

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 05/14/2025
NAME OF PROVIDER OR SUPPLIER Notting Hill of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6535 Drake 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI00151259</p> <p>Based on observation, interview and record review the facility failed to ensure regularly scheduled/routine bathing was offered for one resident (R802) of three residents reviewed for activities of daily living. Findings include:</p> <p>On 5/14/25 a complaint submitted to the State Agency was reviewed that alleged R802 was not being provided regular scheduled bathing.</p> <p>On 5/14/25 at approximately 9:10 a.m., R802 was observed in their room, laying in their bed. R802 was queried if the facility had been offering and providing regularly scheduled bathing and they reported that staff were missing their showers and that R802 prefers showers in the afternoon/evenings. R802 reported if they did not want a shower at that time, nobody comes back to offer it again later and the staff say they refuse. R802 was queried how often the staff are offering showers and they reported that they were lucky if they got bathed once a week and that they needed more than that because they sweat a lot and do not want to smell. R802 reported showers should be provided at a minimum of twice a week.</p> <p>On 5/14/25 the medical record for R802 was reviewed and revealed the following: R802 was initially admitted to the facility on [DATE] and had diagnoses including Adjustment disorder with anxiety, Mood disorder with depressive features, schizoaffective disorder, bipolar disorder, Anxiety disorder and Dysthemic disorder. A review of R802's MDS (minimum data set) with an ARD (assessment reference date) of 3/2/25 revealed R802 was independent with most of their activities of daily living.</p> <p>A review of R802's CNA (Certified Nursing Assistant) documentation revealed R802 was offered bathing four times in the previous 30 days including on 4/16, 4/23, 5/7 (documented refused) and 5/10 (documented refused). The only days in which bathing was provided was on 4/16/25 and 4/23/25. No documentation that R802 was offered bathing twice weekly was provided.</p> <p>On 5/14/25 at approximately 1:58 p.m., during discussion with the Director of Nursing (DON), the DON was queried regarding R802's provision of showers and they reported they should be offered twice weekly at minimum, and all offerings documented in the CNA (Certified Nurse Aid) task documentation. The DON was queried if they could provide any other documentation that R802 was offered showers, and they reported they could not.</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/14/25 a facility document titled Routine Resident Care was reviewed and revealed the following: Residents receive the necessary assistance to maintain good grooming and personal/oral hygiene. Steps are taken to ensure that a resident's capacity for self-performance of these activities does not diminish unless circumstances of the resident's clinical condition demonstrate the decline is unavoidable. Care is taken to ensure resident safety at all times</p> <p>No documentation that R802 had been offered bathing twice weekly in the previous 30 days was received before the end of the survey.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number(s): MI00151142, MI00152404 and MI00151259.</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision and implement effective interventions to prevent falls and accidents for three residents (R804, R806, and R807) reviewed for accidents, resulting in R806 falling and fracturing both legs, R804 sucking on a bleach sheet, and R807 exiting an alarmed door and going down a flight of stairs. Findings include:</p> <p>A complaint received by the State Agency alleged a resident sustained an avoidable fall.</p> <p>R806</p> <p>On 5/14/25 at 12:45 PM, a review of a facility provided document titled, FACILITY PAST NON-COMPLIANCE/QAPI (Quality Assurance and Performance Improvement) PLAN was conducted and read. The plan of care was not implemented while preparing the resident (R806) for transfer to shower chair. The CENA (Certified Nurse Aide 'G') was preparing the resident to be transferred into shower chair and waiting on the second person to assist with the transfer, the CENA sat the resident up on the side of the bed with a 2WW (two wheeled walker) in place. As the CNA (Certified Nurse Aide) was awaiting the second person to assist with the transfer the resident's roommate asked the CENA a question. The CENA turned her back to speak with the resident and during this time resident slid to floor.</p> <p>On 5/14/25 at 12:55 PM, a review of R806's progress notes was conducted and revealed the following:</p> <p>A late entry progress note for 3/7/25 at 1:30 PM, entered into the record by Assistant Director of Nursing 'C' that read, Resident slid out of bed onto the floor, fell on the right side. Resident unable to say what happened. Therapy called to bedside to help with transfer, noticed right leg a little more swollen than usually. EMS (Emergency Medical Services) called, sent out to hospital for further evaluation.</p> <p>A progress note dated 3/8/25 at 12:50 AM, entered into the record by Nurse 'D' that read, resident returned to facility with dx (diagnoses) of right tibial & shin bone fracture.</p> <p>A progress note dated 3/10/25 at 7:05 PM, entered into the record by Dr. 'E' that read, Note Text: chief complaint: fall. called this weekend for fall- sent to ER (Emergency Room) and returned with splint for fx (fracture) R LE (Right Lower Extremity). increased pain in left leg and we ordered an xray at the facility showing a periprosthetic (around a prosthetic joint or implant) femur fx. son at bedside, made son aware of findings and plan to transfer to hospital immediately.</p> <p>A progress note dated 3/17/25 at 4:52 PM, entered into the record by Nurse 'F' that read, Resident has Broken LT (left) femur, RT (right) tibia/fibula.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/14/25 at 2:07 PM, an interview was conducted with CNA 'G' regarding R806's fall. They explained they assisted R806 to sit at the side of the bed waiting for a second CNA to assist with a transfer to the shower chair. At that time R806's roommate asked them a question from the other side of the privacy curtain. They said they took their eyes off R806, opened the curtain to acknowledge the roommate and R806 fell forward off the side of the bed. They said R806 did not complain of any pain after the fall but they could tell something was wrong with their right leg.</p> <p>On 5/14/25 at approximately 2:30 PM an interview was conducted with the facility's Director of Nursing (DON). They acknowledged the deficient practice that resulted in R806's femur and tibia fractures.</p> <p>A review of a complaint submitted to the State Agency revealed an allegation that the facility was not providing adequate supervision for residents on one-to-one (1:1) supervision and utilized unqualified staff to supervise them.</p> <p>On 5/14/25 at 11:20 AM, R804 was observed lying in bed, half sitting up. His pants were down to his knees and his incontinence brief was exposed. Certified Nursing Assistant (CNA) 'B' was observed getting their own food from a lunch cooler. When queried about R804, CNA 'B' reported they were assigned to be R804's sitter because he required 1:1 supervision. When queried about why R804 required that level of supervision, CNA 'B' reported the resident was a fall risk, wandered into other residents' rooms, and was at risk of eating non-food items, such as foam. R804's dresser was observed with the drawers facing the wall. R804's roommate (R807) was not observed in the room at that time.</p> <p>On 5/14/25 at 1:36 PM, R804 was observed eating lunch with CNA 'B's' assistance. CNA 'B' reported both R804 and R807 were assigned to her for 1:1 supervision. When queried about how she provided 1:1 supervision for two residents at once, CNA 'B' reported they could usually redirect R807 by verbally telling him to come back into the room.</p> <p>A review of R804's clinical record revealed R804 was admitted into the facility on 1/29/25 with diagnoses that included: dementia, severe; adjustment disorder, insomnia, and anxiety disorder. A review of MDS assessments dated 2/5/25 and 5/5/25 revealed R804 had severely impaired cognition, physical, wandering, and other behaviors, and was dependent on staff for assistance with all activities of daily living, except walking, which he was able to do with supervision.</p> <p>A review of R804's progress notes revealed the following:</p> <p>On 2/7/25, it was documented in a Behavior Note that R804 was ambulating in other resident rooms, ambulating within his room, pulling the dresser drawers of his and his roommate out and placing them on the floor, consuming his roommate personal snacks, utilizing his roommate personal hygiene supply . It was documented R804 was unable to be redirected.</p> <p>On 2/12/25, it was documented in a Nurses Note that R804 wandered into another resident's room and the facility placed a mesh stop sign to discourage R804 from entering.</p> <p>On 2/13/25, it was documented in a Nurses Note that R804 was going in and out of multiple residents' rooms and was observed standing over another resident's bed. That same day, it was alleged R804 hit that same resident. It was noted R804 was placed on one on one (1:1 supervision - one staff person to supervised one resident).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/22/25, it was documented in a Nurses Note that R804 was found by his sitter (1:1) sucking on bleach sheet. Poison control was contacted by the nurse and they instructed the facility to administer water to the resident and monitor him.</p> <p>On 5/14/25 at 10:15 AM, all incident reports and investigations conducted by the facility for R804 since February 2025 were requested from the Director of Nursing (DON).</p> <p>A review of an incident report dated 2/22/25 revealed no additional information than what was documented in the progress note mentioned above. No investigation was provided by the facility.</p> <p>A review of R804's care plans revealed an active care plan initiated on 2/13/25 that noted, (R804) currently 1:1, until further evaluation .</p> <p>Further review of R804's care plans revealed R804 was incontinent of bladder and bowel, had severely impaired cognition, a language barrier, difficulty communicating and following simple direction, wandered into other residents' rooms, and was a fall risk.</p> <p>A review of the nursing staff assignment sheets revealed on 2/22/25 CNA 'A' was assigned to provide one on one to R804.</p> <p>A review of the nursing staff assignment sheets for May 2025 revealed from 5/1/25 through 5/13/25, had one staff member assigned each shift for 1:1 assigned to both R804 and R807, who shared a room.</p> <p>During the above observations of R804, R807 was not observed in the room. At 1:36 PM, CNA 'B' reported R807 was either in therapy or in the dining room. At approximately 1:40 PM, R807 was observed in the therapy room and at approximately 2:30 PM, R807 was observed with family in the dining room.</p> <p>A review of R807's clinical record revealed R807 was admitted into the facility on 4/18/25 with diagnoses that included: dementia. A review of R807's MDS assessment dated [DATE] revealed R807 had severely impaired cognition, physical and other behaviors, wandering behaviors, and was independent with bed mobility, required supervision for transfers, and was able to walk up to 50 feet with supervision. A review of a MDS assessment dated [DATE] revealed R807 required partial/moderate assistance from staff to walk up to 50 feet. Both assessment noted R807 used a wheelchair.</p> <p>A review of a Nurses Note documented on 3/27/25, revealed, Writer noticed the alarm was going off on (unit) exit door, at that time writer went downstairs to observe if resident was down the stairs, resident located at bottom of staircase, resident was assisted back to his room and designated sitter was to remain doing 1:1 .</p> <p>Further review of R807's progress notes revealed the following:</p> <p>On 1/28/25, it was documented in a Behavior Note that R807 attempted to elope out of the (unit) door.</p> <p>On 2/15/25, it was documented in a Nurses Note that R807 won't stay in his room .also tried pushing through the fire exit doors and saying that he was looking for his keys and car .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/16/25, it was documented in a Nurses Note that R807 tried multiple times to exit room to get his car and leave the facility .</p> <p>On 2/18/25, it was documented in a Nurses Note that R807 got out of his room and began to wander .</p> <p>On 3/13/25, it was documented R807 had a fall in his room.</p> <p>On 3/20/25, it was documented R807 had unsteady gait when walking to the bathroom.</p> <p>A review of R807's care plans revealed R807 had a hearing impairment, cognitive impairment, vision impairment, was at risk for elopement and/or wandering (initiated on 6/6/24), and was at risk for falls.</p> <p>On 5/14/25 at 1:46 PM, the nursing assignment sheets for 3/27/25 were requested from the DON.</p> <p>On 5/14/25 at 1:52 PM, all incident reports with associated investigations for R807 for the past three months were requested from the DON. No incident report regarding the incident where R807 was found to exit through the door on the unit and go down a flight of stairs was provided.</p> <p>On 5/14/25 at 3:15 PM, an interview was conducted with the DON. When queried about the assignment sheets that indicate one staff member assigned 1:1 to both R804 and R807, the DON reported R807 was not actually on 1:1 and we call them resident companions, not 1:1. When queried about whether it was possible to provided supervision to both residents at one time, if they required more consistent supervision and redirection, the DON reported R807 was able to be redirected verbally. When queried about what was done to look into how R807 made it out an alarmed door on the unit and down a flight on stairs on 3/27/25, the DON reported it was not investigated because it was not an elopement. The DON reported R807 did not require 1:1 supervision on that date and it was implemented as needed. When queried about how the root cause was determined to ensure effective interventions were implemented after the incident on 3/27/25, since R807 had a history of exit seeking, the DON did not offer a response. When queried about R804 and how he managed to suck on a bleach sheet on 2/22/25 when he was assigned a staff member for 1:1 supervision, the DON reported she did not now how he got a hold of it. The DON reported it was investigated. When queried about why the investigation was not provided with the incident report, the DON said she must have missed it and said it would be provided.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/14/25 at approximately 3:25 PM, an interview was conducted with CNA 'A'. When queried about the protocols when assigned to R804 and R807's room for 1:1, CNA 'A' reported the 1:1 supervision was for both residents. When queried about how that worked if both residents required supervision, CNA 'A' reported it was very difficult. CNA 'A' explained R807 had dementia and wandered out of the room often looking for his car, house, and children. He required assistance to make sure he did not wander out of the room. He also required assistance with eating at times and going to the bathroom. CNA 'A' further explained R804 required total supervision and care assistance. CNA 'A' reported the aides had to do all the care for him, he frequently gets into things, pulls out the drawers. CNA 'A' stated, It is very challenging to watch both of them. One could be walking out of the room and the other one is trying to stand up. We just learn how to do it, but it's hard. When queried about how R804 got a hold of the bleach sheet on 2/22/25, CNA 'A' explained the bleach sheet was a wipe used to disinfect surfaces. CNA 'A' further explained that the nurse stepped out of the room, CNA 'A' was talking with R807 and by the time she got back over to R804, he had a bleach wipe in his mouth. CNA 'A' reported there was another CNA in the room at the time but must not have been paying attention. CNA 'A' did not notice the bleach wipes in the room and thought they were in the drawer and was not sure if it was a new one or one that was sitting on the dresser, but smelled the strong bleach smell and removed it from the resident and notified the nurse. When queried about whether anyone interviewed her about what happened with R804 on 2/22/25, CNA 'A' reported nobody talked to her about it, she just notified the nurse.</p> <p>On 5/14/25 at 3:48 PM, the DON confirmed she did not have an investigation for the incident with the bleach wipes on 2/22/25 for R804.</p> <p>No additional information was provided prior to the end of the survey.</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI00150658</p> <p>Based on interview and record review the facility failed to ensure pain medications were refilled timely, pulled from the back-up medication supply for administration and administer pain medications per physician orders for one resident (R803) of two residents reviewed for pain management, resulting in uncontrolled pain and a transfer to the emergency room for pain management. Findings include:</p> <p>A complaint received by the State Agency alleged the facility failed to administer pain medications per physician's orders.</p> <p>On 5/14/25 at 9:25 AM, a review of R803's closed clinical record revealed they admitted to the facility on [DATE] and had multiple emergency room discharges and re-admissions to the facility. R803's diagnoses included: morbid obesity, urinary tract infection, diabetes, high blood pressure, peripheral vascular disease, and depression.</p> <p>A review of R803's progress notes was conducted and revealed the following:</p> <p>A progress note dated 1/25/25 at 8:25 PM entered into the record by Nurse 'H' read, .Note Text: Resident requested to be sent to (Hospital Name) .due to uncontrolled pain in her lower back and elevated blood pressure. Resident and sister at bedside is upset that resident did not get her scheduled morphine due to pharmacy shipment delay .</p> <p>A progress note dated 1/27/25, entered into the record by Nurse Practitioner 'I' that read, .Patient is seen today or &lt;sic>; readmission for hospitalization 1/25. Pharmacy was unable to to send Morphine sulfate (pain medication) ER (extended release) 30mg (milligram), last dose patient received 1/24 AM (morning) .</p> <p>A progress noted dated 1/28/25, entered into the record by Nurse Practitioner 'J' that read, .Patient seen in room. Sent to (Hospital Name) on 1/25 for pain control. Over the weekend, there was a delay with pharmacy sending controlled substance scripts. Pt (patient) went 24 hours without MS contin (Morphine sulfate ER), 12 hours without oxycodone (pain medication). At (Hospital Name), she received prescribed pain medication and IV (intravenous) dilauid (pain medication) to achieve pain control .</p> <p>A review of R803's physician's orders and medication administration records (MAR) was conducted and revealed the following:</p> <p>An order for MS contin ER 30mg scheduled for 9AM and 9PM documented as 5 (medication held) for the 9 PM dose on 1/24/25 with an accompanying progress note that read, Nurse to contact pharmacy on status of medication. Not available to administer. The MAR further revealed the 9 AM dose on 1/25/24 was documented as 5 with accompanying progress note that read, Not available to Administer.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #MI00151259</p> <p>Based on observation, interview and record review the facility failed to ensure resident food preferences were honored for one resident (R802) of three residents reviewed for food preferences/palatability. Findings include:</p> <p>On 5/14/25 a complaint submitted to the State Agency was reviewed that alleged R802 was not being provided good tasting food according to their preferences.</p> <p>On 5/14/25 at approximately 9:10 a.m., R802 was observed in their room, laying in their bed. R802 was queried if the facility had been providing food according to their liking and they indicated they had not. R802's breakfast meal tray was observed to contain scrambled eggs and a sausage patty. R802 reported the facility kept getting their meal ticket wrong and that they were supposed to be served double portions and have cheese on their eggs. R802 indicated the kitchen could not get their meal right and they won't eat it and the food is always cold. At that time, R802's food was not projecting any heat. R802's breakfast meal ticket was reviewed and revealed R802 was supposed to have double the amount of standard serving of scrambled eggs with cheese on top which was not provided on their tray.</p> <p>On 5/14/25 at approximately 12:54 p.m., during a conversation with the kitchen Manager K (KM K), KM K was queried regarding the facility procedures for ensuring food preferences and temperatures were met. KM K reported that they have a new person reading the meal ticket on the tray line and they have noticed that they have been missing items on the meal tickets. KM K was queried regarding the standard food temperatures for point of service to the resident and they reported that meats should be 135-145 degrees, sides should be 115-125 and vegetables 120-130 degrees.</p> <p>On 5/14/25 at approximately 1:20 p.m., The meal cart for R802's hall was observed to be brought onto the unit with two trays placed above the cart not being kept warm in the cart. R802's tray was observed to contain BBQ chicken, mixed vegetables and rice. Further review of R802's tray revealed no double portions were provided as indicated on their accompanying meal ticket. KM K was observed taking the temperatures of R802's food items and the temperatures were noted as follows: Chicken was 121 degrees, rice was 112, the soup was 115 and vegetables had a temperature of 110. All temperatures recorded were noted to be lower than the point of service temperatures KM K had reported. A few minutes later R802's replacement tray was observed with KM K and contained mechanical soft chopped meat without double portions. KM K indicated they would have to send a request for a third meal try for R802 because the replacement one was incorrect. A review of R802's lunch meal ticket was conducted which revealed R802 was supposed to have double portions. KM K indicated they would have to talk to their staff about ensuring food preferences and the meal tickets were read correctly when conducting the tray line.</p> <p>On 5/14/25 the medical record for R802 was reviewed and revealed the following: R802 was initially admitted to the facility on [DATE] and had diagnoses including Adjustment disorder with anxiety, Mood disorder with depressive features, schizoaffective disorder, bipolar disorder, Anxiety disorder and Dysthemic disorder.</p> <p>(continued on next page)</p>		

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 05/14/2025
NAME OF PROVIDER OR SUPPLIER Notting Hill of West Bloomfield		STREET ADDRESS, CITY, STATE, ZIP CODE 6535 Drake 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)		
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 5/14/25 a facility document titled Food Preferences was reviewed and revealed the following: Policy-It is the policy of the facility to obtain food preferences for all residents .8. Food preferences will be identified on tray tickets to ensure residents are provided with appropriate food items .</p>		