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 _____	3/9/2022

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 a re-visit survey on 3/9/22. Census= 124.	F0000		
F0886 SS= D	COVID-19 Testing-Residents & Staff §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h) ((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this	F0886	F886 All staff had the potential to be affected. CENA E, F, G and nurse H were all in compliance with Covid 19 testing by March 10, 2022. All tested negative. By March 10, 2022, all unvaccinated staff members were-educated on the guidance-Covid19 CMS Facility Testing Requirements. The Administrator/Designee will review the staff log for Covid tests to ensure all unvaccinated staff are tested per CMS/Facility Testing Requirements. By March 10, 2022, the Unvaccinated tracking log was revised to track test dates. By March 10, 2022, all unvaccinated staff testing were reviewed and testing completed per policy. The Administrator/Designee will conduct random audits on 5 staff weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the facility conducts COVID 19 tests per CMS guidelines and documents the tests accordingly. The results will be presented to the QAA committee for review and considered of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 3/10/22 and	12/6/2021

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

Electronically Signed | 03/21/2022

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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	paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to conduct COVID-19 testing per current guidelines for four unvaccinated staff members: Certified Nursing Assistant (CNA) "E", CNA in Training "F", CNA "G" and Licensed Practical Nurse (LPN) "H", of five staff reviewed for COVID-19 testing. Findings include: Review of the facility's staff vaccination status revealed (CNA) "E", CNA "F", CNA "G" and LPN "H" as unvaccinated for COVID-19. Review of facility Policy/Procedure titled "Infection Prevention and Control" (update 9/20/21) documented, in part, " ...Routine Testing of Staff: Routine testing of unvaccinated staff should be based on the extent of virus in the community ...Table 2: Routine Testing Intervals by County COVID19 Level of Community Transmission ...Substantial (orange) Twice a week ...High (red) Twice a week ..." Review of Centers for Disease Control and Prevention (CDC) COVID Data Tracker,		for sustained compliance thereafter. The Regional Director of Operation will provide oversight to ensure compliance.	

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	documented the "Community Transmission" as orange (Substantial) during the weeks reviewed (2/20/22-3/5/22). On 3/9/22 at approximatley 12:46 PM an interview was conducted with the Administrator regarding an earlier request to provide COVID19 testing documentation. The Administrator reported that they had reviewed testing documentation and determined that the unvaccinated staff as noted above were not tested two times per week as required by the facility's policy and the CDC. On 3/9/22 at approximatley 1:32 PM, a review of paper COVID19 documents and time sheets for the weeks 2/20/22 thru 2/26/22 and 2/27/22 thru 3/5/22 was conducted with the Administrator present and revealed the following: CNA "E" time sheets revealed the CNA worked on 2/4/22, 2/26/22, 2/27/22 and 3/4/22 and was tested on 2/22/26 and 2/26/22. CNA "F" time sheets revealed the CNA worked on 2/21/22, 2/23/22, 2/24/22, and 2/25/22 and was tested on 2/23/22. CNA "G" time sheets revealed the CNA worked on 2/22/22, 2/23/22, 2/25/22, 2/26/22, 2/27/22, 3/3/22, 3/4/22 and 3/5/22 and was tested on 2/22/22. Nurse "H" time sheets revealed the Nurse worked on 2/25/22, 2/28/22, 3/1/22, 3/2/22 and 3/5/22 and was tested on 2/25/22, 3/1/22 and 3/5/22. No additional documentation was provided before the end of the Survey.			