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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Bloomfield Hills	2975 N Adams Road Bloomfield Hills, MI 48304

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34208 This citation pertains to intake #MI00150014 Based on interview and record review the facility failed to notify the responsible party of a change of antipsychotic medication dosage for one resident (R801) of three residents reviewed for notification of changes resulting in complaints they were not informed of the resident's plan of care. Findings include: A complaint received by the State Agency alleged the responsible party is not notified for changes in the resident's condition. On 3/19/25 at 12:00 PM, a review of a facility provided document titled, Grievance and Satisfaction form dated 3/10/25 for R801 was reviewed and indicated their responsible party contacted the facility's Administrator with concerns regarding a medication increase without their knowledge. The form read, . Resident daughter says her and family are upset at this change that happened in December . The section on the form titled, Resolution was reviewed and read, (Psychiatric Service Provider) called to apologize for not notifying the resident daughter of this change . A review of Dr. 'B's psychiatric service note dated 12/5/24 was reviewed and read, .CURRENT MEDICATIONS Seroquel (antipsychotic medication) 25 mg (milligram) tablet (Take 1.5 tablet(s) by oral route, 2 times per day) . ASSESSMENT AND PLAN .Will increase seroquel to 50mg BID (twice daily) for mood instability and psychosis . The note entered by Dr. 'B' did not indicate they informed the resident's responsible party of the increase in the dosage of the Seroquel medication. A review of R801's Social Services Progress notes was also conducted and revealed no evidence the responsible party had been notified of the medication change that occurred in December 2024. Review of Social Services Progress notes further revealed the last note entered into the record for R801 was dated 8/14/24. On 3/20/25 at 9:30 AM, an interview was conducted with the facility's Assistant Administrator regarding the notification of the medication change for R801. They said they thought Social Work informed the family of the change at the time (December 2024). During the interview the facility provided grievance form was shared with the Assistant Administrator that documented neither the Psychiatric Service Provider, nor the facility's Social Services Department contacted the responsible party until they filed the grievance on 3/10/25. (continued on next page)

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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a facility provided document titled, Resident Rights Subject: Informing Residents of Health, Medical Conditions and Treatment Options was conducted, and read, 1. Each resident admitted to our facility will be informed of his/her total health status and medical condition .3. The person informing the resident/representative of his or her medical condition will present such information in a format, language and cultural context that the resident/representative can understand .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 34208 This citation pertains to intake #MI00150014 Based on interview and record review the facility failed to ensure care conferences were coordinated with the inclusion of their responsible party for one resident (R801) of three residents reviewed for care conferences resulting in complaints of not being informed of the resident's plan of care. Findings include: A complaint received by the State Agency alleged the resident's responsible party was not notified or included in care conferences. On 3/19/25 at 2:10 PM, an interview was conducted with Social Worker 'C' regarding documentation of care conferences. They said when a care conference occurred the Social Work Department would enter a progress note into the record. On 3/19/25 at 2:13 PM, a review of R801's Social Services Progress notes was conducted and revealed the last documented note making any mention of a care conference was dated 5/24/24. A review of R801's assessments was also conducted and revealed no evidence of care conferences. On 3/20/25 at 9:20 AM, the facility was requested to provide any documented evidence of R801's care conferences, however; no documentation was provided by the end of the survey. A review of a facility provided document titled Best Practice Care Conference UDA (User Defined Assessment) Utilization was reviewed and read, Care Conferences will be scheduled within the facility based on the following timeframes: .Quarterly based on MDS (Minimum Data Set) schedule .invitations will be provided to patient and/or responsible party .During meeting the following will occur: .All persons in attendance will be documented on the UDA, including notification and attendance of patient and patient representative. Each team member will document a summarization of areas reviewed and discussed during care conference on UDA form .All documentation is expected to be completed timely either during or directly after care conference .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 34208 This citation pertains to intake #MI00150014 Based on interview and record review the facility failed to ensure medications were administered timely and per resident preference for one resident (R810) of three residents reviewed for medication administration, resulting in verbalized complaints and frustration with medications being administered late. On 3/19/25 at approximately 3:25 PM, an interview was conducted with R810. They verbalized complaints regarding late medication administration times. They said nurses go on their breaks prior to passing medications so they don't get them on time. They said the concern was worse at night and it made them, nervous to not get their seizure medications on time. On 3/20/25 at 10:45 AM, a review of R810's medication administration audit report (a report that shows the times medications were documented on the medication administration record) was conducted and revealed the following: 2/4/25 medications scheduled for 9 PM given at 10:33 PM. 2/7/25 medications scheduled for 9 PM given at 11:32 PM 2/8/25 medications scheduled for 9 AM given at 10:30 AM. 2/13/25 medications scheduled for 9 AM given at 11:36 AM. 2/23/25 medications scheduled for 9 PM given at 11:33 PM. 2/27/25 medications scheduled for 9 AM given at 11:53 AM. 2/27/25 medications scheduled for 9 PM given at 5:31 AM on 2/28/25. 2/28/25 medications scheduled for 9 PM given at 8:17 AM on 3/1/25. 3/2/25 medications scheduled for 9 PM given at 11:19 PM. 3/3/25 medications scheduled for 9 AM given at 10:22 AM. 3/3/25 medication scheduled for 3 PM given at 4:51 PM. 3/3/25 medications scheduled for 9 PM given at 11:50 PM. 3/5/25 medications scheduled for 1 PM given at 6:11 PM. 3/6/25 medications scheduled for 9 AM given given at 10:48 AM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/6/25 medications scheduled for 9 PM given at 11:01 PM. On 3/20/25 at 12:28 PM, an interview was conducted with the facility's Director of Nursing and they said medications were to be given up to an hour before or after their scheduled time. They were made aware of the concerns with R810's medications being administered late and said they would look into it. A review of a facility provided policy titled, Medication Administration was reviewed and read, It is the policy of this facility that medications shall be administered as prescribed by the attending physician .7. Medications should be administered in accordance to meet the needs of the resident. Facility that follow standard med pass models .must be administered with one (1) hour before or after their prescribed time .

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F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47283

This citation pertains to intake #'s MI00150014, MI00150295

Based on observation, interview, and record review facility failed to provide appropriate supervision for one (R804) of one resident reviewed for accidents. This deficient practice had the potential to cause burns and or fire related accidents when facility staff applied a non-medical grade heating pad (brought from home) to R804 with no assessment and physician order. Findings include:

Record review revealed R804 was a long-term resident of the facility. R804 was originally admitted to the facility on [DATE]. Recently R804 was admitted to the hospital on 2/12/25 and they were readmitted to the facility on [DATE]. R804's diagnoses included rheumatoid arthritis, ankylosing spondylitis, contractures of both knees, intractable pain, overactive bladder, with history of urinary tract infection and anxiety disorder, and major depressive disorder. Based on the Minimum data Set (MDS) assessment dated [DATE], R804 had a Brief Interview for Mental Status score (BIMS) of 15/15 indicative of intact cognition. R804 needed extensive staff assistance with their mobility and Activities of Daily Living (ADLs) such as dressing, toileting etc.

An initial observation was completed on 3/19/25 at approximately 10:55 AM. An interview was completed during this observation. R804 had a pillow in between the legs. R804 had deformities in their hands and both knees were in bent position. They had an electrical heating pad on their knees. The heating pad was on and connected to the electrical outlet near the bed. R804 was queried if they could reach/touch their legs and they stated that were not able to do without assistance. When queried about the heating pad they reported that their family member had brought it from home and staff had been applying them. When queried who had applied the heating pad they reported their Certified Nursing Assistant (CAN) had put that on her around 10 AM. When they were asked how long they left the heating pad on, they reported that it stayed on for a couple of hours. They added it had an auto shut off and it turned off after 2 hours. The heating pad was a non-medical grade heating pad. During the interview two CNAs (D and E) came into R804's room and reported that there was a mix up with the appointment time and transportation was there to pick them up. They were going to assist R804 to get them dressed and ready for their appointment. CNA D removed the heating pad.

Review of R804's Electronic Medical Record (EMR) revealed no documentation regarding the use of a heating pad under progress notes. There were no physician orders and no care plans regarding the use of the heating pad.

An interview with CNA D was completed on 3/19/25 at approximately 12:10 PM. CNA D was assigned to care for R804 that shift. They were queried about the heating pad for R804. CNA D reported that it was from their family and they recently brought it. They had put it on R804.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with the Unit Manager (UM) G on 3/19/25 at approximately 4:15 PM. They were queried about facility protocol for use of (non-medical grade) heating pads from home. UM G reported that the facility did not use any such heating pads. They were queried if they were aware of any residents who had heating pads in their room and they reported that they were not aware. UM G was notified of the observation and the concern. They also reviewed R804's EMR and reported that there was no documentation and they would follow up. An interview with Registered Nurse (RN) F was completed on 3/20/25 at approximately 8:40 AM. RN F was queried if they were aware of the heating pad that was being used for R804. They reported that they were unaware that R804 had heating pad and staff were applying this for the resident. An interview with the Director of Nursing (DON) was completed on 3/20/25 at approximately 10:50 AM. The DON was queried about the use of heating pads (form home) in the resident room and what was their protocol. The DON reported that the facility did not allow the use of heating pads in resident rooms. They also reported that they were unaware that R804 had a heating pad. The DON was notified of the observations and the concerns. A facility policy or protocol was requested on heating pad use or accident prevention related to use of medical equipment(s) from outside. A facility document titled Policy/Procedure - Nursing Administration with Subject: Risk Management (accident) interventions, dated 4/1/19 read in part, It is the policy of this facility that resident environment remains as free of accidents hazards as possible and that each resident receives adequate supervision and assistance to prevent accidents. The purpose is to ensure that the facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident to prevent avoidable accidents. This includes systems and processes designed to: Identify hazards and risks evaluate and analyze hazards and risks implement interventions to reduce hazards and risks and monitor for effectiveness and modify approaches as indicated .

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	235217	A. Building B. Wing	03/20/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 This citation pertains to intake #'s MI150014, MI00150295, MI00148319 Based on observation, interview, and record review facility failed to provide timely incontinence care for one (R804) of 3 residents reviewed for incontinence care resulting in the potential for impaired skin integrity and urinary tract infection(UTI). Findings include: Record review revealed R804 was a long-term resident of the facility admitted on [DATE]. Recently R804 was admitted to the hospital on 2/12/25 and readmitted to the facility on [DATE]. R804's diagnoses included rheumatoid arthritis, ankylosing spondylitis, contractures of both knees, intractable pain, overactive bladder, with history of urinary tract infection and anxiety disorder, and major depressive disorder. Based on the Minimum data Set (MDS) assessment dated [DATE], R804 had a Brief Interview for Mental Status Score (BIMS) of 15/15 indicative of intact cognition. R804 needed extensive staff assistance with their mobility and Activities of Daily Living (ADLs) such as dressing, toileting etc. A complaint reviewed by the State Agency revealed that R804 had reported their hygiene was poor and they were not receiving the assistance they needed at the facility. An initial observation was completed on 3/19/25 at approximately 10:55 AM. R804's door had a signage that read knock before enter. A housekeeper was in the room and was exiting when the surveyor went in to see the resident. The room had strong offensive questionable urine odor. R804 was observed laying on their bed on their back, leaning more on the right side with pillows behind their back. The offensive odor was strong near their bed. R804 had a pillow in between their legs and they had an electrical heating pad on their knees. The heating pad was connected to the outlet and was on. During this observation an interview was completed. R804 was queried about their stay at the facility and if they were getting the assistance they needed from staff. R804 reported that they needed assistance with feeding and they needed to be changed. When they were queried when their brief was changed last time, R804 reported Monday. R804 stated no one changed me last night. They reported that they were lying in bed soaked with urine and a wet brief throughout the night. When queried if they had refused care, they reported that they did not refuse care. They added that their day shift Certified Nursing Assistant (CNA) was aware and they were going to come and change them. R804 added that they had an appointment to see their rheumatologist in the next few hours. R804 was wearing a facility provided gown. R804 had a folded blanket under them that had a dried up brown stain that covered the entire length of the sheets and extended from under the back of the thighs to mid back. The stained areas were dried up. During the interview, two CNAs (D and E) came into R804's room and reported that there was mix up with the appointment time and transportation was there to pick up. They were going to assist R804 to get them dressed and ready for their appointment. CNA D removed the heating pad and started removing the pillow, R804 started complaining of pain. CNA D was queried about dried up brown sheets and the odor, they reported that mid-night shift did not change R804. R804 did not want to go for their appointment due to their pain and CNA D had to get RN F to the room. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A follow up observation was completed at approximately 12:05 PM. R804 was not in their room. The room had a strong odor. The over lay cushion on top of the mattress had a vinyl cover with large brown stain in the middle. The middle area of the overlay was flattened. Review of R804's hospital records from 2/12/24 revealed multiple consults that revealed concerns about hygiene reported by the resident. Review of hospital records did not reveal any concerns with R804 refusing care during their hospital stay. Review of R804's progress notes revealed a physician note dated 1/21/25 that read daily prophylactic antibiotic for UTI prevention, discussed with patient. Patient declined addition of daily antibiotic at this time. A nursing progress note dated 2/11/25 at 12:15 revealed that R804 was soiled and refused care. R804 was transferred to the hospital on 2/12/25, during their hospital stay they had reported care concerns at the facility. Further review of R804's records did not reveal any nursing progress notes that indicated that R804 had refused care on 3/18/25 on MN shift. Review of R804's CNA task report for 3/18/25 for toileting task revealed that R804 was assisted at 5:28 AM. R804 had refused care on PM shift and R804 was assisted by MN shift at 5:41 AM (on 3/19/25), however observation, resident and staff interviews revealed that no staff assistance was provided to R804 during MN shift. It must be noted that based on task report, observation, and resident interview, R804 was assisted with their incontinence care on 3/18/25 at 5:28 AM, after that they were assisted on 3/19/24 at approximately 11 AM (approximately over 30 hours). Review of R804's care plan for their Activities of Daily Living (ADLs) that read Resident has an ADL self-care performance deficit related to rheumatoid arthritis (RA). Resident states that she does not want to be bothered at times when she is in pain or had increased stiffness related to her disease process. Multiple interventions were listed that included: Provide supportive care, assistance with daily care needs (ADLs) as needed, document assistance as needed; staff to encourage resident to receive care, be gentle with resident, notify nurse of any pain, if not feeling well, reapproach later for care. R804 had a care plan regarding attention seeking and manipulative behavior and making false accusations and interventions included, monitor emotional factors that can contribute behaviors; staff to approach resident in a calm manner, assess for pain and address concerns when arise etc. R804's incontinence care plan had a goal that read, Resident will be clean, dry, and odor free through the review date. Review of R804's change of condition assessment dated [DATE] revealed that they were transferred to hospital due to altered mental status, not due to refusal of care as reported during the interview. It must be noted that hospital admission records did not reveal any change in mentation. An initial interview with Registered Nurse (RN) F who was assigned to care for R804 was interviewed on 3/19/25 at approximately 12:25 PM. During the interview RN F was queried if they had noticed how soiled R804 was? RN F stated yes and added R804 refused care and they had a care plan. RN F was queried if they were aware that R804 was not changed all night and if they had received any report from their mid night shift staff. They added that they were unaware that R804 was not changed all night until the CNA's had called them into the room they had observed how the resident was. When queried about their documentation process, they reported that they did not document everything but they completed a progress note depending on the situation. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview with CNA D was completed on 3/19/25 at approximately 12:10 PM. They reported that they had been at the facility for almost a year. They were queried about the condition how R804 was observed. CNA D reported that it was unacceptable and added R804 was beyond soaked. They added R804 refused care and added they should go back and attempt, notify the nurse. When queried if they had received any report from MN staff that R804 was not changed all night and they stated no. CNA F was queried about the brown stain that was on R804's back. They reported that it was from dried urine and they had cleaned them thoroughly to remove all the brown stain. An interview was completed with CNA E at approximately 12:35 PM. CNA F was assigned on the other side of the hall and they were assisting CNA D to change them. They were queried about their observations when they provided care for R804 and if that was acceptable. CNA F reported that R804 does refuse care at times, but what they had observed was not an acceptable level of care. They stated R804 was soaked all the way through the sheets and the cushion under. CNA F' was queried about the facility process if a resident refused care. They reported that if a resident refused care they would go back at a different time and they would ask for assistance from another CNA; if resident continues to refuse they would notify the nurse and nurse would attempt and they documented their efforts. An interview with Unit Manager (UM) G was completed on 3/19/25 at approximately 4:15 PM. UM G was notified of the observations for R804 and they were queried if that was acceptable and their facility process. They reported that the CNA were able to document once and they were not able to make changes. They were queried about the nurse's involvement with the process and if they expected their nurses to communicate with oncoming nurse so they could prioritize and assist the resident; UM G reported that they expected their nurses to document and communicate with the oncoming nurse. An interview with the Director of Nursing (DON) was completed on 3/20/25 at approximately 10:50 AM. The DON was queried about the facility expectations for incontinence care. They reported the facility attempts to provide care in a timely manner. They were queried how they handled if a resident refused care. The DON reported that they would expect the staff to go back and attempt and they expect them to notify the oncoming nurse. They added that CNA's shift did not overlap and there was no reporting, however outgoing nurses were expected to give reports to the oncoming nurses. A facility provide document tilted Incontinent Care dated 7/11/18, read in part, It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident to prevent infection, skin irritation, and to observe the resident's skin condition .document all appropriate information in medical record; do rounds at least every 2 hours to check for incontinence.