STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235508	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/03/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 This citation pertains to intake MI00147820. Based on observation, interview and record review, the facility failed to provide appropriate treatment and interdisciplinary collaboration to prevent further decrease in range of motion for one resident (R902) of two reviewed for range of motion. Findings include: A review of a complaint reported to the State Agency on 11/1/24 included an allegation the facility failed to apply the residents hand brace/splint. Record review revealed R902 was admitted to the facility on [DATE] with a history of stroke, limitations of activities due to disability, right hand contracture, heart failure, diabetes, and respiratory failure. Psychological history includes depression, schizophrenia, and generalized anxiety disorder. Most recent BIMS (Brief Interview for Mental Status) assessed 11/11/24 was 11/15 indicating R902 was moderately cognitively impaired. On 12/2/24 at 9:40 AM, R902 was observed in their room in a wheelchair with their right hand contracted in a fist resting on their lap. A blue colored brace/splint was observed on the tray table. When inquired about the splint/brace, R902 replied with frustration that they (facility) had not had the brace/splint applied since they were transferred from their previous facility. When inquired why it was not applied, R902 replied in frustration, I cannot put it on myself, I ask but the staff don't help put it on. R902 was observed taking their left hand to open their right contracted hand, and commented, I cannot open my hand like I used to. Record review of the care plan created on 4/25/24 by Unit Manager A (UM A) documented R902 had a diagnosis of contracture to their right hand and was at risk for pain. Record review revealed on 6/21/24 an order was placed for a right-hand splint to be donned daily as tolerated. Further review confirmed the order for the brace was not included in Care plan Interventions and review of the Treatment Administration Record (TAR) from June, July, August, September, October, and November 2024 revealed no documentation of the right-hand splint. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/2/24 at 3:00 PM, The Director of Nursing (DON) and UM A entered the room and R902 informed UM A and the DON that they have not had the brace applied since admission. The resident commented that the last time it was on, was at their previous facility. The DON and UM A were observed looking at the brace and watching R902 point to their contracted right hand and appeared muddled R902 had the splint, and commented they will look into it. On 12/3/24 at 10:30 AM, a record review revealed Occupational Therapist C assessed R904 for the right-hand splint and created an order 12/3/24 at 9:50 AM. Review of the facilities Policy titled; Brace and Splint Program dated 4/2024 documented: .Communicate individualized interventions to the direct care providers. Provide specific directions as needed .Update Care plan and Kardex .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #MI00147667. Based on interview and record review the facility failed to ensure Physician orders were transcribed and implemented for bowel movements for one resident (R903) of of two residents reviewed for bowel and bladder. Findings include: On 12/2/24 a complaint submitted to the State Agency was reviewed which alleged the facility was not monitoring and treating a change in condition for R903. On 12/2/24 the medical record for R903 was reviewed and revealed the following: R903 was initially admitted to the facility on [DATE] and had diagnoses including Constipation and Colostomy status. A review of R903's comprehensive plan of care revealed the following: Focus-[R903] is at risk for altered elimination pattern, altered body image, fluid imbalance, skin breakdown and pain: has a colostomy. Date Initiated: 10/28/2019 .Interventions-Observe for diarrhea, constipation, dehydration, pain Q (every) shift and report if indicated. Date Initiated: 04/25/2018 .Ostomy care as ordered and PRN (as needed). Date Initiated: 04/25/2018 . A Nurse Practitioner Evaluation dated 9/27/24 revealed the following: REASON FOR VISIT: Evaluation and management of abdominal pain. CHIEF COMPLAINT: abdominal pain .Nursing staff notified reported patient has been complaining of abdominal pain. Patient confirms she is endorsing abdominal pain,especially to palpation .ABDOMEN: firm. distended. tender to palpation. Bowel sounds hypoactive. No peritoneal signs. Colostomy is patent and functioning ASSESSMENT/PLAN: #Abdominal pain: -check abdominal XR (X-ray) -monitor vital signs q (every) shift -monitor intake and output -check CBC (complete blood count) , CMP (comprehensive metabolic panel) . A Nursing note dated 9/27/24 revealed the following: .Noted abdomen bloated and firm to touch physician in house new orders for vitals now. stat abdominal xray and cbc,cmp ordered and noted A Nursing note dated 9/28/24 revealed the following: Writer contacted [R903's Physician]regarding resident's abdomen. Resident's abdomen is distended. Bowel sounds present to LLQ (left lower quadrant),RLQ (right lower quadrant), RUQ (right upper quadrant). LUQ (left upper quadrant) presents with no bowel sounds at this time. MD (Medical Doctor) gave orders to give hypodermoclysis at 60ml (milliliters.)/hour. MD also gave order for bisacodyl 5mg (a stimulant laxative to treat constipation) to be inserted into stoma for constipation. Writer gave prn milk of magnesia, 30 ml. Medication was ineffective. Resident has not had any output from stoma. X-ray was completed yesterday, MD made aware. Labs were ordered yesterday by Unit manager. Lab have not yet been drawn. Hypodermocylsis is running at this time. Resident is tolerating well at this time. Resident stated that her stomach was not hurting her at this time. Resident refused breakfast and lunch. Resident drank supplement drinks provided by dietary (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nursing note dated 9/29/24 revealed the following: Patient was noted as unresponsive @ 0540 by CNA (Certified Nursing Assistant). Writer was notified and 911 was called immediately. Fire, police, and ambulance arrived at 0548. Patient is a DNR (do-not-resuscitate). Physician, guardian, and DON (Director of Nursing) notified. A review of R903's Physician ordered medications did not reveal any entered orders for the bisacodyl 5mg to be inserted into stoma for constipation. A review of R903's Medication Administration Record (MAR) for September 2024 was conducted and did not reveal any documentation that R903 received administration of the bisacodyl 5mg into their stoma. On 12/3/24 at approximately 10:39 a.m., R903's death was reviewed with the Director of Nursing (DON), the DON was asked for any documentation that the Physician's order for the biscodyl 5mg via stoma was administered per their order and they indicated they could not find any documentation that it was administered in the medical record. The DON was asked what the process was for implementing a Physicians order and they indicated that the biscodyl order was an order for a different dose and route that what R903 already had and a new order should have been entered into the record, documented and administered. On 12/3/24 at approximately 11:26 a.m., R903's progress notes were reviewed with Physician C and they were asked if the Nurse should have implemented their orders including the bisacodyl 5mg and they reported they should have. No documentation that R903 was administered their bisacodyl 5mg via stoma on 9/28/24 was received before the end of the survey.