STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235487	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld West Bloomfield	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)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to complaint: 2641546. Based on interviews and record reviews the facility failed to develop an adequate safety plan, failed to consistently implement the plan of care and adequate supervision for one (R127) of one resident reviewed for falls with injury, resulting in multiple injuries that included: a hematoma to the right side of forehead, bruise to the right shoulder, pain, bruising/edema to the right eye, laceration to the left side of forehead, a small focus of extra-axial hemorrhage along the anterior left frontal lobe (minor collection of blood outside the brain tissue) and required a transfer to the Emergency Department (ED) for further evaluation. Findings include: A review of the preadmission documents provided to the facility upon R127's admission documented the following in part: .1/31/2025. History and Physical. Chief Compliant: Fall. admitted to the hospital after having an unwitnessed fall down 11 12 stairs. Imaging done. showed SDH (subdural hematoma), SAH (subarachnoid hemorrhage), and IPH (intraparenchymal hemorrhage) as well as T1 acute fracture, T3 and T5, age indeterminate fractures (spinal fractures), as well as left rib 911 fractures, right orbital fracture (break in bones surrounding right eye) with pneumocephalus (presence of air or gas within the cranial cavity). 3/4/2025. Attending Physician. Progress Notes. Pt (patient) is awake. Wean restraints as tolerated and hydroxyzine added. 3/1 -Patient is seen at bedside today, awake and alert, tracks me when I call her name however does not follow commands patient continues to be restless with legs outside the bed rail.Despite the documentation of the resident to be restless and noted to have required restraints the facility accepted the resident to be admitted . A review of the medical record revealed R127 was admitted to the facility on [DATE] with diagnoses that included: intracerebral hemorrhage in hemisphere, subdural hemorrhage, tracheostomy, dysphagia, restlessness, agitation, difficulty walking and lack of coordination. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status score of 00, which indicated severely impaired cognition. R127 required staff assistance for all Activities of Daily Living (ADLs).A review of the medical record and the facility's fall incident reports revealed a total of 10 falls while inpatient from March to September 2025- 3/21/25, 5/10/25, 8/17/25, 9/18/25, 9/23/25, 9/24/25, two on 9/25/25 and two on 9/28/25. A review of the care plan titled Resident is at risk for falls r/t (related to) History of fall(s), Impaired safety awareness, Cognitive impairment, Gait/balance problems, Impulsiveness, constantly moving and trying to get up unattended was initiated on 7/28/25. This care plan included the following interventions . 1:1 (one on one) sitter will switch off with the CNA (certified nursing assistant) for the set resident is in or charge nurse when sitter needs to go on break or take eyes off of resident. Staff educated regarding 1:1 duties.Review of the progress notes revealed the following: A Nursing note dated 9/17/25 at 2:58 PM (late entry), . pt (patient) very agitated during shift. Pt stood up from chair and began walking and would not allow staff to redirect her and would not sit down. Writer had to put wheelchair behind pt for her to fall back into. Dr (doctor) in building and witnessed pt anxiousness and stated she would call guardian to discuss medications. Social work present and witness pt agitation and inconsolableness. Psych dr present and evaluating pt medication and speaking with pt guardian.A Nursing note dated 9/18/25 at 7:37 AM, documented . Cena (aide) stated pt stood up from wheelchair and fell over onto floor, pt was Lying on right side, Pt assessed for injuries, pt has hematoma to right side of head and brise <sic> to right shoulder at this time. Physician notified and ordered neuro-checks, NP (Nurse Practitioner) ordered x-ray for skull, facial and right shoulder.A NP note dated 9/18/25 at 3:23 PM, documented in part . Acute falls secondary to generalized weakness. Patient evaluated today following an acute fall attributed to generalized weakness. According to the staff, the patient stood up from her wheelchair and subsequently fell onto her right side. During the fall, the patient struck her head but did not lose consciousness. A medium-sized hematoma was observed on the right forehead. The patient expressed experiencing pain and also discomfort in her right shoulder. The patient is under the supervision of a 1- on -1 sitter. the fall was witnessed by the sitter. The nursing staff is closely monitoring the patient.A Nursing note dated 9/18/25 at 4:55 PM, documented . upon visitation of family member at 1:39, family concerned about hematoma. After visitation at approximately 4:00 family member called facility and requested for resident to be transferred to hospital for CT scan (computed tomography scan) and further evaluation.A review of a Emergency Medicine hospital note dated 9/18/25 at 7:59 PM, documented in part . Sent to the ED (emergency department) from ECF (extended care facility) for evaluation after unwitnessed fall. Found to have contusion of the forehead. The patient's sister and guardian she noticed a large hematoma on the right forehead with visiting here with her