STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235365	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff spoke to a resident in a dignified manner and treated residents with respect for two sampled residents (R901 and R902) of three reviewed, resulting in a Certified Nursing Assistant (CNA) raising her voice at a resident, and resident verbalization of dissatisfaction with treatment by staff. Findings include: On 8/25/20 at 9:34 AM, while touring the facility, staff were observed collecting breakfast trays on one of the units. While passing by R901's room, CNA A was observed speaking loudly and abruptly to R901. The resident was yelling and a food tray was observed to be on the floor. CNA A pulled down her face mask while yelling to the resident, (R901) did you throw this stuff on the floor?! to which R901 yelled, No! CNA A then loudly and sharply stated to R901, Well then who did then? R901's roommate was also attempting to yell and interject into the situation which escalated the noise level further. CNA A exited the room and was interviewed in the hallway. When asked if that is how she generally speaks to residents, CNA A stated, Well, no. When asked how she has been trained to respond when a resident throws their tray on the floor, CNA A stated, You need to know the residents. But not generally how I speak to them, no. CNA A stated, I just know how (R901) is. When asked if R901 is cognitively intact, CNA A at first stated, No, but then stated, Yes, (R901) is all the way there. On 8/25/20 at 9:42 AM, R901 was observed lying curled up in bed, naked. When an attempt to interview R901 was made, R901 yelled, Get out! I'm sick of all of you! Get out! R901 was unable to be spoken to at this time without R901 responding by yelling, Get out of here! On 8/25/20 at 9:46 AM, CNA B, who was seen working on the same unit as CNA A, was interviewed and queried regarding R901. CNA B stated, The resident is challenging but (R901) can't help it. When asked the best way to speak to R901 and other challenging residents, CNA B stated, Respectful. Just say I'm here to help you, explain what I'm doing. When asked if yelling back at a resident was a proper approach, CNA B stated, No. I don't do that. If there's a problem go get someone else to help. When queried regarding training received on working with residents with behavioral issues, CNA B stated, We consistently get training on how to deal with difficult residents. It's an ongoing thing. On 8/25/20 at 9:53 AM, R902 was observed sitting in the hallway. When asked how they liked staying in the facility, R902 stated, A 2 out of 10. When asked if staff was nice to them, R902 stated, Some of them. When queried further, R902 stated, Some are nice and some are not. When asked if they could elaborate, R902 stated, They say they'll be back and don't return. When asked if staff can be rude or disrespectful, R902 stated, Yes. I don't like to give names to get anyone in trouble. But one day they'll talk to you then the next day they won't say nothing. On 8/25/20 at 10:17 AM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were interviewed and queried regarding expectation for how staff are to respond to difficult situations with residents. The NHA stated, Definitely to be kind. We frequently have training for how to deal with difficult residents. The situation involving R901 and CNA A was then described to the NHA and DON, who both indicated that is not how they expect staff to act towards residents. The DON stated she had just done CNA training which CNA A was a part of. When queried regarding any disciplinary action taken against CNA A recently, the NHA stated CNA A received disciplinary action for insubordination with a nurse but has had no complaints from residents. When queried regarding R901's cognitive status, the DON and NHA indicated the resident was cognitively impaired and frequently took their clothes off. A review of R901's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident was most recently admitted into the facility on [DATE], and had a Brief Interview for Mental Status (BIMS) score of 1 out of 15 indicating a severely impaired cognition. Further review revealed need for total assistance from staff for activities of daily living (ADLs) and medical [DIAGNOSES REDACTED]. A review of R902's MDS assessment dated [DATE] revealed the resident was most recently admitted into the facility on [DATE], and had a Brief Interview for Mental Status (BIMS) score of 6 out of 15 indicating an impaired cognition. Further review revealed need for limited to extensive assistance from staff for activities of daily living (ADLs) and medical [DIAGNOSES REDACTED]. A review of the facility's policy/procedure titled, Resident Rights, dated 7/11/2018, revealed, The Resident has the right: 1. To be treated with consideration, respect, and full recognition of his or her dignity and individuality .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to properly maintain infection control practices during a COVID-19 Infection Control Survey resulting in inadequate handwashing and personal protective equipment (PPE) use, and the potential for spread of infection. Findings include: On 8/25/20 at 9:05 AM, the Director of Nursing (DON) stated the facility had no confirmed positive COVID-19 cases but had areas designated as transition units with rooms under droplet (COVID-19) isolation precautions for new admissions or re-admissions into the facility. Multiple rooms were noted to have door caddies of PPE and signs marking them as under droplet/contact isolation precautions. On 8/25/20 at 9:11 AM, Certified Nursing Assistant (CNA) D was observed in room [ROOM NUMBER] which was clearly marked as a droplet precaution room that required PPE. CNA D was seen at the bedside of the resident and was observed to not be wearing a gown or face shield/eye protection. CNA D was observed adjusting items in the resident's room within close proximity of the resident, and was observed making adjustments to the resident's bed. At this time, CNA C exited the neighboring room [ROOM NUMBER], which was also marked as under droplet precautions. CNA C exited room [ROOM NUMBER], did not perform handwashing or hand sanitizing, and entered into room [ROOM NUMBER] without handwashing, hand sanitizing, or donning a gown or face shield. CNAs C and D were asked if they wore eye protection when going into rooms under isolation precautions and stated, Yes, supposed to. When asked about handwashing upon exiting an isolation room, CNA D stated, Yes we are supposed to. The DON approached at this time and directed CNAs C and D to don isolation gowns. CNAs C and D were not observed to put on face shields at this time prior to closing the door, and were not wearing face shields when the door to the room was opened. On 8/25/20 at 9:25 AM, Staff E was observed with a supply cart standing in the doorway of room [ROOM NUMBER], which was noted to be under droplet isolation precautions. Staff E was wearing a gown, gloves, and face mask and entered the room. Staff E walked towards the window and stood within close proximity of a resident lying in the bed. Staff E had on no eye protection or face shield. When Staff E came back to the doorway of the room, she was asked if staff are supposed to be wearing face shields when in rooms under droplet precautions, as room [ROOM NUMBER] was, and stated, Yes we are wearing them, face shields, masks, and gowns. On 8/25/20 at 9:26 AM, CNAs C and D entered room [ROOM NUMBER] and were observed at the bedside wearing no face shield/eye protection. CNA C came back to the doorway caddy, took out a face shield, and went back into the room, shutting the door. On 8/25/20 at 10:05 AM, room [ROOM NUMBER]'s call light was observed to be on. The room was clearly marked contact/droplet precautions. CNA C entered room [ROOM NUMBER] without donning gloves, gown, or face shield and had on only a mask. CNA C touched multiple items in the room including the call light and cord. Shortly after turning off the call light, CNA C exited the room and was not observed to sanitize or wash hands upon exiting the room or after walking down the

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) hallway and exiting the unit. On 8/25/20 at 10:17 AM, the Nursing Home Administrator (NHA) and DON were interviewed and asked what the expectation for PPE use is when going into transition rooms under droplet precautions. The DON stated, Full PPE. Gown, gloves, face shield, mask. Every time going into the room and interacting with the resident, and certainly need to have it all on if doing patient care. Washing/sanitizing hands when going in and out of the room. On 8/25/20 at 12:49 PM, CNA C was observed to enter room [ROOM NUMBER] to answer the call light. CNA C entered the room without knocking or announcing themselves, and was not observed donning PPE before shutting the door. When the door was opened, CNA C was observed putting on a gown but had no face shield or eye protection. When queried if they had a face shield, CNA C looked in the caddy and stated, I had one, doesn't look like there's one anymore. CNA C continued to put on their gown and resumed going to the bedside to care for the resident with no face shield or eye protection. A review of the droplet precautions sign on room [ROOM NUMBER]'s door revealed, STOP. Everyone must clean their hands, including before entering and when leaving the room, make sure their eyes, nose, and mouth are fully covered before room entry. Remove face protection before room exit. On 8/25/20 at 1:20 PM, CNA D was observed sitting at the bedside of a resident in room [ROOM NUMBER], a transition room under droplet precautions. CNA D was wearing only a mask and had on no gown, gloves, or face shield/eye protection. CNA D was assisting the resident with eating lunch (thus the resident did not have on a mask). A review of the facility's policy/procedure titled, COVID-19 Core Practices, dated 8/20/20, revealed: .10. The facility will have a plan for managing new admissions and re-admissions whose COVID-19 status is unknown, Resident placed in a single person room or in separate observation area, Staff members will wear an N95 or higher level respirator (or facemask if a N95 or respirator is not available), eye protection (eye goggles or face shield that covers the front and sides of the face), gloves and gown when caring for these residents, Resident will be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after admission, Testing at the end of this period can be considered to increase certainty that the resident is not infected .