STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634560	A. BUILDING _____ B. WING _____	3/23/2023

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SKLD BLOOMFIELD HILLS	2975 N ADAMS ROAD BLOOMFIELD HILLS, MI 48304

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F0000 SS=	INITIAL COMMENTS SKLD Bloomfield Hills was surveyed for an Abbreviated survey on 3/23/23. Census=147 Intakes: MI00132591, MI00132269, MI00132815, MI00132357, MI00133001, MI00133174, MI00133180, MI00133212, MI00133766, MI00134621, MI00134918, MI00134743	F0000		
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00133001 and MI00133212. Based on interview and record review the facility failed to ensure medications were available to administer per Physician's order, Physician orders were accurately/timely transcribed into the medical record and accurate documentation of medication administration was completed according to professional standards of practice for one resident (R804) of three residents reviewed for professional standards. Findings include:	F0658	I. Resident #804 no longer resides in the facility. II. All residents have the potential to be affected by this citation. III. An audit was completed of the medication administration portal on the dashboard of the electronic medical record of all residents for administration or lack of administration of resident medications. Any resident identified as having medication available that was not administered by the licensed nurse was addressed by the Director of Nursing (DON) or designee. An audit was completed for the past 30 days of all consults received by residents after attending a physician appointment/consultation for any orders or follow- up needed. Any concerns identified were immediately corrected by the DON/designee. Licensed nurses will be educated on the policy titled Administration of Drugs with	4/20/2023

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

Electronically Signed | 04/06/2023

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

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	On 3/22/23 review of a concern submitted to the Stage Agency alleged R804 did not have some medications available to be administered, their kidney failure was not being appropriately monitored and they were provided thin liquids when they were NPO (nothing by mouth) while at the facility. On 3/22/23 the medical record for R804 was reviewed which revealed R804 was initially admitted to the facility on 10/13/22 and transferred to the hospital on 11/5/22. R804 had diagnoses including type two Diabetes Mellitus and Cerebral infarction (stroke). A review of R804's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/17/22 revealed R804 needed extensive assistance with most of their activities of daily living. R804's BIMS score (brief interview for mental status) was six, indicating severely impaired cognition. An "After visit Summary" form dated 10/25/22 filled out by R804's Nephrologist (Kidney Doctor) that was observed in R804's electronic medical record was reviewed and revealed the following: "The following issues were addressed: AKI (Acute kidney injury)....Instructions: add Calcitriol 0.25 mcg (micrograms) every other day..." Further review of R804's Physician orders revealed no new orders for Calcitriol were added to their medication regimen after their Nephrology appointment. No Nursing or		emphasis on providing resident medications per the physician orders and documenting on the medication administration record. The Assistant Director of Nursing (ADON) or designee will be responsible for providing this education. Education will be completed by 4-10-23. Licensed nurses will be educated on the policy titled Physician Orders to ensure that orders are carried out per the physician under the orders tab in the resident electronic medical record. The ADON or designee will be responsible for providing this education. Education will be completed by 4-10-23. Licensed nurses will be educated on following up on resident consultation orders after physician visits, which include carrying our orders as written by the physician. The ADON or designee will be responsible for providing this education. Education will be completed by 4-10-23. The DON, Unit Manager, or designee will review the medication administration portal on the EMR dashboard daily to ensure that residents are receiving their medications per physician orders. The DON, Unit Manager, or designee will review all consults daily in morning clinical meeting to ensure that any orders given after a resident consultation/appointment are carried out as per the physician order. IV. The DON or designee will randomly audit (5) residents weekly for 4 weeks then monthly for 3 months via the Medication Administration audit portal in the EMR to ensure that residents are receiving their medications per the physician orders.	

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	Physician documentation was present in the record that indicated the Physician had been made aware of the Nephrologist's new medication order for Calcitriol to be added to R804's medication regimen. A Physician's order dated 10/13/22 revealed the following: "Scopolamine Base Patch 72 Hour 1.5 MG (milligram) Apply 1 patch transdermally one time a day every 3 day(s) for nausea and vomiting Place one patch onto the skin every 72 hours and remove per schedule" A review of R804's October and November 2022 MAR (medication administration record) revealed R804 was not administered their scopolamine patch on 10/26, 10/29 and 11/1. the MAR number code was coded as "9" which was indicated to be "other/see notes" A review of R804's progress notes for the dates they were not administered their scopolamine patch revealed the following: 10/26-"On order", 10/29-"no patch available, reordered", 11/1-"patch not available" Further review of R804's progress notes indicated that on each of the days the scopolamine patch was not available to be administered, there was no documentation that the Nurse had notified the Physician of the medication not being available. On 10/26 and 11/1 it was also noted that there was no documentation that the pharmacy had been notified of the medication not being		The DON or designee will randomly audit (5) residents weekly for 4 weeks then monthly for 3 months thereafter residents' consultations to ensure that any orders written after a resident physician appointment/consultation is carried out per the physician order. 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 4-20-2023 and for sustained compliance thereafter.	

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available.

A progress note dated 11/1/22 at 10:38 p.m., revealed the following: "Reported to writer by staff that resident family observed resident drinking water notified hall partner of issue and reported to writer. Water immediately removed. Writer notified residents physician of issue. Physician request writer to monitor oxygen stats for any change."

A review of R804's oxygen saturation stats in the medical record revealed no documented oxygen saturation rates until 11/4. No Physician's orders for monitoring of R804's oxygen saturation rates were observed to be transcribed into the record.

A review of R804's blood sugar (blood glucose) documentation for November 2022 was reviewed and revealed the following: 11/4 at 16:54-]83]...11/4 at 18:25-[152]...11/4 at 23:20-[132]...11/5 at 07:10 [63].

A Physician's order dated 11/4/22 at 16:01 revealed the following: "Glucagon Emergency Injection Kit 1 MG (Glucagon (rDNA)) Inject 1 mg subcutaneously as needed for diabetes mellitus..."

An Emergency Department note from the hospital dated 11/5/22 revealed the following: "HPI (history of presenting illness) [R804]... PMH (previous medical history) of CAD (Coronary artery disease) with stent, CVA (stroke) with residual right-sided

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	weakness and expressive aphasia, hypertension, diabetes, and seizures who was brought in from his extended care facility for concerns of recurrent hypoglycemia. Yesterday, patient was found to have a blood sugar in the 30s and was given glucose solution. Today patient was found to have a blood sugar in the 60s so they gave him glucagon as they were unable to get his port access to work. Patient started vomiting following glucagon and has been continuously coughing since EMS (Emergency Medical Services) arrival..." A review of R804's November 2022 MAR revealed no documentation of Glucagon ever being administered. On 3/22/23 at approximately 2:01 p.m. during a conversation with the Director of Nursing (DON), the DON was queried regarding the multiple concerns identified in R804's medical record. The DON was queried regarding R804's scopolamine patch not being available to be administered and the DON indicated the Nursing staff should have called the Doctor and Pharmacy if the medication could not be given and that information should have been documented in a progress note. The DON was queried regarding the Calcitriol medication that R804's Nephrologist had added to their regimen and the DON reviewed the consultation report and indicated that it must have been missed and that the Nurse should have called the Physician and gotten an order			

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	to add it to the medication list. The DON was queried regarding R804's low blood sugars on 11/4 and 11/5 and they indicated that the Glucagon had been given to raise R804's blood sugars. At that time, the DON was shown R804's MAR which indicated that the Glucagon was never administered. The DON indicated that they would look into the Glucagon concern and come back. On 3/22/23 at approximately 2:20 p.m., the DON presented a cubix report (backup medication supply) that documented the Glucagon kit was pulled from the backup supply at 4:01 PM. The DON indicated that the Nurse should have documented the administration of it on the MAR. On 3/22/23 at approximately 4:55 p.m., Nurse "J" was queried regarding the monitoring of R804's oxygen saturation rates that were ordered by the Physician on 11/122. Nurse "J" reported that they never actually saw R804 being administered the thin liquids but that since they were NPO they called the doctor and he ordered to monitor the oxygen saturation rates. Nurse "J" was queried why no saturation rates or Physician orders for monitoring were observed in the record and they indicated that they did it, but that they must have forgot to put in the order for monitoring. On 3/23/23 at approximately 1:17 p.m., Nurse "I" was queried regarding the administration of Glucagon on 11/5/22 and sending R804 to			

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	the hospital. Nurse "I" indicated that they did administer R804's Glucagon but that they started to have emesis and as a result, had to send them to the hospital. Nurse "I" was queried where they would document the administration of the Glucagon and they indicated it would be on the MAR. On 3/23/23 a facility document titled "Medication Administration" was reviewed and revealed the following: "POLICY: It is the policy of this facility that medications shall be administered as prescribed by the attending physician...PROCEDURE:...8. Unless otherwise specified by the resident's ordering/prescribing physician, routine medications should be administered as scheduled. 9. The nurse administering the medication must record such information on the resident's MAR before administering the next resident's medication. 10. The nurse administering the medications must initial the resident's MAR. 11. When PRN (as needed) medications are administered, the nurse must record: a. The date and time administered b. The dosage c. The route of administration (if other than oral) d. The injection site e. Any complaints or symptoms for which the drug was administered f. Any results achieved for administering the drug and the time such results were observed g. The nurse administrating the PRN medication must initial the resident's MAR. 12. Should a drug be withheld, refused, or given other than the scheduled time, the nurse must enter an explanatory note. NOTE: The			

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	Director of Nursing and attending Physician must be notified when two (2) doses of a medication are refused or withheld..." On 3/23/23 a second facility document titled "Physician orders" was reviewed and revealed the following: "POLICY: It is the policy of this facility to ensure that all resident/patient medications, treatment and plan of care must be in accordance to the licensed physician's orders. The facility shall ensure to follow physician orders as input into the medical chart. PROCEDURE:..2. All medications administered to the resident/patient must be ordered by the resident's attending physician or physician on call. 3. Physician orders may be obtained via telephone or verbally by a licensed nurse. Physician orders must be documented in the orders section of the resident's medical records. 4. The physician may also call-in telephone orders, write physician orders in the resident's medical record, or put orders in electronically personally. 5. The nurse may question and clarify physician orders that are not clear or are questionable...8. If for any reason, the resident's attending physician is not available or cannot be reached by the nurse, the facility appointed medical director may be contacted for orders in accordance to facility policy and professional standard of care. 9. Provision of care, treatment and services administered by the facility to the resident will be approved by the attending physician unless these treatment and services are governed by the facility's clinical policy and			

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	procedures as approved by the medical director..."			