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 _____	12/23/2024

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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 12/23/24. Intakes: MI00148009, MI00148615, MI00148703, MI00148866, MI00148985. Census=114	F0000		
F0552 SS= D	Right to be Informed/Make Treatment Decisions §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is not met as evidenced by: This citation pertains to Intake #MI00148866 Based on observation, interview and record review the facility failed to adhere to a resident's right to decline a urine toxicity test for one resident (R905) of three residents reviewed for resident rights. Findings include:	F0552	F 550 Resident Rights Element #1 Resident #905 did not suffer any ill effects as a result of this citation. Resident #905 was immediately informed of the violation, and an apology was extended. Nurse “H” has been immediately counseled on the violation of the resident's right to informed consent. The nurse was educated on Residents’ rights and the necessity of obtaining informed consent before performing any medical procedure, including urine sample collection. The Policy for resident rights was reviewed with the Director of Nursing and Assistant Director of Nursing with emphasis on obtaining a resident's informed consent prior to performing a medical procedure for a resident to ensure that all legal and ethical guidelines are followed with respect to resident’s rights. Element #2 All residents have the potential to be affected by this citation.	1/3/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/07/2025

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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	A complaint was filed with the State Agency (SA) that alleged facility staff obtained a urine sample for an unexplained reason and without their permission. The complainant further alleged that the facility never divulged the results of the urine test. On 12/23/24 at approximately 9:28 AM, R905 was observed sitting in their wheelchair. The resident was alert and able to answer all questions asked. When asked about life and care in the facility, R905 reported that they felt they were discriminated against based of race and age. They noted that the facility took a urine sample without their permission, sent the results to the laboratory and never explained the reason why they did so. R905 further stated that at times staff would allege that their visitors were smoking marijuana in their room and noted that was not true. A review of R905's clinical record revealed the resident was initially admitted to the facility on 4/11/22 with diagnoses that include, in part: Quadriplegia, anxiety disorder and urinary tract infection site. A review of the residents Minimum Data Set (MDS) dated 11/14/24 noted the resident had a Brief Interview for Mental Status score of 15/15 (cognitively intact cognition) and noted to have no behavior concerns. Continued review of R905's clinical record noted, in part, the following:		The DON/designee conducted an audit/interview of residents in the facility and inquired if they were asked for their consent prior to the nurses completing any medical procedure, there were no related concerns reported. Element #3 By 1/3/25, Licensed Nurses will be educated on the facility policy for residents' rights with emphasis on the necessity of obtaining informed consent before performing any medical procedure, including urine sample collection. Element #4 The DON/designee will perform audits on five residents weekly x 4 weeks and then monthly times 3 months or until substantial compliance is maintained to ensure that residents are being asked for their medical consent prior to the nurses completing any medical procedures. The results of the audits will be presented to the QAA committee for review and consideration of further corrective action. Element #5 The DON/designee will be responsible for assuring substantial compliance is attained through this plan of correction by1/3/25 and for sustained compliance thereafter	

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	11/21/24: Order (Authored by Physician "G") : "Obtain Urine for Toxicology testing ((a test to determine the presence of drugs or toxins in the body) one time only for Day". 12/2/24: Order (Authored by Physician :G:): "Collection Urine one time only for 1 day." 12/2/24: General Progress Note (Authored by Nurse "H): "UA (urinalysis) collected and put in 1 west refrigerator specimen lab). The results of urine collection dated 12/2/24 noted the collection was made for drug screening only and noted anything that was noted as positive, was also noted as "unconfirmed". *It should be noted that there was no documentation in R905's clinical record that indicated the purpose of the urine toxicology test. On 12/23/24 at approximately 12:15 PM an interview was conducted with Social Worker (SW) "F". SW "F" was queried as to R905's need for drug/toxicology testing. SW "F" reported that they were not familiar with any reasons why the resident was tested for drugs. On 12/23/24 at approximately 12:50 PM, a phone interview was conducted with Nurse "H" regarding the order to obtain a urine sample for R905. Nurse "H" reported they were familiar with the resident and worked			

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	with them often. When asked if they were noted as to why they were obtaining the residents urine via their catheter bag and whether R905 consented, Nurse "H" reported that they were following physician orders. With respect to obtaining the residents consent, they noted when obtaining the urine culture R905 appeared to be sleeping. As they were exiting the resident's room, R905 woke up, asked why they were obtaining the urine, and the resident stated "No". Nurse "H" reported that they did not discard the urine or contact other staff for assistance. They noted they placed the urine in a secure place for pick up. On 12/23/24 at approximately 1:14 PM, a phone interview was conducted with Physician "G". Physician "G" was queried as to why they ordered toxicology screening for R905. Physician "G" reported that they were familiar with R905 and felt they had a good repour with them. Physician "G" noted that they recalled the resident wanted to leave the facility for a few days near the Thanksgiving holiday. They noted the resident took their medication with them, including prescribed narcotics for pain. Physician "G" noted that upon their return the resident was talking "gibberish", and it appeared as if the resident had taken "something". When asked by whom it was reported the resident was talking "gibberish" and/or if they had noted anything in the resident's electronic record that indicated a change in condition, Physician "G" noted that they had been			

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	delayed on writing reports and was not certain as to who reported the concern. On 12/23/24 at approximately 1:29 PM, an interview was conducted with the Director of Nursing (DON) and the Acting Director of Nursing (ADON) "I". Both the DON and ADON were queried as to why R905 received toxicology testing and what the facility protocol/policy was on consent. Both the DON and the ADON reported they believed it was done per physician order to determine what drugs were in the resident's body. They both were not aware of the facility's consent protocol. The DON was asked to provide documentation as to why the order was completed and any documentation related to the resident "gibberish" behaviors. *It should be noted that no documentation was provided before the end of the survey. On 12/23/24 at 2:15 PM, an interview was conducted with the Administrator. When asked as to why R905 received toxicology testing without consent, the Administrator noted that they were just made aware of the concern and was not sure as to why it was ordered. With respect to the facility policy, the Administrator noted that the facility did not have a specific policy related to toxicology consent for its residents, but noted residents have a right to refuse treatment and testing.			
F0604	Right to be Free from Physical Restraints	F0604		

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SS= D	§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: This citation pertains to intake #MI00148615 Based on observation, interview and record review, the facility failed to ensure freedom of movement was maintained for one resident (R903 as witnessed by R907 and R908) of three residents reviewed for involuntary seclusion. Findings include: On 12/23/24 a facility reported incident (FRI) was reviewed that alleged R903 was			

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	involuntarily secluded by facility staff on 11/20/24. On 12/23/24 at approximately 9:54 a.m., R903 was observed in their room, laying in their bed. R903 was observed to be dressed appropriately wearing a hair cap. R903 was observed to have a CNA (Certified Nursing Assistant) sitting in a chair in their room providing supervision. On 12/23/24 the medical record for R903 was reviewed and revealed the following: R903 was initially admitted to the facility on 5/21/21 and had diagnoses including Generalized anxiety disorder, Dementia and Delirium. A review of R903's MDS (minimum data set) with an ARD (assessment reference date) of 11/19/24 revealed R903 had behaviors including wandering in the facility. A review of R903's careplan revealed the following: "Focus-[R903] is an elopement risk and/or exhibits wandering behavior r/t (related to) Vascular dementia, severe, with other behavioral disturbance. Resident frequently attempts to get on elevator, wanders the halls, and wanders into other residents' rooms r/t confusion and impaired safety awareness. Resident bumps into wall, doorway, objects when wandering in wheelchair, often does things in the bathroom alone when staff is not around, moves mounted TV around, pushes objects,			

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	is at risk for injury related to behaviors..." On 12/23/24 the facility completed investigation for R903 being involuntarily secluded on 11/20/24 was reviewed and revealed the following: "At approximately 7:30 a.m., on 11/21/24 the Assistant Administrator (AA "O") reported to the Administrator that another resident sent a picture of resident [R903] sitting behind three tables in the dining room. The position where [R903] was sitting appeared to be limiting he access to move. the resident who reported (R908), says the two individuals involved were CNA "J" and LPN (Licensed Practical Nurse) "K" (LPN "K"), both were suspended immediately pending the investigation....Resident [R908] sent a picture to the Assistant Administrator phone on 11/20/24 at 9:30 p.m., stating Nurse [LPN "K"] and aide [CNA "J"] had trapped resident [R903] between the tables because [R908] did not want to deal with her...." A witness interview from CNA "L" completed by the Administrator on 11/27/24 at 12:40 p.m., revealed the following: Asked [CNA "L"] to walk us through her statement again, 'I saw her in there but I don't know if anyone else was in there with her'. When was this? 'Around 7P or 8P'. 'I went to go to rounds and saw her in the corner by the windows with two tables in front of her.' How were the tables aligned? 'Adjusted to be in front of her'. Did it appear [R903] could get out? 'No'. Did this look abnormal to you? 'Yes, because			

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	you don't usually have two tables in front of a resident.' Did you think that could be a violation of resident's right? 'Yes'..." A follow-up witness interview from CNA "M" completed on 11/27/24 at 12:00 PM revealed the following: "Before asking [CNA"M"] a question she said, 'My statement was not true I was just going along with the story...Asked [CNA "M"] what story and she confirmed the story regarding [R903] having limited access to move....[CNA "M"] says [CNA "J"] called her the morning of the suspension, when abuse was brought to the Administrator, and asked her to go along with the story she was providing. [CNA "M"] confirmed [CNA "J"] informed her that she had put [R903] in the corner, behind tables, to limit her from wandering..." A "Disciplinary Action Record" Form for LPN "K" signed by the Administrator on 11/27/24 revealed the following: "Termination-effective date 11/27/24....Date of Infraction: 11/20/24...Employee shall not physically, verbally, emotionally or psychologically abuse a resident, or engage in a serious violation of a residents rights or patient care standards. On the above date employee was observed by a resident involuntarily secluding another resident in the dining room..." An "employee termination form" dated 11/27/24 for LPN "K" was reviewed and revealed the following: "Reason for Termination-Employee terminated for			

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	violating the companies abuse policy (involuntary seclusion) of a resident." A "Disciplinary Action Record" Form for CNA "J" signed by the Administrator on 11/27/24 revealed the following: "Termination-effective date 11/27/24....Date of Infraction: 11/20/24...Employee shall not physically, verbally, emotionally or psychologically abuse a resident, or engage in a serious violation of a residents rights or patient care standards. On the above date employee was observed by a resident involuntarily secluding another resident in the dining room..." An "employee termination form" dated 11/27/24 for CNA "J" was reviewed and revealed the following: "Reason for Termination-Employee terminated for violating the companies abuse policy (involuntary seclusion) of a resident." On 12/23/24 at approximately 1:53 p.m., the Administrator (abuse coordinator) and AA "O" (via phone call) were queried regarding the facility investigation and allegation of involuntary seclusion of R903 on 11/20/24. The Administrator reported they were informed of the allegation the day after the incident occurred by AA "O" on 11/21/24 after R907 and R908 had notified AA "O" via a text message the night before. AA "O" indicated they saw the text message from the residents on the morning of 11/21/24. AA"O" was queried if R903's movement was restricted based on the picture provided in			

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	the text message and they indicated that it was and that they believe the intent of the positioning of the tables was meant to restrict R903's movement in the facility. The Administrator reported that LPN "K" and CNA "J" were terminated as a result of the investigation along with CNA "L" and CNA "M" for having observed that incident and not reporting it to the Administrator. The Administrator reported that CNA "L" had observed it along with the two residents (R907 and R908) and that CNA "M" had initially lied about their statement but then confirmed that the restriction of movement had occurred during the follow-up interview on 11/27/24 and that CNA "J" had asked them to go along with their story as to what had occurred. The Administrator reported that they educated all staff on involuntary seclusion and abuse and that they had implemented a plan of correction due to the incident. The Assistant Administrator reported their compliance date was 12/2/24. On 12/23/24 at approximately 2:48 p.m., R908 was queried regarding their observation of R903 being placed behind tables in the corner of the dining room on 11/20/24. R908 indicated that they had observed R903 being held in "jail" in the dining room behind tables in the corner and had reported it to the Assistant Administrator and sent them a picture of it. R908 indicated that CNA "J" was the staff member who put R903 behind the stables stacked on top of each other and that CNA "J" did it so they would not have to			

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	watch them. R908 indicated that R903 was trapped behind the tables and that R907 had also witnessed it. R908 reported other staff where there with them in the dining room when it happened. On 12/23/24 at approximately 2:55 p.m., R907 was queried regarding their observation of R903 being restrained behind the tables in the dining room on 11/20/24 and they reported that it was true and that R908 was with them in the dining room when it happened. R907 indicated that R903 was trapped behind the tables in the corner of the room so no one had to follow them around.			
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 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	F0609		

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	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: This citation pertains to intake #MI00148615 Based on interview and record review, the facility failed to report an allegation of involuntary seclusion in a timely manner to the Administrator and the State Agency for one resident (R903) of three residents reviewed for abuse. Findings include: On 12/23/24 a facility reported incident (FRI) was reviewed that alleged R903 was involuntarily secluded by facility staff on 11/20/24. Further review of the FRI revealed it was received by the State Agency on 11/21/24. On 12/23/24 at approximately 9:54 a.m., R903 was observed in their room, laying in their bed. R903 was observed to be dressed appropriately wearing a hair cap. R903 was observed to have a CNA (Certified Nursing Assistant) sitting in a chair in their room providing supervision. On 12/23/24 the medical record for R903 was reviewed and revealed the following: R903			

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(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 initially admitted to the facility on 5/21/21 and had diagnoses including Generalized anxiety disorder, Dementia and Delirium. A review of R903's MDS (minimum data set) with an ARD (assessment reference date) of 11/19/24 revealed R903 had behaviors including wandering in the facility. On 12/23/24 the facility completed investigation for R903 being involuntarily secluded on 11/20/24 was reviewed and revealed the following: "At approximately 7:30 a.m., on 11/21/23 the Assistant Administrator reported to the Administrator that another resident sent a picture of resident [R903] sitting behind three tables in the dining room. The position where [R903] was sitting appeared to be limiting he access to move. the resident who reported (R908), says the two individuals involved where CNA "J" and LPN (Licensed Practical Nurse) "K" (LPN "K"), both were suspended immediately pending the investigation....Resident [R908] sent a picture to the Assistant Administrator phone on 11/20/24 at 9:30 p.m., stating Nurse [LPN "K"] and aide [CNA "J"] had trapped resident [R903] between the tables because [R908] did not want to deal with her...." On 12/23/24 at approximately 1:53 p.m., The Administrator (abuse coordinator) and AA "O" (via phone call) were queried regarding the facility investigation and allegation of involuntary seclusion of R903 on 11/20/24. The Administrator reported they 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 _____	**12/23/2024**

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	informed of the allegation the day after the incident occurred by AA "O" on 11/21/24 after R907 and R908 had notified AA "O" via a text message the night before. AA "O" indicated they saw the text message from the residents on the morning of 11/21/24. AA "O" was queried if R903's movement was restricted based on the picture provided in the text message and they indicated that it was and that they believe the intent of the positioning of the tables was meant to restrict R903's movement in the facility. The Administrator reported that LPN "K" and CNA "J" were terminated as a result of the investigation along with CNA "L" and CNA "M" for having observed that incident and not reporting it to the Administrator. The Administrator reported that CNA "L" had observed it along with CNA "M" and the two residents (R907 and R908) and that CNA "M" had initially lied about their statement but then confirmed that the restriction of movement had occurred during the follow-up interview on 11/27/24 and that CNA "J" had asked them to go along with their story as to what had occurred. The Administrator reported that they educated all staff on involuntary seclusion and abuse reporting and that they had implemented a plan of correction due to the incident. The Assistant Administrator reported their compliance date was 12/2/24. A "Disciplinary Action Record" Form for CNA "L" signed by the Administrator on 11/27/24 revealed the following: "Termination-effective			

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	date 11/27/24....Date of Infraction: 11/20/24...Not reporting suspected, alleged or actual acts of abuse towards a resident. On the above date employee failed to report that she observed a resident involuntarily secluded in the 'two west dining room'..." An "employee termination form" dated 11/27/24 for CNA "L" was reviewed and revealed the following: "Reason for Termination-Employee terminated for not reporting abuse in a timely manner..." A "Disciplinary Action Record" Form for CNA "M" signed by the Administrator on 11/27/24 revealed the following: "Termination-effective date 11/27/24....Date of Infraction: 11/20/24...Not reporting suspected, alleged or actual acts of abuse towards a resident. On the above date employee failed to report knowledge of a resident being involuntarily secluded..." An "employee termination form" dated 11/27/24 for CNA "M" was reviewed and revealed the following: "Reason for Termination-Employee terminated for not reporting abuse in a timely manner..." On 12/23/24 a facility document titled "Abuse and Neglect" was reviewed and revealed the following: "Policy: It is the policy of this facility to provide professional care and services in an environment that is free from any type of abuse, corporal punishment, involuntary seclusion, misappropriation of			

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	property, exploitation, neglect or mistreatment. This includes but is not limited to freedom from any physical or chemical restraint not required to treat the resident's medical symptoms. The facility follows the federal guidelines dedicated to prevention of abuse and timely and thorough investigations. This guidelines include compliance with the seven federal components of preventions and investigation...Reporting/Response-All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's designee...All Allegations of abuse will be reported to the appropriate State Agencies immediately after the initial allegation is received...."			