| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235508 | A. BUILDING _____ B. WING _____ | 05/14/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| 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) |
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| F 0678<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | **Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This citation pertains to MI 1364: Based on interview and record review the facility failed to perform cardiopulmonary resuscitation (CPR) and call Emergency Medical Services (EMS) for one (R#803) of three residents reviewed for CPR, resulting in an Immediate Jeopardy when CPR was not provided to R#803, who was a full code, when the resident was found without pulse and respirations and the resident expired at the facility. Findings include: The Immediate Jeopardy (IJ) started on [DATE]. The Immediate Jeopardy was identified on [DATE]. The Administrator was notified of the Immediate Jeopardy electronically on [DATE] at 1:49PM. The immediacy was removed on [DATE]. Although the immediacy was removed, the facility remained out of compliance at the scope of isolated and a severity of potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that has not been verified by the State Agency. A complaint was filled with the State Agency that alleged there were several deaths in the Facility due to Covid-19. Review of the clinical record for R#803 revealed the resident was admitted to the facility on [DATE] and was readmitted on [DATE] with [DIAGNOSES REDACTED]. Per the resident's minimum data set assessment dated [DATE] the resident scored 8 out of 15 on a brief interview for mental status (BIMS) exam, which indicated the resident was moderately cognitively impaired. A clinical note dated [DATE] indicated that R#803 had tested positive for Covid-19. Continued review of R#803's clinical record revealed a Nurse's Note authored by LPN 'B', effective date [DATE] at 9:00AM (created on [DATE] at 3:45PM), that documented the following: Writer was informed by the CENA (Certified Nursing Assistant) the resident was observed ambulating from the restroom back to the bed at approximately 7:20am. When Cena went to pass resident breakfast tray resident noted to be non responsive. Writer and another staff nurse went to assess resident. Noted absence of pulse no respirations resident cold and stiff. RN (Registered Nurse) in building notified time of death pronounced at 8:35 am by RN. Staff nurse notified family and NP (Nurse Practitioner) (Name Redacted) on call . Review of a physician order [REDACTED]. Review of an Incident and Accident Investigation Form dated [DATE] revealed the following brief description of the incident: Don (Director of Nursing) was informed on the morning of [DATE] that resident (R#803) was deceased . The assigned LPN, (LPN 'B's) medical opinion was resident was cold and stiff, to <sic> far gone to be resuscitated an RN in the building called time of death. Per the conclusion section of the form it was documented, It was in the medical opinion of the LPN assigned to resident that she was to <sic> far gone to be resuscitated.Also per the form was the following: Nurse educated on code process and checking code status . The Quality Assurance Interview Summary of Resident Interview form revealed, in part, the following: Per an interview summary with LPN 'B' it was documented: 745 rounded and resident was lying in bed, Food carts came out around 830, CNA told (LPN 'B') resident was not responding. When I went in the room, resident was cold and stiff, no vital signs or signs of life. Per an interview summary with LPN 'A' dated [DATE] it was documented,(LPN 'A') was completing tx (treatment) <sic> across the hall from (R#803's) room, overheard CNA tell (LPN 'B') that resident was not breathing offered to assist with calling police and family. Per a CNA interview summary also dated [DATE] it was documented,Saw resident ambulate to bathroom around 720am, layed back down in bed, when passing trays noticed she was not responding and was cold to touch, went to get nurse. On [DATE] at 2:15PM, LPN 'A' was queried in regard to R#803. LPN 'A' acknowledged she was at the facility when the resident passed away, and indicated she was not the resident's nurse. LPN 'A' explained she had been doing wound care, and had been in a resident's room providing care. Per LPN 'A', a CNA had said loud enough for her to hear something like, She's not okay. LPN 'A was queried as to who the assigned nurse was for R#803, and LPN 'A' identified LPN 'B' as the resident's nurse. Per LPN 'A' she had gone in, the resident was laying straight with their feet up and the resident was not moving at all. When queried as to the time of day, LPN 'A' indicated this had occurred in the morning. LPN 'A' was queried as to whether CPR had been performed, and responded it had not been performed when LPN 'A' had been there. LPN 'A' explained she had asked what they had wanted her to do, and per LPN 'A' she was going to get the paperwork. LPN 'A' explained she did not know whether CPR had been performed for R#803, was unable to recall if emergency medical services (EMS) had responded, but did recall the police had responded. Per LPN 'A' after she looked at the paperwork she knew R#803 was a full code. On [DATE] at 3:09PM, LPN 'B' was interviewed via telephone in regard to R#803. LPN 'B' acknowledged she was the nurse on the day R#803 passed away. When queried in regard to detals of the situation, LPN 'B' explained she would have to look at her notes and would call back. On [DATE] at 3:09PM a second call was placed to LPN 'B', and a voicemail message was left at this time. A return call was not received prior to the exit of the survey. Review of a One to One Inservice Record dated [DATE] for LPN 'B' documented the following: Topic of Discussion: Checking code status and following preferences noted in the resident record. Reason: (R#803) did not recieve CPR she was a full code. Expected Outcome: CPR will be performed on all full code residents. This document was noted to have been signed on [DATE] by LPN 'B' and the facility's Director of Nursing (DON). On [DATE] at 4:17PM, the facility's DON was queried in regard to R#803. Per the DON, CPR had not been done for the resident, and the DON had completed an investigation. The DON explained the nurse (LPN 'B') who was assigned to the resident had the opinion the resident was too far gone. Per the DON the nurse explained the resident was cold to the touch and stiff. The DON was queried as to whether CPR should have been performed for the resident, and responded yes because the resident was a full code. When queried as to whether EMS had been contacted, the DON acknowledged they had not been contacted. When queried as to when EMS would be contacted, the DON explained that if a code blue was called and CPR was initiated then EMS then 911 would be called. Review of a facility policy titled, Medical Emergency Management dated ,[DATE] revealed, in part, the following: The facility ensures guests/residents receive timely and appropriate interventions in the event of a medical emergency. The staff takes actions to ensure that the guest's/resident's Airway, Breathing, and Circulation are maintained until emergency personnel arrive. Staff is aware of each guest's/resident's code status prior to the administration of cardio-pulmonary resuscitation .4. Once a medical emergency is identified, qualified staff evaluates the guest/resident, initiates the appropriate emergency procedure(s), and calls Emergency services 911. The staff continues to provide care and monitor the guest/resident until the emergency personnel arrive. The facility submitted the following accepted plan of removal: (Facility Name) Removal of Immediate (Facility Name) submits the following Credible Allegation of Compliance outlining the measures it has completed to remove the findings of immediate jeopardy for F678 regarding the facility's alleged failure to perform cardiopulmonary resuscitation (CPR) on resident #803, who was a full code. 1. Resident identified to be affected by the alleged deficient practice. R#803 no longer resides in the facility. 2. Residents with the potential to be affected by the alleged deficient practice. On [DATE] the 9 residents that resided in the facility that expired in the facility were reviewed to ensure CPR was performed in accordance with resident preferences. 8 out 9 residents had CPR performed in accordance with their preferences. On [DATE] there are 77 residents currently residing in the facility and 77 out of 77 resident charts were reviewed to ensure the code status reflects the resident preferences. 3. Systemic Measures The facility policy on Emergency |

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

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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| F 0678<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Few | (continued... from page 1)<br>Medical Management and Code Status was reviewed and deemed appropriate on [DATE] and no changes were made to the policies. There are currently 25 licensed Nurses on staff at the facility. The re-education began on [DATE] at 2:00 pm with staff that was in the facility regarding the Emergency Medical Management and Code Status as of 3:30pm on [DATE] there are been 13 out 25 nurses educated. The remaining licensed nurses will be re-educated prior to the start of their next shift scheduled. 4. Quality Assurance An Ad Hoc QA meeting was held on [DATE] with the Medical Director via tele-conference and with the IDT team to review the policies on Emergency Medical Management and Code status. The administrative nurses will review residents who have expired in the facility weekly for 4 weeks and monthly for 2 months to ensure CPR was performed in accordance with the resident's preferences. Any areas of non-- compliance will be addressed immediately and will be reported to QAPI Committee for further recommendations. The Administrator is responsible for sustained compliance. Date of compliance is [DATE] |
| F 0684<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>This citation pertains to intake #MI 023 Based on interview and record review the facility failed to ensure timely care coordination/follow up for a medical appointment for one resident (R#801) of three residents reviewed for quality of care, resulting in the increased potential for unmet care needs/delay in care. Findings include: A complaint was received by the State Agency which alleged, in part, that the resident did not receive [MEDICAL CONDITION] appointments/follow-up. On 5/12/20 the medical record for R#801 was reviewed and revealed the following: R#801 was initially admitted to the facility on [DATE] and last readmitted from a hospital stay on 12/16/19. R#801 had the following [DIAGNOSES REDACTED]. R#801's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/29/20 revealed R#801 needed extensive assistance from facility staff with most of their activities of daily living. R#801's BIMS score (brief interview for mental status) was seven indicating severely impaired cognition. A review of R#801's hospital discharge instructions with a printed date of 12/16/19 revealed the following: Follow-up & future appointments-Dec. (December) 30-Follow up with (name of Oncologist) Monday [DATE]. -Specialty: Medical Oncology and Hematology Appointment at 12:15 p.m. A Physician evaluation for R#801 dated 12/17/19 revealed the following: Reason for visit: History and physical readmission comprehensive evaluation. Chief complaint: Debility .Emergent hospitalization at (name of hospital) on 12/12/2019 and returned to (name of facility) on 12/16/2019. HPI (history of presenting illness): (R#801 demographics) who was out to see (name of Oncologist) hematology/ oncology .The patient has a history of [MEDICAL CONDITIONS], diabetes type 2 , heart failure, [MEDICAL CONDITION] gout, hypertension, and [DIAGNOSES REDACTED]. Again was sent to the hospital secondary to [MEDICAL CONDITION], ataxia. The patient was seen in evaluation by hematology/ oncology, internal medicine, and neurosurgery. The patient was seen by (name of Oncologist) He is planning for outpatient Revlimid ([MEDICAL CONDITION] treatment) .Assessment : 1. (R#801 demographic) status [REDACTED].PLAN : 1. Follow-up with (name of Oncologist) hematology/oncology outpatient for Revlimid . A Physical Medicine and Rehabilitation (PM&R) Note dated 12/17/19 revealed the following: .The patient was sent to the hospital on [DATE] with CC (chief complaint) of [MEDICAL CONDITION]. He was found to have hgb (hemoglobin) of 7.4 (low) and was transfused PRBC (packed red blood cells) .He was also seen by Oncology 2/2/ mm (secondary to [DIAGNOSES REDACTED]). patient to follow-up with his Oncologist O/P (outpatient) . An internal medicine NP (Nurse Practitioner) note dated 12/19/19 revealed the following: .Reason for visit: review lab results, clarification of meds (medications), S: patient seen and examined. Patient with recent discharge from hospital for [MEDICAL CONDITION] due to MM ([DIAGNOSES REDACTED]). Also see by hematologist, (name of Doctor) in hospital for [MEDICAL CONDITION] due to MM. Also see by hematologist, (name of Doctor)in<br>hospital and placed on [MEDICATION NAME] Q (every) Monday for neuro[DIAGNOSES REDACTED]. Currently c/o low back pain. East<br><sic>about 75% of meals .Impression/Plan: .Smoldering myeloma-seen by (name of Doctor) in the hosiptalnthis <sic> neuro[DIAGNOSES REDACTED] with sarcoidoisis; alert. -continue with [MEDICATION NAME]. Order clarified. Discussed with nurse. -hospital record reviewed; s/p (status/post) transfusion in hospital. F/U (follow up) with (name of Doctor) to determine if he is to be started on revlimid (per hospital notes) . A resident at risk note dated 12/19/19 revealed the following: Reviewed Clinical Indicator: (R#801) readmitted after being admitted to the hospital from doctors appointment .(R#801) is also at risk for further decline r/t (related to) cancer dx (diagnosis) . F/u (follow up) appointments scheduled with oncology, plan to start oral [MEDICAL CONDITION] medication. Response to Previous Actions Taken: IDT (Interdisciplinary team) to f/u as needed. An NP note dated 2/6/20 revealed the following: Smoldering myeloma Neurosarcoidoisis with sarcoidoisis; alert. - continue with [MEDICATION NAME]. - f/u with (name of Oncologist) to determine if he is to be started on revlimid (per hospital notes). A Physician evaluation dated 4/13/2020 revealed the following: (R#801 demographics) who is seen today. The patient remains lethargic. He is on two liters of oxygen via nasal cannula. He has a history of [DIAGNOSES REDACTED]. Brother never followed up who is his power of attorney with treatment with oncology, (name of Oncologist) A review of R#801's careplan revealed the following: Focus-IMMUNODEFICIENCY: (R#801) is at risk for complications of [MEDICAL CONDITION] r/t (realted to) neuro[DIAGNOSES REDACTED] .Goals-(R#801) will remain free of complications related to [MEDICAL CONDITION] side effects through review date .Interventions-Give medications and treatments as ordered. Observe for/document for side effects and effectiveness .Obtain lab/diagnostic work as ordered. Report results to MD and follow up as indicated. On 5/13/20 at approximately 9:24 a.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the disposition of R#801's follow-up appointment with the Oncologist for their [MEDICAL CONDITION] treatment that was indicated on the Nurse Practitioner evaluation dated 12/19/19. The DON indicated that they believed R#801's brother had not signed the consent for the [MEDICAL CONDITION] treatment. At that time documentation regarding the disposition of the follow up appointment was requested. On 5/13/20 at approximately 10:33 a.m., the DON indicated that R#801 did not attend their follow-up appointment with the Oncologist that was scheduled for 12/30/19. The DON was queried if the appointment was canceled or what the disposition was and the DON indicated again that there was an issue with getting the consent for treatment signed by R#801's brother. The DON was queried if the facility have any record of the canceled appointment or if transportation had ever been arranged for it and they indicated they didn't. The DON was queried if the appointment with the Oncologist was ever rescheduled to get R#801's [MEDICAL CONDITION] started and they indicated that the appointment was never rescheduled. The DON was queried if any facility staff had reached out to R#801's brother to reschedule the appointment or to assist in facilitating the consent process and the DON indicated that nobody had. The DON was queried who was responsible to assist resident family members with medical appointments and consents and the DON indicated that Social Services was and the facility Scheduler schedules the outpatient appointments for the residents. On 5/13/20 at approximately 12:42 p.m., Scheduler E was queried regarding the disposition of the scheduled Oncologist appointment for R#801 on 12/30/19. Scheduler E indicated they had no knowledge of R#801's appointment but they would check their records. On 5/13/20 at 12:47 p.m., Social Worker F was queried if they had assisted any of R#801's family members with obtaining the consent for [MEDICAL CONDITION]/Oncology or in rescheduling R#801's Oncology appointment and they indicated that they only assist with ancillary medical appointments such as Dental, Podiatry, Vision and Audiology. Social Worker F indicated that nursing would assist with other medical appointments. On 5/14/20 at approximately 11:40 a.m., the DON was queried again if they had any documentation pertaining to R#801's scheduled Oncology appointment on 12/30/19 other than the discharge instructions from the hospital that it had been scheduled and they indicated they didn't. The DON was queried if they had any documentation that any follow up had been done after the appointment date and they indicated they didn't. The DON was queried if the facility had any specific policies on scheduling outpatient medical appointments other than ancillary services and anything pertaining to outpatient appointment follow up and they reported they did not. No further documentation was received regarding the disposition or follow-up of R#801's Oncology appointment scheduled 12/30/19 was provided before the end of the survey. |