

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235487	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/13/2024
NAME OF PROVIDER OR SUPPLIER Skld West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6950 Farmington Rd West Bloomfield, MI 48322	

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)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271</p> <p>This citation pertains to intake# MI00142611.</p> <p>Based on interview and record review the facility failed to protect the resident's right to be free from verbal abuse by facility staff for one resident (R901) of two residents reviewed for abuse. Findings include:</p> <p>On 5/13/24 a FRI (facility reported incident) was reviewed which alleged Certified Nursing Assistant C (CNA C) verbally abused R901.</p> <p>On 5/13/24 the medical record for R901 was reviewed and revealed the following: R901 was Initially admitted to the facility on [DATE] and had diagnoses of Chronic Obstructive Pulmonary Disease and Adjustment Disorder. A review of R901's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/3/24 revealed R901 was independent with most of their activities of daily living. R901's BIMS score (brief interview for mental status) was 14 indicating intact cognition.</p> <p>(continued on next page)</p>

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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/13/24 a review of the facility investigation pertaining to the allegation was reviewed and revealed the following: On 1/27/2024, [R901] alleged that [CNA C] threatened him with physical harm if he did not leave the Mackinaw unit nurse station. The facility suspended [CNA C] pending the outcome of this investigation. The investigation included staff and patient interviews, a review of [R901's] medical record and a review of the personnel file of [CNA C]. The facility Administrator interviewed [R901] on the unit and asked him to walk through and explain what happened the night of the 26th. [R901] walked to the nurse's desk and demonstrated how and where he was standing. He explained that he was at the nurse's desk because he had noticed a box he had wanted for his room. He said that [CNA C] and [Receptionist B] had been going through the box looking for information. That's when [CNA C] told him to go back to his room and that he couldn't stand at the nurse's desk. [R901] said he lost his cool and began swearing at [CNA C]. [R901] states that as he was yelling at [CNA C], she went belligerent saying she didn't care about this job and I will beat your ass. [R901] stated that [Recep B] had intervened and diffused the situation. [R901] denied any physical contact with [CNA C]. [R901] was asked if he may have incorrectly heard beat your ass instead of being an ass and he responded, c'mon man, there is no way she said, being an ass. [R901] states that [CNA A] and [Recep B] are witnesses. [CNA C] was interviewed by the facility administrator with the Human Resources Director present. [CNA C] states that she was at the Mackinaw nurse station looking over a new admission chart trying to find the diet order so the patient could receive a meal from the kitchen. As she was reviewing the new admission information with receptionist [Recep B], she asked [R901] to step away from the nurse desk to respect HIPAA (health insurance portability and accountability act)/patient information. She said at that point, [R901] started yelling and swearing at her. She states that [R901] told her that he can stand wherever the f*** he wants to and she can go f*** herself as well as shut the f*** up. [CNA C] states that she told [R901] that he was being an ass and that she would not tolerate him acting like that. At that point, [CNA C] states that a fellow CENA encouraged [CNA C] to not continue interacting with [R901]. [CNA C] was asked if she threatened [R901], specifically beat his ass and she denied stating that she had a mask and may not have been heard correctly. She again stated that she told him he was being an ass. We asked [CNA C] if she verbally abused [R901]; she stated that she had not but regretting using any type of cuss word when talking to him. The facility interviewed [Recep B]. [Recep B] confirms that she was at the nurse's desk during the incident between [R901] and [CNA C]. Receptionist [Recep B] states that she originally thought the two were playing around but then heard [CNA C] say, I will beat your mother f***** ass. Receptionist [Recep B] states that she immediately intervened and diffused the situation. The facility interviewed CENA [CNA A]. CENA [CNA A] confirms she was at the nurse's desk during the incident between [R901] and [CNA C]. She said [R901] had been hanging around the nurse's desk butting in and listening to our conversation; [CNA C] told him that he couldn't be at the desk overhearing our conversation about PHI. [CNA A] said that [R901] had gone off yelling and swearing at [CNA C], calling her a little b*** and challenging her to a fight. [CNA A] said at that point she heard [CNA C] tell [R901] something to the effect of I'll slap the s*** out of you or something like that. The facility investigation could verify that [CNA C] did violate no less than four work rules during her exchange with [R901]. [CNA C] has been terminated from the facility effective 1/26/2024. The facility has begun re-education of facility staff on abuse/reporting policy to ensure staff can define and recognize potential allegations of abuse. The facility has also begun educating the staff on how to deal with residents with difficult behavior.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/13/24 at approximately 10:00 a.m., The Director of Nursing was queried regarding the incident between R901 and CNA C. The DON reported that CNA C was unprofessional during the incident and was terminated due to multiple violations of work rules and that they did a house sweep of all the staff and reeducated the staff on abuse and neglect. The first inservice that was completed post incident was done on 1/29/24.</p> <p>On 5/13/24 at approximately 10:23 a.m., during an interview with CNA A who witnessed incident, reported that R901 was butting in on the conversation they were having with CNAC at the Nursing station. CNA A indicated they moved down and R901 followed saying they could stand wherever they wanted. R901 then called CNA C a b**** or something like that. when that happened CNA A indicated that CNA C said something Like I'll slap you or something like that. At that point they were separated and CNA C was sent home.</p> <p>On 5/13/24 at approximately 10:41 a.m., during an interview with Receptionist B (Recep B), Recep B reported that they heard R901 and CNA C arguing and they heard CNA C tell R901 that they were going to beat his ass. Recep B Stated they were in shock at hearing an employee tell a resident that. Receipt B reported that no residents should be treated like that. Recep B indicated that CNA C had informed the Administrator of the incident so they thought they did not have to call them but CNA C was sent home in regards to the incident.</p> <p>On 5/13/24 a facility document titled Disciplinary Action Record-Work Rules for CNA C with a date of infraction on 1/26/24 was reviewed and revealed the following: Termination 1/26/24 .Describe reasons for disciplinary action 34. Engaging in conduct that is improper or inappropriate that may put the facility and/or company's reputation at risk. 42. Engaging in any other disorderly conduct affecting another employee, resident, or visitor. 53. Using profane, obscene, or abusive language. 10. Not showing acceptable standards of respect and/or cooperation to residents, visitors, employees, or supervisors. on 1/26/24 Employee at the Nursing Station use profanity and not showing respect to a resident and staff .</p> <p>On 5/13/24 a second facility document titled Resident Rights-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 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 of allegations. These guidelines include compliance with the seven (7) federal components of prevention and investigation .Verbal: Verbal abuse includes but not limited to the use of oral, written or gestured language. This definition includes communication that expresses disparaging and derogatory terms to residents within their hearing/seeing distance. Examples: name calling, swearing, yelling, threatening harm, trying to frighten the resident, racial slurs, etc</p>		