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 01/14/2025
NAME OF PROVIDER OR SUPPLIER: The Manor of Farmington Hills		STREET ADDRESS, CITY, STATE, ZIP CODE: 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 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 38271

This citation pertains to intakes #'s MI00149299 and MI00149193.

Based on observation, interview and record review the facility failed to implement effective interventions including accurate wound treatments and completing accurate assessments for two residents with pressure injuries (R901 and R902) of two residents reviewed for Pressure Ulcers.

R901

On 1/14/25 a concern submitted to the Stage Agency was reviewed which alleged R901's skin had broken down while at the facility.

On 1/14/25 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted on [DATE] and had diagnoses including Diseases of biliary tract and Limitations of activities due to disability. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 12/27/24 revealed R901 needed assistance from staff with most of their activities of daily living. R901's BIMS score (brief interview for mental status) was 15 indicating intact cognition.

A facility form titled Nursing Comprehensive Evaluation dated 12/20/24 revealed the following: Section K Skin: 16. left antecubital-The fold has rashes and it pink. 14. Abdomen-Stitches from surgery in 3 places. 21. Right iliac crest (rear)-Scrabe <sic> (scrape).

A progress note dated 12/20/24 revealed the following: she has scrabe at the back and sacrum on the left armfold she has rashes, at the abdomen there is stitches in three places from her surgery .

A Braden Scale for Predicting Pressure Sore Risk dated 12/22/24 revealed R901 had a score of 14 indicating moderate risk of skin break down.

A Skin/Wound progress note dated 12/24/24 revealed the following: Resident ADM (admitted) 12/20/24. Resident wears reading glasses, lives alone in home, sits up to sleep in a chair at home, is incontinent of bowel and bladder. Resident required writer and additional two staff to assist with repositioning and turning, resident is unable to lift or move legs. Skin alterations noted are as follows: B/L (bilateral) arm bruising, redness in b/l folds to arms, abdomen, breast, and legs, 4 small surgical incisions with surgical tape in place, redness with no drainage or warmth observed, healed incision to right lateral foot,b/l foot/heels blanchable redness, b/l Lelymphedema, open abrasion to sacrum. Area cleaned and dressed

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Skin and Wound Evaluation dated 12/24/24 revealed the following: Describe: 15. Pressure .Stage: Stage 3-Full thickness skin loss. Location: Sacrum. Acquired: Present on admission .Wound Measurements: Area-2.7 CM2 (centimeters squared). Length-3.0 CM. Width-1.3 CM .2a. % Granulation-100% of wound filled .Exudate: 1. Amount-3. Moderate. Type: 2. Type-4. Serosanguineous .Orders: 1. Goal of Care-2. Slow to Heal: wound healing is slow or stalled but stable, little/no deterioration . Further review of the medical record revealed no treatment orders for R901's sacrum wound were implemented until 12/24/24 which revealed the following: Clean sacrum abrasion with NS, pat dry, apply triad foam, 4x4 gauze, foam border/ABD (abdominal) pad and secure with tape every day shift every Tue, Thu, Sat for wound care. A review of R901's treatment administration record (TAR) and medication administration record (MAR) for December 2024 revealed no treatments were documented as completed on R901's sacrum until 12/26/24. On 1/14/25 at approximately 12:45 pm., Wound Care Nurse B (WCN B) was interviewed regarding R901's pressure ulcer. WCN B reported that R901 admitted with the pressure ulcer and when they assessed it, it was a Stage 3 sacrum wound. WCN B was queried why no treatment orders were implemented for the wound upon admitting to the facility and they reported that the admitting Nurse should have had a treatment ordered for it but that they were working on educating the Nursing staff on obtaining wound treatments upon admission and not having to wait until WCN B had assessed them. WCN B reported that a treatment should have been ordered and completed after R901 had been assessed by the admitting Nurse on the day they arrived. On 1/14/25 at approximately 1:50 p.m., during a conversation with the Director of Nursing (DON), the DON as asked what the process was for ensuring wound dressing are ordered and they reported that the Nurse doing the admission assessment should be contacting the Doctor and implementing a treatment order to treat the wound until they are assessed by the wound care team. 41415 R902 Review of a complaint submitted to the State Agency (SA) documented concerns of the facility's failure to provide adequate and appropriate care to prevent a pressure wound for R902. A review of the medical record revealed R902 was readmitted to the facility on [DATE] with diagnoses that included: end stage renal disease and dependence on renal dialysis. On 1/14/25 at 10:55 AM, R902 was observed sitting up in bed eating breakfast. A brief interview was conducted with R902 at that time. At 11:17 AM, an observation of R902's buttocks was conducted with the assistance of Unit Nurse Manager (UNM) A. A pink wound dressing, no date noted was observed on the right side of R902's buttocks. On the left side was an identified open area with maceration. There was no treatment applied to the left buttocks. UNM A confirmed the left side opening and stated treatment should be applied to that area. Shortly after, an observation of the facility's treatment cart was conducted and the wound dressing observed on R902 was identified as an Allevyn dressing. (continued on next page)

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	235508	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the medical record revealed no documentation of the identification of the left buttock skin impairment and no treatment implemented for the left buttock. A review of a Skin & Wound assessment completed 1/13/25 documented no new skin impairments identified for R902. Review of R902's January 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented the following order: Cleanse with Normal Saline, pat dry, apply Triad Hydrophillic Wound Dressing every shift also apply Allevyn Gentle Border dressing Q3 (every three) days and PRN (as needed) for Skin Abrasion to right upper buttocks every shift for Skin Abrasion Cleanse with NS (Normal Saline) pat dry, apply Triad Hydrophillic Wound Dressing. Start Date 1/4/25. This order was signed as completed twice a day. A second order documented: Cleanse with Normal Saline, pat dry, apply Triad Hydrophillic Wound Dressing every shift also apply Allevyn Gentle Border dressing Q3 days and PRN for Skin Abrasion to right upper buttocks every 72 hours for Skin Abrasion Cleanse with NS pat dry apply Allevyn Dry Dressing. Start Date 1/4/25. This order was signed as completed every three days. Both orders were for the same area, the right upper buttocks. A review of the medical record revealed no documentation of the identification of the duplicate orders or clarification on the correct treatment that should have been implemented for the right buttocks. On 1/14/25 at 12:44 PM, an interview was conducted with the Wound Care Nurse (WCN) B. WCN B was asked if they were informed of the skin impairment to R902's left buttocks and WCN B replied they were not. WCN B stated the staff should notify them of any skin issues identified on the residents. WCN B was asked about the two duplicate treatment orders for the right buttock area that was being applied by staff twice a day and every three days and asked to clarify what the order should be. WCN B stated they were unaware of the two implemented treatment orders but would look into it and follow back up. At 1:38 PM, WCN B returned and stated R902 was assessed and excoriation was identified on the left buttock and staff was in the process of notifying the physician for treatment orders. WCN B stated R902 orders were reviewed and is now fixed to reflect the correct order. At 1:48 PM, the Director of Nursing (DON) was interviewed and asked about R902's skin observation, the unidentified skin impairment to the left buttocks and the two treatments implemented for the right buttocks, without the error to have been identified by the staff and clarified. The DON replied that all breaks in the residents' skin should be reported to the physician and have treatment in place. The DON stated the treatment dressing that was observed on the right buttock should have been dated by the staff. The DON confirmed R902's treatment orders had been reviewed and should have been identified and clarified with the physician to reflect the correct treatment order. No further explanation or documentation was provided by the end of the survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00149193. Based on observation, interview and record review the facility failed to accurately obtain and monitor weights for one (R902) of one resident reviewed for weight loss. Findings include: During an interview conducted with the complainant on 1/14/25 at 9:50 AM, the complainant verbalized concerns of weight loss and the facility staff not providing assistance for meals for R902. A review of the medical record revealed R902 was readmitted to the facility on [DATE] with diagnoses that included: end stage renal disease and dependence on renal dialysis. On 1/14/25 at 10:55 AM, R902 was observed sitting up in bed eating eggs with their fingers. A white towel covered the front of their chest area, with eggs observed all over the towel. R902's tray consisted of ham, eggs, toast and oatmeal. There was no staff observed in the room. When asked if staff offered to help them with their meal, R902 stated they had but they declined their offer. A review of a Weight Summary for R902 documented the following: 11/7/24 - 126 lbs. (pounds) 10/4/24 - 162.1 lbs. 9/27/24 - 160.3 lbs. A review of the dialysis communication forms for R902 revealed the following weights: 9/30/24 - 127.2 lbs. 10/2/24 - 129.4 lbs. This revealed a big discrepancy when compared to the weights obtained by the facility staff. Record review revealed R902 had amputations completed of the right and left legs in July and September 2024. This affected the baseline weights for R902, which was not identified by the facility staff and reflected in the weights obtained until November 2024. This indicated the facility staff failed to obtain and document the accurate weights for R902. On 1/14/25 an interview was conducted with the Director of Nursing (DON) and the DON was asked how it went unidentified that the facility staff failed to obtain accurate weights for R902 for September and October 2024. The DON was asked why no one reviewed and compared the weights obtained by the dialysis center of R902 which was provided to the facility weekly. The DON stated they identified inaccurate weights to have been obtained by the facility staff and was in the process of implementing a strategy to ensure the weights obtained are accurate and consistent. The DON was asked the date of when the facility identified this to have been a concern and the DON was unsure of the date. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further explanation or documentation was provided.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 41415 This citation pertains to intake: MI00149193. Based on observation, interview and record review the facility failed to ensure the assessment and monitoring of an Intravenous (IV) catheter and Permacath site, for one (R902) of one resident reviewed for wounds. Findings include: On 1/14/25 at 11:17 AM, a partial skin assessment was completed with the assistance of Unit Nurse Manager (UNM) A. Observed on the right side of R902's chest was a split catheter, colored red and the other blue with a dressing dated 12/31/24. On the left side of R902's chest was an IV port covered with a white gauze at the insertion site, no date was noted. A review of the medical chart revealed no documentation, physician orders or care plan that identified the type of each catheter nor the location. Further review of the medical record revealed no orders or care plans implemented for the monitoring and assessment of the catheter sites. A review of the physician orders contained the following order: Change Transparent dressing to PICC every day shift every 7 day(s) for IV maintance <sic>. Ordered 12/17/24. At 1:48 PM, the Director of Nursing was interviewed and asked about the assessment, monitoring and care of the right and left catheter devices observed on the chest of R902. The DON was asked to clarify each catheter device. The DON replied that staff should follow the policies on the care and each IV dressing should be dated. The DON stated they would look into it and follow back up. At 2:42 PM the DON returned and stated they are following up on the access site care now. No additional explanation or documentation was received by the end of the survey. An additional review of the progress notes, noted a physician visit on the day of the survey that noted in part, . has IV catheter to the right anterior chest wall-clean dry and intact. Permacath to the left anterior chest wall-clean dry and intact . No further explanation or documentation was provided by the end of the survey.