours later noted in part . 4:15 p.m. Summoned to room by Nurse Manager. Resident was observed lying in supine position on the floor non responsive to verbal, tactile and painful stimulus, with his head near the oxygen concentrator. Noted laceration to the right side forehead with small amount of bleeding . B/p (blood pressure) ,d+[DATE], O2 sat at 60% . 911 was called . resident was transferred out of the facility to (hospital name) . Review of a facility provided Post Fall Evaluation dated [DATE] at 4:15 PM, documented in part . Fall Description Details . Non-responsive . Lost strength/appeared weak . lying on supine position on the floor with head near the oxygen concentrator . Observed on the floor (unwitnessed) . What was the guest/resident doing during or just prior to fall? On the bed . resident's usual mental status- usually alert + responsive . Were temperature, pulse, respirations and/or O2 Sat out of normal range for this guest/resident? (not answered and left blank) . root cause- non-responsive respiratory distress . sent to the hospital for further evaluation . Review of the hospital medical record revealed the following: An Emergency Medicine consult dated [DATE] at 4:38 PM, documented in part . Chief Complaint Patient presents with - Unresponsive . arrived to ED (emergency department) . Suspected fall, Pt (patient) found on the ground unresponsive to verbal or painful stimuli . Patient on the ground at his nursing facility unresponsive to painful stimuli and saturating at 60%. Patient arrived and was being bagged by EMS in the low 90s . He is in acute distress . Noted hematoma to patient's right parietal region . Pupils equal but unreactive . Patient mechanically ventilated . Capillary refill takes more than 3 seconds . Skin is cyanotic, mottled and pale . He is unresponsive . CT Trauma Protocol Head/Brain w/o IV contrast . Impression . Right frontal soft tissue hematoma . Standard CT of the cervical spin was obtained . Impression: Acute corner fracture of the C5 vertebral body anteriorly and inferiorly Critical findings . Patient was started on fentanyl and propofol drip . Patient to remain intubated until family gets to the bedside. However, patient's family is out of town and will not be back for a couple of hours. At this time patient was admitted to ICU . A Nursing note dated [DATE] at 11:02 PM, documented in part . Decision made by family to extubate pt. See orders. Family at bedside . A Nursing note dated [DATE] at 12:25 AM, documented in part . RN (registered nurse) paged ICU resident (Doctor name) regarding declining heart rate and respirations. (Doctor name) at bedside to assess pt. (patient) TOD (Time of Death) called 0025 (12:25 AM). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 1:25 PM, an interview was conducted with RN E (the nurse that readmitted R707 on [DATE]) with the Director of Nursing (DON) in attendance. When asked if they were aware that R707 was supposed to be on a CPAP/BiPAP machine for naps and sleep at night, RN E replied they were not aware. RN E explained it was their first time being assigned to R707 at the facility. RN E explained they reviewed the discharge paperwork and didn't see anything on there. RN E stated they were not aware that (R707) was on a CPAP until days later when staff was looking for the CPAP machine that was located in the medication room. RN E was asked if they reviewed the referral packet sent from the hospital with the pulmonologist instructions to ensure R707 had the CPAP/BiPAP on when taking naps and at hour of sleep and RN E stated they did not receive or review the referral packet. The DON was then asked the facility's protocol on receiving and the reviewal of the referral packet to ensure the facility is equipped to provide the services and have the equipment that is needed to provide care for the resident once the resident is accepted for admission. The DON explained they have a centralized admission personnel who reviews the packet and they (the DON) also reviews the packet as well to ensure the resident is appropriate and the facility have all the required equipment and supplies. The DON was then asked if they were aware that the RT was unable to provide the settings for the CPAP/BiPAP machine as ordered by the hospital pulmonologist for R707's initial admission to the facility and the DON stated they did not recall being informed. The DON was asked if they were aware of the staff/physician failure to ensure orders were implemented for the necessary supplemental oxygen and CPAP/BiPAP for both inpatient stays for R707, the DON stated they were not aware however would look into that and follow back up. The DON stated they were able to review the readmission discharge orders for the [DATE] readmission and it did not note an order for a CPAP/BiPAP. The referral was pointed out to the DON that was provided to the facility on [DATE], which contained the documentation of R707 to be dependent on the CPAP/BiPAP and to be utilized during naps and sleeping at night. It was also brought to the DON's attention that the supplemental oxygen was not ordered on the readmission discharge orders either, however the facility staff provided it because they knew R707 required it, just as R707 required the use of a CPAP/BiPAP for naps and sleeping at night. The DON was asked why the staff provided supplemental oxygen if it wasn't on the hospital discharge orders and they did not have a current order to provide it and failed to provide the necessary CPAP/BiPAP, the DON acknowledged the concern. The DON was then asked why there was no plan of care/interventions implemented for the primary diagnosis of this resident for acute and chronic respiratory failure and the use of supplemental oxygen and CPAP/BiPAP. The DON stated they would look into it and follow back up. The DON was also asked why the resident had not received their antibiotic as ordered on [DATE] and [DATE], the DON stated they would look into it and follow back up. At 2:33 PM, the DON returned and stated they were unable to find the requested care plans and physician orders for the supplemental oxygen and CPAP/BiPAP machine. The DON acknowledged the omission of the resident's antibiotic on [DATE] and [DATE]. The DON stated they had plans to implement measures and to provide additional education to prevent this from occurring in the future. No further explanation or documentation was provided by the end of the survey.