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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235529	A. Building B. Wing	08/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Manor of Novi	24500 Meadowbrook Rd Novi, MI 48375

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation pertains to Intakes #MI00146313 and MI00146302 Based on observation, interview and record review the facility failed to protect the resident's right to be free from physical abuse by another resident resulting in R501 hitting R502 in the head out of four residents reviewed for abuse. Findings include: A facility reported incident (FRI) was submitted to the State Agency (SA) that documented on 6/30/24, R502 entered R501's room and when R502 would not leave, R501 hit R502 on the head/face causing redness. A review of the facility's Incident report documented, in part, the following: .Summary of incident: On 6/30/24, (R502) entered (R501)'s room. (R501) asked (R502) to leave (R501) hit him on his head .(R501): He came into the room. I didn't want him to take anything and asked him to leave. He wouldn't leave so I hit him on the side of the head. He was standing at the end of the bed. He hollered out, and the nurse came down .Nurse K interview statement: (R502) went into (R501)'s room. I heard shouting and went in there. I saw (R502) had redness on his head. I asked (R501) what happened, he said (R502) was going in his room so he pop (R502)'s head with his fist .The facility conducted a thorough investigation .could not substantiate abuse. It was confirmed that (R501) did hit (R502) . On 8/27/24 at approximately 9:50 AM, R501 was observed in their wheelchair on the A-unit hallway. The resident was alert and able to answer questions asked. When queried as to the incident that occurred on 6/30/24, R501 reported that R502, who continues to wander in and out of their room, entered into their room and got too close to them so they punched them in the face/head. R501 noted that if the resident does it again and gets too close to them, they would hit them again. A review of R501's clinical record noted the resident had a Brief Interview for Mental Status (BIMS) score of 13/15 (cognitively intact cognition). On 8/27/24 at approximately 9:58 AM, R502 was observed walking down the hallway near the B-Hall. R502 was pushing another resident (hereinafter their wife) in a wheelchair. R502 opened the door to another resident's room and attempted to enter. The other Resident yelled out and told R502 to leave the room. R502 left and continued pushing the resident in their wheelchair. No staff were observed to redirect the resident. An attempt to interview R502 was made. The resident was alert but unable to answer questions asked. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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NAME OF PROVIDER OR SUPPLIER The Manor of Novi		STREET ADDRESS, CITY, STATE, ZIP CODE 24500 Meadowbrook Rd Novi, MI 48375	

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at approximately 10:07 AM, an interview was conducted with the other Resident. When asked about R502 trying to enter their room, they reported that they do that all the time. When asked if they feel safe when that happens, the Resident stated that they do because if the resident were to get to close to them, they would hit them and held up their fist to demonstrate how they would hit R502. A review of R502's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that include adjustment disorder with depressed mood, adjustment insomnia and dementia. A review of the resident Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 0/15 (severe cognitive impairment). Continued review of R502's clinical record documented, in part, the following: Social Service Note(3/20/24): .Resident .pleasantly confused .Resident speaks Russian as native language; resident able to communicate with use of some basic English .Resident displays wandering behaviors throughout facility, CP (care plan) and wander-guard in place, resident is easily redirectable .Russian stop sign located at each exit door in facility as precaution . Nurse Notes (3/26/24): Resident was caught naked from the waist down urinating in room (D-3A) trash can The resident in room D3 is very disgusted and furious about the incident. Nurse Notes(4/13/24): Resident wandering into other residents' rooms . Nurse Notes (4/14/24): Resident wandered into B unit and tried to open the emergency exit door . Nurses Notes (4/18/24): Patient is ambulating more this afternoon and wandering around facility and going into different rooms . Nurses Notes (4/27/24):Writer observed resident to resident contact. [Perpetrator} begin yelling profanities telling R502 to get the F out of his room. R502 stood confused as [Perpetrator] pushed him multiple times. When writer went over to separate the two [Perpetrator] began chest bumping R502 still yelling profanities . Instructed [Perpetrator] to stop pushing R502 . Social Service Note (5/15/24): .SW(social worker) spoke with rep (representative) .on psych visit yesterday . feels a secured unit would be in resident's best interest . Behavior Note (6/1/24): Resident was wandering the halls went inside another residents room .It was reported to writer that R502 opened the bathroom door on the resident while she was in there undressed . staff was made aware to monitor resident closely and redirect him from going on other units. Behavior Note (6/22/24): res (resident) was seen .walking into res .room. Res was seen grabbling and tugging on R (right) arms . Encounter (6/30/24): .resident wandered into another residents room and was punched in the head . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R502's care plan documented, in part: Focus: R502 is at risk for elopement r/t (due too) wandering throughout the building, impaired cognition .he displays wandering behaviors going into rooms looking for family (created 3/15/24) .5/24 .Stop signs and Caution signs in Russian place at Exits and rooms resident frequently attempts to enter .Interventions: Apply Russian stop signs and caution signs on Exit doors and rooms residents frequent (initiated 5/20/24) Wanderguard to Ankle (initiated 3/15/24) .Approach in a slow, calm manner and redirect away from exit doors as needed (initiated 3/15/24) Observe wandering behavior and attempted diversion interventions when wandering into inappropriate locations such as other residents rooms when not invited, behind nurses stations, shower rooms, attempts at exiting facility (initiated 3/15/24) .Provide structured activities .as needed (initiated 3/15/24) Resident observation Q (every) 30 min (minutes)checks (initiated 7/21/24) . *It should be noted that R502's Kardex did indicate Q 30 min checks however there were no logins for time checks in the electronic TASK section. On 8/27/24 at approximately 10:30 AM, an interview was conducted with Nurse I who was assigned to the hall where R502 resided. Nurse I was asked as to R502's wandering in and out of other residents' rooms. Nurse I reported that they were aware the resident wanders throughout the building either trying to exit and/or enter other resident's rooms. Nurse I stated that they do try to redirect but can't always get to them soon enough. On 8/27/24 at approximately 11:31 AM, a phone interview was conducted with Nurse K. Nurse K was asked about the FRI incident that occurred on 6/30/24 and additional information pertaining to R502. Nurse K confirmed that R502 was punched in the head by R501 on 6/30/24. Nurse K stated that they were aware of R502 wandering in and out of other residents' rooms and the intervention regarding redirecting but noted that staff often loses track of R502's location as they ambulate quickly. On 8/27/24 at approximately 1:16 PM an interview was conducted with the Administrator/Abuse Coordinator regarding the incident that occurred on 6/30/24 between R501 and R502 as well as other incidents that occurred when R502 entered other resident's rooms. The Administrator confirmed that R501 did hit R502 on 6/30/24 however they felt it was not intentional as R501 just wanted R502 out of their room. When asked what additional interventions had been put into place to ensure R502's safety as they had been pushed by another resident in April 2024 and observed trying to enter other resident's room during the survey, the Administrator noted that they continue to try to redirect the resident, but they do not always track them prior to entry. When asked if R502 received 30-minute checks, the Administrator was not certain. On 8/27/24 at approximately 2:13 pm, a phone interview was conducted with Social Worker (SW) J. SW J was queried as to R502's wandering into other resident's rooms including the room where R501 resided. They reported that they were very aware of R502 wondering throughout the building and noted that while there were interventions to prevent and redirect staff were not always around to redirect the resident. SW J noted that R502 was not aggressive however was aware that the other residents, including R501, where aggressive with R502 as they did not like them entering their room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Abuse Prohibition Policy (9/9/22) documented, in part: Policy: each resident shall be free from abuse, neglect .To assure guests/residents are free from abuse, neglect .It is the responsibility of all staff to provide a safe environment for all guests/residents .Definitions: Abuse means the willful infliction of injury .intimidation or punishment resulting in physical harm, pain or mental anguish .Willful as used is this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 This citation has two deficient practices. Deficient Practice #1-This citation pertains to Intake MI00146302 Based on observation, interview and record review, the facility failed to protect a likely accidental opioid ingestion for one (R503) of three residents reviewed for narcotic medications. Findings include: A complaint was filed with the State Agency (SA) that alleged in part that R503 does not take any narcotic medications, but on 6/23/26, R503 was found unresponsive and EMS (emergency medical services) administered Narcan (opioid reversal agent) and then R503 became responsive. Review of a National Institute on Health (NIH) article titled, Naloxone (Narcan) DrugFacts dated January 2022 read in part, .Naloxone is a medicine that rapidly reverses an opioid overdose. It is an opioid antagonist. This means that it attaches to opioid receptors and reverses and blocks the effects of other opioids . But, naloxone has no effect on someone who does not have opioid in their system . On 8/27/24 at 9:01 AM, R503's Guardian was interviewed by phone and asked about what happened on 6/23/24. The Guardian explained they were notified on 6/23/24 that R503 was taken to the hospital because R503 had been unresponsive and that EMS had given Narcan . R503 does not take any narcotic medications . they were very concerned about what had happened . and were concerned of it happening again . and had not received any answers from the facility. On 8/27/24 at 9:45 AM, R503 was observed lying in bed. R503 was asked if they had been in the hospital recently. R503 happily explained they had gone to the hospital in high school when they hurt their arm. Review of the clinical record revealed R503 was admitted into the facility on [DATE] with diagnoses that included: chronic obstructive pulmonary disease (COPD), depression and dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R503 had severely impaired cognition and was independent for most activities of daily living (ADL's). Review of R503's physician orders revealed no opioid medications had ever been ordered at the facility for the Resident. Review of R503's progress notes revealed a nurse note dated 6/23/24 at 6:25 PM by Licensed Practical Nurse (LPN) B that read in part, res (resident) was laying in bed CNA (Certified Nursing Assistant) tried to awake (them) for dinner. res was lethargic, slurred speech with pin point pupipls [sic], writer entered the room and took res vs (vital signs) . res still looked lethargic with minimum speech. 911 was dispatched and 1 Narcan was administered . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R503's EMS Patient Care Record dated 6/23/24 read in part, .Primary Impression: Overdose - Unspecified . Protocols Used: General-Overdose/Poisoning/Toxic Ingestion - Adult Only . Onset Time: 16:30:00 (4:30 PM) 6/23/24 . Chief Complaint: UNRESPONSIVE . Patient's Level of Distress: Moderate . Signs & Symptoms: Unspecified drug or medicament (substance used in therapy) - adverse effect (Primary) . Narrative: .(R503) laying in bed fully clothed with feet hanging off side of bed. Pt (patient) breathing shallow and slow. Pt not responding to voice or pain. Pts eyes pinpoint . Pt given 2mg (milligrams) Narcan slow push and line flushed . Pt became responsive and alert. Pt denies taking anything besides what staff gave (them) . Pt transported to (hospital) . Condition of Patient at Destination (hospital): Improved . Review of R503's hospital paperwork dated 6/23/24 at 6:34 PM read in part, .Hx (history) of Present Illness/Mech (mechanism) of Inj (Injury)/Onset: from (facility) for unintentional OD (overdose) - pt received 2mg narcan, and became alert after. pt a&o (alert and orientated) x 4 now, states not on any narcotic medication . On 8/27/24 at 10:48 AM, LPN B was contacted by phone and a voice mail was left. No return call was received by the end of the survey. On 8/27/24 at 11:53 AM, CNA D, R503's assigned CNA on 6/23/24, was interviewed and asked about R503 on 6/23/24. CNA D explained she was going to take R503 to the dining room, but they were lying on the bed and was not acting like themselves, they were very groggy, normally if R503 was sleeping, they would wake up immediately and talk . she immediately got the nurse, LPN B, and LPN B took R503's vital signs then called 911. When asked if R503 had been groggy all day, CNA D explained R503 had been their normal self all day, she had seen them about an hour or so earlier, and they had been fine. CNA D was asked if R503 would wander into other resident rooms or in the hallways. CNA D explained R503 liked to stay mostly in their room, but would walk to the nurse station and ask for the snacks that were kept behind the desk at the nurse station. Review of a facility census on 6/23/24 revealed Unit D, R503's Unit, had seven residents. An adjacent Unit, Unit C, had 31 residents. Review of a nursing schedule for 6/23/24 revealed LPN F had been assigned to Unit C. On 8/27/24 at 12:55 PM, LPN F was interviewed and asked on 6/23/24 when Unit D had seven residents, was LPN B assigned to any of Unit C's residents. LPN F explained yes, LPN B was assigned to the residents in rooms 1, 2, 3 and 4. Review of the closed record for R504 revealed R504 was admitted into the facility on [DATE] with diagnoses that included: lymphoma (cancer), diabetes and depression. According to the MDS (Minimum Data Set) assessment dated [DATE], R504 had moderately impaired cognition and was independent for most ADL's (activities of daily living). Review of R504's June 2024 Medication Administration Record (MAR) revealed a physician order for Norco (Hydrocodone-Acetaminophen) 7.5-325 mg (milligrams), 1 tablet three times a day at 9:00 AM, 2:00 PM and 9:00 PM. The MAR was documented by LPN B as given at 2:00 PM on 6/23/24. (It should be noted that Hydrocodone is an opioid medication.) (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R503's picture in the electronic medical record (eMR) revealed the resident looked very similar to another resident that were of similar age. On 8/27/24 at 1:30 PM, the Administrator was interviewed and asked about the investigation into R503 becoming unresponsive and receiving Narcan. The Administrator explained when R503 was interviewed, they said they did not take any medications not given by staff and the Director of Nursing (DON) checked and verified all the narcotic medication on the D Unit were accounted for and the DON had also checked the backup supply of narcotics, but those narcotic medications were also accounted for. The Administrator was asked if she was aware LPN B was also assigned residents on the C Unit and at least one resident, R504, had received narcotic medications. The Administrator explained she had not been aware of LPN B being assigned other residents. The Administrator was asked if R504 had been interviewed to ensure they had received their 2:00 PM Norco on 6/23/24 that was documented as given. The Administrator explained they had not interviewed R504. When asked if LPN B was still employed by the facility, the Administrator explained LPN B no longer worked there. The Administrator was asked if the DON was at the facility. The Administrator explained the DON was not working that day. On 8/27/24 at 1:48 PM, Dr. G, R503's attending physician, was interviewed by phone and asked what would cause R503 to have pin point pupils and lethargy to unresponsiveness. Dr. G explained the symptoms would suggest the presence of an opioid, but it would not be known for sure without a drug screen. When asked if he had ordered a drug screen for R503, Dr. G explained he had thought one was ordered in the hospital, so had not ordered one. On 8/27/24 at 2:24 PM, Human Relations (HR) H was interviewed by phone and asked why LPN B did not work at the facility anymore. HR H explained LPN B had resigned without notice on 6/30/24 when she put a resignation letter under her office door on 6/30/24. Review of a facility policy titled, Incidents and Accidents for Guests/Residents or Visitors revised 4/29/22 read in part, .Potential witnesses shall be interviewed and the occurrence of such interviews will be documented . 34275 Deficient Practice #2 Based on observation, interview and record review the facility failed to ensure timely interventions were implemented to prevent a resident, with a known history of elopement and wandering, from exiting out of the facility, for one (R502) out of three residents reviewed for accidents/elopement. Findings include: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Incident and Accident Investigation Form (I/A) was reviewed and documented, in part, the following: Alleged Incident .Date: 7/21/24 .Resident involved: R502 .Location - D wing (*The hall where R502 resided) .Brief Description of the incident: R502 opened the fire exit door on the D-wing and exited through the door. Staff redirected him back into the building .Conclusion:the facility conducted a thorough investigation through staff interviews and camera review. It was determined that R502 did exit through the fire exit door on D-wing, but staff responded appropriately and was able to redirect R502 into the facility .Summary of Staff Interviews: .(Nurse M): Was in a resident's room providing care .when the C-Wing nurse told her that she heard alarm and saw R502 going out the D-wing door .(Certified Nursing Assistant - CNA N): was in a resident's room providing care with the nurse .I did not hear the alarm going off .(CNAO) . Was on the C-wing when she heard alarm go off .Saw R502 down the hall at the door. I ran down the hall with the nurse. He went through the door On 8/27/24 at approximately 9:58 AM, R502 was observed walking down the hallway near the B-Hall. R502 was pushing another resident (hereinafter their wife) in a wheelchair. R502 opened the door to another resident's room and attempted to enter. The Resident yelled out and told R502 to leave the room. R502 left and continued pushing the resident in their wheelchair. No staff were observed to redirect the resident. An attempt to interview R502 was made. The resident was alert but unable to answer questions asked. A review of R502's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that include adjustment disorder with depressed mood, adjustment insomnia and dementia. A review of the resident Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 0/15 (severe cognitive impairment). Continued review of R502's clinical record revealed the following: 3/13/24 (Nurses Notes): Resident arrived at 9:15 PM .Resident does not speak or understand English .he is a fall risk and continues to get up without assistance .is here for rehab. 3/18/24 (Nurse Note): Resident keeps putting on roommates' clothes and eating his food .caught resident trying to cut off his wanderguard with a butterknife . 3/26/24 (Nurses Note): Resident was caught naked from waste down urinating in D-3A trash can .resident in room D-3A is very disgusted . 4/1/24 (Nurses Note): Resident was seen wandering the hall naked while urinating on the floor . 4/10/24 (Social Service Notes): Resident was observed at lobby door with visitor attempting to open door for resident to enter lobby . 4/14/24 (Nurses Notes): Resident wandered to B unit and tried to open emergency exit door . 4/27/24 (Nurses Notes): .notified that resident went into another residents room .the other resident pushed R502 against the wall 3 times . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/13/24 (Social Service Note): .Spoke with R502's daughter .via phone r/t (related to) POC (plan of care) exit seeking, safety, psych referral, wandering behaviors .suggested with daughter .placement at a secured facility .expressed facility was too far from where she lived .SW (social worker) suggested reviewing alternative placement . 5/24/24 (Social Service Note): SW (Social Worker) spoke with SW at facility daughter was supposed to tour and they report that they never showed up for scheduled appointment .PA (physician assistant) spoke with daughter and she declined to meet with SW at this time . 6/16/24 (Behavior Note):Res (Resident) attempted to open B wing exit door causing alarm to disengage . writer interceded before res could open door . 6/21/24 (Behavior Note): Res was seen pushing on the service hall exit door .res was redirected from door 30 minute checks initiated. 6/24/24 (Behavior Note): Resident tried to open C unit's emergency exit door. 6/30/24 (Encounter): .R502 wandered into another residents room and was punched in the head . 7/21/24 (Nurses Notes): Writer was notified regarding resident exiting the building .heard the alarm on D wing exit door Both staff were on C wing when observed . 7/30/24 (Behavior Note): res observed pushing on back doors on b wing setting off alarm . A review of R502's care plan documented, in part: Focus: R502 is at risk for elopement r/t (related to) wandering throughout the building, impaired cognition .he displays wandering behaviors going into rooms looking for family (created 3/15/24) .5/24 .Stop signs and Caution signs in Russian place at Exits and rooms resident frequently attempts to enter .Interventions: Apply Russian stop signs and caution signs on Exit doors and rooms residents frequent (initiated 5/20/24) Wanderguard to Ankle (initiated 3/15/24) .Approach in a slow, calm manner and redirect away from exit doors as needed (initiated 3/15/24) Observe wandering behavior and attempted diversion interventions when wandering into inappropriate locations such as other residents rooms when not invited, behind nurses stations, shower rooms, attempts at exiting facility (initiated 3/15/24) .Provide structured activities .as needed (initiated 3/15/24) Resident observation Q (every) 30 min checks (initiated 7/21/24) . *It should be noted that R502's Kardex did indicate Q 30 min checks however there were no logins for time checks in the electronic TASK section . On 8/27/24 at approximately 10:30 AM, an interview was conducted with Nurse I who was assigned to the hall where R502 resided. Nurse I was asked as to R502's wandering in and out of other residents' rooms. Nurse I reported that they were aware the resident wanders throughout the building either trying to exit and/or enter other resident's rooms. Nurse I stated that they do try to redirect but can't always get to them soon enough. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/27/24 at approximately 1:16 PM an interview was conducted with the Administrator/Abuse Coordinator. The Administrator was queried as to R502's history of wandering into other resident's room along with elopement seeking behaviors and actual elopements. The Administrator reported that they were aware of R502's behaviors and the staff were working on redirecting the resident, but noted that staff were not always present to check and redirect the resident prior to the elopement attempt and wandering incidents. continue to try to redirect the resident, but they do not always track them prior to entry. When asked if R502 received 30-minute checks, the Administrator was not certain. On 8/27/24 at approximately 2:13 pm, a phone interview was conducted with Social Worker (SW) J. SW J was queried as to R502's wandering into other resident's rooms including many elopement attempts and the actual elopement. SW J reported that they were very aware of R502 wandering throughout the building, elopement attempts and actual elopement and noted that while there were interventions to prevent and redirect R502, however staff were not always around to redirect the resident. When asked as to attempt to transfer R502 to a locked unit facility, SW J did report that suggestions were made to the resident's daughter, but they did not follow through on looking at other facilities. When asked if R502's daughter was the DPOA (durable power of attorney) or guardian for R502, SW J reported that they were not as the DPOA document provided pertained to financial only. SW J did report that there was no current guardian for the resident but that attempts were being made by daughter to obtain guardianship. A review of the facility policy titled, Elopement Policy documented, in part: Policy: it is the policy of this facility to prevent to the extent reasonably possible, the elopement of guests/residents from the facility .Definitions: Wandering is random or repetitive locomotion/ambulation .Unsafe wandering may occur when the guest/resident at risk enters an area that is physical hazardous .while alarms can help to monitor a guest/resident activities, staff must be vigilant in order to respond to them in a timely manner. Alarms do not replace necessary supervision .Elopement occurs when guest/resident who needs supervision leaves a safe area without authorization .Procedure:The Behavior Management Committee at minimum will review all plans of care .the care plan will have revisions as appropriate .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
NAME OF PROVIDER OR SUPPLIER The Manor of Novi		STREET ADDRESS, CITY, STATE, ZIP CODE 24500 Meadowbrook Rd Novi, MI 48375	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 This citation pertains to Intake MI00146302 Based on observation, interview and record review, the facility failed to ensure a urine drug test was collected per physician orders for one (R503) of three residents reviewed for narcotic medications. Findings include: A complaint was filed with the State Agency (SA) that alleged in part that R503 does not take any narcotic medications, but on 6/23/26, R503 was found unresponsive and EMS (emergency medical services) administered Narcan (opioid reversal agent) and then R503 became responsive. Review of a National Institute on Health (NIH) article titled, Naloxone (Narcan) DrugFacts dated January 2022 read in part, .Naloxone is a medicine that rapidly reverses an opioid overdose. It is an opioid antagonist. This means that it attaches to opioid receptors and reverses and blocks the effects of other opioids . But, naloxone has no effect on someone who does not have opioid in their system . On 8/27/24 at 9:01 AM, R503's Guardian was interviewed by phone and asked what happened on 6/23/24. The Guardian explained they were notified on 6/23/24 that R503 was taken to the hospital because R503 had been unresponsive and that EMS had given Narcan . R503 does not take any narcotic medications . after R503 had returned from the hospital, they had stayed at the facility for a week . they had repeatedly asked for a urine drug test to be done . it was finally ordered, and they had been told it had been done, but it was never done . had been told R503 would not pee in a cup . as they had been there, they could have gotten R503 to pee in a cup if anyone had tried to collect the sample. On 8/27/24 at 9:45 AM, R503 was observed lying in bed. R503 was asked if they had been in the hospital recently. R503 happily explained they had gone to the hospital in high school when they hurt their arm. Review of the clinical record revealed R503 was admitted into the facility on [DATE] with diagnoses that included: chronic obstructive pulmonary disease (COPD), depression and dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R503 had severely impaired cognition and was independent for most activities of daily living (ADL's). Review of R503's progress notes revealed a nurse note dated 6/23/24 at 6:25 PM by Licensed Practical Nurse (LPN) B that read in part, res (resident) was laying in bed CNA (Certified Nursing Assistant) tried to awake (them) for dinner. res was lethargic, slurred speech with pin point pupipls [sic], writer entered the room and took res vs (vital signs) . res still looked lethargic with minimum speech. 911 was dispatched and 1 Narcan was administered . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235529	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/27/2024
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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R503's EMS Patient Care Record dated 6/23/24 read in part, .Primary Impression: Overdose - Unspecified . Protocols Used: General-Overdose/Poisoning/Toxic Ingestion - Adult Only . Chief Complaint: UNRESPONSIVE . Patient's Level of Distress: Moderate . Signs & Symptoms: Unspecified drug or medicament - adverse effect (Primary) . Narrative: .(R503) laying in bed fully clothes with feet hanging off side of bed. Pt (patient) breathing shallow and slow. Pt not responding to voice or pain. Pts eyes pinpoint . Pt given 2mg (milligrams) Narcan slow push and line flushed . Pt became responsive and alert. Pt denies taking anything besides what staff gave (them) . Pt transported to (hospital) . Condition of Patient at Destination (hospital): Improved . Review of R503's hospital paperwork dated 6/23/24 revealed no blood or urine drug testing was ordered. Review of R503's physician orders revealed an order for a urine drug screen with a start date of 6/25/24 and an end date of 7/2/24 that was ordered by Psychiatric Nurse Practitioner (NP) L. The order had a status of completed. Review of R503's laboratory results revealed no results of the urine drug screen. On 8/27/24 at 1:30 PM, the Assistant Director of Nursing (ADON) was interviewed and asked why there were no results of the urine drug screen for R503. The ADON explained it was never collected, the nurse said she could not get the sample. When asked why the order said it was completed, the ADON explained when the order reached the end date, it was automatically changed to completed. The ADON was asked if the order was put in for multiple days, could any nurse that worked on those days have collected the urine. The ADON agreed all the nurses that worked from 6/25/24 to 7/2/24 could have collected the urine. On 8/27/24 at 1:48 PM, Dr. G, R503's attending physician, was interviewed by phone and asked what would cause R503 to have pin point pupils and lethargy to unresponsiveness. Dr. G explained the symptoms would suggest the presence of an opioid, but it would not be known for sure without a drug screen. Review of a facility policy titled, Physician's Order revised 10/20/23 read in part, .Orders given by a physician or state permitted health care professional must be accepted by a licensed nurse .