STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide sufficient nursing staff to meet the needs of residents, including R46 and R27, resulting in unmet care needs. This deficient practice had the ability to affect all residents that resided in the facility.On 9/23/25 at 10:16 AM, R46 was observed lying in bed. R46 was asked about care in the facility. R46 explained on 9/22/25 she had asked to be put back into bed around 5:00 PM, before dinner was served. was told they did not have enough staff as she required a mechanical lift and two staff members and had to wait until after dinner. was not assisted back to bed until 9:40 PM. was very tired from sitting in chair that long, and her bottom hurt.On 9/23/25 at 10:26 AM, R27 was observed lying in bed. R27 was asked about care in the facility. R27 explained she was not changed for 12 hours on 9/22/25. was changed around 4:00 PM, then was not changed again until early morning approximately 3:00 or 4:00 AM on 9/23/25. was told they were short of staff.Review of the clinical record revealed R46 was admitted into the facility on 2/26/25 with diagnoses that included: stroke, diabetes and pressure ulcer of sacral region. According to the Minimum Data Set (MDS) assessment dated [DATE], R46 was cognitively intact and dependent on staff for transfers.Review of the clinical record revealed R27 was admitted into the facility on 4/27/23 and readmitted [DATE] with diagnoses that included: heart disease, chronic obstructive pulmonary disease and diabetes. According to the MDS assessment dated [DATE], R27 was cognitively intact and was dependent on staff for toileting hygiene.Review of the four Afternoon Assignment Sheet dated 9/22/25 revealed three Certified Nursing Assistants (CNA's) assigned for Unit 1 and Unit 2. None were provided that documented Unit 3. One sheet had CNA Z' assigned to rooms 101-1 - 115-2, and another had 101-1 - 116-1. One sheet had CNA Y assigned to 116-1 - 236-1, another sheet had 226 - 236-2, another 116-2 - 123, and another had 226 - 241-1. One sheet had CNA AA assigned to 236-2 - 252-2, another had 238 - 252, and another had 241-2 - 252. On 9/25/25 at 12:22 PM, a phone call was made to CNA Y and a voicemail was left. No return call was made prior to the end of the survey.On 9/25/25 at 12:24 PM, CNA Z was interviewed by phone. CNA Z was asked how many CNA's were working the afternoon shift on 9/22/25. CNA Z explained there were four CNA's for the entire building. she had most of Unit 1, CNA Y was split between Unit 1 and Unit 2, CNA AA had the rest of Unit 2, and another CNA had Unit 3. When asked how many CNA's usually work the afternoon shift, CNA Z explained they usually had six. CNA Z was asked if there were things she could not complete on her shift. CNA Z explained she tried as hard as she could, but there were some things she could not get to, with three CNA's for 100 residents. Review of the facility daily staff postings revealed on 9/22/25 there were 98 residents.On 9/25/25 at 1:36 PM, The Administrator and Director of Nursing (DON) were interviewed and asked if the Scheduler, who was not at the facility, was working on 9/22/25. The Administrator explained the Scheduler was off on that day. When asked about only having four CNA's on the afternoon shift on 9/22/25, the DON explained they had more CNA's scheduled, but there were call-ins. The DON was asked what was done to provide care for the residents. The DON explained three managers stayed over to help with the afternoon shift. The DON was asked which managers had stayed. The DON explained it was Unit Manager (UM) C, Wound Care (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Coordinator (WCC) E and UM J. The DON was asked to provide the time punches for the three managers on 9/22/25.On 9/25/25 at 1:45 PM, UM J was interviewed and asked about the afternoon shift on 9/22/25. UM J explained she stayed to help on Unit 2. passed water, pass dinner trays, answered call lights and changed residents. When asked how long she stayed, UM J explained it was after 11:00 PM.On 9/25/25 at 1:55 PM, WCC E was interviewed and asked if she stayed to help out with the afternoon shift on 9/22/25. WCC E explained she did and helped out on Unit 1 to pass water, dinner trays and change residents. WCC E was informed of the resident complaints of care not being done. WCC E explained she was sure there were things that did not get done that afternoon. When asked how long she stayed, WCC E explained she stayed until 11:00 PM.Review of the time punches for the three managers revealed: UM C punched out at 7:26 PM, WCC E punched out at 7:27 PM, and UM J punched out at 7:26 PM.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in foodborne illness among all residents that consume food from the kitchen. Findings include:On 9/23/25 at 8:47 AM, during an observation of the main kitchen conducted with the Certified Dietary Manager (CDM 'G'), the following concern was observed:The reach in cooler #1 was observed to have a clear, watery liquid coming from the top fan unit (fan was not functioning). CDM ?G' reported the reach in cooler #1 was not functioning properly and someone had been out about a week ago to make repairs and they needed a new gasket part and drip pan. CDM ?G' reported the liquid was coming from the ceiling of the reach in cooler (where the fan was). Directly stored underneath this fan and surround shelving units were several food items that were visibly contaminated with the clear watery substance, including a carboard box soaked with several two pound tubs of pesto sauce, several large bags of shredded cheese, two packages of sliced cheese, a container of prepared sandwiches which had the clear liquid substance on the outside of the clear sandwich bags that were also seated in the clear, watery liquid in the bottom of the plastic bin the sandwiches were stored in. There was also a container of pre-made chicken salad that was covered in clear liquid.When asked if there should be any food items stored underneath the active draining ceiling in the reach in cooler and why they didn't utilize the several other surrounding reach-in coolers, CDM ?G' reported the food should not have been stored under that and began removing the food items from the reach in cooler to discard. CDM ?G' further reported the reach-in cooler was not leaking this bad before now. A policy titled, Food Purchasing and Storage dated 12/10/2024 did not address the issue with the leaking reach in cooler.According to the 2017 FDA Food Code section 3-305.11 Food Storage, (A) Except as specified in (B) and (C) of this section, food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination .According to the 2017 FDA Food Code section 3-307.11 Miscellaneous Sources of Contamination, FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents' right to personal privacy during clinical assessment and provision of care for five (R14, R22, R31, R65, and R104) of five residents reviewed for privacy. Findings include:R14 On 9/23/25 at 10:09 AM, Ancillary Ear Care Nurse Practitioner (NP 'Q') was observed from the hallway providing ear care (wax removal) from the resident. They did not close the door or pull the privacy curtain to ensure personal privacy. Review of the clinical record revealed R14 was admitted into the facility on 5/27/22 and readmitted on [DATE] with diagnoses that included: vascular dementia with psychotic disturbance, unspecified dementia with other behavioral disturbance, psychotic disorder with delusions due to known physiological condition. R31 & R22 On 9/23/25 at 9:51 AM, R31 was observed from the hallway lying in bed watching their roommate (R22) receive ear care from NP 'Q'. They did not close the door or pull the curtain to ensure personal privacy. Review of the clinical record revealed R31 was admitted into the facility on [DATE], readmitted on [DATE] with diagnoses that included: cerebral infarction, abdominal aortic aneurysm ruptured, and other seizures. Review of the clinical record revealed R22 was admitted into the facility on 3/19/22 and readmitted on [DATE] with diagnoses that included: peripheral vascular disease, essential hypertension, and encounter for orthopedic aftercare following surgical amputation. R65 On 9/23/25 at 11:28 AM, Physical Medicine and Rehabilitation (PMR) NP 'R' was observed entering R65's room. NP 'R' did not close the door or pull the privacy curtain. The evaluation was heard from across the hallway, outside of R65's room, including when the resident last had a bowel movement. A review of R65's clinical record revealed R65 was admitted into the facility on 7/12/25 with diagnoses that included: femur fracture, type 2 diabetes mellitus, schizoaffective disorder, autistic disorder, and bipolar disorder. A review of a MDS (Minimal Data Set) assessment dated [DATE] revealed R65 had moderately impaired cognition. R104 On 9/23/24 at 11:32 AM, NP 'R' entered R104's room. NP 'R' did not close the door or pull the privacy curtain. The evaluation was heard from the hallway outside of R104's room. A review of R104's clinical record revealed R104 was admitted into the facility on 9/10/25 with diagnoses that included: type 2 diabetes mellitus with polyneuropathy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/24/25 at 1:48 PM, an interview was conducted with the Director of Nursing (DON). When queried about privacy given to residents during medical evaluations, the DON stated, Privacy is privacy and explained all staff who provided care should close the door or pull the curtain and talk in a manner that ensures privacy. A review of a facility policy titled, Resident Dignity & Personal Privacy, revised 3/28/24, revealed, in part, the following, .Each resident's right to personal privacy includes the confidentiality of his or her personal and clinical affairs .Examine and treat residents in a manner that maintains their privacy .Use a closed door, a drawn curtain, or both, to shield the resident during all personal care and treatment procedures .Speak in lowered tones, as appropriate, when discussing clinical or private issues with the resident .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, homelike environment, for 14 resident rooms (Room #s 101, 103, 106, 107, 110, 116, 118, 121, 237, 243, 244, 246, and 247) and throughout the hallways on Unit 1 and Unit 2. Findings include:On 9/23/25 between 12:45 PM-1:30 PM, observations of Unit 1 and Unit 2 revealed environmental concerns with the wall corners just outside the doorways of resident rooms. There were numerous broken off plastic wall corner edges (that protected the vertical edges of the wall) that had splintered and sharp edges. Most of the broken and/or missing pieces of the plastic were at the ankle level. Additionally, the handrail outside of room [ROOM NUMBER] was observed to have a large gap (about two inches) that exposed the sharp metal bracket inside the plastic covering. On 9/24/25 at 8:56 AM, the facility was requested via email to provide documentation which included policies for maintaining equipment including handrails, wall and/or doorway wall coverings, and any documentation for maintenance repairs. On 9/24/25 at 9:10 AM, an interview was conducted with the Maintenance Director (Staff ?H') who reported they had been in their role at the facility for about seven years. When asked about how they monitored the environment for potential concerns, they reported they did audits. Staff ?H? reported when staff observed concerns, they reported that in their electronic reporting system so it could be tracked and followed up on. At that time, observations with Staff ?H? confirmed the broken, sharp edges of the protective wall edge coverings. Staff ?H? reported those areas were always getting hit by carts and were easily broken. When asked about why those areas had not been maintained or replaced to prevent potential accidents/injuries, Staff ?H? reported it usually took a while once an order was requested and parts were not always easy to get right away. They were requested to provide any documentation of past order requests including their environmental audit tools. When the handrail outside of room [ROOM NUMBER] was observed, Staff ?H? reported they were not aware of that and did not know that could happen but confirmed the sharp edges and proceeded to try to pull the handrail pieces together but was unsuccessful. Review of the documentation provided by the facility revealed only repairs for items in the kitchen and did not include the electronic reports by staff for the past six months. Review of the maintenance audits for the environment revealed no identification of the broken wall edge coverings, or the handrail. There was no documentation provided of any invoices, or requests for previous orders of the plastic wall corner edging. Review of the facility's policy titled Federal & State - Resident Rights & Facility Responsibilities dated 5/14/2024 documented, in part: .The facility must provide .A safe, clean, comfortable, and homelike environment .This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of mistreatment to the Abuse Coordinator and/or the State Agency within the required time frame for one (R5) of two residents reviewed for abuse. Findings include:Review of the clinical record revealed R5 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: acute respiratory distress syndrome, vascular dementia moderate with psychotic disturbance, delusional disorders, generalized anxiety disorder, and adult failure to thrive.According to the Minimum Data Set (MDS) assessment dated [DATE], R5 had moderately impaired cognition and was dependent on staff for most activities of daily living.Review of the progress notes included:An entry on 9/22/25 at 11:49 AM by the facility's contracted psych Nurse Practitioner (NP ?L') documented, in part: .(R5).is seen today in her room.She wants to go home, stating she does not like the facility and feels that she is being mistreated by certain people, however cannot state exactly who it is or what they are doing. She feels that they think she is crazy, for which she used the Latin word to describe this .Concerns will be forwarded to the social worker.An entry on 9/23/25 at 12:06 PM by Social Worker (SW ?K') documented, in part:SW met with (R5) today to follow up on report from Psych Nurse Practitioner (NP) of (R5) reporting to her that she felt like she was being mistreated by certain people. When SW asked (R5) if she thought that she was being mistreated by certain people she stated, I can't think right now. SW indicated that SW would come back later to meet with (R5) and she stated, I don't think that will help. SW left (R5) SW name and extension per her request to contact SW if she is feeling mistreated by others.On 9/24/25 at 1:25 PM, an interview was conducted with SW ?K'. When asked what they could explain about details of R5's allegation of mistreatment, including what had been reported following their notification of the allegation, SW ?K' reported the resident had been seen by Psych NP ?L' on Monday and both SW ?K' and the Administrator had been notified by an email about that. SW 'K' further explained they attempted to talk with R5 but the resident was asleep and yesterday they went in to talk to her and did not get many details. When asked if they were aware of whether that incident had been reported to the State Agency, SW ?K' reported they were not sure and deferred to the Administrator.On 9/24/25 at 1:35 PM, an interview was conducted with the Administrator and Director of Nursing (DON) in the presence of the Regional Clinical Director (Staff ?M'). When asked about the facility's process for reporting allegations of mistreatment, and whether they had been notified of R5's allegations of mistreatment and if that had been reported to the State Agency, the Administrator reported they were not aware of that. The Administrator was informed about the discussion with SW ?K' and that they had been notified by email from Psych NP ?L' and reported they probably had not pulled it up yet (email) and further reported because the State came in yesterday, they did not have any morning meetings which would normally have discussed that.According to the facility's policy titled, Abuse Prohibition Policy dated 8/31/22: .Staff members, volunteers, family members, and others shall immediately report incidents of abuse and suspected abuse .Injuries of unknown source - An injury should be classified as an injury of unknown source when ALL of the following criteria are met: The source of the injury was not observed by any person; and the source of the injury could not be explained by the guest/resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the extent of the injury, or the injury is located in an area not generally vulnerable to trauma), or the number of injuries observed at one particular point in time or the incidence of injuries over time .The staff will report any allegations or suspicions of mistreatment, abuse, neglect, exploitation, misappropriation of property, and injuries of unknown source to the Administrator and DON immediately .The Administrator or designee will notify the guest's/resident's representative. Also, any State or Federal agencies of allegations per state guidelines (2 hours if abuse allegation or serious injury; all others not later than 24 hours). At the conclusion of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation, and no later than 5 working days of the incident, the facility must report the results of the investigation and if the alleged violation is verified, take corrective action .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure appropriate diet orders were entered upon admission for one (R101) of one resident reviewed for tube feeding, who was not supposed to eat anything by mouth, resulting in the potential for aspiration when the resident consumed food by mouth. Findings include:On 9/23/25 at 10:20 AM, R101 was observed lying in bed. R101 was able to say some words but had difficulty communicating. R101 reported he understood what others said but was unable to respond appropriately at times. A family member was at R101's bedside at that time. The family member explained R101 recently had a stroke and lost his ability to speak clearly and use one side of his body. On 9/24/25 at 9:00 AM, R101 was observed in bed. R101 reported his stomach hurt. When queried about whether he ate food by mouth, R101 nodded his head. When queried about whether he had a feeding tube, R101 nodded his head. On 9/24/25 at approximately 2:00 PM, R101 was observed in bed visiting with a family member. R101's family member stated, My biggest complaint is the communication between staff. Nobody knows what the other one is doing. A review of R101's clinical record revealed R101 was admitted into the facility on 9/18/25 with diagnoses that included: cerebral infarction (stroke). A review of a Nursing Summary completed upon admission on [DATE] at 4:18 PM revealed, .Resident .aphasic (difficulty speaking) r/t (related to) CVA (cerebral vascular accident). Resident is strict NPO (Nothing by mouth), bolus feed (a method of feeding through a feeding tube where large doses of the formula are given multiple times a day) .Orders and follow up appointments entered into (electronic medical record) . A review of a Nurses Note dated 9/19/25 at 3:32 PM, written by Licensed Practical Nurse (LPN) 'F', revealed, MD (medical doctor) ordered CXR (chest x-ray) .r/o (rule out) aspiration after the resident consumed a meal tray. Resident diet order is strict NPO. Diet slip updated, kitchen staff notified . A review of R101's Physician's Orders revealed an order for Nothing By Mouth was ordered on 9/19/25 in the afternoon. On 9/25/25 at 1:15 PM, an interview was conducted with LPN 'F'. When queried about what happened with R101 on 9/19/25 when he consumed a meal tray per her documentation, LPN 'F' reported R101 was a new admission. LPN 'F' reported she entered R101's admission orders and did not put in a diet order but put in the bolus tube feeding orders. LPN 'F' explained the dietary department entered a diet order for R101 on 9/19/25 and a Certified Nursing Assistant (CNA) notified her that R101 was eating a meal tray during the lunch meal. LPN 'F' asked the CNA if she gave him someone else's tray and the CNA reported R101 had a meal ticket included with the tray. LPN 'F' notified the unit manager, and it was discovered the dietary department created a meal ticket for R101. When queried about whether an order for NPO was entered upon admission, LPN 'F' reviewed R101's Physician's Orders and confirmed it was not entered until after the event of R101 consuming part of a meal tray. On 9/25/25 at 1:25 PM, an interview was conducted with the Director of Nursing (DON). When queried about the incident of R101 receiving a meal tray on 9/19/25 when he was NPO, the DON stated, It wasn't a nursing issue. It was something dietary did. On 9/25/25 at 1:30 PM, an interview was conducted with Certified Dietary Manager (CDM 'G'), Registered Dietitian (RD) 'B', and RD 'V'. When queried about what happened with R101 on 9/19/25 and why he received a meal tray when he was not supposed to eat anything by mouth, CDM 'G' reported when she came in on 9/19/25 he did not have a diet ticket, so she put one in for him. CDM 'G' reported there was no indication R101 was NPO. R101 received a meal tray and when the error was discovered, management was notified, and an x-ray was ordered to rule out aspiration. When queried about which meal was served to R101 and on which date, a clear answer was not given by CDM 'G', RD 'B' and RD 'V'. CDM 'G' later followed up and confirmed it was the lunch tray on 9/19/25. When queried about how she would have known if a resident was NPO and not supposed to receive a meal tray, CDM 'G' reported there would be a physician's order. On 9/25/25 at 1:35 PM, the Administrator was asked to provide any incident reports and any associated investigations regarding R101. A review of an incident report completed by (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN 'F' revealed on 9/19/25 at 1:32 PM the nurse was notified R101 had a lunch meal tray at his bedside. It was documented R101 was strict NPO. The meal tray was removed from the resident's room, the resident was assessed, the unit manager and the physician were notified, and a chest x-ray was ordered to rule out aspiration. It was documented that there was miscommunication in the dietary dept. (department). No investigation was provided by the facility. A review of a facility policy titled, Physician's Order, revised on 8/20/25, revealed, in part, the following, .Physician orders are obtained to provide a clear direction in the care of the resident .Once the order is verified, the receiving licensed nurse transcribes the order in the EMR (electronic medical record) system .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. This citation has two deficient practice statements (DPS).DPS #1Based on observation interview and record review the facility failed to assess and treat a skin impairment in a timely manner for one (R99) of three residents reviewed for wounds. Findings include: On 9/23/25 at 10:02 AM, R99 was observed lying in bed. When queried about the care provided in the facility, R99 reported he had pain in his left leg. R99 reported he was a victim of multiple gunshot wounds and had surgery to his left leg. R99 pulled the blanket off his leg which revealed an external fixation device that extended from the front of his left lower leg to the front of his left upper leg. R99 reported he was able to turn over a bit in bed but could not move the left leg. On 9/24/25 at 9:02 AM, R99 was observed lying in bed. R99 reported he was given pain medication an hour ago, but he was upset about a wound on the back of his left calf. R99 reported he got the wound while in the hospital due to pressure but the facility was not treating it adequately. R99 pulled back the blanket which revealed his left leg on top of a pillow that was stained with blood. R99 reported it was painful and bleeding and he had been trying to get someone to put a dressing on it since 3:00 AM. R99 reported he was concerned about it getting worse or infected if it was not covered. On 9/24/25 at approximately 9:10 AM, an observation of R99's left calf was made with the Unit Manager, Registered Nurse (RN) 'C'. RN 'C' assisted R99 to roll to the right and revealed an open area to the back of R99's left calf that was pink with two red bleeding areas in the center. There was no dressing applied to the skin impairment. R99 reported there was supposed to be a dressing on the wound, and she was going to notify the treatment nurse. On 9/24/25 at 9:53 AM, a review of R99's clinical record revealed the following:R99 was admitted into the facility on 9/19/25 with diagnoses that included: hypotension and acute embolism and thrombosis of unspecified deep veins of right lower extremity. A review of a Nursing Comprehensive Evaluation dated 9/19/25 and locked on 9/21/25 revealed R99 did not have any skin conditions.A review of a Nursing Summary dated 9/19/25 at 7:14 PM, revealed, Resident arrived at the facility via EMS (emergency medical services) at approximately (6:30 PM) on 9/19 .A skin assessment was performed by writer and aide. Writer observed a pin extrenal <sic> fixation to the LLE (left lower extremity) and resident unable to move L (left) toes. Resident appears to be in excruciating pain stating it to be in 10/10 .A review of a Nurses Note dated 9/19/25 at 7:52 PM revealed, .Resident has a pin fixation to left leg .Writer is endorsing to oncoming nurse to complete nursing comp (comprehensive evaluation) .A review of another Nurses Note (a late entry entered on 9/21/25 for 9/19/25 at 11:45 PM) revealed, .Skin tear noted to posterior aspect of L calf (lower/underside) dry dressing of gauze secured with tape in place . Further review of R99's progress notes revealed no documented assessment of the skin tear on the left calf documented on 9/19/25. A review of R99's wound assessments revealed assessments of the surgical wounds to the front of R99's left leg that included the external fixation device. A review of R99's Physician's Orders 9/19/25 to 9/24/25 revealed no order for treatment to R99's left calf. On 9/24/25 at 3:00 PM, R99 was observed lying in bed. When queried about the wound to his left calf, R99 reported a treatment was done after the observation with RN 'C' earlier that day. R99 turned his leg slightly and revealed a dressing dated 9/24/25 with RN 'C's initials. On 9/24/25 at 3:05 PM, an interview was conducted with RN 'C'. When queried about who administered the treatment to R99's left calf that day, RN 'C' reported it was the Treatment Nurse, Licensed Practical Nurse (LPN) 'S'. When queried about why there was no treatment order, RN 'C' said there was a treatment order in the Electronic Medical Record (EMR). At that time, R99's Physician's Orders were reviewed with RN 'C'. RN 'C' referred to an order for a treatment to left thigh surgical incision but there was no order for the wound to R99's left calf, which was not a surgical incision. When queried about the order, RN 'C' did not offer a response and said LPN 'S' would be the person to talk to. When queried about whether the open area to R99's left calf was assessed after it was observed that morning, RN 'C' reported it was not. On 9/24/2025 3:50 PM, an interview was conducted with LPN 'S'. When queried about her role, LPN 'S' reported she did all of the wound treatments in the facility. LPN (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	'S' explained if a new wound was identified, LPN 'E', the Wound Care Coordinator, assessed the wound, put in a note, entered a treatment, and contacted the wound provider. LPN 'S' further explained once the treatment order was in, she was alerted to do wound treatment for those residents. When queried about the wound to R99's left calf, LPN 'S' reported she had never seen that wound. LPN 'S' said she attempted to do the treatment on Monday (9/22/25), but R99 was in a lot of pain and he was unable to turn so she was unable to do it. When queried about if she did the treatment on that day (9/24/25), LPN 'S' said RN 'G' came to her to ask her to do it, but the order was for the night shift. LPN 'S' explained she did not administer a treatment to R99's calf (It should be noted that there was no active order for a treatment to R99's calf). On 9/24/25 at 4:12 PM, an interview was conducted with LPN 'E'. When queried about her role, LPN 'E' reported she was the wound care coordinator and was responsible for coordinating with the physician and wound nurse practitioner (NP). LPN 'E' explained when a new wound was identified, she was supposed to be notified, then she would assess the wound, and talk to the physician and NP. When queried about what was going on with R99's left calf, LPN 'E' stated, Looks like a skin tear. When queried about when she assessed the wound, LPN 'E' reported it was an abrasion. LPN 'E said she did not document an assessment of the wound anywhere, but LPN 'S' took a picture. A review of the wound assessments in R99's clinical record did not reveal any assessment or picture of the left calf, as mentioned earlier. LPN 'E' said both herself and LPN 'S' were able to assess wounds, add physician's orders, and take pictures and document the wounds. LPN 'E' followed up and reported a nurse documented a skin tear to the rear left calf on 9/19/25. When queried about why that wound was not assessed, LPN 'E' reported she was not notified. LPN 'E' confirmed she did not know about the open area to R99's left calf until that day (9/24/25). On 9/24/25 at 4:29 PM, an observation of the back of R99's left thigh was conducted with LPN 'E'. R99 reported he did not have any skin impairments on the back of his thigh. Observation revealed no skin impairment to the left thigh. When queried about the order that was in place for the left thigh surgical incision that did not exist, LPN 'E' reported she must have made a mistake and said read instead of front, referring to the surgical wound to the front of R99's thigh. LPN 'E' confirmed she did not know about the calf wound until today. A review of R99's clinical record on 9/24/25 at 4:42 PM revealed no documented assessment of the calf wound and no treatment order despite a treatment being applied to the calf. On 9/25/25 at 8:35 AM, an interview was conducted with the Director of Nursing (DON). When queried about the protocol when a skin impairment was identified, the DON reported the nurse documented the impairment, initiated a treatment, and notified the physician and wound care coordinator, LPN 'E'. When queried about LPN 'E' and LPN 'S's roles, the DON reported LPN 'E' was not wound care certified and was responsible for assessing wounds, initiating treatments, and coordinating with the wound provider. The DON reported LPN 'S' primarily did the wound treatments in the facility but could also assess and initiate treatments. The DON reported new skin impairments were supposed to be documented on a change in condition assessment. On 9/25/25 at approximately 12:30 PM, an interview was conducted with NP 'EE'. NP 'EE' reported today would be the first time evaluating R99. An observation of R99's left calf was conducted with NP 'EE'. A small amount of drainage was observed on the dressing. A pink open area was observed on the left calf. NP 'EE' stated, That's an abrasion. When asked how an abrasion could occur in that area of the body, NP 'EE' stated, From friction or shearing. NP 'EE' further stated, That's not a skin tear. A skin tear would have a flap of skin. When NP 'EE' referred to the area as a new wound, R99 stated, That's not new. I've had that longer than I've been here! On 9/25/25 at 12:35 PM, an interview was conducted with Certified Nursing Assistant (CNA) 'FF'. CNA 'FF' reported she was assigned to R99 for the past couple days. When queried about whether she noticed any skin impairments to the back of his left calf, CNA 'FF' reported she did not notice anything. A review of a Visit Report for R99, completed by NP 'EE' on 9/25/25 revealed, .Wound #1 Left, Posterior Calf is an acute Partial Thickness Abrasion .measurements are 1.6 cm (centimeters) length x (by) 0.8 cm width x 0.1 cm depth .There is a small amount of serous drainage noted . A review of a facility policy titled, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Skin Management, revised 8/14/25, revealed, in part, the following, .Residents admitted with any skin impairments will have appropriate interventions implemented to prevent healing .A physician's order for treatment .Skin impairment location, measurements and characteristics documented . DPS #2 Based on observation, interview, and record review, the facility failed to administer insulin according to physician's orders and contact the physician for a hypoglycemic (low blood sugar) event. Findings include: On 9/23/25 at 10:30 AM, R102 was observed seated in a chair. R102 reported he was recently admitted into the facility and was there for antibiotics to treat a diabetic wound on his foot. R102 reported he had a hypoglycemic incident the other night and the facility did not have anything quickly available to bring his blood sugar back up. R102 said the nurse gave him two mini chocolate bars but he would typically need a large chocolate bar or glass of orange juice. R102 further reported his blood sugar level was 50 and dropping. R102 reported he received a certain type of insulin at night and stated, I should not have let them give me that amount. R102 expressed feeling lightheaded, dizzy, and was afraid he was going to die. A review of R102's clinical record revealed R102 was admitted into the facility on 9/12/25 with diagnoses of acute osteomyelitis of left ankle and foot and type 2 diabetes mellitus. A review of R102's Physician's orders revealed the following orders: Lantus (long acting) 100 unit/ml (unit per milliliter)- inject 40 unit subcutaneously (beneath the skin) at bedtime for DMInsulin Lispro (short acting) 100unit/ml inject 7 unit subcutaneously with meals for DM A review of R102's progress notes revealed the following: A Nurses Note dated 9/21/25, written by Licensed Practical Nurse (LPN) 'A', documented, During the (9:00 PM) med pass (on 9/20/25), residents BS (blood sugar) was taken and was 305 mg/dl (milligrams per deciliter). 40 units of insulin were administered per MD (physician) order. At (10:57 PM) resident c/o (complained of) feeling lightheaded, dizzy, and reported diplopia (double vision). Resident expressed concern that he could 'possible die in the night.' BS was 50 (mg/dl) at this time. Writer and aide gave resident two chocolate candy bars and 2 bottles of ensure. At (12:00 AM) blood glucose rechecked and noted to be 109 mg/dl. Resident stated that he was feeling a little better, no further c/o dizziness or visual changes at this time .Writer will reach out to MD via communication book to have the 40 Unit order reviewed and possibly changed to a lower unit or sliding scale to avoid a hypoglycemic crisis. A review of eMAR (electronic medication administration record) - Medication Administration Notes revealed R102 received different doses of Lantus than what was ordered by the physician (40 units) on multiple days as follows:On 9/12/25, 11 units were given.On 9/13/25, it was documented that R102 only accepted 20 units.On 9/14/25, R102 only accepted 30 units.On 9/15/25, 25 units per resident.On 9/16/25, 25 units given.On 9/19/25, Resident only requested half the dose of 20 units.On 9/21/25, Resident insisted on 25 units instead of 40 units.On 9/22/25, 7 units accepted.On 9/23/25, 25 units administered. A review of a Physican Note dated 9/22/25 revealed no documentation of R102's hypoglycemic event on the night of 9/20/25 and no mention of the Lantus being given at doses not consistent with the physician's orders. On 9/24/25 at 11:33 AM, an interview was conducted with LPN 'A' via the telephone. When queried about the hypoglycemic event R102 experienced on the night of 9/20/25, LPN 'A' responded with I haven't worked here that long. When queried about whether she completed training and orientation and was assigned to provide nursing care to residents, LPN 'A' reported she completed training, was licensed, and provided nursing care to residents. When queried about what type of insulin she administered to R102 on the night of the hypoglycemic event, LPN 'A' stated, I gave 40 units of lispro because his blood sugar was over 300. (It should be noted that Insulin Lispro is a short/fast acting insulin and R102's orders were to receive that insulin before meals). When queried about whether she contacted a medical provider after R102 had a hypoglycemic incident, LPN 'A' said she contacted Physician 'U'. When queried about Physician 'U's response, LPN 'A' clarified that she did not call him but wrote it in the communication book. When asked why she did not call him, LPN 'A' stated, I work on the midnight shift, and he doesn't respond. When queried about why 40 units of Insulin Lispro were given at 9:00 PM on 9/20/25 and not Lantus which was the insulin ordered to receive at bedtime, LPN 'A' stated, When you look at the orders, he only has an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order for Lispro 40 units. LPN 'A' then stated, I don't really know what I gave. It's whatever is documented on the MAR. At that time LPN 'A' said she was uncomfortable answering anymore questions and hung up the phone. On 9/24/25 at11:45 AM, an interview was attempted with LPN 'D' (one of the nurses who gave Lantus at different doses than what was ordered) via the telephone. LPN 'D' was not available prior to the end of the survey. On 9/24/25 at 12:03PM, an interview was conducted with Physician 'U' via the telephone. Physician 'U' confirmed he was familiar with R102. When queried about R102's hypoglycemic event on the night of 9/20/24, Physician 'U' reported he as not notified about it and was not aware that happened. Physician 'U' reported the nurse should have called him at the time of the event. When queried about whether the nurses should administer different doses of Lantus than what was ordered (40 units), Physician 'U' stated, They can't just change it. Physician 'U' explained that if the nurses contacted him and if he was aware of the resident's noncompliance with taking that dose, he would have evaluated and educated the resident. Physician 'U' said R102 was in the facility to treat a diabetic wound and his blood sugar needed to be controlled in order to aid in wound healing. Physician 'U' reported he had never been contacted about R102 refusing the 40 units of Lantus. On 9/24/25 at 12:52 PM, an interview was conducted with Unit Manager, Registered Nurse (RN) 'C'. When queried about R102's hypoglycemic event and random doses of Lantus being given instead of the ordered 40 units, RN 'C' reported she was not aware he had a hypoglycemic event. RN 'C' reported the physician should have been called. RN 'C' reviewed R102's clinical record and said she was not sure why staff were giving R102 different doses of Lantus and explained the physician should be contacted before administering a medication outside of the orders or if the resident was refusing it. RN 'C' read the progress note regarding the hypoglycemic event on 9/20/25 and confirmed the note did not indicate what kind of insulin was administered at that time. RN 'C' said it was unlikely that it was the long-acting insulin (Lantus) if his blood sugar dropped that low, that quickly. If the nurse gave the wrong insulin, a medication error should have been reported. RN 'C' reported she would have to look into it. On 9/24/25 at 1:10 PM, an interview was conducted with the Director of Nursing (DON). When queried about whether she was aware of R102's hypoglycemic event on 9/20/25, the DON reported she would not have been notified about that. If the resident had low blood sugar, the physician should have been contacted. When queried about R102 receiving different doses of Lantus than what was ordered, the DON reported the nurses were not supposed to alter from the order said. The DON further reported that if the resident did not want that much, the nurse still should have notified the physician. A review of a facility policy titled, Diabetic Management dated 9/22/23 revealed, in part, the following, .If BG (blood glucose) is below 70 mg/dl and the resident is presenting with signs/symptoms of hypoglycemia and can swallow, administer: 4 ounces of fruit juice, or administer three (3) 5gm oral glucose tablets, or One tube of glucose gel massaged into the buccal space .Notify the physician of abnormal blood glucose test results, symptoms exhibited, and interventions implemented .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to timely identify and treat a facility acquired pressure ulcer for one (R10) of three residents reviewed for pressure ulcers resulting in R10 acquiring a Stage 4 (full-thickness skin and tissue loss) pressure ulcer. Findings include:On 9/23/25 at 9:11 AM, R10 was observed lying in her bed flat on her back. R10 was asked if she had wounds or sores on her body. R10 explained she thought she did.Review of the clinical record revealed R10 was admitted into the facility on 8/19/22 and was readmitted on [DATE] with diagnoses that included: hypertensive urgency, fracture of left pubis and stroke. According to the Minimum Data Set (MDS) assessment dated [DATE], R10 had severely impaired cognition. The MDS assessment also indicated R10 had one facility acquired Unstageable (obscured full-thickness skin and tissue loss) pressure ulcer.Review of R10's impaired skin care plan revealed interventions that read in part, .Conduct weekly head to toe skin assessments, document and report abnormal findings to the physician. Date Initiated: 08/19/2022. Observe skin with showers/care. Notify nurse immediately of any new areas of skin breakdown: Redness, Blisters, Bruises, discoloration noted during bath or daily care. Date Initiated 08/22/2022.Review of R10's progress notes revealed a Skin/Wound Progress note dated 8/15/25 at 4:03 PM by Licensed Practical Nurse (LPN) E, who served as the Wound Care Coordinator, read in part, During skin assessment resident observed with 3 new areas, not including sacrum MASD (moisture associated skin damage) already being treated.Review of a Skin & Wound Evaluation dated 8/15/25 for R10 read in part, .Type: 15. Pressure. Stage 4: Full-thickness skin and tissue loss. Location: Right Gluteal Fold. Acquired: 1. In-House Acquired. Exact Date: 8/15/2025. Length 6.4 cm (centimeters). Width 1.8 cm. % Slough (non-viable yellow, tan, gray, green or brown tissue): 1. 100% of wound filled. Progress: 1. New. Review of the picture attached to the Skin & Wound Evaluation dated 8/15/25 revealed an open wound completely obscured by slough on R10's left gluteal fold. It should be noted the Skin & Wound Evaluation documented the wound as right gluteal fold. On 9/24/25 at 10:05 AM, R10's left gluteal fold wound was observed with LPN S, who served as the Wound Care Treatment Nurse. LPN S assisted R10 to turn on her left side and the wound was immediately observed as there was no dressing covering it. The wound appeared on the left gluteal fold, was approximately 4 cm x 3 cm and the wound bed was obscured with eschar (dead or devitalized tissue that is hard or soft in texture). LPN S then removed R10's brief to reveal a wound on R10's sacrum, that was previously identified as MASD on 8/15/25. On 9/4/25 at approximately 10:30 AM, LPN S was asked why R10's left gluteal fold wound was not identified until it was a Stage 4. LPN S explained the facility had done a skin evaluation on every resident in the facility on 8/15/25 and the wound was discovered at that time. LPN S was asked would the left gluteal fold wound be visible to the nurse providing care to R10's sacrum wound. LPN S explained the wound was visible. LPN S was asked if the Certified Nursing Assistants (CNA's) informed the nurses if they noticed any skin impairment while providing care to residents. LPN S explained sometimes they did, but sometimes they would tell her after the fact that they would just put a little cream on reddened areas.Review of R10's August 2025 Treatment Administration Record (TAR) revealed an order with a start date of 8/16/25 that read, Wound care: clean right gluteal fold with NS (normal saline), pat dry, apply medihoney gel, 4x4 gauze, border gauze . On 9/24/25 at 1:00 PM, LPN E was interviewed and asked why R10's left gluteal fold wound was first identified as a Stage 4. LPN E explained a wound should not be discovered at a Stage 4, it should be identified by staff as soon as there is a change. On 9/25/25 at 8:37 AM, the Director of Nursing (DON) was interviewed and asked about the delay in identifying R10's pressure ulcer. The DON explained pressure ulcers should be identified and treated timely Review of a facility policy titled, Skin Management revised 8/14/25 read in part, .A skin and wound total body skin evaluation is completed for each resident by the licensed nurse weekly. The licensed nurse will document findings on the skin evaluation. The CNA/STNA (state-tested nursing (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assistant) will report any new skin impairment to the licensed nurse that is identified during daily care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to store medication in a secure and safe manner and ensure proper disposal of medication for one of three medication carts observed for medication storage and labeling. Findings include:On 9/23/25 at 11:16 AM, a large green pill was observed on the hallway flooring just outside of room [ROOM NUMBER]. Nurse ?I' was observed several doors down at the medication cart. When asked to come over to room [ROOM NUMBER], Nurse ?I' confirmed the pill on the floor. When asked if they could identify what the pill was, or who it was for, Nurse ?I' used a disposable glove to wrap around the pill and picked it up to inspect and reported there were no markings, and it looked similar to a seizure pill but that was blue. Nurse ?I' then proceeded to discard the pill and disposable glove in the resident's trash can in room [ROOM NUMBER] and returned to their med cart to continue with medication administration.On 9/23/25 at 11:27 AM, an interview was conducted with Nurse Manager ?J'. When asked to about the pill that was found on the floor and discarded in the trash can inside room [ROOM NUMBER], Nurse Manager ?J' observed the pill in the trash can and reported they would have to re-educate Nurse ?I' immediately and removed the pill from the trash can.According to the facility's policy titled, Medication Storage dated 7/23/2019 documented, in part:Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel or staff members authorized to administer medications .[Name of Pharmacy] dispenses medications in packaging/containers that meet regulatory requirements. Medications shall be kept and stored in these packages/containers .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235508	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Farmington Hills	21017 Middlebelt Rd Farmington Hills, MI 48336

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. Based on observation, interview and record review, the facility failed to obtain physician ordered x-rays for one (R14) of one resident reviewed for radiology/diagnostic services. Findings include:On 9/23/25 at 10:15 AM, R14 was observed lying in bed with a visitor (Family Member/FM ?BB') seated next to the resident. The resident's left chin/jawline was observed to have dark reddish colored areas.Review of the documentation provided by the facility included:A report dated 9/15/15 12:15 PM documented, .Nursing Description: Resident <sic> noticed resident had discoloration to left side of chin.Writer notified MD (Medical Doctor). Skull xray ordered .Injury Type Bruise Injury Location 4) Face .An entry on 9/18/25 at 4:58 AM by Physician ?DD' read: .09/16/2025 .was seen today as staff reported no <sic> patient had a bruising on her chin laterally on the left side. Will order x-ray.Review of the physician orders included:An x-ray ordered 9/15/25, created 9/16/25 by Nurse ?N' for skull x-ray R/T (related to) swelling and discoloration of chin.Another x-ray ordered 9/15/25, created 9/16/25 by Nurse ?O' for facial x-ray of lower left jaw.Review of the electronic medical records (EMR) revealed there were only radiology results for the skull x-ray, and there was no documentation that the lower left jaw x-ray had been completed as ordered.There was no documentation in the EMR to explain the discrepancies of why the x-rays were documented as ordered on 9/15/25 but had created dates of 9/16/25.On 9/24/25 at 11:56 AM, an interview was conducted with the Director of Nursing (DON). When asked about details of R14's injury of unknown origin from 9/15/25 and discrepancies in dates of the orders and notes, the DON deferred to Nurse Manager ?J' and then requested they come to join the interview.Nurse Manager ?J' was asked about R14's x-rays, they reported the x-ray had been completed. When asked to review the documentation in the EMR, Nurse Manager ?J' confirmed only the skull x-ray was completed and in the medical record. Nurse Manager 'J' further confirmed the order for the lower left jaw x-ray was not available and reported they would follow-up.On 9/24/25 at 2:00 PM, Nurse Manager ?J' reported they could not find out any more information about why the left lower jaw x-ray had not been completed.On 9/25/25 at 3:00 PM, the DON reported they didn't have a policy for radiology and would follow the policy for following physician orders.According to the policy titled, Physician's Order dated 8/20/25: .Orders must be recorded in the resident record, restated back to the ordering licensed health professional, and then signed by the person who recorded the order.It is the responsibility of the licensed nurse to follow physician orders.