

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235663	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/26/2024
NAME OF PROVIDER OR SUPPLIER Notting Hill of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6535 Drake Road 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 - Some</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** 39592</p> <p>This citation pertains to Intake MI00146159</p> <p>Based on observation, interview and record review the facility failed to protect the residents' right to be free from deprivation of goods and services by a nurse for three (R701, R704 and R705) of three residents reviewed for neglect. Findings include:</p> <p>Review of a facility document titled, Charge Nurse Job Description undated read in part, .The Charge Nurse plans, coordinated, provides and manages nursing care, nursing services and health education to nursing home residents . 2. Provides safe and accurate Medication Related interventions to residents. a. Administers and documents medications and treatments according to each resident's medication schedule using current standards of medication pass technique .</p> <p>R701</p> <p>A complaint was filed with the State Agency (SA) on 8/6/24 that alleged in part, on 7/31/24, R701's Family Member visited R701 from 7:32 PM until approximately 12:30 AM 8/1/24 and Registered Nurse (RN) B never came to R701's room to administer their medications, however RN B had documented the medications had been given around 8:30 PM 7/31/24, then when R701's Family Member talked to RN B the next day, RN B told them she had given R701's medication on 7/31/24 at 7:20 PM because she had to leave early that day, but did not document them until 8:30 PM.</p> <p>On 8/26/24 at 10:00 AM, R701 was observed lying in bed. R701 appeared sleepy, and would only nod their head to questions asked.</p> <p>Review of the clinical record revealed R701 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: end stage renal disease, diabetes and dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R701 had severely impaired cognition and was dependent on staff for all activities of daily living (ADL's).</p> <p>Review of R701's July 2024 Medication Administration Record (MAR) revealed RN B had documented she had given/completed the following physician ordered medications and treatments on 7/31/24 at 9:00 PM:</p> <p>Acetic Acid Irrigation Solution 0.25 % for suprapubic (urinary catheter) irrigation</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 - Some</p>	<p>Atorvastatin 40 mg (milligrams) (statin - for cardiovascular disease)</p> <p>CPAP (continuous positive airway pressure) settings at 16 cm (centimeters) with H2O (water)</p> <p>Donepezil 5 mg (dementia)</p> <p>Gabapentin 100 mg (anti-epileptic - for nerve pain)</p> <p>Lantus 5 Units (Insulin)</p> <p>Latanoprost Ophthalmic Solution 0.005 % 1 drop in the left eye (glaucoma)</p> <p>Lorazepam 0.5 mg (anti-anxiety)</p> <p>Assess for pain (documented 0, indicating no pain)</p> <p>Check Clonidine patch placement (hypertension)</p> <p>Eliquis 5 mg (a blood thinner)</p> <p>Metoprolol Tartrate 100 mg (beta blocker)</p> <p>Nifedipine ER (extended release) 60 mg (hypertension)</p> <p>Normal Saline Flush Solution 10 ml for Biliary tube irrigation</p> <p>Timoptic Ophthalmic Solution 0.5 %, 1 drop in left eye (glaucoma)</p> <p>Active Liquid Protein 30 ml</p> <p>Lispro 100 Unit/ml, (Insulin) documented blood sugar 150, and gave 1 Unit</p> <p>Famotidine 20 mg (acid reflux) (the MAR documented the time RN B marked it as given at 8:38 PM)</p> <p>Further review of R701's July 2024 MAR revealed two medications, GlycoLax Powder (constipation) 17 gram and Hydralazine 50 mg (hypertension), due to be given at 10:00 PM had blank boxes indicating they were not given.</p> <p>Review of R701's progress notes revealed no nursing notes or medication administration notes from 7/31/24.</p> <p>Review of RN B's time card punches on 7/31/24 revealed RNB punched in at 2:39 PM and punched out at 7:22 AM 8/1/24.</p> <p>On 8/26/24 at 11:11 AM, RN B was contacted via phone and a voicemail was left.</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 - Some</p>	<p>On 8/26/24 at 12:38 PM, the Director of Nursing (DON) was interviewed and asked if RN B had left early on 7/31/24. The DON explained she had thought RN B had worked a double shift since she had punched out on 8/1/24. The DON was asked what time did the electronic medical record (eMR) document all R701's medications as given. The DON explained most medications were documented at 8:38 PM, and there were a couple that were documented at 8:54 PM. When asked what was the time frame for medication administration, the DON explained medications can be administered an hour before to an hour after the specified time. The DON agreed that medications due at 9:00 PM were only supposed to be given from 8:00 PM to 10:00 PM.</p> <p>On 8/26/24 at 1:00 PM, the Scheduler was interviewed and asked if RN B had left early on 7/31/24. the Scheduler explained RN B had been scheduled to work from 3:00 PM to 9:00 PM on 7/31/24 and did not know if she had left early as she was not at work at that time. When asked who would be informed if a nurse had to leave early, the Scheduler explained it would be the On-Call Nurse. The Scheduler was asked who had been the On-Call Nurse on 7/31/24. The Scheduler explained it had been Licensed Practical Nurse (LPN) E.</p> <p>On 8/26/24 at 1:05 PM, LPN E was contacted via phone and a voicemail was left. No return call was made by the end of the survey.</p> <p>On 8/26/24 at 1:22 PM, RN B was interviewed by phone and asked if she had left early on 7/31/24. RN B agreed she had left early that day. When informed of what the time card punches were, RN B explained she must have forgotten to punch out when she left on 7/31/24, and that the 7:22 AM on 8/1/24 punch was from when she came into work the next morning. RN B was asked what time she had left the facility. RN B explained she had left around 8:30-9:00 PM. RN B was asked what time she had given R701 their medications. RN B asked what time was documented. When informed the Famotidine documented 8:38 PM, RN B explained she had given all the medications at the same time. RN B was asked if she had seen R701's Family Member when she had given R701 their medications. RN B explained R701's Family Member had not been in R701's room when she administered the medications however, she had talked to R701's Family Member the next day and they said they were in the room at 7:00 PM. RN B was asked how she did not see R701's Family Member when giving medications at 8:38 PM if R701's Family Member had arrived at 7:00 PM. RN B had no explanation.</p> <p>On 8/26/24 at 3:10 PM, review of the facility's surveillance camera on 7/31/24 from 6:30 PM to 10:00 PM on R701's Unit with the Administrator revealed RN B never entered R701's room, nor was she ever seen administering medications and/or treatments to R701. R701's Family Member was seen entering R701's room at 7:32 PM. Throughout the entire time frame of 6:30 PM to 10:00 PM, RN B did not enter rooms 102, 103, 104, 105 or 106. (It should be noted all five of these rooms were occupied with residents.) It was observed on the surveillance feed, in one block of approximately 30 minutes, RN B was seen sitting in a chair in front of the medication cart in the hallway talking to another staff member. Prior to 8:28 PM, the time documented on R701's MAR, RN B had moved the medication cart off the Unit and was not seen again on the surveillance feed on R701's Unit. The Administrator was asked about the surveillance of R701's Unit. The Administrator agreed RN B did not enter five rooms on the Unit, and was not seen administering medications to those same rooms.</p> <p>On 8/26/24 at 3:37 PM, the DON was informed of the surveillance feed on 7/31/24 and that RN B was not seen entering five rooms or administering medications to R701. The DON had no answer.</p> <p>34275</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 - Some</p>	<p>Following the review of the facility's surveillance camera dated 7/31/24 from 6:30 PM to 10:00 PM, interviews were conducted with R704 and R705, who resided in the rooms observed not to be entered into by RN B. Both R704 and R705 were noted to have cognitively intact cognition.</p> <p>R704</p> <p>On 8/26/24 at approximately 3:44 PM, R704 was observed sitting in their wheelchair in their room. The resident had just returned from a Dialysis treatment, was alert and able to answer questions asked. When queried as to whether they had any difficulty at the facility getting their medication, R704 replied that at times they either did not receive their medications timely and on occasion the resident noted that they did not receive them at all.</p> <p>A review of R704's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: end stage renal disease, type II diabetes and disease of the bone.</p> <p>Review of R704's July 2024 MAR revealed RN B had documented the following physician ordered medications had been completed at 9:00 PM:</p> <p>B Complex-Coral Capsule (supplement)</p> <p>Glycol ax Powder 17 Gram by mouth for constipation</p> <p>Latanoprost Solution .005% install 1 drop in both eyes at bedtime (glaucoma)</p> <p>Lidoderm Patch 5% (apply to left shoulder for pain)</p> <p>Sennosides-Docusate Sodium give two tablets at bedtime for constipation</p> <p>Timolol Maleate Gel forming solution .5% install 1 drop both eyes for eye pressure</p> <p>Allopurinol Tablet 100 MG (give every 12 hours for Gout)</p> <p>Eliquis Oral Tablet 2.5 MG (give 1 tablet by mouth every 12 hours for blood clot)</p> <p>Lidocaine Gel 2.5% (apply to STUMP topically tow times a day for pain)</p> <p>Metoprolol 25 MG (Give 1 tablet by mouth every 12 hours for blood pressure)</p> <p>Isosorbide Dinitrate (Give 1 table by mouth three times a day for heart failure)</p> <p>R705</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 - Some</p>	<p>On 8/26/24 at approximately 3:58 PM, R705 was observed lying in bed. The resident was alert and able to answer questions asked. The resident reported they were admitted to the facility in July 2024 for rehabilitation following a fracture. When asked whether they were receiving their medication they indicated they did most of the time, but noted that in late July they were not given their medication and reported it to a nurse. R705 was not able to recall the exact date they missed their medication or the nurse they reported it to but recalled it was their nighttime medication.</p> <p>A review of R705's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: displaced fracture of left tibia, generalized anxiety and difficulty walking.</p> <p>Review of R704's July 2024 MAR revealed RN B had documented the following physician ordered medications had been completed at 9:00 PM:</p> <p>Doxepin 100 MG (give one tablet at bedtime for anxiety/depression)</p> <p>Ipratropium Nasal Solution (give .03% -2 sprays in both nostrils every 12 hours for allergy)</p> <p>O2 at 4 L (liters) - Nurse B checked that the resident's O2 was at 100 %.</p> <p>Oxycodone 5 MG give 1 tablet by mouth as needed for pain. *It was noted that the resident received the medication at 8:49 PM.</p> <p>In addition, the medication Buspirone an anti-anxiety medication to be administered at 10:00 PM was not signed off as being administered.</p>		