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 _____	04/16/2020

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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0661 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure necessary information is communicated to the resident, and receiving health care provider at the time of a planned discharge.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 394 Based on interview and record review the facility failed to complete a thorough and accurate discharge summary for one resident (R#801) of three residents reviewed for admit/transfer/discharge, resulting in the potential for R#801 to be unaware of their post discharge care instructions and available services. Findings include: A complaint was filed with the State Agency that alleged the Facilty did not provide the most current health update for the Resident upon discharge. On 4/15/20 the medical record for R#801 was reviewed and revealed the following: R#801 was initially admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. R#801's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/12/20 revealed R#801 needed extensive assistance with bed mobility, transfers and dressing. A review of R#801's BIMS score (brief interview on mental status) was 14 indicating intact cognition. A Medical Practitioner Note dated 3/26/2020 reveled the following: (R#801) is seen for follow up as he is being discharged in a couple of days. He was admitted here for rehab after a fall .He as <sic> a complicated medical conditions for which he is under treatment. Today he states he is ok. He wants to go home .Assessment/plan: 1. cutaneous T-cell [MEDICAL CONDITION]: - dermatology : care with topical treatments .Currently on doxy ([MEDICATION NAME])- to be contd (continued) as per derm (dermatology) note from recent follow up .5. Pancytopenia: .EGD (esophagogastroduodenoscopy) done shows severe esophagitis, gastritis, .repeat endoscopy in 8 weeks. monitor. 6. [MEDICAL CONDITION] and [MEDICAL CONDITION] Multifactorial, due to .[MEDICAL CONDITIONS], .Continue outpatient ESA (Erythropoiesis-stimulating agents) support and IV (intravenous) iron to lower transfusion needs Ok to use GCSF (Granulocyte-colony stimulating factor) as needed to keep ANC (absolute [DIAGNOSES REDACTED] count) > 1. Transfuse PRBC (Packed red blood cells) as needed to keep Hg (Hemoglobin) > 8. -Darbepoetin 150 mcg (microgram) was on 11/15/19 No s/o (signs of) hemolysis. Monitor Hb (hemoglobin). 7. [MEDICATION NAME] - .follow up with primary hematologist, 8. GIB ([MEDICAL CONDITION])-to repeat endoscopy in three months .Patient will be given scripts (prescriptions) for medications, PT/OT (physical therapy/occupational therapy, home care ,visiting nurse. He will be discharged with a list of discharge medications as needed. A nursing note dated 3/28/2020 revealed the following: Resident was discharged with wife. Resident had no c/o (complaints of) pain or discomfort. Resident was given medication education along with prescriptions from MD (medical doctor). Resident had no new wounds noted and was given discharge instructions. A discharge summary (set of discharge instructions and services provided to R#801 upon discharge for post-discharge care) dated 3/26/20 for R#801 was reviewed and reveled the following: Section A-1. Date of discharge: 3/26/20. B.-Reason for discharge:Resident/Family request. C.- You are being discharged to the following: Home .B.-Community Services-Social Services & Nursing to complete. 1.- Community Service Recommendations-A.-You are being discharged with recommendations for the following services in the community: 1.- Physical Therapy (PT). 2. Occupational Therapy (OT). 3. Speech Therapy (ST) 4. Visiting Nurse. 5. Social Worker. 6. Other (describe). 7. None .(No indications of what services recommended were circled or checked on the summary). B.-Physician in the community (Blank) .B1.-Physican phone number(Blank) B2.-Physician address: (Blank) B3.-Appointment scheduled (Blank) B5.-reason for follow up appointment: (Blank) C.-Additional physician in community (Blank) C1.-Physician phone number (Blank) C2.-Physician address (Blank) C3.-Appointment scheduled (Blank) C5.-Reason for follow up appointment (Blank) D.-Homecare services recommended (Blank) E.-Medical equipment arrangements needed (Blank) F.-Are oxygen services required upon discharge? (Blank) G.-Any additional referrals for services or agencies in the community: (Blank) H.-Name of person completing this section: (Blank) I.-Date section completed: (Blank) .D.-Therapy Services (Therapy to complete) D .1A.-Speech therapy provided-(Blank) 1B.-Physical therapy provided (Blank) 1C.-Occupational therapy provided (Blank) .E.-Dietary recommendations (Dietary to complete} 1.- Dietary information: A.- Recommended diet: (in terms layperson can understand) (Blank) B.-Additional special instructions/recommendations: (Blank) C.-Food allergies [REDACTED].-Dental condition (no options checked) E.-Name of person completed this section: (Blank). F.-Date section completed (Blank) .G.-Acknowledgement and Signatures (All section Blank) . On 4/16/20 at approximately 2:48 p.m., during a conversation with the facility Administrator and the Director of Nursing (DON), the discharge summary for R#801 was reviewed with the DON. The DON indicated there were a few sections of the discharge summary that were not completed, that should have been. The DON was queried if it was their expectation that all sections of the discharge summary should be completed, accurate and reviewed with the resident prior to discharge and they indicated it was. On 4/16/20 a facility document with the subject Discharge Planning (7/11/2018) was reviewed and revealed the following: Policy: It is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of the residents to be active partners and effectively transition the resident to post-discharge care, and the reduce <sic> factors leading to preventable readmissions .Information: Discharge planning is started at the time of admission. The interdisciplinary team members (IDT), along with the resident and resident representative, if applicable are key components to the discharge process, and the social worker is the person responsible to drive the discharge process. An interdisciplinary team approach involves collaborative communication of shared goals and responsibilities between those who are involved in the care of the resident. The post-discharge plan of care is required for an anticipated discharge of a resident when they are discharged to a private residence, to another nursing facility or skilled nursing facility, or to another type of residential facility. Procedures: .8. The Social Services Director/designee completes the post-discharge plan of care for anticipated discharges. 9. Social Service Department arranges for post-discharge services. 10. Initiate the discharge paperwork with all IDT members to ensure that the resident/responsible party obtains detailed and confidential protected health information upon discharge .Documentation:.3. Complete the Post-Discharge Plan of Care and the discharge summary on anticipated discharges. 4. Upon discharge the resident, or the resident representative, will sign the discharge plan of care/discharge summary as appropriate .
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI 394 Based on interview and record review the facility failed to ensure Physician orders [REDACTED].#806) of six residents reviewed for infections/assessments, resulting in the potential for fever (common symptom of COVID-19) to go untreated. Findings include: On [DATE]5/20 the medical record for R#806 was reviewed and revealed the following: R#806 was last admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of R#806's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/14/20 revealed R#806 needed extensive assistance from staff with bed mobility, transfers and bathing. A physician's orders [REDACTED].> (greater than) 99.0 F. A Medical Practitioner Note dated 4/7/20 revealed the following: CC (chief complaint): fever HPI (history of present illness): (R#806 demographics). Pt (patient) with chronic [MEDICAL CONDITIONS]. He has COVID-19 exposure. Per computer records, elevated

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 -** Few	(continued... from page 1) temp (temperature) on 4/5 of 100.1 and 100.9 on 2 different occasions.Diagnosis/Plan: 1.Acute fever - NEW- unsure of accuracy per pt ' s report, will cont (continue) to monitor temp q4h at this time, if any further documented fever, will COVID-19 swab patient, orders written in computer, will cont to monitor patient closely, he is aware and will report any ill-feelings to nursing. A review of R#806's documented temperatures for 4/7/20 and 4/8/20 revealed R#806 only had their temperature taken twice on 4/7 and only once on 4/8. On [DATE]6/20 at approximately 2:48 p.m., during a conversation with the facility Administrator and the Director of Nursing (DON), R#806's temperatures were reviewed with the DON. The DON was queried if R#806 should have had their temperature taken and documented every four hours as indicated per the physician's orders [REDACTED]. The DON indicated they only saw two temperatures recorded for 4/7 and only one on 4/8. The DON was queried if it was their expectation that the nursing staff follow the Physician orders [REDACTED]. On [DATE]6/20 a facility document with the subject Physician order [REDACTED]. [REDACTED].