STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235365	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld Livonia	29270 Morlock Livonia, MI 48152

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This citation pertains to Intake: MI00147554. Based on interview and record review, the facility failed to notify the resident representative of a change of condition for one resident (R901) of three residents reviewed for notification. Findings include: A review of R901's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes, and Heart Failure. Further review revealed that the resident was cognitively intact, oxygen dependent, and required 1-2-person assistance for transfers, toileting and dressing. Further review of R901's medical record revealed the following progress note: 10/6/2024 17:35 (5:35pm). General Progress Note Patients left, and right hand noticeably shaking, unable to grasp things without it falling. MD (medical doctor) notified via Doctors book. Will continue to monitor patient duration of this shift. 10/7/2024 17:19 (5:19pm) Change of Condition Note Text: pt (patient) hypotensive in am (morning), bs (blood sugar) wnl (within normal limits), general weakness, lethargy difficulty speaking, [insurance company] NP (nurse practitioner) present, straight cath (catheter) for possible u/a, (urinalysis) STAT CXR (immediate xray) ordered, lasix (diuretic) on hold, parameters added,02 (oxygen) tank replaced .continue to monitor and notify oncoming shift. (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	On 10/23/24 at 9:19 AM, an interview was completed with LPN F, assigned nurse to R901 on the morning shift on 10/7/24. LPN F was asked about R901's change of condition, and they explained that the resident was not their normal self. They explained that the resident is usually talkative, but was sparingly using their words and was in and out of it. They explained that the resident was also weak and lethargic. LPN F explained that he checked the resident's vitals in which at that time the resident's blood pressure was 80/50. He explained that he left the room to allow the resident to rest, and returned approximately a half hour later hoping that the resident's blood pressure would have improved but upon assessing the resident, there was no improvement, so he called EMS to take the resident to the hospital. LPN F further explained that they had everything ready for the resident to be transferred and was providing EMS with everything needed for the transfer when the NHA (Nursing Home Administrator), Unit Manager, and Nurse Practitioner approached the room. LPN F explained that the Nurse Practitioner advised that they would take over, asked him to retrieve supplies to obtain urine for a urinalysis, and a suppository. LPN F explained that EMS left, and he continued to monitor the resident for the duration of their shift which was until 7:00pm, noting no improvement in R901's mental status or condition. On 10/23/24 at 12:55 PM, an interview was completed with the resident's representative, Family Member I regarding R901. Family member I explained they visited R901 on 10/7/24 between 2:00pm-5:30pm and someone mentioned to them upon arrival to the facility that R901 wasn't feeling well that day, as R901 could usually be located in the activity room. Family Member I explained when they arrived to R901's room, they found the Nurse Practitioner in the room who explained they would be conducting a urinalysis of R901. Family Member I explained they were unaware R901 had been assessed by their assigned nurse who determined the resident needed to be trasnferred to a higher level of care, and that EMS had been called, and left withthout R901. Family Member I explained they observed R901 in bed, and they did not seem like themselves as they were lethargic, not speaking clearly, stated that they felt dizzy and tired. Family Member I explained R901 seemed out of it as they would say something and then float off. Family Member I explained they stopped by the office where the Nurse Practitioner was located after visiting with R901, and explained to them she wanted them to check out R901 again because they seemed out of it, and the nurse practitioner confirmed that they would. A review of the facility's Change in a Resident's Condition or Status policy revealed the following, The facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This citation pertains to Intake: MI00147554 Based on interview and record review, the facility failed to provide ongoing monitoring and treatment for a change in condition for one resident (R901) of four residents reviewed for change of condition resulting in the initiation of Cardiopulmonary Resuscitation (CPR). Findings include: A review of Intake: MI00147554 revealed the following, Complainant states the resident was exhibiting an altered mental status and the nurse on duty called EMS (emergency medical services) to have the resident sent to the hospital. The complainant states EMS arrived at the residents bedside and the administrator made them leave and told the Nurse Practitioner to treat the resident in house. The complainant states the resident was found dead the next day. The complainant states they don't know the residents cause of death but appeared fine prior to showing signs of altered mental status. A review of R901's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, Diabetes, and Heart Failure. Further review revealed the resident was cognitively intact, oxygen dependent, and required , d+[DATE]-person assistance for transfers, toileting and dressing. Further review of R901's medical record revealed the following progress note: [DATE] 17:35 (5:35pm). General Progress Note Patients left, and right hand noticeably shaking, unable to grasp things without it falling. MD (medical doctor) notified via Doctors book. Will continue to monitor patient duration of this shift. [DATE] 17:19 (5:19pm) Change of Condition Note Text: pt (patient) hypotensive (low blood pressure) in am (morning), bs (blood sugar) wnl (within normal limits), general weakness, lethargy difficulty speaking, [insurance company] NP (nurse practitioner) present, straight cath (catheter) for possible u/a, (urinalysis) STAT CXR (immediate xray) ordered, lasix (diuretic) on hold, parameters added,02 (oxygen) tank replaced .continue to monitor and notify oncoming shift. On [DATE] at 12:33 PM, an interview was completed with Licensed Practical Nurse (LPN) A regarding R901 on [DATE], and they explained they were inside the resident's room when staff were attempting to get the resident up in the sit to stand lift (used to help transfer patients from a seated to a standing position) however, the resident was exhibiting decreased strength with the inability to grasp the bars to the sit to stand, as each time they attempted to hold on to the bar, they would become too weak and let go. LPN A explained R901 kept stating they didn't feel good. LPN A explained the following morning, [DATE], they observed the resident with an altered mental status, with the inability to feed themselves due to their decreased strength with attempting to hold their spoon. LPN A confirmed R901's assigned nurse attempted to send the resident out via EMS on [DATE] however, it they were directed the resident could be treated in the facility. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:40 PM, Registered Nurse (RN) B was asked about the incidents leading up to [DATE] when CPR was initiated on R901. RN B explained the resident's assigned nurse called 911 on [DATE] due to R901 exhibiting a change of condition however, there was a directive for EMS to leave without the resident as they could be treated at the bedside. RN B explained they observed R901, and they looked like they needed to be sent out, as their mental status had declined. They explained R901 normally was alert and oriented to person, place and things with the ability to express their needs, however, R901 was observed as alert, but lethargic and not able to get out of bed. RN B explained the resident's assigned Nurse Practitioner (NP E) who is familiar with the resident was not in the building during this time, and the Nurse Practitioner covering for her (NP J) was not familiar with the resident. RN B confirmed the covering Nurse Practitioner ordered labs, a chest x-ray, and a urinalysis. RN B further explained on [DATE] between 9:,d+[DATE]:00am a code blue (need for immediate medical intervention) was called for R901 who later died . On [DATE] at 12:51 PM, Certified Nursing Assistant (CNA C) who was assigned to R901 on [DATE] and [DATE] was asked about the resident's baseline on those dates. CNA C explained the resident was shaky and in pain for those two days, explaining they had to assist the resident with eating the morning of [DATE] due to their inability to hold their spoon, and consumed, a little (name of gelatin). CNA C explained on [DATE], R901's assigned nurse called EMS for the resident due to a change of condition however, they left without R901. On [DATE] at 2:30 PM, the Director of Nursing (DON) was interviewed regarding R901's change of condition, and she explained she was not in the building however, in interviewing facility staff, she learned R901 showed a decline and attempts to send the resident to a higher level of care was unsuccessful. The DON explained she relies on her nurses to assess the residents, and they did what was expected of them. The DON explained she would have liked for the resident's physician to have been contacted regarding the resident so they could assess the timing of when their results (labs, Xray, urinalysis) would have been received. The DON explained there was also discussion among facility staff regarding the Nursing Home Administrator (NHA) becoming involved in the decision for the resident to be treated at beside and EMS's directive to leave, and indicated that if this was the case, she (the Administrator) should have stayed in her lane. A review of R901's progress notes revealed the following: [DATE] 02:39 (2:39am) General Progress Note. Note Text: chest Xray result was faxed in and result shows Heaviness in the lower chest, with blunting of the costophrenic angle (pleural effusion), and Loculated pleural effusion (a buildup of fluid between the tissues that line the lungs and the chest) on the L (left) Side appears to be present. I tried calling the Dr (doctor) but no response, so I sent a text message to him and notified the morning shift nurse for follow up. On [DATE] at 3:09 PM, Physician D was interviewed regarding R901 and their change of condition, and acknowledged the resident experienced a change of condition, and that the nurse texted them at 2:00am, which he didn't receive until 9:00am, and upon review attempted to reach someone at the facility for the resident to be sent out. At that time, Physician D was informed that CPR had already been initiated on the resident. Physician D acknowledged the resident should have been sent out to the hospital upon their change of condition as they were hypoxic, had chronic kidney disease, high potassium levels, and the hospital is approximately 1 mile away. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 3:30 PM, Nurse Practitioner (NP) E was interviewed via phone regarding R901's change of condition. NP E explained she saw R901 regularly with the last time being [DATE], as there were other Nurse Practitioners assigned to the building while she was off. NP E explained that upon returning to the building on [DATE], and going to see R901, she located the resident with blueish lips, and called a code blue. NP E explained she was informed that leading up to [DATE], R901 showed a change of condition resulting in EMS arriving to the building and although appearing ill looking and sick, EMS was directed to leave as the resident would be treated at the bedside. NP E explained the staff at the nursing facility know her very well, and explained that if she would have seen the resident, she would have sent them out (to the hospital). NP E explained if treatment would have occurred at bedside, she would have expected for IV (intravenous) fluids to have been provided if the resident was arousable however, continued monitoring would also have been appropriate. NP E further explained, an altered mental status and lethargy in R901 warranted them sending the resident out. On [DATE] at 4:07 PM, an interview was completed the with the Nursing Home Administrator (NHA) regarding R901's change of condition, and she explained the ambulance arrived, and the nurse practitioners from R901's health plan indicated they could treat the resident at the bedside, and would contact the physician. On [DATE] at 9:19 AM, an interview was completed with LPN F, assigned nurse to R901 on [DATE]. LPN F was asked about R901's change of condition, and they explained the resident was not their normal self. They explained the resident is usually talkative, but was sparingly using their words and was in and out of it and was also weak and lethargic. LPN F explained he checked the resident's vitals in which at that time the resident's blood pressure was ,d+[DATE]. He explained he left the room to allow the resident to rest, and returned approximately a half hour later hoping the resident's blood pressure would have improved but upon assessing the resident, there was no improvement, so he called EMS to take the resident to the hospital. LPN F further explained they had everything ready for the resident to be transferred and was providing EMS with everything needed for the transfer when the NHA, Unit Manager, and Nurse Practitioner approached the room. LPN F confirmed the Nurse Practitioner advised they would take over, asked him to retrieve supplies to obtain urine for a urinalysis, and a suppository. LPN F explained EMS left, and he continued to monitor the resident for the duration of their shift which when until 7:00pm, noting no improvement in R901's mental status or condition. On [DATE] at 11:10 AM, an interview was completed with LPN G regarding the change of condition of R901, and explained the morning of [DATE], she was approached by CNA C who asked she assess R901 as their assigned nurse had taken a break and she had concerns about the resident. LPN G explained she assessed R901 and observed them to be unable sit up, appeared in and out of consciousness to the point they had to be held up to obtain their vitals. LPN G explained in R901's state of unconsciousness, they said, Please help me. LPN G explained she informed the resident's assigned nurse upon their return from break, and reports approximately 10 minutes later, EMS arrived and later left without R901. LPN G explained the Nurse Practitioner asked them if she had a suppository in her medication cart because they wanted to clean [R901] out. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 11:45 AM, an interview was completed with Central Supply Staff H (CS H) regarding observations of R901 on [DATE], and she explained on that date she entered R901's room regarding supplies for their oxygen, and while in the room, she observed R901 crying and stating, Help me. CS H explained upon exiting the room, she witnessed the CNA talking to the assigned nurse about R901, and later witnesses EMS enter the building for R901. CS H further explained later that day, after EMS exited the facility, she continued to witness R901 crying, which was unlike R901, as they were an active resident who was usually up daily participating in activities. On [DATE] at 2:48 PM, Nurse Practitioner (NP J), the covering NP on [DATE] for R901 was interviewed via phone. NP J explained upon assessing R901, she observed them lethargic appearing weak and was asking for their oxygen as their concentrator was malfunctioning. NP J explained this was her first time seeing the resident, and orders were placed for the resident following her assessment, and any continued monitoring would be done by nursing staff. NP J was asked if she contacted R901's physician, in which she explained she did not. NP J was asked what treatments were provided to R901and why the condition didn't warrant a transfer to the hospital, NP J stated, My progress note speaks for itself. A review of R901's progress note written by NP J revealed the following: [DATE] 13:00 (1:00pm) Late Entry: Note Text .New Patient Encounter ([DATE]) .History of Present Illness Resident seen today for acute change in condition or left and right hand tremors reported by NH (nursing home) staff yesterday evening. Upon arrival to the resident's room, EMS was present due to NH staff's concerns regarding the resident's lethargy, and weakness, which the nurse observed while administering medications that morning. It was noted that the resident's oxygen concentrator was malfunctioning, with an unclear duration of time without oxygen, SPO2 85%. The resident is oxygen-dependent at baseline, requiring 2L (liters) continuous NC (nasal cannula). Resident was transitioned to a portable oxygen tank set at 4L NC and administered a DuoNeb breathing treatment while EMS assessed the resident at the bedside. The resident responded well to the breathing treatment, with SPO2 improving to 96%. It was agreed upon by the writer and paramedics that the resident's condition was likely r/t (related to) hypoxia and it was appropriate to treat in place in which resident consented to .Upon further exam, the resident appeared lethargic but conversational and orientedx4. Afebrile . resident requested oral fluids and expressed a desire for lunch. Able to make her needs known . On [DATE] at 12:55 PM, an interview was completed with the resident's representative, Family Member I regarding R901. Family member I explained they visited R901 on [DATE] between 2:00pm-5:30pm. Family Member I was unaware EMS had arrived earlier and was advised to leave the facility after being called by LPN F. They explained that upon arriving to the facility, they had no idea the resident hadn't been feeling well all day, and upon observing R901 in bed, explained they did not seem like themselves as they were lethargic, not speaking clearly, stated they felt dizzy and tired. Family Member I said R901 seemed out of it as they would say something and then float off. Family Member I said they stopped by the office where the Nurse Practitioner (NP J) was located after visiting with R901, and explained to them they wanted her to check out R901 again because they seemed out of it, and NP J confirmed they would. Family Member I explained there was no way that she thought her family would have died the following morning, as they hadn't been ill, hadn't been hospitalized , and was going to outside appointments regularly. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Further review of R901's medical record revealed that following, NP J's initial assessment of the resident, there was no further documentation of any treatment and/or monitoring provided to the resident after a noted change of condition. A review of the facility's Change in a Resident's Condition or Status policy did not address ongoing monitoring and/or treatment related to a resident showing a change of condition.