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|--|---|--|---|--|--|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION              |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>634560</b> |   | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____                                 |  | (X3) DATE SURVEY<br>COMPLETED<br><br><b>2/4/2025</b> |  |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>SKLD BLOOMFIELD HILLS</b> |   |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br><b>2975 N ADAMS ROAD<br/>BLOOMFIELD HILLS, MI 48304</b> |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY<br>FULL REGULATORY OR LSC IDENTIFYING<br>INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTION (EACH<br>CORRECTIVE ACTION SHOULD BE CROSS-<br>REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) |  |  | (X5)<br>COMPLETION<br>DATE                           |  |
| F0000<br><br>SS=   | INITIAL COMMENTS<br><br>Request to Accept Evidence of Deficiency<br>Correction in Lieu of a Revisit Accepted. Facility<br>is in compliance with 42 CFR Part 483,<br>Requirements for Long Term Care Facilities. | F0000  |   |  |  |  |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/06/2025

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.