

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>634520</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>6/18/2025</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE MANOR OF FARMINGTON HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>21017 MIDDLEBELT RD FARMINGTON HILLS, MI 48336</b>	
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F0000 SS=	INITIAL COMMENTS  The Manor of Farmington Hills was surveyed for an Abbreviated survey on 6/18/25.  MI00153376, MI00153737. Census=89	F0000		
F0583 SS= D	Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by:	F0583	F-583  ELEMENT I Residents residing on Unit 300 hall (short stay rehab unit) on May 24, 2025 no longer resides in the facility. LPN "D" is no longer employed at the facility.  ELEMENT II Residents residing within the facility has the potential to be affected. Residents residing on Unit 300 hall with the potential for unauthorized disclosed protected health information had no negative effects due to this practice.  Rounds were made throughout the facility to validate no HIPPA related information is discussed or visible in non-confidential areas, no concerns were noted.  ELEMENT III The facility Policies with respect to HIPPA, Standard of Nursing Practice and Notice of Privacy was reviewed and deemed appropriate.  Active staff were re-educated on the facility's policy r/t HIPPA to ensure compliance with maintaining personal privacy and confidentiality of his or her personal and medical records in accordance with CFR (s): 483.10(h)(1)-(3)(i)(ii). In addition, the	7/3/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

07/07/2025

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.

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	<p>This citation pertains to Intake MI00153376</p> <p>Based on observation, interview and record review the facility failed to protect Protected Health Information (PHI) for all residents residing on the 300 Hall on May 24, 2025, resulting in the potential for unauthorized disclosure without consent of resident protected health information.</p> <p>Findings include:</p> <p>On 5/28/25, an anonymous complaint was filed with the State Agency alleging residents' health information was not kept private as a staff member identified as Licensed Practical Nurse (LPN) "D" had their daughter present on 5/24/25 while preparing medications, administering medications, and taking care of residents.</p> <p>On 6/18/25, a record review of the facility's schedule and room assignment from 5/24/25 was reviewed. Per the Nursing Home Administrator (NHA) the 300 Unit is a short stay rehabilitation unit and LPN "D" was assigned to Cart 5 which assigned them to rooms 301-318. The 300 Unit resident census from 5/24/25 was compared to the 300 Unit census from 6/18/25 and no Residents were identified as still residing at the facility.</p> <p>On 6/18/25 at 11:48 AM, an interview with Certified Nurse assistant (CNA) "C" who was</p>		<p>professional license nurses were re-educated on the Standard of Nursing Practice.</p> <p><b>ELEMENT IV</b> The DON/designee will audit the resident areas to validate no HIPPA related information is discussed or visible in non-confidential areas weekly for 4 weeks and monthly for 2 months. Any areas of concern will be addressed immediately.</p> <p>Findings from the audit will be brought to the Monthly QAPI Meeting for further review and recommendations.</p> <p>The DON is responsible for obtaining and maintaining compliance.</p>	

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	<p>the assigned CNA on the 300 Unit on 5/24/25 and confirmed they were introduced to LPN "D"'s daughter and witnessed her escorting LPN "D" into room 315 to administer medications.</p> <p>On 6/18/25 at 11:36 AM, a telephone interview with LPN "E" was conducted, who was assigned to Cart 5 (rooms 319-339) and confirmed they were introduced to LPN "D"'s daughter, was told they wanted to be a Nurse, and was observed following LPN "D" around the Unit that evening. LPN "E" commented they overheard being told by LPN "F" they cannot have their daughter there.</p> <p>On 6/18/25 at 12:42 PM, LPN "D" arrived in the facility and inquired about the investigation being conducted. LPN "D" confirmed on May 24, 2025, at the end of their shift (around 6:30 PM), their 15-year-old daughter who wants to be a Nurse, was present while they took care of their assigned residents. LPN "D" acknowledged they took their daughter into a female resident's room (room 317 or 319) and inquired if they would permit her daughter to observe their blood pressure being taken. LPN "D" confirmed there was a male resident in the hallway, and they allowed their daughter to observe medication preparation and administration. LPN "D" stated another nurse named LPN "F" was introduced to their daughter, mentioned she (my daughter) watched me pass a medication to a resident and was told I</p>			

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	<p>shouldn't be doing that because it could be against HIPAA (Health Insurance Portability and Accountability Act, establishes standards for privacy and security of health information).</p> <p>When questioned if it was appropriate and professional for them to have their daughter present while they provided resident care, LPN "D" admitted it was not appropriate, it was a violation of HIPPA and apologized.</p> <p>On 6/18/25, a request of video footage from 5/24/25 from 5-7:30 PM was reviewed with The Director of Nursing (DON) and Nursing Home Administrator (NHA) and revealed the following:</p> <p>5/24/25 at 6:39 PM, LPN "D" and daughter were observed standing together at the medication cart while medications were prepared.</p> <p>5/24/25 at 6:42 PM, LPN "D" and daughter observed walking away from the medication cart and the daughter was observed standing next to LPN "D" as they (LPN "D") administered medications to a male resident sitting in a wheelchair in the hallway.</p> <p>5/24/25 at 6:45, LPN "D" and daughter were observed walking back then standing at the medication cart.</p> <p>5/24/25 at 6:57 PM, LPN "D" was observed with daughter returning to the Nurse's</p>			

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	<p>station where the daughter was observed following LPN "D" behind the desk. The daughter was observed standing behind the desk, retrieved their cell phone, and holding their cell phone.</p> <p>The NHA acknowledged LPN "D" having their daughter present and observing resident care was not appropriate and had the potential to be a violation of HIPAA.</p>				