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	11/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Notting Hill of West Bloomfield	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)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2574455Based on interview and record review the facility failed to thoroughly investigate an injury of unknown origin for one resident (R701), of two residents reviewed for abuse, resulting in the potential for undetected incidences of abuse. Findings include: A complaint received by the State Agency alleged R701 was intentionally handled roughly causing a skin tear to their forearm.On 11/25/25 at 9:40 AM, an interview was conducted with the complainant, and they alleged a facility staff member intentionally caused a skin tear to R701's during a transfer from the toilet to their wheelchair. They reported R701 told the staff member they were hurting them, and rather than stop grabbing them by their forearm the staff member grabbed it tighter causing a skin tear.On 11/25/25 at 9:53 AM, a review of R701's clinical record revealed they admitted to the facility on [DATE] and discharged to the emergency room on [DATE]. R701's diagnoses included: left pubis fracture, heart failure, falls, diabetes, and heart disease.A review of a progress note entered into the record on 11/17/25 at 8:34 PM by Nurse 'I' read, .Writer observed resident with a skin [NAME] [sic] to left forearm after being transferred from toilet to w/c (wheelchair) by two staff members . Drssing [sic] applied to left forearm .On 11/25/24 at 12:24 PM, an interview was conducted with Nurse 'I' regarding their progress note entered into the record on 11/17/25. They were asked to describe the incident and said Certified Nurse Aide (CNA) 'J' needed assistance transferring R701 off the toilet and Unit Manager 'K' went to assist them. They said they did not witness the transfer but after it occurred, they noticed a skin tear to the resident's forearm. Nurse 'I' said Unit Manager 'K' instructed them not to do an incident report, but they did one anyway as they felt it was the facility's policy. They further said they reported the incident to another Unit Manager, Unit Manager 'L' who agreed an incident report should be done. They then went on to say a nurse orientee they were working with applied a dressing to the wound. They were asked if anyone from the facility interviewed them or investigated the incident. They said they were not interviewed and they were unsure whether anyone else investigated the incident. On 11/25/25 at 12:45 PM, a telephone interview was conducted with CNA 'J'. They were asked about the incident and denied any knowledge of the transfer or the skin tear sustained by R701.On 11/25/25 at 12:49 PM, a phone call was placed to Unit Manager 'K' (who assisted with the transfer), and a voicemail was left. On 11/25/25 at 12:50 PM, a phone call was placed to Unit Manager 'L' (who agreed with Nurse 'I' on doing an incident report), however their phone was not able to receive calls at the time the call was placed. On 11/25/25 at 2:31 PM, an interview was conducted with the facility's Director of Nursing (DON) regarding R701 sustaining a skin tear. They were asked if they had any additional information such as an interview with the resident, interviews with the two staff members who transferred R701, or interviews with Nurse 'I' and Unit Manager 'K' and they said they were going to look for additional information. No additional information regarding the incident was provided by the end of the survey. On 11/25/25 at 3:24 PM, an interview was conducted with the facility's Administrator/Abuse Coordinator. They said they did not have any additional information regarding the skin tear and also volunteered knowledge of Unit Manager 'J' turning in their two-week notice saying their last day of work was coming up. A review of a facility provided policy titled, Abuse Prohibition Policy revised 9/2022 was conducted and defined Injuries of unknown source, however; the policy did not address investigating, Injuries of unknown source.

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(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 - Minimal harm or potential for 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** This citation pertains to Intake 2660427.Based on interview and record review, the facility failed to provide care for a cholecystostomy tube (biliary drainage tube inserted into the gall bladder to relieve symptoms of gall bladder disease) consistent with professional standards and in accordance with Physician orders for one (R704) of one resident reviewed with a cholecystostomy (biliary) tube resulting in a delay of surgical intervention to exchange R704's biliary catheter.Findings include:A complaint was filed with the State Agency on 10/31/25 alleging the facility did not provide care for a cholecystostomy biliary drain consistent with professional standards and in accordance with Physician orders. On 11/25/25 at 9:26 AM, a telephone interview with R704's family (complainant) confirmed on October 11, 2025, while visiting with R704 they had observed drainage from the area of the biliary drain which grossly soiled R704's linens and clothing. The family had to get a nurse at which time they observed the nurse reinforcing the area with gauze and never assessed underneath the dressing. On 10/15/25, R704 had an appointment at the hospital to exchange their biliary drain. The Physician stated the drain was no longer placed internally but was outside of his body and could not be replaced as scheduled because the internal tract had closed. The Physician informed the family, based on the closure, it was estimated the tube was dislodged for at least three days. The surgery had to be rescheduled and would require R704 to undergo an abdominal CT (computed tomography) scan (X-ray with detailed cross-sectional images) with contrast (special dye administered to highlight vessels, organs, and tissues) prior to replacing the biliary tube. The family indicated they could not recall the name of the nurse from 10/11/25 but did inform the Director of Nursing (DON) who would further review what happened.Clinical record review revealed R704 was a long-term resident of the facility since June 2019 and was last readmitted on [DATE]. R704 had end stage renal disease and was on hemodialysis three times a week. R704 had a cholecystostomy tube related to their gall bladder disease. A review of the Medical Data Set (MDS) assessed on 10/29/25 documented R704 had severely impaired cognition.Record review of the Interventional Radiologist Physician consultation dated 10/15/25 documented that R704 .presented for chole (cholecystostomy) tube exchange.TUBE WAS DISLODGED, TRACT WAS CLOSED.We were unable to replace tube at this time.Previous exchange cystic duct was open.Please get abdominal CT with contra <sic> in 10-14 days.Record review of R704's October 2025 Treatment Administration Record (TAR) documented . Change Biliary dressing once daily.Every shift.Drain Biliary Drain every shift and document the amount every shift.The TAR was reviewed for the month of October 2025 and revealed that a consistent pattern from 10/1/25 to 10/15/25, nursing did not document their assessment of the drain every shift, except for 10/5/25. On 11/25/25 at 3:00 PM, the DON was interviewed and recalled their familiarity with the incident. The DON was updated that during the interview with the family, the Physician at the hospital had identified on 10/15/25 the tube had been outside of the body for at least three days. The DON reviewed the October 2025 TAR and nursing should have identified zero output dated 10/12/25, 10/13/25, 10/14/25 from the drain was abnormal. When asked how on 10/15/25 there was documentation of 60 milliliter (ml) of drainage upon record review of the TAR by the day shift Nurse H, the DON indicated they had discussed the same concern with Nurse H and once confronted of the documented drainage on a tube that was not in place, Nurse H became upset told the DON they did not have to deal with this, and quit. The DON acknowledged that Nurse H had falsified their documentation, and this was a concern.