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 _____	8/2/2022

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 Recertification survey on 8/2/22. Intakes: MI00126902, MI00128472, MI00128604, MI00128706, MI00128770, MI00128835, MI00128940, MI00129283, MI00129703, MI00129796 MI00129797 Census=146	F0000		
F0550 SS= E	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The	F0550	F Tag 550- D (Resident Rights/Exercise of Rights) Resident #35 received ADL care which included toileting by the clinical staff to ensure dignity and respect will be maintained. Social Services completed a psychosocial follow up with the resident on or before 8/29/2022 to ensure dignity and respect have been maintained. Resident#98 no longer resides in the facility. Resident #108 received grooming, ADL care as provided by the clinical staff which included ensuring that resident was properly dressed to ensure dignity and respect will be maintained. Social Services completed a psychosocial follow up with the resident on or before 8/29/2022 to ensure dignity and respect have been maintained. All residents in the facility have the potential to be affected. An audit was completed on all residents residing in the facility to ensure that residents received ADL Cares and are treated in a dignified manner. The Facility Administrator will assign Interdisciplinary team members to each resident to assist in ensuring adl care needs are met on a day to day basis. Findings	8/29/2022

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

Electronically Signed | 08/22/2022

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 _____	8/2/2022

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
	resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to treat residents in a dignified manner affecting three (R35, R98, and R108) of five residents reviewed for dignity and 15 of 15 residents who wished to remain anonymous, who attended the resident council interview and to ensure staff members wore identification badges. Findings include: On 7/28/22 at 10:30 AM, an interview with resident council members was conducted. During the interview residents expressed that staff did not treat them or residents who were not able to speak for themselves in a dignified and respectful manner. One resident stated, "If they don't like the situation, they will just ignore you. The agency (contracted) staff don't know anything about us." Another resident stated, "You will see the staff sitting around on their phones and talking." Another resident stated, "They (agency staff)		will be addressed as needed and brought to daily stand up meeting and followed up on during daily stand down meeting in afternoon. An Audit was completed of all active employees working in the facility to identify staff members in need of name badges. All staff will receive name badges by 8/24/22 in the interim, any staff noted not to have a name badge will be provided a temporary name sticker to wear while working in the facility, this includes agency staff. Upon hire, staff will be provided a name tag by the Human Resource Dept to ensure residents are able to identify who who there care providers are per shift i.e nurses/cenas. By 8/25/22, nursing staff will be educated on Resident Rights Dignity & Respect which will include but is not limited to caring for and treating all residents in a respectful and dignified manner specifically to ensure grooming, dressing, toileting and ADL cares are met. The Administrator/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure residents are cared for and treated in a respectful and dignified manner specifically to grooming, shaving, toileting, dressing, and ADL cares. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22 and for sustained compliance thereafter.	

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 _____	8/2/2022

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

treat residents who can't speak up like animals."

When asked by a show of hands how many residents experienced treatment from staff in an undignified or disrespectful manner, 15 of 15 residents put their hands up.

On 7/28/22 at approximately 7:45 AM , during an observation of the 2 West unit, five to six staff members were observed seated at the nurse's station having personal conversation amongst themselves.

Resident #35

On 7/28/22 at 2:35 PM, upon entrance to the 2 West unit, a very strong bowel movement (BM) odor was observed near the nurses' station. R35 was seated in a chair, R108 was reclined in a geriatric chair to the side of the nurses' station, and one other resident (who was unable to state their name) was ambulating in a wheelchair in the area. One Certified Nursing Assistant (CNA) 'J' was seated at the nurses' station. No other staff was observed on both hallways of the 2 West unit or the Center Unit.

On 7/28/22 at 2:48 PM, the BM odor remained. R35 was observed reaching behind himself in the chair and then had brown substance on his fingers. R35 appeared visibly uncomfortable as he held his hand out to look at it. An observation from the side of the chair R35 was seated in, revealed the

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 _____	8/2/2022

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
	chair and the back of R35's pants and bottom of their shirt was visibly soiled. When addressed, R35 softly stated, "I need help. I need to be cleaned." On 7/28/22 at 2:50 PM, Registered Nurse (RN) 'S' entered the 2 West unit. When queried about R35 being soiled with BM, RN 'S" reported she was aware and she would find somebody to help him. At that time CNA 'J' and CNA 'F' were providing care to another resident. No other staff were observed on the unit at that time. RN 'S' returned to the medication cart. On 7/28/22 at 2:58 PM, R35 remained seated in the chair, soiled with BM. R35 repeatedly reached behind himself which then soiled his hand with BM. R35 was observed to sniff his hand and hold it away from his body. A very strong BM smell remained in the area and R108 remained seated in the chair beside the nurses' station. RN 'S' was seated at the nurses' station at that time and was observed to call a staff member on the phone. RN 'S' told the staff member R35 needed to be changed before they left for the day. On 7/28/22 at 3:01 PM, RN 'S' and CNA 'K' were observed seated at the nurses' station. R35 remained soiled, seated in the chair. At that time LPN 'Z' entered the 2 West Unit, said hello to R35 and sat down at the nurses' station with RN 'S' and CNA 'K'. RN 'S' told LPN 'Z' that she paged R35's CNA, CNA 'L' but she was on break.			

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 _____	8/2/2022

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

On 7/28/22 at 3:05 PM, CNA 'H' who was not wearing a name tag, entered the 2 West Unit along with CNA 'L' who was not wearing a name tag. At that time, RN 'S' had R35 stand up from the chair and told CNA 'L' he had to be cleaned. The backside of R35's pants and shirt were visibly soiled with a large amount of BM and the chair he was seated in was soiled on the seat and up the back of the chair. At that time, CNA 'H' stated, "Look what (R35) did!!". R108 was within earshot of CNA 'H's statement. Then CNA 'K' walked near the chair and stated, "Oh God!" and placed her hand over her nose. RN 'S' brought the chair soiled with BM into R35's room.

On 7/28/22 at 3:10 PM, RN 'S" was interviewed. When queried as to why R35 was left to sit soiled with BM for a half hour, RN 'S' reported his CNA was on break and she said he was showered earlier that day.

On 7/28/22 at 3:24 PM, the Director of Nursing (DON) was interviewed. When queried about who was responsible to clean a resident if they were visibly incontinent and soiled in the common area. The DON reported any nursing staff could provide care if the assigned CNA were on break. When queried about how residents knew who staff were, the DON reported they were required to wear name tag.

On 7/28/22 at 4:16 PM, three CNAs were

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 _____	8/2/2022

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

observed standing around the nurses' station on the 2 West Unit having personal conversations. CNA 'R' was observed seated on top of the counter using their personal cell phone.

On 7/28/22 at approximately 4:30 PM, the DON was interviewed regarding personal cell phone use by staff and personal conversations. The DON reported staff should not be engaging in personal conversation or using their personal cell phones.

R98 and R68:

On 7/26/22 at 10:39 AM, R98 was observed lying in bed and appeared to be sleeping. They were lying in bed with their entire upper torso exposed and appeared very sweaty. Upon approach, the resident appeared extremely debilitated (severely contracted bilateral hands/wrists). R98 did not open their eyes, but exhibited jerking/twitching movements.

On 7/26/22 at 10:47 AM, during observation of R98, their roommate (R68) began yelling, screaming, and swearing loudly to come talk to them and reported concerns about their medication, missing glasses and then proceeded to report that they were the president and part owner of the facility. R68's behaviors continued to escalate and the resident proceeded to yell and swear loudly.

Upon stepping out of the room and into the

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 _____	8/2/2022

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

hallway, two other residents whose rooms were located directly across the hallway from R68 and R98 were observed shaking their heads and reported the yelling and profanity was almost constant, day and night and were very frustrated.

On 7/26/22 at 11:10 AM, R68 could still be heard yelling and screaming profanities loudly. A resident in the hallway nearby reported "Let this be a mental house, that's what it is, screaming all night.".

On 7/26/22 at 2:25 PM, an interview was conducted with Social Service Tech (Staff 'G') who reported they were the only social service staff full time at the facility. When asked about R98, Staff 'G' reported the resident had recently signed onto hospice services just last week and was unable to verbalize, but had shared a room for a while now with R68. When asked about R68's behaviors of yelling/swearing loudly and whether the facility had considered alternate placement of R98, especially since they were not able to verbalize their needs and since they were recently signed onto hospice, Staff 'G' reported they had not.

On 7/27/22 at 10:52 AM, Staff 'G' reported R98 was moved to a private room away from R68 following the discussion yesterday (after concerns were identified during the survey).

R108:

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 _____	8/2/2022

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
	On 7/26/22 at 3:38 PM, a phone interview was conducted with R108's legal guardian (LG). R108's LG reported concerns with dignity and how R108 was frequently found wearing a hospital gown, instead of their clothes. When asked how long this had been going on, they reported there seemed to be a change over the past three to four weeks. R108's LG further reported R108 had plenty of clothes, and thought staff were aware he liked to be dressed daily. Observations of R108 included: On 7/26/22 at 11:18 AM and 1:29 PM, the resident was lying in a Geri chair recliner at the nursing desk, wearing a hospital gown. On 7/27/22 at 3:15 PM, R108 was observed lying in a Geri chair recliner in the lounge area with three other female residents. At that time, R108 was wearing a hospital gown which had bunched up to and exposed their stomach and yellow colored disposable brief. The resident was wearing socks and shoes and yelling out loudly while banging the right armrest repeatedly. Upon approach, R108 stopped yelling. At that time, Unit Manager 'AA' entered the lounge area, and when asked about the president's state of dress and brief exposure, they reported R108 should not have been dressed like that as they had many clothes and the reason was possibly due to the fact the resident had an agency CNA (Certified Nursing Assistant) assigned to them today. When asked about			

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 _____	8/2/2022

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

the relevance of an agency staff vs facility staff, they offered no further response but reported they would have the resident changed.

On 7/27/22 at 11:16 AM, Certified Nursing Assistant (CNA 'H') reported they were currently assigned to work on 2 West and worked for the facility (not an agency). At that time, CNA 'H' was observed not wearing a name badge. When asked about the lack of name badge and how residents, staff or visitors would know who they were, CNA 'H' offered no response.

On 7/27/22 at 3:14 PM, CNA 'MM' was observed not wearing a name badge. CNA 'MM' was asked about their employment and reported they had worked at the facility for about two and a half years. When asked about why they were not wearing a name badge, they reported they were not able to wear their usual uniform (which had names stitched on the top) and needed to get a new one. When asked if they attempted to obtain a badge or label to identify who they were in the meantime, they reported they had been without a badge for a few days and needed to get it replaced but that they should be wearing it as part of their uniform. CNA 'MM' proceeded to report that there were several staff from the agency that did not wear their name badge as well.

On 7/28/22 at 8:51 AM, an interview was conducted with the Human Resources

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 _____	8/2/2022

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
	Director (Staff 'LL'). When asked if name badges should be a part of the staff's uniform, they reported they should. Staff 'LL' reported they could go around now and make sure staff wore them, and were informed of the multiple observations since the start of the survey of staff not wearing their badges. When asked about the facility's use of agency staff and whether they were offered a name tag, Staff 'LL' reported they should be bringing their own. When asked how the agency staff would know to do that, or who was ensuring this was done, they were not able to offer any further explanation. Review of a facility policy titled, "Resident Rights and Quality of Life", adopted 7/11/28, revealed, in part, the following: "It is the policy of the facility that all residents have the right to a dignified existence..."			
F0558 SS= D	Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a call light was within reach for two (R9 and R99) of two residents reviewed for call light placement,	F0558	F 558 Reasonable Accommodations Needs/Preferences Residents R9 and R99 did not suffer any ill effects as a result of this citation. Staff ensured that resident R9 adaptive call light is within reach and working properly. Staff ensured that resident R99 call light is within reach and working properly. All residents have the potential to be affected by this citation. An audit was conducted in house by maintenance on or before 8/22/22 checking the functioning of all call lights in residents rooms to ensure that they are working properly.	8/29/2022

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 _____	8/2/2022

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
	resulting in the potential delay in services, unmet care needs, and isolation. Findings include: According to the facility's policy titled, "Call Light" dated 7/11/2018, "...Be sure call lights are placed within reach of residents who are able to use it at all times..." R9: On 7/26/22 at 11:01 AM, 11:41 AM R9 was observed lying in bed on their back, asleep and did not wake up upon approach. There was a gray colored adaptive call light observed on the floor near the head of the bed and wall, out of the resident's reach. On 7/28/22 at 10:32 AM, the adaptive call light was observed clipped to the top of R9's bed, but the end to press for help was hanging down (almost touching the floor) and was out of reach. R9 was sleeping but woke up and when asked if they could reach the call light for help, they reported "No''. Review of the clinical record revealed R9 was admitted into the facility on 1/1/20 and readmitted on 8/21/21 with diagnoses that included: multiple sclerosis, dysphagia, neuromuscular dysfunction of bladder, and hemiplegia and hemiparesis following cerebral infarction affecting left dominant side.		An audit was conducted on all residents to ensure that every resident had access to their call light. On or before 8/25/22, all staff were educated on accommodations of residents needs/preferences with emphasis on ensuring that residents call lights, including adaptive call lights are within residents reach to avoid a delay in services, unmet care needs and isolation. The DON/designee will conduct random audits on 5 residents weekly x4 then monthly thereafter times 3 months or until substantial compliance is attained and maintained to ensure that residents have call lights, including adaptive call lights within reach to avoid a delay I services, unmet care needs and isolation. The results of these audits will be presented to the QAA committee for review and consideration of further corrective actions monthly. The DON/designee will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22, and for sustained compliance thereafter	

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 _____	8/2/2022

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

According to the Minimum Data Set (MDS) assessment dated 4/21/22, R9 had intact cognition, had no communication concerns, and was dependent upon two or more staff for most aspects of care.

R99:

On 7/26/22 at 11:03 AM, R99 was observed lying in bed, watching tv. The call light was observed on the floor near the bedside dresser and wall, out of reach. When asked what they would use to call for help, R99 reported, "The light but I don't see it anywhere."

Review of the clinical record revealed R99 was admitted into the facility on 9/25/19 and readmitted on 7/27/20 with diagnoses that included: cerebral infarction due to embolism of unspecified cerebral artery, chronic kidney disease stage 3, vascular dementia without behavioral disturbance, personal history of malignant neoplasm of prostate, atrial fibrillation, insomnia, and type 2 diabetes mellitus with other diabetic kidney complication.

According to the MDS assessment dated 6/24/22, R99 had impaired short and long-term memory and required extensive assistance of one-person physical assist for bed mobility, dressing, toilet use, and personal hygiene.

Review of the care plans included a fall care

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 _____	8/2/2022

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
	plan initiated on 6/18/20 with an intervention added on 12/19/20 which read, "Be sure call light is within reach, provide cueing and reminders for use as appropriate due to level of cognition." On 7/27/22 at 1:56 PM, an interview was conducted with the Assistant Director of Nursing (ADON). When asked about the placement of resident call lights, specifically R9 who had an adaptive call light, and R99 they reported the call light should be within reach for all residents and staff should be doing rounds to ensure this was occurring.			
F0565 SS= E	Resident/Family Group and Response §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for	F0565	F 565 Resident/Family Group and Response No residents suffered any ill effects as a result of this citation. All residents have the potential to be affected. The Administrator conducted Grand rounds with the Maintenance Director, Regional Environmental director of the company that provides the facility housekeeping and laundry services to 8/10/22 to identify areas of concern related to clean environment for the staff and residents. The process for addressing grievances/concerns have been reviewed/modified as it relates to providing adequate and timely response to resident concerns expressed during weekly resident council meetings. The Facility has begun reviewing previous weeks resident council minutes at start of meeting to ensure resident satisfaction with new process in place of having residents sign off on concerns mentioned as an indication that they satisfied with resolution. We then address any new concerns and ensure proper follow up occurs.	8/29/2022

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 _____	8/2/2022

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
	such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide adequate and timely resolutions to grievances expressed by the resident council for 15 of 15 residents who attended a confidential resident council interview, resulting in unresolved complaints from residents. Findings include: On 7/28/22 at 10:30 AM, a confidential interview was conducted with 15 members who reported they either sometimes or frequently attended the resident council meeting in the facility. During the interview, the residents reported multiple complaints that they said were expressed in previous resident council meetings that have not yet been resolved. When queried about the facility's response to their concerns, it was reported that the staff say they will work on it, but the concerns remain unresolved. It was reported by multiple residents that their rooms and the building is not kept		Grievances will be reviewed daily to ensure proper follow up occurs. Residents have expressed that they would like the involvement of different interdisciplinary team members attending meeting depending on nature of concern and when invited. Facility Administrator will help bridge this request from residents and ensure proper leadership are attending meetings week over week as well as addressing concerns timely. On 8/11/22 the Administrator and Director of Nursing held an emergency Resident Council meeting to address any and all concerns expressed by residents. A grievance form was completed for all concerns given by residents to be followed up in a timely manner. By 8/25/22 all staff were educated on the grievance process, responding to concerns in a timely manner, residents rights, dignity, answering call lights, professionalism in the workplace, and resident care. The Administrator/designee will conduct random audits on 5 residents weekly x4 then monthly thereafter times 3 months or until substantial compliance is attained and maintained to ensure that grievances expressed by residents are provided adequate and timely solutions. The results of these audits will be presented to the QAA committee for review and consideration of further corrective actions monthly. The Administrator/designee will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22, and for sustained compliance thereafter	

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 _____	8/2/2022

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
	clean. One resident reported housekeeping does not clean their room thoroughly, sometimes only emptying the trash can. Another resident reported someone came in to sweep the floor, but did not mop it. One resident said bed linens were not changed when soiled or dirty and explained that staff will provide care to them in bed, but would not change the sheets if they got dirty in the process. Another resident said the same bed sheets were left on their bed for a month before anyone changed them. The group was asked by a show of hands how many experienced a lack of cleanliness in their rooms or in the facility and 15 of 15 residents raised their hands. When queried about whether it had been brought up as a concern during resident council meetings, the residents reported it had. When queried about the facility's response to the concern about cleanliness of the facility, one resident reported it was not being addressed and it remained a concern for a long period of time. The group was asked by a show of hands, how many had concerns with their bed sheets not being changed and all 15 residents raised their hands. Multiple residents expressed concerns about nursing staff, specifically those who were contracted to work in the facility and were not regular employees of the facility (agency staff). One resident reported it sometimes			

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 _____	8/2/2022

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
	took hours for call lights to be answered and expressed concerns about residents who were confined to their beds and unable to make their needs known. Another resident reported agency staff had attitudes and if they did not like certain situations, they would ignore residents for the resident of the shift, take longer breaks, or go home. Another resident reported the agency staff did not know the residents personally or what they needed medically and he had to constantly explain to them what to do. Multiple residents reported nursing staff were seen "sitting around on their phones". Another resident reported they felt like the agency staff "were just here for a paycheck". Another resident reported that if she asked for something, it felt like they would purposely delay what you asked for. Another resident reported, "They don't care about us. They just leave us high and dry" and also reported when agency staff come back from break, they are observed just sitting around doing nothing. One resident reported agency staff treated residents who had impaired cognition "like animals" and when you ask for something, they will often say, "It's not my job." When asked by a show of hands, how many residents experienced lack of respect, dignity, and care from the nursing staff, especially the agency staff, all 15 residents raised their hands. One resident reported he just received the			

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 _____	8/2/2022

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
	first shower in two weeks. Another resident reported they only received two to three showers a month. When asked by a show of hands, how many residents did not receive showers regularly, 7 of 15 residents raised their hands. One resident reported a delay in getting clean laundry back after it was washed. Another resident reported it sometimes took two weeks to get their clean laundry back and reported there were equipment issues at one time, but the delay in laundry still remained an issue. Another resident reported it took over a month to get their clean clothing back and did not have any clean clothes to wear. Another resident reported her laundry was taken to be washed over a week ago and it has not been returned. That resident reported she currently one had one pair of pants in their closet. In addition, multiple resident reported they had many items of missing clothing that they had reported missing. Five of 15 residents reported they had missing clothing and had told somebody it was missing. A resident reported they did not always get their medication on time, sometimes waiting two to four hours in the morning. The resident stated, "I can't get healthy without my medication." Another resident reported they did not get their medication prior to going to dialysis and had to ask for it and that medication administration was often			

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 _____	8/2/2022

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

delayed. Another resident reported they often ran out of pain medication and it took a couple days to get it.

When asked by a show of hands, how many residents experienced issues with receiving their medications, all 15 residents raised their hands.

Multiple residents reported they did not always have water available. One resident explained the weekends were worse and said, "You can't get water on the weekends." Another resident reported it was especially difficult on hot days when water was not available. The residents also reported the staff left empty water cups in their rooms.

When queried by a show of hands, how many residents experienced concerns with receiving water, all 15 residents raised their hands.

On 8/1/22 at 11:14 AM, the Administrator of the facility was interviewed. When queried about the facility's process for responding to and resolving grievances expressed by the resident council, the Administrator reported he started attending resident council meetings weekly in June 2022 and completed grievance forms for any concerns. The Administrator reported at that time, any past concerns were discussed to determine if the problem was resolved. The Administrator reported he would provide all grievance forms generated as a result of concerns

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 _____	8/2/2022

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

expressed by resident council.

Review of documented meeting minutes from resident council meetings from January 2022 through July 2022 revealed the following:

Housekeeping was documented as a concern expressed by resident council during resident council meetings in January 2022, February 2022, March 2022, April 2022, and July 2022. A concern with bed sheets not being changed was documented as a concern in February 2022.

Call light response time was documented as a resident council concern in February 2022, April 2022, May 2022, and June 2022.

Showers not being given was documented as a resident council concern two times in June 2022 (The Administrator began meeting with resident's weekly in June 2022).

Water not being passed regularly was documented as a resident council concern three times in June 2022 and July 2022.

Laundry issues were documented as a resident council concern in February 2022, April 2022, and May 2022. During all three months it was documented that the washer and/or dryer required maintenance.

Staff using their personal phones was documented as a resident council concern in

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 _____	8/2/2022

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
	February 2022 and April 2022. Review of grievance forms completed by the local ombudsman from a resident council meeting on 5/30/22 revealed the resident council had the following concern: "Issues addressed in resident council are never resolved. Grievances are not investigated and resolutions aren't communicated back to them", "Council feels that staff are rude and have attitude", "Council stated that they haven't met the administrator, that he was invited to council but he has an excuse and something always more important", "Water not passed regularly", Review of "Grievance and Satisfaction Forms" provided by the Administrator and explained that they were completed based on concerns expressed by the resident council revealed the following: Nurses being on phones at the nurses' station was documented as a concern 4/19/22. Long call light response times were documented as concerns 4/19/22, 5/23/22, and 6/21/22. Resident rooms not being cleaned regularly was documented as a concern on 4/19/22 and 7/18/22. Water not being passed regularly was documented as a concern on 6/21/22 and			

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 _____	8/2/2022

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
	7/18/22. Showers not being given consistently was documented as a concern on 6/22/22. All grievance forms were signed off by the Administrator and documented residents were satisfied with the resolutions. During the annual survey conducted from 7/26/22 to 8/2/22, deficiencies were identified with the facility not having a clean environment, water not being passed regularly, staff not treating residents in a dignified manner, clean laundry not being brought back in a timely manner, and showers not being given. Review of a facility policy titled, "Resident Council", adopted 7/11/18, revealed, in part, the following: "...The Grievance and Satisfaction Form will be utilized to track issues and their resolution. The facility department related to any issues will be responsible for addressing the item(s) of concern..."			
F0567 SS= D	Protection/Management of Personal Funds §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the	F0567	F-567 Resident #394 no longer resides at the facility. All residents who receive mail at the facility have the potential to be affected. Interviews were completed with all alert and oriented residents with a BIMs of 12 or greater on or before 8/25/22 to ensure they did not have any concerns with their mail being opened without their permission, specifically social	8/29/2022

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 _____	8/2/2022

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
	facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00128706. Based on interview, and record review, the facility failed to ensure one (R394) of three residents reviewed for resident rights gave permission to open their mail and authorize		security checks or other potential forms of monies. If any form of mail specifically addressed to resident will be delivered directly to resident by facility activity staff. In addition, residents were also asked the option of opening a resident trust acct. When they wish to withdraw money, a form of receipt is signed and kept for their record keeping. Further, residents will also be provided a quarterly statements which outlines what their deposits and withdrawals. By 8/25/22, the Receptionists, Business Office Manager and Activities were educated on the Mail Policy with emphasis on resident□s receiving their mail unopened unless they have provided the facility permission to open, specifically that social security checks and other potential forms of monies are not to be opened or cashed without the resident□s permission. The Administrator/designee will conduct random interviews/audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure they do not have any concerns with receiving their mail opened without their permission, specifically social security checks or other forms of monies. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22 and for sustained compliance thereafter.	

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 _____	8/2/2022

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

the facility to manage their social security checks.

Findings include:

Review of a complaint submitted to the State Agency alleged the facility was mishandling the resident's social security checks.

According to the facility's policy titled, "Mail" dated 7/11/2018, "...Mail will be delivered to the resident unopened unless otherwise indicated by the Attending Physician and documented in the resident's medical record...Staff members of this facility will not open mail for the resident unless the resident requests them to do so. Such request will be documented in the chart (i.e., on the resident's plan of care)..."

Review of the clinical record revealed R394 was admitted into the facility on 7/8/20, readmitted on 9/1/20 and discharged to community on 5/27/22. Diagnoses included: multiple sclerosis and bipolar disorder current episode depressed, mild. According to the profile information, although the former guardian was still listed as a contact, the resident was identified as their own responsible party.

According to the Minimum Data Set (MDS) assessment dated 5/18/22, R394 had no communication concerns, and had intact cognition.

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 _____	8/2/2022

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
	According to the MDS assessment dated 2/18/22, R394's response to the question "How important is it to you to take care of your personal belongings or things?" was marked as "1. Very Important". On 8/1/22 at 10:20 AM, an interview was conducted with the Corporate Business Office Manager (Staff 'FF') and the facility's Business Office Manager (Staff 'GG'). Staff 'GG reported they had worked at the facility since September 2021 and prior to that, Staff 'FF' had assisted with business office needs. When asked about R394's account while at the facility, Staff 'GG' reported the resident had a balance of over $17,000. Staff 'GG' further reported that there were several changes with the guardianship, at one point it was the son, then a public guardian, but then R394 went to court and had their guardianship removed in 12/29/21, and was their own responsible party at that point. Staff 'GG' further reported that once that happened, R394 did not pay their deductible and had discharged from the facility to a local senior living facility on 5/27/22. Staff 'GG' printed a ledger which showed a current balance of $17,490 from the resident's time from 7/8/20-5/31/22. Neither Staff 'FF' nor Staff 'GG' mentioned anything about issuing checks to R394 at this time. On 8/1/22 at 11:46 AM, an interview was conducted with the Administrator who			

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 _____	8/2/2022

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
	discussed details of an allegation of missing money that was unsubstantiated for a separate concern. The Administrator further reported that R394 was fixated on funds and had balance due. The facility got (name of local long term care ombudsman - Staff 'II') and that the resident ended up receiving a check for $5080.00 and a second payment was sent to the resident. The Administrator continued to report that they had dealt a lot with this resident who was always fixated on that check and was a reason for hold-up to their discharge to (name of local senior living facility). On 8/1/22 at 12:14 PM, the Administrator reported they had a call out to Social Service Tech (Staff 'G') as they were currently on vacation and would be able to provide additional information. On 8/1/22 at 12:24 PM, the Administrator provided an investigation into R394's other allegation of missing cash. Review of this documentation included the resident alleged that while they were putting a check into their wallet at the time of discharge, they alleged missing cash. Staff interview identified the resident's discharge was held up as the resident was waiting on a check being issued from the business office manager. Staff further reported that the Business Office Manager and Social Services presented the resident with a refund check in the amount of $5,080 upon their discharge.			

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 _____	8/2/2022

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
	On 8/1/22 at 2:03 PM, a second interview was conducted with Staff 'GG'. When asked to explain about the checks that were provided to R394 as this was not mentioned during the first interview, Staff 'GG' reported there were two checks provided to the resident, one was for $5080 and the second which had been sent via certified mail was for $728. When asked to explain why the facility had issued checks since they had mentioned earlier a balance over $17,000, Staff 'GG' reported the former guardian sent checks over to the facility made out to (name of R394) and the bottom of the check said social security so, they ran them through the bank and applied the money to their account. Staff 'GG' further reported R394 was supposed to get those (checks from the former guardian) directly. When asked how the facility ended up with R394's checks instead of the resident, they reported the receptionist goes through the mail and determines what envelopes are checks and what's regular mail, so somehow it was given to me and that's how I got the money. They reported they had opened up the envelopes without paying attention and saw social security written on the bottom so they cashed the check and applied it to the resident's monthly bill. Staff 'GG' further reported that in discussion with the long-term care ombudsman (Staff 'II', they were informed those checks were mailed directly to the resident and in the end, should not have done that, so issued refund			

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 _____	8/2/2022

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
	of the checks. Staff 'GG' provided an "A/R (Accounts Receivable) REFUND REQUEST" form which identified there were four of R394's checks, each for $1452.00 and had service dates (date checks were cashed) on: 1/1/22, 2/1/22, 3/1/22, and 4/1/22. On 8/1/22 a 3:54 PM, an interview was conducted with the main receptionist (Staff 'JJ') who reported their supervisor was Staff 'GG'. When asked about their process of sorting resident mail and how they determined what was given to their supervisor, Staff 'JJ' reported certain medical things or the state, social security items were supposed to go to Staff 'GG', so they separated their mail, notified activities and they (activity staff) distributed the mail to the residents. When asked if they could recall any specific details for R394's mail, Staff 'JJ' reported the resident got a lot of mail and packages and would always call them to give a heads up to look out for it. When asked if anyone had discussed or provided additional education following R394's discharge from the facility on 5/27/22, Staff 'JJ' reported no one talked about them having mail that should've gone to R394.			
F0582 SS= A	Medicaid/Medicare Coverage/Liability Notice §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for	F0582		8/22/2022

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 _____	8/2/2022

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
	Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on			

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 _____	8/2/2022

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
	behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a SNF-ABN (Skilled Nursing Facility Advance Beneficiary Notice-Form 10055) for two residents (R36 and R109) of three residents who were reviewed for notices of Medicare non-coverage (NOMNC) and appeal rights. Findings include: On 8/1/22 the notices of Medicare non-coverage (NOMNC) and Advance Beneficiary Notifications (ABN) for R36 and R109 were reviewed. R36's NOMNC had a coverage ending date of 3/11/22. R109's last day of coverage was noted to be 5/16/22. No ABN's for R36 or R109 was provided for review. On 8/1/22 at approximately 9:45 a.m., During an interview with the Business Office Manager "GG" (BOM "GG"), BOM "GG" was queried if they were responsible for ensuring the notices of non-coverage including the NOMNC's and the ABNs were issued and BOM "GG" indicated they were. BOM "GG" was queried why R36 and R109 did not receive an Advance Beneficiary Notice that explained the estimated costs of continued services and they indicated they did not provide either of them with an ABN only the NOMNC. BOM "GG" was queried if R36 and			

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 _____	8/2/2022

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
	R109 should have received an ABN and they indicated they should have but did not. No ABN's for R36 or R109 were provided for review by the end of the survey. On 8/1/22 a facility document titled "Notice of Medicare Non-Coverage" was reviewed but did not contain information on how and when to issue an advance beneficiary notice. It only contained information on when to issue the NOMNC.			
F0584 SS= E	Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified	F0584	F584 Safe/Clean/Comfortable/Environment Deficient Practice #1: Resident # R9, R26, R48, R61, R67, R68, R72, R87, R91, R92, R94, R98, R99, R108, R114, R121, R122, R126, and R135 rooms were cleaned, provided a clean privacy curtain. All residents have the potential to be affected. A facility wide audit was completed by the Administrator, Regional Environmental service and facility Environmental Service Director on 8/10/22 to ensure the residing residents rooms were clean and free of dirt/debris, with clean privacy curtains. By 8/22/22, facility staff will be educated by the Administrator/designee on the policy and procedure for Quality of Life- Homelike Environment Policy specifically addressing a comfortable and homelike environment. Further, the facility environmental staff were in-serviced on daily cleaning procedures, privacy curtain policy, and deep cleaning	8/29/2022

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 _____	8/2/2022

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
	after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00128706 and has two deficient practice statements. Deficient Practice #1 Based on observation, interview, and record review, the facility failed to maintain a clean, comfortable, homelike environment for 19 residents (R9, R26, R48, R61, R67, R68, R72, R87, R91, R92, R94, R98, R99, R108, R114, R121, R122, R126, and R135) whose room environment was observed, and 15 of 15 residents who attended the confidential resident council interview. Findings include: According to the facility's policy titled, "Housekeeping Guidelines" dated 3/8/2021, "...Housekeeping personnel shall adhere to daily cleaning assignments developed so to maintain the facility in a clean and orderly manner...The Administrator and Environmental Services Director will routinely make visual quality control observations to ensure that a high level of sanitation is maintained..." Resident #87 and #67		procedures. Laundry was in-serviced on personal clothing policy. 2 additional housekeepers, as well as 2 additional floorcare technicians were provided for daily support to help with the deep cleans and privacy curtain changes. Additionally, 2 new housekeepers started in the facility to provide daily cleaning. Administrator/designee will conduct random audits on 5 resident rooms weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure a comfortable and homelike environment specifically to cleanliness of resident room free of dirt/debris, and clean privacy curtains. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/2022 and for sustained compliance thereafter. Deficient Practice #2 Resident #39 clothing was found and labeled per the facility process on 8/19/22. Resident #68 SW followed up with resident regarding eyeglasses, resident was scheduled to be evaluated by the Optometrist on 8/16/22 in regard to evaluation for new eye glasses and declined, citing “I will see them another day”. This was documented. Resident was added to next scheduled visit for the Optometrist. Sw will continue to follow up with resident regarding his care needs.	

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 _____	8/2/2022

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
	On 7/26/22 at 9:47 AM, R87 and R67s floor was dirty, dull, and caked with debris and trash and was sticky. The privacy curtain between R87 and R67's bed was observed with a large tan colored stain. On 7/26/22 at 11:15 AM, the floor in R87 and R67's room remained dirty and sticky. Bags of dirty linens were observed on the bathroom floor along with multiple rags soaked with tan liquid. The privacy curtain remained stained. On 7/26/22 at 3:45 PM, the floor remained unmopped, dirty, and sticky in R87 and R67's room. The privacy curtain remained stained. An interview was attempted with R87. However, she was unable to answer questions regarding the condition of her room. On 7/27/22 at approximately 9:00 AM, R87 and R67's room remained in the same condition as it was during the prior day's observations. Resident #61 On 7/26/22 at 9:56 AM and 11:45 AM, R61's floor was observed to be dirty, dull, covered with debris and trash including straw papers and a plastic lid. The floor was sticky and appeared unmopped. The wall near the window was observed to have a large area of		All residents have the potential to be affected. The process for labeling residents clothing was not being utilized per the facility process. An audit was completed on all residents to ensure that residents clothing is labeled The facility has revised its process related to the safeguard of residents personal property. BY 8/22/22, The laundry staff were in-serviced on the personal clothing policy. By 8/25/22, facility staff will be educated by the Administrator/designee on the policy and procedure for Lost and found Policy specifically addressing process for tracking personal clothing for residents. Weekly audits of resident rooms will be completed by housekeeping manager. These audits will track personal clothing of 5 rooms per week. This will be done weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained	

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 _____	8/2/2022

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

tan substance dried onto it. The toilet in the bathroom had dried fecal matter on the seat. The trash can in the bathroom was filled to the top with trash. The privacy curtain between R61 and their roommate's bed was visibly stained in multiple areas.

On 7/26/22 at 2:20PM, R61's room remained dirty as mentioned above. The dried fecal matter remained on the toilet seat and the toilet was filled with feces. Room remained dirty, dried feces on toilet, toilet filled with feces. Tan splashed substance on wall.

On 7/26/22 at 3:39 PM, the dried fecal matter remained on R61's toilet seat and the floor remained dirty, sticky, and the trash and debris remained. The tan substance on the wall by the window remained. The privacy curtain remained stained.

On 7/27/22 at 9:15 AM, R61's room remained in the same condition as it did the previous day.

Resident #94 and #72

On 7/26/22 at 9:10 AM and 11:54 AM, R94 and R72's room was observed with a dirty, sticky floor covered with multiple trash items, including sugar packets and straw wrappers. The floor was covered with food crumbs and caked on debris which were observed toward the wall behind R94's bed and multiple areas of sticky brown and red colored substances. The molding was peeled from the corner of

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 _____	8/2/2022

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
	the wall near the bathroom. The headboard to R94's bed was hanging down on one side. R94 reported her room was not regularly cleaned and when the housekeeping staff came in, they did not do a thorough job. The floor next to R72's bed was sticky and dirty with debris. R72's closet was observed with built up dirt and debris in the metal tracking on the floor. A white powdery substance, trash, and food was observed underneath R72's night stand. The privacy curtain between R94 and R72's bed was visibly stained. On 7/27/22 at 9:10 AM, R94 and R72's room remained in the same condition as it was the previous day besides some crumbs were no longer present behind R94's bed. R94 reported housekeeping came into her room the previous day, but only quickly swept and did not mop. The handle to the call light in the bathroom was observed with built up dirt. A brown substance was observed on the bathroom floor. Resident #91 On 7/26/22 at approximately 10:15 AM, 11:35 AM, and 2:34 PM, R91 was observed lying in bed. The floor throughout the room appeared dirty, sticky, and dull. Brown stains were observed on the privacy curtain between R91 and his roommate's bed. R91 reported he was not sure if his room was cleaned and that he did not get out of bed.			

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 _____	8/2/2022

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
	On 7/27/22 at 11:10 AM, an interview was conducted with Floor Technician 'A' who explained he also helped out with housekeeping at times. Floor Technician 'A' reported resident rooms were cleaned daily and it included taking out trash, sweeping, and mopping which typically took about 25 minutes per room. Floor Technician 'A' reported they were short on housekeepers. At that time, the Assistant Director of Nursing (ADON 'B') was asked who was in charge of housekeeping and reported it was the District Manager of Environmental Services (EVS) 'D'. When queried about how often resident rooms were cleaned, ADON 'B' reported rooms were cleaned daily. On 7/27/22 at 11:22 AM, an interview was conducted with Housekeeping Manager 'C' who reported EVS 'D' was in charge, but was out of the building at that time. Observations were made of the rooms on the 2nd floor that had dirty floors that were sticky and with debris, the fecal matter on R61's toilet seat, and the stained privacy curtains. Housekeeping Manager 'C' reported EVS 'D' would have more information about what was going on. At that time, Housekeeper 'E' was interviewed. Housekeeper 'E reported there was typically two housekeepers for the second floor and that they worked from 7:30 AM until 3:30 PM. Housekeeper 'E' reported she typically had approximately 25 rooms that took approximately 20 minutes to clean each one (note that this equates to 8.33 hours to clean all 25 rooms, and			

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 _____	8/2/2022

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
	Housekeeper 'E' was only scheduled to work 8 hours). Housekeeping Manager 'C' acknowledged the facility did not have any housekeepers after 3:30 PM. When queried about who was responsible to change out the dirty privacy curtains, Housekeeping Manager 'C" reported she had to check with EVS 'D' and Housekeeper 'E' reported Floor Technician 'A' was in charge of changing the privacy curtains. At that time, Floor Technician 'A' was interviewed and reported he changed the privacy curtains when it was brought to his attention. On 7/28/22 at 9:15 AM, EVS 'D' was interviewed. When queried about how it was ensured that resident rooms were cleaned daily and thoroughly, EVS 'D' reported housekeepers completed a checklist and managers signed off that the tasks were completed. EVS 'D' confirmed there were no housekeeping staff after 3:30 PM. EVS 'D' further reported that his staff were in charge of laundry as well. When queried about privacy curtains, EVS 'D' reported curtains were a "monthly project" and they change out a certain amount each month. At that time, the checklists used by the housekeepers were requested for 7/26/22. Review of the checklist dated 7/26/22 provided by EVS 'D' revealed all cleaning tasks were documented as completed for the 2 West and 2 East Units as indicated by a check mark in the box that noted, "Check the box once finished cleaning resident room".			

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 _____	8/2/2022

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
	The form instructed to "Check off resident room immediately after it has been cleaned". However , the individual resident rooms were not checked off, only one box that indicated all of the rooms were cleaned. The form documented, "7:00 AM CLOCK IN Gather HSK (housekeeping) Cart and Supplies Needed, Complete morning walk thru (Identify and Fix: spills, odors, debris...2:45 PM Final walk through of unit...Identify and Fix: spills, odors, debris..." Note: As documented above, there were several rooms on the 2 West and 2 East units that were not cleaned on 7/26/22, as evidenced by them remaining in the same condition the following morning on 7/27/22. On 7/28/22 at 10:30 AM, a confidential interview was conducted with 15 residents who attend resident council meetings. During the interview, 15 of 15 residents expressed dissatisfaction with the cleanliness of the facility. One resident reported housekeeping did not clean their room thoroughly, sometimes they only emptied the trash can. Another resident reported someone came in to sweep the floor, but did not mop it. Multiple residents said bed linens were not changed when soiled or dirty and the same bed sheets were left on their bed for a month before anyone changed them. On 7/28/22 at 12:05 PM, the Administrator was interviewed regarding the cleanliness of the facility, specifically resident rooms. The Administrator reported housekeeping was identified as a concern in the building and			

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 _____	8/2/2022

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

they were changing leadership and a new EVS director was hired and has not started yet.

On 8/1/22 at 8:15 AM, an observation was made of the 2 West unit. Bloody gauze and a cotton ball with tape on it was observed underneath a medication cart located in the hallway. A glucose test strip and an orange and tan capsule of medication was observed on the ground in the hallway.

On 7/26/22 at approximately 9:28 AM, R114's room was observed to have debris all over the floor, the bathroom had dirt and debris covering the floor and dark feces/urine were covering the toilet seat. Nurse "O" who was working outside R114's room was interviewed as to housekeeping care, and reported that there was no employed housekeeper in the building for about two months.

On 7/26/22 at approximately 10:06 AM, R26 was observed to have heavily soiled privacy curtains with unidentifiable debris cover the curtain.

On 7/26/22 at approximately 10:24 AM, R121 and R122's room was observed to have debris all over the floor. Near R121 was a large pile of crusted tube feeding liquid near the resident's bed. R122 stated that R121 pulled out his tube feeding and everything spilled and they need to clean the floor. CNA "YY" was outside the resident's room and noted that she was aware the tube feeding was all over the floor and stated that nobody is cleaning residents' rooms.

On 7/26/22 at approximately 10:39 AM, R135's room was observed to have dirty debris on the floor and dirty linen covered in what appeared to be food and possible urine/feces. R135, who was

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 _____	8/2/2022

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

wearing a dirty shirt and pants stated nobody is cleaning his room and has not had his clothing washed.

On 7/26/22 at 10:39 AM, R98's room was observed to have a dried substance on the flooring near the urinary catheter drainage bag; the bedside dresser handles were broken and hung down; and the privacy curtain was heavily soiled with dark stains.

On 7/26/22 at 10:47 AM, R68's room was observed to have multiple dried tan-colored stains throughout the area surrounding the resident's bed; and the privacy curtain was heavily soiled with dark stains.

On 7/26/22 at 11:01 AM, R9's room was observed to have multiple debris on the floor throughout the area surrounding the resident's bed; and the privacy curtain was heavily soiled with dark stains.

On 7/26/22 at 11:03 AM, R99's room was observed to have a heavily soiled privacy curtains.

On 7/26/22 at 11:18 AM, 1:29 PM and 7/27/22 at 11:00 AM, R108's room was observed to have multiple unidentifiable debris scattered on the floor throughout the room.

On 7/26/22 at 11:37 AM, R126's room was observed to have a heavily soiled privacy curtain which were red and yellow in color.

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 _____	8/2/2022

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
	On 7/26/22 at 11:40 AM, R92's room was littered with wrappers/trash on the floor throughout the room. On 7/26/22 at 11:46 AM, R48's door facing the hallway was observed to have a dark brown fecal-like substance smeared on the left bottom portion of the door (at knee height). Deficient practice #2 Based on observation, interview, and record review, the facility failed to protect resident's property from loss for two (R68 and R39) of three residents reviewed for personal property. Findings include According to the facility's policy titled, "Lost and Found" dated 7/11/2018, "...Resident or family complaints of missing items must be reported to the Administrator...Reports of misappropriation or mistreatment of resident property are immediately investigated." R68: On 7/26/22 at 10:47 AM, an interview was conducted with R68. When asked about whether there were any concerns with their personal belongings, R68 became upset and stated somebody stole their reading glasses. During this interview, Staff 'KK' entered the room and R68 began to ask the resident if they could read the daily times. R68 asked Staff 'KK' where their glasses were and Staff			

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 _____	8/2/2022

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
	'KK' stated to the resident "Remember last time we couldn't find them?". Staff 'KK' was asked when they first became aware of R68's missing glasses and they reported it was last week. When asked if anyone had been informed of R68's missing glasses and concerns somebody stole them, Staff 'KK reported they had looked in the resident's drawers (dresser) and let the nurse aides know but still couldn't find them. Staff 'KK' offered to provide the resident with an extra pair they had but R68 stated they wanted their own glasses that they had. On 7/28/22 at 10:28 AM, an interview was conducted with Social Services (Staff 'Q') who reported they assisted with social work at the facility a few times a week, but was from another facility. When asked if they had any grievance/concern forms for R68, Staff 'Q' ' reported that they would follow up. On 7/28/22 at 11:25 AM, Staff 'Q' reported they had followed up with Social Service Tech (Staff 'G'), the Administrator and the Director of Nursing (DON) and none of them had been aware of R68's concern about missing reading glasses. Staff 'Q' further reported they had initiated a grievance form and would have resident re-evaluated for new glasses. When informed of the earlier discussion with Staff 'KK' that the glasses had been allegedly missing for a week and whether that should've been reported at the time it was identified, Staff 'Q' reported they reported they were not aware of that and			

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 _____	8/2/2022

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

would follow up.

On 7/28/22 at 11:35 AM, the Administrator was asked about R68's missing glasses and reported they had just spoke to Staff 'Q' and had not heard of that before now. When informed of the concern that this had been discussed earlier with Staff 'KK' who had reported they were aware about a week ago, and again on 7/27/22, the Administrator reported they should have been notified immediately.

Resident #39

On 7/26/22 at approximately 10:35 a.m., R39 was observed in their room, laying in their bed. R39 was observed to be in a brief without any clothing on. R39 was queried if they had any concerns regarding their care and they indicated they have not had any clothes since they were sent down to the laundry room be washed around a month ago. R39 indicated the facility had lost their clothes. R39's closet was observed to contain no clothing. R39 was observed only with a gray sweatshirt on a chair next to their bed.

On 7/27/22 at approximately 11:29 a.m., R39 was observed in their room laying in their bed. R39 was now observed to have one pair of pants, one fleece shirt, one t-shirt and the same gray sweatshirt on their chair next to the bed. R39 indicated that they had informed the Nurse Manger (Nurse Manager "RR") about their missing clothes over a week

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 _____	8/2/2022

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

ago and that the facility had found some "donated clothes" that were not his to hold him over until they had located their lost clothing.

On 7/28/22 at approximately 12:02 p.m., R39 was observed in their room, laying in their bed. R39 was still observed with one pair of pants in their room and the same clothes in the closet. R39 indicated that the facility had yet to find his lost clothing and none of the clothes were his that were in the closet.

On 7/27/22 the medical record for R39 was reviewed and revealed the following: R39 was initially admitted to the facility on 5/20/22 and had diagnoses including Adult Failure to thrive and Type two diabetes. A review of R39's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/23/22 revealed R39 needed supervision from facility staff with dressing. R39's BIMS score (brief interview of mental status) was 15 indicating intact cognition.

On 7/28/22 at 12:07 p.m., Nurse Manager "RR" (NM "RR") was queried regarding R39's missing clothing. NM "RR" indicated that R39 had reported his missing clothes last week and nothing of his had been found. NM "RR" reported that R39 had informed them that they had been missing the clothing for about a month.

On 7/28/22 at approximately 1:41 p.m., Environmental Services Manager "D" (ESM

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 _____	8/2/2022

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
	"D") was queried regarding R39's missing clothes and they Indicated that they had just located R39's missing clothing. ESM "D" reported R39's clothing was in the laundry room in an unlabeled bag that had been taken down there. ESM "D" was queried regarding the process for ensuring residents receive their clothing after it has been sent down to laundry to be washed and ESM "D" indicated that the bags of soiled clothing should have been sent down with a paper on it indicating who's clothing it was so that it could be properly labeled and returned. ESM "D" was queried why R39's clothing wasn't labeled per the facility's process and they indicated they did not know but the process was not followed as there was no paper attached to bag of clothing to be labeled so nobody knew who's clothing it was. On 8/2/22 a facility document titled "Lost and Found" was reviewed and revealed the following: "POLICY: It is the policy of this facility that the facility shall assist all personnel and residents in safe-guarding their personal property...6. Resident or family complaints of missing items must be reported to the Administrator..." Further review of the document did not contain instructions on how and when to label residents clothing to avoid misplacing it.			
F0585 SS= D	Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other	F0585	F585 Grievance Resident #102 no longer resides in the facility.	8/29/2022

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 _____	8/2/2022

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
	agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is		Resident #68 SW followed up with resident regarding eyeglasses, resident was scheduled to be evaluated by the Optometrist on 8/16/22 in regard to evaluation for new eye glasses and declined, citing I will see them another day. This was documented. Resident was added to next scheduled visit for the Optometrist. Sw will continue to follow up with resident regarding his care needs. All residents have the potential to be affected. Residents who are able to be interviewed were interviewed about any care concerns/grievances by Social Services and/or designee on or before 8/25/22. Family member/responsible party for those residents who are not able to participate in the interviews were contacted about any care concerns/grievances per Social Services on or before 8/25/22 and/or designee Identified concerns/grievances were addressed and followed up on according to facility□s Grievances Policy. The process for addressing grievances/concerns have been reviewed/modified as it relates to providing adequate and timely response to resident concerns expressed during weekly resident council meetings. The Facility has begun reviewing previous weeks resident council minutes at start of meeting to ensure resident satisfaction with new process in place of having residents sign off on concerns mentioned as an indication that they satisfied with resolution. We then address any new concerns and ensure proper follow up occurs. Grievances will be reviewed daily to ensure proper follow up occurs. Residents have expressed that they would like the involvement of different interdisciplinary team members attending meeting depending on nature of concern and when invited. Facility	

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 _____	8/2/2022

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
	responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of		Administrator will help bridge this request from residents and ensure proper leadership are attending meetings week over week as well as addressing concerns timely. The Administrator has been invited to all Resident Council meetings by the resident council until otherwise indicated by the Resident Council to ensure that any concerns/grievances are promptly documented, investigated and resolved per facility grievance policy. Resident Council minutes will be reviewed to ensure concerns and/or grievances have been followed up on per Grievance Policy by Social Services and/or Administrator. The Administrator/designee will review all grievances/concerns during AM meeting to ensure that all grievances/concerns are investigated, documented and followed up in a timely manner. By 8/25/22, facility staff will be educated by the Administrator/designee on the facility□s Grievance Policy to ensure resident/family/responsible party□s concerns/grievances are reported, tracked, documented, thoroughly investigated with appropriate response and resolution timely. Administrator/Designee will randomly interview 5 residents and 2 family/responsible party weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure adherence to the facility□s Grievance Policy, specifically prompt documentation, investigation, and resolution of grievances. The results will be presented to the QAA committee for review and consideration of further corrective actions.	

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 _____	8/2/2022

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
	responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00129602. Based on interview and record review the facility failed to ensure that grievances were promptly documented, investigated, and resolved for two residents (R102 and R68) of two residents reviewed for grievances. Findings include: Resident #102 On 7/26/22 a concern submitted to the State Agency was reviewed which indicated that R102 was sent out on a Dermatology appointment on 6/15/22 without the appropriate tracheostomy (trach) equipment including oxygen and a trach mask and that the Director of Nursing (DON) was made of the concern. On 7/26/22 at approximately 12:06 p.m., R102 was observed in their room with a trach collar. R102 was observed to have cool mist infusing via trach mask. On 7/27/22 at approximately 3:39 p.m., R102 was observed in their room laying in their bed, with trach collar on. R102 was observed to have the cool mist infusing. Suctioning		The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22 and for sustained compliance thereafter.	

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 _____	8/2/2022

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
	equipment was observed at the bedside. On 7/26/22 the medical record for R102 was reviewed and revealed the following: R102 was initially admitted to the facility on 8/1/19 and had diagnoses including Chronic respiratory failure with hypoxia, Tracheostomy and Anoxic brain damage. A review of R102's (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/30/22 and was dependent on staff for their activities of daily living. R102's cognition was documented as severely impaired. On 7/27/22 at approximately 3:49 p.m., The DON was queried regarding their knowledge of the concern pertaining to R102 being sent on an appointment without their trach mask. The DON indicated they were aware of the concern, but did not remember who had informed them of it. At that time, the DON was queried for any grievance/concern forms for the concern pertaining to R102. On 8/01/22 at approximately 12:56 p.m., The facility Administrator was queried regarding the grievance form for R102 regarding being sent out to an appointment without the appropriate trach supplies. The Administrator Indicated they did not have one. The Administrator was queried if a concern about R102 being sent on an appointment without tracheostomy supplies should have been placed on a grievance form and investigated and they indicated it should have.			

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 _____	8/2/2022

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
	On 8/01/22 at approximately 10:52 a.m., The DON was queried regarding the grievance investigation of the concern regarding R102. The DON indicated that the resident was not on oxygen but is provided a cool mist while they are at the facility with a trach mask. The DON indicated that the mist is not required to go out on an appointment. The DON was queried again for the concern/grievance form pertaining to the investigation around the concern and they indicated they were still looking for one. On 8/01/22 at approximately 2:14 p.m., The DON was queried again regarding R102's concern regarding their appointment and being sent without the and trach mask being provided for the appointment. The DON reported that she had talked to the Nurse on duty that day and that the trach collar was on R102 when they went to the appointment but was sent without the trach mask because R102 was not on oxygen and just on the mist while at the facility. The DON was queried regarding the investigation documentation pertaining to the concern and the follow-up with the complainant and they indicated that no grievance form was initiated. The DON was queried regarding the grievance process and they indicated that upon learning of the concern, the grievance/concern form should have been started and the investigation documented on the form. R68:			

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 _____	8/2/2022

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
	On 7/26/22 at 10:47 AM, an interview was conducted with R68. When asked about whether there were any concerns with their personal belongings, R68 became upset and stated somebody stole their reading glasses. During this interview, Staff 'KK' entered the room and R68 began to ask the resident if they could read the daily times. R68 asked Staff 'KK' where their glasses were and Staff 'KK' stated to the resident "Remember last time we couldn't find them?". Staff 'KK' was asked when they first became aware of R68's missing glasses and they reported it was last week. When asked if anyone had been informed of R68's missing glasses and concerns somebody stole them, Staff 'KK reported they had looked in the resident's drawers (dresser) and let the nurse aides know but still could not find them. Staff 'KK' offered to provide the resident with an extra pair they had but R68 stated they wanted their own glasses that they had. On 7/28/22 at 10:28 AM, an interview was conducted with Social Services (Staff 'Q') who reported they assisted with social work at the facility a few times a week, but was from another facility. When asked if they had any grievance/concern forms for R68, Staff 'Q' ' reported that they would follow up. On 7/28/22 at 11:25 AM, Staff 'Q' reported they had followed up with Social Service Tech (Staff 'G'), the Administrator and the Director of Nursing (DON) and none of them had been aware of R68's concern about missing			

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 _____	8/2/2022

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
	reading glasses. Staff 'Q' further reported they had initiated a grievance form and would have resident re-evaluated for new glasses. When informed of the earlier discussion with Staff 'KK' that the glasses had been allegedly missing for a week and whether that should have been reported at the time it was identified, Staff 'Q' reported they reported they were not aware of that and would follow up. On 7/28/22 at 11:35 AM, the Administrator was asked about R68's missing glasses and reported they had just spoke to Staff 'Q' and had not heard of that before now. When informed of the concern that this had been discussed earlier with Staff 'KK' who had reported they were aware about a week ago, and again on 7/27/22, the Administrator reported they should have been notified immediately, especially as they were the facility's grievance officer. According to the facility's policy titled, "Lost and Found" dated 7/11/2018, "...Resident or family complaints of missing items must be reported to the Administrator...Reports of misappropriation or mistreatment of resident property are immediately investigated."			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including	F0609	F Tag 609 Reporting of Alleged Violations Resident #68, the allegation of abuse was reported by the administrator on 8/1/22 to the appropriate state agencies. Social Services completed a psychosocial follow up with no	8/29/2022

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 _____	8/2/2022

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
	injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c) (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report allegations of physical abuse to the Administrator for one (R68) of seven residents reviewed for abuse. Findings include: According to the facility's policy titled, "Abuse and Neglect" dated "Revised 6/17/2019", "...Physical abuse includes but not limited to infliction of injury that occur other than by accidental means. Examples: hitting, slapping, kicking, squeezing,		further concern identified. The investigation was closed by the State on 8/9/22. All residents in the facility have the potential to be affected. An audit which consisted of interviewing all alert and oriented residents to identify any allegations of abuse and neglect or concerns with care/treatment from staff was completed on or before 8/25/22 to ensure all allegations of abuse and neglect have been reported timely to the administrator/designee and appropriate state agencies. The facility Administrator will assigned the interdisciplinary team resident rooms and have them conduct daily rounds on residents with emphasis on ensuring residents feel safe in facility and are free from abuse. Any areas of concerns will be brought immediately to the Administrator who is the Abuse Coordinator to investigate/report per state guidelines. By 8/25/2022, the facility administrator and DON will be educated by the regional director of operations on Abuse and Neglect policy, specifically on the reporting guidelines and timeframes. The administrator will educate the physicians to ensure timely reporting of any allegation of abuse immediately to the administrator per the policy. By 8/25/22, staff will be educated on the Abuse and Neglect policy specifically to ensure resident allegation are immediately reported to the Administrator. The Administrator/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure resident	

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 _____	8/2/2022

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
	grabbing, pinching, punching, poking, twisting, roughly handling...All allegations and/or suspicions of abuse must be reported to the Administrator immediately...All allegations of abuse will be reported to the appropriate State Agencies immediately after the initial allegation is received..." Review of R68's progress notes included: On 7/7/22 at 4:58 PM, an entry from Nurse Practitioner (NP 'M') read, "...Pt (patient) reports head pain secondary to being beat in the head with a club..." On 7/28/22 at 2:56 PM, an entry from NP 'M' read, "...Pt is currently on Invega, Haldol and Depakote for schizoaffective disorder with severe disconnect from reality...Pt reports that he was beaten x 2 days ago and his arms and legs were broken during the assault. Pt in bed smiling, laughing, and eating breakfast prior to exam..." There was no further documentation that these allegations had been reported to the Administrator (who was also the Abuse Coordinator) or the State Agency, and investigated to rule out abuse. Further review of the clinical record the resident was admitted into the facility on 5/4/17 and readmitted on 12/13/21 with diagnoses that included: chronic obstructive pulmonary disease, delusional disorders, unspecified dementia with behavioral		allegations of abuse and neglect are immediately reported to the Administrator and reported to the appropriate state agencies timely. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/2022 and for sustained compliance thereafter. The results will be presented to the QAA committee for review and consideration of further corrective actions.	

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 _____	8/2/2022

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

disturbance, and schizoaffective disorder bipolar type.

According to the Minimum Data Set (MDS) assessment dated 6/8/22, R68 had intact cognition, had no communication concerns, delusions, hallucinations, or behavioral symptoms during this review period of seven days.

According to the Social Service Review Assessment dated 6/29/22, had paranoia, and other "Resident has history of making false statement of things not true and things that are not presently happening...consult/treat with intervention as needed Continue Medication Regimen to stabilize Psychosis and Improve Mood, resident is due to be seen".

On 8/1/22 at 1:55 PM, NP 'M' was interviewed by phone. When asked about their documentation of R68's abuse allegations, NP 'M' reported they had taken care of R68 for six years and their psychosis was constant. When asked when residents make allegations of abuse, what should be done, NP 'M' reported the Administrator should be notified. When asked if they did that for R8, NP 'M' reported they did not report every time but they had never seen the resident stable on medication, therefore had delusions every time they were seen.

On 8/1/22 at 2:26 PM, an interview was conducted with the Administrator (who is

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 _____	8/2/2022

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
	also the Abuse Coordinator). When asked about how their practitioners were trained on reporting abuse allegations, the Administrator reported they should be educated as well. When asked if they were informed of any allegations of physical abuse in the past month or so regarding R68, they reported "No". At that time, upon review of NP 'M's progress notes, the Administrator reported they were not informed of those allegations and should have been. The Administrator was informed that although R68 had a history of psychosis and delusions, the concern remained that R68 was at an increased risk of abuse because of this. On 8/2/22 at 8:40 AM, the Medical Director (Physician 'V') requested to speak to the survey team regarding R68. Physician 'V' reported the resident had active psychosis on a daily basis and was asking about the reporting of every delusional allegation. The regulatory requirements were reviewed and also discussed concerns that although R68's allegations may be delusions; they may also be true and were at an increased risk for being subjected to abuse.			
F0645 SS= E	PASARR Screening for MD & ID §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health	F0645	Resident #9 has an updated 3877/3878 that was reviewed, revised and sent to the local state agency for review and/or evaluation. Resident #17 has an updated 3877/3878 that was reviewed, revised and sent to the local state agency for review and/or evaluation.	8/29/2022

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 _____	8/2/2022

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
	authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility		Resident #47 has an updated 3877/3878 that was reviewed, revised and sent to the local state agency for review and /or evaluation. Resident #68 has an updated 3877/3878 that was reviewed, revised and sent to the local state agency for review and or/evaluation. Resident #91 has an updated 3877/3878 that was reviewed, revised and sent to the local state agency for review and/ or evaluation. All residents in the facility have the potential to affected An audit was completed on or before 8/25/22 to ensure that residents that have the appropriate mental medical diagnosis and reside in the facility for more than 30 days, receive their 3878, and that 3877/3878 documents are current, reviewed, revised and sent to the local state agency for review and/or evaluation. In addition, facility has designated a nurse to assist in ensuring PAASAR are followed through timely so that residents can receive the necessary care and services appropriate to meet their mental health needs. Upon admissions, the facility SW and/or designee will also review all new admissions and readmissions to facility to ensure if there is a mental illness that PASSAR is completed and timely s to OBRA. Residents PASSAR will be reviewed quarterly by SW and/or designee to ensure compliance. Any areas of concern will be addressed and followed up on as needed. Administrator/Designee will educate Social Services by 8/25/22 on ensuring that residents that have the appropriate mental medical diagnosis and reside in the facility for more than 30 days, receive their 3878 and that PASARR documents are reviewed,	

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 _____	8/2/2022

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
	services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure "Preadmission Screening (PAS)/Annual Resident Review (ARR) Mental Illness/Intellectual Disability/Related Conditions Identification (forms DCH-3877 and/or DCH-3878) documents were reviewed, revised, and sent to the local state agency for review and/or evaluation for five (R9, R17, R47, R68, and R91) of six residents reviewed for PASSARs. This deficient practice resulted in the potential for residents to be excluded from receiving necessary care and services appropriate to meet their mental health needs. Findings include: R9 Review of R9's clinical record revealed the resident was admitted into the facility on 1/1/20 and readmitted on 8/21/21 with diagnoses that included: hallucinations and		revised and sent to the local health agency for review and/or evaluation. Administrator/Designee will randomly audit 5 residents for PASARR Screening weekly X 4 weeks then monthly thereafter X 3 months or until substantial compliance has been maintained by ensuring that residents that have appropriate mental medical diagnosis and or 3877/3878 documents are reviewed, revised, and sent to the local state agency for revie and/or revaluation. The results will be presented to the QAA committee for review and consideration of further corrective actions. The administrator is responsible for ensuring and maintaining substantial compliance Date of Compliance: 8/29/22	

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 _____	8/2/2022

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
	major depressive disorder recurrent moderate. Review of the Minimum Data Set (MDS) assessment dated 4/21/22 documented R9 had intact cognition and received antidepressant and antianxiety medication for seven of seven days during this review period. Review of the most recent available DCH-3877 (PASARR Level 1 Screening form) completed by the facility on 12/24/2020 revealed R9 had a current diagnosis of mental illness (indicated by Yes being checked). The form instructed to explain any section marked "Yes" and further documented under the explanation section, "DX: (diagnosis) Major Depressive D/O (Disorder) RX (Prescriptions) 0". The form also documented, "Note: The person screened shall be determined to require a comprehensive Level II OBRA evaluation if any of the above items are "Yes" UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria..." There was no exemption documented for R9 and there was no evidence that a level II evaluation had been completed by community mental health. Additionally, the instructions on the DCH-3877 form also identified for screening that this form must be completed by the nursing facility annually or with a change in condition and screening criteria included receipt of treatment for mental illness or dementia			

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 _____	8/2/2022

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

within the past 24 months including referral for psychiatric consultation, evaluation, or prescription of psychopharmacological medications, including antidepressant and antipsychotic medications.

Review of R9's current physician orders revealed they were prescribed an antipsychotic medication (Risperidone) from 6/8/22 to 6/15/22 and was currently receiving an antidepressant (Duloxetine HCl) since 8/22/21.

On 7/27/22 at 10:53 AM, Social Service Tech (Staff 'G') was asked to provide any documentation that a level II evaluation had been completed, or a revised DCH-3877 form had been done since 12/24/20. Staff 'G' reported they had identified concerns with this process and needed to have someone reassigned in the electronic system which they now have as of today and identified MDS Nurse 'DD'.

On 8/1/22 at 11:50 AM, Social Worker (Staff 'Q') provided documentation for R9 of the same DCH-3877 form dated 12/24/20 and reported a new DCH-3877 form was completed today and sent to (name of local mental health) for consideration of a level II evaluation.

R68:

Review of R68's clinical record revealed the resident was admitted into the facility on

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 _____	8/2/2022

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
	5/4/17 and readmitted on 12/13/21 with diagnoses that included: delusional disorders and schizoaffective disorder bipolar type. Review of the MDS assessment dated 6/8/22 documented R68 had intact cognition and received antipsychotic and antidepressant medication for seven of seven days during this review period. Review of the most recent available OBRA Level II Evaluation dated 3/27/2020 documented, "...The individual may continue to reside in a nursing facility and may choose to receive specialized mental health/developmental disabilities services...If the above-named individual remains in the nursing facility, a Level II Evaluation is needed by March 26, 2021..." Review of the recommendations from the Level II evaluation dated 3/27/2020 included: "...(R68) has a lengthy history of severe and persistent mental illness including a history of delusions, auditory, and visual hallucinations. He has required inpatient psychiatric care and had been receiving mental health services from (contracted mental health company) since admitted in 2017. (R68) will benefit from close and frequent monitoring of his psychotropic medications and mood and thought process. It is recommended that the consumer remain in the nursing facility where he has been since 2017...Continue to provide mental health services, daily and prn orientation...Continue with long term care...It			

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 _____	8/2/2022

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

is recommended that (R68) continues to be followed by (contracted mental health company) for medication review and for psychotherapy. It is also recommended that the facility social worker and staff monitor for any changes in mood or behaviors to refer for follow up as needed..."

Further review of the clinical record revealed although R68 remained in the facility, there was no other Level II Evaluation completed. There was a dementia exemption completed by a former social worker on 6/1/21 which noted R68 had dementia, paranoid schizophrenia and received an antipsychotic and antidepressant medication. There was no evidence this had been submitted for consideration of a Level II Evaluation.

Resident #91

Review of R91's clinical record revealed R91 was admitted into the facility 8/6/21 and admitted on 6/15/22 with diagnoses that included: schizoaffective disorder. Review of a MDS assessment dated 6/20/22 revealed R91 had intact cognition and was prescribed antipsychotic medications.

Review of R91's level one PASAAR Level 1 Screening form completed in the hospital prior to admission to the facility, dated 8/3/21, revealed R91 had a current diagnosis of mental illness (indicated by Yes being checked) and routinely received one or more prescribed antipsychotic medications within

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 _____	8/2/2022

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
	the past 14 days. It was also documented there was "presenting evidence of mental illness...including significant disturbances in thought, conduct, emotions, or judgment..." The form instructed to explain any section marked "Yes" and revealed the following documentation: "Schizoaffective disorder, bipolar type. On meds Zyprexa (an antipsychotic medication)". The form documented, "Note: The person screened shall be determined to require a comprehensive Level II OBRA evaluation if any of the above items are "Yes" UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria..." There was no evidence that a Level II OBRA evaluation or DCH-3878 (exemption form) was completed for R91. R47 A review of R47's clinical record documented that the resident was admitted to the facility on 9/5/19 with diagnoses that included: bipolar disorder, vascular dementia with behavior and alcohol dependent. Continued review of R47's clinical record noted last completed PASARR document(s) (3877/78) was documented as 12/2020. There was no further documentation in the resident's record. SW "Q" was interviewed on 7/28/22 at approximately 3:52 PM. When asked if there was any updated annual PASARR documentation for			

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 _____	8/2/2022

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

R47, she responded that there was not.

Resident #17

On 7/26/22 The medical record for R17 was reviewed and revealed the following: R17 was initially admitted into the facility on 5/4/22 and had diagnoses including Anxiety Disorder and Schizoaffective disorder. A review of R17's MDS (minimum data set) with an ARD (Assessment Reference Date) of 5/7/22 revealed R17 needed assistance from facility staff with their activities of daily living.

A review of R17's level one PASARR/OBRA form (form DCH-3877) from the hospital dated 5/2/22 indicated R17 had no mental illness or was ordered any psychotropic medications. Further review of the record did not reveal any updated 3877 forms reflecting R17 diagnoses of Schizoaffective disorder or Anxiety disorder. No level two assessments were observed in the medical record.

On 7/28/22 at approximately 11:24 a.m., R17's medical record was reviewed with Social Worker "Q" (SW "Q"). SW "Q" was queried why R17 did not have an updated level one screening reflecting her mental illnesses and they indicated they did not know but that one should have been updated and sent in to the local Community Mental Health Services Program (CMHSP) for a level two evaluation due to their diagnosis of schizoaffective disorder and Anxiety disorder.

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 _____	8/2/2022

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
	According to the documentation provided by the facility regarding their process for PASARRs, there was no actual policy provided, only the revised state process for electronic system for PASARR completion from August 2021, and the actual DCH-3877 and DCH-3878 forms.			
F0656 SS= D	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and	F0656	F656 Development/Implement Comprehensive Care Plan Resident #R6 medical record was updated by the Nurse Practitioner on or before 8/22/2022 and care plan updated to reflect changes. All residents residing in the facility have the potential to be affected. On or before 8/15/22, a skin sweep on all residents was completed by the treatment nurse. Any abnormal skin findings were addressed which included documentation and care plan reviewed and/or revised as needed. The treatment nurse/designee will assess residents skin upon admission/readmission to the facility and as needed and ensure that any resident with chronic/acute skin condition are care planned accordingly. Any new documentation/diagnosis completed by the residents physician regarding resident skin will be updated in the residents care plan. The facility will continue to monitor the status of resident skin through weekly skin assessments completed by the charge nurses and as needed. By 8/25/22, Licensed nurses and CENAS will be in serviced on the Skin Management Program/policy to ensure that residents with skin conditions have appropriate documentation and care plan developed/updated to reflect the resident□s current status. The DON/designee will conduct random	8/29/2022

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 _____	8/2/2022

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
	potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan to address chronic and severe ecchymosis (bruising) to the upper and lower extremities for one (R6) of 35 residents reviewed for care plans. Findings include: On 7/26/22 at 2:23 PM, R6 was observed being pushed in a geriatric chair by Staff 'XX'. Both of R6's arms were observed to have very dark purple discolorations that covered the lower and upper arms extending toward the shoulders. Staff 'XX' was queried about the discolorations and stated, "It's always like that." An interview was attempted with R6, but R6 was not able to answer questions regarding her arms. On 8/1/22 at 8:20 AM, Registered Nurse (RN) 'N' was interviewed and R6's arms were observed. RN 'N' reported he was not assigned to the resident and was not sure about the discoloration and would look into it.		audits/skin observations on 5 residents weekly x4 then monthly thereafter times 3 months or until substantial compliance is attained and maintained to ensure that residents identified with skin conditions are documented with care plan developed/revised to reflect the resident□s current status. The results of these audits will be presented to the QAA committee for review and consideration of further corrective actions monthly. The DON/designee will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22, and for sustained compliance thereafter	

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 _____	8/2/2022

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

Review of R6's clinical record revealed R6 was admitted into the facility on 4/15/22 with diagnoses that included: peripheral vascular disease and type 2 diabetes mellitus. Review of Minimum Data Set (MDS) assessment dated 4/18/22 revealed R6 had severely impaired cognition and required extensive physical assistance for bed mobility, transfers, and all activities of daily living.

Review of Skin Assessments from 7/9/22 to 7/26/22 revealed no documentation of discoloration to R6's arms.

Review of Nurse Practitioner, Physician, and Nursing progress notes revealed no documentation of discoloration to R6's arms.

On 8/1/22 at 8:45 AM, an observation of R6's skin was conducted with the Director of Nursing (DON). Both arms were observed to have large areas of very dark purple discoloration which extended to the shoulder area. Both shins were observed to have dark purple solid discoloration that extended from below the knees to above the ankles. When queried about the cause of the discoloration to R6's upper and lower extremities, the DON reported she would look into it.

On 8/1/22 at approximately 10:15 AM, the DON reported the Medical Director (Physician 'V') was familiar with R6 from a stay at a sister facility and that the resident always had the discoloration. The DON

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 _____	8/2/2022

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
	reported R6 was admitted with the discoloration and provided the following: A "Medical Practitioner Progress Note" dated 7/27/22 that documented, "...SKIN: chronically discolored over BLE (bilateral lower extremities), areas of chronic ecchymosis..." Review of R6's care plans revealed a care plan that addressed R6's risk for skin alterations, but did not address the discoloration to R6's upper and lower extremities. On 8/1/22 at 10:30 AM, NP 'M' was interviewed. When queried about the dark purple discoloration that covered R6's arms and legs, NP 'M' reported she had "chronic ecchymosis. What that means, I don't know." NP 'M' explained R6 has always had the discoloration, but the cause of it was unknown. NP 'M' further explained R6's daughter reported R6 always had thin skin and bruised easily. When queried about whether the discoloration was the same, worse, or improved since admission, R6 reported she was unsure. When queried about what the nursing staff should be monitoring to determine if it worsened or when to contact a practitioner and if there were any interventions in place to prevent it from worsening, NP 'M' reported she was not sure. On 8/1/22 at approximately 11:10 AM, an interview with the DON was conducted.			

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 _____	8/2/2022

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
	When queried about any interventions that were in place to monitor R6's severe ecchymosis to the arms and legs or to protect her skin, the DON reported it should have been reflected in the care plan. The DON reported there was nothing in the care plan and there should have been. On 8/2/22 08:56 AM, Physician 'V' was interviewed. When queried about the ecchymosis to R6's arms and legs, Physician 'V' reported it was a chronic issue, but the cause was unknown. Physician 'V' reported the medical record should have reflected R6's condition.			
F0677 SS= E	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: This citation pertains to intake MI00129703. Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADLs) including shaving, bathing, dressing, and nail care for four (R17, R91, R98, and R108) of seven residents reviewed for ADLs, resulting in an unwanted beard, long fingernails, and dry/flaky skin. Findings include:	F0677	F 677 ADL Care Provided for Dependent Residents Resident #9 had his ADLs attended to including grooming/shaving. Resident #98 no longer resides at the facility. Resident #108 had his ADLs attended to including dressing, grooming/shaving and incontinence care. Resident # 17 had ADLs attended to, including bathing, grooming and incontinence care. All residents who reside in the facility are at risk for a similar occurrence. On or before 8/22/2022, All residents were visually assessed to determine if additional ADLcare was needed, including shaving, grooming, dressing and bathing. Additional	8/29/2022

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 _____	8/2/2022

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
	Resident #91 On 7/26/22 at 11:35 AM, R91 was observed lying in bed with a full, shaggy, white beard. When queried about his preference to have a beard, R91 reported he liked to be clean shaven. R91 reported he was able to shave himself with a personal electric razor. However, the razor needed to be cleaned out from hair build up and be recharged. R91 reported the staff say they will clean the razor but they never do. When queried about whether staff had offered another way to shave, R91 reported they had not. On 7/27/22 at 9:14 AM, R91 was observed lying in bed. A full beard remained on his face. R91 expressed that he would really like to shave, but he cannot use his razor due to buildup of hair. R91 reported staff have not offered to assist with shaving. Review of R91's clinical record revealed R91 was admitted into the facility on 8/6/21 and readmitted on 6/15/22 with diagnoses that included: pneumonia, chest pain, and leukemia. Review of a Minimum Data Set (MDS) assessment dated 6/20/22 revealed R91 had intact cognition and required extensive physical assistance with personal hygiene. On 7/27/22 at 2:40 PM, an interview was conducted with Certified Nursing Assistant (CNA) 'H'. When queried about when		ADL care was provided to any resident requiring it. The DON/Unit Managers will provide visual rounding and focus oversight of the nursing staff to ensure that residents activities of daily living are completed for all residents. Clinical alerts on the electronic medical record dashboard will be reviewed daily to ensure any triggered areas of concerns are addressed immediately. By 8/25/22, certified CNAs and Licensed nurses will be educated on ensuring the activities of daily living for residents with focus on all areas, including bathing, grooming and personal hygiene are met per facility policy as scheduled/needed. The DON/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents activities of daily living, including, but not limited to bathing, grooming and personal hygiene are provided to the residents as scheduled/needed. The results of the ADL audits will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22and for sustained compliance thereafter.	

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 _____	8/2/2022

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
	residents were assisted with shaving, CNA 'H' reported they were shaved as often as they needed it. When queried about R91's beard, CNA 'H' reported he was able to shave himself with a personal electric razor. On 7/27/22 at 2:48 PM, an observation of R91's electric razor was conducted with CNA 'H'. CNA 'H' pointed to where the razor and charger were located and R91 stated, "It won't work because it's dirty and needs to be cleaned." CNA 'H' told R91 that she did not know how to clean it. R91 became tearful and explained that he was not able to clean it himself and needed help cleaning it because he wanted to be shaved. The razor, when opened, was observed to be clogged with hair. On 7/27/22 at 4:22 PM, R91 remained with a full beard. R91 reported the razor was not cleaned and he really wanted to be shaved. When queried about whether anyone had ever assisted him with a non-electric razor, R91 reported a nurse helped once and if he cannot use the electric razor, he would like staff to assist another way. On 8/1/22 at 10:41 AM, the Director of Nursing (DON) was interviewed. When queried about when staff should assist residents with shaving, the DON reported on shower days or as needed. When queried about R91 not being able to use his electric razor and having a full, scruffy beard which was not his preference, the DON reported			

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 _____	8/2/2022

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

staff should have offered assistance to shave another way.

R98

On 7/26/22 at 10:39 AM, R98 was observed lying in bed and appeared to be sleeping. They were lying in bed with their entire upper torso exposed and appeared very sweaty. Upon approach, the resident appeared extremely debilitated with severely contracted bilateral hands/wrists. The fingernails on both hands were observed to be very long and extended about ¼ inch past the fingertips. R98 did not open their eyes, but exhibited jerking/twitching movements.

On 7/26/22 at 1:41 PM, and 7/28/22 at 8:15 AM, R98's fingernails on both hands remained long in length.

On 7/28/22 at 8:20 AM, Nurse 'DD' was asked to observe R98's fingernails and confirmed they were very long. When asked about who was responsible to provide nail care, Nurse 'DD' reported they would be trimmed today.

On 7/28/22 at 3:30 PM, R98's nails on both hands remained long. The resident's skin on their upper right clavicle area (directly under the contracted hand with long nails) was observed to have about an inch long red mark that appeared to be a scratch and was not observed at earlier observations.

On 7/28/22 at 3:35 PM Nurse 'DD' was asked

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 _____	8/2/2022

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

about the nails and why they were not done as they indicated they would be trimmed earlier and Nurse 'DD' reported the Unit Manager told them to get a list together of who needed nails cut.

Review of the clinical record revealed R98 was initially admitted into the facility on 9/13/18, and signed onto hospice on 7/22/22 with diagnoses that included: quadriplegia, encounter for palliative care, unspecified protein-calorie malnutrition, contracture of right and left knee, and right and left hand, and anoxic brain damage.

According to the MDS assessment dated 6/28/22, R98 was rarely/never understood or able to understand others, and was totally dependent upon one to two people for all aspects of care.

R108:

On 7/26/22 at 3:38 PM, a phone interview was conducted with R108's legal guardian (LG). R108's LG reported concerns with ADL care and reported they did not normally speak up but had concerns that there seemed to be a change for the worse over the past three to four weeks. When asked to explain further, R108's LG reported R108's skin was so built up on his face it is like no one is cleaning his face. When the resident first moved in, his facial hair was trimmed up, was dressed, and cleaned, but feels like his skin is so much worse. R108's LG further

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 _____	8/2/2022

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

reported the skin build up in the resident's facial hair was new and that it has never been like that. R108's LG further stated that R108 was frequently found wearing a hospital gown, instead of their clothes. When asked how long this had been going on, they reported there seemed to be a change over the past three to four weeks. The LG further reported R108 had plenty of clothes, and thought staff were aware he liked to be dressed daily.

Observations of R108 included:

On 7/26/22 at 11:18 AM and 1:29 PM, the resident was lying in a Geri chair recliner at the nursing desk, wearing a hospital gown. The resident had a full beard with visible dried skin (white flakes) throughout the beard and mustache area.

On 7/27/22 at 3:15 PM, R108 was observed lying in a Geri chair recliner in the lounge area with three other female residents. At that time, R108 was wearing a hospital gown which had bunched up to and exposed their stomach and yellow colored disposable brief. The resident was wearing socks and shoes and yelling out loudly while banging the right armrest repeatedly. Upon approach, R108 stopped yelling. The resident's skin remained with white flakes throughout the beard and mustache area. At that time, Unit Manager 'AA' entered the lounge area, and when asked about the resident's state of dress and brief exposure, they reported R108 should

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 _____	8/2/2022

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

not have been dressed like that as they had many clothes and the reason was possibly due to the fact the resident had an agency CNA (Certified Nursing Assistant) assigned to them today. When asked about the relevance of an agency staff vs facility staff, they offered no further response but reported they would have the resident changed. When asked about the condition of the resident's skin, Unit Manager 'AA' acknowledged the same condition and reported they would have staff put lotion on.

Review of the clinical record revealed R108 was admitted into the facility on 2/25/21 and readmitted on 3/22/21 with diagnoses that included: multi-system degeneration of the autonomic nervous system, dementia in other diseases classified elsewhere with behavioral disturbance, and Parkinson's disease.

According to the MDS assessment dated 7/1/22, R108 was rarely/never understood or understands others, had severely impaired cognition, and required extensive assistance of one person for dressing and personal hygiene, and was totally dependent upon two or more people for bathing.

Resident #17

On 7/26/22 at approximately 10:33 a.m., R17 was observed up in wheelchair. R17 was queried if they had any concerns regarding their care at the facility and they indicated

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 _____	8/2/2022

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
	they were not getting showered enough. R17 reported they were supposed to be showered every day and were not receiving it. R17 was queried if they knew why they were not receiving their showers and they indicated that the staff told them they do not have enough time. On 7/26/22 The medical record was reviewed. R17 was initially admitted to the facility on 5/4/22 and had diagnoses including Anxiety Disorder and Schizoaffective disorder, End stage renal disease and morbid obesity. A review of R17's MDS (minimum data set) with an ARD (Assessment Reference Date) of 5/7/22 revealed R17 needed assistance from facility staff with their activities of daily living. R17 BIMS score (brief interview of mental status) was 15 indicating intact cognition. A review R17's care plan revealed the following: "Focus-Resident has an ADL (activity of daily living) self-care performance deficit r/t (related to) deconditioning. Date Initiated: 05/04/2022...Interventions: BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated. A review of R17's CNA (Certified Nursing Assistant) bathing task revealed the following "shower/bath every day shift." Further review of the documentation for bathing of the last 30 days revealed R17 was only bathed on 7/12, 7/23 and 7/26.			

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 _____	8/2/2022

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
	On 8/1/22 at approximately 10:52 a.m., The Director of Nursing (DON) was queried regarding CNA shower documentation and where staff document that at shower is completed and they indicated it would be in the EMR (electronic medical record) CNA task screen and on a shower sheet. On 8/1/22 at approximately 1:45 p.m., shower sheets for R17 were reviewed for the last month. No shower sheets were provided. Nurse "TT" was queried regarding the lack of shower sheets for R17 and they indicated that it should be documented in the electronic record. No further shower documentation for R17 was provided by the end of the survey. On 8/2/22 a facility document titled "Routine Procedures" was reviewed and revealed the following: "Subject-Bath/Shower...Policy-It is the policy of this facility to promote cleanliness, stimulate circulation and assist in relaxation..."			
F0684 SS= E	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	F0684	F684 Quality of Care DPS #1 R #393 No longer resides in the facility. All residents residing in the facility have the potential to be affected. An audit was completed of the Orders tab dating back to July 2022 to current 8/22 to ensure that all pending or medications on order were received by the pharmacy for administration and documentation on the residents MAR.	8/29/2022

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 _____	8/2/2022

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
	evidenced by: This citation pertains to intake MI00128835 and has two Deficient Practice Statements (DPS). DPS #1 Based on interview and record review the facility failed to ensure a seizure medication was documented on the Medication Administration Record (MAR) appropriately for one (R393) of 29 sampled residents reviewed for quality of care. Findings include: Review of the medical record revealed R393 was admitted to the facility on 4/12/22 with a readmission date of 5/20/22 and diagnoses that included Epilepsy. A Minimum Data Set (MDS) assessment dated 5/27/22 documented "severely impaired" cognitive skill for daily decision making and required extensive staff assistance for all Activities of Daily Living (ADLs). Review of the April 2022 Medication Administration Record (MAR) documented an order for "Lacosamide (Vimpat) Solution 10 MG (milligram)/ML (milliliter), Give 25 ml via PEG (Percutaneous Endoscopic Gastrostomy)- Tube every 12 hours for seizures (9 AM and 9 PM)" The medication was supposed to start on 4/13/22, but the first administered dose was documented on 4/14/22 at 9 PM. The next dose documented as administered was on 4/15/22 and 4/18/22 both at 9 AM. All other doses were documented as not administered.		An audit was completed on residents Medication Administration record to ensure that the resident□s medications are available and administered as ordered. Residents identified with having orders for IVs were observed by the nurse managers and are patent and functioning properly. The DON/nurse managers/designee will review in daily am clinical meeting the alert on the main electronic medical record dashboard named not administered med passes in the last 24 hours to identify any medications that were missed and/or not given to residents in the facility for immediate action. By 8/25/22, Licensed nurses were educated on the Medication Administration policy specifically addressing ensuring that medication orders are carried out, received timely for residents and documented on the residents MAR as ordered. The DON/Nurse managers will provide over-sight monitoring the Orders panel in the electronic medical record during clinical meetings to ensure that medications are received timely per the physicians order for administration and documentation on the resident MAR. The DON/designee will conduct random audits 5 residents weekly x4 then monthly thereafter times 3 months or until substantial compliance is attained and maintained to ensure that new orders for residents are received timely for residents and documented on the MAR by the nurses. The results of these audits will be presented to the QAA committee for review and consideration of further corrective actions monthly. The DON/designee will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22, and for sustained compliance thereafter	

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 _____	8/2/2022

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
	Review of the progress notes documented the following: A Nursing note dated 4/13/2022 at 4:54 PM, " ... Lacosamide Solution ... Give 25 ml via PEG-Tube every 12 hours for seizure on order ..." A Nursing note dated 4/14/2022 at 1:04 PM, " ... Lacosamide Solution ... Give 25 ml via PEG-Tube every 12 hours for seizure on order ..." A Nursing note dated 4/18/2022 at 8:41 AM, " ... Lacosamide Solution ... Give 25 ml via PEG-Tube every 12 hours for seizure pharmacy called, and need CII (Controlled medication) prescription, Dr. notify <sic> ..." Review of the census revealed R393 was transferred to the hospital on 4/18/2022 and readmitted back into the facility on 5/11/2022. Review of the May 2022 MAR revealed the following: "Vimpat Solution ... (Lacosamide) Give 25 ml via PEG-Tube every 12 hours for seizures" The staff did not administer this on 5/11/22 or 5/12/22. Further review of the medical record revealed R393 was transferred to the hospital on 5/12/22 and readmitted back into the facility on 5/20/2022. Review of the hospital paperwork (dated 5/12/2022) provided to the facility upon		DPS #2 Resident # 94 still resides in the facility. She was treated for UTI and does not have any s/s of infection. All like residents have the potential to be affected. An audit was completed on all residents with an order for IV antibiotic medication to ensure that the residents medication was available and administered as ordered and residents with IVs were observed to be patent and functioning properly. An audit was completed on residents Medication Administration record to ensure that the residents medications are available and administered as ordered. When an order is placed for antibiotic medication in any form, the ICP nurse or designee will follow up to ensure that the medication is delivered from the pharmacy in a timely manner and/or ensure that the charge nurse retrieves that medication when available from the back up medication system provided by the pharmacy to avoid a delay in treatment. The DON/designee will discuss all residents with new orders for antibiotic therapy including reviewing the medical record in am clinical meeting to ensure that medications are received and documented per the physicians orders. The DON/designee will review orders for labs daily, in particular urinalysis and urine cultures to ensure that testing orders for suspected UTI are completed in a timely manner. The nurse managers will follow up on their designated units and report back to the Director of Nursing their findings for follow up. By 8/25/22 licensed nurses were educated on the Medication Administration policy and policy for obtaining testing for suspected UTI per the physicians orders to ensure that residents are treated for infections in a timely	

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 _____	8/2/2022

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
	readmission (on 5/20/2022), documented the "Principal Diagnosis" as "Status epilepticus". Further review of the May 2022 MAR documented the following: Lacosamide Solution ... Give 250 mg via PEG-Tube two times a day for Seizures. Out of the 14 doses that should have been administered to the resident, only 9 doses were documented as administered. Further review of the progress notes revealed the following: A Nursing note dated 5/21/2022 at 12:12 PM, " ... Lacosamide Solution ... Give 250 mg via PEG-Tube two times a day for Seizures n/a (not applicable) awaiting on script ..." A Nursing note dated 5/23/2022 at 10:09 AM, " ... Lacosamide Solution ... pharmacy notified ..." A Nursing note dated 5/24/2022 at 8:49 AM, " ... Lacosamide ... Pharmacy notified ..." A Nursing note dated 5/25/2022 at 10:58 AM, " ... Lacosamide ... No CII form. MD (Medical Doctor) and pharmacy contacted ..." A Nursing note dated 5/26/2022 at 8:36 PM, documented in part " ... Lacosamide ... MED (medication) not available at this time ..." A Nursing note dated 5/27/2022 at 11:09 AM, documented in part " ... Lacosamide ...		manner. The DON/designee will conduct random audits on 5 residents weekly x4 then monthly thereafter times 3 months or until substantial compliance is attained and maintained to ensure that residents orders for testing of suspected UTI are obtained timely per physician order. The DON/designee will conduct random audits on 5 residents weekly x4 then monthly thereafter times 3 months or until substantial compliance is attainted and maintained to ensure that residents with infections are treated in a timely manner. The results of these audits will be presented to the QAA committee for review and consideration of further corrective actions monthly. The DON/designee will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22, and for sustained compliance thereafter	

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 _____	8/2/2022

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

Med not available. Pharmacy contacted and will be in tonight's shipment ..."

On 8/1/2022 at 12:20 PM, the Director of Nursing (DON) was interviewed and asked about the missed doses of lacosamide and how the medication was available for some nurses that signed the medication off as administered but not available for the other nurses documenting that the medication was unavailable. The DON stated they would look into it and follow up. At 2:59 PM, the DON and Assistant Director Of Nursing (ADON) "B" returned and ADON "B" stated they called the pharmacy and the pharmacy confirmed that Lacosamide (Vimpat) was never delivered to the facility in April or in May until May 26th when two doses were delivered. It was clarified with the DON and ADON "B" that every nurse that signed in April and May 2022 that they administered the resident's Lacosamide medication had indeed not administered it because it was not delivered from the pharmacy, both the DON and ADON "B" confirmed that as being accurate. When asked, the DON stated they were not aware that there were issues with obtaining R393's Lacosamide medication until asked by the surveyor. The Nurse's note documented on 5/27/2022 confirmed the resident was sent to the hospital before the delivery was made by the pharmacy. R393 did not receive one dose of their Lacosamide seizure medication while admitted in the facility as prescribed by the physician.

Deficient Practice #2

Based on observation, interview, and record

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 _____	8/2/2022

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

review, the facility failed to ensure physician ordered testing and treatment for a urinary tract infection (UTI) was implemented in a timely manner for one (R94) of three residents reviewed for UTIs. Findings include:

On 7/26/22 at 11:54 AM, R94 was observed sitting up in bed. When queried about her care in the facility R94 reported that sometimes newly ordered medications were not available and you had to wait a couple days before they were started. R94 reported on 1/17/22, she was diagnosed with a UTI and experienced a delay in receiving an oral an intravenous (IV) antibiotic medication.

Review of R94's clinical record revealed R94 was admitted into the facility on 3/17/18 and readmitted on 5/25/22 with diagnoses that included: hemiplegia, dysphagia, chronic obstructive pulmonary disease, lymphedema, and chronic kidney disease. Review of a Minimum Data Set (MDS) assessment dated 6/24/22 revealed R94 had intact cognition, required extensive physical assistance with toilet use, and was always incontinent of urine.

Review of R94's progress notes revealed the following:

A "General Progress Note" dated 1/7/22 documented, "...complains of irritation when urinating. Vaginal area has no open areas and urine was collected to r/o (rule out) infection...Noted in doctor log. Order made

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 _____	8/2/2022

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
	and awaiting lab..." A "Medical Practitioner Progress Note" dated 1/9/22 documented, "CC (chief complaint): dysuria (painful urination)...Pt (patient) reports intermittent moderate suprapubic aching pain for several weeks...Diagnosis/Status/Plan: ... Acute dysuria...UA (urinalysis)/C&S (culture and sensitivity) today. Will monitor..." A "General Progress Note" dated 1/14/22 documented, "Clean cath (catheter) urine collected per doctor order awaiting lab for pick up..." A "Medical Practitioner Progress Note" dated 1/17/22 documented, "CC: UTI...Pt seen today for evaluation for c/o (complaints of) suprapubic pain and pressure. Pt urine cultures returned (positive) Proteus mirabillis (greater than) 100K (100,000) as well as Providencia Stuartii (greater than) 100K...Diagnosis/Status/Plan...Acute UTI-NEW: PICC (peripherally inserted central catheter - a long thin tube inserted into a vein to allow medications to be administered into the bloodstream) ordered, cont (continue) on Cefazolin 1gm (gram) IV BID (twice a day) for 7 days with Bactrim DS BID for 7 days to cover with organisms..." Review of R94's Physicians Orders and Medication Administration Record (MAR) for January 2022 revealed the following:			

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 _____	8/2/2022

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
	An order dated 1/7/22 for "Urinalysis C&S". An order dated 1/10/22 for "UA/C&S - straight cath specimen". An order dated 1/11/22 for "'Urine culture improperly collected' per results, recollect Urine culture x 1 today via straight cath one time only for dysuria..." An order dated 1/17/22 for "Please order PICC line today one time only for UTI for 2 Days". An order dated 1/19/22 for "Picc line one time only". An order with a start date of 1/17/22 for "Cefazolin Sodium Solution Reconstituted 1 GM Use 1 gram intravenously every 12 hours for UTI for 7 Days". Review of the MAR revealed R94 did not receive this medication on 1/17/22 (9:00 PM dose), 1/18/22 (9:00 AM and 9:00 PM doses), and 1/19/22 (9:00 AM and 9:00 PM doses). The medication was discontinued on 1/20/22. Review of R94's progress notes revealed the medication was not given on 1/17/22 due to "waiting on PICC line to be placed" and was not given on 1/19/22 due to the medication being "on order". An order with a start date of 1/17/22 for "Bactrim DS Tablet 800-160 MG (milligrams)...Give 1 tablet by mouth every 12 hours for UTI for 7 Days". Review of the MAR			

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 _____	8/2/2022

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

revealed R94 did not receive this medication on 1/17/22 (9:00 PM dose), 1/18/22 (9:00 AM and 9:00 PM doses), 1/19/22 (9:00 AM dose), and 1/20/22 (9:00 AM dose). The medication was discontinued on 1/20/22. Review of R94's progress notes revealed the medication was not given on 1/17/22 due to the medication being "on order".

There was no progress note that indicated the physician was contacted about the delay in getting a PICC line placed or the medications not being available until 1/20/22 (four days later) at which time the physician changed the antibiotic order to the following: "Ampicillin-Sulbactam Sodium Solution Reconstituted 2 (2-1) GM Use 3 gram intravenously every 8 hours for UTI for 10 days."

There was no progress note that indicated why there was a three-day delay (1/11/22 to 1/14/22) in getting a urine sample when it was determined the sample collected on 1/10/22 was not properly collected.

On 8/1/22 at 10:45 AM, the Director of Nursing (DON) was interviewed. When queried about when a PICC line should be inserted after it was ordered by the physician, the DON reported it depended on how long it took the PICC line access company to place it. When queried about what should be done if it could not be placed in time to start the IV medication per physician's order, the DON did not offer a response. When queried about

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 _____	8/2/2022

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
	the delay in getting a PICC line for R94, the delay in getting a urine sample, and the missed antibiotic doses between 1/17/22 and 1/20/22, the DON reported she would look into it. On 8/1/22 at 3:05 PM, the DON reported she asked the floor nurses how long it took to get a PICC line placed and they reported sometimes it took 24 hours and sometimes two to three days. When queried about what should be done if there was a delay, the DON reported the physician should be contacted to see if an IV should be started or an alternative treatment should be ordered. The DON reported the PICC line company should have been called as well. When queried about why there was a delay in getting the urine sample or why the oral and IV antibiotics were not available to be administered according to physician's orders, the DON reported she was still looking into it. On 8/2/22 at 11:14 AM, Assistant Director of Nursing (ADON) 'B' followed up regarding the above questions. ADON 'B' explained on 1/7/22 R94 complained of irritation when urinating, was seen by the Nurse Practitioner (NP), and a UA/C&S was done. ADON 'B" reported it was discovered on 1/10/22 that the original urine sample was contaminated and the NP directed nursing to obtain a straight cath urine specimen. ADON 'B' reported the straight cath specimen was obtained four days later on 1/14/22 and should have been done immediately. ADON			

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 _____	8/2/2022

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
	'B' did not have an explanation as to why it took three days to get the PICC line placed or why the medications were not available, but reported the physician should have been contacted.			
F0686 SS= G	Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake #MI00128835 Based on observation, interview and record review the facility failed to promptly identify skin concerns, timely implement preventative interventions for residents noted at high and very high risk for the development of pressure sores, timely report skin concerns to the physician and consistently perform treatments for three (R95, R114 and R393) out of four residents reviewed for pressure ulcers, resulting in the residents developing Stage IV, Stage III and Stage II pressure ulcer(s) at the facility. Findings include:	F0686	F686 Treatment/SVCS to Prevent/Heal Pressure Ulcer Resident #95 no longer resides in the facility. Resident #393 no longer resides in the facility. Resident 114 was assessed by the wound consultant and/or clinical wound team to ensure a weekly skin assessment is completed, wounds are assessed, treatments are applied as ordered by the physician, interventions implemented per plan of care and documented in the medical record according to the skin guidelines. All residents have the potential to be affected. The Wound Care Team completed a skin sweep audit for residing residents by 8/16/22 to ensure a weekly skin assessment is completed, identified wounds are assessed, treatments applied as ordered by physician, interventions implemented per plan of care and documented in the medical record according to the skin guidelines for residents noted at high and very high risk for the development of pressure ulcers. A report of the Medication Administration Audit- section- missed medications, will be ran and reviewed daily M-F by the DON/designee with the clinical nurse manager team to identify any concerns of non-compliance with nurses administering treatments per the physicians orders. Any identified areas of non-compliance will be addressed by the DON.	8/29/2022

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 _____	8/2/2022

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
	Review of a complaint submitted to the State Agency (SA) documented allegations of the facility failing to provide adequate care to prevent and treat pressure wounds for resident R393. Review of a facility policy titled "Skin Monitoring and Management- Pressure Ulcer", dated 7/11/2018 "... A resident having pressure ulcer receives necessary treatment and services to promote healing, prevent infection, and prevent new, unavoidable sores from developing... The purpose of this policy is that the resident does not develop pressure ulcers unless clinically unavoidable, and that the facility provides care and services... Assessment/evaluation should include but not be limited to... Measuring the wound... Staging the wound... Describing the nature of the wound... Describing the characteristics of the wound..." R95 On 7/26/22 at approximately 11:12 AM, R95 was observed lying in bed receiving oxygen via a nasal cannula (tubing that consists of two prongs leading into the nostril and hooked around the ears). A non-labeled/dated piece of what appeared as gauze was observed behind the resident's left ear. R95 was alert and able to answer questions asked. R95 reported that he had been in the facility for about a month. When asked what was behind his left ear, R95 responded that he had a "sore" behind the ear. When asked if he had the "sore" when he entered the building, he stated that he did not. A review of R95's clinical record documented the resident was admitted to the facility on 6/23/22 with diagnoses that included: acute respiratory failure, acute kidney failure, dysphasia, and lack of coordination. A review of the resident's Minimum Data Set (MDS) noted the resident had		The treatment nurse/designee will assess residents upon admission, with a change in condition and as needed that are identified as high and very high risk for the development of pressure sores to ensure that appropriate preventative interventions are in place to aid in the prevention of pressure ulcers. The DON/nurse managers/designee will review skin assessments to be completed weekly by the charge nurses to ensure that nurses are following the schedule for performing resident skin assessments per facility policy. By 8/25/22 the Nurses and CENA's will be educated on "Skin Monitoring and Management Policy" and Best Practice Skin policy to ensure that skin assessments are completed per policy, skin concerns are promptly identified, timely implementation of preventative interventions for residents noted to be of high and very high risk for the development of pressure sores, timely reporting of skin concerns to the physician and consistently performing treatments to aid in the prevention of pressure ulcers. DON/designee will randomly audit 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that skin assessments are completed per policy, skin concerns are promptly identified, timely implementation of preventative interventions for residents noted to be of high and very high risk for the development of pressure sores, timely reporting of skin concerns to the physician and consistently performing treatments to aid in the prevention	

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 _____	8/2/2022

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
	a Brief Interview for Mental Status (BIMS) score of 14/15 (cognitively intact) and required extensive one to two person assist for most Activities of Daily Living. Continued review of R95's clinical record revealed, in part, the following: Braden Scale (4/4/22): Score of "10" (High Risk). An order detail note (7/8/22): "Consult wound care to evaluate B/L (bilateral) Ear skin alterations." *There was no indication in R95's clinical record that there was a wound care evaluation to the B/L ear or order for treatment until 7/26/22 as seen below. Skin Alteration Evaluation: 7/26/22: Site: Left ear ...Type: Pressure: Length: 2.0, Width 0.5 ...Depth.4 ...Stage III ...Acquired: In-House Acquired. Order: Obtain foam ear protectors for nasal cannula (7/26/22). Review of R95's Care Plan documented, in part the following: Focus: The resident has oxygen therapy ineffective gas exchange ...Interventions: Change out oxygen tubing every Thursday ... Focus: Resident has actual stage III to sacrum (6/28/22) .... resident has stage III pressure injury to posterior L ear (7/26/22) ...Interventions: *no interventions pertaining to the Stage III pressure injury to posterior L ear were noted in the resident's care plan. On 7/27/22 at approximately 11:51 AM, an interview was conducted with Wound Nurse "EE". When asked about the facility acquired		of pressure ulcers. . The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 8/25/2022 and for sustained compliance thereafter.	

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 _____	8/2/2022

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
	State III Pressure Wound to the Left ear, Nurse "EE" confirmed that it was acquired at the facility. When asked what interventions were put in place to protect R95 who was a high risk for Pressure Sores and was continuously wearing O2 tubing, Nurse "EE" stated that he started to complain that it was hurting and an order for an ear protector was placed today (7/26/22). Nurse "EE" noted that any resident wearing oxygen tubing should wear ear protectors all the time but was not able to place orders. R114 On 7/26/22 at approximately 9:28 AM, R114 was observed lying in bed. The resident had severe contractions, dry cracked lips that appeared to have dried blood and while alert was not able to answer any questions asked. The resident appeared to be crying but could not explain why. Nurse "O" was interviewed and reported that the resident had just been changed and often gets upset following a brief change. A second observation of R114 was made on 7/26/22 at approximately 12:27PM. The resident was observed lying on her left side. No boots were observed on either the right or left foot. Review of R114's clinical record documented the resident was admitted to the facility (hereinafter facility #2) on 4/2/22 with diagnoses that included: Dysphasia, chronic kidney disease, repeated falls, and acute kidney failure. A review of the resident's MDS noted the resident was severely cognitively impaired and required extensive one to two person assist for most ADL's. Continued review of the clinical record noted the resident resided at a sister facility (herein after facility #1) from 9/30/2021 to 4/1/22. A			

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 _____	8/2/2022

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

document titled, "Discharge Instructions" and accompanying documents provided by facility #1 revealed, in part: "1. Date of Discharge: 4/1/2022 ...You are being discharged to the following location: Name of Location (Facility #2) ... Order Summary Report: Active orders as of 3/31/2022: cleanse left lateral foot with normal saline, apply triple verbal antibiotic ointment and cover with dry dressing qday ...Low air loss mattress to bed ...".

Review of R114's clinical record following transfer to facility #2 documented the following:

Braden Scale (4/4/22): Score of "8" (Very High Risk).

Care Plan: Focus: Resident has unavoidable pressure ulcer status (4/4/2022): Interventions dated 4/4/2022: Encourage good nutrition and hydration in order to promote healthier skin (4/4/2022) ...Observe skin daily with care activities. Report any changes in coloration, integrity etc. to nurse ...". *It should be noted that those were the only interventions put in place following the Braden Scale Score noted as "Very High Risk". In addition, based on Discharge documentations from facility #1 that indicated R114 had a "Low Air Loss Mattress", that intervention was not put into place upon entry to the facility. Further there was no documentation that noted that on 4/4/22, R114 had unavoidable pressure ulcer status. Documents provided by facility #1 noted that R114 had a stage II pressure ulcer on the left foot and right hip that had resolved.

Continued review of R114's clinical record from documented as follows:

Wound #1

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 _____	8/2/2022

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

Skin Observation Tool (4/26/22): L lateral foot DTI (deep tissue injury).

An order dated 4/26/22 documented: Cleanse with betadine to wound bed. Cover with ABD, wrap with kerlix. Treatment QD and PRN ...." R114's Treatment Administration Record (TAR) noted Betadine Solution order to L. Lateral Food Wound was documented as given on 4/27, 4/28, 4/29, 4/30 (no treatment was documented as given on 5/1, 5/2, 5/3).

An order dated 4/26/22 documented: bilateral soft heel protectors.

An order dated 5/17/22 documented: Wound L Lateral foot DTI ...Length ...2.5 ...Width ...2.5 ...Depth ...2 ...Clean with Dakin's ...Apply Silver (Ag+) ...Cover with ABD ...Kerlix (D/C 6/14). Review of R114's TAR for the order noted above documented no treatment was done on 5/22, 5/23, 5/27, 6/3, 6/4, 6/11.

A General Progress Note dated 5/31/22 (authored by Wound Nurse "EE") noted: "Nurse Practitioner "AAA" from wound care clinic is in to visit today. Resident has a L later foot Stage III ...".

A document titled Pressure Ulcer Unavoidable evaluation (dated 6/7/22): Risk factors: 1. Terminally ill (blank/nothing checked). Two or more of the following diagnoses: checked for Quadriplegia, Dementia, Bowel Incontinence, Urinary Incontinence, Immunosuppression, Pain, Chronic Kidney ... 3. Two or more of the following treatments (blank/nothing checked). 4. Lab Results 2.9 serum Albumin (below 3.4) and Hgb Blood 8.1 below 12mg.

A Wound Care Progress Note: (6/14/22) (authored by Wound Nurse "EE") noted: "L foot

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 _____	8/2/2022

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
	Stage IV ....". A Skin Observation Tool (6/23/22) noted: "Resident has a L lateral foot stage IV measuring 2.0 x 1.5. ...Apply calcium alginate ...cover with ABD, wrap with Kerlix. The order started 6/22/22 and per the TAR missing treatment was noted on 6/25, 6/27, 7/3 and 7/10. Wound #2 6/14/22 Default eMAR Note: Skin assessment ...one time a day every Tue ...Resident has a skin alteration noted to right hip ...". * No further information/descriptions as to skin alteration was found in the clinical record on 6/14/22 and 6/15/22. 6/16/22: General Progress Note (5:50 PM): Resident has a new injury to R hip. The Skin Observation Tool (6/16/22): has no note as to the R hip and addressed only the L foot stage IV. An order dated 6/16/22 documented: "Xeroform Oil Emulsion Gauze Pad ...apply to R hip topically every day shift for wound care ...cleanse, pat dry. Apply 2-layer xeroform, cover with border foam. (D/C 6/28/22)." The MAR/TAR was reviewed and noted that R114 did not start receiving the treatment until 6/17/22 and did not received treatment on 6/25/22 and 6/27/22. A General Progress Note (6/23/22): "Resident has a L lateral foot stage IV ...R has a L hip stage II ...R has a UTD (unstageable) measuring 3.0x1.8x.1 ...". An order for Medi honey Wound/Burn Dressing Gel - Apply to R hip wound was ordered on 6/28/22 The MAR/TAR was reviewed and noted the treatment was not given on 7/3/22, 7/10/22.			

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 _____	8/2/2022

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

A Skin Alteration Evaluation (7/12/22) noted: Site: Right ...hip ...Type ...Pressure ...Length 3.5 ...Width...4.5 ...Stage IV ...Acquired: In house ...Unavoidable".

A Skin Alteration Evaluation (7/22/22) noted ...Site: Right ...hip ...Type ...Pressure ...Length 3.5 ...Width 4.0 ...Copious purulent drainage with odor ...

An order for Bactrim DS 800-160 MG was ordered on 7/22/22 ...

Wound #3

Skin observation (6/23/22) R has L hip stage II measuring 3.0 x1.8 x.1 ....

An order dated 6/21/22 read: Medi honey Dressing Gel ...Apply to L hip wound with a D/C order 7/5/22. Review of the MAR/TAR noted the resident did not receive the treatment on 6/25/22 and 6/27/22.

General Progress Note (6/28/22): ...Nurse Practitioner from wound care clinic ...Resident has L hip UTD (unstageable) measuring 2.5 x 3.0 ...

A second order dated 7/5/22 read: Medi honey Wound/Burn Dressing Gel ... Apply to L hip wound with a D/C order of 7/12/22. Review of the MAR/TAR noted the resident did not receive treatment on 7/3/22 and 7/10/22.

A Skin Alteration Evaluation dated 7/12/22 read: Site ...Left Hip ...Type Pressure ...Length 2.0 ...Width ...Stage: Unstageable ...In house Acquired.

A Skin Alteration Evaluation dated 7/22/22 read:

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 _____	8/2/2022

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

Site ...Left Hip ...Type Pressure ... Length 2.0 ...Width ... Stage IV ...In house Acquired ...copious purulent drainage with odor ...resident put on Bactrim...q 12 hours x 14 days ...'.

On 7/27/22 at approximately 11:53AM, R114's wounds were observed. Wound Nurse "EE" was present. The resident's low-air loss mattress was set at normal pressure (there were two options visible normal and low). No offloading devices were noted on the feet or R/L hip area. The left wound was half dollar in size, depth was noted (stage IV). A left foot wound below the pinky toe was dime size, pink in color and appeared to be healing. The right hip wound was the size of quarter, red and open with minimum depth. The resident was moaning in pain when the treatments were removed.

On 7/28/22 at approximately 11:02 AM, an interview and record review were conducted with the Director of Nursing (DON) and Wound Nurse "EE". When asked what interventions were put into place upon admission and following a Branden Score of High Risk, Wound Nurse "EE" reported that she was told per facility policy, low air loss mattresses are not provided to residents until a pressure ulcer has developed. When asked about R114's transfer from a sister facility #1 and interventions provided there, Wound Nurse "EE" was not aware of that information. When asked how it was determined on 4/4/22 (two days after admission) that R114 had unavoidable pressure ulcer status. Wound Nurse "EE" noted that she did not originally include that statement in the resident's Care Plan and could not give an explanation. When asked about the order for bilateral heel protectors. Wound Nurse "EE" reported that R114 likes to kick them off. Wound Nurse "EE" was asked to provide documentation that noted staff indicated the resident kicked them off and they were not being worn. When asked as to the delay in treatment pertaining to the 6/14/22

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 _____	8/2/2022

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

note that indicated discoloration to the Right hip, the DON reported that the Nurse who put the note in the system incorrectly and it was not seen by other staff until 6/16/22. When asked about the several missed treatments by Staff, the DON indicated they should be noted in the MAR/TAR.

On 7/28/22 at approximately 2:21PM, a phone interview was conducted with Wound Doctor (WD) "ZZ". WD "ZZ" was asked about interventions put into place for resident's, including R114, who enter the building with a "Very High Risk" Branden Score. WD "ZZ" noted that residents will receive a foam pressure reducing mattress and barrier cream. When asked about R114 not receiving an air loss mattress until 4/26/22, WD "ZZ" responded that to his knowledge insurance does not pay for the mattress until it has been determined that the resident has a pressure ulcer. WD "ZZ" was aware that the facility had some extra low air loss mattresses but noted that it often is a battle as to who gets the mattresses. When asked about the floating botties, WD "ZZ" reported that he remembered R114 as very contracted and needed the floating booties. When asked about R114 and documentation that indicated the wounds to the foot and hip(s) were unavoidable, WD "ZZ" reported that they determined the status based on lab results that indicated a low albumin rate and low Hgb level. WD "ZZ" noted that surprisingly the resident's protein rate was still very good. When told that the resident's electronic record indicated several mistreatments and asked whether that would alter the determination as unavoidable, WD "ZZ" reported he was not aware of any mistreatments and indicated that treatments ordered should be administered.

R393

Review of the medical record revealed R393 was

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 _____	8/2/2022

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
	admitted to the facility on 4/12/22 with a readmission date of 5/20/22 and diagnoses that included: Epilepsy, gastrostomy, multiple sclerosis, paraplegia, and protein-calorie malnutrition. A Minimum Data Set assessment dated 5/27/22 documented "severely impaired" cognitive skills for daily decision making and required extensive staff assistance for all Activities of Daily Living (ADLs). Review of a readmission nursing assessment dated 5/20/22 at 3:45 PM, documented in part "... SKIN... Scar on right top foot, BL (bilateral) LE (lower extremity) scattered discoloration, left arm edema +1, right hip open area, BL dry heels and buttocks 3 open areas..." There was no measurements or wound characteristics documented. Review of a facility policy titled "Skin Monitoring and Management- Pressure Ulcer", dated 7/11/2018 "... A resident having pressure ulcer receives necessary treatment and services to promote healing, prevent infection, and prevent new, unavoidable sores from developing... The purpose of this policy is that the resident does not develop pressure ulcers unless clinically unavoidable, and that the facility provides care and services... Assessment/evaluation should include but not be limited to... Measuring the wound... Staging the wound... Describing the nature of the wound... Describing the characteristics of the wound..." Review of a May 2022 Medication Administration Record (MAR) and Treatment Administration Record (TAR) was reviewed and documented an order for Peri Guard Ointment (Skin Protectants) Apply to buttocks and hip topically three times a day for skin health. This order was started on 5/21/2022.			

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 _____	8/2/2022

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
	Review of the progress notes revealed no documentation of the physician being notified of the skin concerns identified on the admission body assessment and no documentation of the physician who ordered the Peri Guard Ointment. On 8/1/2022 at 2:03 PM, Registered Nurse (RN) "T" (the RN who admitted R393 on 5/20/22 and also serves as one of the facility's unit managers) was interview and asked if they informed the physician on the skin issues identified on the admission skin assessment for R393. RN "T" stated they did not inform the physician. When asked the name of the physician they obtained the order from for the Peri Guard Ointment for the open wounds identified on the right hip and buttocks, RN "T" stated they did not receive the order from a physician. When asked if they ordered the treatment without a physician consent, RN "T" admitted they ordered the ointment without the physician consent. When asked if that was the normal protocol in the facility to not inform the physician of identified skin assessment concerns and implement treatment without their approval, RN "T" did not reply. On 8/2/2022 at 8:55 AM, the Medical Director (MD) "V" (primary physician for R393 and the physician name used to input the order for the Peri guard ointment) was interviewed and asked if RN "T" notified them of R393's readmission skin assessment concerns on 5/20/22 and if they gave the order to start Peri guard ointment for the open wounds on the right hip and buttocks, MD "V" stated the nurse did not inform them of the skin concerns identified on the readmission assessment and they did not give the order for Peri guard to be started on open wounds. The Peri guard ointment continued until R393 was evaluated by Wound Nurse (WN) "EE" on			

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 _____	8/2/2022

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
	5/25/2022. Review of the WN "EE" note dated 5/25/22 at 3:28 PM, documented in part "... Skin assessment completed on resident r/t (related to) reports of impaired skin integrity. Resident has a healed wound to R (right) buttock. Healed wound to right hip, dry scabbing... open abrasion on inner R thigh. Open abrasion inner L (left) leg. Open abrasion L rear shoulder. Multiple fluid filled blisters on BLE (bilateral lower extremities) and BUE (bilateral upper extremities). Fragile skin on L hip. Wound care NP (Nurse Practitioner) notified. Orders given ..." WN "EE" failed to document the measurements, staging and wound characteristics as documented in the facility's policy. Review of the May 2022 MAR revealed the following orders started on 5/26/22 & 5/27/22: - Apply dry dressing to R hip for protection, every day shift for protection, cleanse with NS (Normal Saline), pat dry, apply dry dressing (5/26/22). - Cleanse open abrasions to R inner thigh, L inner leg, and R rear shoulder with NS, pat dry. Apply dry dressing. Every day shift for wound care cleanse with NS, pat dry, apply dry dressing (5/26/22). - Protective dressing to R buttock every day shift for wound care cleanse with NS, pat dry, apply protective dressing (5/26/22). - Xeroform Oil Emulsion Gauze Pad, apply to L buttock topically every day shift for wound care cleanse with NS, pat dry, apply 2-layer xeroform. Cover with border foam (5/27/22). - Xeroform Oil Emulsion Gauze Pad, apply to L			

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 _____	8/2/2022

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

inner leg topically every day shift for wound care cleanse with NS, pat dry. Apply 2-layer xeroform. Cover with border gauze (5/27/22).

- Xeroform Oil Emulsion Gauze Pad, Apply to L rear shoulder topically every day shift for wound care cleanse with NS, pat dry. Apply 2-layer xeroform. Cover with border gauze (5/27/22).

- Xeroform Oil Emulsion Gauze Pad, Apply to R inner thigh topically every day shift for wound care cleanse with NS, pat dry. Apply 2-layer xeroform. Cover with border gauze (5/27/22).

On 8/2/22 at approximately 10:30 AM, WN "EE" was interviewed and asked about the assessment on 5/25/2022. WN "EE" stated they assessed R393 because they were told R393's wife had concerns. WN "EE" then explained that a full body assessment was completed with the wife present. When asked WN "EE" stated they are not certified in Wound Care and have a license as a Licensed Practical Nurse (LPN). WN "EE" stated the wound physician did not consult with the resident and was unable to evaluate the resident due to the resident being transferred to the hospital on 5/27/2022. WN "EE" stated after their body assessment they called the Wound Nurse Practitioner to tell them of their findings and treatment was given to WN "EE" via telephone.

Review of the progress notes documented the resident was transferred to the hospital on 5/27/2022 at 12:23 PM, for a change in condition.

Review of ED (Emergency Department) to Hosp (Hospital)- Admission document dated 5/27/22, documented in part "... Wound... 05/27/22 ... Abrasion Distal; Right; Anterior Thigh... Left Axilla... Left Heel... Left; Anterior Thigh... Right Heel... Right; Anterior... right; Anterior Ankle... Left; Anterior Foot..."

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 _____	**8/2/2022**

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
	Review of hospital wound consultation dated 5/28/2022 at 9:34 AM, documented in part "... Reason for Consultation/Chief Complaint: Evaluation of the patient's multiple wounds... He was found on current RN (Registered Nurse) admission skin assessment to have multiple wounds... The patient is known to our Surgical Wound Care service. His stage 2 coccyx/left buttock wound and left heel DTI (Deep Tissue Injury) were last evaluated... on 5/9/2022. The coccyx/left buttock wound was noted to have been healed at that time. Outpatient wound care therapy is not known... Wound Care service, is now consulted to assess the patient's wounds... Sacrum ... 9.5 cm (centimeters) x 7 cm x 0.3 cm ... Wound base- Moist, pink/red base with full thickness tissue loss, extending down to subcutaneous tissue... Right hip... 1.5 cm x 4 cm... Unable to determine wound depth... The center of the wound with a dry brown eschar base... Left hip... 8 cm x 5 cm x 0.2 cm ... red base with partial thickness tissue loss, extending down to dermis... Left posterior shoulder... 1.5 cm x 5 cm x 0.2 cm... pink base with partial thickness tissue loss, extending down to dermis... Left upper back... 2.2 cm x 2 cm. Unable to determine wound depth... Dry brown eschar base... Left anteromedial knee... 4.5 cm x 1.6 cm x 0.2 cm... pink base with partial thickness tissue loss, extending down to dermis... Xerotic skin along the bilateral legs and feet... Left lateral leg/ankle... 13 cm x 2 cm. Unable to determine wound depth... Intact non-blanchable maroon skin... Right anteromedial leg... 4.5 cm x 1.6 cm. Unable to determine wound depth... Intact non-blanchable maroon skin... Right medial ankle... 1.2 cm x 2 cm... Intact non-blanchable maroon skin... Right medial foot... 1.2 cm x 2 cm... Intact non-blanchable maroon skin... Right 1st MT (Metatarsal) head... 2 cm x 2 cm... Intact non-blanchable maroon skin... Left lateral leg... 13 cm x 2 cm... Intact non-blanchable skin... Left heel...			

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 _____	8/2/2022

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
	2.8 cm x 2 cm... Intact non-blanchable maroon skin... Right heel... 1 cm x 1.8 cm... Intact non-blanchable maroon/brown skin... Open stage 3 sacral pressure injury, Open unstageable right hip pressure injury, Open stage 2 left hip pressure injury, Open stage 2 left posterior shoulder pressure injury, Open unstageable left upper back pressure injury, Open stage 2 left anteromedial knee pressure injury. Left lateral leg/ankle DTI (Deep Tissue Injury), Right anteromedial leg DTI, Right lateral ankle DTI, Right lateral ankle DTI, Right lateral foot DTI, Right 1st MT head DTI, Right heel DTI, Left heel DTI..." This assessment revealed the facility failed to identify multiple wounds at various stages.			
F0690 SS= D	Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F0690	F690 Bowel/Bladder Incontinence, Catheter DPS#1 Resident #9 catheter bag/tubing was addressed and was properly secured without tubing touching the floor per policy. All residents in the facility have potential to be affected The central supply clerk has been asked to order the privacy bags for indwelling catheters which can hold the tubing in place as well in lieu of ordering the indwelling drainage bags with the flap that provides privacy but does not give opportunity to keep the tubing off the floor. An audit was completed on residents with indwelling catheters on or before 8/22/22 to ensure privacy bag and securement device is in place and that residents catheter bags are secured with tubing not touching the floor. Nursing Managers will conduct rounds on each unit frequently throughout the day to identify any concerns with resident care. This includes indwelling catheter bags and tubing is secured and off the floor.	8/29/2022

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 _____	8/2/2022

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
	incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: This citation pertains to intakes MI00128835 and MI00129602 and and has two deficient practice statements (DPS). DPS#1 Based on observation, interview and record review, the facility failed to provide urinary catheter care and services to one (R9) of two residents reviewed for use of urinary catheter, resulting in the increased potential for urinary tract infections, cross contamination, and the potential for dislodgement of the catheter tubing. Findings include: According to the facility's policy titled, "Catheter, Drainage Bag" dated 7/11/2018, "...The catheter and drainage bag should be changed...if sediment is accumulating in the lumen of the tubing, or if the system has been contaminated...The resident should not be lying on the tube...Drainage bags should be attached to an immovable object such as bed frame or wheelchair frame..." This policy did not address use of a securement device		The DON/designee will educate certified nursing assistants and licensed nursing staff by 8/25/22 on the facility policy, Catheter related to drainage bag, to ensure privacy bag and secure device are in place and that catheter tubing is not touching the floor. Director of Nursing/Designee will randomly audit 5 residents weekly X 4 weeks then monthly thereafter X 3 months or until substantial compliance has been maintained by ensuring that residents with indwelling catheters have privacy bags and a secure device in place and that catheter tubing is not touching the floor. The results will be presented to the QAA committee for review and consideration of further corrective actions. Director of Nursing is responsible for ensuring and maintaining substantial compliance. Date of Compliance: 8/29/22 DPS #2 Resident #393 no longer resides in the facility. All residents have the potential to be affected. An audit was completed on all residents Task in the electronic medical record on or before 8/24/22 to ensure that all residents had toileting task attached for documentation and monitoring. The DON/nurse managers/designee will review clinical alerts during each AM clinical meeting to identify if there are any triggered residents that have not had a BM in at least 3 days. Resident noted to have triggered this	

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 _____	8/2/2022

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
	for the urinary catheter. On 7/26/22 at 11:01 AM, R9 was observed lying in bed with their legs curled up under the blanket. The entire urinary catheter drainage bag was observed not secured to anything and the bag and tubing were lying directly on the floor (the port of entry was directly touching the floor) under the bed. The catheter tubing was observed to have thick, chunky yellowish colored sediment throughout the tubing. On 7/27/22 at 11:02 AM, the Assistant Director of Nursing (ADON) approached to ask if there were any questions. At that time, the ADON was requested to observe R9's catheter. The ADON confirmed the thick, chunky sediment in the catheter tubing and reported that was not in the drainage bag, only the tubing. When asked to see if R9 had a securement device for the urinary catheter, the ADON checked and reported the tubing was actually secured under the resident's disposable brief. When asked if that was how the catheter tubing should be secured, the ADON reported no, there should be a securement device to the leg. On 7/27/22 at 1:56 PM, the ADON reported they had additional information to share about R9 and explained that the resident had a history of urinary tract infections, had stents placed and was followed by the nephrologist. The ADON reported the resident's last day of antibiotic was on 7/9 and concluded the		alert will have the physician notified to ensure that appropriate action is taken. By 8/25/22, certified nursing assistants and licensed nurses will be educated on ensuring that residents have toileting task in the electronic medical record upon admission, and that the certified nursing assistants are documenting on residents toileting status, specifically whether or not a resident had a bowel movement every shift to ensure monitoring. The Director of Nursing/designee will randomly audit 5 residents toileting record documentation under Tasks weekly x4 weeks then monthly thereafter x3 months or until substantial compliance has been maintained to ensure that residents are documented and monitored for having regular bowel movements. The results will be presented to the QAA committee for review and consideration of further corrective actions. Director of Nursing is responsible for ensuring and maintaining substantial compliance. Date of Compliance: 8/29/22	

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 _____	8/2/2022

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
	sediment was recurrent. When asked at what point would the catheter tubing be replaced to ensure adequate urine flow/drainage, the ADON reported the Nurses did catheter care two times a day and also were to monitor for securement device every 7 days. When asked if the catheter care was being monitored twice daily, how did staff fail to ensure a securement device was in place before it was brought to their attention and the ADON reported they were not sure but did provide R9 with a new securement device. When asked at what point should the catheter tubing be changed, given the visible chunky sediment, the ADON reported there were orders to irrigate if occluded and that each nurse should be monitoring the urine flow as part of their assessment. When asked about the handling/placement of the catheter tubing and drainage bag, the ADON reported should be secured to the side of the bed and off the floor. The ADON was informed of the earlier observation of the entire catheter drainage bag and tubing being stored directly on the floor and concern as a potential contributing factor to urinary tract infections and the ADON reported that could definitely be a possibility. Review of the clinical record revealed R9 was admitted into the facility on 1/1/20 and readmitted on 8/21/21 with diagnoses that included: multiple sclerosis, neuromuscular dysfunction of bladder, presence of			

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 _____	8/2/2022

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
	urogenital implants, pressure ulcer of sacral region state 4, colostomy status, and hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. According to the Minimum Data Set (MDS) assessment dated 4/21/22, R9 had intact cognition, was totally dependent upon two or more people for toilet use, and had a urinary catheter. Review of the care plans included one for R9's use of a suprapubic catheter which was initiated on 11/12/21 and revised on 5/4/22 with interventions that included, "Ensure catheter securement device in place" initiated 6/29/22' Review of the physician orders included: -Bactrim Tablet 400-80 MG (sulfamethoxazole-Trimethoprim) Give 1 tablet by mouth two times a day for Urinary Tract Infection for 7 Days" (last dose administered on 7/9/22 at 9:00 AM). -Change catheter securement device every night shift every 7 day(s) for management routine. -Catheter care Q shift every shift (7AM-7PM, 7PM-7AM). -Change catheter securement device every 24 hours as needed PRN.			

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 _____	8/2/2022

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

DPS #2

Based on interview and record review the facility failed to monitor the bowel movements for one (R393) of one resident reviewed for bowel incontinence. Findings include:

Review of an allegation submitted to the State Agency documented that the facility failed to ensure the resident had regular bowel movements.

Review of the medical record revealed R393 was admitted to the facility on 4/12/22 with a readmission date of 5/20/22 and diagnoses that included: Epilepsy, gastrostomy, multiple sclerosis, paraplegia, and protein-calorie malnutrition. A Minimum Data Set assessment dated 5/27/22 documented "severely impaired" cognitive skills for daily decision making and required extensive staff assistance for all Activities of Daily Living (ADLs).

Review of the April and May 2022 Medication Administration and Treatment Administration Records (MAR & TAR) revealed no documentation of bowel movement monitoring.

Review of April and May 2022 Certified Nursing Assistant (CNA) task documentation revealed no documentation for the monitoring R393's bowel movements.

Review of a "Medical Practitioner Progress Note" dated 5/24/2022 at 5:42 AM and 5/25/2022 at 8:14 PM, documented in part " ... Comprehensive therapies to increase independence ... bowel and bladder program ..."

On 8/1/22 at 12:16 PM, the Director of Nursing (DON) was interviewed and asked how the facility was monitoring R393's bowel movements

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 _____	8/2/2022

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
	to ensure they were having them, the DON stated they would look into it and follow up. At 12:56 PM, the Assistant Director Of Nursing (ADON) "B" stated they could not find bowel documentation for April and May 2022. The ADON "B" then stated every resident in the facility has an order to monitor their bowel movements. The ADON "B" admitted that the bowel management order was not triggered by the admitting nurse for R393 during their inpatient care at the facility.			
F0692 SS= E	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: This citation pertains to intakes MI00128835 and MI00128706 and has two deficient practice statements.	F0692	F Tag 692- D (Nutrition/Hydration Status Maintenance) DPS #1 Residents #9 received fresh water from the staff. Resident #68 received fresh water from the staff. Resident #99 received fresh water from the staff. All residents inhouse who receive nutrition/hydration fluids have the potential to be affected An observation audit was conducted of all residents in the facility to ensure that fresh water was passed and administered per policy and as needed. The DON/nurse managers or designee will continue to conduct rounds on the units to ensure that residents are receiving water per facility policy and as needed. All nursing staff were educated 8/25/22 policy regarding water pass to ensure that residents receive fresh water per facility policy and as	8/29/2022

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 _____	8/2/2022

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
	DPS #1: Based on observation, interview and record review, the facility failed to provide water at bedside for three (R9, R68 and R99) of five residents reviewed for hydration, including additional residents that attended the anonymous resident council meeting, resulting in the potential for dehydration and electrolyte imbalances. Findings include: According to the facility's policy titled, "Hydration" dated 7/11/2018, "...Each resident will be provided fresh ice water every shift, unless contraindicated..." On 7/26/22 at 11:01 AM, 11:41 AM, 1:33 PM, and 3:29 PM, R9 and R99 (shared rooms) were observed to have a cup of water at their bedside labeled "7/26 MN (midnight shift)". On 7/26/22 at 10:47 AM, and 11:13 AM, R68 was observed to have a cup of water at their bedside labeled "7/26 MN". During these observations, residents were asked about whether staff provided water on each shift, and residents reported they were not always provided with water each shift. On 7/26/22 at 3:29 PM, Certified Nursing Assistant (CNA 'SS') was observed delivering cups of cold water (cups were observed to have beaded condensation on the outside of		needed. The DON/designee will conduct random observation audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure residents receive fresh water per facility policy and as needed. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22 and for sustained compliance thereafter. DPS #2 Resident #393 no longer resides in the facility. All like residents have the potential to be affected. An audit was conducted on residents in need of weights to ensure that all weights were obtained by the RD request for follow up of any weight changes. The DON/Nurse manager/designee will review daily clinical alerts to identify residents with poor meal consumption and address any clinical concerns with the registered dietitian. If a resident is identified for needing weights or monitoring the RD will provide the list to the DON who will monitor this process daily to ensure that weights are obtained so that any weight changes can be addressed in a timely	

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 _____	8/2/2022

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
	the Styrofoam cups) from a push cart to residents on the 2-west unit. The cups were labeled "7/26 3-11". When asked if they had seen or removed any cups of water from residents for the day shift, they reported they had not and deferred any further discussion to the nurse. On 7/27/22 at 11:02 AM, an interview was conducted with the Assistant Director of Nursing (ADON) who reported they began working at the facility on 7/11/22. When asked what the facility's process was to ensure all residents were offered water throughout the day, they reported the expectation is that all CNAs pass water to their assigned residents and that water should be passed every shift. The ADON was informed of the observations throughout the day shift and reported they were unable to offer any further explanation and would follow up. Clinical record review revealed: R9 was admitted into the facility on 1/1/20 and readmitted on 8/21/21 with diagnoses that included: multiple sclerosis, dysphagia, neuromuscular dysfunction of bladder, hallucinations, pressure ulcer of sacral region stage 4, colostomy status, hydronephrosis, hyperlipidemia, and other seizures. According to the MDS assessment dated 4/21/22, R9 had intact cognition and had no communication concerns.		manner. The facility has assigned a designated staff member who will obtain the weekly log provided by the dietician for residents weights that are needed. The residents weights will be obtained and documented in the resident s medical record. The Director of Nursing or designee will provide focused oversight to ensure that residents weights are being obtained and documented in a timely manner and given to the RD for accurate monitoring and follow up on any weight changes identified. . By 8/24/22 an audit will be completed to ensure weights are obtained and documented in the medical record per policy. By 8/25/22 the CNAs and licensed nursing staff will be educated on the Nutrition Monitoring and Management Program specifically on obtaining weights and documenting weights in the medical record per policy to ensure residents nutritional status is accurately monitored and follow up I completed for any weight changes. The DON/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure resident weights are obtained timely and documented in the medical record to ensure timely evaluation and monitoring of resident s nutritional status. The results will be presented to the QAA committee for review and consideration of further corrective actions.	

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 _____	8/2/2022

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
	R68 was admitted into the facility on 5/4/17 and readmitted on 12/13/21 with diagnoses that included: chronic obstructive pulmonary disease, schizoaffective disorder bipolar type, and chronic kidney disease stage 3. According to the MDS assessment dated 6/8/22, R68 had intact cognition and no communication concerns. R99 was admitted into the facility on 9/25/19 and readmitted on 7/27/20 with diagnoses that included: cerebral infarction due to embolism of unspecified cerebral artery, chronic kidney disease stage 3, vascular dementia without behavioral disturbance, personal history of malignant neoplasm of prostate, and type 2 diabetes mellitus with other diabetic kidney complication. According to the MDS assessment dated 6/24/22, R99 had severe cognitive impairment. DPS#2: Based on interview and record review, the facility failed to accurately monitor and follow up on weight changes for one (R393) of eight residents reviewed for nutrition. Findings include: Review of a complaint submitted to the State Agency (SA) documented concerns regarding the lack of nutrition and hydration the facility provided to R393. Review of the medical record revealed R393		The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction 8/29/22 and for sustained compliance thereafter.	

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 _____	8/2/2022

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
	was admitted to the facility on 4/12/22 with a readmission date of 5/20/22 and diagnoses that included: Epilepsy, gastrostomy, multiple sclerosis, paraplegia, and protein-calorie malnutrition. A Minimum Data Set assessment dated 5/27/22 documented "severely impaired" cognitive skills for daily decision making and required extensive staff assistance for all Activities of Daily Living (ADLs). Review of the "Weight summary" documented the following: 4/13/2022- 218 lbs. (pounds) 5/11/2022- 203 lbs. 5/25/2022- 213 lbs. A 10-pound weight gain was documented from the 5/11/2022 weight when compared to the 5/25/2022 weight. There was no follow-up documented in the medical record regarding the rapid weight gain or no documentation of an additional weight obtained to confirm the accuracy of the 10 lb. weight gain. Review of the April and May 2022 Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented the resident received their enteral feedings as prescribed by the physician while inpatient at the facility.			

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 _____	8/2/2022

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
	Review of the progress notes revealed R393 was transferred to the hospital on 5/27/2022 for respiratory distress. Review of R393's hospital "ED (Emergency Department) to Hosp (Hospital)- Admission) note dated 5/28/22 at 1:47 PM, documented in part " ... Weight- 69.9 kg (kilograms) (154 lb 1.6 oz) (05/28/22 0300) ... FOOD AND NUTRITION HISTORY ... Wt (weight) Readings from Last 5 Encounters: 05/28/22 ... 154 lb 1.6 oz ... 05/07/22 ... 203 lb 0.7 oz ... 4/10/22 ... 188 lb 4.4 oz ... Severe protein Calorie malnutrition in the context of chronic disease related to PEG malfunction, inadequate enteral intakes as evidenced by severe muscle wasting temple, severe fat loss orbital and buccal regions, clavicles, shoulders ..." This indicated a 59 lb. loss and a -24.14 % of body weight loss in 3 days. On 8/2/2022 at 11:18 AM, Registered Dietician (RD) "I" was interviewed and asked if they identified the 10 lb. weight gain from the 5/11/22 to the 5/25/22 weights that was obtained. RD "I" began to look through R393's medical record and stated the resident should had been reweighed to confirm the 10 lb. gain. When asked if they knew why the resident was not reweighed RD "I" stated they have educated staff numerous times on this same issue. When asked how they ensure that residents who require enteral feedings are receiving their intended amount of nutrition, RD stated they review the weights, nurse documentation and do rounds on the			

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 _____	8/2/2022

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
	residents. When asked if R393 received their required intended nutrition while at the facility, RD "I" stated they have to trust what the nurses are documenting, the nurses are professionals. When asked how it was possible that the facility obtained a 203 lb. weight on 5/25/22 and the resident is transferred to the hospital and the hospital weight obtained indicates a 59 lb. loss in three days, RD "I" then questioned the accuracy of the facility's weight obtained. A facility policy for monitoring weight gain or loss was requested at this time. Review of a facility policy titled "Nutrition Monitoring & Management Program" dated 7/11/2018, documented in part " ... Weight Gain ... Rapid or abrupt increases in weight may also identify significant fluid and electrolyte imbalance. After assessing the resident for the cause of weight gain (conditions related to fluid retention), care plan interventions may include dietary alterations according to the resident's medical condition ..."			
F0693 SS= D	Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical	F0693	F693 Tube Feeding Mgmt/Restore eating skills Resident #87 tube feeding was observed to ensure that it was running per the physician order and labeled properly. Resident # 114 tube feeding was observed to ensure that it was running per the physician order and labeled properly. All residents residing in the facility have the potential to be affected. An audit was completed on all residents that	8/29/2022

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 _____	8/2/2022

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
	condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: This citation pertains to intakes MI00128604 and MI00129602. Based on observation, interview, and record review, the facility failed to accurately monitor administration of tube feeding formula and label the tube feeding bottle when hung for two (R87 and R114) of four residents reviewed for tube feeding. Findings include: Resident #87 On 7/26/22 at 9:47 AM, R87 was observed sitting up in bed drinking a nutritional supplement. A tube feeding pump was observed and it was infusing at the time of the observation. The bottle was labeled that it was hung at 6:30 AM on 7/25/22 and there were 200 milliliters remaining in the bottle. On 7/27/22 at 9:45 AM, R87 was observed eating breakfast in her room. A bottle of tube		receive enteral nutrition to ensure that tube feeding is hung and running and/or discontinued per the physicians orders and all tube feeding is labeled properly but the licensed nurses. The DON/nurse managers/designee will conduct daily rounds prior to am clinical meeting and routinely on their designated units to observe for any resident care concerns, including ensuring that residents tube feeding is running per the physician□s orders and labeled properly. A resident list has been generated that includes the resident, type of tube feeding, run time and amount to be infused, to be provided to the clinical team and updated as needed. Any issues identified will be addressed immediately by the DON/designee. By 8/25/22, Licensed nurses were educated on the policy for administering eternal tube feeding, specifically handing feeding as ordered to ensure resident receive all of the nutrition ordered and proper labeling of tube feeding bottles. The DON/designee will conduct random audits 5 residents who receive enteral nutrition weekly x4 then monthly thereafter times 3 months or until substantial compliance is attained and maintained to ensure that the facility accurately monitors the administration of tube feeding formula and label the tube feeding bottle when hung. The results of these audits will be presented to the QAA committee for review and consideration of further corrective actions monthly. The DON/designee will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22, and for sustained compliance thereafter	

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 _____	8/2/2022

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

feeding formula was hung, but not infusing. Less than 200 milliliters were gone from the bottle.

On 7/27/22 at 4:40 PM, R87 was observed in the common area of the unit. The bottle of tube feeding formula remained hung in the resident's room with the same amount of formula as the previous observation. At that time, Registered Nurse (RN) 'O' was interviewed about R87's tube feeding. RN 'O' reported the midnight nurse hung R87's tube feeding and the resident "snatched it and pulled it out" so she shut it off. RN 'O' reported since R87 got up for breakfast it was not started in the morning. When queried about what should have been done if the resident refused the tube feeding, RN 'O' said nothing was done on day shift because it would not be due to be hung again until 9:00 PM. At that time Unit Manager, Nurse 'T' was interviewed. When queried about what should be done if R87 refused her tube feeding, Nurse 'T' explained that the physician and dietician should have been notified. At that time, RN 'O' reported she did talk to the dietician but she did not document for the day yet.

Review of R87's clinical record revealed R87 was originally admitted into the facility on 12/3/21 with diagnoses that included: adult failure to thrive, protein-calorie malnutrition, and dementia. Review of a Minimum Data Set (MDS) assessment dated 6/16/22 revealed R87 had severely impaired cognition, no

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 _____	8/2/2022

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

behaviors including rejection of care, and received more than 50 percent of nutrition via a feeding tube.

Review of R87's Medication Administration Record (MAR) for July 2022 revealed RN 'O' documented R87 received 1200 mL of tube feeding formula on 7/27/22. The associated physician's order was for "Enteral Feed Order every shift Continuous Enteral feeding: Formula Osmolite 1.5 at 70 ml/hr (milliliters per hour) up at 9p (9:00 PM) and down at 14p (2:00 PM) or when 1200 mL infused..."

On 8/1/22 at 10:44 AM, the Director of Nursing (DON) was interviewed. When queried about what should be done if a resident refused their tube feeding, the DON reported it should be documented. When queried about whether it would be reflected on the MAR if a resident refused, the DON reported it would be and it should not be signed off as completed.

On 8/2/22 at 11:36 AM, Registered Dietitian (RD) 'I' was interviewed. When queried about how residents with tube feedings were monitored to ensure they were receiving the appropriate amount of tube feeding, RD 'I' reported the main way he monitored was by what the nurses documented on the MAR.

Review of a facility policy titled, "Enteral Nutrition - Resident Care", adopted on 7/11/18, revealed, in part, the following: "It is the policy of this facility that the nurse, in

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 _____	8/2/2022

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
	cooperation with other health team members, must carefully monitor the resident's response to the feedings and feeding techniques to assure the attainment of therapeutic goals...Document all appropriate information in medical record..." R114 A complaint was filed with the State Agency (SA) that alleged the facility failed to take care of the residents PEG tube, resulting in the inability to administer food, water, and medicine. On 7/26/22 at approximately 9:28AM, R114 was observed lying in bed. R114 was alert, but unable to answer any questions asked. A bottle of Jevity 1.5 tube feeding formula was hung on the tube feeding pole. There was no label on the tube feeding formula bottle that indicated the resident's name, rate of the tube feeding and the date and time it was hung. A second observation was made at 12:09 PM, the tube feeding bottle was removed. An interview was conducted with R114's assigned Nurse "O". Nurse "O" was asked as to the policy as to labeling and dating tube feeding formula bottles. Nurse "O" reported that she believed the midnight nurse must have hung the bottle but forgot to label it. Review of R114's clinical record documented the resident was admitted to the facility on 4/2/22 with diagnoses that included: Dysphasia, chronic kidney disease, repeated falls, and acute kidney failure. A review of the resident's Minimum Data Set (MDS) noted the resident was severely cognitively impaired and required extensive one to two person assist for most Activities of Daily Living (ADL).			

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 _____	8/2/2022

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
	Physicians' orders for R114 were reviewed and revealed the resident was to receive Jevity 1.5 at 100 mL to run for 12 hours or when 1200 mL infused. Up at 1800 (6:00 PM) and down at 0600 (6:00 AM). On 8/01/22 at approximately 10:45 AM, the DON was asked as to whether resident's receiving tube feeding should have their bottles labeled and dated to ensure proper administration. The DON responded that they should.			
F0756 SS= D	Drug Regimen Review, Report Irregular, Act On §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical	F0756	F756- Drug Regimen Review Resident #87 did not have any medication regimen reviews to complete at this time per the pharmacy. Resident # 91 did not have any medication regimen reviews to complete at this time per the pharmacy. Resident # 94 medication regimen review and residents orders were reviewed by the physician and orders addressed accordingly. Resident continues on Clopidogrel bisulfate, Omperazole was discontinued. There were no ill effects noted with the above residents as a result of this citation. All residents in the facility have the potential to be affected It was confirmed with the pharmacy representative that all residents receive a monthly medication review per regulation and that when the notation on residents medication review record states “see report for any noted irregularities” it does not always mean that the resident has a recommendation in need of a review at that time. All recommendations that are in need of review and/or action by the facility is sent to the Director of Nursing for follow up.	8/29/2022

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 _____	8/2/2022

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
	record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to consistently conduct medication regimen reviews and ensure physician approved recommendations from the pharmacist were implemented for three (R87, R91, and R94) of five residents reviewed for unnecessary medications. Findings include: Resident #87 Review of R87's clinical record revealed R87 was originally admitted into the facility on 12/3/21 with diagnoses that included: adult failure to thrive, protein-calorie malnutrition, and dementia. Review of a Minimum Data Set (MDS) assessment dated 6/16/22 revealed R87 had severely impaired cognition, no behaviors including rejection of care, and received more than 50 percent of nutrition via a feeding tube. Review of R87's monthly medication regimen reviews (MRR) revealed on 1/19/22 and 3/17/22, the consultant pharmacist		An audit was completed of the medication regimen reviews for the month of July to ensure that physician approved recommendations from the pharmacist were implemented. The Director of Nursing will distribute to the nurse managers/designee all Drug Regimen Reviews for residents as soon as received so that the mangers can follow up with recommendations in a timely manner, ensuring that orders are carried out per the physician recommendation and then turn back in to the DON after completion. The DON will monitor this process to ensure compliance. Nursing Management team was educated by the DON by 8/25/22 on ensuring residents that have a Medication Regimen Review are completed and implemented timely as approved by the physician The Director of Nursing will follow up and provide oversight. Director of Nursing/Designee will randomly audit 5 residents weekly X 4 weeks then monthly thereafter X 3 months or until substantial compliance has been maintained to ensure consistent medication regimen reviews are completed and ensure physician approved recommendations from the pharmacist are implemented in a timely manner. The results will be presented to the QAA committee for review and consideration of further corrective actions Director of Nursing is responsible for ensuring and maintaining substantial compliance Date of compliance: 8/29/22.	

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 _____	8/2/2022

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

documented, "See report for any noted irregularities".

On 8/1/22 at approximately 3:30 PM, the Director of Nursing (DON) was interviewed about where the pharmacist's recommendations would be documented. The DON reported they would be scanned into the electronic medical record. When queried about how often MRRs were conducted, the DON reported at least monthly. At that time, the recommendations made by the pharmacist along with the physician's response was requested for R87 from the 1/19/22 and 3/17/22 MRRs.

On 8/2/22 at 9:00 PM, the DON reported she was unable to find the pharmacist's recommendation reports for R87.

Resident #91

Review of R91's clinical record revealed R91 was admitted into the facility on 8/6/21 and readmitted on 6/15/22 with diagnoses that included: pneumonia, chest pain, sepsis, chronic leukemia, type 2 diabetes, asthma, and schizoaffective disorder. Review of a MDS assessment dated 6/20/22 revealed R91 had intact cognition, no behaviors, and required extensive to total physical assistance with activities of daily living.

Review of R91's monthly MRR reports revealed the consultant pharmacist documented, "See report for any noted

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 _____	8/2/2022

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

irregularities and/or recommendations" on 8/23/21, 10/19/21, 12/15/21, and 4/22/22. There was no documentation that a MRR was completed for the month of January 2022.

On 8/1/22 at approximately 3:30 PM, the DON was asked to provide the pharmacist's recommendation reports and physician's response for the R91's MRRs conducted on 8/23/21, 10/19/21, 12/15/21, and 4/22/22 and to confirm whether a MRR was completed in January 2022.

On 8/2/22 at 9:00 AM, the DON reported she could not find the pharmacist's recommendation reports from 8/23/21, 10/19/21, and 12/15/21 and could not verify that a MRR was completed in January 2022.

Resident #94

Review of R94's clinical record revealed R94 was admitted into the facility on 3/17/18 and readmitted on 5/25/22 with diagnoses that included: hemiplegia, dysphagia, chronic obstructive pulmonary disease, Lymphedema, and chronic kidney disease. Review of a MDS assessment dated 6/24/22 revealed R94 had intact cognition.

Review of R94's monthly medication regimen reviews revealed the consultant pharmacist documented, "See report for any noted irregularities and/or recommendations" on 6/9/22 and there was no MRR in the electronic medical record for the month of

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 _____	8/2/2022

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

May 2022.

On 8/1/22 at approximately 3:30 PM, the DON was asked to provide the pharmacist's recommendation report and physician's response for the MRR conducted on 6/9/22 and to confirm whether a MRR was completed for R94 in May 2022.

On 8/2/22 at 9:00 AM, the DON reported she was unable to confirm that a MRR was completed for R94 in May 2022. The DON provided the following for the MRR conducted on 6/9/22:

Review of a form titled, "Pharmacist Recommendation to Prescriber" dated 6/9/22 for R94, revealed, "This resident receives clopidogrel (Plavix) and also receives a proton pump inhibitor (PPI), Omeprazole (Prilosec). Recommendation: If PPI therapy remains the most appropriate gastroprotective therapy, please consider discontinuing Omeprazole and beginning PANTOPRAZOLE 20 mg (milligrams) daily as an alternative. Co-administration of these two medication can result in significant reductions in clopidogrel's active metabolite levels and antiplatelet activity. Individuals at risk of heart attacks or strokes, who are given clopidogrel to prevent blood clots, will not get the full anti-clotting effect if they also take Omeprazole..." In the section for the "Physician/Prescriber Response", Nurse Practitioner (NP) "M" checked the box that indicated they agreed with the pharmacist

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 _____	8/2/2022

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
	recommendation which instructed "Please enter new order into Electronic Chart...or flag for nurse". NP 'M' signed off on the form on 6/19/22. Review of R94's Physician's Orders revealed Omeprazole was not discontinued as recommended and agreed upon by the medical practitioner. R94's Omeprazole order remained at 20 mg twice a day with a start date of 5/26/22 and clopidogrel bisulfate 75 mg one time a day with a start date of 5/26/22. Review of a facility policy titled, "Medication Monitoring", effective date 6/21/17, revealed, in part, the following: "...The Consultant Pharmacist performs medication regimen review for each resident in compliance with Federal, State, and Local regulations and contractual requirements...The Consultant Pharmacist shall document the Medication Regimen Review on the individual's...designated area of the resident's Electronic Health Record (EHR)...A written report of all irregularities and recommendations resulting from the medication regimen review are provided to a facility designee for the Attending Physician, Director of Nursing and Medical Director...Report will be submitted within 72 hours of the actual review...For non-Urgent recommendations, the Facility and Attending Physician must address the recommendation (s) in a timely manner that meets the needs of the resident - but no later than their next			

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 _____	8/2/2022

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
	routine visit to assess the resident - and the Attending Physician should document in the medical record:...What irregularity has been reviewed...What action has been taken to address the issue...The pharmacy recommendation itself can be used as a tool to document in the medical record, or a notation may be indicated in the medical record/EHR...If the Attending Physician fails to address a recommendation...The Director of Nursing will be notified, and a summary shall be provided to the QAPI (Quality Assurance and Performance Improvement) committee on a periodic basis...The DON, Medical Director or designee should review the incomplete recommendation with the Attending Physician..."			
F0757 SS= D	Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-§483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F0757	F757 Drug Regimen is Free from Unnecessary Drugs Resident #91 Blood pressure orders were reviewed by the physician and deemed appropriate. Resident did not suffer any ill effects as a result of this citation. All residents residing in the facility have the potential to be affected. An audit was completed on the residents Medication Administration Audit report to identify any additional concerns related nurses not following physicians orders as written. Competency evaluations have begun to ensure that nurses are documenting the residents blood pressure on the MAR prior to administering residents medications and ensuring that any parameters or special orders are reviewed and followed per the physicians orders for administering or holding	8/29/2022

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 _____	8/2/2022

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
	Based on interview and record review, the facility failed to hold a blood pressure medication when the residents blood pressure was outside of physician ordered parameters for one (R91) of five residents reviewed for unnecessary medications. Findings include: Review of R91's clinical record revealed R91 was admitted into the facility on 8/6/21 and readmitted on 6/15/22 with diagnoses that included: hypertension. Review of a MDS assessment dated 6/20/22 revealed R91 had intact cognition, no behaviors, and required extensive to total physical assistance with activities of daily living. Review of R91's Physician's Orders revealed an order for Metoprolol Tartrate 25 MG every 12 hours. The order instructed to "hold for sbp (systolic blood pressure - the top number that indicates the pressure in your arteries when your heart beats) < (less than) 110)..." Review of R91's Medication Administration Record (MAR) from July 2022 revealed Metoprolol was administered (indicated by a check mark and the nurse's electronic signature) outside of the physician ordered parameters (SBP less than 110) on the following dates and times: 7/3/22 at 9:00 PM, BP was 102/55 7/10/22 at 9:00 AM, BP was 102/53		medications. By 8/25/22, Licensed nurses were educated on the medication administration policy specifically including following physicians orders when there are blood pressure parameters in place for residents. The DON/designee will conduct random audits 5 residents MARs who have blood pressure parameters in place for blood pressure medication weekly x4 then monthly thereafter times 3 months or until substantial compliance is attained and maintained to ensure that the nurses accurately monitor and adheres to following blood pressure parameters for residents per the physicians orders. The DON/Designee will conduct random audits on 5 residents MARs weekly x4 weeks then monthly times 3 months or until substantial compliance is attained and maintained to ensure that the nurses are administering resident medications per the physicians orders. The results of these audits will be presented to the QAA committee for review and consideration of further corrective actions monthly. The DON/designee will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22, and for sustained compliance thereafter	

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 _____	8/2/2022

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
	7/12/22 at 9:00 AM, BP was 98/56 7/22/22 at 9:00 AM, BP was 108/69 7/26/22 at 9:00 AM, BP was 104/69 7/27/22 at 9:00 PM, BP was 98/54 On 8/02/22 at 11:23 AM, Assistant Director of Nursing (ADON) 'B' was interviewed and R94's MAR was reviewed. ADON 'B' reported R94's Metoprolol should have been held according to physician's orders.			
F0758 SS= D	Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN	F0758	F758 Free from Unnecessary Psychotropic medication Resident #87 psychotropic medication were reviewed by the appropriate psych agency and were deemed appropriate. Gradual dose reduction has been initiated for this resident. All like residents with ordered psychotropic medications in the facility have the potential to be affected. An audit was completed on all residents on psychotropic medications to ensure justification of psychotropic usage, dosage, monitoring, and gradual dose reductions initiated. Any deficiencies were corrected accordingly. The facility Admin and Director of Nursing will meet with its provider who assist in managing the medical diagnosis for psychiatric medications on or before 8/25/22 to further review facility expectations as it relates to the managing residents with psychiatric medications inhouse. IDT behavior weekly meetings will be established. Weekly	8/29/2022

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 _____	8/2/2022

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
	orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide justification for the use of an antipsychotic medication, document and monitor targeted behaviors and symptoms, and perform a gradual dose reduction for one (R87) of five residents reviewed for unnecessary medications. Findings include: On 7/26/22 at 9:47 AM, R87 was observed sitting up in bed drinking a nutritional supplement. R87 was pleasant, but did not really engage in conversation. On 7/26/22 at 3:28 PM, R87 was observed seated in the common area of the unit and was calm. On 7/27/22 at 9:45 AM, R87 was observed eating breakfast in her room. R87 was calm		IDT behavioral meetings will be held with emphasis on ensuring residents in house that are on antipsychotic medications have an appropriate medical diagnosis in place as well as care plan and attempts of gdr per medical providers recommendations. If a concern is noted, attempts to gain compliance will be made by end of day. The Psychotropic Drug Use Policy was reviewed and deemed appropriate. By 8/25/22 the facility nurses and social services worker designee will be educated on the Psychotropic Drug Use Policy, specifically to ensure the justification for the use of an antipsychotic medication, documentation of behaviors and monitoring of targeted behaviors and symptoms and performing gradual dose reduction are completed. SW/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the justification for the use of an antipsychotic medication, documentation of behaviors and monitoring of targeted behaviors and symptoms and performing gradual dose reduction are completed. The results will be presented to the QAA committee for review and consideration of further corrective actions. The DON will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22 and for sustained compliance thereafter	

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 _____	8/2/2022

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
	and pleasant On 7/27/22 at 4:40 PM, R87 was observed in the common area of the unit. R87 was observed to be sleeping in their wheelchair. Review of R87's clinical record revealed R87 was originally admitted into the facility on 12/3/21 with diagnoses that included: adult failure to thrive, protein-calorie malnutrition, and dementia. Review of a Minimum Data Set (MDS) assessment dated 6/16/22 revealed R87 had severely impaired cognition, no behaviors including rejection of care, and received more than 50 percent of nutrition via a feeding tube. Review of R87's Physician's Orders revealed an active order for Haldol (an antipsychotic medication) 1 milligram (MG) for "agitation" with a start date of 5/29/22. Review of R87's Physician's Orders revealed the following discontinued orders for Haldol: Haldol 1MG every 8 hours PRN started on 12/3/21 (R87's admission date) and discontinued on 12/7/21 Haldol 1MG every 8 hours PRN for "agitation due to delirium" started on 12/3/21 and discontinued on 12/10/21 Haldol 1 MG every 8 hours with no associated diagnosis started on 12/21/21 and discontinued on 2/28/22			

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 _____	8/2/2022

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

Haldol 1MG every 8 hours for "anxiety" started on 3/2/22 and discontinued on 5/24/22

There was no evidence that a gradual dose reduction (GDR - tapering of a dose to see if symptoms can be managed at a lower dose or if the medication can be discontinued) had been attempted since R87's admission on 12/3/21.

Review of progress notes written by the facility's nurse practitioner (NP) 'P' revealed the following:

On 12/6/21, an initial evaluation was conducted by NP 'P'. NP 'P' documented, "...Haldol for agitation, plan to stop..."

On 12/28/21, NP 'P' documented, "Haloperidol (Haldol) for agitation. Plan to stop..."

On 1/11/22, NP 'P' documented, "...Lethargic...Haloperidol for agitation. Plan to stop/wean..."

Review of "Behavioral Care Services Progress Notes" revealed R87 was seen two times by the contracted behavioral health provider, as follows:

A progress note dated 3/16/22 documented, "...poor oral intake, becoming lethargic, refusing medications...combative behaviors,

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 _____	8/2/2022

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

pulls out peg (Percutaneous Endoscopic Gastrostomy) tube (feeding tube)...no documentation of hallucinations. Delusions cannot be excluded..."

A progress note dated 3/8/22 documented, "...Chart indicates she is combative with staff during peg tube cleaning and hygiene care..."

Further review of R87's clinical record revealed she was transferred to the hospital on 12/7/21 and was readmitted with a PEG tube. A "Medical Practitioner H&P (history and physical) written on 12/22/21 documented, "...Despite patient's prior wishes against PEG, family decided to pursue PEG tube. PEG was placed and patient was discharged back to (facility) for further rehabilitation..."

On 8/2/22 at 10:43 AM, an interview was conducted with Social Worker (SW) 'Q' (who did not work regularly at the facility, but was filling in in absence of the regular social services staff). When queried about where behaviors were documented for residents who were prescribed antipsychotic medications in order to monitor the effectiveness, SW 'Q' reported behaviors were documented in 'mood/behavior' progress notes and in "Behavioral Care Services" progress notes, and also by the Certified Nursing Assistants (CNA) in their "Tasks". When queried about when GDRs were attempted, SW 'Q' reported she was not sure, but she thought it was on a quarterly basis.

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 _____	8/2/2022

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
	SW 'Q' reported the contracted behavioral health practitioner came to the facility on a weekly basis. At that time, SW 'Q' was asked to provide documented justification for the use of Haldol for R87, the targeted symptoms and behaviors that were monitored, any non-pharmacological interventions used, and whether a GDR had been attempted. SW 'Q' was additionally asked if R87 was seen by the contracted behavioral health practitioner any other times besides twice in March 2022. On 8/2/22 at 12:27 PM, SW 'Q' reported R87 was seen by the contracted behavioral health practitioner two times in March and two times in June and provided the following documentation: A "Behavioral Care Services Progress Note" dated 6/8/22 that documented, "...Patient is alert and oriented, cooperative...Speech appears non-sensical and mostly smiles or nods her head...profound confusion at baseline. Documented with pulling out peg tube multiple times...No documentation or report of depression, suicidal ideation, homicidal ideation, hallucination. Delusions cannot be ruled out...Chronic combative/aggressive behaviors with care; multiple peg tube replacements secondary to being pulled out by patient. Continues with Haldol 1mg q(every) 8h (hours) to assist with behaviors. Recommend to continue at time time...Continue to monitor behaviors..." A "Behavioral Care Services Progress Note"			

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 _____	8/2/2022

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
	dated 6/15/22 that documented, "Patient is reported by staff to continue with behaviors such as spitting, hitting, scratching and resisting care. Continues with difficulty accepting peg tube - pulling/tugging on it...Reported to be chronically restless and wanders...Behaviors are reported as chronic and staff report approach can benefit outcomes however at times patient is generally agitated and confused where they feel the overall POC (plan of care_ is beneficial...if behaviors continue while receiving Haldol, potential to switch to Zyprexa (an antipsychotic medication) which patient may respond better to with similar efficacy..." Review of nursing progress notes revealed almost all documented behaviors were related to R87's PEG tube. Note, it was documented in December 2021, that R87's family decided to have a PEG tube placed despite 87's desire to not have one). Review of progress notes revealed the following: A "General Progress Note" dated 1/22/22 documented, "Pt (patient) displaying combative behaviors also refusing care..." A progress note dated 2/19/22 documented, "Pt not tolerating tube feeding, PT more than once attempted and or threatened to pull tube feeding cord out. Pt also became agitated when asked not to..." A "General Progress Note dated 2/21/22			

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 _____	8/2/2022

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

documented, "Resident continues to be combative, when trying to do peg tube and hygiene care. When attempting care, resident will hit, attempt to bite, and kick staff members. Writer and CNA unable to change resident clothes. Social worker made aware, and family and psych to be consulted..."

SW 'Q' further explained that she spoke with the nurses assigned to R87 and they reported they documented R87's behaviors on the Treatment Administration Record (TAR). Review of the TAR provided by SW 'Q', there were orders for "ANTIDEPRESSANT BEHAVIOR MONITORING: Document # of times patient voiced feeling sad and/or lonely each shift..." and "ANTIDEPRESSANT BEHAVIOR TRACKING: Document # of episodes of crying each shift..." There were no orders to monitor and track psychotic symptoms or behaviors. When queried about what was in place to monitor R87 for the effectiveness of an antipsychotic medication, SW 'Q' did not offer a response. When queried about whether R87 exhibited psychotic symptoms versus behaviors due to not wishing to have a PEG tube, R87 did not offer a response.

On 8/2/22 at 12:40 PM, the Administrator and Director of Nursing (DON) were interviewed. When queried about the process for overseeing resident who were prescribed antipsychotic medications, the Administrator reported social services was responsible to coordinate those services and interventions.

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 _____	8/2/2022

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
	When queried about when GDRs were conducted, the Administrator stated, "We follow our policy". When queried about how often the contracted behavioral health practitioners saw residents, the Administrator reported they had issues with their current contracted behavioral health services and were in the process of changing agencies. At that time, all CNA documentation for behavior monitoring for R87 was requested since December 2021. Review of CNA documentation since December 2021 revealed the following: December 2021 - no documented behaviors January 2022 - no documented behaviors March 2022 - On 3/9/22, rejection of care; kicking/hitting; and abusive language was documented. April 2022 - no documented behaviors May 2022 - no documented behaviors June 2022 - no documented behaviors July 2022 - On 7/10/22, rejection of care and grabbing was documented. Review of R87's care plans revealed a care plan initiated on 12/29/21 that documented, "Resident uses anti-psychotic medications r/t (related to) Symptom Management (Note: no			

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 _____	8/2/2022

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
	specific symptoms were identified)". Documented interventions initiated on 12/29/21 were, "Administer anti-psychotic medications as ordered by physician. Monitor/document...effectiveness q shift and prn (as needed)..." There were no identified targeted symptoms or behaviors linked to the use of antipsychotic medications. Review of a facility policy titled, "Psychoactive Drug Use", adopted 7/11/18, revealed, in part, the following: "...The Director of Nursing will have overall responsibility for policy and procedures regarding psychoactive drug use within the facility...Gradual dose reductions (GDR) will be attempted...Within the first year in which a resident is admitted on a psychoactive medication...the facility must attempt a GDR in (2) separate quarters (with at least one (1) month between the attempts, unless clinically contraindicated..."			
F0760 SS= G	Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f) (2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to prevent a significant medication error for two (R393 and R135) of two residents reviewed for significant medication errors, resulting in R393 not receiving multiple doses of anti-seizure medication and being hospitalized and R135	F0760	F760 Residents are Free from Significant Med Errors Resident #393 no longer resides at the facility. Resident #135 no longer resides at the facility. All residents residing in the facility have the potential to be affected. An audit was completed of the Orders tab dating back to July 2022 to current 8/22 to ensure that all pending or medications on order were received by the pharmacy for administration and documentation on the residents MAR. An audit was completed on all resident medication administration record to ensure that the residents medication was available and administered as ordered.	8/29/2022

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 _____	8/2/2022

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
	not receiving multiple doses of an antibiotic. Review of the medical record revealed R393 was admitted to the facility on 4/12/22 with a readmission date of 5/20/22 and diagnoses that included Epilepsy. A Minimum Data Set (MDS) assessment dated 5/27/22 documented "severely impaired" cognitive skill for daily decision making and required extensive staff assistance for all Activities of Daily Living (ADLs). Review of the April 2022 Medication Administration Record (MAR) documented an order for "Lacosamide (Vimpat) Solution 10 MG (milligram)/ML (milliliter), Give 25 ml via PEG (Percutaneous Endoscopic Gastrostomy)- Tube every 12 hours for seizures (9 AM and 9 PM)" The medication was supposed to start on 4/13/22, but the first administered dose was documented on 4/14/22 at 9 PM. The next dose documented as administered was on 4/15/22 and 4/18/22 both at 9 AM. All other doses were documented as not administered. Review of the progress notes documented the following: A Nursing note dated 4/13/2022 at 4:54 PM, " ... Lacosamide Solution ... Give 25 ml via PEG-Tube every 12 hours for seizure on order ..." A Nursing note dated 4/14/2022 at 1:04 PM, " ... Lacosamide Solution ... Give 25 ml via PEG-Tube every 12 hours for seizure on order ..."		Residents identified with having orders for IV's were observed by the Nurse Manager and are patent and functioning properly. The Director of Nursing/Nurse Managers/Designee will review in daily am clinical meeting. The alert on the main medical record dashboard named "Not administered" med passess in the last 24 hours to identify any medications that were missed and/or not given to residents in the facility for immediate action. By 8/25/22, Licensed nurses were educated on the Medication Administration policy specifically addressing ensuring that medication orders are carried out, received timely for residents and documented on the residents MAR as ordered. The DON/Nurse managers will provide over-sight monitoring the Orders panel in the electronic medical record during clinical meetings to ensure that medications are received timely per the physicians order for administration and documentation on the resident MAR. The DON/designee will conduct random audits 5 residents weekly x4 then monthly thereafter times 3 months or until substantial compliance is attained and maintained to ensure that new orders for residents are received timely for residents and documented on the MAR by the nurses. The DON/designee will conduct random audits on 5 residents weekly x4 then monthly thereafter times 3 months or until substantial compliance is attainted and maintained to ensure that residents with infections are treated in a timely manner The results of these audits will be presented to the QAA committee for review and consideration of further corrective actions monthly. The DON/designee will be responsible for	

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 _____	8/2/2022

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
	A Nursing note dated 4/18/2022 at 8:41 AM, " ... Lacosamide Solution ... Give 25 ml via PEG-Tube every 12 hours for seizure pharmacy called, and need CII (Controlled medication) prescription, Dr. notify <sic> ..." Review of the census revealed R393 was transferred to the hospital on 4/18/2022 and readmitted back into the facility on 5/11/2022. Review of the May 2022 MAR revealed the following: "Vimpat Solution ... (Lacosamide) Give 25 ml via PEG-Tube every 12 hours for seizures" The staff did not administer this on 5/11/22 or 5/12/22. Further review of the medical record revealed R393 was transferred to the hospital on 5/12/22 and readmitted back into the facility on 5/20/2022. Review of the hospital paperwork (dated 5/12/2022) provided to the facility upon readmission (on 5/20/2022), documented the "Principal Diagnosis" as "Status epilepticus". Further review of the May 2022 MAR documented the following: Lacosamide Solution ... Give 250 mg via PEG-Tube two times a day for Seizures. Out of the 14 doses that should have been administered to the resident, only 9 doses were documented as administered.		assuring substantial compliance is attained through this plan of correction by 8/29/22, and for sustained compliance thereafter	

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 _____	8/2/2022

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
	Further review of the progress notes revealed the following: A Nursing note dated 5/21/2022 at 12:12 PM, " ... Lacosamide Solution ... Give 250 mg via PEG-Tube two times a day for Seizures n/a (not applicable) awaiting on script ..." A Nursing note dated 5/23/2022 at 10:09 AM, " ... Lacosamide Solution ... pharmacy notified ..." A Nursing note dated 5/24/2022 at 8:49 AM, " ... Lacosamide ... Pharmacy notified ..." A Nursing note dated 5/25/2022 at 10:58 AM, " ... Lacosamide ... No CII form. MD (Medical Doctor) and pharmacy contacted ..." A Nursing note dated 5/26/2022 at 8:36 PM, documented in part " ... Lacosamide ... MED (medication) not available at this time ..." A Nursing note dated 5/27/2022 at 11:09 AM, documented in part " ... Lacosamide ... Med not available. Pharmacy contacted and will be in tonight's shipment ..." On 8/1/2022 at 12:20 PM, the Director of Nursing (DON) was interviewed and asked about the missed doses of lacosamide and how the medication was available for some nurses that signed the medication off as administered but not available for the other nurses documenting that the medication was unavailable. The DON stated they would look into it and follow up. At 2:59 PM, the DON and Assistant Director Of Nursing			

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 _____	8/2/2022

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
	(ADON) "B" returned and ADON "B" stated they called the pharmacy and the pharmacy confirmed that Lacosamide (Vimpat) was never delivered to the facility in April or in May until May 26th when two doses were delivered. It was clarified with the DON and ADON "B" that every nurse that signed in April and May 2022 that they administered the resident's Lacosamide medication had indeed not administered it because it was not delivered from the pharmacy, both the DON and ADON "B" confirmed that as being accurate. When asked, the DON stated they were not aware that there were issues with obtaining R393's Lacosamide medication until asked by the surveyor. The Nurse's note documented on 5/27/2022 confirmed the resident was sent to the hospital before the delivery was made by the pharmacy. R393 did not receive one dose of their Lacosamide seizure medication while admitted in the facility as prescribed by the physician. On 7/26/22 at approximately 10:39 AM, R135 was observed sitting in his wheelchair. His right foot was wrapped. The resident was alert and able to answer questions asked. R135 reported that he had been in the building for two weeks due to an infection in his right foot. R135 stated he was moved to his current room two days ago. The resident had a Peripherally Inserted Central Catheter (PICC) line. When asked about medication administration, R135 stated that he has not had his medication administered since Sunday (7/25/22) because the line was "clogged" and they were waiting for a PICC line specialist to unclog it. On 7/26/22 at approximately 3:23 PM, R135 was observed again in his room. When asked about			

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 _____	8/2/2022

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
	his PICC line status, R135 reported that they still have not unclogged it. A review of the resident's clinical record revealed the resident was admitted to the facility on 7/15/22 with diagnoses that included: local infection of the skin, displaced extraarticular fracture of right heel and type II diabetes. A physician order dated 7/15/22 read: "Meropenem-Sodium Chloride Intravenous Solution Reconstituted 500MG ...Use 500 mg Intravenously every 6 hours for antibiotic." A review of R135 Medication Administration Record (MAR) for the month of July 2022 documented several missing doses of R135's antibiotic (Meropenem-Sodium) as follows: 7/19: (12:00 AM) 7/20: (6:00AM, 12:00PM, 6:00PM) 7/21: (12:00AM, 6:00AM) 7/26: (12:00AM, 6:00AM, 12:00PM) 7/28: (12:00AM, 6:00AM, 12:00PM, 6:00PM) 7/29: (12:00AM, 6:00AM) A general progress note dated 7/20/22 (9:42 AM): "Writer contacted RN access about discontinue of current PICC ...Awaiting ETA for RN ...". It should be noted that there was no indication as to the delay in response to replace the PICC line. R135 missed six doses of the ordered antibiotic. A general progress note dated 7/26/2022 (12:33 AM): " ...IV clogged, IV assess contacted ...". It should be noted that R135 missed an additional			

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 _____	8/2/2022

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

three doses of the ordered antibiotic.

A progress note dated 7/28/2022 (2:42 AM): "Pt Picc line clogged"

It should be noted that R135 missed six does of the ordered antibiotic. It should be noted that R135 missed an additional six doses of the ordered antibiotic.

On 8/1/22 at approximately 10:45 AM, an interview was conducted with the Director of Nursing (DON) and Assistant DON "B". When asked why there were so many missed administrations of R135's antibiotic through the PICC line and whether they were able to address the root cause as to why the line kept clogging. The DON noted that they were never contacted by any of the nursing staff and noted that staff was contacting the "access RN (Registered Nurse -paid vender)" for assistance. When asked if they were aware of delay in response by the "access RN" the DON noted again they were not aware. The DON stated that staff are aware that could contact her and/or the ADON "B" who were and stated that they were trained and able to assist with PICC line clogging and replacement.

On 8/2/22 at approximately 8:53AM, the Medical Director was informed of the missed antibiotic administration due to possible PICC line clogging and/or replacement need. The Medical Director stated that there was no reason a resident should miss so many doses of an ordered antibiotic and staff could have contacted her directly.

On 8/2/22 at approximately 1:46PM, a phone interview was conducted with Nurse "WW". Nurse "WW" was assigned to R135 on 7/28/22. When asked about R135 and the failure to administer the resident's antibiotic through the PICC line, Nurse "WW" stated it was clogged and

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 _____	8/2/2022

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
	they needed to contact the "access nurse". When asked if they responded to the contact, Nurse "WW" reported that they did not on her shift. When asked if she contacted the DON, Nurse "WW" stated that she did not. A facility policy titled, "Catheter Insertion and Care" (October 1, 2010) was reviewed and documented, in part, the following: "Policy ...Peripheral IV catheters will be inserted by Nurses with demonstrated competency in IV therapy ... contracts with the call center to make arrangements for a ...PICC line insertion ...3. The Infusion Nursing Agency will contact the family nurse or physician in approximately one hour ...".* It should be noted that the document provided did not contained only 18/53 pages.			
F0761 SS= E	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F0761	F761 Label/Store rugs and Biologicals No residents suffered any ill effects as a result of this citation. All residents have the potential to be affected by this citation. An audit was completed on each unit of all medication carts and medication rooms to ensure the proper storage, labeling and discarding of drugs and biologicals, food discarded, and any opened applesauce/pudding is dated upon opening for use. Nurse leadership will be responsible for conducting rounds on all units multiple times daily with emphasis on checking the medication carts for the proper labeling and storage of biologicals applesauce/pudding used for the medication pass and auditing the medication rooms for items that should not be stored in the medication room and/or refrigerators for proper labeling and storage of	8/29/2022

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 _____	8/2/2022

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
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper storage, labeling, and discarding of drugs and biologicals, resulting in the potential for misuse, contamination, and medication administration errors. Findings include: On 7/27/22 at 3:27 PM, an observation of the 2 west (north hall) medication cart was conducted with Nurse 'Z' and revealed the following concerns: One opened and undated container of assure glucose test strips (one strip remained). On 7/27/22 at 3:42 PM, an observation of the 2 West medication room was completed with Unit Manager 'AA' who reported they had been in that position since March 2022. Upon observation of the medication room refrigerator, there were multiple vials of unopened insulin, six containers of influenza vaccine, four vials of tuberculin solution and a cup of applesauce that was not labeled or dated. When asked about whether food should be stored in the refrigerator used to store drugs and biologicals, Unit Manager 'Z' reported there should be no food stored in there.		biologicals. Starting in the am before clinical meeting and ending prior to stand down meeting in the afternoon. Areas of non compliance with be addressed on the spot when feasible with the charge nurse. The DON/designee will educate License Nurses by 8/25/22 on the facility policy: Medication Administration and Medication Access and Storage related to ensuring medication are stored in an appropriate space and other non-medication items will not be stored in the refrigerators, insulins are dated when opened, no food items are stored in refrigerators, biologicals are properly labeled, discarded or stored, applesauce/pudding is dated upon opening/use, eye gtts are dated upon opening. Director of Nursing/Designee will audit the medication rooms and medication carts weekly X 4 weeks then monthly thereafter X 3 months or until substantial compliance has been maintained to ensure proper storage, labeling, and discarding of drugs and biologicals per policy. The results will be presented to the QAA committee for review and consideration of further corrective actions Director of Nursing is responsible for ensuring and maintaining substantial compliance. Date of Compliance: 8/25/22	

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 _____	8/2/2022

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
	When asked about the use and storage of the insulin pens and glucometer strips in the medication carts, Unit Manager 'Z' reported they should be labeled and dated when opened. When asked who was responsible for monitoring the medication carts and medication room to ensure drugs and biologicals were properly labeled, discarded, or stored, they reported the Unit Managers should do a weekly audit. When asked if they had done any recent audits, Unit Manager 'Z' reported they had not been able to do to. On 7/27/22 at 4:55 PM, observation of the medication cart for 2 West (South) the following concerns were identified: There were two opened Novolog Flex Pens with a pharmacy label dated 7/20/22 but no resident names. When asked which residents those insulin pens belonged to, Nurse 'BB' reported they were not sure. On 7/27/22 at approximately 4:08 p.m., a Medication cart titled "one east-cart two" was reviewed for medication storage and labeling with Nurse "UU" and the following were observed: A SoloStar Lantus pen for R17 was observed opened and undated. A Humalog pen for R40 was observed opened and undated. A Solostar Lantus pen for R40 was observed opened and undated and a second humalog pen for R40 was observed opened and undated. Nurse "UU" was queried regarding the opened and undated medications and indicated that the			

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 _____	8/2/2022

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

medications that were opened should have had a date on them that indicated they day they were opened so they know if they are still good.

On 7/27/22 at approximately 4:27 p.m., A medication cart on one West was reviewed with Nurse "VV" and the following was observed: A Novalog Flex Pen for R84 was observed opened and undated and an opened, undated prednisolone Acetate Ophthalmic Suspension 1 % eyedrop for R105. Nurse "VV" was queried if the Novalog for R84 should have been dated when it was opened and they indicated that it should have been. Nurse "VV" was also queried regarding the opened eyedrops for R105 and they indicated they should have been dated when they were opened as well.

On 8/1/22 at approximately 10:53 a.m., The Director of Nursing (DON) was queried regarding the labeling and storage of medications in the carts and the observations of the opened and undated insulin's and eyedrops. The DON indicated that if a medication such as insulin or eyedrops was opened it should have been dated with the day it was opened.

On 8/2/22 a facility document titled ""Medication Administration" was reviewed and revealed the following: "Subject: Labeling of Medications and Biologicals-POLICY: It is the policy of this facility that medications and biologicals are labeled in accordance with

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 _____	8/2/2022

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
	facility requirements, state and federal laws. Only the provider pharmacy modifies or changes prescription labels..."			
F0812 SS= F	Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure food items were labeled and dated and failed to maintain kitchen equipment in a sanitary manner, resulting in the increased potential for cross contamination and foodborne illness. These deficient practices had the potential to affect all residents that consume food from the kitchen. Findings include: On 7/26/22 between 9:07 AM - 9:45 AM,	F0812	F812 (Food Procurement, Store/Prepare/Serve/Sanitary) Element 1 Residents inhouse who were served the food item located in walk in cooler that was undated had no ill effect from being served meal. However, immediate education on facility dating and labeling policy was initiated to staff same day of observation, 7/26/2022. The large box of lettuce and two large bags undated identified was discarded. The two door reach in cooler now has an internal thermometer in place that is functioning properly. The scoop holder for the large bin of sugar has been stored in a protected location. The ice machine identified to be contaminated was emptied and deeply sanitized by dietary staff on 7/26/22. A log for ice machine monitoring has been put in place. Element 2 All residents has the potential to be affected. On 8/10/2022, the facility administrator and Dietary Manager conducted a round of kitchen to ensure compliance. All deficiencies were corrected on observation. The Administrator and Dietary manager will begin conducted weekly rounds in kitchen to ensure compliance. Any non compliance will be brought to QA for further review. The Dietary Manager will conduct a daily walkthrough of kitchen to ensure all equipment which includes ice machine are being maintained in a sanitary condition, logs are up to date, and proper dating and labeling are in place. Findings of daily rounds will then be reported to the to daily admin meeting. Element 3:	8/29/2022

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 _____	8/2/2022

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
	during an initial tour of the kitchen with Dietary Manager (Staff 'W'), the following items were observed: The walk-in cooler had two large containers filled with cut red potatoes. The label on top of these containers were dated as prepared on 7/21 and were to be used by 7/23/22. At that time, Staff 'W' reported those were to be used for today's lunch meal. When asked about the use by date, they reported the potatoes had been prepared too soon and should not be used. At 9:45 AM, two dietary staff were observed placing the same cut red potatoes on a baking sheet to prepare for lunch. Staff 'W' reported those should have been discarded and asked the staff if they had seen the date on the lid in which they did not respond and Staff 'W' then informed them to discard. A large box of lettuce and two large bags of raw carrots were opened to air and not sealed properly. Staff 'W' reported all food items should be covered. The two door reach in cooler located behind the meal prep area had an internal thermometer that was not working, the reading on the external display indicated that temperature of the cooler to be 50 degrees Fahrenheit (F). There were several trays of jello and bowls of pineapple that were not covered and open to air. Staff 'W' was asked about the current temperature and reported it could have been likely due to it being		The Dietary staff was in-serviced on revised sanitation checklist, labeling and dating of food, and ensuring ice machine is checked weekly. Element 4: Dietary Manager/ Designee will audit sanitation practices weekly x 4 weeks monthly times 3 to ensure proper sanitation methods are incorporated, dating and labeling of for, and ensuring kitchen utensils are being stored properly. Dietary Manager will be responsible for sustained compliance and present findings to the Quality Assurance Committee. The QA committee will receive report and direct actions as appropriate. Element 5:The Administrator/Dietician is responsible for compliance. 8/29/22	

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 _____	8/2/2022

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
	opened for breakfast. Staff 'W' reported there should be an internal thermometer and would get a new thermometer placed. According to the 2013 FDA Food Code section 3-305.11 Food Storage, "(A) Except as specified in (B) and (C) of this section, food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (6 inches) above the floor." According to the 2013 FDA Food Code section 3-501.17: "Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date			

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 _____	8/2/2022

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

based on food safety."

The large bin which stored sugar was observed to have a scoop that was stored directly on top of the sugar product. Staff 'W' reported the internal scoop should not have been stored like that and attempted to place back in the scoop holder located near the top of the storage bin in which the scoop fell directly back into the sugar. Staff 'W' reported they would have to replace with another scoop.

According to the Food & Drug administration (FDA) 2013 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, "During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: ...(E) In a clean, protected location if the utensils, such as ice scoops, are used only with a food that is not potentially hazardous (time/temperature control for safety food)..."

On 7/27/22 at 11:35 AM, a follow-up visit was conducted with Staff 'W' and Regional Dietary Consultant (Staff 'X'). The inside of the ice machine was observed to have a pink colored build-up on the internal bottom corners (where the ice comes out of) which was confirmed by both Staff 'W' and Staff 'X'. When asked who was responsible to monitor and maintain the ice machine, Staff 'W' reported that was the Maintenance Director (Staff 'Y'). Staff 'W' was requested to provide documentation of when the ice machine was

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 _____	8/2/2022

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
	last cleaned and upon removing the door on the upper portion of the ice machine, the log inside indicated the last date was on 11/13/20. On 7/28/22 at 10:54 AM, Staff 'Y' reported the machine had last been cleaned on 5/10/22. Staff 'Y' reported it was cleaned quarterly and the logs were no longer kept inside the machines as they were getting wet. Staff 'Y' was asked if anyone had informed them of any concerns with the ice machine prior to now, they reported they were not and was informed of the findings on 7/27/22. On 7/28/22 at 11:00 AM, Staff 'Y' reported staff should have contacted them if they identified concerns with the ice machine, such as need for increased cleaning. Staff 'Y' further reported that they had seen the areas of concern and already took care of it. The FDA Food Code 2013 states: 4-601.11 Equipment, Food-Contact Surfaces, Nonfood_Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch.			
F0814 SS= F	Dispose Garbage and Refuse Properly §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by:	F0814	Element 1 The litter identified near the exterior trash/refuse area was discarded by Maintenance Director on 7/26/22 and placed in the dumpster.	8/29/2022

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 _____	8/2/2022

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
	Based on observation, interview, and record review, the facility failed to maintain the exterior trash/refuse area in a sanitary manner, resulting in the increased potential for odors and the attraction of pests and rodents. This deficient practice had the potential to affect all residents, staff, and visitors. Findings include: On 7/28/22 at 10:35 AM, the exterior trash/refuse area was observed. There were three gates surrounding the trash/refuse area that were left open. There were three dumpsters which were opened and the surrounding ground was observed to be littered with trash which included used face masks and food items. Stored on the ground just outside the trash/refuse area were discarded resident equipment, kitchen equipment, wooden pallets, and broken-down boxes. There was an abundance of flies hovering the ground surrounding the dumpsters. On 7/28/22 at 10:50 AM, the exterior trash/refuse area was observed in the same manner with the Maintenance Director (Staff 'Y'). When asked who was responsible for monitoring and maintaining the facility's exterior trash/refuse area, they reported that was the Environmental Services Director whose last day was Friday and currently was (name of Regional Environmental Services		Element 2 All residents have the potential to be affected by this deficiencies. The Environmental Director conducted a thorough assessment of the exterior trash/refuse area, ensured environment was cleaned, top of dumpster lip closed and gates closed. The Environmental Service Director and/or designee will conduct daily rounds and will ensure Trash be removed daily from building and disposed of in dumpster. All areas behind gates will remain free of debris and trash. Dumpster lids will remain closed at all times. Gates will remain shut. Outside perimeter of facility will remain free of debris and trash. Outside trash cans will be removed daily and disposed of in dumpster.in am prior to facility admin meeting to report on any finding related to exterior trash/refuse area. Findings will be brought to the facility stand up meeting. Environmental Staff were reeducated on ensuring exterior trash/refuse area was maintained in a sanitary manner to prevent the potential for odors and attraction of pests and rodents element 4 Environmental Service Director and/or designee will be conducting a random audit of exterior trash/refuse area weekly x 4 monthly x 3 to ensure compliance. Any non compliance will be brought to QA committee. The Environmental Service Director is responsible for maintaining and sustaining compliance.	

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 _____	8/2/2022

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
	Staff 'D'). When asked how often the garbage was picked up, they reported every day except Sunday. Staff 'Y' further reported that they had informed Staff 'D' yesterday that the gates were left opened and there was trash everywhere and offered to help but nothing further happened. When asked about the placement of the broken-down boxes, wood pallets, hospital bed and kitchen food steamer, Staff 'Y' reported they were not as concerned with those items as they were usually only there for a few days. On 8/1/22 at 10:32 AM, the exterior trash/refuse area was observed to have the lids left open on all three dumpsters. One of the dumpsters had a side door opened and resident equipment (hospital bed) and wood pallet were observed stored along the wall surrounding the dumpster. According to the 2013 FDA Food Code section 5-501.113 Covering Receptacles, "Receptacles and waste handling units for REFUSE, recyclables, and returnables shall be kept covered: (B) With tight-fitting lids or doors if kept outside the FOOD ESTABLISHMENT." According to the 2013 FDA Food Code section 5-501.115 Maintaining Refuse Areas and Enclosures, "A storage area and enclosure for REFUSE, recyclables, or returnables shall be maintained free of unnecessary items, as specified under § 6-501.114, and clean."			

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 _____	8/2/2022

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
F0838 SS= C	Facility Assessment §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including	F0838	F838 Facility Assessment All residents have the potential to be affected. In similar situation, for resident safety, the facility will follow policy and procedures best practice, and guidelines to ensure care and services are provided to protect the residents. By 8/25/2022, the facility assessment will be revised according to policy and guidelines ensuring staff competencies necessary to provide the level and type of care for resident, resources, training facility and community based risk assessment are updated. The facility assessment will be updated annually as required and reviewed monthly to ensure the current resident population and level of care are addressed. The Administrator will review/audit the facility assessment monthly and results presented to the QAA Committee for review and consideration of further corrective actions and/or updated as needed.	8/29/2022

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 _____	8/2/2022

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
	managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that the facility assessment was reviewed and updated annually, with the potential to affect all 146 residents residing in the facility. Findings include: The facility "Facility Assessment" Policy (adopted 7/11/2018) documented, in part: "It is the policy of this facility to conduct and document a facility-wide assessment to determine what resources are necessary ...Time of assessments: The facility will review and update that assessment as necessary and at least annually ...". A review of the facility assessment indicated an 'Assessment Date" of 3/21/21 and the "Health Administrative (license holder) was noted as the former Administrator.			

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 _____	8/2/2022

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
	On 8/2/22 at approximately 12:19 p.m. the Administrator was asked about the lack of an updated Facility Assessment. The Administrator noted that he started at the facility in April 2022 and had not updated the assessment. He further indicated that the assessment should be updated annual and if there are any significant changes at the facility.			
F0850 SS= F	Qualifications of Social Worker >120 Beds §483.70(p) Social worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is: §483.70(p)(1) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology; and §483.70(p)(2) One year of supervised social work experience in a health care setting working directly with individuals. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to employ a qualified social worker on a full-time basis to meet the psychosocial, mental, and behavioral health care needs of the residents, resulting in deficient practices related to social services. This deficient practice had the potential to affect all residents that reside within the facility. Findings include:	F0850	Element 1 The Facility has hired social work director support to ensure compliance in meeting the psychosocial mental, and behavioral health care needs of the residents until facility secures a Fulltime licensed Social Work Director. Element 2 All residents have the potential to be affected. A facility-wide audit has been completed by Interdisciplinary team of Residents receiving antipsychotic medication use, timely completion of PASRR assessments on or before 8/24/22 to ensure compliance. Resident were audited to ensure they have the appropriate mental medical diagnosis and reside in the facility for more than 30 days, receive their 3878, and that 3877/3878 documents are current, reviewed, revised and sent to the local state agency for review and/or evaluation. Further, residents on psychotropic medications were audited to ensure to ensure justification of psychotropic usage, dosage, monitoring, and gradual dose reductions initiated. Any deficiencies were corrected accordingly. Any areas of deficiency was corrected, care plans updated accordingly. Further a facility wide assessment of residents was completed by SW to ensure psychosocial wellbeing is	8/29/2022

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 _____	8/2/2022

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
	During the recertification survey conducted 7/26/22 to 8/2/22, substandard quality of care was identified in regard to the facility not having a qualified social worker to provide medically related social services full-time to the 146 residents who resided in the facility. The facility was certified for 159 beds. Deficient practices were identified during the survey related to social services, specifically concerns with the lack of behavior monitoring and monitoring the use of antipsychotic medications, timely completion of PASRR (Pre-Admission Screening and Resident Review) assessments, and advocacy for a resident who had severely impaired cognition. On 7/26/22 at 2:25 PM, an interview was conducted with Social Service Technician 'G' who reported they worked at the facility full-time. When asked if there were any other social work staff who worked at the facility, SST 'G' reported there was a Social Service Director from another facility that came to the facility two times a week (part-time). On 8/2/22 at 12:40 PM, the Administrator and Director of Nursing (DON) were interviewed. When queried about who served as the qualified full-time social worker for the facility, the Administrator identified SST 'G'. When queried about whether SST 'G' had a bachelor's degree in a human services field, the Administrator reported she did not and		met. Findings were addressed. Behavior Care meetings will occur weekly to ensure compliance. The facility has reevaluated the SW job posting and has modified its marketing efforts to assist in increasing the applicant flow for a Qualified SW director. The facility Administrator will review the facility system used to recruit staff and monitor the system to gauge applicant flow for SW Director. In the meantime, the facility will continue to use the support of a licensed social work director from a sister facility and during evening hours to ensure the overall systems of the sw dept are being followed. element 3 The Psychotropic Drug Use Policy was reviewed and deemed appropriate. By 8/25/22 the facility nurses and social services worker designee will be educated on the Psychotropic Drug Use Policy, specifically to ensure the justification for the use of an antipsychotic medication, documentation of behaviors and monitoring of targeted behaviors and symptoms and performing gradual dose reduction are completed. Administrator/Designee will educate Social Services by 8/25/22 on ensuring that residents that have the appropriate mental medical diagnosis and reside in the facility for more than 30 days, receive their 3878 and that PASARR documents are reviewed, revised and sent to the local health agency for review and/or evaluation. Element 4 SW/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the justification for the use of an antipsychotic medication, documentation of behaviors and monitoring of targeted behaviors and symptoms and performing	

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 _____	8/2/2022

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
	that she was an SST. The Administrator reported Social Worker 'Q' came in sometimes from another building to help but currently the facility did not have a qualified social worker working full time. When queried about when the last time a qualified social worker was employed full-time in the facility, the DON reported when she started in February 2022, there was a Social Work Director, but she terminated her employment after a couple of weeks. The Administrator and DON were unable to provide information about the previous social worker and reported they were trying to hire someone. Review of a list of employees provided by the Administrator upon entrance to the facility listed SST 'G' as a "Social Worker - BA (Bachelor's)". Review of SST 'G's personnel file revealed no evidence that they were a social worker or had a bachelor's degree in a human services field. Review of the facility's job description for "Social Services Coordinator", revised 10/22/20, revealed, in part, the following: "...Requires a bachelor's or associates degree in gerontology or related field and at least one-year experience in social service program for the elderly or related field". However, the regulatory requirement does not include those with associate degrees to meet the status of a qualified social worker. Review of a facility policy titled, "Behavioral Health Services", adopted 7/11/18, revealed,		gradual dose reduction are completed. Administrator/Designee will randomly audit 5 residents for PASARR Screening weekly X 4 weeks then monthly thereafter X 3 months or until substantial compliance has been maintained by ensuring that residents that have appropriate mental medical diagnosis and or 3877/3878 documents are reviewed, revised, and sent to the local state agency for revie and/or revaluation. The results will be presented to the QAA committee for review and consideration of further corrective actions.	

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 _____	8/2/2022

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
	in part, the following: "...A qualified social worker is defined as an individual with: bachelor's degree in social work or a bachelor's degree in human services field including but not limited to special education, rehabilitation counseling, and psychology; one year of supervised social work experience in a health care setting working directly with individuals..."			
F0867 SS= F	QAPI/QAA Improvement Activities §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement an effective Quality Assurance & Performance Improvement (QAPI) program that identified quality issues and implemented appropriate plans of action to correct quality deficiencies and maintain sustained compliance. Findings include: An annual recertification survey was conducted from 7/26/22 through 8/2/22 and the following deficiencies were identified by the onsite survey team: 1. The facility did not maintain a clean, comfortable, homelike environment, which was evidenced by soiled floors; dirty linens, privacy curtains, and	F0867	F867 QAPI/QA No specific residents were identified in 2567. All residents have the potential to be affected. By 8/25/22 the Regional Director of Operations and Regional Nurse Consultant completed an in-service with the facility Quality Assessment and Assurance (QA&A) Committee regarding an effective QA&A Committee and Process which included but was not limited to a QAPI Overview, Perceptions of Quality, Six Step Process, Data Collection, Root Cause Analysis, Outcomes, appropriate plan of action, Leadership Oversight, Quality Assessment and Assurance Committee (Purpose, Membership, Roles, Expectations of the Committee, communication, Confidentiality of the Committee, Conducting a Meeting, Monthly Meeting, QA&A Committee Meeting Minutes, QAA Subcommitte Subcommittee Planning and Development, QA&A AD HOC Committee, Celebrate Success,) Quality Assurance Performance Improvement, QAPI Annual Reporting Schedule, Quality Assurance Performance Improvement Action Plan, Quality Assurance Summary Report and Federal Regulatory Groups for Long Term Care Facilities. The QA&A Program guidelines will be followed to address identified facility issues.	8/29/2022

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 _____	8/2/2022

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
	resident equipment, some that were caked with fecal matter. 2. The facility did not ensure kitchen staff kept a sanitary kitchen by failing to ensure food items were labeled and dated and failed to maintain clean kitchen equipment. 3. The facility did not ensure a full time qualified social worker was present in the building resulting substandard care with multiple areas of deficiency in the social services department. 4. The facility failed to maintain skin integrity resulting substandard care with the development of pressure ulcers for multiple residents that had resided in the facility. On 8/2/22 at 12:55 p.m., the facility Administrator was interviewed regarding the facility's QAPI program. The Administrator reported the QAPI committee meets quarterly but since they have taken over as the Administrator, they have met monthly to discuss any quality deficiencies and/or action plans. When queried about whether concerns related to the resident environment (cleanliness of the facility, and missing clothes were identified as a concern through the QAPI process, the Administrator reported housekeeping issues were identified by facility via the resident council and that they were in process of making managerial improvements and had just recently hired a new environmental services manager and implemented a new "guardian angel" program but had not officially brought the environmental service concerns through the QAPI process and had not developed an		Oversight will be provided by Regional Director of Operations and Regional Nurse Consultant monthly for 3 monthly to ensure the implementation of the revised QA&A Program and the QA&A Committees performance in identifying and addressing compliance issues and implementing an appropriate plan of action to ensure that effective plans of actions to correct identified quality deficiencies are corrected and maintained. Any discrepancies identified in the audits will be documented, investigated, and corrected immediately by Administrator. As discrepancies and trends are identified through these Quality Assurance audits further education and training will be provided. If trends or discrepancies are noted this QA&A process will be revised by the QA&A Committee. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22 and for sustained compliance conducted to determine compliance with deficiencies identified during an abbreviated survey conducted on 7/26/22 to 8/2/22. According to a CMS (Center for Medicare and Medicaid) 2567 form dated 8/2/22, the facility was found to be noncompliant with regulatory requirements related to maintaining clean, comfortable, homelike environment, kitchen staff kept a sanitary kitchen and ensure food items were labeled and dated and failed to maintain clean kitchen equipment, did not ensure a full time qualified social worker was present in the building resulting in substandard care with multiple areas of deficiencies in the social services department, failed to maintain skin integrity resulting in substandard care with the development of pressure ulcers for multiple residents in the	

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 _____	8/2/2022

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
	audit tool to identify objective measurable performance. The Administrator was queried about whether any concerns regarding the kitchen had been identified through the QAPI program, the Administrator reported they were unaware of any issues and did not know the kitchen staff were not completing the labeling requirement per the food service code. The Administrator indicated that a "kitchen rounding" form had been developed but they had not had a chance to put it into place and had not reviewed any kitchen deficiencies within the QA process. The Administrator was queried regarding the multiple areas of concern identified in the Social Service Department and they indicated that they had been aware of the need to hire another Social Worker but were still reviewing applications. The Administrator was queried if they had begun a performance improvement plan through QAPI for the Social Service Department and the indicated they had not. The Administrator reported the last full time social worker for their facility left around February 2022. The Administrator was queried regarding the identification by the onsite survey team of new pressure ulcers for residents in the facility. They indicated that they had put wound care through the QA process in May 2022 with an audit form that was created to identify if wound care is being completed.		facility. The Director of Nursing/designee will conduct random audits through observation on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure the facility is following the treatment orders, completing the treatment administration record, weekly skin assessments, preventative measures are implemented for residents at high risk for pressure ulcers. Administrator/designee will conduct random audits on 5 resident rooms weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure a comfortable and homelike environment and residents are receiving back clothing. Administrator/designee will conduct random audits on social work assessments weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance to ensure social work practices and procedures are being followed. The results will be presented to the QAA (Quality Assurance and Assessment) committee for review and consideration of further corrective actions. The Director of Nursing will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22 and for sustained compliance thereafter	

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 _____	8/2/2022

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
	The Administrator indicated that they did a "house sweep" of all residents to try to identify new wounds and that after the initial sweep the audit tool would be used for compliance. The Administrator was queried regarding the frequency and length of the wound audit tool and they indicated that the performance improvement plan is done for weekly for four weeks and monthly for three months. The Administrator was queried how the survey team had identified wound treatments not being completed and interventions for high-risk residents had not been implemented timely they indicated that they thought that they were doing well with the facility wound care but it had appeared that the plan was ineffective and needed to be carried forward. On 8/2/22 a facility document titled "Quality Improvement" was reviewed and revealed the following: "QAPI OVERVIEW-Quality Assurance is a continuous process towards quality management. Improving services begins with the realization that higher levels of quality are achieved through every interaction between employees, residents, families, and caregivers. Each person's effort contributes to improving resident outcomes and satisfying service expectations. In the quest for continuous improvement, team members bring together multidisciplinary expertise from all levels of the organization in approaching problems and finding solutions. Interventions are analyzed and targeted key performance improvement steps identified.			

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 _____	8/2/2022

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
	PERCEPTIONS OF QUALITY-Quality Assurance and Performance Improvement (QAPI) builds upon traditional quality assurance methods by emphasizing the organization and systems. QAPI incorporates systems, programs, clinical practice, and clinical development driving system integrations and inter-program coordination through organized leadership oversight...ROOT CAUSE ANALYSIS-Root Cause Analysis (RCA) is a problem-solving method aimed at identifying primary causes of problems or issues. RCA is predicated on the belief that issues are best resolved by eliminating or correcting root causes, as opposed to addressing obvious symptoms or popular assumptions. By directing corrective action to the underlying cause, it is likely reoccurrence will be minimized. RCA can be used for both reactive post occurrence problem analysis and as a proactive method to forecast likelihood of reoccurrence. The RCA process starts by asking why until the causal chain leads to the root cause of the issue. Begin by asking, "Why did the problem happen?" Continue asking why and exploring associated symptoms until a single cause can be determined, sometimes the root cause will be multifactorial and will require simultaneous and/or prioritized approaches. After the root cause of a problem is identified, a Quality Assurance and Performance Improvement Action Plan is developed. OUTCOMES-When a QAPI Action Plan is final, audits are completed to monitor for continued compliance. Audits are evaluated and trends			

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 _____	8/2/2022

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
	identified by the project champion or committee chair prior to the QAA meeting. Outcomes may also come from additional sources such as outside vendor reports. LEADERSHIP OVERSIGHT-Quality Assurance and Performance Improvement is facilitated through leadership oversight. This is achieved through structured and ad hoc committee meetings daily, monthly, and quarterly. The focus of a QAA meeting is to identify systems to better meet the needs of residents, organize interdisciplinary teams, clarify the knowledge of the situation, understand the causes of variation within a system, select improvement strategies and monitor outcomes...QUALITY ASSESSMENT AND ASSURANCE COMMITTEE-PURPOSE-The QAA Committee has the overall responsibility and authority to conduct a confidential and privileged review of resident care and service trends to identify opportunities for performance improvement, identify quality issues and develop plans of action..."			
F0880 SS= E	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying,	F0880	F Tag 880- Infection Control and Prevention Residents #29, #45, #75, #99, and #137 were assessed by a Licensed Nurse for s/s of infection with no adverse effects noted. Respiratory assessments were completed with no adverse findings. The Licensed Nurse will continue to monitor for signs and symptoms of infection and report any symptoms to the physician. All facility residents have the potential to be affected for the potential of cross	8/29/2022

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 _____	8/2/2022

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
	reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.		contamination and spread of disease. The Licensed Nurse completed an respiratory assessment of the residing residents for s/sx of infection. No new infections were identified to the residing residents related to the deficiency cited. A widespread audit was conducted by the Infection Preventionist/Designee by 8/24/2022 to ensure staff adherence to the guidelines related to cleaning and disinfecting procedures specifically blood glucose glucometer equipment and the mouthpiece of resident inhalers after use. A widespread audit was conducted by the Infection Preventionist/Designee by 8/24/2022 to ensure staff adherence to the guidelines for PPE specifically to donning/doffing procedure for TBP's for residents in isolation rooms. By 8/25/2022, Licensed Nurses will be educated on Glucometer Decontamination policy regarding the cleaning/disinfecting procedure for the blood glucose equipment per manufacturer instructions as well as cleaning of the mouthpiece of inhaler after use to prevent the risk for cross contamination and spread of disease. By 8/25/2022, All Staff will be educated on Guidance- COVID 19 CORE Practices specifically to donning/doffing of PPE for TBP's to ensure infection control practices are maintained to prevent the spread of infection. Infection Preventionist/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 proper infection control practices are being followed by staff specifically to cleaning/disinfecting of blood	

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 _____	8/2/2022

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
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to utilize appropriate infection control standards and practices during medication administration, cleaning of shared blood glucose monitoring equipment and consistently implement and utilize infection control standards and practices for proper use of personal protective equipment (PPE) for three residents R29, R45, R75, R99 and R137 of five residents reviewed for infection control, resulting in the increased potential for cross-contamination, disease exposure, and/or the development and spread of infection. Findings include: On 7/26/22 at approximately 1:08 p.m., Nurse Manager "RR" (NM "RR") was observed going into R75's room to provide care (A room on the Observation Unit that requires droplet precautions to be utilized for all resident rooms). NM "RR" was observed to not have doffed any gloves, isolation gown or N95 mask before entering the room. When NM "RR" came out of the room, they were queried why they were in the room without the required PPE when R75 was on droplet precautions and they indicated that they should have had on the appropriate PPE but had forgotten to put it on.		glucose equipment and cleaning of the mouthpiece for inhalers post treatment. Infection Preventionist/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 proper infection control practices are being followed by staff specifically to donning/doffing of PPE for TBP's to prevent the spread of infection. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Director of Nursing will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/2022 and for sustained compliance thereafter. Directed Plan of Correction: Directed Plan of Correction- Infection Control Consultant • The facility Director of Nursing will ensure adherence to the Infection Control Policies. o Director of Nursing/Infection Preventionist will exercise independent judgement in performance of duties under the contract. o Director of Nursing/Infection Preventionist completed certification from Centers for Disease Control and Prevention. o Director of Nursing/Infection Preventionist will assist the facility in completing/reviewing the CMS IC Self-Assessment o Director of Nursing/Infection Preventionist will review the IC Policies and procedures and make recommendations for revisions based off the root cause analysis. o Director of Nursing/Infection Preventionist responsibilities and QAPI Committee completed a Root Cause analysis and addressed noncompliance identified in the	

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 _____	8/2/2022

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
	On 7/26/22 at approximately 1:15 p.m., Certified Nursing Assistant "K" (CNA "K") was observed entering Rooms 124, 126, 131 and 134 (rooms on the observation unit requiring droplet precautions) without any gloves, or isolation gown being applied. CNA "K" was queried why they were going into the rooms on droplet precautions without gloves or the isolation gown and they indicated they did not know they had to wear the additional PPE and were just "helping out from another hall." On 08/1/22 at approximately 10:52 a.m., during a conversation with the Director of Nursing (DON), the DON was informed of the observations of facility staff not donning the required PPE on the observation unit. The DON was queried regarding their expectation of donning and doffing the appropriate PPE when entering rooms on the unit and they indicated that all staff who enter resident rooms on the observation unit should be wearing gloves, an isolation gown, N95 mask and eye protection. According to the facility's policy titled, "Glucometer Decontamination" dated "Revised 09/24/18", "...The glucometers should be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus...Glucometers should be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use..."		CMS 2567. ¿ The facility Director of Nursing/Infection Preventionist, Quality Assurance and Performance Improvement (QPI) committee and Governing Body participated in the completion of the RCA. ¿ The Director of Nursing/Infection Preventionist and QAPI committee will complete a root cause analysis and address the non-compliance by 8/24/22/2022. • Immediate actions were taken, and an Infection Prevention Plan and practices were implemented consistent with the requirement at 42 CFR 483.80 for the affected residents impacted by noncompliance identified in the CMS 2567. • Director of Nursing/Infection Preventionist will work with facility and ensure that all appropriate staff that provided direct care, as well as staff that enter resident rooms: dietary, therapy, activities, laundry, housekeeping and maintenance are fully trained on infection prevention and control to include the following topics: This plan includes: o Targeted COVID 19 Training for Nursing Homes o Sparkling Surfaces o Lessons o Standard Infection Control Practices o Transmission-Based Precautions o Disinfecting Shared Medical Equipment o Nursing Home Infection Preventionist Training Course o Clean Hands o Closely Monitor Residents o Isolation o Hand Hygiene o Appropriate Use of PPE o Proper Storage of Clean Linens • Residents impacted by the failure of the above practices are identified for enhanced	

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 _____	8/2/2022

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
	On 7/27/22 at 4:55 PM, during an observation of the medication cart for 2 West (South) with Nurse 'BB', when asked about what was used to clean the glucose monitoring machine, they reported "Alcohol pads". When asked if they were sure that is what was used, they pointed to the individually packaged alcohol pads in the box which contained the glucose monitoring machine. When asked which residents had accuchecks obtained today while on their shift, Nurse 'BB' reported the names of R29 and R99. On 7/27/22 at 5:03 PM, Unit Manager 'Z' and the Director of Nursing (DON) were asked about what the facility's process was for cleaning the glucose monitoring machines. Unit Manager 'Z' reported the alcohol pads with the purple top. The DON reported there used to be cleaning wipes for the glucometer machines but they were not used at this facility, and nurses should be using the container with the purple top (germicidal wipes). Both were informed of the concern that Nurse 'AA' reported only using alcohol pads and reported they would follow up. The DON was requested to provide the manufacturer's recommendation for how it should be cleaned, however no further documentation was provided by the end of the survey. On 7/26/22 at 9:38 AM, Licensed Practical Nurse (LPN) "NN" was observed while administering the residents' morning medications. LPN "NN" prepared the morning medications for R137 which included a Symbicort Aerosol inhaler. At 9:55 AM, LPN "NN" was observed to have administer all of R137's medications including the Symbicort inhaler. LPN "NN" placed the inhaler back into the box and placed the box back into the medication cart. LPN "NN" failed to wipe clean the mouth area of the inhaler after administering to R137.		monitoring and/or precautions to minimize further spread of infection. • Required staff will receive instruction before they begin their next work shift. The instructions will include demonstration. • The facility will develop a plan for monitoring the progress of the corrective action plan and tracking performance improvement. This plan will include requiring facility supervisors to conduct scheduled and objective rounds throughout the facility to ensure appropriate infection control procedures are followed. During these round, ad hoc education will be provided to persons who are not correctly utilizing equipment and/or infection prevention/control practices. o Disinfection and cleaning of blood glucose equipment and mouthpiece of inhalers. o Appropriate donning/doffing of PPE specifically for residents in TBP's. o Residents impacted by failure of the above practices are identified for enhanced monitoring and/or precautions to minimize further spread of infection. o Required staff will receive instructions before they begin their next work shift. The instructions will include demonstrations. o The facility will develop a plan for monitoring the progress of the corrective action and tracking performance improvement. This plan will include requiring facility supervisors to conduct scheduled and objective rounds throughout the facility to ensure appropriate infection control procedures are followed. During the rounds, ad hoc education will be provided to persons who are not correctly utilizing equipment and/or infection prevention/control practices. • Upon completion of the trainings, the facility	

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 _____	8/2/2022

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
	On 7/26/22 at 10:01 AM, LPN "NN" was observed to have prepared the morning medications for R45 which included a Fluticasone-Umeclidinium-Vilant Aerosol powder inhaler. LPN "NN" administered all of the morning medications including the inhaler and failed to wipe the inhaler clean before returning it back into the medication cart. Review of a facility policy titled "Orally Inhaled Medications" dated 7/26/2018, documented in part "... Rinse the mouthpiece after each dose for wet inhalers. Wipe mouthpiece after each use for powdered inhalers..." On 7/27/22 at 1:03 PM, the Director of Nursing (DON) was interviewed and asked when staff are supposed to clean the inhalers administered to the residents, the DON stated the inhalers should be wiped after use.		must validate staff competency using a post training test. • Based on the training above the facility will develop a schedule for employee follow up supervision and work performance appraisal. o Facility supervisors will observe and appraise employee implementation of the knowledge, skills and procedures.	
F0883 SS= D	Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided	F0883	F883 Influenza and Pneumococcal immunizations Resident #91 was discharged to the hospital and returned on 8/19/22. Resident will receive the appropriate pneumococcal immunization (PPSV23) by 8/31/22. All facility residents have the potential to be affected. An audit was completed on all residents currently residing in the facility who received the pneumococcal immunization to ensure that appropriate vaccination was received per residents consent. By 8/25/22 facility nurses will be educated on Immunization- Pneumococcal and Immunization- Influenza Policies specifically providing education regarding the benefits and potential side effects of the immunizations, Pneumococcal vaccination consent/declination forms, and administering	8/29/2022

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 _____	8/2/2022

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
	education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to administer a pneumococcal vaccine that was consented for by one (R91) of five residents reviewed for immunizations. Findings include: Review of the medical record revealed R91 was admitted to the facility on 8/6/2021 with a readmission date of 6/15/22 and diagnoses that		the appropriate Pneumococcal vaccines per resident consent. The ICP nurse/designee will obtain resident consents/declinations upon admission by the resident and/or representative to ensure accuracy of consent for resident immunizations. The ICP nurse/designee will then follow up to ensure that the immunization is appropriate and administered in a timely manner for that resident and then documented under the immunization tab in the residents medical record. The DON/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure residents are administered the appropriate immunization including the pneumococcal vaccines as consented by the resident. The DON/designee will audit residents medical records who are admitted to the facility each week for offering of the Pneumococcal and Influenza vaccines, consents/declinations by the resident/resident representative, education provided on the benefits and potential side effects of the immunization and ensure that the appropriate vaccine is administered in a timely manner upon resident consent and documented in the residents medical record. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained through this plan of correction by 8/29/22.	

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 _____	8/2/2022

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
	included: leukemia, asthma, type 2 diabetes, and hypertension. Review of R91's Immunization tab in the facility's Electronic Medical Record (EMR) documented Pneumovax as "Consent Refused". Further review into R91's EMR revealed a consent for the Pneumococcal (PPSV23 and PCV13) checked off as "YES, I wish to receive...", both consents signed on 11/16/2021. Review of an additional consent for the PCV13 dated 8/31/21 was also checked as "YES, I wish to receive..." Review of the Centers for Disease Control and Prevention (CDC) recommendations from the CDCs Advisory Committee on Immunization Practices (ACIP), R91's recommended pneumococcal dose was to be given one dose of PCV15 or PCV20. If PCV20 is used, their pneumococcal vaccination would have been completed. If PCV15 is used, follow with one dose of PPSV23 to complete their pneumococcal vaccination. The recommended interval between PCV15 and PPSV23 is at least 1 year. The minimum interval is 8 weeks and can be considered in adults with immunocompromising conditions. R91 has a diagnosis of "Chronic Leukemia of unspecified cell type no having achieved remission" which would be considered an Immunocompromising condition. https://www.cdc.gov/vaccines/schedules/downloads/adult/adult- combined-schedule.pdf On 7/27/22 at 12:43 PM, the Infection Control Preventionist (ICP) "PP" was interviewed and asked why R91's Pneumococcal was documented in the EMR as refused when the resident signed a consent multiple times to receive the vaccine. ICP "PP" stated they would look into it and follow back up. At 1:36 PM, ICP "PP" returned and			

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 _____	8/2/2022

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
	stated they were unsure on why R91 did not receive the vaccine, however, will follow up and ensure that he receives it. At 1:58 PM, the Director of Nursing (DON) provided a Medication Administration Record (MAR) for September 2021 that documented R91 was administered the PCV13 on 9/20/2021. The DON was asked why the facility did not administer a dose of PPSV23 at least 8 weeks after the PCV13 vaccine as recommended by CDC to complete the resident's Pneumococcal vaccine and the DON stated they would look into it. Review of the recommended CDC Pneumococcal vaccine schedule documented to give 1 dose of PPSV23 at least 8 weeks after PCV13. The facility failed to administer the PPSV23 as recommended by CDC and consented for by R91 on 11/16/2021. https://www.cdc.gov/mmwr/volumes/71/wr/mm7104a1.htm Review of a facility policy titled "Immunizations-Pneumococcal" dated 7/11/2018, documented in part " ... It is the policy of this facility that all residents will be offered the pneumococcal vaccines to aid in preventing pneumonia ... residents will be assessed for eligibility to receive the pneumococcal vaccines and when indicated, will be offered the vaccinations..."			
F0886 SS= F	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)	F0886	F886 COVID Testing F-886 No residents suffered any ill effects as a result of this citation. All residents had a respiratory assessment completed with no adverse findings or s/s of infection noted. All Staff had the potential to be affected.	8/29/2022

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 _____	8/2/2022

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
	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 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:		The Administrator/Designee will review the staff testing log for COVID 19 with emphasis on all staff members to ensure all staff are tested per the CMS Facility Testing Requirements. An audit was completed on exempt/unvaccinated staff to ensure that all staff are up to date with testing requirements as of 8/22/22. Any staff member noted not to be up to date with COVID-19 testing will be taken off the schedule until in compliance. A staffing roster will be provided to the receptionist at start of week to began to distribute to the assigned nurse leader and/or testing provider to ensure all staff are tested. Findings will be reported to Administrator by end of week to reconcile with infection to identify any employees our of compliance. As mentioned, staff noted not to be up to date with covid 19 testing will betaken off schedule until compliance. By 8/25/2022, All Staff will be educated on the Guidance- COVID 19 CMS Facility Testing Requirements. The Administrator/designee will conduct audits on exempt/unvaccinated staff weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure COVID-19 testing is completed . The results will be presented to the QAA committee for review and consideration of further corrective actions and maintaining a clean urinary drainage system. The Administrator will be responsible for assuring substantial compliance is attained	

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 _____	8/2/2022

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
	Based on interview and record review the facility failed to ensure COVID 19 testing for two unvaccinated staff Activity Staff (AS) "QQ" and Licensed Practical Nurse (LPN) "DD" of four staff members reviewed for COVID 19 testing, which could potentially affect every resident and staff member in the building. Findings include: On 7/26/2022 at 12:59 PM, weekly COVID 19 tests and timecards were requested from the Infection Control Preventionist (ICP) "PP" and Administrator for staff AS "QQ" and LPN "DD", both unvaccinated staff with approved exemptions. Review of a Centers for Medicare & Medicaid Services (CMS) memo (Ref: QSO-20-38-NH) revised 3/10/2022, documented in part "... Routine testing of staff, who are not up to date, should be based on the extent of the virus in the community... Facilities should use their community transmission level as the trigger for staff testing frequency... Level of COVID-19 Community Transmission ... High (red)... Minimum Testing Frequency of Staff who are not up-to-date... Twice a week... The facility should test all staff, who are not up to date, at the frequency prescribed... based on the level of community transmission... The guidance above represents the minimum testing expected..." Review of the Community Transmission Rate for June and July of 2022 documented a High (Red) community transmission rate for the county. Review of AS "QQ" COVID 19 tests for July 2022 revealed a test completed on 7/7/2022- negative and a test on 7/12/2022- positive. Review of AS "QQ" timecard revealed AS "QQ" worked on 7/2/22, 7/4/22, 7/7/22, 7/8/22, 7/9/22 and 7/12/22. The facility failed to ensure AS		through this plan of correction by 8/29/2022 and for sustained compliance thereafter.	

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 _____	8/2/2022

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

"QQ" was tested twice for the second week in July.

Review of LPN "DD" COVID 19 test for June and July 2022 provided by the facility documented for the following dates: 6/2/22, 6/7/22, 6/21/22, 6/30/22 and 7/14/22.

Review of LPN "DD" timecard revealed LPN "DD" worked on 6/2/22, 6/7/22 (Tested once this week), 6/11/22, 6/12/22 (Not tested this week), 6/17/22, 6/20/22, 6/21/22, 6/25/22 (Tested once this week), 6/26/22, 6/30/22 (Tested once this week), 7/1/22, 7/9/22 (Not tested this week), 7/10/22, 7/14/22 (Tested once this week), 7/18/22, 7/23/22 (Not tested this week) and 7/24/22 (Not tested as yet this week- from the date of review 7/26/22). The facility failed to conduct twice weekly testing for LPN "DD" for multiple weeks.

On 7/27/22 at 2:38 PM, ICP "PP" confirmed that AS "QQ" tested once prior to the week of testing positive and that LPN "DD" failed to test multiple times as required. ICP "PP" stated at this point they will have to go to the next step and pursue disciplinary action for not getting their required COVID-19 test completed. When asked who was responsible to ensure that all unvaccinated staff members test as required, ICP "PP" stated it was their responsibility to ensure that all unvaccinated staff test per the requirement.

Review of a facility policy titled "COVID-19 CMS Facility Testing Requirements" updated 6/2/2022, documented in part "... This document is designed to provide guidance to the facility on how to comply with the CMS interim rule... requiring testing of staff members... providing services... Routine testing of staff, who are not up to date, should be based on the extent of the virus in the community... Level of COVID19

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 _____	8/2/2022

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
	Community Transmission ... High (red)... Minimum Testing Frequency of Staff, who are not up to date... Twice a week..." Review of a facility policy titled "Mandatory COVID-19 Vaccinations" revised 3/14/2022, documented in part "... If an exemption is granted the staff member will be informed of the following accommodations... Testing twice a week..."			
F0887 SS= F	COVID-19 Immunization §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change	F0887	F887 COVID-19 Immunization Resident #5, #8, #136, #51 received COVID-19 booster vaccination on 8/16/22. These residents were educated and consented to the vaccination. Resident #91 was discharged to the hospital. Will re-eval upon return. Resident #34 responsible party was unable to be contacted x5 to get consent as required by the pharmacy, the facility continues to attempt to contact RP, and will send out a certified letter to contact the facility. All facility residents have the potential to be affected. A COVID vaccination clinic was held on 8/16/22 for residents, 15 residents received the COVID-19 booster vaccination who were offered, and educated and consented on COVID 19 immunization, with another vaccine clinic scheduled for staff and residents. An audit was completed by the ICP nurse/designee for all consent obtained for residents for COVID-19 vaccine to ensure that COVID 19 vaccine is administered in a timely manner. The DON/designee will audit residents medical records who are admitted to the facility each week for offering of the COVID 19 vaccine/booster, consents/declinations by the	8/29/2022

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 _____	8/2/2022

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
	their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to offer, educate, and administer the COVID-19 booster to six (R's 91, 5, 8, 34, 136 and 51) of six residents reviewed for the COVID 19 vaccination. Findings include: On 7/28/2022 at 11:35 AM, R91 was interviewed and reported they had COVID-19 earlier in the year and received the first two vaccinations and was told that he was eligible for the first booster		resident/resident representative, education provided on the benefits and potential side effects of the immunization and ensure that the COVID 19 vaccine/booster is administered in a timely manner upon resident consent and documented in the residents medical record. The DON/designee will offer, educate new hire staff on the COVID vaccine/booster and administer upon consent in a timely manner and document accordingly. The ICP nurse/designee will continue to offer vaccine clinics on a regular basis with the vaccination offered by the pharmacy used by the facility to ensure that residents and staff are offered, educated and administered the COVID 19 vaccination or COVID 19 booster in a timely manner. By 8/25/22 the ICP nurse was educated on offering, educating and providing the COVID 19 vaccination to staff and residents who consent to the vaccine, and administering vaccine timely, which is offered by the pharmacy that is used by the facility, and will host our own vaccine clinics in lieu of reaching out to an outside company that may not have the availability to ensure that residents and staff are offered, educated and administered the COVID 19 vaccine which includes the COVID 19 booster in a timely manner. The ICP nurse/designee will conduct random audits on 5 residents weekly times 4 weeks and then monthly thereafter times 3 months or until substantial compliance has been maintained to ensure that residents and staff are offered, educated and administered the COVID-19 vaccine/booster timely. The results will be presented to the QAA committee for review and consideration of further corrective actions. The Administrator will be responsible for assuring substantial compliance is attained	

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 _____	8/2/2022

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
	in June 2022. R91 stated they would like to have the booster but have not received it yet. Review of R91's Immunizations revealed the primary vaccine was completed on 1/25/2022 and the resident did not receive their first booster. Further review of the clinical record revealed no education or consent provided to the resident regarding the COVID- 19 booster. Review of the Centers for Disease Control and Prevention (CDC) guidance titled "Stay Up to Date with Your COVID-19 Vaccines" dated 7/19/2022, documented in part "... Boosters ... For most people at least 5 months after the final dose in the primary series..." Stay Up to Date with Your COVID-19 Vaccines | CDC. The resident was eligible to receive their first booster in June 2022 as R91 stated. On 7/26/22 at 12:59 PM, the Infection Control Preventionist (ICP) "PP" was asked if the facility is offering education and the booster vaccine to residents who are eligible and/or request to have the COVID-19 booster, ICP "PP" stated the county was coming in to do the facility's vaccine however they were informed the last week in June that the County would no longer be able to do them. When asked what the facility put in place for residents/staff to receive the COVID-19 vaccine and/or booster, ICP "PP" stated at the present time there was no plan "B" in place. At that time ICP "PP" was asked to provide all documentation of R91 having been educated and offered the COVID-19 vaccine booster. ICP "PP" stated they would look into and follow up. Review of additional residents (R5, 8, 34, 51 & 136) immunizations revealed all of the residents completed their primary series and was eligible to receive their first booster. Further review of the medical records revealed no education or consent		through this plan of correction by 8/29/22.	

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 _____	**8/2/2022**

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
	provided to the residents regarding receiving their COVID-19 booster vaccination. On 7/27/22 at 12:43 PM, ICP "PP" was interviewed and asked about the additional residents that were eligible to receive the COVID-19 but had not received education or been offered the booster, ICP "PP" stated they made a roster and identified 57 residents residing in the facility that are eligible to receive the COVID-19 booster. ICP "PP" stated they talked to their corporate company and the plan is to provide all 57 residents with the education and consents over the weekend and the pharmacy will be in next week to administer all 57 COVID-19 booster vaccines to the residents.			