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F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for a re-visit survey on 6/10/21. Census = 143	F0000		
F0677 SS= D	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure and provide appropriate personal hygiene care in a timely manner for six (R#'s: 706, 708, 709, 710, 721, and 725) of six residents reviewed for Activities of Daily Living (ADLs), resulting in unshaven facial hair, overgrown fingernails, unkempt personal hygiene, and unidentifiable odors. Findings Include: R706 On 6/9/21 at 2:00 p.m., R706 was observed in bed wearing a wet hospital gown and a soaked and wet urine filled brief. R706 also had unshaven hair on his lips, cheeks, and chin that appeared to be more than several days. When asked about the care provided at the facility, R706 appeared confused and stated, "They're supposed to give me showers, but they don't want to. They won't give me my money, so I can get a haircut and shave. When ask the last time they received a shower or bed bath, R706 stated, "I would like to take a shower..." A review of the clinical record revealed R706 was	F0677	Residents # 706, 708, 709, 710, 721, and 725 have had their ADLs attended to including showers, hair care, nail care and shaving. Residents who reside in the facility are at risk for a similar occurrence. Like residents have been visually assessed to determine if additional ADL care was needed, additional ADL care was provided to any residents requiring it. The facility policy for ADLs has been reviewed and deemed appropriate. CNAs and nurses have been educated on providing ADL care including the trimming and cleaning of fingernails, facial hair, showers, and documentation of ADL care to ensure that the policy is being followed for continued compliance. Facility managers will be providing focused oversight, observation, and guidance to the nursing staff to follow the facility□s policy to ensure that the in-services on trimming and cleaning of fingernails, facial hair and showers are being followed as scheduled/needed. The master shower schedule has been entered into the electronic medical record so that missed showers will trigger on the dashboard and can be reviewed daily to ensure that the process and system is being followed to prevent recurrence. The DON/designee will conduct random ADL audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure adherence to the ADL Care Policy and residents nails observed to be cleaned/trimmed.	5/24/2021

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

Electronically Signed | 06/23/2021

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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	originally admitted into the facility on 5/4/17 and readmitted on 2/16/21 with diagnoses that included in part: Dementia, Unsteadiness on Feet, and Polyarthritis. Further review of the annual Minimum Data Set (MDS) assessment dated 5/14/21 revealed R706 had a Brief Interview for Mental Status (BIMS) exam score of 12 out of 15 which indicated moderately impaired cognition, had no behaviors, or rejection of care, and required extensive assistance with one-person physical assist with ADL care. The facility's ADL care plans were reviewed and revealed the following: "Focus: ADL Self care deficit r/t (related to) COPD (Chronic Obstructive Pulmonary Disease), interstitial lung disease, extensive psych history... Interventions: ADL Assist - 1 person assistance with ADLs... Assist with daily hygiene, grooming, dressing... [NA (Nurse Aide), NURSE]." Review of the "Progress Notes" dated 5/25/21 through 6/10/21 did not document that R706 had refused/reject ADL care. Further review of the CNA "Task: Shower/bath: PRN (DOC)" for the 30 day look back documented R706 received a bed bath on 6/1/21 only. The CNA Task for showers/bathing documented "Not Applicable on 5/12/21 through 6/10/21. On 6/10/21 at 9:50 a.m., R706 was observed in a hospital gown while lying in the bed, with unshaven hair on the lower part of their face (lips, cheeks, and chin). When asked if they had a shower, R706 stated, "I washed myself in the sink. "When queried about shaving, R706 stated, "They won't give me my money, so I can get a haircut and a shave." On 6/10/21 at 9:55 a.m., during an interview with		The results of ADL audits will be presented to the QAA committee for review and consideration of further corrective action. The DON and Unit Managers will be responsible for assuring substantial compliance is attained through this plan of correction and for sustained compliance thereafter.	

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	Licensed Practical Nurse (LPN)/Unit Manager (UM) 'A', when asked how often the R706 received showers at the facility, LPN/UM 'A' explained the resident get a "skin assessment weekly and showers are twice a week and PRN (as needed)." There were no shower sheets in the binder at the nurses' station. At that time shower sheets were requested for the months of May and June 2021. Review of "Skin Monitoring: Comprehensive CNA Shower Review" sheet dated 5/27/21, 5/31/21 and 6/3/21 revealed the following: ...Does the resident need his/her toenails cut? "No." The sheet was signed by the CNA and the Unit Manager. There was no documentation on the sheet that addressed hair or nail care. There were no other sheets provided by the end of the survey. R721 On 6/9/21 at 1:50 p.m., R721 was observed in bed dressed in a hospital gown. When asked if they wanted to get dressed, R721 stated, "I don't have nothing..." At that time, R721's fingernails were observed to be long, and their hair was unkempt. On 6/9/21 at 2:00 p.m., during an interview with Certified Nursing Assistant (CNA) 'F', when asked how often R721 received routine showers, CNA 'F' stated, "Residents get showers two times a week unless they ask for one, or if they are smelling or something." A review of the clinical record revealed R721 was admitted into the facility on 4/7/20 with diagnoses that included in part: Alzheimer's Disease, Dementia, and Traumatic Brain Dysfunction. Further review of the quarterly			

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	MDS assessment dated 5/28/21 revealed R721 had severely impaired cognition with disorganized thinking, no mood, or behaviors, and did not reject care. R721 required extensive assistance with one-person physical assist for ADL care. The facility's ADL care plans revealed the following: "Focus: [Name Redacted] (R721) has an ADL deficit r/t Alzheimer disease, mobility impairments. Goals: ... will receive the necessary staff assistance to ensure that daily care needs are met thru next review. Interventions: ... BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. [NA, NURSE]." Further review of the CNA "Task: Shower/bath: PRN (DOC)" for the 30 day look back documented R721 received one shower/bed bath from 6/1/21 through 6/10/21. The CNA Task documented "Not Applicable on 6/2/21 through 6/10/21. On 6/10/21 at 10:30 a.m., during an interview, when queried what days were assigned for R721's routine showers/bed baths, LPN/UM 'A' stated, "R721's showers are on Monday and Thursday. The Skin Assessments are on Mondays. When they miss their shower days, I still do a skin assessment." At that time, LPN/UM 'A' was asked if the facility used shower sheets for R721. LPN/UM 'A' said, "Yes, I'll get them..." Review of shower sheets dated 5/31/21 and 6/3/21 revealed the following: Does the resident need his/her toenails cut? "No." The sheet was signed by the CNA and the Unit Manager. At that time, LPN/UM 'A' stated, "I had			

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a sheet for 5/28/21. I don't know what happened to it." It was noted that the shower/bed bath sheets received at that time, did not address R721's hair or nail care.

R725

On 6/9/21 at 1:50 p.m. and 6/10/21 at 10:05 a.m., R725 was observed in their room sitting on the side of the bed with facial hair around their upper and side lips and chin.

Review of the clinical record revealed R725 was admitted into the facility on 2/14/19 with diagnoses that included in part: Parkinson's Disease. Further review of the quarterly MDS assessment dated 5/25/21 revealed R725 had a BIMS score of 00 out of 15 which indicated severely impaired cognition, no behaviors, and did not reject care. The MDS revealed R725 required total assistance with one-person physical assist for ADL care.

The facility's ADL care plans revealed the following:

"Focus: [Name Redacted] (R725) has an ADL self-care performance deficit r/t advanced Dementia with significant cognitive deficits, Parkinson disease... Interventions: ... Provide supportive care, assistance with daily care needs (ADLs) as needed. Document assistance as needed. Showering/Bathing per schedule or as needed... PERSONAL HYGIENE: The resident requires by 1 staff with personal hygiene..."

A review of the "Progress Notes" dated 5/24/21 through 6/8/21 did not document that R725 had refused/rejected ADL care. Further review of the CNA "Task: Shower/bath: PRN (DOC)" for the 30 day look back documented R725 received a bed bath on 6/1/21 only. The CNA Task

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documented "Not Applicable on 5/12/21 through 6/10/21.

Further review of the shower sheet dated 6/2/21 documented "shaved" "nail care". It should be noted that R725 was observed with an excessive amount of facial hair around the upper and side of their lips and chin. When asked why R725 had facial hair if they had been shaved on 6/2/21, LPN/UM 'A' did not have an explanation and stated, "I know..."

Review of the Skin Monitoring: Comprehensive CNA Shower Review sheet dated 6/9/21 revealed R725 received a bed bath. The sheet did not document nail care or have a space for facial hair care. Care provided by staff was signed by the CNA and Nurse.

On 6/10/21 at 10:45 a.m., LPN/UM 'A' was queried about R725's routine shower days and unshaven facial hair. LPN/UM 'A' explained that R725's showers are on "Wednesday and Saturday. She walks and is very combative." LPN/UM 'A' was asked if facial hair and nail care is provided during showers. LPN/UM 'A' stated, "Yes." When queried if R725 received their shower yesterday, Wednesday (6/9/21), LPN/UM 'A' said, "Let me check." LPN/UM 'A' returned with a shower sheet, and stated, "She did get a shower yesterday, but didn't get a shave. I think they (CNAs) was just running around..." When asked what care was provided during resident showers, LPN/UM 'A' stated, "We shampoo their hair, facial hair removal, clean their ears, and assess if their nails and toenails need to be cleaned/clipped." At that time LPN/UM 'A' was asked what CNA was assigned to R725 and stated, CNA 'B', but they are not here today."

On 6/10/21 at 1:20 p.m., an attempt was made to contact CNA 'B' to inquire if they had tried to

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shower/bath or provide nail care and facial hair removal for R725. The Director of Nursing (DON) was also notified of the attempt and stated she would try to contact CNA 'B' via text. There was no return call by the end of the survey.

On 6/10/21 at 4:05 p.m., an interview was conducted with the DON regarding the expectation of staff that provide ADL care for R706, R721, and R725. The DON explained that staff should be making a progress note/documenting for residents that refuse ADL care, Unit Managers assist with showers a lot and should notice whether ADL care was being provided, showers are provided at least twice a week, and bed baths consist of complete head to toe (including their hair, nails, and changing their sheets). The DON further stated, "Sometimes they (staff) are using the shower sheets, and sometimes they are putting them (sheets) in the system..." The DON stated, "They need to get better with their documentation."

A policy titled "Shaving" dated 7/11/2018 documented the following:

"POLICY: It is the policy of this facility to improve the resident's appearance. In accordance with the resident's preference... Document all appropriate information in medical record.

R708

On 6/9/21 at 12:00 PM, R708 was observed in their bed. R708's upper lip, cheeks, and chin were observed to have several days of facial hair growth. It was further observed R708 had a green/yellow crusty substance from their left nostril and dried to the facial hair growth under their nose. The substance appeared to occlude R708's left nostril. R708 had a white crusty substance dried to their face near the right corner

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of their lower lip. Both of R708's hands were observed to have long fingernails extending approximately 1/2 or more of an inch beyond the fingertips. It was further observed R708's left hand index and middle finger had adhesive bandages between the first and second knuckles. At that time, an interview with R708 was attempted, however; R708 did not respond to verbal communication.

On 6/9/21 at 3:00 PM, R708 was observed in bed working with a staff member from the Therapy Department on neck strengthening exercises. R708 remained with the facial hair, crusty substance to their left nostril, long fingernails, and bandages to the fingers.

On 6/10/21 at 9:45 AM, an observation of medication pass for R708 was conducted with Licensed Practical Nurse (LPN) 'I'. It was observed R708 remained with facial hair, the crusty green/yellow substance to their left nostril, long fingernails, and bandages to their fingers. During the medication pass, R708 sneezed and while they sneezed the inside of R708's mouth was observed to have a thick, white, coating on the inside including on their tongue and teeth.

A review of R708's clinical record was conducted on 6/9/21 and revealed a most recent re-admission date of 5/26/21 with diagnoses that included: brain cancer, Parkinson's Disease, paraplegia, aphasia, dysphagia, and presence of a feeding tube. R708's most recent MDS assessment dated 4/1/21 revealed R708 had severe cognitive impairment, did not exhibit any behaviors including rejection of care, required total assistance from one staff member for personal hygiene and was coded "8" for bathing, meaning, "Activity itself did not occur."

On 6/9/21 at 12:50 PM, a review of the shower

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schedules at the nursing station revealed R708's room was to receive their showers on the afternoon shift on Tuesdays and Fridays. At that time, a review of the "Skin Monitoring: Comprehensive CNA Shower Review" sheets in the binder at the nursing station were reviewed and revealed only one sheet for R708 dated 6/8/21 that had, "PRN (as needed) bed bath" handwritten on it. It was noted this document had been signed off by the charge nurse on 6/8/21. The form did not indicate that any other personal hygiene (shaving, oral care, nail care, etc.) had been provided. A review of a 30-day look-back for the CNA task for bathing in the electronic medical record was conducted and revealed one entry documented 6/8/21 for an as needed bed bath.

R709

On 6/921 at 12:10 PM, R709 was observed in their room in bed. It was noted a foul, unidentifiable odor was present in the room. R709 did not verbally communicate and tracked with their eyes. R709's arms, hands, fingers and knees were contracted and R709 was wiggling around in the bed. R709's hair was greasy in appearance. R709 was able to slightly lift their head off their pillow and it was observed the hair on the back of their head appeared matted. An observation of R709's hands revealed long nails extending approximately a half an inch beyond the tip of their fingers. The left hand index finger was noted to be contracted over the middle finger and the nail on the index finger was nearly pressing into the skin of the middle finger.

A review of R709's clinical record was conducted and revealed a most recent re-admission date of 5/19/21 with diagnoses that included: cerebral palsy, anoxic brain damage, spastic quadriplegia, and contractures. R709's most recent MDS

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	assessment dated 3/22/21 revealed R709 had severe cognitive impairment, exhibited no behaviors including rejection of care and required total assistance from one staff member for personal hygiene and total assistance from two staff members for bathing. On 6/9/21 at 1:10 PM, a review of the shower schedules at the nursing station revealed R709's room was to receive their showers on Wednesdays and Saturdays during the evening shift. At that time, a review of the "Skin Monitoring: Comprehensive CNA Shower Review" sheets in the binder at the nursing station were reviewed and did not reveal any sheets in the binder for R709. A review of a 30-day look-back for the CNA task for bathing in the electronic medical record was conducted and revealed seven documentation's of, "Not Applicable" in the 30-day look-back period. R710 On 6/9/21 at 11:36 AM, R710 was observed dressed and lying in bed. R710 was asked if they received routine showers at the facility. R710 appeared confused and explained they were able to wash themselves in the bathroom every day. Review of the clinical record revealed R710 was originally admitted into the facility on 10/31/20 and readmitted 12/27/20 with diagnoses that included: seizures, traumatic subdural hemorrhage, and psychotic disorder with delusions. According to the MDS assessment dated 5/7/21, R710 scored 9/15 on the BIMS exam, indicating moderately impaired cognition. The MDS assessment also indicated R710 required the limited assistance of staff for personal hygiene and bathing did not occur during the assessment period.			

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	Review of the 30 day look back for Shower/Bath PRN revealed only three dates: 5/19/21, 5/23/21 and 6/3/21. For each of these days there were check marks in the "Not Applicable" box, indicating showers or baths were not done. There was no other documentation in the look back for showers or baths. On 6/9/21 at 1:07 PM, Unit Manager "K" was interviewed and asked about paper shower sheets. Unit Manager "K" explained the schedule for the showers was in the assignment book at the nurses' station and the nurse would write who was to get a shower on the assignment for the day. The CNA's would fill out a shower sheet and the nurse would sign the sheet when it was completed, then she would sign the bottom of the sheet and file it in her office. Review of the shower schedule revealed R710 was supposed to receive showers every Tuesday and Saturday afternoons. Review of shower sheets for R710 revealed two sheets. One dated 5/25/21 had "Skin Intact" circled, no CNA signature, a signature on the "Charge Nurse" line and a signature on the "Unit Coordinator" line. The other sheet dated 6/4/21 was blank except for a signature on the "Unit Coordinator" line. On 6/9/21 at 1:36 PM, CNA "J" was interviewed and asked about showers. CNA "J" explained residents were supposed to get two showers a week. CNA "J" was asked how showers were documented. CNA "J" explained the nurses put it on the daily schedule, the CNA's would fill out a shower sheet then give it to the nurse. When asked if it was documented in POC, CNA "J" explained it depended on how it was put into POC, if it was as PRN, it didn't alert for documentation, but some people only had PRN			

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	and not actual days listed in POC. On 6/10/21 at 4:13 PM, the DON was interviewed and asked about the lack of documentation of R710 receiving showers. The DON explained documentation had been an issue at the facility and they needed to do better with that. When asked if R710 had received a shower on the days the shower sheets were left incomplete, the DON explained the sheets should be filled out completely.			
F0689 SS= G	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure care planned interventions for the prevention of falls and care planned interventions for the reduction of injuries from falls were implemented for one resident, (R714) of three residents reviewed for falls, resulting in a fall from a geri-chair in their room and a second fall from their geri-chair at the nurses station. Findings include: On 6/9/21 at 10:50 AM, R714 was observed directly across from the nurses station in the hallway reclined in their geri-chair. R714 was fidgeting around in the chair and appeared to be attempting to sit up from their reclined position. At that time, it was observed the seat of the geri-chair did not have Dycem (a tacky, non-slip sheet type material) applied to its surface and R714 was	F0689	The Unit Manager ensured resident #714□s dycem and floormats were in place. Resident #714□s fall care plan, Kardex and safety interventions were reviewed to ensure that the resident receives adequate supervision and assistance devices to prevent falls. Like residents in the facility that have the potential to be affected, care plan, Kardex and safety interventions were reviewed by the Unit Manager to ensure that the residents receive adequate supervision and assistive devices to prevent falls. The Fall Prevention policy has been reviewed and deemed appropriate. Licensed Nurses and Nursing Assistants have been educated on the Fall Prevention policy to ensure Fall Care Plan safety interventions are in place for continued compliance. Fall interventions will be checked during Unit Manager rounds to ensure that the interventions are in place. The DON/designee will conduct random audits on 5 residents who have safety interventions weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that fall interventions are in place. A review of DON/Designee audits will be	5/24/2021

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	634560	A. BUILDING _____ B. WING _____	6/10/2021

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

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	easily sliding from side to side in the seat of their chair as they attempted to sit up. On 6/9/21 at 1:10 PM, R714 was observed directly across from the nurses station reclined in their geri-chair. R714 was heard to say, "Please help" as they fidgeted and moved around in their geri-chair. Staff were not present at the nurses station supervising R714, but three staff members were observed around the corner in the hallway passing lunch trays. It was noted, R714 could not have been directly observed from their location. At approximately 1:05 PM, a staff member entered the unit and observed R714. On 6/10/21 at 11:30 AM, R714 was observed in their bed asleep. It was observed R714 had a fall mat only on the right side of their bed. R714's geri-chair was at the foot of the bed and was not observed to have Dycem in the seat. On 6/10/21 at 12:35 PM, R714 was observed directly across from the nurses station reclined in their geri-chair. At that time, R714's assigned Certified Nursing Assistant (CNA), CNA 'F' was asked if R714's geri-chair had Dycem in the seat. CNA 'F' asked if Dycem was, "that blue stuff?" CNA 'F' was then asked if the seat of R714's wheelchair could be observed for the presence of Dycem. CNA 'F' was able to easily slide R714 from side to side in the geri-chair and turn them enough to the left and right to observe no Dycem was present in the seat of the chair. A review of R714's clinical record was conducted and revealed an admission date of 2/25/21 and a re-admission date of 3/22/21 with diagnoses that included: syncope and collapse, unsteadiness on feet, dementia with behaviors, and Parkinson's Disease. R714's most recent Minimum Data Set assessment dated 3/25/21 was reviewed and indicated R714 had moderately impaired		presented to the QAA committee for review and consideration of further corrective action if needed. The DON and Unit Managers will be responsible for assuring substantial compliance is attained through this plan of correction and for sustained compliance thereafter.	

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cognition and required extensive assistance from two staff members for transferring and ambulation. Fall assessment scores calculated on 5/27/21 and 6/7/21 indicated R714 was at a "High Risk" for falls. A review of R714's care plan for falls was conducted and revealed the following interventions:

An intervention initiated 3/10/21 that read, "Bilateral floor mats while in bed"

An intervention initiated 4/22/21 that read, "Educate staff on safety awareness, place resident in dining room with assigned staff monitoring as tolerated"

Interventions initiated 5/27/21 that read, "Not to be unattended in dining room. Not to be unattended while up in the gerichair...add dycem in geri chair..."

A review of a facility provided incident report was conducted on 6/9/21. The report revealed on 5/28/21, R714 had been left alone in their room in their geri-chair, had slid out of the chair and was found on the floor. After the fall, the intervention added to the care plan was for Dycem to be placed in the chair.

A review of a second facility provided incident report was conducted on 6/9/21 and revealed R714 fell out of their geri-chair on 6/7/21. The report was not clear as to the location of the fall. It had been documented in one section of the report the fall occurred "...in the room..."; and in another part of the report, it was documented the fall occurred in the hallway across from the nursing station. The report documented, "...Staff did not follow plan..." Continued review of the report revealed the following information, "...Nursing Description: Resident was found on the floor...Per (CNA 'H') she last saw resident

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	rocking back and forth at the end of his wheelchair. (CNA 'H') told resident to sit back and went into another resident's room..." On 6/10/21 at 8:40 AM, an interview with the facility's Director of Nursing (DON) was conducted regarding R714's falls on 5/28/21 and 6/7/21. The DON explained they did not believe the intervention to not leave R714 unattended in their room wasn't added until after the fall on 5/28/21. When queried about the intervention dated 4/22/21 that indicated R714 was to be up in the dining room with staff, the DON had no explanation. The DON did admit staff did not follow the care plan for supervision, and R714 had been left unattended on 6/7/21. On 6/10/21 at 11:25 AM, an interview with CNA 'H' was conducted. CNA 'H' was asked to recall from memory the fall on 6/7/21. CNA 'H' said they were not assigned to R714 but on their way to another room they observed R714 in their geri-chair in the hallway across from the nursing station. CNA 'H' continued to explain that it looked like R714 was trying to stand up from the geri-chair and they told them to sit down. After advising R714 to remain seated, CNA 'H' said they continued down the hall to assist in another room. They said they did not see R714 fall but was called to assist after he had been found on the floor in front of the nursing station. On 6/10/21 at approximately 4:25 PM, a follow-up interview was conducted with the DON regarding R714's falls and the observations. The DON indicated they would check into why a floor mat was only observed on the right side of the bed and why the Dycem had not been placed in the wheelchair. When informed of the observation of R714 being left in their geri-chair in front of the nursing station on 6/9/21 with no staff present, the DON said they were always			

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	reminding the staff to watch R714 and if they were passing trays in the other hallway, they should have taken R714 with them. A review of a facility provided policy titled, "Fall Prevention" adopted 7/11/18 was conducted and read, "POLICY: It is the policy of this facility that the Fall Prevention Program is designed to ensure a safe environment for all residents..."			