		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON NG		(X3) DATE SURVEY COMPLETED	
		634560	B. WING			10/4/2	2022
NAME OF PRO	VIDER OR SUPPLIE	<u>l</u> ER			STREET ADDRESS, CITY, STA	TE, ZIP CO	DE
SKLD BLOO	MFIELD HILLS				2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48	304	
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULATION	NTEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE (EFERENCED TO THE APPROPR DEFICIENCY)	CROSS-	(X5) COMPLETION DATE
F0000 SS=	Intakes: MI001300 MI00130355, MI0	Hills was surveyed for an	F0000				
F0695 SS= D	Respiratory/Trac Suctioning § 483 including trached suctioning. The fresident who ned including trached suctioning, is prowith professional comprehensive professional successional professional comprehensive pro	cheostomy Care and 3.25(i) Respiratory care, postomy care and tracheal facility must ensure that a eds respiratory care, postomy care and tracheal ovided such care, consistent I standards of practice, the person-centered care plan, als and preferences, and bpart. MENT is not met as tains to intake # MI00130616 ation, interview and record by failed to ensure respiratory rel Positive Airway Pressure a type of non-invasive vailable for one (R702) of viewed for respiratory care.	F0695	time an physicia Bipap r Track for the facin resident audit we machin resident Bipap r By Octocentral coordinist importation track of a resident time of By Octowill be returning term catter the poor re-acin and the state of the poor re-acin and the state of the poor re-acin and the state of the poor re-acin the poor re-acin and the state of the poor re-acin the	Int # 702 resides in the facility and has her BIPap machine per an's orders. It was determined machine was omitted from the orm used by clinical liaison infility of the need of the machine at. Tesidents who have an order the have the potential to be affected as completed for all residents uses in the facility. There are not as identified as having an order and the interest in the facility. There are not as identified as having an order and the interest in the facility. There are not an interest in the facility in the facility of the facility of the interest in the facility of the facility via fany respiratory equipment need the interest in the equipment available their admission to the facility. Ober 18, 2022, the central supeducated on the new process and any respiratory equipment are resident unless it is confirm ident will not be returning to the DN/designee will conduct audifficient will residents weekly times an monthly thereafter times 3 in bestantial compliance has been	the I that the Fast orming of for this for BiPap otted. An on Bipap other or for a sons, on e fast eeded for that olle at the ply clerk of not of a long-ned that its on new is 4 weeks months or	10/18/2022
LABORATORY	Agency on 8/22/ that upon the re	22 included an allegation	ATIVE'S SIGN	or re-ad and the until su	dmitted residents weekly times on monthly thereafter times 3 r	s 4 weeks months or	TE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Electronically Signed

10/18/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED		
		634560	B. WING _			10/4/2022	
NAME OF PRO	VIDER OR SUPPLIE	IER			STREET ADDRESS, CITY, STATE	, ZIP CO	DE
SKLD BLOOMFIELD HILLS					2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 4830	04	
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULATION	TEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION (I RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIA' DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	BiPAP machine. reported they we this equipment r matter of life and to go all night Fr calling 911 on 8/ hospital because make them go a of a BiPAP mach On 10/3/22 at 1: conducted with I could recall about upon their readn 8/19/22, R702 re that had been at August, then was while they were available when the facility to make sweren't sure of the wasn't too long I 8/19/22. R702 furner late on Friday (8/ wasn't there, the use oxygen. Their when the facility they called 911 to they didn't want it. R702 reported several times sin told me if I didn' got to emergence.	lity couldn't locate their The complainant further ere told by their Physician needed to be used as it was a d death, and the resident had iday without it and ended up (20/22 to return to the the facility was trying to nother night without the use ine. 45 PM, an interview was R702. When asked what they at the events that occurred nission to the facility on ported their BiPAP machine the facility since early is returned to the company in the hospital and was not hey returned on 8/19/22. heir brother had come to the sture it was available but they he timeframe but that it before their return on rther reported they arrived (19/22) and since the BiPAP by took it upon themselves to n on Saturday (8/20/22) still couldn't find the BiPAP o go to emergency since to go another night without I they had been hospitalized ce July 2022 and the Doctor t use it, I could die. When I ty, the Doctor realized I'd the night before and asked		respiratinclude residen that the	ned to ensure residents with tory equipment needs are met a d on the Fast Track prior to the ts admission to the facility to ene resident has the respiratory ent as ordered by the physician	sure	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		634560	B. WING _				0/4/2022	
NAME OF PRO	VIDER OR SUPPLIE	<u>l</u> ER			STREET ADDRESS, CITY, S	STATE, ZIP CC	DDE	
SKLD BLOO	MFIELD HILLS				2975 N ADAMS ROAD BLOOMFIELD HILLS, M	I 48304		
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	JIDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	,	ck and I told him it was have my BiPAP and he said I lecision.						
	was admitted intreadmitted on 8, included: acute rhypoxia, acute rehypercapnia, obs	nical record revealed R702 to the facility on 2/4/20 and /25/22 with diagnoses that respiratory failure with structive sleep apnea, rtension, chronic diastolic d lymphedema.						
	9	e Minimum Data Set (MDS) d 8/20/22 R702 had intact						
	hospitalizedHy OSA (obstructive	ncluded, "Why you were percapnic respiratory failure, e sleep apnea)Your primary espiratory Failure; Acute						
	Pulmonary & Cri 8/2/22 included, Complaint Acute Failuremedical controlled OSA/concern of hype failurePatient p (Medical Intension chronic hypercal failurePulmona	s consultation with a itical Care Physician dated "Reason for Consult/Chief thypercapnic Respiratory history including poorly OHSwho presentedfor reapnic respiratory placed on BiPAP. MICU ve Care Unit) for acute on onic respiratory ry: Acute of Chronic piratory Failure OSA/OHS						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		634560	B. WING _	G		10/4/2022			
NAME OF PRO	VIDER OR SUPPLIE	ER .			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE		
SKLD BLOOM	MFIELD HILLS				2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48	304			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE C FERENCED TO THE APPROPRI DEFICIENCY)	ROSS-	(X5) COMPLETION DATE		
	dischargePatier conversational on the improvem intubationDue will monitor over BiPAPD/w (Disc they confirmed they con	ed BiPAP following recent int awake and alert and in admission to a degree with tent on BiPAPHigh risk for to level of alertness clinically, rnight on continuous cussed with) care manager, that her ECF (Extended Care ed and BIPAP is in her room do not need a new script harge)" ed that this consultation was it's hospitalization on 8/2/22. In hospitalized from 7/18 to not have order for a BiPAP 2/22. The BiPAP machine was facility on 8/2/22 after the it to the hospital on 8/2/22. In documentation available in ind from their readmission on it is a nursing admission progress note from Nurse is note dated 8/19/22 at 10:39 ent readmitted from (local with a Dx (diagnosis) of it is apnea, Resident alert and ere was no documentation ere of a BiPAP, or that the eren contacted for further							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		634560	B. WING _	WING		10/4/2	10/4/2022	
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, ST	TATE, ZIP CC	DE	
SKLD BLOOMFIELD HILLS					2975 N ADAMS ROAD BLOOMFIELD HILLS, MI	48304		
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	PIDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BIOUS RECTIVE ACTION SHOULD BIOUS RECTION SH	E CROSS-	(X5) COMPLETION DATE	
	about not having aware of situation unable to locate began to become going into distressive facility could cornessident was un resolve issue and A physician programmer. Pt (Phospitalized from (Acute Mental Strespiratory failur vascular congest facility on 8/19. absence of bipage hospitalized from On 10/3/22 at 30 conducted with Nursing (DON). not in that role areadmission on a the clinical recompapers, the DON documentation is BiPAP machine. that since the face resident's previous equipment, that upon their readmission on their readmission on the clinical recompapers, the DON documentation is BiPAP machine. The DON reports	30 PM, an interview was the Interim Director of The DON reported they were at the time of R702's 8/19/22 and upon review of d and the hospital discharge						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING			(X3) DATE SURVEY COMPLETED 10/4/2022	
		634560	B. WING				
NAME OF PRO	VIDER OR SUPPLIE	<u>l</u> ER			STREET ADDRESS, CITY,	STATE, ZIP CC	DDE
SKLD BLOOMFIELD HILLS					2975 N ADAMS ROAD BLOOMFIELD HILLS, N	/II 48304	
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORREC' RECTIVE ACTION SHOULD EFERENCED TO THE APPRODEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE
	resident specific tube feeding, Bif review the docur readmission on a the electronic cli they were not at for that particula the process of co DON reported the gets information Admissions Cool heads up of spec for admissions a was responsible needs such as bi reported that we staff (Staff 'E'). On 10/3/22 at 3: conducted with (Staff 'F') who re role since 8/8/22 several weeks af R702's readmissions they were not in would've been the Coordinator (Staff When asked to ecoordinating a reneeds such as a reported they us Fast Track and u ECIN (Extended	form which identified care needs such as oxygen, PAP, etc. When asked to mentation from R702's 83/19/22, the DON reviewed nical record and reported ble to find the FAST TRACK or date. When asked about coordinating admissions, the ne Admissions Coordinator from the Liaisons and the redinator gives the facility a cific resident needs, especially fiter hours. When asked who for ordering the equipment pap equipment, the DON could be their Central Supply 142 PM, an interview was the Admissions Coordinator ported they had been in their e and had been training for ter that. When asked about on on 8/20/22, they reported the role at that time, that the former Admissions ff 'J'). Explain their process for esident's admission and care BiPAP machine, Staff 'F' ed an internal form called a pon reviewing the referral in Care Information Network imputer referral system					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		634560	B. WING _	WING		10/4/2	10/4/2022	
NAME OF PRO	VIDER OR SUPPLIE	I. ER			STREET ADDRESS, CITY, S	TATE, ZIP CO	DE	
SKLD BLOO	MFIELD HILLS				2975 N ADAMS ROAD BLOOMFIELD HILLS, MI	48304		
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULATION	TEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD E FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	would review the information, as winformation, as winformation to the They were able to from their email scheduled to read at 7:00 PM. The pidentified specifical BiPAP, but was discharge docum reported Staff 'J' admission and site of Staff 'E' to made BiPAP machine areadmission. Staff 'F' further remachine might he company since it weren't sure. On 10/3/22 at 3: conducted with Shad been in that asked about how specific medical BiPAP machine, notification from When asked about they recalled where recalled where ported they have soming backed equipment had been in that asked about how specific medical BiPAP machine, the stage of the s	Is and nursing homes) they encoming resident's well as the Liaison would send hem on what was needed. Track form which showed R702 was dmit to the facility on 8/19 portion of the form which care needs did not include included in the hospital hentation. They further had coordinated that hould've sent the information ke arrangements to have the vailable upon R702's heported that R702's BiPAP have been sent back to the swas rented, but they role for 10 years. When we they have been sent back to the equipment needs such as a shey reported they received the Admission Coordinator. They further had coordinator with R702, Staff 'E' reported at happened with R702 and do not been aware that R702 of which was why the been returned since the en out of the facility since then reported they ended up						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		634560	B. WING _			10/4/2	10/4/2022	
NAME OF PRO	VIDER OR SUPPLIE	ER			STREET ADDRESS, CITY, STATE	, ZIP CO	DE	
SKLD BLOOM	IFIELD HILLS				2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 483	04		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (RECTIVE ACTION SHOULD BE CF FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE	
	went to the hosp had arrived by 3: still wanted to go could confirm what actually ordered reported they were considered to the still wanted to go could confirm what actually ordered reported they were considered they were considered they were considered they were considered to the still wanted the single considered to the still wanted the single considered to the still wanted the single considered the singl	30 PM, Staff 'E' provided which identified the line was first delivered to the 2. (R702 was sent to hospital 8/19/22.) ine was picked up on line was ordered on 8/23/22. but the delivery of the BiPAP is in hospital from 8/20-t 8/20/22 as they indicated was unable to offer any						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		634560		B. WING _			10/4/2	022
NAME OF PROVIDER OR SUPPLIER SKLD BLOOMFIELD HILLS						STREET ADDRESS, CITY, STATE, 2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 4830		DE
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	OSS-	(X5) COMPLETION DATE
	the hospital. The 8/23/22.	second time was not until						
		57 PM, a message was left it there was no return call of the survey.						
	there was no faci of medical equip	30 PM, the DON reported lity policy for coordination ment upon admission, but cess they had discussed						