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	05/16/2025

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** 38271 This citation pertains to intake# MI00152482 Based on observation, interview and record review, the facility failed to prevent new wounds from developing, provide wound care and complete/accurately document new skin impairments for two residents (R302 and R303) of three residents reviewed for wounds, resulting in R303's wound care not being completed per Physician's orders and R302's wounds including their right lateral hip, right heel, right toe, right lateral ankle and right lateral foot not being identified and treated in a timely manner. Findings include: On 5/15/25 a concern submitted to the State Agency was reviewed which alleged R302's wounds were not appropriately cared for and nobody knew about them. On 5/15/25 the medical record for R302 was reviewed and revealed the following: R302 was initially admitted to the facility on [DATE], discharged on [DATE] and had diagnoses including Peripheral Vascular Disease, Dementia and Protein-Calories Malnutrition. A review of R302's MDS (minimum data set) with an ARD (assessment reference date) of 4/10/25 revealed R302 needed assistance with facility staff. R302's cognition was documented as severely impaired. A review of R302's comprehensive plan of care revealed the following: Focus-[R302] is at risk for impaired skin integrity/pressure injury R/T (related to): weakness, incontinence, malnutrition,fragile skin. Date Initiated: 06/05/2023 .Interventions: Conduct weekly head to toe skin assessments, document and report abnormal findings to the physician. Date Initiated: 06/05/2023 .Observe skin with showers/care. Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care. Date Initiated: 06/13/2023 . A review of R302 weekly skin assessment titled Total Body Skin assessment dated [DATE] revealed R302 had no newly identified skin impairments. A review of R302's weekly skin assessment dated [DATE] revealed a struck out assessment that was entered in error. No further weekly Nursing skin assessments were noted in the record until 3/28/25. A review of R302's shower documentation for 3/26/25 indicated they had no skin impairments. A review of R302's weekly skin assessment dated [DATE] documented R302 had one newly identified skin impairment. (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	A skin/wound progress note completed by the facility wound care coordinator dated 3/28/25 revealed the following: Skin/Wound Progress Note-Residents daughter came in to facility to speak with writer and view resident. Writer went in with daughter to complete and <sic> assessment, right foot dorsal/lateral/heel observed blackened, left outer ankle observed with non blanchable redness, right buttock observed with discolored edges and peeling skin, b/l (bilateral) hips are intact with preventative dressings in place A review of R302's shower documentation for 3/29/25 documented R302 had no skin impairments. A wound evaluation/assessment completed by the wound care medical provider on 4/3/25 revealed the following: Wound #1 Right, Lateral Hip is an acute Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 5cm (centimeters) length x 3cm width x 0.1 cm depth, with an area of 15 sq cm (square centimeters) and a volume of 1.5 cubic cm There is a Moderate amount of serosanguineous drainage noted which has no odor. The patient reports a wound pain of level 0/10. The wound margin is undefined Wound bed has no, granulation, 100% slough; . Wound #2 Right Heel is an acute Partial Thickness Vasculitic Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 5.3cm length x 2.3cm width with no measurable depth, with an area of 12.19 sq cm Wound #5 Right All toes is an acute Eschar covered Vasculitic Ulcer acquired on 04/01/2025 and has received a status of Not Healed. Initial wound encounter measurements are 4.2cm length x 1. lcm width with no measurable depth, with an area of 4.62 sq cm The wound margin is undefined Wound bed has no, granulation, 100% eschar; . Wound #6 Right, Lateral Ankle is an acute Eschar covered Vasculitic Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 6cm length x 5cm width with no measurable depth* with an area of 30 sq cm The wound margin is attached to wound base Wound bed has no, granulation, 100% eschar; . Wound #7 Right, Lateral Foot is an acute Eschar covered Vasculitic Ulcer and has received a status of Not Healed. Initial wound encounter measurements are 17cm length x 3.4cm width with no measurable depth, with an area of 57.8 sq cm The wound margin is attached to wound base Wound bed has no, granulation, 100% eschar; . A review of R302's weekly skin assessment dated [DATE] revealed R302 had no newly identified skin impairments. A review of R302's Physician orders revealed no treatment orders to treat any of R302's identified wounds previous to 3/28/25. A review of R302's treatment administration record (TAR) for March 2025 revealed no treatments were documented as being completed for R302's wounds until 3/29/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/16/25 at approximately 10:30 a.m., the DON (Director of Nursing) and Wound Care Nurse A (WCN A) were queried regarding R302's wounds all being initially identified on 3/28/25 with no documentation or treatments having been initiated prior and WCN A reported R302's wounds should have been identified earlier when they first started to develop. WCN A reported the facility has had problems with completing skin assessments on time and accurately. WCN A indicated that they should have been notified of the wounds so treatments could have been initiated and accurate documentation could have been completed and a wound consult been ordered for an evaluation by the medical Wound Care Provider. WCN A reported that in April they identified an issue with reporting changes of condition to management and were working to correct the deficiency. 41415 R303 On 5/15/25 at 10:57 AM, R303 was observed lying on their back in bed. A brief interview was conducted with the resident. Review of a complaint submitted to the State Agency (SA) documented concerns regarding the facility's care for R303 pressure wounds. Review of the medical record revealed R303 was admitted to the facility on [DATE], with diagnoses that included: Multiple sclerosis and was dependent on staff assistance for all ADLs (Activities of Daily Living). A review of the Skin & Wound Evaluation(s) revealed the resident had a Stage 4 pressure (Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer) wounds to the Sacrum and Left Gluteal Fold and a Stage 3 (Full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled edges are often present) pressure wounds to the Right Gluteal Fold and Left Gluteus Lateral. Review of the Medication and Treatment Administration Records (MAR/TAR) revealed the following: March 2025- 13 omitted treatments. April 2025- 11 omitted treatments. May 2025 (as of 5/15/25)- three omitted treatments. A review of a facility policy titled Skin Management revised 8/14/2024, documented in part . Resident with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/16/25 at 10:27 AM, the Wound Nurse (WN) A and Director of Nursing (DON) were both interviewed. WN A was asked if they were the responsible staff for the wound care treatments in the facility and WN A replied they initially were responsible for all stage 3 and 4 wounds, however had most recently been responsible for all wounds with the exception of skin tears and preventative creams. WN A was asked if they were ever pulled to work the units as a floor nurse and WN A stated they were. WN A stated on the days they are pulled to work the floor, the assigned nurses to the resident with wounds are responsible for doing the wound treatment. WN A was asked if they noticed that some floor nurses were not completing the wound treatment whenever they (WN A) were unable to do them and WN A stated they had noticed that lately the nurses have not been doing the wound treatments when they were supposed to. WN A and the DON was then asked about the identified omitted treatments for March, April & May 2025 for R303. WN A stated they noticed the treatments becoming a problem lately and started putting the residents with wound treatments due on the home screen for all nurses to review and on the facility's communication board. The DON explained that the facility had recently terminated nurses they were having care issues with. No further explanation or documentation was provided by the end of the survey.