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 _____	5/19/2022

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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F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for an Abbreviated survey on 5/19/22. Intakes: MI00127575, MI00127766, MI00127843, MI00127995, MI00128077, MI00128277, MI00128292. Census = 146	F0000		
F0684 SS= D	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 Intake # MI00128292 Based on interview and record review, the facility failed to ensure proper protocols were followed before initiating chest compressions on a resident with a pulse for one (R711) of one resident reviewed for cardiopulmonary resuscitation (CPR). Findings include: A complaint was filed with the State Agency on 5/4/22 that stated in part, "...The staff at the facility administered CPR for approximately five to ten minutes even though (R711) had a pulse. (R711) was given an unknown medication which caused her to become lethargic. (R711) was then pulled to the floor and the staff began CPR... The staff administered CPR negligently as (R711) had a continuous pulse..."	F0684		

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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Review of the closed record revealed R711 was admitted to the facility on 3/28/22 with diagnoses that included: synovial cyst of popliteal space (Baker's cyst), dementia and diabetes. According to the Minimum Data Set (MDS) assessment dated 3/29/22, R711 had severely impaired cognition and required the extensive to total assistance of staff for activities of daily living (ADL's).

Review of a "Patient Care Record" from [Name of Fire Department] dated 5/3/22 read in part, "...11:03 (AM)... BP (blood pressure) 115/63... Pulse (P) 147... 11:13 (AM)... BP 123/62... Pulse 81... Upon arrival we found the female in [sic] the ground with staff bagging (a bag used to give rescue breaths) pt. Upon getting to the pt (patient) staff from [Name of Facility] stated they had done 5 minutes' worth of CPR. When asked the staff stated the pt maintained a palpable pulse through the event. Staff stated the did do CPR knowing the pt had a pulse. Pt was placed on the monitor and the above vitals were found..."

Review of R711's progress notes revealed a general note dated 5/3/22 at 12:43 PM by Licensed Practical Nurse (LPN) "D" that read in part, "Writer was called to residents room by therapy to assist with the patient who was unresponsive. Resident was in wheelchair. Resident was slid to floor, vital signs were taking [sic] P (pulse) 55, 98/57 BP (blood pressure)... One round of CPR was performed writer observed... Resident left in ambulance responsive and was able to respond to commands..."

On 5/18/22 at 8:35 AM, LPN "D" was interviewed by phone and asked what happened with R711 on 5/3/22. LPN "D" explained she was giving R711 her morning medications when R711 said she was having some pain, so she gave R711 an as needed (PRN) pain medication. LPN "D"

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	continued to explain that it was a little while after that when someone from therapy came and got her and told her R711 was unresponsive. When asked what she did then, LPN "D" explained R711's was sitting in the wheelchair, her head was down and she was breathing hard, a snoring-like breathing, so they moved R711 to the floor and that was when another nurse came in the room and started chest compressions on R711. LPN "D" was asked the name of the nurse that initiated chest compressions. LPN "D" explained she did not know her name, she was new to the facility. LPN "D" was asked who was bagging R711. LPN "D" explained she was but had not done any chest compressions. When asked if R711 had a pulse when chest compressions were initiated, LPN "D" explained the other nurse said she felt a weak pulse. Review of R711's May 2022 Medication Administration Record (MAR) revealed a physician order for, "Acetaminophen-Codeine Tablet 300-30 MG (milligrams), Give 1 tablet by mouth every 8 hours as needed for Mild / Moderate pain". The medication was marked as given by LPN "D" at 9:13 AM. It should be noted Acetaminophen-Codeine is an opioid medication. On 5/18/22 at 11:29 AM, Physical Therapist (PT) "F" was interviewed and asked about R711. PT "F" explained she had stopped by to say goodbye to R711 as she was supposed to go home that day. R711 was sitting in the wheelchair with her head down, but she did not respond to her name. PT "F" explained she then tried rubbing R711's arm, then tried a sternal rub, but R711 did not respond, so she went and got LPN "D", R711's nurse, and told her R711 was unresponsive. Then LPN "D" grabbed the vital signs machine and rushed into R711's room calling for help. When asked if she had seen anyone perform CPR on R711, PT "F" explained she had left before any CPR was started as there were several nurses in the room.			

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On 5/18/22 at 11:52 AM, the Assistant Director of Nursing (ADON) was interviewed and asked who had performed CPR on R711 on 5/3/22. The ADON explained LPN "G", who had not been working the floor but doing required training, initiated the chest compressions and LPN "D" had bagged. When asked if there were other nurses that had responded to the code (Code Blue), the ADON explained she had been there along with LPN "J", Registered Nurse (RN) "I" and a couple more nurse. When asked if R711 had a pulse before chest compression were initiated, the ADON explained LPN "D" had told her she felt a pulse.

On 5/18/22 at 11:59 AM, LPN "G" was interviewed by phone and asked about R711. LPN "G" explained she had been sitting at the nurse station doing course work when LPN "D" called for someone to call 911 and call a Code Blue. LPN "G" explained she went into the room and felt for a pulse. When asked if R711 had a pulse, LPN "G" explained it was a weak pulse, but that R711 was not responding and was limp, so then she asked if R711 was a full code and when the staff said R711 was, she started chest compressions. LPN "G" was asked if any vitals were taken before she started chest compressions. LPN "G" explained there was a blood pressure taken, but she did not know what it was. When asked why she had started chest compressions on someone that had a pulse, LPN "G" explained to her, R711 was a full code, was unresponsive and she did not want to just stand there and watch R711, so she started chest compressions. LPN "G" was asked how long she did chest compressions. LPN "G" explained as she was doing them, R711 took a big breath in, so she stopped. When asked if she was CPR certified, LPN "G" explained she was.

On 5/18/22 at 1:59 PM, Human Capital Partner

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	(HCP) "H" was asked to provide LPN "G's" CPR certification card. Review of the CPR certification card for LPN "G" revealed an Issue Date of 4/4/22 from American Heart Association for BLS (Basic Life Support) Provider training. Review of an "Adult Basic Life Support Algorithm for Healthcare Providers" dated 2020 by American Heart Association read in part, "...Look for no breathing or only gasping and check pulse (simultaneously). Is pulse definitely (bold print) felt within 10 seconds?" Three choices were provided, 1. "Normal breathing, pulse felt - Monitor until emergency responders arrive." 2. "No normal breathing, pulse felt - Provide rescue breathing, 1 breath every 6 seconds or 10 breaths/min (minute). Check pulse every 2 minutes; if no pulse, start CPR. If possible opioid overdose, administer naloxone if available per protocol." 3. "No breathing or only gasping, pulse not felt - Start CPR..." On 5/18/22 at 3:05 PM, LPN "J" was interviewed by phone and asked about R711. LPN "J" explained she was a Unit Manager and had responded to the code and had gotten the paperwork to give to the Fire Department when they transported R711 to the hospital. LPN "J" was asked if R711 had a pulse before chest compressions were initiated. LPN "J" explained afterwards, LPN "G" told her she had done chest compressions even though she had felt a pulse. When asked if chest compressions should be done on someone with a pulse, LPN "J" said no. Review of R711's records from [Name of Hospital] dated 5/3/22 read in part, "...Physical exam notable for tenderness to palpation of sternum and right chest wall... Chest x-ray obtained demonstrating possible pulmonary			

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	contusion. Rib series and sternum obtained with no definitive fracture... ECG (electrocardiogram) unchanged from previous. Troponin (cardiac marker) negative. Per history, patient did not ever lose a pulse, but CPR was initiated due to "weak Pulse". Feel that cardiac arrest less likely. Did receive Norco (an opioid medication, different than what R711 was given) prior to episode of altered mentation, which could have precipitated the event... Unresponsive episode with questionable cardiac arrest s/p (status post) CPR - no consistent with cardiac arrest given the fact she had a pulse per documentation. ?pain medication contributing..." On 5/18/22 at 5:23 PM, the Director of Nursing (DON) was interviewed by phone and asked about R711. The DON explained she had not been in the facility on 5/3/22 but was aware of the incident. When asked if chest compressions should be initiated on someone with a pulse, the DON explained that generally no, CPR is not done on someone with a pulse. Review of a facility policy titled, "Cardiopulmonary Resuscitation (CPR)" dated 7/11/18 read in part, "... Procedure: Refer to American Heart Association CPR Guidelines... 1. Recognition: a. Determine unresponsiveness; b. No Breathing or no normal breathing (i.e., only gasping); c. No pulse palpated within 10 seconds..."			