STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235663	A. Building B. Wing	11/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notting Hill of West Bloomfield	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)
F 0684 Level of Harm - 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** 32568 This citation pertains to Intake Number(s): MI00147948. Based on interview and record review, the facility failed to accurately assess, timely treat, and identify the worsening of a diabetic ulcer for one (R801) of two residents reviewed for wounds, resulting in a hospital transfer facilitated by an outside provider which resulted in an amputation of R801's left great toe. Findings include: A review of a complaint submitted to the State Agency (SA) revealed an allegation R801 was not assessed for a change in condition. On 11/18/24, an unannounced, onsite investigation was conducted. A review of R801's clinical record revealed R801 was admitted into the facility on [DATE], had readmissions on 6/21/24 and 9/5/24, and discharged on [DATE] with diagnoses that included: acute osteomyelitis (bone infection) right ankle and foot, acquired absence of right toes, peripheral vascular disease, and type 2 diabetes mellitus. A review of a Minimum Data Set (MDS) assessment revealed R801 had moderately impaired cognition, was dependent on staff for activities of daily living and transfers, required substantial/maximum assistance from staff for bed mobility, and had diabetic ulcers. A review of R801's progress notes revealed on 5/22/24, R801 was diagnosed with osteomyelitis in the right foot. They were admitted into the hospital on 5/29/24 and required amputation of the third toe on their right foot and were readmitted to the facility on [DATE]. A review of a Nursing Comprehensive Evaluation dated 6/22/24 revealed R801 was readmitted with, amputation of the 3rd right toe. No other skin impairments were documented on the evaluation. A review of a Total Body Skin Assessment progress note dated 6/22/24 revealed R801 refused to allow the nurse to complete a full body skin assessment at that time. A review of a Total Body Skin Assessment form dated 6/22/24 revealed R801 had one new wound (which was likely the site of the toe amputation on the right foot). A review of R801's Total Body Skin Assessment forms revealed the next assessment was dated 9/5/24, approximately two and a half months after R801 was readmitted into the facility from the hospital. A review of R801's progress notes revealed the following documentation: (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/23/24, a Dietary Note documented R801 had a [NAME] grade 1 diabetic ulcer (superficial ulcer on the outer layer of the skin) to the left great toe. At that time it was recommended to add active liquid protein to support wound healing. It should be noted that there were no progress notes prior to the dietary note that mentioned a wound to R801's left great toe. A review of a Skin & Wound Evaluation for R801 dated 8/5/24 (the assessment was not locked until 9/5/24) revealed R801 was assessed to have a diabetic ulcer to the Left Dorsum - 1st Digit (Hallux) (top of the great toe) that was present on admission. The measurements of the ulcer were 1.5 centimeters (cm) by 0.7 cm. It was documented the wound bed was bleeding and pink or red in color with light sanguineous (bloody) exudate (drainage). It was documented the ulcer was healable and stable. The photo included as part of the assessment did not show an ulcer to the dorsum of the left great toe, but a bloody area to the tip of the left great toe and an open area on the second digit. A review of a consultation report written by the facility's contracted wound Physician Assistant (PA 'B') on 8/5/24 revealed R801 had a [NAME] Grade 1 Diabetic Ulcer to the left great toe that measured 0.6 cm by 0.9 cm with no drainage and a wound bed with one hundred percent eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like). The treatment plan documented, .Cleanse wound with Normal Saline (NS) .Betadine wipe to all scabs on R (right) and L (left) feet (protectively) . A review of R801's physician's orders revealed no treatment orders to address the left great toe until 8/26/24 at which time, the ordered treatment was Cleanse left foot (first, second digit) with NS, pat dry, apply Betadine moistened gauze to wound bed, and cover with ABD (abdominal pad), and kerlix (bulky dressing) QD (every day) and PRN (as needed) .for diabetic ulcer . Further review of R801's physician's orders revealed the active liquid protein recommended per the dietary note written on 8/12/24 was not ordered until 9/9/24. Further review of R801's Skin & Wound Evaluations and consultations completed by PA 'B' revealed the following: On 8/12/24, it was documented on a Skin & Wound Evaluation R801 had a diabetic ulcer to the left dorsum great toe that measured 2.8 cm x 2.0 cm with a wound bed covered with 60% slough (non-viable yellow, tan, gray, green or brown tissue). In the section that assessed if there was evidence of infection, Warmth was documented. It was noted there was a moderate amount of serosanguineous (serum mixed with blood) drainage. It was documented the wound was slow to heal and the progress was stalled. The attached photograph revealed a black area on the tip of R801's great toe and an open area to the top of R801's great toe that was pink with an area of yellow. On 8/12/24, it was documented by PA 'B' R801's left great toe diabetic ulcer increased in size to 4 cm x 3 cm and was 100% eschar with no slough. That was not consistent with the facility assessment and photograph from the same date. The treatment recommendation remained the same as 8/5/24. It should be noted that there was no treatment ordered for that wound as of 8/12/24. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 8/19/24, a Skin & Wound Evaluation of R801's Left dorsum great toe diabetic ulcer did not include any measurements and noted the wound was slow to heal and stable. The attached photograph revealed a blurry, far away photograph that showed a large dark area at the tip of the toe, but was not clear. On 8/19/24, it was documented by PA 'B' that R801's left great toe diabetic ulcer measured the exact same as the week prior at 4 cm x 3 cm with 100 % eschar. The treatment recommendation remained the same as 8/5/24. It was noted as of 8/19/24, there were no treatment orders for the left great toe. On 8/26/24, a Skin & Wound Evaluation of R801's Left dorsum great toe diabetic ulcer noted measurements of 3.8 cm x 2.5 cm with 100% eschar in the wound bed. It was documented the wound was healable and improving. The attached photograph revealed a black area on the tip of the left great toe and multiple black areas on the top of the toe. On 8/26/24, it was documented by PA 'B' that the diabetic ulcer to R801's great toe measured the exact same as on 8/19/24 (4 cm x 3 cm) with 100% eschar. It was unspecified if the area evaluated was the tip of the toe or the top of the toe. The treatment included additional instructions to wrap the toes individually with Betadine gauze to help dry off the toes. It was also recommended for R801 to have a vascular consult for severe PVD (peripheral vascular disease). A review of a Nurses Note dated 8/27/24 revealed R801's family member requested R801 was transferred to the hospital due to the, healing progress of bilateral feet. R801 was sent to the hospital on that date. A review of a Skin/Wound Progress Note dated 8/30/24 documented the wound to R801's left great toe was acquired on 6/21/24 and remained 4 cm x 3 cm with 100 % eschar. However, R801 was at the hospital on that date (8/30/24). A review of the hospital records from R801's 8/27/24 through 9/5/24 hospital stay revealed the following: Results from an X-ray to R801's left foot revealed the following, .Clinical date: Pain, gangrene .Possible erosions of the [NAME] (tips) of the first and second distal phalanges (bones of the toes). Osteomyelitis is not excluded. MRI could be considered to further evaluate . An Infectious Disease Consultation dated 8/28/24 read, .He has 2 open wounds with minimal drainage affecting the dorsal aspect of the left great toe and left 2nd toe .Ulcers involving left great toe and left 2nd toe with probable ischemic component. Ulcers have progressed in the last few months .Cellulitis of the left foot . A Cardiovascular Medicine and Vascular Medicine Consultation dated 8/28/24 revealed, .Sores on left 1st and 2nd toes, necrotic appearing distal (end) 1st toe . A Cardiovascular Medicine and Vascular Medicine Consultation dated 9/3/24 revealed results from an angiogram that showed 99% occluded left anterior tibial artery (blocked blood flow to the left lower extremity). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R801 was readmitted to the facility on [DATE]. A review of a Nursing Comprehensive Evaluation dated 9/5/24 revealed R801 did not have any skin conditions (indicated by checking 'no' in the section that asked if the resident had any skin conditions). There was no mention of R801's left great toe diabetic wound in the section for potential for skin breakdown care plan. A review of a Physician Note dated 9/6/24 revealed, H&P (History & Physical): re-admit .was sent back to the hospital for Left foot worsening wound .worsening diabetic ulceration . A review of a wound consultation completed by PA 'B' on 10/28/24 noted R801's diabetic ulcer to the left great toe was resolved. A review of the facility's Skin & Wound Evaluations revealed on 10/21/24, a week prior to the wound being resolved, the wound measured 5.6 cm x 4.6 cm with fragile surrounding skin. The assessment did not include an assessment of the wound bed tissue. The photograph taken as part of the assessment revealed black areas on the top of the left great toe and at the tip. The skin above the ulcer appeared black/brown, thick, dry and cracked. There was no wound consult by PA 'B' on 10/21/24 included in the medical record. Further review of R801's physician's orders revealed the treatment to the left great toe was discontinued on 10/28/24. Continued review of R801's progress notes revealed on 11/5/24 R801 was transferred to (hospital) 11/02/24 from podiatrist appointment . Review of R801's hospital records dated 11/5/24 revealed the following: It was documented in an ED (emergency department) Notes dated 11/5/24 that .concern of worsening ulcer in left great toe .evaluated by his podiatrist who sent him to ED for admission and left great toe amputation tomorrow. Patient said he has been feeling feverish .gangrene of left great toe .concerning for underlying osteomyelitis . A consultation by the podiatrist on 11/6/24 revealed, .presents with a diabetic foot infection and worsening foot wounds bilaterally. He was noted to have a significant infection yesterday during his outpatient podiatry evaluation and reported fevers, chills, pain, and general malaise. He also reports that the facility where he has been staying was not taking care of him or performing dressing changes or wound exams as advised. He is requiring a left great toe amputation for source control .Necrotic and gangrenous tissue appreciated to the left hallux to the level of IPJ (interphalangeal joint) and slightly proximal to this. Malodor and drainage noted .Positive probe to bone with concern for underlying osteomyelitis .OR (operating room) today for left hallux amputation . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 11/18/24 at approximately 1:35 PM, an interview was conducted with the facility's Wound Care Coordinator, Licensed Practical Nurse (LPN) 'A'. LPN 'A' reported her job responsibilities included updating care plans, ensuring physician's orders were transcribed appropriately, ensuring treatments were changed per physician's orders, assuring preventative measured were in place, and conducting assessments along with the facility's contracted wound provider, PA 'B' who came to the facility on e time per week. LPN 'A' explained PA 'B' was responsible for diagnosing residents' wounds and determining treatments. LPN 'A' entered assessments of residents' wounds into the Skin & Wound Evaluation in the clinical record by taking a photograph of the wound which calculated the measurements. LPN 'A' reported her assessment was based off of the wound providers and she transcribed it into the record. LPN 'A reported she started working as the Wound Care Coordinator in August 2024. When queried about when R801's diabetic wound to the left great toe was first identified, LPN 'A' reported it was first assessed on 8/5/24. LPN 'A' acknowledged that PA 'B' documented it was acquired on 6/21/24, but did not know when it was first identified prior to her working in that position. LPN 'A' reported the wound was resolved by PA 'B' on 10/28/24 and treatment was discontinued. LPN 'A' did not know why there was no photograph of the wound from 10/28/24. LPN 'A' reported her assessment of R801's left great toe wound was based off of the photograph and PA 'B's evaluation, including the documentation that the wound was healable. LPN 'A' did not offer a response as to why the treatment to R801's left great toe was not ordered until 8/26/24, On 11/18/24 at 1:50 PM, an interview was conducted with PA 'B'. PA 'B' reported R801 had severe PVD and previous history of other amputations and therefore an amputation of R801's left great toe was unavoidable. When queried about the documentation that the wound was resolved on 10/28/24, PA 'B' reported she resolved it because, there was nothing open to the eye and there was some eschar and no drainage. When queried about the delay in treatment to R801's left great toe between 8/5/24 and 8/28/24, PA 'B' reported it would not have made any difference if it was treated sooner. On 11/18/24 at 2:53 PM, an interview was conducted with the Director of Nursing (DON) and LPN 'A'. The DON reported prior to August 2024, the previous Wound Care Coordinator was not doing what she was supposed to be doing and was terminated. When queried about the delay in treatment to R801's left great toe diabetic wound, the DON reported R801 had multiple areas that were all treated at once. A review of a physician's order the DON provided for reference was specific to the left heel. When queried about PA 'B's documentation that did not correspond with the photographs and documented R801's wound to the great left toe was acquired on 6/21/24, the DON reported she would look into it. On 11/18/24 at 3:30 PM, the DON followed up and reported that she did not think the wound consults were accurate and the great toe wound was identified on 8/5/24, not 6/21/24. On 11/28/24 at 4:28 PM, the DON reported she had PA 'B' change her assessments to document R801's left great toe diabetic ulcer was acquired on 8/5/24 instead of 6/21/24 because, There's no way it was there on 6/21/24 and we didn't do anything about it. When queried about the lack of Total Body Skin Assessments between 6/22/24 and 9/5/24 and whether they were documented anywhere else, the DON reported she was unable to locate skin assessments for that time frame. When queried about how it was known the wound was acquired on 8/5/24 when there were no weekly skin assessments prior to that, the DON did not offer a response. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A review of a facility policy titled, Skin Management revised 8/14/24 revealed, in part, the following, Resident with wounds .are identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 32568 This citation pertains to Intake Number(s): MI00147948. Based on observation and interview, the facility failed to maintain a sanitary and comfortable environment in the hallway near the main dining room. Findings include: On 11/18/24 at 8:16 AM, a strong, putrid, sour odor was experienced in the hallway that extended from the main dining room to the hallway that led to the lobby. At that time, Registered Dietician (RD) 'E' was asked what the odor was from and reported she thought it was due to a problem with the dish machine. The door to the dish room was located on the hallway where the odor was observed. On 11/18/24 at 8:40 AM, an interview was conducted with the Infection Control Nurse/Staff Development Nurse, Staff 'D' who acknowledged there was a pungent odor in the hallway that ran along side the dining room. On 11/18/24 at 10:00 AM, an interview was conducted with Housekeeping Supervisor (HK) 'F'. When queried about the odor, HK 'F' reported it was due to an issue with the dish machine that needed repairs. On 11/18/24 at 12:00 PM, an observation was made of the dish room. The ground was wet and according to Dietary Manager 'G' they were waiting for repairs for the dish machine. The odor that was present in the hallway was not present in the dish room. Upon exiting the dish room, the odor remained in the hallway outside. On 11/18/24 at 12:05 PM, an interview was conducted with the Administrator. The Administrator reported she could not smell the odor present in the hallway that ran along side the main dining room. On 11/18/24 at approximately 4:45 PM, an interview was conducted with Maintenance Assistant 'H' who said he was aware of the strong odor present on the hallway near the dining room. When queried about what was causing it, maintenance Assistant 'H' reported they have not yet figured out the source of the odor and it had been present for a couple weeks.