STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	12/9/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for an abbreviated survey and facility reported incident on 12/8/20. MI00116095 and MI00116111. Census = 146.	F0000		
F0684 SS= D	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This citation pertains to Intakes MI00116111 and MI00116095. Based on interview and record review the facility failed to document an assessment of one (R#707) of 3 residents reviewed for a change of condition, for a pulse and breathing, resulting in the inability of staff to identify signs of life or cessation of breathing and pulse and potential delay of emergency services. Findings include: A report submitted to the State Agency documented in part, " ... (R#707) was unresponsive in the bathtub ... The nurse noted (R#707) was not breathing, code status was checked, and (R#707) was noted to be a DNR (Do Not Resuscitate) ..." A review of the clinical record revealed the	F0684	Resident #707 no longer resides in the facility Residents residing in the facility are at risk for a similar occurrence. Residents who have a change in condition resulting in unresponsiveness will have two nurses assess and document vials to ensure accurate and complete initial assessments are done and that there is no potential for delay in emergency services. Nurses have been in-serviced on complete assessment of unresponsive residents including two nurses assessing and documenting vitals for accuracy and to ensure that there is no potential for delay in emergency services. Ant change in condition noted for a patient will be reviewed to ensure two sets of vitals have been obtained to ensure sustained compliance. DON/Designee will review of any incidents of unresponsive residents for 4 weeks, then monthly thereafter or until sustained compliance has been achieved to. Audits will be reviewed at weekly Ad Hoc QAPI meetings to monitor continued performance and compliance and will be submitted to monthly QAPI for further review to ensure compliance. The DON and Administrator will be responsible for continued compliance.	12/21/2020

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

Electronically Signed | 12/17/2020

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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	following: R#707 was admitted into the facility on 11/19/20 with diagnoses that included: COVID-19, viral pneumonia, acute respiratory failure with hypoxia, emphysema, Parkinson's, lack of coordination and benign prostatic hyperplasia. A Minimum Data Set (MDS) dated 11/20/20 documented a Brief Interview for Mental Status score of 15 (indicating intact cognition) and required limited assistance with most Activities of Daily Living (ADLs). A "Medical Practitioner Note" dated 11/20/20 at 5:27 pm, documented in part " ... recent hospitalization for covid pneumonia. Pt (patient) is currently a full code. Pt states a general decline and decrease quality of life. Further, pt states that he does not have a living will or advanced directives. Pt reports that his wife is his health care advocate ... Discussed at length patient's wishes regarding advanced directives. Benefits and risks of CPR (Cardiopulmonary Resuscitation) discussed. Pt verbalized understanding. Patient states that he wishes to be a Do Not resuscitate ..." A "Nursing" note dated 11/20/20 at 10:25 pm, documented in part " ... Approx. 6:35p I was informed by the CNA (Certified Nursing Assistant) picking dinner tray that resident drowned in tub. I immediately went in room to assess. I observed the pt sitting in the tub with his back against the tub wall with both legs bent to the left and his head back and slightly to the right. I saw that the pt was unresponsive and called for code status and nurse assigned to resident informed that pt is a DNR ..." A "Nursing" note dated 11/20/20 at 10:05 pm, documented in part " ... At approximately 6:40pm I was notified by another nurse that resident is			

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	unresponsive in the bathtub. Upon entering the room resident was noted in his gown both legs bent to the left with his back at the edge of the tub, with his head to the right. Resident was not breathing, code status checked, resident DNR ..." On 12/8/20 at 12:03 pm, an interview was conducted with LPN (Licensed Practical Nurse) "A" (the first nurse to observe R#707). When queried on the incident with R#707, LPN "A" stated in part, " ... The aide saw me and said come here, he is unresponsive. He was on his bottom. I didn't know his code status. I ran out the room and went to the nurse (R#707's assigned nurse) and asked ... it turned out to be a DNR. I told the nurse that was assigned to him that he was unresponsive and died in his bathtub ..." When asked if they assessed the resident for a pulse or breathing, LPN "A" replied in part " ... I did not want to touch him ..." When asked how they confirmed that the resident didn't have a pulse or was breathing, LPN "A" stated in part, " ... The aide told me that wasn't the original position that he was in when she found him (indicating that the resident was originally submerged under water)". On 12/8/20 at 1:55 pm, an interview was conducted with LPN "B" (R#707 assigned nurse). When queried on the incident with R#707, LPN "B" stated in part, " ... At around 6:40 pm - 6:45 pm, the other nurse (the first nurse to observe R#707) came up to me and asked for code status and he rushed me to check code status ...I checked the orders and saw that he was a DNR. I asked him what happened, he said that he was unresponsive in the bathtub ..." When asked if they checked the resident for breathing or a pulse, LPN "B" stated in part, " ... The nurse that checked him did an assessment. I thought that he (the first nurse to observe R#707) already did it ..."			

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	On 12/8/20 at 3:11 pm, Certified Nursing Assistance (CNA) "C" was queried regarding the incident with R#707 and stated in part, " ... I went in the room, heard water running. I thought he was washing his hands because he was using the bathroom back and forth. I opened the door and his head was under the running water. He was in a fetal position. I pulled him up and he wasn't moving or breathing ... I ran out to get the nurse ... I asked (LPN "A" name redacted) if we should be doing CPR and (LPN "A" name redacted) said he is a DNR ..." On 12/8/20 at 3:45 pm, the Director Of Nursing (DON) was queried on if the nursing staff should have assessed the resident to see if they were breathing or had a pulse and the DON replied that they were under the impression that the nurses assessed the resident for that. The DON agreed that the nurses should have checked for a pulse and breathing. A policy titled "Risk Management (Accident)" dated 4/1/19 documented in part, "... It is the policy of this facility that the resident environment remains as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents... The purpose is to ensure that the facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident to prevent avoidable accidents... Assess resident fully. Provide needed emergency care - neuro checks if head injury or possible head injury..." A policy titled "Change in Condition" dated 7/11/18 documented in part, " ... Purpose: To clearly define guideline for timely notification of a change in resident condition ... Life Threatening Change ... Licensed nurse will initiate appropriate			

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	first aid measures until emergency response personnel arrive on the scene ... All nursing actions .... And resident assessment information will be documented in the nursing progress notes ..."			