| 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 _____ | 12/20/2023 |

| 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 |
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| F0000 SS= | INITIAL COMMENTS<br><br>SKLD Bloomfield Hills was surveyed for an Abbreviated survey on 12/20/23.<br><br>Intakes: MI00140379, MI00140403, MI00140532, MI00140580, MI00140749, MI001401008, MI00141031, MI00141203, and MI00141275. Census: 136. | F0000 | | |
| F0689 SS= D | Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:<br><br>This citation pertains to intake #MI00140379 and #MI00140532.<br><br>Based on observation, interview, and record review the facility failed to ensure a patient assessment, a root cause analysis investigation, and timely clinical documentation of a fall for one resident (R902) of three residents reviewed for falls, resulting in the potential for undetected injuries and future incidences of falls. Findings include:<br><br>A complaint received by the State Agency alleged R902 had a fall on 8/31/23, they were not assessed post-fall and clinical documentation of the fall had not been entered into the record in a timely manner.<br><br>On 12/19/23 at approximately 10:15 AM, R902 | F0689 | Resident #902 did not suffer any adverse effects as a result of this occurrence. The residents care plan has been reviewed and updated specifically for falls to ensure the appropriate plan of care is in place.<br><br>All residents have the potential to be affected.<br><br>The nurse involved was disciplined related to not completing a risk management report for falls and notifying the DON of a fall in a timely manner.<br><br>Residents that were able to be interviewed were asked if they had experienced any incident/accidents that were not reported per the facility policy.<br><br>By 1/5/24 Licensed nurses and certified nursing assistants will be educated on the falls policy and risk management process, with emphasis on the investigation and notification of an incident in a timely manner when it occurs and completion of risk management report timely per policy.<br><br>The DON/designee will interview 5 residents weekly x4 weeks and then every month x3 months or until substantial compliance has been maintained to ensure that there are no incident/accidents that have not been | 1/5/2024 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 12/28/2023 |

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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| | was observed seated in their wheelchair at the nursing station. At numerous times on 12/19/23 R902 was also observed self-propelling through the hallway of the facility.<br><br>A review of R902's clinical record was conducted and revealed they admitted to the facility on 8/18/20, with diagnoses that included: schizoaffective disorder, diabetes, dysphagia, dementia, and repeated falls. A review of R902's progress notes was conducted and revealed a late entry progress note for 8/31/23, entered into the record by Nurse 'A' on 9/6/23 at 2:28 PM that read, "...Activities reported resident on floor..." Continued review of R902's progress notes revealed the following:<br><br>A note entered into the record by Nurse 'C' dated 9/6/23 at 1:02 PM that read, "...patient complains of right knee and hip pain..."<br><br>A note entered into the record by Unit Manger 'B' on 9/6/23 at 3:59 PM that read, "...observed lying in bed. C/o (complaint of) pain of right knee/leg. States, 'my leg is sore from my fall the other day.' Resident performed AROM (active range of motion) with noted facial grimacing and guarding of right leg..."<br><br>Continued review of the record included a post fall assessment dated 9/6/23 and an SBAR (situation, background, assessment, recommendation) assessment of the fall also dated 9/6/23.<br><br>On 12/19/23 at 3:22 PM, a review of a facility provided form (which at the bottom reads, "...Part of facility Quality Assurance Performance Improvement-Not a part of the Medical Record...) was conducted that briefly summarized the fall incident. The facility was asked if they had any additional documentation such as any witness | | reported/investigated.<br><br>The DON will be responsible for compliance and will review the action plan at the monthly QAA meeting for any further recommendations. | |

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| | statements or proof of a root cause analysis into the fall, however; nothing was provided by the end of the survey.<br><br>On 12/19/23 at 3:01 PM, a review of Nurse 'A's personnel file was conducted and revealed they no longer worked at the facility. Continued review of the file revealed a form titled "DISCIPLINARY ACTION RECORD WORK RULES" that read, "...Describe the reason(s) for disciplinary action, including date, time and supporting documentation: On 8/31/2023 Employee was the nurse caring for a resident with reported fall. Employee as resident's nurse failed to assess, report or follow facility's police and procedure for incident reporting and follow up intervention..." It was noted the form was signed by nurse 'A' and Unit Manager 'B'. Attached to the form was a written statement confirmed as written by Unit Manager 'B' that read, "...Activity Aide reported to writer (R902) 'hasn't been the same since she fell'. Writer asked Activity Aide when did (R902) fall. She stated, 'Last Thursday it was about 3:30-4:00 PM. I saw her on the floor and I called for help. 2 CENAS (certified nurse aides) came in, then they went to get the nurse.' Writer spoke to (Nurse 'A') on 9/6/23 she stated she was the nurse assigned to (R902) on 8/31/23. She stated she assisted her off the floor. Writer asked why she didn't follow policy she stated, 'I was swamped.'"<br><br>On 12/20/23 at 11:00 AM, an interview was conducted with the facility's Director of Nursing, they acknowledged the concern of the timely assessment and documentation of R902's fall not being completed.<br><br>A review of a facility provided policy titled, "Fall Prevention" was conducted, however; the policy did not address resident assessment, documentation, or root cause analysis | | | |

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| | investigation after a fall occurs. | | | |