

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/06/2026
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 3055372. Based on observation, interview, and record review, the facility failed to protect the residents' right to be free from verbal abuse and mistreatment by staff for two (R801 and R803) of three residents reviewed for abuse. Findings include: A review of a complaint submitted to the State Agency revealed an allegation that on 6/7/26, a Certified Nursing Assistant (CNA) told R801 to go to his room because he was sitting in the doorway of his room. (R801) was sitting in his wheelchair. The nurse's aide repeated herself. She then shoved him in his room. It is unknown if (R801) was shoved by the wheelchair or by his shoulders. (R801) defecated in his diaper. It is unknown if there was an argument. The same nurse's aide shoved the diaper with feces in (R801's) face. (R801's family member) said (R801) was upset when telling her about the incident. (R801 has a roommate in his room, and he was present during the altercation. On 7/6/26 at 12:05 PM, an interview was conducted with R801's roommate. When queried about any abuse, mistreatment, or altercations between R801 and staff, R801's roommate reported last month he heard a CNA talking to R801 not in a nice tone. R801's roommate said he could not see anything because the privacy curtain was pulled but could hear them from the other side of the curtain. R801's roommate did not recall any cussing but said the CNA sounded out of line. R801's roommate said he checked on R801 after the CNA left the room and R801's eyes appeared glassy, like he was about to cry. On 7/6/26 at 12:10 PM, an interview was conducted with R801. When queried about any altercations or mistreatment by staff the previous month, R801 reported there was an incident where he was seated in a wheelchair, half in and half out of his room. The CNA (later identified as CNA 'A') stood near the kitchen at the end of the hallway and yelled out to R801 to Get back in your room!. R801 further reported, CNA 'A' came to his doorway and pushed me into the room. When queried about what he meant by pushed, R801 gestured with his arms and hands that she had pushed him aggressively into the room in his wheelchair, not just pushed him in the wheelchair in a regular manner. R801 explained once in the room, CNA 'A' closed the door and then pushed the wheelchair against the bed. R801 said he was pushed in the wheelchair against the bed in the same manner he was pushed into the room. R801 explained his pants were soiled with urine and CNA 'A' took them off and held them in his face (R801 gestured with his hand that they were held approximately one inch from his face) and said, We don't like doing this (referring to changing R801's soiled clothing). R801 reported he was very angry and stated, She is lucky I don't have a temper like I used to and said it made him feel so badly that he felt like punching her. R801 stated, Before that, I really thought she was a nice person!. R801 further explained he reported what happened to his daughter and that he thought she called the police because the police came to talk to him. R801 did not recall being interviewed by facility staff. R801 said CNA 'A' no longer worked at the facility, and he heard she was moved to work on another hallway where she was (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mean to another resident. A review of R801's clinical record revealed R801 was admitted into the facility on 3/1/24 with diagnoses that included: heart disease and vascular dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had intact cognition and no behaviors and was frequently incontinent of urine and stool. On 7/6/26 at 11:00 AM, an interview was attempted via the telephone with CNA 'A'. CNA 'A' was not available for interview prior to the end of the survey. A review of a Case Report from the local police department revealed, the police were contacted on 6/11/26 for suspicious circumstances. The report documented the following, On June 11, 2026, (Officer names) were dispatched to (facility address) for a resident who called his daughter who then called the facility about a dispute with a worker. Upon arrival officers made contact with the manager of the facility (The Administrator) who .was conducting her own investigation . It was documented the Administrator explained (R801's) side of the story and his roommate .(R801) stated that he was in the doorway of his room waiting for his appointment with physical therapy. When (CNA 'A') came down the hall he lives on stating he should not be in the doorway pushing his wheelchair against the bed and then proceeded to change his soiled pants and brief. Additionally, upon changing his pants (CNA 'A') took his soiled pants and put them close to (R801's) face scolding him that he should not be soiling his pants. (R801's roommate) stated that he did not definitively see anything, but he heard (CNA 'A') using foul language towards (R801) . It was documented that CNA 'B' was in the room and denied any assault, foul language, or holding R801's soiled pants near his face occurred. The report further documented, .Officers proceeded to ask (R801) his account of the events and he stated that (CNA 'A') came down the hall while he was waiting in the doorway of his room wheeled his wheelchair against the room [sic] and started changing his pants and taking his pants holding them inches from his face telling him he cannot be soiling himself. He also stated this is the first altercation they have had seeing as though she (CNA 'A') is typically nice .Officers then interviewed his roommate .he stated he did not see anything but heard (CNA 'A') being 'rough' with (R801) stating it was verbal not physical. Additionally, he stated he could see her take off his pants but could not see anything else occur . A review of an investigation conducted by the facility revealed an Investigation Summary that documented R801 denied being mistreated which was inconsistent with the above-mentioned interviews with R801 (who had intact cognition) and his roommate, the reported allegations, and the police report. A review of a Resident, Employee, and Visitor Assistance Form completed by R801's daughter revealed, My father said he was pushed in his wheelchair by the CNA and she closed the door. He also said put the brief in his face. On 7/6/26 at 11:05 AM, CNA 'B' was contacted for an interview via the telephone. When queried about what occurred on 6/7/26 with R801, CNA 'B' reported CNA 'A' was in R801's room getting ready to change him and she called CNA 'B' into the room to be a witness because she said he (R801) called her a bitch. CNA 'B' explained she went into R801's room and R801 was very upset. CNA 'B' said R801 denied calling CNA 'A' a bitch and agreed to let her change him at that time. CNA 'B' did not assist with care and was called into the room to be a witness. CNA 'B' further reported she did not know what occurred prior to being called into the room and that CNA 'A' was already in there with R801. A review of CNA 'A's personnel file revealed the following: A Disciplinary Action Record that noted CNA 'A' received a Final Warning on 6/9/26. The reason for disciplinary action was Staff member was discourteous to resident (R801). She was speaking to resident disrespectfully while providing care. The form was signed by CNA 'A' on 6/11/26. A Disciplinary Action Record that noted CNA 'A' was terminated from employment. The date of the infraction was 6/12/26. The reason for the disciplinary action was Employee was overheard speaking inappropriately to a resident while in their room by another staff member. This form was signed by the Director of Nursing (DON) and not dated. An Investigation Summary was (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	included with the Disciplinary Action Record that revealed, in part, the following, On 6.12.26, the administrator was made aware of an allegation of a staff member engaging in verbal inappropriateness. Upon notification of this alleged allegation, the administrator conducted a complete and thorough investigation. The administrator and the DON interviewed the alleged employee (CNA 'A') with respect to this alleged allegation. (CNA 'A') denied being aware of any incident regarding her remarks. When made aware of this allegation by the DON, (CNA 'A') stated she did not say that. After interviewing this employee, she was made aware that she was being suspended, pending an investigation. The administrator interviewed the reporting staff member regarding this alleged allegation. Per the reporting staff member, she was walking down the hallway and overheard an employee said, 'get your ass up, I don't have time for this bullshit today'. The employee followed the facility's abuse policy and immediately reported this to her supervisor. The administrator asked the reporting staff member is [sic] she could identify the perpetrator, and she replied (CNA 'A'). The resident in question in non-interview-able and was unable to recall the allegation in question. A Conclusion attached to the Investigation Summary revealed, .the facility was able to substantiate that this event took place. Employee (CNA 'A') had just returned from a suspension without validation of the same allegation with respect to some of the same identical verbiage. In addition, recent disciplinary for poor customer service related to the same behavior. Therefore, it has been surmised based upon the previous pattern of this employee that this incident occurred .the facility has completed its investigation and will uphold the decision to terminate employment of (CNA 'A') . On 7/6/26 at approximately 11:30 AM, an interview was conducted with the Administrator who was the Abuse Coordinator for the facility. When queried about who the staff member was who overheard CNA 'A' verbally abusing a resident and who the resident was, the Administrator reported Housekeeper 'C' was the witness and R803 was the resident involved. When queried about the alleged mistreatment of R801 by CNA 'A', the Administrator reported they were unable to verify abuse occurred based on their investigation. They allowed CNA 'A' to return to work on 6/11/26, at which time CNA 'A' was given a disciplinary action due to being discourteous and speaking disrespectfully to R801. The Administrator was asked what was said and did not offer a response. When queried about why that was not included in the facility's investigation, the Administrator said it was separate from the abuse allegation but verified through interview with R801's roommate. The Administrator confirmed on 6/12/26, one day after CNA 'A' was brought back to work, she was overheard verbally abusing R803. The Administrator reported R803 was not able to be interviewed, but Housekeeper 'C' knew it was CNA 'A' based on her voice and R803's roommate is unable to get up on their own, so they deduced it to be R803. On 7/6/26 at 12:30 PM, an interview was conducted with Housekeeper 'C'. When queried about what they witnessed between R803 and CNA 'A', Housekeeper 'C' reported they were walking down the hallway and heard (CNA 'A') say, Don't start that shit now. We don't have time for that. Get your ass up. Housekeeper 'C' reported they did not recall the exact words, but it was very mean and was heard from the hallway. Housekeeper 'C' said they felt they needed to tell someone because what if that was your family member. Housekeeper 'C' reported they later learned from R801 and R801's roommate that CNA 'A' put R801's soiled pants in his face just a couple days before that. A review of R803's clinical record revealed R803 was admitted into the facility on 2/23/26 and discharged on 6/26/26 with diagnoses that included dementia. A review of a MDS assessment dated [DATE] revealed R803 had severely impaired cognition and no behaviors. Further review of R803's record revealed no documentation of the verbal abuse and no documented follow up to assess her psychosocial status. A review of a facility policy titled, Abuse Prohibition Policy, last revised 9/9/22, revealed, in part, the following, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation .Abuse (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shall include freedom from verbal, mental .physical abuse .Vermal Abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the guest/resident to experience humiliation, intimidation, fear, shame, agitation, or degradation regardless of their age, ability to comprehend or disability .Mistreatment means inappropriate treatment .of a guest/resident		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number: 3055372. Based on interview and record review, the facility failed to report a witnessed incident of verbal abuse by staff to the State Agency and the Nurse Aide Registry, and report results of the investigation for one (R803) of three residents reviewed for abuse. Findings include: A review of Certified Nursing Assistant (CNA) 'A's personnel file revealed the following: A Disciplinary Action Record that noted CNA 'A' received a Final Warning on 6/9/26. The reason for disciplinary action was Staff member was discourteous to resident (R801). She was speaking to resident disrespectfully while providing care. The form was signed by CNA 'A' on 6/11/26. A Disciplinary Action Record that noted CNA 'A' was terminated from employment. The date of the infraction was 6/12/26. The reason for the disciplinary action was Employee was overheard speaking inappropriately to a resident while in their room by another staff member. This form was signed by the Director of Nursing (DON) and not dated. An Investigation Summary was included with the Disciplinary Action Record that revealed, in part, the following, On 6.12.26, the administrator was made aware of an allegation of a staff member engaging in verbal inappropriateness. Upon notification of this alleged allegation, the administrator conducted a complete and thorough investigation. The administrator and the DON interviewed the alleged employee (CNA 'A') with respect to this alleged allegation. (CNA 'A') denied being aware of any incident regarding her remarks. When made aware of this allegation by the DON, (CNA 'A') stated she did not say that. After interviewing this employee, she was made aware that she was being suspended, pending an investigation. The administrator interviewed the reporting staff member regarding this alleged allegation. Per the reporting staff member, she was walking down the hallway and overheard an employee said, 'get your ass up, I don't have time for this bullshit today'. The employee followed the facility's abuse policy and immediately reported this to her supervisor. The administrator asked the reporting staff member is [sic] she could identify the perpetrator, and she replied (CNA 'A'). The resident in question in non-interview-able and was unable to recall the allegation in question. A Conclusion attached to the Investigation Summary revealed, .the facility was able to substantiate that this event took place. Employee (CNA 'A') had just returned from a suspension without validation of the same allegation with respect to some of the same identical verbiage. In addition, recent disciplinary for poor customer service related to the same behavior. Therefore, it has been surmised based upon the previous pattern of this employee that this incident occurred .the facility has completed its investigation and will uphold the decision to terminate employment of (CNA 'A') . On 7/6/26 at approximately 11:30 AM, an interview was conducted with the Administrator who was the Abuse Coordinator for the facility. When queried about who the staff member was who overheard CNA 'A' verbally abusing a resident and who the resident was, the Administrator reported Housekeeper 'C' was the witness and R803 was the resident involved. When queried about the termination of employment for CNA 'A', the Administrator reported they allowed CNA 'A' to return to work on 6/11/26 after an investigation into an allegation of mistreatment, at which time CNA 'A' was given a disciplinary action due to being discourteous and speaking disrespectfully to R801. The Administrator further explained on 6/12/26, one day after CNA 'A' was brought back to work, CNA 'A' was overheard verbally abusing R803 as documented in the investigation summary. The Administrator reported R803 was not able to be interviewed, but Housekeeper 'C' knew it was CNA 'A' based on her voice and R803's roommate is unable to get up on their own, so they deduced it to be R803. When queried about whether the verbal abuse was reported (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the State Agency, the Administrator reported she did not think she reported it but would look into it. On 7/6/26 at approximately 12:00 PM, the Administrator confirmed the witnessed verbal abuse toward R803 by CNA 'A' was not reported to the State Agency and acknowledged that it should have been. On 7/6/26 at 12:30 PM, an interview was conducted with Housekeeper 'C'. When queried about what they witnessed between R803 and CNA 'A', Housekeeper 'C' reported they were walking down the hallway and heard (CNA 'A') say, Don't start that shit now. We don't have time for that. Get your ass up. Housekeeper 'C' reported they did not recall the exact words, but it was very mean and was heard from the hallway. Housekeeper 'C' said they felt they needed to tell someone because what if that was your family member. Housekeeper 'C' reported they later learned from another resident that CNA 'A' put that resident's soiled pants in his face a couple days before the verbal abuse of R803. A review of R803's clinical record revealed R803 was admitted into the facility on 2/23/26 and discharged on 6/26/26 with diagnoses that included dementia. A review of a MDS assessment dated [DATE] revealed R803 had severely impaired cognition and no behaviors. Further review of R803's record revealed no documentation of the verbal abuse and no documented follow up to assess her psychosocial status. A review of the Michigan Facility Reported Incidents for Long Term Care (MI-FRI) application revealed no submitted incidents pertaining to CNA 'A' verbally abusing R803. A review of a facility policy titled, Abuse Prohibition Policy, last revised 9/9/22, revealed, in part, the following, .The Administrator or designee will notify .any State or Federal agencies of allegations per state guidelines (2hours if abuse allegation .). At the conclusion of the investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective action .Substantiated complaints against nurse aides for acts of guest/resident abuse .shall be reported to the state Nurse Aide Registry when the facility has knowledge .		