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	08/06/2025

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 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2573641 and #1249526Based on interview and record review, the facility failed to ensure timely admission orders and assessments were completed for two residents (R#'s 902 and 905), of three residents reviewed for admissions, resulting in complaints of missed medications. Findings include: R902 On 8/5/25 a concern submitted to the State Agency for reviewed alleged R905 was not provided their medications and was not properly assessed when the day they were admitted to the facility. On 8/5/25 the medical record for R902 was reviewed and reveled the following: R902 was initially admitted to the facility on [DATE], discharged on 6/14/25 and had diagnoses including Type 2 Diabetes and Congestive heart failure. A review of R902’s census data revealed R902 was admitted to the facility on [DATE] and discharged home on 6/14/25. A review of R902’s Hospital After Visit Summary (Discharge Orders) were reviewed and revealed the following medication administration orders: BD Pen Needle Nano U/F-One each six times daily, Duloxetine 30mg (milligrams) delayed release capsule (AM), Furosemide 40 mg tablet (AM), Ibprofen 800mg tablet-TID (three times daily), Lantus SoloStar 100 unit/ml pen-injector-Inject 26 units under the skin nightly (HS), Linaclotide 145 mcg (micrograms) capsule-take one capsule by mouth daily, macitentan 10mg tabs-take one tablet by mouth once daily, Pregabalin 150 mg capsule-take one capsule by mouth two times daily (BID), Sildenafil 20 mg tablet-Take one tablet by mouth TID, carvedilol 6.25 mg tablet-take one tablet by mouth BID, metformin 500 mg tablet-take two tablets by mouth twice daily before breakfast and dinner, Omeprazole 40mg delayed-release capsule-take one capsule by mouth once daily before breakfast, rosuvastatin 20 mg tablet-take one tablet by mouth once every night (HS). A review of R902's Physican Order Summary revealed the following medications that were transcribed for administration: DULoxetine HCl Oral Capsule Delayed ReleaseSprinkle 30 MG (Duloxetine HCl) Give 1 capsule by mouth one time a day for depression and Furosemide Oral Tablet 40 MG (Furosemide) Give 1 tablet by mouth one time a day for fluid retention A review of R902's July 2025 medication administration record revealed R902 was not administered any medications while they were at the facility. A review of R902's admission Nursing Assessments revealed R902 was never assessed by the Nurse during their admission to the facility. (continued on next page)

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

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/5/25 at approximately 3:57 p.m., during a conversation with the Director of Nursing (DON), the DON was queried why R902 did not have a Nursing assessment or the medications from the hospital transcribed timely/accurately into their record upon admission and they indicated they did not know but that it was their expectation that Nursing staff complete an initial assessment shortly after residents are admitted to the facility along with transcribing their medication list from the hospital so they can get their medications administered appropriately. R905 A complaint received by the State Agency alleged the resident did not get evening medications when they admitted to the facility on [DATE]. On 8/5/25 at 10:05 AM, a review of R905's closed clinical record was conducted and revealed they admitted to the facility on [DATE] at 6:09 PM per the census data entered into the record by Nurse 'A'. R905's diagnoses included: pneumonia, diabetes, heart disease and high blood pressure and their most recent Minimum Data Set assessment indicated they had intact cognition. A review of R905's hospital discharge medications dated 7/15/25, facility physician's orders, and medication administration records was conducted and revealed the following: An order for atorvastatin (cholesterol medication) with instructions to give the medication at night-time (per hospital discharge instructions) with the last dose given 7/14/25 in the hospital, ordered at the facility on 7/15/25 to begin on 7/16/25 at 9 PM. An order for Lantus (long acting insulin) 14 units with instructions to give the medication nightly (per hospital discharge instructions) with the last dose given on 7/14/25 in the hospital, ordered at the facility on 7/15/25 to begin on 7/16/25 at 9 PM. On 8/5/25 at 3:57 PM, an interview was conducted with the facility's Director of Nursing regarding admission orders. They said they did not know exactly why the orders were put in on 7/15/25 with start dates to begin on 7/16/25 and explained when the orders were put in the computer system it may have generated the start dates for the next day. They further went on to say given R905 admitted to the facility at 6:09 PM, they should have received their scheduled night-time medications on 7/15/25 despite the computer generated start dates.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2573641Based on interview and record review the facility failed to timely assess, treat, notify the physician, and facilitate a transfer to the emergency room after an acute change of condition for one resident (R905), of three residents reviewed for change of condition, resulting in a transfer to the emergency room with a diagnosis of a heart attack requiring surgical intervention. Findings include: On [DATE] at 9:45 AM, a phone call was placed to the complainant, and they reported the facility failed to appropriately treat R905 for signs and symptoms of a heart attack. They said R905 requested to go to the hospital when they experienced chest pain, but the facility did not send them in a timely manner. When R905 got to the hospital it was discovered they suffered a massive heart attack requiring surgical intervention. They went on to say R905 was placed in the intensive care unit but was alert and talking to them postoperatively, however; after the surgery R905 suffered cardiac arrest and expired.On [DATE] at 10:05 AM, a review of R905's closed clinical record was conducted and revealed they admitted to the facility on [DATE] with diagnoses that included: heart disease, diabetes, pneumonia, and major depressive disorder. R905's most recent Minimum Data Set assessment indicated they had intact cognition.A review of R902's progress notes was conducted and revealed the following:A note entered into the record by Nurse ‘B' on [DATE] at 2:52 AM that read, Resident with complaint of chest pain. Nitro given x2 with no relief .Tylenol for generalized discomfort around 2100 (9 PM) .MD (medical doctor) called and voice message left. Resident requesting to go to hospital.A note entered into the record by Nurse ‘B' on [DATE] at 3:56 AM that read, NP (nurse practitioner) notified at 0339 (AM). Informed of above. Received order to transfer to ER (emergency room) for evaluation. 911 called at 0346 (3:46 AM).EMS (emergency medical services) arrived at 0355 (3:55 AM) and took over care. Transferred to ER at (Hospital Name) at 0406 (4:06 AM).A review of R905's documented vital signs did not indicate they were obtained at the time R905 complained of chest pain and requested a transfer to the emergency room.A review of R905's physician orders for nitroglycerin (a medication used for the treatment of chest pain) read, Give 1 tablet sublingually (under the tongue) every 5 minutes as needed for Chest Pain X 3 doses. If no relief, call MD). R905's MAR (medication administration record) was reviewed and revealed they only received one dose of the nitroglycerin, however; Nurse ‘B's documentation indicated they administered two.On [DATE] at 8:30 AM a review of a facility provided investigation from the Director of Nursing regarding the incident was conducted and read, .On [DATE] the Resident (R905).with history of coronary artery disease with past Percutaneous Coronary Intervention (a procedure to treat narrowed or blocked coronary arteries), CHF (congestive heart failure), Chronic <sic> kidney disease.was transferred to the hospital related to chest pain. The resident was admitted to the ICU status post STEMI (heart attack) with cardiac catheterization with 100% occlusion of the distal LAD (left anterior descending artery), angioplasty (a procedure to open blocked or occluded arteries) performed.Per hospital records, patient was placed on mechanical ventilation on [DATE] at 12:49 AM. On [DATE], the facility was informed the resident had coded and expired at 0526 am. Upon review of the resident's medical record at (Facility Name), it was noted the assigned nurse failed to: (1) Properly assess an acute change in condition of chest pain by not obtaining vital signs at the time of complaint. (2) Properly administer nitroglycerin.as ordered. (3) Documented 1 PRN (as needed) nitro (nitroglycerin) given on the MAR and documented 2 nitro given in a progress note. Order was for 3 nitro to be given 5 minutes apart, notify physician of ineffective after 3 doses. (4) Notify Physician in a timely manner, first dose of Nitro given at 0242 am, NP (Nurse Practitioner) documented as notified at 0339 am on [DATE]. (5) Transfer the resident to acute care setting immediately per resident request when administered nitroglycerin ineffective to relive chest pain. Nurse call 911 at 0346 am per her documentation.An interview was conducted with the Director of Nursing (DON) on [DATE] at 9:10 AM and they were asked how they identified the concern to prompt their investigation. They said they routinely reviewed resident transfers to the hospital to see if anything different could have been done and they identified concerns regarding R905's documented complaints of chest pain and Nurse ‘B's response. The DON went on to say that if the nitroglycerin had been administered properly per the physician's order (three doses, five minutes apart) and the chest pain had not resolved, the physician should have been notified and R905 should have been sent to the emergency room sooner based on timing. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: (1) Suspension of Nurse ‘B' with consultation with Human

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1249414Based on observation, interview and record review, the facility failed to ensure a call system was operational for one resident (R901) of three residents reviewed for call systems. Findings include:On 8/5/25 a concern submitted to the State Agency was reviewed which alleged R901's call light (a system used to notify staff of the need for assistance) was not being answered. On 8/5/25 the medical record for R901 was reviewed and reveled the following: R901 was initially admitted to the facility on [DATE] and least readmitted on [DATE] and had diagnoses including Dysphagia, End stage renal disease and Congestive heart failure. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 6/18/25 revealed R901 needed assistance from facility staff with most of their activities of daily living. R901's BIMS score (brief interview of mental status) was 15 indicating intact cognition. On 8/5/25 at approximately 11:24 a.m., R901 was observed in their room, laying up in their bed. R901 was queried regarding their call light being answered timely if they needed assistance and they reported that nobody ever answers them on time and sometimes had to wait hours or it is never answered. At that time, R901 turned on their call light for staff to refill their water cup with cold water. On 8/5/25 at approximately 12:16 p.m., R901's call light was observed to still be on with no staff having entered the room to see what R901 was requesting assistance with for the previous 45 minutes. A check to see if R901's call was functioning properly was conducted which revealed the indicator light over R901's doorway was not on. CNA C (Certified Nursing Assistant C) was queried regarding the reason nobody had assisted R901 with their request for assistance and they indicated that the call light button was working but that the light was out, so nobody knew that R901 needed help. CNA C reported that R901's call light had been broken all weekend, and nobody was available to fix it. CNA C was queried regarding the process for having Maintenace fix equipment on the weekend and they reported they weren't aware of any because there were not any maintenance personnel that work on weekends. On 8/5/25 at approximately 3:01 p.m., the Maintenance Director (MD) was queried regarding the call lights not functioning for rooms 116, 118 and 120 and they reported that the batteries on the call light system were out of energy and needed to be replaced. The MD was queried when the maintenance department had become aware of the malfunctioning call light system, and they reported that it had been that morning around 11:00AM. the MD was queried regarding maintenance being available on the weekend to fix broken essential equipment and they reported that they are on call but that nobody had called them regarding the issue. The MD indicated that had they been made aware of the issue then they could have replaced the batteries and fixed the system. The MD indicated the process is for staff to call them if they need something and nobody had notified them of the concern until that morning (8/5/25). On 8/6/25 a facility document titled Call Lights was reviewed and revealed the following: Policy-Call lights will be placed within the resident's reach and answered in a timely manner. Procedure: 1. New residents will be informed about the location of the call light at the bedside and in the bathroom/shower room. 2. Demonstrate how the call light works, 3. When a resident is in bed or confined to a chair ensure the call light is within easy reach of the resident. 4. Notify maintenance if a call light is not working .