STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235487	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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.

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F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 303 Based on observation, interview, and record review, the facility failed to report an allegation of abuse/neglect/mistreatment (threats of harm) to the facility's Abuse Coordinator and the SA (State Agency) in a timely manner for one of three residents reviewed for abuse, resulting in the potential for unidentified and/or continued abuse/neglect/mistreatment. Findings include: On 6/23/20 the medical record for R#903 was reviewed and revealed the following: R#903 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#903's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/21/20 revealed R#903 needed extensive assistance from facility staff with most of their activities of daily living. R#903's BIMS score (Brief Interview for Mental Status) was 15 indicating intact cognition. A nursing progress note dated 3/12/20 at 10:00 a.m., that was unreported to the abuse coordinator revealed the following: Nurse was notified by aide that patient was refusing care. Writer to assessed <sic> patient, took patient vitals. Writer asked patient was she ready to get ready for [MEDICAL TREATMENT]. Patient stated she didn't want that B**** coming back in her room! writer asked who? Patient stated the aide from night shift. patient also yelled she got the right one and ain't nobody gone whoop my ass! Patient didn't go into detail about why and stated she wanted a certain aide to get her ready for [MEDICAL TREATMENT]. Writer quickly got her another aide that she felt more comfortable with and they got her ready for [MEDICAL TREATMENT] . On 6/23/20 a review of a facility reported incident and facility investigation involving R#903 on 3/12/20 submitted to the SA at 7:28 PM. was reviewed and revealed the following: Incident Summary: At 5:45 pm, resident (R#903) reported to social worker (SWI) that at approximately 6:00 am this morning, CENA (Certified Nursing Assistant) (CNA J), CENA whisper to her 'I would whoop your ass.Investigation Summary/Actions Taken: On March 12, 2020 at approximately 5:50pm, patient (R#903) reported to social worker that CENA (CNAJ) told her she was going to whoop her ass at approximately 6:30 am. (SWI), Social worker came to (Name of Administrator), Administrator office immediately and reported that (R#903) made allegation that a CENA made inappropriate statement to her early this morning by saying she was going to 'whoop her ass.' .(SWI) and (Administrator) went to the unit to interview (R#903) immediately. (R#903) was escorted to the empty dining room for privacy. (R#903) was asked what happened with her this morning. (R#903) stated, this morning around 6:00am, (CNAJ) asked me if l can clean myself up, I told her to get out my room and I don't want you coming into my room asking me if I can clean myself up. I told her yes, I can clean myself. I told her I always clean myself up. I wanted to know why she would come into my room asking if I can clean myself up like I can't do for myself. That is when she bends down over to me and told me l would whoop your ass today. She got sassy with me, I told her she did not have to whisper, say it out loud. I told her I would whoop her ass. (Administrator) asked if she reported it to the nurse, she stated they know, and I went to [MEDICAL TREATMENT] and just getting back. (Administrator) asked patient did she get help with getting ready for [MEDICAL TREATMENT], she stated that (CNA H) helped me, he is a very kind man, he makes sure he takes care of me. He got my breakfast for me and he does every day, he takes care of me . A facility witness statement from Nurse K completed on 3/17/20 revealed the following: On March 17, 2020, (Nurse K) was interviewed, she stated: On March 12,2020 at 6:00am, I entered the room and patient started yelling get the hell out of my room, you people never let me sleep, I said ma'am I need your vitals, blood sugar and I have medications for you, she said get the hell out of my room, I said ok. I left the room and called (Name of R#903's Physician) and notified her of what happened and patient refused medications. (Name of Physician) said to document and call her daughter. At approximately 6:15am I heard the patient yelling you are not going to F me up, I am going to 'F' you up.' The CENA (CNAJ) was coming out of the room and I asked what happened, CENA (CNAJ) stated when she entered the room, the patent started yelling at her and the CENA came back out of the room. I entered the room and the patient stated the CENA (CNA J) told her she was going to 'F' her up this morning. On 6/23/20 at approximately 9:50 a.m., the facility reported incident for R#903 was reviewed with the Regional Director of Operations (RDO) (facility Administrator/Abuse Coordinator at time of R#903's allegation). The RDO indicated they had reported the incident to the SA after SWI had became aware of the allegation in the evening of 3/12/20. The RDO was queried if they were aware of R#903's allegation before SWI had informed them of it and indicated they were not. The statement from Nurse K which indicated Nurse K was aware of the allegation in the morning of 3/12/20 was reviewed with the RDO and the RDO was queried if nurse K should have reported the allegation to them at that time and the RDO reported they should have informed them. The RDO was queried regarding when facility staff are expected to report allegations of abuse to them and they indicated they should report them immediately so the allegations could be reported to the SA within the required timeframe. The RDO stated they did notice there was a delay in informing them of the R#903's allegation. On 6/23/20 a facility document titled Policy/Procedure-Nursing Administration-Subject: Abuse and Neglect (last revised 6/17/19) was reviewed and revealed the following: 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. 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 .VII. Reporting/Response: Have procedures to: All allegations and/or suspicions of abuse must be reported to the Administrator immediately. If the Administrator is not present, the report must be made to the Administrator's Designee. All allegations of abuse will be reported to the appropriate State Agencies immediately after the initial allegation is received .REPORTING: .allegations and/or suspicions of abuse/neglect must be immediately reported to the facility Administrator or designee in the absence of the administrator. Failure of an employee to report an allegation and/or suspicion of abuse will result in disciplinary action .The Administrator is the Abuse Coordinator Preliminary Investigation Report: The abuse coordinator must submit a preliminary investigation report to the appropriate State Agencies immediately once assurances for the resident's or other resident's safety have been established. However, if the event that caused the allegation involved abuse or resulted in serious bodily injury, the allegation of abuse must be reported to appropriate state agencies immediately and not later than 2 hours after receiving the allegation of abuse .
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #'s MI 758, MI 509 and MI 520. Based on observation, interview and record review the facility failed to ensure showers were provided for two residents (R#902 and R#905) of three residents reviewed for activities of daily living, resulting in the potential for poor personal hygiene. Findings include: R#902 On 6/22/20 at

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

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.

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) approximately 1:30 p.m., R#902 was observed in their room, up in their wheelchair. R#902 was queried regarding the care in the facility and they stated, to be honest, it's gone down. I didn't get one of my showers last week, I think it was either Thursday or Friday. One of the aides told me they ran out of washcloths so I couldn't get it. I need my showers. I only get them twice a week. I haven't had one in almost 6 days. R#902 was queried how they felt and they reported they deserve better. On 6/22/20 the medical record for R#902 was reviewed and revealed the following: R#902 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#902's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/26/20 revealed R#902 needed extensive assistance from facility staff with most of their activities of daily living and was dependent for bathing. A review of R#902's active careplan revealed the following: Focus-The resident has an ADL (activities of daily living) self-care performance deficit as evidenced by need for maximal assistance with toileting hygiene r/t (related to) Impaired balance, Limited Mobility, Limited ROM (range of motion) .Goal-Will receive assistance necessary to meet ADL needs .Interventions-Assist to bathe/shower as needed . A review of R#902's CNA (Certified Nursing Assistant) documentation for R#902's showers in June 2020 revealed R#902 did not receive a shower nor a bed bath on 6/15 or 6/18 (scheduled shower days). CNA documentation was indicated as not applicable. R#905: Review of the clinical record for R#905 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per review of the resident's admission MDS assessment dated [DATE] the resident scored 15 out of 15 on a brief interview for mental status exam, which indicated the resident was cognitively intact. Also per this assessment it was documented the resident required the total dependence of one person for bathing. Review of documentation of showers for R#905 for the time period of 5/1/20 through 5/10/20 revealed the following: R#905 received a shower on 5/2/20, documentation for 5/6/20 indicated not applicable, and the resident refused a shower on 5/9/20. Review of documentation provided by the facility's DON for R#905 for 5/6/20 documented the following: 1. Shower or Bath? Not Applicable. 2. Hair Washed? Not Applicable. 3. Was bathing completed by family or Hospice? Not Applicable . On 6/23/20 at approximately 3:04 p.m., during an interview with the DON (Director of Nursing), the DON was queried regarding the standard for bathing in the facility and they indicated that residents are to receive showers twice a week. The CNA shower documentation for R#902 was reviewed with the DON and the DON was queried if they had any other documentation indicating that R#902 had received a shower or bed bath and they indicated they did not. No additional documentation was received by the end of survey. A facility policy was requested pertaining to activities of daily living and showers. A Review of a policy titled, AM (Morning) Cares dated 7/11/18 revealed, in part, the following: It is the policy of this facility to prepare resident for morning activities and to observe resident's general condition.
F 0684 **Level of harm** - Minimal harm or potential for 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** This citation pertains to MI 8, MI 9, and MI 0: Based on observation, interview, and record review the facility failed to consistently perform skin assessments and/or promptly address/provide treatment to non-pressure skin areas for three (R#901, R#902, R#905) of three residents reviewed for wounds, resulting in delay in treatment and the potential for worsening of wounds and/or wound infection. Findings include: R#901: The clinical record for R#901 was reviewed and revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per review of the resident's admission Minimum Data Set (MDS) assessment dated [DATE] the resident scored 0 out of 15 on a brief interview for mental status exam, which indicated the resident was severely cognitively impaired. Per this assessment the resident required the extensive assistance of two plus persons for physical assistance with bed mobility. Review of R#901's nursing admission assessment dated [DATE] revealed the following per the skin section of the assessment: a scar to the vertebrae (upper-mid), a scar to the chest, an abdominal peg (percutaneous endoscopic gastrostomy-tube to the stomach used for nutrition) tube incision, a scar to the front of the right knee, and a scar to the front of the left thigh. Per a physician order [REDACTED]. Review of the resident's Electronic Medication Administration Record [REDACTED]. Review of a physician order [REDACTED]. Assigned nurse to then open and complete skin observation tool located under assessments every shower day .3. If changes in skin integrity are present, nurse to contact doctor for new treatment orders, inform nurse manager, and document in progress notes. every night shift every Tue, Fri. One skin observation tool, dated 2/29/20, was observed to be present in the resident's electronic medical record. No additional assessments by this name were observed. Review of R#901's SKIN OBSERVATION TOOL-(License Nurse) dated 2/29/20 documented the resident had an area to the coccyx, documented as a blister. Per the notes section of the form it was documented, beginning sore in between buttocks. Review of progress notes for R#901 for 2/29/20 did not document the presence of a wound or give additional information pertaining to the resident's skin assessment findings. Review of a progress note authored by Licensed Practical Nurse (LPN) 'C' for R#901 dated 3/4/20 at 2:44 PM documented, .writer and CNA (Certified Nursing Assistant) were providing care to resident. writer noticed residents bilateral coccyx was open and red. there was bleeding noted. writer cleansed site with NS (Normal Saline), pat dry, applied (brand name barrier cream), and applied dry dressing. wound care aware. consult order put in, as well as order for ETAR (Electronic Treatment Administration Record). Review of a late entry skin note for R#901 dated 3/5/20 at 9:29 AM documented, in part, Patient was evaluated today by wound care multiple skin alterations on 3/05/2020. Coccyx MASD (moisture associated skin damage) with avulsions that measures 4.5x2.0x0.1cm (centimeter), dry pink scabbing blanching wound bed, min serous drainage, surrounding skin macerated, odorless .Left glut avulsion that measures 2.0x6.0x0.1cm, dry pink blanching wound bed, wound edges attached, no drainage, surrounding skin macerated . On 6/23/20 at 12:59 PM LPN 'C' was queried via telephone in regard to R#901. LPN 'C' explained that she had found the resident's skin area. LPN 'C' explained that she wanted to let the family member know, and explained that she had obtained orders. Per LPN 'C, the wound looked like it had been there for a minute. LPN 'C' further explained that she had put a cream and dressing on the site before she obtained orders, and had made a note. When queried as to whether she had been aware of the area prior to that day, LPN 'C' acknowledged that she was not aware. Review of treatment administration records (TAR) for February 2020 and March 2020 for R#901 revealed, in part, the following: Review of R#901's TAR for February 2020 did not reveal documentation of wound treatment to address the resident's alteration in skin integrity to the coccyx noted 2/29/20. Review of the resident's TAR for March 2020 revealed treatment to the coccyx and left glut started on 3/5/20. On 6/23/20 at 1:38 PM, the facility's Director of Nursing (DON) was queried in regard to treatment for [REDACTED]. The DON explained that on R#901's TAR for March, treatment was initiated on 3/5 (2020). The DON was queried as to the process staff were to follow if they identified a new area on a resident's skin. Per the DON the doctor was to be notified, staff would do an initial treatment, and a referral would be made to wound care. The DON explained that currently the facility had made a lot of improvement related to skin (management), the DON indicated that the facility had multiple areas to improve upon with regards to skin management. R#905: Review of the clinical record for R#905 revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per review of the resident's admission MDS assessment dated [DATE] the resident scored 15 out of 15 on a brief interview for mental status exam, which indicated the resident was cognitively intact. Review of the nursing admission assessment for R#905 dated 4/28/20 revealed section L, the skin section of the assessment, revealed no relevant history/[DIAGNOSES REDACTED]. There were also no notes documented per the bottom part of section L on the assessment. Review of skin observation tools for R#905 in the electronic medical record revealed assessments dated 5/10/20, 5/17/20, and 5/24/20. An assessment was not observed between the resident's admission assessment on 4/28/20 and the skin observation assessment on 5/10/20. On 6/23/20 at 2:01 PM, the DON was queried in regard to skin assessments, and acknowledged they were to be completed weekly. R#902 On 6/22/20 at approximately 1:30 p.m., R#902 was observed in their room, up in their wheelchair. R#902 was queried regarding the care in the facility and they stated, to be honest, it's gone down. R#902 was queried if they had any sores and they indicated that they had one on their back. R#902 was queried if the nursing staff were putting any dressings on it and they stated sometimes. On 6/22/20 the medical record for R#902 was reviewed and revealed the following: R#902 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#902's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/26/20 revealed R#902 needed extensive assistance from facility staff with most of their activities of daily living and was dependent for bathing. A physician's orders [REDACTED]. A Nursing Skin Observation dated 6/9/20 revealed the following: Site: Left Buttock .Type: Open Area. A review of R#902's TAR (treatment administration record) for June 2020 revealed no documentation that R#902 received their wound dressing care on 6/1,6/5, 6/6, 6/7, 6/11,

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) 6/13, 6/14 and 6/17. No documentation of treatment refusals were noted. A review of R#902's active careplan revealed the following: Focus-The resident has potential impairment to skin integrity r/t (related to) impaired mobility .Goal-The resident's Skin injury will be healed by review date .Interventions-Administer treatment per physician orders. On 6/23/20 at approximately 12:15 p.m., during an interview Wound Care Nurse B (WCNB) was queried regarding R#902's wound. WCN B indicated that the floor nurses were responsible for the wound treatments being completed. WCN B further indicated that R#902 had an abrasion on their back and that was why their dressing was ordered but they would have to review the Nurse Practitioners notes (NP). At that time, a request was made for documentation of the NP's notes. None were provided by the end of the survey. On 6/23/20 at approximately 1:49 p.m., during a conversation with the DON (Director of Nursing), R#902's treatment documentation was reviewed and the DON indicated that the reason why R#902 had missing treatments is because the order was confusing and the DON indicated that some nurses must have thought the order was for as needed. The DON was queried if it was their expectation that all wound orders are completed per Physician orders [REDACTED]. Review of a facility policy titled,Skin Monitoring and Management-Non PU (Pressure Ulcer) dated 7/11/18 revealed, in part, the following: It is the policy of this facility that a resident having areas of skin breakdown (unrelated to pressure) receive necessary treatment and services to promote healing, prevent infection, and prevent new non-pressure sores from developing. Also per the assessment was the following: 5. MONITORING .D. Weekly skin check conducted by a facility licensed nurse -All residents will have a head to toe skin check performed at least weekly by a facility licensed nurse. -The licensed nurse should document the performance of the skin check in the resident's clinical record. -Any skin issues identified as a result of the weekly skin check should be documented and responded to as outlined above.
F 0686 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 8: Based on interview and record review the facility failed to consistently assess the resident's risk for pressure ulcer development per physician order [REDACTED].#901. The clinical record for R#901 was reviewed and revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Per review of the resident's admission Minimum Data Set (MDS) assessment dated [DATE] the resident scored 0 out of 15 on a brief interview for mental status exam, which indicated the resident was severely cognitively impaired. Per this assessment the resident required the extensive assistance of two plus persons for physical assistance with bed mobility. Review of a physician order [REDACTED]. 3. If changes in skin integrity are present, nurse to contact doctor for new treatment orders, inform nurse manager, and document in progress notes. every night shift every Tue, Fri. Review of a (Pressure Ulcer Risk Name Redacted) SCALE FOR PREDICTING PRESSURE SORE RISK assessment dated [DATE] for R#901 included the following responses to questions per the assessment: R#901 was identified as having very limited sensory perception, had very moist skin, was chairfast in terms of activity, had very limited mobility, indicated nutrition was probably inadequate, and indicated the resident had a potential problem with friction and shear. The assessment identified R#901 as high risk with a score of 12 on the assessment. It was noted that scores per the assessment indicated the following: 15-18 indicated at risk, 13-14 indicated moderate risk, 10-12 indicated high risk, and 9 or less indicated very high risk. Additional (Pressure Ulcer Risk Name Redacted) assessments were not observed to be present in the resident's electronic clinical record. On 6/23/20 at 12:16 PM Wound Care Nurse (WCN) 'B' was queried in regard to (R#901's) pressure sore risk assessments. Per WCN 'B' nurses would do the assessment for some residents weekly, and explained that after a certain amount of time (not specified) they would no longer be weekly. Review of a facility policy titled, Skin Monitoring and Management-Pressure Ulcer dated 7/11/18 revealed, in part, the following: The purpose of this policy is that the resident does not develop pressure ulcers unless clinically unavoidable, and that the facility provides care and services to: -Promote the prevention of pressure ulcer development; -Promote the healing of pressure ulcers that are present (including prevention of infection to the extent possible); and -Prevent the development of additional, avoidable pressure ulcers.