

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 08/21/2024
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675</p> <p>This citation has two deficient practice statements (DPS).</p> <p>DPS#1</p> <p>Based on observation, interview and record review, the facility failed to ensure residents were treated in a dignified manner for one (R34) of one resident reviewed for dignity, and multiple residents observed during dining.</p> <p>Findings include:</p> <p>According to the facility's policy titled, Federal & State - Resident Rights & Facility Responsibilities dated 5/14/2024:</p> <p>.A facility must treat each resident with respect and dignity and care for each resident in a manner in an environment that promotes maintenance or enhancement of his or her quality of life .A resident is entitle to know who is responsible for and who is providing his or her direct care .</p> <p>R34</p> <p>On 8/19/24 at 12:15 PM, R34 was observed attempting to self-propel in their wheelchair from their room doorway into the hall. The wheelchair brakes were engaged as R34 grunted and attempted to propel themselves forward. Numerous staff were observed to pass by R34 without assisting them to disengage the wheelchair brakes. Nurse 'G' was observed to stop at R34 and adjust their clothing as R34 continued to attempt to propel themselves forward, but Nurse 'G' did not disengage the wheelchair brakes. Finally at 12:25 PM, a staff member observed R34 struggling to move their wheelchair forward and disengaged the brakes. R34 then easily propelled themselves towards the dining room.</p> <p>On 8/20/24 from 8:22 AM to 8:45 AM, Certified Nursing Assistant (CNA 'B') was observed not wearing any name badge and proceeded to remove meal trays from the food cart on the 300 halls and enter in and out of resident rooms without knocking, or announcing themselves before entering the rooms.</p> <p>(continued on next page)</p>		

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/20/24 at 8:43 AM, CNA 'B' was also observed entering room [ROOM NUMBER] in response to the activated call light, but did not knock or announce themselves prior to entering the room. The resident was overheard talking to CNA 'B' about how upset they were that another staff came in the room about a half hour earlier and didn't pull them up, change them and had not been back. The resident also indicated they were wet and asked how they were supposed to eat like that?</p> <p>On 8/20/24 at 8:45 AM, CNA 'B' was observed observed re-entering the room with a Nurse, but neither knocked or announced themselves before entering the room.</p> <p>On 8/20/24 at 10:45 AM, an interview was conducted with the Director of Nursing (DON). When asked about whether staff should be knocking and announcing themselves before entering the residents' rooms, the DON reported they should be doing that and have been educated on that. The DON was informed of the multiple observations during the survey of staff entering rooms without knocking or announcing themselves and reported that should not have happened.</p> <p>When asked if staff should be wearing name badges to ensure residents and visitors were aware of who they were, the DON reported some staff have stickers and at times come off easily. They further reported they had a lot of new staff and some don't have permanent badges for 90 days, but staff should be going to the front desk to get a name badge. The DON was informed of multiple staff not wearing name badges.</p> <p>34208</p> <p>DPS#2</p> <p>Based on observation, interview, and record review the facility failed to ensure a resident's right to personal possessions for one resident, (R22) of one resident reviewed for use of personal possessions resulting in verbalized complaints and frustration of not being allowed to have and use their own belongings. Findings include:</p> <p>On 8/19/24 at 10:40 AM, an interview was conducted with R22. R22 said, Staff here are not fair. They were asked to explain what they meant and said recently they purchased a plastic, three drawer, storage bin and the facility told them they were not allowed to have it. R22 demonstrated the room was large enough to accommodate the bin and said they did not understand why they were not allowed to keep it. They were asked if they knew where the bin was and said it was up at the receptionist's desk.</p> <p>On 8/19/24 at 4:14 PM, a plastic, three drawer, storage bin was observed behind the receptionist's desk. At that time, Receptionist 'C' was asked if they knew anything about the bin. They said the bin belonged to R22 and their son was supposed to come to the facility to pick it up. Social Worker 'D' also happened to be at the desk and both Social Worker 'D' and Receptionist 'C' were asked if they knew why R22 could not have the bin. Neither staff member knew and directed further inquiries about the bin to the facility's Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>8/19/24 at 4:30 PM, an interview was conducted with the facility's Administrator regarding R22 not being allowed to have the bin. They said R22 had, hoarding tendencies and because the bin was not on wheels it was an infection control issue as far as cleaning around it. They were asked how housekeeping staff cleaned around the facility provided night stands and free standing closets that were not on wheels; and had no rebuttal.</p> <p>On 8/19/24 at 4:45 PM, an observation of room [ROOM NUMBER] and 112 was conducted and each room contained similar plastic bins with drawers not equipped with wheels.</p> <p>A review of a facility provided document titled, Federal & State - Resident Rights & Facility Responsibilities revised 5/2024 was conducted and read, .e. Respect and dignity .2. Personal Possessions. The right to retain and use personal possessions, including furnishing, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents .</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675</p> <p>Based on observation, interview and record review, the facility failed to provide reasonable accommodation of resident needs and preferences (including bed length and water in reach) for four (R34, R76, R89, and R170) of eight residents reviewed for accommodation of needs, resulting in residents complaining of being uncomfortable, frustrated over loss of independence with grooming or being able to get out of bed, and residents unable to hydrate with or without staff assistance.</p> <p>Findings include:</p> <p>R170</p> <p>On 8/19/24 at 11:04 AM, R170 was observed lying in bed with no clothing on their upper body and the top blanket covering over their lower extremities. The resident's feet were extended out of the blankets and hung over the end of the bed to the left side of the footboard. The footboard was observed pushed out and down slightly. When asked if they were comfortable as they currently were, they reported No, no I'm not. When asked if the bed was too short, they reported Yes. When asked if anyone else had asked them about the bed, they reported No.</p> <p>On 8/20/24 at 8:48 AM, R170 was observed lying in bed with their feet now pressed directly up against the bottom of the footboard. The resident reported they were uncomfortable and felt the bed was too small for them.</p> <p>Review of the clinical record revealed R170 was admitted into the facility on [DATE] with diagnoses that included: unilateral primary osteoarthritis right knee, type 2 diabetes mellitus without complications, cerebrovascular disease, hemiplegia affecting right dominant side, and chronic kidney disease.</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE], R170 had intact cognition and was dependent upon staff for mobility and most activities of daily living, weighed 241 pounds and was 74 inches tall.</p> <p>On 8/20/24 at 10:45 AM, an interview was conducted with the Director of Nursing (DON). When asked what their facility's process was if staff were to identify a concern with a resident's bed being too small (short), the DON reported that should be brought to the nurse's attention and the Nurse or CNA (Certified Nursing Assistant) should be communicating that to the administrative team. The DON reported they were not made aware of any similar concerns until now.</p> <p>34208</p> <p>R34</p> <p>On 8/19/24 at 11:00 AM, R34 was observed in their bed fidgeting with their blanket and overbed table. R34's foam cup of water was observed to be at the foot of the bed on the night stand approximately six feet from their reach.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/20/24 at 8:20 AM, R34 was observed in their bed asleep. R34's foam cup of water was observed to be at the foot of the bed on the night stand approximately six feet from their reach.</p> <p>On 8/20/24 at 12:21 PM, a review of R34's clinical record revealed they had severe cognitive impairment, was not ambulatory, required maximal assist with transferring but was independent with wheelchair mobility and eating.</p> <p>R76</p> <p>On 8/19/24 at 11:08 AM, R76 was observed in bed awake and alert but did not engage in attempts at a verbal interview. R76's foam water cup was observed at the foot of their bed on the television stand, approximately six feet from their reach.</p> <p>On 8/19/24 at 12:31 PM, R76 was observed in their bed and their water approximately six feet from their reach. R76 water remains out of reach, with no date on it.</p> <p>On 8/20/24 at 2:00 PM, R76 was up at the bedside in their wheelchair. R76 had no water or other fluids for drinking observed at their bedside.</p> <p>R89</p> <p>On 8/20/24 at 10:40 AM, R89 was observed in their bed asleep. R89's foam cup of water was observed on the nightstand approximately five feet out of their reach and slightly behind the head of the bed.</p> <p>On 8/21/24 at 9:49 AM, R89 was observed in bed with their foam cup of water on the nightstand approximately five feet out of their reach and slightly behind the head of the bed. It was further noted the cup of water had no lid or straw and no ice was observed in the cup.</p> <p>An interview was conducted with Unit Manager 'E' on 8/20/24 at 2:15 PM regarding the observations of water out of reach and said it should be within the resident's reach.</p> <p>47283</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675</p> <p>This citation pertains to intake # MI00145991.</p> <p>Based on interview and record review the facility failed to ensure that the Notice of Medicare Non-Coverage (NOMNC) and a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNFABN) were provided and completed for four (R169, R27, R42, and R62) of four residents reviewed for beneficiary notification, resulting in complaints of not being informed timely of private pay charges for continued services at the facility, and the inability to file an appeal.</p> <p>Findings include:</p> <p>Review of an allegation reported to the State Agency included concerns that the resident and/or representative was not provided with a timely notice for insurance end dates.</p> <p>On 8/19/24 during the entrance conference, the Administrator reported they were currently in transition with their Business Office Manager (BOM) as the former BOM was no longer employed at the facility and had been gone about a week. They were currently having alternating corporate staff fill-in temporarily.</p> <p>On 8/20/24 at 1:28 PM, the facility was requested to provide any NOMNC/SNFABN forms to review for R27, R42, and R62.</p> <p>Additionally, the facility was requested on 8/21/24 at 9:45 AM to provide any billing and NOMNC/SNFABN forms for review for R169 (there was no NOMNC/SNFABN forms provided by the end of the survey).</p> <p>Review of the documentation of beneficiary notices provided by the facility revealed multiple concerns that residents were not provided with the notices timely, or at all affecting all residents reviewed. These included:</p> <p>R169</p> <p>Review of the clinical record revealed R169 was admitted into the facility on [DATE] and discharged on [DATE] with diagnoses that included: displaced intertrochanteric fracture of left femur, opioid dependence, unspecified severe protein-calorie malnutrition, chronic obstructive pulmonary disease, unspecified fall, and essential hypertension. According to the profile section of the EMR (electronic medical record), R169 was their own responsible party.</p> <p>Further review of the documented payor source information in the electronic clinical record revealed R169 admitted into the facility on [DATE] under Medicare A, became private pay on 7/23/24, and discharged on [DATE]. There was no documentation of any discussion of costs of care, or details of the residents bill available for review in the clinical record.</p> <p>Review of the billing information provided by the facility documented R169 had a current Amount Due of \$5, 306.00.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>R27</p> <p>Review of R27's NOMNC form indicated the resident's services ended on 8/7/24. The resident signed the NOMNC on 8/8/24. The section of the form which read, Additional Information (Optional): read, On 8/6/24 at 3p (3:00 PM), I [name of Nurse 'M'] spoke with [R27] and financial liability will begin on 8/8/24 . The staff signature was documented as 8/8/24. The resident's signature on this NOMNC was 8/8/24. Also, the SNFABN was not signed by the resident until 8/8/24. This form read, Beginning on 8/8/26 <sic>, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs .</p> <p>Review of the clinical record revealed R27's census information included: the resident was admitted into the facility on [DATE], had a payor change from Medicare A to Private Pay on 8/8/24. Diagnoses included: chronic obstructive pulmonary disease, malignant neoplasm of unspecified part of bronchus or lung, and breast. According to the Electronic Medical Record (EMR), R27 was their own responsible party. These forms were not provided timely to afford the resident the opportunity to request an appeal if desired.</p> <p>R42</p> <p>Review of R42's NOMNC form indicated the resident's services ended on 6-25-2027 <sic> (meant to read 6/25/2024). The resident signed the NOMNC on 6/25/24. There was no documentation on this form to identify the resident had been notified in advance. Also, the SNFABN was not signed by the resident, nor was there documentation that reflected the resident had refused to sign. This form read, Beginning on June 26, 2024, you may have to pay out of pocket for this care if you do not have other insurance that may cover these costs . These forms were not provided timely to afford the resident the opportunity to request an appeal if desired.</p> <p>Review of the clinical record revealed R42's census information included: the resident was admitted into the facility on [DATE] under Medicaid, discharged on [DATE], readmitted on [DATE] under Medicare A and changed back to Medicaid on 6/26/24. Diagnoses included: chronic respiratory failure with hypoxia, rheumatoid arthritis, type 2 diabetes mellitus without complications, lymphedema, chronic kidney disease state 3, chronic diastolic (congestive) heart failure, malignant neoplasm of connective and soft tissue of left lower limb, including hip, neoplasm of unspecified behavior of bone, soft tissue, and skin, and personal history of pulmonary embolism. According to the profile section of the EMR, R42 was their own responsible party.</p> <p>R62</p> <p>Review of R62's NOMNC and SNFABN forms documented:</p> <p>A check mark by No for Was a SNF ABN, Form CMS-10055 provided to the resident?. The explanation under Other read, Previous BOM (Business Office Manager) No Longer Employed.</p> <p>A check mark by No for Was a NOMNC, Form CMS-10123 provided to the resident?. The explanation under Other read, Previous BOM No Longer Employed.</p> <p>(continued on next page)</p>		

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<p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of the clinical record revealed R62's census information included: the resident was initially admitted into the facility on [DATE], discharged to hospital on 1/14/24 and readmitted on [DATE] under Medicare A, then changed to Medicaid on 3/14/24. According to the profile section of the EMR, R62 was their own responsible party.</p> <p>On 8/21/24 at 9:09 AM an interview was conducted with the Administrator. When informed of the concerns with the beneficiary notices for all residents reviewed, the Administrator reported their former business office manager had been put on a pip (personal improvement plan) and corporate had been in conducting audits and identified issues with the beneficiary notices. The Administrator was informed of the continued concerns with the beneficiary notices.</p> <p>On 8/21/24 at approximately 1:30 PM, an interview was conducted with the Corporate Business Office (Staff 'N'). When asked about R169's billing and lack of NOMNC and SNFABN, they reported they were not able to locate any NOMNC or SNFABN and also was not able to explain what the charges included. They reported concerns with communication of financial information between the former business office staff and clinical staff and were not able to offer any further explanation regarding R169's billing situation.</p> <p>A request was made for the facility's policy regarding beneficiary notices on 8/21/24 at 8:56 AM, however there was no documentation provided by the end of the survey.</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675</p> <p>Based on observation, interview and record review the facility failed to secure resident health information from being displayed in a manner viewable to anyone that passed by the nursing station for five (R119, R120, R121, R122, and R123) of five residents reviewed for privacy.</p> <p>Findings include:</p> <p>On 8/20/24 at 8:24 AM, an observation of the 300 hall nursing station revealed there was a piece of paper taped to the top of the nursing desk facing towards the outside of the desk to the hallway. This paper contained personal resident information which included room numbers, names, current weights and type of scales used to weight R119, R120, R121, R122, and R123.</p> <p>Record reviews included:</p> <p>R119</p> <p>Review of the clinical record revealed R119 was admitted into the facility on [DATE] with diagnoses that included: displaced fracture of olecranon process without intraarticular extension of left ulna, dysphagia, malignant neoplasm of esophagus, and unspecified severe protein-calorie malnutrition.</p> <p>R120</p> <p>Review of the clinical record revealed R120 was admitted into the facility on [DATE] with diagnoses that included: unspecified fracture of T11-T12 vertebra, hypo-osmolality and hyponatremia, anemia, and morbid (severe) obesity due to excess calories.</p> <p>R121</p> <p>Review of the clinical record revealed R121 was initially admitted into the facility on [DATE], and readmitted on [DATE] with diagnoses that included: type 2 diabetes mellitus with ketoacidosis without coma, chronic kidney disease stage 3, acute kidney failure, hyperkalemia, dysphagia oral phase, obesity, malignant neoplasm of prostate, and malignant neoplasm of lingual tonsil.</p> <p>R122</p> <p>Review of the clinical record revealed R122 was admitted into the facility on [DATE] with diagnoses that included: heart failure, moderate protein-calorie malnutrition, difficulty in walking, and type 2 diabetes mellitus without complications.</p> <p>R123</p> <p>Review of the clinical record revealed R123 was admitted into the facility on [DATE] with diagnoses that included: syncope and collapse, chronic obstructive pulmonary disease, muscle wasting and atrophy, gout, anemia, chronic kidney disease, and transient cerebral ischemic attack.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>34208</p> <p>Based on interview and record review, the facility failed to address grievances for one resident (R31), of one resident reviewed for grievances, resulting in unresolved concerns. Findings include:</p> <p>On 8/19/24 at 10:13 AM, an interview was conducted with R31 in their room and they said, I need some antibiotics. When queried about the need for antibiotics R31 said the facility was not regularly supplying them with new, sterile, intermittent straight urinary catheters. They further explained they had been re-using catheters and believed they developed a urinary tract infection (UTI). They were asked if they made the facility aware of their concerns with a possible UTI and re-using catheters and they said they had. They were then asked if they filled out any type of complaint/grievance form and said they did not.</p> <p>On 8/19/24 at 11:49 AM, a review of a progress note dated 8/14/2024 at 12:50 PM entered into the record by Nurse 'J' read, .While in care conference Resident c/o (complains of pain) pain in groin area and upon urinating also stating having a discharge from his penial <sic> area informed nurse and UN (Unit nurse) resident needs a UA (urinalysis) and order from physician and to follow up . A review of R31's active, completed, and discontinued orders was conducted and did not reveal an order for a urinalysis. A review of R31's laboratory testing was also conducted and revealed no recent results for a urinalysis.</p> <p>On 8/20/24 at 10:15 AM, a follow-up interview was conducted with R31. R31 said staff did not provide them with a new catheter in the morning and they re-used one from the previous night. They further revealed they had two used catheters in their nightstand drawer and said they were kept in case staff did not bring them a new one when requested. They were then asked if they experienced any signs or symptoms of a urinary tract infection and said their urine was cloudy and they had pain and burning with urination.</p> <p>On 8/20/24 at 11:05 AM, an interview was conducted with Nurse 'J' regarding their progress note. Nurse 'J' said they recalled R31 expressing concern about possibly having a UTI. They asked what they did with that information and said they informed the unit managers, left a note in the physician's communication book, and, thought they filled out a resident concern/grievance form.</p> <p>On 8/20/24 at 11:08 AM, an interview was conducted with Unit Manager 'E'. They were asked if anyone reported R31's concerns about a UTI and re-using catheters to them and said no one had.</p> <p>On 8/21/24 at 12:55 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding the delay in addressing R31's concerns. The DON said the concerns should have been communicated and addressed.</p> <p>A review of a facility provided policy titled, Federal & State - Resident Rights & Facility Responsibilities was conducted and read, j. Grievances .2. The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the may have, in accordance with this paragraph .</p>		

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NAME OF PROVIDER OR SUPPLIER The Manor of Farmington Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 21017 Middlebelt Rd Farmington Hills, MI 48336	
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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083</p> <p>This citation pertains to intake #MI00145754</p> <p>Based on observation, interview, and record review, the facility failed to provide necessary care and services consistent with the residents needs and choices. Findings include:</p> <p>A review of a complaint reported to the State Agency included an allegation the facility staff failed to provide adequate and appropriate care based on the patient's needs.</p> <p>Clinical record review revealed R47 was admitted to the facility on [DATE] for hypertension, heart disease, peripheral vascular disease, diabetes, and multiple myeloma. R47 underwent debridement of nonviable tissue and a partial calcanectomy (removal of heel bone) of the left foot. A Vacuum assisted closure pump (Wound VAC) was applied to the left foot on 6/7/24 and required infectious disease for antibiotic treatment. R47 is care planned as a decline in ambulation, coordination, and strength related to falls and application of wound healing appliance. R47 required substantial/maximal assistance with one helper, including rolling side to side, lying to sitting on side of bed, and requires assistance with self-care. A Brief Interview for Mental Status (BIMS) score totaled 12/15 indicating R47 had moderate cognitive impairment.</p> <p>On 8/19/24 at 10:25 AM, R47 was observed lying in bed, wearing a food-stained hospital gown and their general appearance was unkept with patchy facial hair, hair appeared unclean and disheveled. R47 stated he has not had a bath in a long time. R47 commented that since admission to the facility, he has not been able to get up independently and relies on the staff, but the staff will not get him up. R47 explained that the only time they are out of the bed, dressed, and cleaned up, is when attending an outside doctor's appointment. R47 admitted that getting into a shower is difficult because of the Wound VAC but has made multiple unsuccessful requests to have water and soap set up so they could clean up themselves while sitting at side of the bed. R47 commented they had an electric razor is in the bedstand and would shave, but the staff never get it out for him.</p> <p>On 8/19/24 at 4:00 PM, R47 was observed lying in bed with the same appearance as noted at 10:25 AM. R47 stated an unfamiliar staff member told R47 we must get you up out bed, because The State is here. R47 said to the staff member, I ask all the time to get up, and now that the State is here, you are getting me up.</p> <p>A Progress note dated 8/19/24 at 10:48 by Certified Nurse Assistant (CNA) X documented .The resident was offered to get up by staff at 10:48 AM and refused to get of bed .</p> <p>R47 was questioned by this note and replied with frustration; when asked at 10:48 AM, I did not refuse, I was just finishing up breakfast and requested to the staff member to do it later.</p> <p>On 8/20/24 at 1:47 PM, The Director of Nursing (DON) was observed at R47's bedside and informed by resident that the offer to be cleaned up on 8/19/24 never happened and still has not been assisted. The DON asked nursing to assist with getting R47's razor and assist with a bedside bath.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/20/24 at 02:03 PM, R47 was observed lying in bed with a towel laying under their chin on their chest. When asked if he was cleaned up, R47 said the brief was changed, but still not cleaned up. Registered Nurse (RN) Z entered R47's bedside and informed they would have a CNA come back and assist.</p> <p>On 8/20/24 at 2:24 PM, R47 stated, The lady who picked up my Kleenex box (DON) came and told me my cleanup will be done this afternoon.</p> <p>A Record review of the Facility's Shower/Bathing Task revealed documentation on 7/29/24 at 12:31 PM, 8/1/24 at 12:11 PM, and 8/5/24 at 2:59 PM nursing documented Not Applicable Further documentation revealed on 8/19/24 at 22:59 Both columns were checked Yes and No and identified the author as CNA AA</p> <p>On 8/20/24 at 3:55 PM , Charge Nurse LPN E When provided the shower/bath task check off, LPN E acknowledged this was not acceptable documentation. Documentation from 8/19 by CNA AA was reviewed and at 22:59 both Yes & No were marked. CNA AA was questioned what documentation was correct, and CNA AA confirmed a bed bath was performed. R47 confirmed this morning, this was never done and R47 was not clean. CNA AA and LPN E went to R47's bedside, and when asked if CNA AA provided bedside clean up last night, R47 shook his head no and said I never got cleaned up yesterday. When asked by LPN E when the last time he was cleaned, he stated at least a week ago.</p> <p>On 8/20/24 at 4:18 PM, R47 commented I can't believe they told you I had bed bath!</p> <p>On 8/20/24 4:40 PM, The DON was updated on the delay of R47's bedside bath and documentation made by CNA AA , the DON acknowledged this was not appropriate.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208</p> <p>Based on observation, interview, and record review, the facility failed to provide meal set-up and one-to-one feeding assistance for one resident (R89) of four residents reviewed for activities of daily living. Findings include:</p> <p>On 8/19/24 at 11:28 AM, R89 was observed in their bed asleep with a breakfast tray that appeared to be approximately 25% consumed. It was observed with food and beverage spilled on the plate and tray. At that time, R89's roommate said R89 was legally blind. They were asked if staff ever assisted R89 with eating and said staff set the tray up but do not assist them with eating.</p> <p>On 8/19/24 at 1:38 PM, R89 was observed in their bed attempting to consume their lunch meal. R89 was observed to be picking at their meal with their fingers and had food spilled on the tray, on their clothing, and in their bed. R89's roommate and roommate's family said the resident could not see and was legally blind. During the observation, R89 was observed struggling to open with plastic container containing cake. R89's roommate's family member assisted R89 by opening up the container and giving R89 the cake. A review of R89's meal ticket on the tray was conducted and indicated R89 required one-to-one assistance with eating.</p> <p>On 8/19/24 at 1:40 PM, Certified Nurse Aide (CNA) 'I' was observed to enter the room and place a clothing protector over R89's soiled clothing. CNA 'I' was not observed to assist R89 with consuming their meal and R89 continued to eat with their fingers including dipping their fingers in soup and licking them.</p> <p>On 8/20/24 at 8:40 AM, R89 was observed in their bed eating their breakfast meal. R89 was observed eating yogurt with their fingers, no staff were present to offer assistance.</p> <p>On 8/20/24 at 12:50 PM, R89 was observed in their bed eating their lunch meal. It was observed food had been spilled on the bedside table, meal tray, and down the front of R89's clothing. R89 was observed to be eating refried beans with their fingers, staff were not present in the room to offer assistance. At that time, R89 was asked if they needed assistance eating and said, Sometimes. They were then asked if staff ever assisted them with eating and said they did not.</p> <p>On 8/20/24 at 2:10 PM, an interview was conducted with R89's family member. They were asked if staff ever assisted R89 with eating and said the assistance was not given with any regularity. They further reported they tried to schedule their visits around meal times so they could assist R89 with eating. In addition R89's family member expressed concerns saying staff should let R89 know the tray is there, what foods are on the tray and where the food items were located on the tray.</p> <p>On 8/21/24 at 11:15 AM, an interview was conducted with Dietician 'H' regarding who was responsible for giving one-to-one feeding assistance. Dietician 'H' said CNA's were supposed to provide 1:1 feeding assistance if indicated by the meal ticket.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of R89's clinical record was conducted and revealed they originally admitted to the facility 11/2022 and most recently readmitted to facility on 10/13/23 with diagnoses that included: dysphagia, stroke, falls, and legal blindness. A Minimum Data Set assessment dated [DATE] revealed R89 had severe cognitive impairment and was dependent eating. A review of R89's care plan included the following: an intervention for activities of daily living that read, .EATING: Resident requires 1;1 assistance with meals, initiated 7/12/24, an intervention for alteration in nutrition that read, .Assist resident with meals, explain food on trays in a clockwise manner, assist as needed initiated 11/2022, and an intervention for vision that read, .Identify type and location of food on plate .</p> <p>On 8/20/24 at 4:46 PM, an interview was conducted with the facility's Director of Nursing regarding observations of R89 not having their meal trays set up or being provided with one-to-one assistance and said assistance should have been provided.</p> <p>On 8/20/24 at 3:34 PM, a request for a policy on one-to-one feeding assistance was made via e-mail, however; it was not provided by the end of the survey.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083</p> <p>This citation pertains to intake #MI00145754.</p> <p>Based on observation, interview, and record review, the facility failed to provide consistent monitoring and assessment of changes in skin, and implementation of pressure-relieving interventions for two (R47 and R96) of five residents reviewed for pressure ulcer management.</p> <p>Findings include:</p> <p>A review of a complaint reported to the State Agency included an allegation the facility staff failed to provide adequate and appropriate care to prevent and/or treat pressure sores.</p> <p>R47</p> <p>Clinical record review revealed R47 was admitted to the facility on [DATE] for hypertension, heart disease, peripheral vascular disease, diabetes, and multiple myeloma. R47 underwent debridement of nonviable tissue and a partial calcanectomy (removal of heel bone) of the left foot. A Vacuum assisted closure pump (Wound VAC) was applied to the left foot on 6/7/24 and required infectious disease for antibiotic treatment. R47 is care planned as a decline in ambulation, coordination, and strength. R47 required substantial/maximal assistance with one helper, including rolling side to side, lying to sitting on side of bed, and required assistance with self-care. A Brief Interview for Mental Status (BIMS) score totaled 12/15 indicating R47 had moderate cognitive impairment.</p> <p>On 8/19/24 at 4:00 PM, R47 was observed lying in bed, with a wound vac on the left lower extremity. R47 denied pain with the left foot but indicated recent burning pain on his lower back/buttock area and was concerned. R47 commented that since admission to the facility, he has not been able to get up independently and relies on the staff, but the staff will not get him up. R47 explained that the only time they are out of the bed, dressed, and cleaned up, is when attending an outside doctor's appointment.</p> <p>R47 further voiced concerns of sores developed on his lower back, buttock area and has been feeling burning pain sensation. R47 confirmed nursing was made aware of this concern, and nothing has been done.</p> <p>On 8/20/24, A clinical record review revealed the facility identified on a skin assessment dated [DATE] bilateral buttock non blanchable redness. Stage 1 non-blanchable erythema of intact skin. Further wound/skin progress notes did not identify any other monitoring or evaluate the progress of the wound since 6/18/24.</p> <p>On 8/20/24 at 2:35 PM, an interview was conducted with the facility's Wound Care Nurse (Licensed Practical Nurse/LPN Y). When asked about the lack of further documentation of the Stage 1 Pressure Sore on R47's sacral area identified on 6/18/24, LPN Y stated there were no concerns with the area and did not document any assessments. LPN Y was asked to observe R47's skin.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/20/24 at 2:40 PM, during a skin observation with LPN Y, R47 was placed on their left side exposing the sacral buttock area and revealed an intact pink foam dressing dated 8/20 with initials from LPN Y. Removal of the dressing revealed scant areas of [NAME] (moisture barrier) creme and two open areas. The lower sacral area right buttock revealed two open areas, one measuring 2x2 Centimeter (cm) oval shaped and actively bleeding bright red blood. The second wound measuring 3x3 cm elongated area was noted open, colored bright pink, and appeared macerated.</p> <p>LPN Y acknowledged the areas have developed into stage 2 pressure Ulcers. (Stage 2 Pressure Ulcer: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis, presenting as a shallow open ulcer. The wound bed is viable, pink or red, moist, and may also present as an intact or open/ruptured blister) and were unable to offer any further explanation.</p> <p>On 8/20/24 at 4:45 PM, the Director of Nursing (DON) was informed that R47 had developed a worsening pressure sore, and there was no documentation of nursing evaluation and monitoring available by the facility prior to concerns identified by the survey team.</p> <p>Review of the facility policy titled; Skin Management dated 8/2024 documented:</p> <p>.Residents 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.</p> <p>30675</p> <p>R96</p> <p>On 8/19/24 at 11:16 AM, 8/20/24 at approximately 12:00 PM, and 8/21/24 at 10:20 AM, R96 was observed laying in bed, positioned on their back and their limbs were very contracted into a fetal position. At each of these observations, the resident was awake and only responded to simple, one-word communication. Additionally, during each of these observations, there were no heel protectors observed in use. The positioning of the resident revealed their bilateral feet were directly on the mattress and there were no heel protectors observed in place.</p> <p>Review of the clinical record revealed R96 was admitted into the facility on [DATE] with diagnoses that included: attention-deficit hyperactivity disorder combined type, vascular dementia unspecified severity with agitation, mixed receptive-expressive language disorder, and other seizures.</p> <p>According to the MDS assessment dated [DATE], R96 has severe cognitive impairment, had impairment on one side of their upper extremity, impairment on both sides of their lower extremities, and used a wheelchair for mobility. The resident was documented as dependent for most aspects of care, were at risk for developing pressure ulcers/injuries, and had two venous and arterial ulcers present.</p> <p>Review of the resident's physician orders included wound care treatments to address the resident's bilateral venous/arterial ulcers.</p> <p>Review of the care plans included an actual impairment to skin integrity that was initiated on 6/27/24 which identified pressure-relieving interventions which read, Soft heel protector boots. (Initiated on 8/1/24) by the Wound Care Nurse.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/21/24 at 10:30 AM, CNA 'BB' was asked about R96 and reported they were not assigned to that resident but asked what they could help with. When asked if they had seen R96 with boots to their heels, they reported No.</p> <p>On 8/21/24 at 10:32 AM, review of the staffing assignments revealed CNA 'BB' was assigned to the room set which included R96. When asked why they reported they were not assigned when they were, CNA 'BB' reported they weren't sure why they said that. When asked to review the kardex, they pulled up the information via the wall monitor which also indicated R96 was to use soft heel boots. When asked about why the resident didn't have any in place, CNA 'BB' reported they were not aware that was there.</p> <p>On 8/21/24 at 10:39 AM, an interview was conducted with Unit Manager (Nurse 'A'). When asked to observe the resident's feet, they reported they could help. Nurse 'A' confirmed there were no heel protectors in place and then asked this surveyor if those were the ones in the medication room. Nurse 'A' was asked if they wanted to show what they meant and proceeded to pull out a new package of foam heel protectors. When asked why they were not already implemented since the intervention had been added to the care plan on 8/1/24, Nurse 'A' offered no further explanation.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208</p> <p>Based on observation, interview, and record review, the facility failed to ensure assessment, monitoring, and provision of supplies for two residents (R#'s 31 and 15) who used urinary catheters, of two residents reviewed for urinary catheters, resulting in the potential for the development of urinary tract infections.</p> <p>Findings include:</p> <p>R31</p> <p>On 8/19/24 at 10:13 AM, an interview was conducted with R31 in their room and they said, I need some antibiotics. When queried about the need for antibiotics R31 said the facility was not regularly supplying them with new, sterile, intermittent straight urinary catheters. They further explained they had been re-using catheters and believed they developed a urinary tract infection (UTI). At that time, no catheter kits were observed in the resident's room.</p> <p>On 8/19/24 at 11:49 AM, a review of a progress note dated 8/14/2024 at 12:50 PM entered into the record by Nurse 'J' read, .While in care conference Resident c/o (complains of pain) pain in groin area and upon urinating also stating having a discharge from his penial <sic> area informed nurse and UN (Unit nurse) resident needs a UA (urinalysis) and order from physician and to follow up .</p> <p>A review of R31's clinical record revealed a physician's note dated 5/3/24 that read, .Paraplegia 2/2 (secondary) remote gunshot wound in th <sic> 1970s <sic> .Urinary incontinence (self catheterizes) <sic> . R31's care plan was reviewed and read, .Focus: .Is at risk for urinary tract infection and catheter-related trauma: Self straight caths <sic> for urinary output .Interventions .Resident is able to properly perform self straight catheterization using a sterile technique .</p> <p>On 8/20/24 at 10:15 AM, a follow-up interview was conducted with R31. R31 said they requested a catheter earlier in the morning but staff did not provide them with a new catheter and they re-used one from the previous night. They further revealed they had two used catheters in their nightstand drawer and said they kept them in case staff did not bring them a new one when requested. At that time, there were no catheter kits observed in the resident's room.</p> <p>On 8/20/24 at 10:45 AM, an observation of the central supply closet and and the three medication rooms that contained supplies were conducted with Central Supply Staff 'P'. During the observations it was observed there were 14 straight catheter kits stocked in the facility. Staff 'P' was asked about additional supplies and said the facility had an offsite storage space approximately a three minute drive away where additional supplies were stored should more need to be retrieved.</p> <p>On 8/20/24 at 11:08 AM, an interview was conducted with Unit Manager 'E'. They were asked if anyone reported R31's concerns about re-using catheters to them and said no one had. They were asked why R31 couldn't be provided a couple of catheter kits in their room as opposed to having to ask each time they needed one, and said there was no reason why they couldn't have a couple kits stored in their room.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of a facility provided policy titled, Catheter Associated Urinary Tract Prevention, revised 8/2021 was conducted and read, .4. Catheters are inserted using aseptic technique and sterile equipment .</p> <p>49083</p> <p>R15</p> <p>Clinical record review revealed R15 was admitted to the facility on [DATE] and managed under Hospice Services. Medical diagnoses include: hypertension, hypothyroidism, dementia, Alzheimer's, and chronic kidney disease. R15 is identified at risk and has a history of frequent urinary tract infections related to history of neurogenic bladder dysfunction and required a suprapubic catheter (surgical tube placed into the bladder to drain urine). A Brief Interview for Mental Status (BIMS) scored totaled three denoting R15 had severe cognitive impairment.</p> <p>On 8/19/24 at 11:09 AM, R15 was observed with a urine catheter container bag and drainage tubing was observed containing cloudy, white milky sediment urine.</p> <p>On 8/19/24 at 2:56 PM, R15 was awake and replied to conversation with their eyes closed. The urine catheter container bag drainage tubing was observed containing cloudy, white milky sediment.</p> <p>On 8/20/24 at 1:30 PM, R15 was observed asleep, urine catheter bag was hanging on bed with the tubing containing cloudy, white milky sediment.</p> <p>On 8/21/24 at 11:21 AM, Observation of the catheter was conducted with Licensed Practical Nurse (LPN) F and acknowledged the tubing of the catheter presented with abnormal white cloudy sediment. The urine container bag was observed with dark amber urine and LPN F commented: looks like R15 is dehydrated.</p> <p>Record review of the Hospice documentation revealed the catheter was changed on 8/13/24 by Hospice without complication and no signs or symptoms of infection.</p> <p>Record review of interventions from R15's care plan for nursing to Observe/record/report to physician for S/SX [sic] UTI (urinary Tract Infection): cloudiness, deepening of urine color.</p> <p>Unit Manager LPN R arrived to the bedside and was informed of the urine catheter urine observations. LPN R reviewed the treatment record and was informed order to monitor urinary output and record every shift was signed off by nursing, but no documentation was noted of physician notification on the observations made from 8/19/24, 8/20/24, and 8/21/24. LPN R acknowledged the physician should have been notified of white cloudy sediment in the tubing.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283</p> <p>Based on observation, interview and record review facility failed consistently monitor weights for one (R29) of two residents reviewed for nutrition resulting in the potential for undetected weight loss, and overall decline in functional status.</p> <p>Findings include:</p> <p>R29 was a long-term resident of the facility. R29 was originally admitted to the facility on [DATE]. R29 most recently was hospitalized and readmitted to the facility on [DATE]. R29's admitting diagnoses included seizures, hemiplegia (stroke), diabetes, and dysphagia (difficulty swallowing) and chronic pain. Based on the Minimum Data Set (MDS) assessment dated [DATE], R29 had a Brief Interview for Mental Status (BIMS) score of 7/15, indicative of severe cognitive impairment. R29 needed extensive staff with their mobility in bed and their Activities of Daily Living (ADLs) such as transfers, dressing, toileting, etc.</p> <p>An initial observation was completed on 8/19/24 at approximately 10:30 AM. This surveyor observed staff delivering the breakfast approximately 15 minutes prior in the hallway where R29 resided. R29 was observed sitting in their wheelchair and had their breakfast tray. The meal ticket read that they were on a mechanical soft diet. R29 had the following items on their tray: French toast, minced sausage/meat, a cup of oatmeal, glass of orange juice and milk. The drink glasses were empty. R29 did not eat any of their breakfast. When the surveyor queried, R29 reported that they were not hungry and they were done with their breakfast.</p> <p>Review of R29's progress revealed that R29 had significant weight loss and had a recent change in skin condition. A dietary progress note dated 7/26/24 at 12:00 read in part, Weight warning: Value: 183.4. A (-16.4%) loss over 180 days and (-5.7%) loss in 30 days. There was no updated plan. The note read see nutrition quarterly evaluation 7/9/24.</p> <p>Review of R29's weight record revealed the following entries. Significant weight variation from the previous weight were calculated and noted next to the entries from clinical record:</p> <p>8/10/24 192.4 lbs. (pounds) Variance from the previous weight ->(+9 lbs.)</p> <p>7/9/24 183.4 lbs. Variance from the previous weight -> (- 5 lbs.)</p> <p>6/25/24 188.4 lbs.</p> <p>6/19/24 188.8 lbs. Variance from the previous weight ->(-7.1 lbs.)</p> <p>6/12/24 181.7 lbs. Variance from the previous weight -> (-12 lbs.)</p> <p>6/10/24 193.7 lbs. Variance from the previous weight -> (+11.3 lbs.)</p> <p>5/30/24 182.4 lbs. Variance from the previous weight -> (-19.4 lbs.)</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5/27/24 201.8 lbs.</p> <p>5/10/24 201.7 lbs. Variance from the previous weight -> (-14.6 lbs.)</p> <p>4/24/24 216.3 lbs. Variance from the previous weight -> (+9.2 lbs.)</p> <p>4/17/24 207.1 lbs.</p> <p>4/10/24 208.3 lbs.</p> <p>Resident was readmitted from the hospital on 4/3/24 and an initial re-admission weight was completed on 4/10/24 (7 days after readmission to the facility). Clinical record revealed multiple entries with significant weight variation (loss or gain) from - 19 lbs. up to +9 lbs. between 4/17/24 and 8/10/24 with no timely follow-up with re-weights to ensure the accuracy of weights and address the significant weight variations.</p> <p>Review of progress notes from 4/19/24 revealed an RD (Registered Dietician)'s note dated 6/4/24 after multiple weight variation triggers. The note revealed in part, Remains at risk for wt. (weight) loss r/t (related to) side effects of psych meds question CBW (Current Body Weight), likely not 19 lbs. wt. loss .weight of 201.7 is a 91.6 lbs. loss in 90 days .Awaiting new weight to confirm CBW). There was no timely follow-up or re-weight completed and weight entry on 6/10/24 (6 days) after the RD note. The weight variations since the readmission until 6/4/24 were not addressed timely by Registered Dietician (RD) and or the Interdisciplinary Team.</p> <p>Further review revealed an RD note dated 7/7/24 that read in part, RD review for significant weight loss. CBW 188.4 lb. on 6/25/24 - 14 # (lbs.) /7% x 30 days, -24 #/11% x 90 days, -45#/19% x 180 days). Awaiting July weights . Remains at increased risk for weight loss .). Review of 7/9/24 weight entry revealed 183.4 lbs. (loss of 5 lbs. more from the previous weight). There was no further timely follow up by RD, Physician, or IDT and there was no evidence of re-weight. There were no orders or plan in monitoring R29's weight more frequently due to significant loss. There were no other dietary progress notes with change in interventions between 7/9/24 and 8/19/24.</p> <p>Review of R29's care plan revealed updated goals to main their weight on 7/9/24. Further review of plan/intervention reveled the most recent update dated 2/27/24 that read provide diet/supplements as ordered.</p> <p>R29 was at risk for compromised skin integrity related to their limited mobility and nutritional risk. An order dated 8/3/24 that read wound care practitioner to eval and treat as indicated for buttocks.</p> <p>Review of R29's order revealed an order dated 7/7/24 that read Med pass 2.0 two times a day for wound 240 ml (milliliters) PO (by mouth) BID (twice a day).</p> <p>'</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was completed with RD H' on 8/20/24 at approximately 4:10 PM. RD was queried about the facility process about ensure weight accuracy and how they had followed up timely. They reported that once the weights are completed and they would review and any variation of 5 lbs. from the previous weight required a re-weight and they would follow up with nursing team to ensure they were completed and documented on residents Electronic Medical Record (EMR). If there were significant loss or gain RD, interdisciplinary team and physician would address the variation and monitor weights more frequently weekly or daily as needed. RD H was queried about R29's weight loss, why there was not timely follow up to re-weigh accuracy and address the variations. RD H reported that the facility scales were recently calibrated and added that that they were aware that R29 had weight fluctuation and has lost some weight during recent hospitalization . RD H reported that they were questioning the accuracy of some of the weights they did not input and did not provide any further explanation. They were queried why R29 who was at high risk with significant weight variations was not weighed more frequently and monitored closely and they did not provide any further explanation.</p> <p>An interview was completed with the Director of Nursing (DON) on 8/21/24 at approximately 10:15 AM. The DON was queried about their weight monitoring and re-weight process. They reported that the RD and IDT (interdisciplinary team) reviewed the resident diagnosis and risk and followed up as needed to monitor their nutrition, weights and labs as needed based on physician orders. The DON was notified of the concerns with R29's significant weight loss and RD's concern about accuracy with no timely re-weights and timely follow up by the RD and IDT. The DON reported that they understood the concern and they would follow up.</p> <p>A request for facility weight monitoring policy/protocol via e-mail was sent on 8/21/24 at 8:28 AM and was not received prior to survey exit.</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675</p> <p>Based on observation, interview and record review, the facility failed to ensure a physician order for use of supplemental oxygen was obtained, including monitoring of the resident's respiratory status and maintaining the humidifier secured to the oxygen concentrator for one (R42) of one resident reviewed for respiratory care.</p> <p>Findings include:</p> <p>R42</p> <p>On 8/19/24 at 11:38 AM, R42 was observed laying in bed. The resident reported they had been at the facility since May 2024 when they transferred from another nursing home that was closing. R42 reported they were receiving supplemental oxygen via nasal cannula from an oxygen concentrator with humidified air. The rate of the oxygen flow was set to 4 liters. R42 was asked if they had recently started on oxygen and reported they used their oxygen continuously and had since admission. The container secured to the oxygen concentrator which held water for humidification was empty. R42 was asked who ensured the water was maintained and they reported they had to keep reminding the staff to fill it and their nose gets super dry and hurts.</p> <p>On 8/20/24 at 11:55 AM, R42 was observed seated in the wheelchair exiting their bathroom. At that time, the humidifier secured to the oxygen concentrator was observed to remain empty. When asked if anyone had identified the need to add more water, R42 reported No. That's probably why my nose is so sore!</p> <p>Review of the clinical record revealed R42 was admitted into the facility on [DATE], and readmitted on [DATE] with diagnoses that included: chronic respiratory failure with hypoxia, lymphedema, chronic diastolic (congestive) heart failure, malignant neoplasm of connective and soft tissue of left lower limb, including hip, neoplasm of unspecified behavior of bone, soft tissue, and skin, and personal history of pulmonary embolism.</p> <p>According to the MDS assessment dated [DATE], R42 had intact cognition and received continuous oxygen therapy since admission.</p> <p>Review of the physician orders for oxygen since admission revealed there were none as of this review on 8/20/24 at 2:45 PM.</p> <p>On 8/20/24 at 12:04 PM, an interview was conducted with the Nurse 'K' who was assigned to R42. When asked about who monitors the humidifier on the oxygen concentrators, Nurse 'K' reported that would be the nursing staff. When asked if they had observed that earlier, should they have ensured there was water filled, Nurse 'K' reported they did not notice that but they should have and would do that now. Nurse 'K' was informed that observations and interviews with the resident revealed the humidifier had been empty since yesterday, and they reported they should've identified that.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/20/24 at 2:57 PM, an interview was conducted with the Unit Manager (Nurse 'L'). At that time, Nurse 'L' was asked to confirm R42's orders for use of oxygen, and monitoring of respiratory care. Nurse 'L' reviewed the resident's electronic clinical record and reported there were no orders in place for the use of or monitoring of the resident's pulse ox since their admission. When asked who should be monitoring the level of humidification on the oxygen concentrator, they reported that would be the nurses.</p> <p>Review of the facility's documentation provided for respiratory care, revealed a policy that did not address resident respiratory care, but was for fit testing and requirements for staff.</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide safe, appropriate dialysis care/services for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283</p> <p>Based on interview and record review the facility failed to provide ensure consistent dialysis communication documentation and assessments were completed for two residents (R94 and R270), and failed to provide meals prior to hemodialysis appointment for one (R269) of three residents reviewed for dialysis.</p> <p>Findings Include:</p> <p>R94</p> <p>R94 was long-term resident of the facility. R94 was originally admitted to the facility on [DATE]. R94's admitting diagnoses included end stage renal disease, atrial fibrillation, and diabetes. Based on the Minimum Data Set (MDS) assessment dated [DATE], R94 had a Brief Interview for Mental Status (BIMS) score 15/15 indicative of intact cognition.</p> <p>Review of R94's Electronic Medical Record (EMR) revealed that R94 was scheduled for hemodialysis 3 days per week since they were admitted to the facility. Review of R94's care plan dated 4/8/24 that read, For hemodialysis: facility will utilize the dialysis communication form to communicate with the dialysis center. Send the dialysis communication book to the dialysis center with each appointment. Upon return from the dialysis center, review the communication book including any progress notes. Provide an update to the physician and any staff member/disciplines as needed.</p> <p>Further review of R94's EMR did not reveal any recent dialysis communication forms between the facility and hemodialysis center. The document section had one communication document from dated 3/22/24 (approximately 5 months ago).</p> <p>An interview was completed with Licensed Practical Nurse (LPN) F' on 8/21/24 at approximately 10 AM. They reported that they worked part time and they had been at the facility for a few months. They were queried about the dialysis communication process between the facility and dialysis center. They reported that forms were sent with the residents in their book and when residents returned from dialysis the nurse would review, chart, follow up with the physician as needed. The forms get filed for scanning into EMR. When queried about the communication forms for R94, LPN F checked the EMR and reported that they did not find it and confirmed that was the only document on R94's EMR.</p> <p>R270</p> <p>A record review revealed R270 was a long-term resident of the facility. R270 was originally admitted to the facility on [DATE] and they were recently hospitalized and readmitted to the facility on [DATE]. R270's admitting diagnoses included end stage renal disease, peripheral vascular occlusive disease (blockage of blood vessels) and osteomyelitis of right heel. R270 had a recent left above knee amputation. Based on MDS assessment dated [DATE], R270 had BIMS score of 14/15, indicative of intact cognition. R270 was on hemodialysis 3 days/week at an offsite location.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review R270's EMR revealed multiple comorbidities. R270 had multiple hospitalizations in the recent past. A physician progress note dated 8/20/24 read in part, Reason for visit: Skilled visit, evaluation and management of comorbidities to reduce hospitalization. Review of R270's care plan revealed an intervention dated 9/12/23 that read, For hemodialysis: facility will utilize the dialysis communication form to communicate with the dialysis center. Send the dialysis communication book to the dialysis center with each appointment. Upon return from the dialysis center review the communication book including any progress notes. Provide an update to the physician and any staff member/disciplines as needed. Further review of R270's EMR did not reveal a dialysis communication form dated 1/18/24 (approximately seven months ago). The EMR did not have any other evidence of dialysis communication forms.</p> <p>An interview was completed with the Unit Manager (UM) R on 8/21/24 at approximately 10:10 AM. They were notified of the concerns on dialysis communication not on R94 and R270's EMR. They were also notified that the nurse had checked the EMR and they were not able to locate any communication documents. UM R reported that they would check and report back in 20 minutes and did not provide any further updates.</p> <p>An interview was completed with Scheduler/Med Rec. Assistant (SM) W on 8/21/24 at approximately 11:30 AM. When queried about dialysis communication forms, they reported that they were behind scanning the documents. When queried about R94 and R270's communication forms they reported that they did not handle scanning for that unit. They were responsible only for unit 3 and the unit where R94 and R270 resided were handled by staff member who handled the Central Supplies (CS) P.</p> <p>An interview was completed with staff member handling the Central Supply (CS) P on 8/21/24 at approximately 11:45 AM. They were queried about the dialysis communication for R94 and R270 and if they were responsible for scanning and if they knew where the forms were. CS P reported that they did not know where the form was and they were not responsible for scanning them. They also added that they helped medical records assistant SM W when they had asked for help with scanning and that was not part of the role.</p> <p>An interview was completed with Director of Nursing (DON) on 8/21/24 at approximately 10:15 AM. The DON was queried about the facility process to maintain consistent communication with the dialysis provider and the identified concerns of missing communication for R94 and R270 over an extended period of time. The DON reported that they understood the concern and they also added they were aware of the concerns with communication with dialysis providers. They reported that communication forms should have been scanned into residents' EMR. They would check and provide additional information. No additional information was provided prior to exit.</p> <p>R269</p> <p>R269 was admitted to the facility on [DATE] for short-term skilled nursing and rehabilitation needs after recent hospitalization. R269's admitting diagnoses included end stage renal disease, type 2 - diabetes, asthma and gout. R269 was on dialysis 3 days/ week at an offsite location. R269 was living in the community prior to hospitalization. Review of physician progress note dated 8/14/24 and a practitioner note dated 8/13/24 revealed that R269 lived alone in the community and had intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0698</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An initial attempt to interview R269 was made on 8/19/24 at approximately 10:35 AM. Staff notified that R269 was at dialysis. Later that day at approximately 1:00 PM, R269 was observed sitting on the bed. They reported that they were very upset and had not eaten anything since last night. When queried further they reported that they had asked staff to get their lunch bag before going to dialysis and staff did not listen. Their pick up time was at 5:45 AM and they have not had anything to eat and stated, hungry man is angry man.</p> <p>Review of R269's EMR revealed a physician order dated 8/8/24 that read at nutritional risk. Review of nursing progress note dated 8/19/24 at 5:45 AM read, LOA (leave of absence) to dialysis with footrests on wheelchair.</p> <p>An interview was completed with Registered Dietician (RD) H on 8/20/24 at approximately 4:15 PM. They were queried about R269's concerns about missed breakfast/meal on 8/19/24. RD H reported that they were of aware of the concern. R269 had a care conference and they and had mentioned during the meeting. When queried about the process and what had happened, they reported the bagged meals/snacks were prepared the night before by the kitchen staff and they were left in the fridge in the kitchen. Nursing staff picked up the bag and handed to residents before the pick up and they were not sure what had happened.</p> <p>A facility policy/protocol for residents who were on dialysis was requested via e-mail to facility administrator on 8/21/24 at 11:31 AM and was not received prior to exit.</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283</p> <p>This citation pertains to intake #s MI00145754 and MI00146358.</p> <p>Based on observation, interview, and record review facility failed to provide sufficient number of staff based on their facility assessment to meet the needs of residents who were dependent of staff for their care needs, including 12 residents (R31, R27, R28, R65, R67, R76, R93, R41, R42, R47, R77, R170 and R171 and other anonymous residents who attended the confidential Resident group meeting). This deficient practice has the potential to affect all 112 residents of the facility.</p> <p>Findings include:</p> <p>A confidential Resident group meeting was conducted on 8/20/24 at approximately 11:30 AM. Five residents attended the meeting. During this meeting anonymous Resident-1 reported that the facility did not have enough staff on weekends and they added that they did not know if the issue was because of staffing calling off or facility not scheduling adequate staff. Anonymous Resident-1 also added that hallways were empty because most of the residents stayed in bed. They added that that were several occasions that they had to wait between 1-2 hours for the staff to respond to call lights and some staff say, I have 29 residents. They added that the facility needed to hire more people. They added some of the residents waited all day for staff to assist them to get out of bed. They also added that there is more help on day shift on weekdays with the management staff onsite and they leave around 5PM and they did not have enough help during afternoon and midnight shifts.</p> <p>Anonymous Resident-2 reported that on weekends they had to wait longer for staff to assist them to get out of bed. They added we don't want to be confined to bed, I stayed in bed all day Saturday and Sunday because they did not have enough people (to get me up). They also added on weekends they had observed several call lights blinking in the hallway for an extended period of time. When queried if it was an isolated weekend they reported that it happened on most of the weekends and they had missed showers because of not having enough staff.</p> <p>Anonymous Resident-3 reported the facility did not have enough staff and agreed with the staffing concerns reported by anonymous Resident 1 and Resident 2. Two other anonymous residents who were present at the meeting were queried about the staffing concerns and one resident reported that they concurred with the facility staffing concerns reported by other residents in the group. One resident reported that they had noticed some improvements however, they had ongoing staffing concerns.</p> <p>Review of Resident Council meeting minutes from February-2024 to July-2024 revealed ongoing staffing and call light concerns reported by the residents. The meeting notes from most recent Resident Council meeting dated 7/25/24 read, Residents state call lights on mid-nights are not being answered in a timely manner. The meeting note dated 6/27/24 read, Residents state call lights on mid-nights are not being answered in a timely manner.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Review of Facility assessment dated [DATE] revealed the following: Under QAPI (Quality Assessment and Performance Improvement) Action/Plan Summary under Function, Acuity, and Cognitive sections read in part, Together with our recruitment, recruiter, sign-on-bonuses, and incentives (shift pick up bonus) to fill in the gaps, and potential gaps as needed, overall analysis of the MDS driven resident profile assist in obtaining positive outcomes.</p> <p>Review of the facility submitted staffing report from 1/1/24 to 3/31/24 revealed that the facility's weekend staffing was excessively short during this period.</p> <p>An interview with CNA T was completed on 8/20/24 at approximately 1:15 PM. They reported that they were a full-time employee. They were queried about the staffing and they reported that they ongoing staffing concerns. On a holiday they reported that they were assigned 42 residents. Reported that they usually had 28-32 residents and the schedule that was put was not always accurate. When queried about the accuracy concern they added that staff who were on time off or the ones who did not commit to work were added on the schedule. When queried how they provided the care including the showers, they reported that they prioritized and did their best. They provided bed baths instead of showers. When queried about the support from the facility and nursing leadership team, they reported that they did not get enough support. They added it would run well if every day they would have had the same staffing as today.</p> <p>An interview was completed with a CNA U on 8/21/24 at approximately 12:50 PM. They reported that they had over 21 residents or more to care for depending on day. When queried if they were able to provide the care they needed for their residents, they added I do the best I can.</p> <p>An interview was completed with a CNA V on 8/20/24 at approximately 4:30 PM. They were queried about the staffing. They reported that they needed more staff. They added that they had between 22-24 residents to care for during their shift and some their residents needed Hoyer lift (a total body mechanical lift used to transfer patients). When queried if they were able to provide the care their residents needed, they stated, I do my best and they added that they had to skip showers and do bed baths if they needed a Hoyer lift.</p> <p>An interview was completed with Staffing Coordinator (SC) W on 8/21/24 at approximately 11:40 AM. They were queried about the facility's current staffing situation, how they had covered the shifts, and number of open positions etc. They reported the facility had staffing challenges and been trying to hire more staff and they were offering incentives for new hires and current staff. When queried about the weekend staffing they reported that the on-call managers handled the weekend staffing concerns that came up. They reported that they had 9 nurse openings and 14 CNA openings across all shifts for full/part time positions.</p> <p>An interview was completed with Director of Nursing (DON) on 8/21/24 at approximately 10:30 AM. The DON reported that they were trying to address the staffing challenges and had been hiring new staff. They also reported that they were working on staff retention and attributed most of their staffing challenges and turnover were related staff attendance issues.</p> <p>An interview was completed with the Administrator on 8/21/24 at approximately 11:50 AM. They reported that they were offering incentives and trying to hire new staff and they were also working on retention. The Administrator was notified of the concerns from resident's group meeting and observations. They reported that staffing was getting better and they understood the concerns.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>34208</p> <p>R31</p> <p>On 8/19/24 at 10:13 AM, an interview was conducted with R31. R31 said the facility was short of staff. When asked what types of things happened to make them believe the facility was short staffed they said they activated their call light on the night shift and no one answered it so they kept pushing the button. They further said when they saw the nurse in the morning around 7 AM they asked if they were short staffed on the night shift and said the nurse told them they were.</p> <p>R28</p> <p>On 8/19/24 at 10:50 AM an interview was conducted with R28 and they said the facility did not have enough staff. When asked why they believed the facility was under staffed they said staff take too long to answer the call light when they have to go to the bathroom and they suffered from incontinent episodes.</p> <p>R67</p> <p>On 8/19/24 at 11:28 AM, R67 was asked about staffing in the facility and said, The aides are lazy. They further reported they have to wait a long time for their call light to be answered.</p> <p>R27 & R93</p> <p>On 8/19/24 at 12:13 PM, an interview was conducted with R27 and R93 regarding staffing. They said the facility, Needed more people to ensure quality of care. Both R27 and R93 said they had not had given regularly scheduled showers.</p> <p>R65</p> <p>On 8/19/24 at 12:33 PM, R65 was asked about facility staffing and said they were , Sometimes low. When asked why they thought they facility was understaffed they said, Because no one checks in on you for a couple of hours.</p> <p>Anonymous Family Member</p> <p>On 8/19/24 at 1:15 PM, an interview was conducted with a family member who wished to remain anonymous. They said weekends were typically very understaffed and their loved one remained in wet incontinence briefs for extended periods of time.</p> <p>On 8/19/24 at 3:30 PM, an interview was conducted with Nurse 'G'. They were asked how many resident's were assigned to them on the day shift and said they had 29 residents. They said they had half of the 100 unit and some residents on the 200 unit. They said three different nurses shared an assignment and the medication cart on the 200 unit. They said they had difficulty tending to their residents because one of the other nurses would always be on the cart. They were asked if the unit that was split between the three nurses could justify an additional nurse and they said it should.</p> <p>R76</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 8/20/24 at 8:57 AM, R76 was observed tearful, crying, and making guttural distressed sounds. Nurse 'G' was observed on the hallway at the medication cart, two Certified Nurse Aides were observed wheeling a resident on a shower gurney down the hall for a shower, and CNA 'I' was passing breakfast trays. Nurse 'G' was overheard to ask CNA 'I' what was going on with R76 and CNA 'I' told Nurse 'G' R76 was hungry but she couldn't go into the room at that time to give one-to-one feeding assistance because she still had breakfast trays to pass. When CNA 'I' finished passing the trays they retrieved R76's tray from the cart, but as they were pulling the tray from the cart, R28 called out into the hallway they had to use the bathroom. CNA 'I' placed R76's tray back in the cart and went to assist R28.</p> <p>30675</p> <p>R41</p> <p>On 8/19/24 at 11:12 AM, the resident was observed laying in bed with supplemental oxygen via nasal cannula from an oxygen concentrator. When asked if they had any concerns with lack of sufficient nursing staff, R41 reported concerns with not having enough at times and having to wait long periods of time before staff will respond to their needs. They further reported it seemed like staffing was worse on the weekends.</p> <p>R42</p> <p>On 8/19/24 at 11:38 AM, the resident was interviewed at bedside. When asked if they felt there was sufficient staffing to meet their needs, R42 reported they need to hire more people all around and couldn't get their pain pill this morning. They further reported at times they waited for help longer than 30 minutes.</p> <p>R77</p> <p>On 8/19/24 at 12:50 PM, the resident was observed seated on the side of their bed. They reported they had transferred from another nursing facility about five months ago and their top concern since coming to this facility was there were not enough aides on afternoons and midnight shift. They expressed concern with late medications due to short staffing of nurses and felt it was getting worse, not better. They reported they were very vocal about their concerns in the resident council meetings and staffing concerns had been a continuous discussion in those meetings without any improvement.</p> <p>R170</p> <p>On 8/19/24 at 11:04 AM, the resident was observed laying in bed. When asked if they had any concerns regarding sufficient nursing staff, they reported they had concerns and felt there wasn't enough staff and had to wait long times for assistance with getting up, and getting their medications on time.</p> <p>R171</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 8/19/24 at 12:22 PM, R171 was interviewed at bedside. When asked how they felt their care was going, the resident reported they were frustrated. When asked to explain further, R171 reported just this morning they pressed their call light three times for help to get dressed and to get pain medication before therapy. They reported staff would come in and turn the light off but not help them. After an hour, then two hours the therapist came in to assist with dressing them. They weren't sure what the reason was for the delay but were very frustrated and fed up. They further reported this was their second time as a resident of the facility in a short time after breaking their hip two times and this time it was much more painful. The resident reported at times they have to wait a long time to get their pain medication when they request it.</p> <p>49083</p> <p>R47</p> <p>Clinical record review revealed R47 was admitted to the facility on [DATE] for hypertension, heart disease, peripheral vascular disease, diabetes, and multiple myeloma. R47 underwent debridement of nonviable tissue and a partial calcanectomy (removal of heel bone) of the left foot. A Vacuum assisted closure pump (Wound VAC) was applied to the left foot on 6/7/24 and required infectious disease for antibiotic treatment. R47 is care planned as a decline in ambulation, coordination, and strength related to falls and application of wound healing appliance. R47 required substantial/maximal assistance with one helper, including rolling side to side, lying to sitting on side of bed, and requires assistance with self-care. A Brief Interview Mental Status (BIMS) score totaled 12/15 indicating R47 had moderate cognitive impairment.</p> <p>On 8/19/24 at 10:25 AM, R47 was observed lying in bed, wearing a food-stained hospital gown and general appearance was unkept, patchy facial hair, hair appeared unclean and disheveled. R47 stated he has not had a bath in a long time. R47 commented that since admission to the facility, he has not been able to get up independently and relies on the staff, but the staff will not get him up. R47 explained the only time out of the bed, dressed, and cleaned up, is when attending an outside doctor's appointment. R47 admitted that getting into a shower is difficult because of the Wound VAC but has made multiple unsuccessful requests to have water soap set up and could clean up self-sitting at side of the bed. R47 commented an electric razor is in the bedstand and would shave self, but the staff never get it out for him.</p> <p>On 8/19/24 at 4:00 PM, R47 was observed lying in bed with the same appearance as noted at 10:25 AM. R47 stated an unfamiliar staff member told R47 we must get you up out bed, because The State is here. R47 said to the staff member, I ask all the time to get up, and now that the State is here, you are getting me up.</p> <p>A Progress note dated 8/19/24 at 10:48 by Certified Nurse Assistant (CNA) X documented .The resident was offered to get up by staff at 10:48 AM and refused to get out of bed .</p> <p>R47 was questioned by this note and replied with frustration; when asked at 10:48 AM, I did not refuse, I was just finishing up breakfast and requested to the staff member to do it later.</p> <p>On 8/20/24 at 1:47 PM, The Director of Nursing (DON) was observed at R47's bedside and informed by resident that the offer to be cleaned up on 8/19/24 never happened and still has not been assisted. The DON asked nursing to assist with getting R47's razor and assist with bedside bath.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 8/20/24 at 02:03 PM, R47 was observed lying in bed with a towel laying under chin on chest. When asked if he was cleaned up, said the brief was changed, but still not cleaned up. Registered Nurse (RN) Z entered R47's bedside and informed they would have a CNA come back and assist.</p> <p>On 8/20/24 at 2:24 PM, R47 stated that the lady who picked up my Kleenex box (DON) came and told me my cleanup will be done this afternoon.</p> <p>A Record review of the Facility's Shower/Bathing Task revealed documentation on 7/29/24 at 12:31 PM, 8/1/24 at 12:11 PM, and 8/5/24 at 2:59 PM nursing documented Not Applicable Further documentation revealed on 8/19/24 at 22:59 Both columns were checked Yes and No and identified the author as CNA AA</p> <p>On 8/20/24 at 3:55 PM , Charge Nurse LPN E When provided the shower/bath task check off, LPN E acknowledged this was not acceptable documentation. Documentation from 8/19 by CNA AA was reviewed and at 22:59 both Yes & No were marked. CNA AA was questioned what documentation was correct, and CNA AA confirmed a bed bath was performed. R47 confirmed this morning, this was never done and was observed appearance was evident R47 was not clean. CNA AA and LPN E went R47's bedside, and when asked if CNA AA provided bedside clean up last night, R47 shook his head no and said I never got cleaned up yesterday When asked by LPN E time he was last cleaned, he stated at least a week ago.</p> <p>On 8/20/24 at 4:18 PM, R47 commented I can't believe they told you I had bed bath!</p> <p>On 8/20/24 4:40 PM, The DON was updated on the delay of R47's bedside bath and documentation made by CNA AA The DON acknowledged this was not appropriate.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34208</p> <p>Based on observation, interview, and record review, the facility failed to properly label, store, and discard expired medications and biologicals in four of seven medication carts reviewed, resulting in the potential for misuse and decreased efficacy of medications. Findings include:</p> <p>A review of a facility provided policy titled, Storage and Expiration Dating of Medications and Biologicals revised 8/2024 was conducted and read. .3. Facility should ensure that food is not to be stored in the refrigerator, freezer, or general storage areas where medications and biologicals are stored .5. Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors .8. Facility should ensure that test reagents, germicides, disinfectants, and other household substances are stored separately from medications .10. Facility should ensure that medications and biologicals that: (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed. 11. Once any medication or biological package is opened, facility soul follow manufacturer/supplier guidelines with respect to expiration dated for opened medications. Facility staff should record the date opened on the primary medication container .16. Facility should ensure that medications and biologicals are stored at their appropriate temperatures .16.2 Refrigeration: 36-46 F (Fahrenheit) .</p> <p>On 8/20/24 at 10:58 AM, a medication cart on Unit 2 was observed unattended. The top of the medication cart contained a Breo Ellipta inhaler.</p> <p>On 8/21/24 at 9:53 AM, medication cart #6 was reviewed with Unit Manager 'A'. The cart was observed to contain the following: fish oil supplements with an expiration date of 6/2024, [NAME] oil supplements with an expiration date of 7/2024 and a bottle of COVID-19 test reagent stored with oral medications. A bag of potato chips was observed stored in the bottom left drawer of the cart.</p> <p>On 8/21/24 at 10:06 AM, a medication cart on the 100 unit was observed unattended with two vials of albuterol inhalation solution stored on top of the cart.</p> <p>On 8/21/24 at 10:08 AM, an observation of medication cart #3 was conducted with Nurse 'F'. The bottom right drawer of the cart was observed to have bleach disinfecting wipes stored with oral medications.</p> <p>On 8/12/24 at 10:20 AM, medication cart #1 was conducted with Unit Manager 'E'. The cart was observed to contain the a vial of Aplisol Tuberculin Purified Protein Derivative (a medication used to aide in the diagnosis of tuberculosis) with an open date of 8/18/24. The box containing the vial was observed to read, Store between 36-46 Fahrenheit. The cart further contained packaged iron supplements stored in a box with rectal suppositories. The bottom right drawer of the cart was observed to contain a small, open cosmetic bag. Contents of the bag included: a tube of Anbesol (oral pain reliever) with an expiration year of 2022 and a tube of muscle rub that expired 12/2020.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the pharmacy package insert for Aplisol Tuberculin Purified Protein Derivative was reviewed and revealed the medication was to be stored in refrigerator between 36-46 degrees Fahrenheit.</p> <p>On 8/21/24 at 10:35 AM, medication cart #2 was conducted with nurse 'G'. The cart revealed a Levemir insulin flex pen with no open date stored in a plastic bag that read, Refrigerate, and a Lantus insulin flex pen with no open date.</p> <p>49083</p> <p>On 8/21/24 at 11:41 AM, an observation was made on Medication Cart #6 of a transdermal lidocaine patch (topical anesthetic used to treat pain) dated 8/20/24 and initialed. Licensed Practical Nurse (LPN) K was observed away from the cart, conversing with a colleague and then provided care to a resident in the room. LPN K returned to the cart and when asked if the patch was their initials, LPN K confirmed that the patch was opened and dated by self and left on top of the medication cart because the resident was in the shower. LPN K acknowledged that medications should not be left unattended.</p> <p>On 8/20/24 at 11:46 AM, an observation of an orange round pill stamped 44227 (pill identifier confirmed being 325 milligram of aspirin) lying on top of a white plastic trash shield on Medication Cart #5. LPN CC commented that the pill was not disposed by them and replied was not sure how it ended up there, removed, and disposed into the trash receptacle on the cart.</p> <p>On 8/21/24 at 1:05 PM, The Director of Nursing was informed of the above observations and acknowledged that medications should not be left unattended.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283</p> <p>Based on interview and record review, the facility failed to order laboratory tests timely for one resident (R31) who experienced signs and symptoms of a Urinary Tract Infection (UTI) and obtain physician ordered routine labs for one (R87) of two residents reviewed for laboratory service.</p> <p>Findings include:</p> <p>R87</p> <p>Review of the clinical record revealed R87 was a long-term resident of the facility. R87 was originally admitted to the facility on [DATE]. R87's admitting diagnoses included osteoarthritis, bipolar disorder, anxiety disorder, and heart failure. Based on the Minimum Data Set (MDS) assessment dated [DATE], R87 had a Brief Interview for Mental Status (BIMS) score of 15/15, indicative of intact cognition. R87 needed extensive staff assistance with their mobility in bed, transfers, and Activities of Daily Living (ADLs) such as grooming, dressing, toileting etc.</p> <p>Review of R87's clinical record revealed a physician order for Depakote oral tablet delayed release 125 mg (milligrams) two times a day. Further review of the record revealed a physician order dated 12/20/23 that read valproic acid lab draw on next lab day. Redraw every 6 months and 1 week after any dosage changes. Review of R87's lab results revealed a lab report dated 12/27/23 for valproic acid level. There was no evidence in R87's clinical record that follow-up/6-month valproic acid level were completed in June-2024 or after.</p> <p>An interview was completed with LPN F on 8/21/24 at approximately 1 PM. LPN F was queried about R87's lab results for valproic acid level that were due in June-2024. They checked the Electronic Medical record (EMR) for R87 and reported that they did not find any results and they were not able to log to the facility's laboratory portal and they would have another nurse or manager assist them.</p> <p>An interview was conducted with Unit Manager (UM) R on 8/21/24 at approximately 1:25 PM. They were queried about R87's lab results for valproic acid level that were due in June-2024. They had checked the EMR and reported they did not find any results. UM R also had other managers check the facility's lab portal and later they reported that they ordered lab for valproic acid level were not completed in June and they were contacting the physician to get stat (immediate) order to complete the test.</p> <p>34208</p> <p>R31</p> <p>On 8/19/24 at 10:13 AM, an interview was conducted with R31 in their room and they said, I need some antibiotics. When queried about the need for antibiotics R31 said the facility was not regularly supplying them with new, sterile, straight urinary catheters. They further explained they had been re-using catheters and believed they developed a urinary tract infection (UTI).</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 8/19/24 at 11:49 AM, a review of a progress note dated 8/14/2024 at 12:50 PM entered into the record by Nurse 'J' read, .While in care conference Resident c/o (complains of) pain in groin area and upon urinating also stating having a discharge from his penial <sic> area informed nurse and UN (Unit nurse) resident needs a UA (urinalysis) and order from physician and to follow up . A review of R31's active, completed, and discontinued orders was conducted and did not reveal an order for a urinalysis. A review of R31's laboratory testing was also conducted and revealed no recent results for a urinalysis.</p> <p>On 8/20/24 at 10:15 AM, a follow-up interview was conducted with R31. R31 said staff did not provide them with a new catheter in the morning and they re-used one from the previous night. They were then asked if they experienced any signs or symptoms of a urinary tract infection and said their urine was cloudy and they had pain and burning with urination. Finally, R31 was asked if they knew if the facility collected a urine specimen to send to the the lab for testing and said they did not.</p> <p>On 8/20/24 at 11:05 AM, an interview was conducted with Nurse 'J' regarding their progress note. Nurse 'J' said they recalled R31 expressing concern about possibly having a UTI. They said they informed the unit managers and left a note in the physician's communication book.</p> <p>On 8/20/24 at 11:08 AM, an interview was conducted with Unit Manager 'E'. They were asked if anyone reported R31's concerns about a UTI to them and said no one had. At that time, Unit Manager 'E' was asked to provide any labs for R31. Unit Manager 'E' provided two lab results, one dated for May 2024 and dated June 2024.</p> <p>On 8/20/24 at 11:15 AM, a review of the physician's communication binders on the unit was conducted and revealed a written communication entry for 8/14/24 that indicated R31 had experienced signs and symptoms of a UTI.</p> <p>On 8/20/24 at 11:28 AM, a follow-up interview was conducted with Unit Manager 'E' regarding the delay of notifying the physician and ordering labs. Unit Manager 'E' said the information should have been reported to them and they would have called the physician for an order.</p> <p>On 8/21/24 at 12:55 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding the delay. The DON said the concern should have been communicated and the physician should have been notified for an order for labs.</p> <p>A request for a policy on laboratory services was made, however; it was not provided by the end of the survey.</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675</p> <p>Based on interview and record review the facility failed to obtain and/or coordinate radiology services for an MRI (Magnetic Resonance Imaging) for one (R42) of one resident reviewed for radiology/other diagnostic services, resulting in verbalized concerns of the delay in obtaining the MRI, and the potential for delayed identification of any abnormalities which may require additional medical/treatment intervention.</p> <p>Findings include:</p> <p>On 8/19/24 at 11:38 AM, an interview was conducted with R42. When asked if they had any concerns, R42 reported they had pain all over, especially their left thigh and arm. They reported concerns with the lack of scheduling and coordination of an MRI and stated their cancer doctor wanted them to have an MRI done for their left thigh. The resident reported they gave that information to the facility to coordinate, but no one has contacted them about if/when that was scheduled. R42 was worried about their cancer diagnosis and also expressed concern that another part of their thigh is hurting. The resident reported they were trying to put it out of their mind cause they didn't want to worry, but they are worried.</p> <p>Review of the clinical record revealed R42 was admitted into the facility on [DATE], and readmitted on [DATE] with diagnoses that included: chronic respiratory failure with hypoxia, rheumatoid arthritis, type 2 diabetes mellitus without complications, lymphedema, chronic kidney disease stage 3, chronic diastolic (congestive) heart failure, malignant neoplasm of connective and soft tissue of left lower limb, including hip, neoplasm of unspecified behavior of bone, soft tissue, and skin, and personal history of pulmonary embolism.</p> <p>According to the Minimum Data Set (MDS) assessment dated [DATE], R42 had no communication concerns and had intact cognition.</p> <p>Review of the resident's physician orders included an active order that started on 7/10/24 which read, MRI left femur with and without contrast. Please schedule with [name of local hospital] within 48 hours. There was no documentation in the clinical record that this had been completed as of this review.</p> <p>On 8/20/24 at 10:39 AM, an interview was conducted with the Director of Nursing (DON). When asked about the facility's process for ensuring coordination for appointments for an MRI, the DON reported those appointments were done by the scheduler/ward clerk. When asked if documentation should be reflected in the clinical record of whether those were scheduled or completed, the DON reported the nurse should proceed with any instructions and if an appointment needs to be scheduled, that information is turned over to Staff 'W'.</p> <p>On 8/20/24 at 11:04 AM, an interview was conducted with Staff 'W' who was responsible for the facility's nurse scheduling, medical records, and ward clerk duties. They reported they started doing ward clerk duties and medical records back in October 2023 and had another ward clerk (Staff 'P') that also performed central supply duties.</p> <p>(continued on next page)</p>		

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<p>F 0776</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When asked about whether the facility's process of scheduling appointments, Staff 'W' reported generally they received an order and will make an appointment. When asked to confirm whether R42 had an appointment for an MRI, Staff 'W' reviewed their documentation and reported they were waiting for the hospital to return their call, but they didn't put a date on when they had called the hospital. Staff 'W' was asked if there was any other follow-up done since the initial call to the hospital and they reported they gave the follow up to the nurse to do. They were unable to identify which nurse, or when that occurred. Staff 'W' further confirmed the only scheduled appointment they could see for R42 was with a cardiologist on 9/3/24. Staff 'W' was asked to see if they could find any additional documentation regarding the MRI for R42, however there was no further documentation or clarification provided by the end of the survey.</p> <p>Review of the documentation provided by the facility for coordination of outside providers included a policy titled, Social Services Referral to Outside Providers dated 10/27/2023 did not address the coordination of radiology services.</p>		

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<p>F 0806</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.</p> <p>34208</p> <p>Based on observation, interview, and record review, the facility failed to ensure menu items listed on meal tickets were provided for seven residents (R#'s 12, 101, 64, 34, 89, 59, and 100) of 28 residents reviewed for dining resulting in the potential for disappointment with meals. Findings include:</p> <p>On 8/19/24 at 1:20 PM, an observation of the lunch meal was conducted in the facility dining room and the following was observed: R12's meal ticket revealed they were to be provided a nutritional juice supplement, it was not observed the nutritional juice was provided to them during the meal service, R101's meal ticket revealed they were to be provided a magic cup supplement, no magic cup was observed to be provided to them during the meal service, R64's meal ticket indicated they were to be provided a double dessert and a nutritional juice supplement, the dessert provided was a single serving and no nutritional juice was observed as provided during the meal service.</p> <p>On 8/19/24 at approximately 1:45 PM, an observation of R34's meal ticket on the tray at their bedside revealed they were to be provided a cup of hot tea and a nutritional juice supplement, neither item listed on the ticket was provided on the meal tray.</p> <p>On 8/20/24 from 8:20 AM until 9:05 AM, observations of the breakfast meal served on the 100 unit was conducted. It was observed the top of the meal cart contained a carafe of coffee and a carafe of hot water. A caddy on top of the cart also contained creamer, sugar, tea bags, and plastic coffee cup lids. It was not observed there were coffee mugs or disposable foam cups for service of hot coffee or tea. Further observations revealed the following: R12 and R89's meal tickets indicated they were to receive coffee, no coffee was observed to be provided to them, R59, R100, and R34's meal tickets indicated they were to receive hot tea, no hot tea was observed to be provided with their meals.</p> <p>On 8/20/24 at 12:45 PM, R100 was observed in their room eating their lunch meal. Their meal ticket indicated they were to receive a carton of nutritional juice, the juice was not observed to be provided on the meal tray.</p> <p>On 8/21/24 at approximately 9:00 AM, R34 was observed in their bed eating their breakfast meal. R34's meal ticket indicated they were to receive hot tea, hot tea was not observed to be provided with the meal.</p> <p>On 8/21/24 at 11:15 AM, an interview with Dietician 'H'. They were asked if residents should receive the meal items such as magic cups and nutritional juices listed on the meal tickets and said they should have been placed on the trays from the dietary department during the tray line. They were then asked about numerous residents who were not provided with coffee or tea. They explained coffee and tea were provided at the point of service by the Certified Nurse Aides and if the ticket had those items listed they should have been provided.</p> <p>A review of a facility provided policy titled, Food Preferences revised 11/2021 was reviewed but did not address the facility's responsibility to provide food/beverages per resident preferences.</p>		

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<p>F 0807</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration.</p> <p>34208</p> <p>Based on observation, interview and record review, the facility failed to ensure fresh water and assistance with consuming fluids for four residents (R#'s 59, 34, 89, and 100) of four residents reviewed for hydration, resulting in the potential for dehydration. Findings include:</p> <p>On 8/19/24 at 11:05 AM, R59 was observed in bed, asleep. A foam cup full of water, with no ice and felt room temperature to the touch was observed on the bedside table. It was observed the cup was not dated and the top of the straw was contained in it's paper wrapper.</p> <p>On 8/20/24 at 8:20 AM, R34 was observed in their bed. A foam cup full of water with, 8/20 11-7 (Date/midnight shift time) written on the cup was observed. The cup felt room temperature to the touch and the top of the straw was contained in it's paper wrapper.</p> <p>On 8/20/24 at 10:40 AM, R89, R59, and R100's water cups were observed dated 8/20 with 11-7 written on them. The cups all felt warm to the touch and none contained ice. The top of the straw in R59's cup was observed to be contained in it's paper wrapper.</p> <p>On 8/20/24 at 12:45 PM and 2:00 PM, R34 was observed in bed, asleep. A foam cup full of water with no ice was observed on the bedside table. It was further observed the top of the straw in the cup remained in it's paper wrapper.</p> <p>On 8/20/24 at 2:00 PM, the following was observed: R89, R100 and R59's water cups were observed at the bedside dated 8/20 11-7. The cups felt room temperature to the touch and none contained ice. It was further observed the top of the straw in R59's cup remained in it's paper wrapper.</p> <p>On 8/20/24 at 2:10 PM, an interview was conducted with Unit Manager 'G'. They were asked about the process of providing drinking water and said the midnight shift provided the cups and they were refreshed with ice and water throughout the day. An observation of several room temperature cups with no ice in them were shared with Unit Manager 'G', and they said staff were supposed to be refreshing them throughout their shift. They were then asked about the straw wrappers remaining in place and acknowledged a concern residents were not being given assistance with drinking fluids if the wrappers remained in place from the midnight shift up until 2 PM the next day.</p> <p>A review of a facility provided policy titled, Oral Hydration revised 11/2021 was conducted and read, Policy: It is the policy of this facility to assist guests/residents to maintain adequate hydration whenever possible .</p>		

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<p>F 0809</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times.</p> <p>22960</p> <p>Based on observation, interview, and record review, the facility failed to ensure meals were served in a timely manner and in accordance with the scheduled mealtimes for the residents (including R39), resulting in late meals and resident dissatisfaction. Findings include:</p> <p>Review of an undated facility policy Meal Times noted: Tray line/Room trays/Dining room: Lunch 12:30 pm. All times are within +/- 10 minutes.</p> <p>On 8/19/24 at 1:05 pm, the first lunch cart left the kitchen to be delivered to the resident rooms.</p> <p>On 8/19/24 at 1:55 pm, the last lunch cart left the kitchen to be delivered to the resident rooms.</p> <p>On 8/19/24 at 2:00 pm, Certified Dietary Manager O was queried about the late lunch meal delivery and stated that they had a call-in for the morning shift, and that it put them behind for the rest of the day.</p> <p>47283</p> <p>A confidential Resident group meeting was conducted with five residents on 8/20/24 at approximately 11:30 AM. During the meeting, all five residents reported that they were not served meals timely on many occasions. When asked what time they ate their breakfast, Anonymous Resident 1 stated today was 9 AM, tomorrow it may be 9:30 AM, another day it may be after 10 AM. They added that meal times were dependent on who is cooking in the kitchen. When queried if it was any specific meal or day, they reported No, it is the same for lunch and dinner. Additional residents in the group were in agreement with the extent of meal time concerns.</p> <p>R39</p> <p>An interview was completed with R39 on 8/20/24 at approximately 4:25 PM. During the interview R39 reported that it was few weeks ago they were served late lunch and dinner. They reported that lunch was served between 2:30 PM and 3 PM and dinner was served around 8 PM.</p> <p>An interview was completed with a family member on 8/19/24 at approximately 1:00 PM. The family member had reported that were in the facility on most days. They had reported that a few weeks lunch was served between 2:30 and 3:00 PM and dinners were served around 8:00 PM and added it was not just one day.</p> <p>An interview was completed with Certified Dietary Manager (CDM) O on 8/20/24 at approximately 4 PM. During the interview when queried about the resident concerns about meals not being served on time on multiple occasions, CDM O reported that they had staffing challenges. If there was call off for breakfast then that delayed all the whole process for that entire day. They reported that they understood the concerns with the delayed meal times, and they had been working on it.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083</p> <p>Based on observation, interview and record review, the facility failed to utilize appropriate infection control standards and practices including adherence to implementation of and donning proper Personal Protective Equipment (PPE) specific to Enhanced Barrier Precautions (EBP) (R172), proper hand hygiene, and unsafe disposing of human waste (R15), resulting in the potential for spread of infection that could potentially affect all residents in the facility.</p> <p>On 8/21/24 at 7:46 AM, Licensed Practical Nurse (LPN X) was observed during medication administration not performing hand hygiene. LPN X donned gloves to administer eye drops, and when the residents telephone fell to the ground, LPN X picked the phone up off the floor, hands remained gloved, placed the phone back to the resident, and attempted to administer eye drops without changing gloves and performing hand hygiene. When prompted, LPN X acknowledged hand hygiene should have been performed and gloves changed.</p> <p>Resident 15</p> <p>Clinical record review revealed R15 was admitted to the facility on [DATE] and managed under hospice services. Medical diagnoses include hypertension, hypothyroidism, dementia, Alzheimer's, and chronic kidney disease. R15 is identified at risk and has a history of frequent urinary tract infections related to history of neurogenic bladder dysfunction and required a suprapubic catheter (surgical placed tube into the bladder to drain urine). A Brief Interview for Mentals Status (BIMS) exam score totaled three denoting R15 had severe cognitive impairment.</p> <p>On 8/21/24 at 11:36 AM, LPN F was observed manipulating R15's suprapubic catheter without proper personal protective equipment as indicated per Enhanced Barrier Precaution guidelines (gown). When questioned if the proper PPE was donned, LPN F replied ah gotcha then acknowledged a gown was not worn. LPN F was identified before and after care of the resident's catheter and care of the resident not performing hand hygiene and required prompting to do so. LPN F acknowledged hand hygiene was not performed.</p> <p>On 8/21/24 at 11:51 AM, LPN F was then observed entering the room of R15, donned gloves then took a urine catheter bag filled with urine and placed into the trash container. LPN F removed their gloves, and did not perform hand hygiene. LPN F then took the same trash bag, and walked to the 300 Unit, passing the dining room, with trash containing the resident's urine. When questioned why the trash was disposed on another unit, LPN F responded she did not know of any other area to throw the garbage out.</p> <p>On 8/21/24 at 1:05 PM, The Director of Nursing (DON) and LPN Unit Manager R acknowledged hand hygiene should be performed before and after resident care, and PPE should be maintained with residents on EBP. The trash filled with urine was not to be disposed in that manner and stated that one on one education would be conducted with LPN F.</p> <p>30675</p> <p>R172</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/19/24 at 11:23 AM, R172 was heard yelling out for the main nurse over and over. Upon entering the room, the resident was observed lying in bed with the head of the bed elevated up and there was an intravenous (IV) line attached to a pole that went to a midline in the resident's right upper arm. When asked about the reason for the IV antibiotics, R172 reported they had no idea. There was no signage or Personal Protective Equipment (PPE) to identify if the resident was on any enhanced barrier precautions (EBP). Continued observations of the resident from 8/19 - 8/20/24 revealed no staff were utilizing any PPE for R172.</p> <p>On 8/19/24 at 11:32 AM, R172's Nurse (Nurse 'K') was asked why the resident had the IV and what medication was being administered. Nurse 'K' reviewed the physician orders and reported the medication was not an antibiotic, but was IV Potassium.</p> <p>Review of the clinical record revealed R172 was admitted into the facility on [DATE] with diagnoses that included: late syphilis, latent and acute on chronic diastolic (congestive) hear failure.</p> <p>Review of the physician orders included multiple orders for the care of R172's midline catheter for IV maintenance and wound care for open skin areas that were present upon admission. There were no physician orders implemented as of this review for R172 to be placed on enhanced barrier precautions (EBP) due to the midline catheter IV and wounds. Additionally, the antibiotic order actually read, Penicillin G Potassium Injection Solution Reconstituted Use 4 million units intravenously every 4 hours for neurosyphilis until 8/19/2024 21:00.</p> <p>On 8/20/24 at 8:30 AM, an interview was conducted with Unit manager (Nurse 'A') who reported they had been in their role since 8/12/24. When asked about R172's lack of EBP and whether he should have had one due to having a Midline and open wounds, Nurse 'A' reported they had spoken about his diagnosis yesterday but didn't hear back. When asked who they spoke to they reported the Infection Control Nurse and the Director of Nursing (DON) but confirmed R172 had not been placed on EBP since their admission. When asked what the process would be to identify if EBP was needed upon admission, Nurse 'A' reported that would be the nurse handling the admission and was unable to offer any further explanation of why that wasn't done for R172.</p> <p>On 8/20/24 at 10:40 AM, an interview was conducted with the Director of Nursing (DON) and the Infection Preventionist (IP). When asked about whether R172 should have been placed on any infection control precautions for their use of a midline IV and open wounds, the DON reported EBP should've been placed upon admission. The DON reported they thought the resident may have come to the facility on Friday evening, but the IP Nurse indicated the resident had come on Thursday evening. When asked regardless of when the resident arrived, should the nursing staff have known to implement EBP for the resident and the DON reported the floor nurses initially do the nursing admission comprehensive assessment and the nurse's should know to automatically put the resident on precautions. The DON further reported outside of that, management staff which is normally the nurse manager would go through and make sure everything is completed.</p> <p>According to the facility's policy titled, Enhanced Barrier Precautions (EBP) dated Effective 4/1/2024:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>.Enhanced Barrier Precautions are indicated for residents with any of the following .a wound or indwelling medical device .Indwelling medical devices include central lines .Post signage for precautions on the door or wall outside of the residents room indicating the type of precautions and required PPE (e.g. gown and gloves) .Health care personnel caring for residents on Enhanced Precautions should wear gloves and gowns during high-contact resident care .dressing .bathing/showering .Providing hygiene .Changing briefs or assisting with toileting .Device care or use .wound care .</p>		

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<p>F 0924</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Put firmly secured handrails on each side of hallways.</p> <p>30675</p> <p>Based on observation and interview the facility failed to ensure all corridor areas used by residents were provided with safe and secure hand rails. This deficient practice has the potential to affect all residents who are independently ambulatory with, or without an assistive device.</p> <p>Findings include:</p> <p>Observations conducted during survey between 8/19/24 - 8/20/24 at 3:00 PM revealed concerns regarding the facility's handrails. These concerns included multiple sections of the handrails and hard plastic corner caps/molding were observed to have broken, jagged, missing pieces which exposed the sharp plastic and/or metal underneath throughout the 100 and 200 hallways. Additionally, the handrail near the exit hallway closest to the kitchen was observed pulled away and down from the wall slightly.</p> <p>On On 8/20/24 at 3:06 PM, an interview and observation of the 100 and 200 hallways was done with the Maintenance Director (Staff 'S'). When asked if the conducted any audits of the facility's handrails, Staff 'S' reported they didn't do anything like a monthly audit, but checked once every blue moon. When asked to observe the handrails, Staff 'S' reported they were aware there were several areas closer to the flooring of the same faux wood plastic material that were broken and confirmed those during the walk-through. On the 200 hallway, the handrail leading to the exit door near the dish room was observed to be broken, with sharp plastic and the entire handrail hung down slightly. At that time, Staff 'S' confirmed the same and reported they were not aware of that and would have to fix asap (as soon as possible). They were informed that was observed on the first day of the survey. When asked what their process was for staff to inform of issues observed such as broken handrails, they reported there was an electronic system staff could report to and they would follow-up.</p>