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	02/12/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 This citation pertains to intake #' MI00149666, MI00149701, MI00149703 and MI00149863. Based on observation, interviews and record review, the facility failed to protect the resident's right to be free from physical abuse and neglect by facility staff for two residents (R901 and R902) of five residents reviewed for abuse/neglect/mistreatment resulting in R901 being forcefully slapped in the face by a staff member and R902's lower extremities being wheeled into a medication cart and a metal doorframe. Findings include: R901 On 2/12/25 a facility reported incident (FRI) that was submitted to the State Agency was reviewed which indicated R901 was slapped in the face by Certified Nursing Assistant A (CNA A) on the morning of 1/18/25. On 2/12/25 at approximately 8:56 a.m., R901 was observed in their room, laying in their bed. R901 was observed to have a low bed with their wheelchair against the wall. R901 was observed to be confused and unable to follow specific conversation pertaining to the allegation. On 2/12/25 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted to the facility on [DATE] and had diagnoses including Adjustment disorder, Anxiety and Dementia. A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 1/15/25 revealed R901 needed assistance from facility staff with most of their activities of daily living. R901's BIMS score (brief interview of mental status) was four indicating severely impaired cognition. On 2/12/25 at approximately 9:59 a.m., during a conversation with the facility Administrator (Abuse Coordinator), the Administrator was queried regarding the abuse allegation between R901 and CNA A. The Administrator reported that the CNAA was terminated after the incident had been reviewed from a video recording and that the allegation was substantiated. The Administrator indicated that in the video recording of the incident, CNA A was observed slapping R901's face while Nurse B was having their hair pulled. At that time, the facility investigation was requested along with the recorded video for review. (continued on next page)

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

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 02/12/2025
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	On 2/12/25 at approximately 11:19 a.m., The recorded video of the incident between R901 and CNA A was reviewed and it showed CNA A and Nurse B were in an altercation with R901 in which they were trying to wheel R901 in their wheelchair down the hallway but R901 was resistive. Nurse B was observed to try and maneuver R901's legs in the wheelchair in which R901 was then observed to pull their hair. At approximately the 05:30 time mark in the video, CNA A was observed forcefully slapping R901 with open hand using an extended arm and a voice reviewing the video stating D**. On 2/12/25 a review of the facility investigation pertaining to CNA A hitting R901 on 1/18/25 was reviewed and revealed the following: This writer was alerted by Maintenance Director that the Nurse [Nurse B] asked to review footage in regards to the resident pulling her hair off. Upon review of camera footage it as noted that the CNA [CNA A] placed hand on residents face. Maintenance Director alerted writer immediately after review at 9:50 AM., Writer notified Administrator immediately. Writer reviewed assignment sheets dated for Friday 17, 2025 for midnight shift CNA [CNA A] was assigned to [R901]. Writer immediately called [CNA A] to alert her that she was suspended immediately pending investigation .[Local Police Department] notified .At this time the facility is able to validate alleged concern due to CNA (CNA A) stating that she did make contact with resident On 2/12/25 at approximately 11:54 a.m., Maintenance Director E (MD E) was queried regarding the incident between R901 and CNA A on 1/18/25. MD E reported they were made aware of the incident by Nurse B on 1/21/25 and that Nurse B had asked them if they had seen the video and the Maintenance Director E indicated they had not. MDE then reviewed the video, and reported they saw CNA A hit R901. At that time, they reported the allegation the facility management. On 2/12/25 at approximately 1:12 p.m., Detective I (DI) was queried regarding their investigation of the incident and they reported that the police department had issued a warrant for CNA A's arrest and that the department will be pressing charges for assault and battery and the process was currently with the court. DI indicated that in their observation of the incident on the recorded video, CNA A slapped R901 in the face even though they were not the staff member being threatened by R901's behavior. On 2/12/25 a facility document titled Separation of Employment Form with an effective date of separation of 1/21/25 was reviewed and documented that CNA A was terminated from employment at the facility for resident abuse and that it was signed by the facility Administrator on 1/28/25. 30675 R902 On 2/12/25 at 9:13 AM, Nurse 'D' was observed pushing a resident (R902) who was seated in a wheelchair towards the medication cart across from room [ROOM NUMBER]. R902's wheelchair was observed to hit into the medication cart. Nurse 'D' was not observed to say anything to the resident and proceeded to access the cart. Nurse 'D' then proceeded to quickly turn the resident's wheelchair to the right, to turn around in the hallway. While being turned around, R902's bilateral bare feet were observed to hit into the metal doorframe of room [ROOM NUMBER]. The resident flinched and Nurse 'D' did not appear to identify what had occurred. Nurse 'D' proceeded to push R902 in their wheelchair in a forward motion, letting go of the wheelchair and returned to the medication cart. R902 continued to propel forward for several feet while Nurse 'D' was at the cart. (continued on next page)

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 02/12/2025
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)
F 0600 Level of Harm - Actual harm Residents Affected - Few	At 9:15 AM, Nurse 'D' was then observed to push R902 in their wheelchair towards the nursing station and making an overhead page to ask for staffing to call them back. This occurred several times. Nurse 'D' then attempted to make another call and was heard stating they needed someone to sit with [Room number of R902] as he was going in other doors. Nurse 'D' was asked to identify the resident's name and they reported they didn't know, only knew his room number (Nurse 'D' was R902's assigned nurse). Throughout the discussion with Nurse 'D', Nurse Practitioner (NP 'H') was observed a few feet away at a counter next to the nursing station and offered if they could help. Nurse 'D' was asked to speak with them to further discuss what had just been observed in the hallway and they reported, I'm a little busy, can we talk later. They were informed that would not be possible and would like to discuss the concerns immediately and was asked to have another staff come stay with the resident before they proceeded with anything else. Nurse 'D' was then observed to make another phone call to the Human Resource (HR) Manager and stated, She said she's from the State, wants to talk, and doesn't understand that I'm busy. Nurse 'D' was asked to have the Director of Nursing (DON) come to the area and Nurse 'D' reported, She's not here. When asked to have the Administrator come up, Nurse 'D' reported She's not here. At that point, Nurse 'D' was asked to have the HR Manager come up and they proceeded to call and request they come up to the area. At that time, NP 'H' reported they would stay with R902. Nurse 'D' was then observed to walk off the unit and towards the east side of the hallway, towards the elevator and when asked where they were going, Nurse 'D' reported You're really, like . and did not finish speaking. They were asked to accompany to the HR office. At 9:19 AM, the HR Manager was informed of the specific observations of Nurse 'D' with R902 and the HR Manager directed Nurse 'D' to punch out and go home. Review of the clinical record revealed R902 was admitted into the facility on [DATE] with diagnoses that included: unspecified dementia, severe, with agitation, adjustment disorder with mixed anxiety and depressed mood, and dementia in other diseases classified elsewhere, unspecified severity, with other behavioral disturbance, and generalized anxiety disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R902 had severely impaired cognitive skills for daily decision making, had long and short term memory problems, had physical and other behavioral symptoms directed towards others which occurred one to three days, which significantly interfered with the resident's participation in activities or social interactions, and had wandering behaviors which occurred one to three days. Review of the progress notes identified concerns with R902 wandering throughout the facility and other resident rooms. (continued on next page)

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 02/12/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	An entry on 2/12/25 at 10:47 AM by NP 'H' documented in part, .demented male seen today for wondering <sic> . Patient was found in neighbors <sic> room. Patient is alert and oriented x 0 .Patient is easily redirectable, but spontaneous. Patient is able to get up out of bed or chair easily and walk around independently. Patient appears in no acute physical or mental distress. Discussed with staff and social work importance of patient being monitored while awake. Patient has wander guard on. Will continue to monitor . ASSESSMENTS AND PLANS .UNSPECIFIED DEMENTIA, SEVERE, WITH AGITATION: Unstable. A&O x 0 at baseline. Easily redirectable but spontaneous, patient needs 1:1 monitoring . There was no identification of any follow-up based on the observations that were reported to the HR Manager earlier. Further review of the clinical record revealed there was no social service assessment completed yet for review. On 2/12/25 at 11:10 AM, the Administrator (also the facility's Abuse Coordinator) requested to meet with this surveyor to review the incident from earlier. They were provided with the same events as documented above and the Administrator further reported Nurse 'D' had been suspended and they were working on reporting to the State Agency. On 2/12/25 a facility document titled Abuse Prohibition Policy was reviewed and revealed the following: Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse, corporal punishment, involuntary seclusion and any physical or chemical restraint imposed for purposes of discipline or convenience that are not required to treat the guests/resident's medical symptoms Physical Abuse includes hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment Neglect is the failure of the facility, its employees or service providers to provide goods and services to a guest/resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware, or should have been aware of, goods or services that a guest/ resident(s) requires but the facility fails to provide them to the resulting in physical harm, pain, mental anguish or emotional distress. Alleged violations of neglect include cases where the facility demonstrates indifference or disregard for guest/resident care comfort or safety, resulting in physical harm, pain, mental anguish or emotional distress .