STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235663	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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** This citation pertains to intake: MI 825 Based on interview and record review the facility failed to ensure consistent and accurate skin assessments, ensure an antidepressant medication that aided in resident's compliance with wound care was reordered upon readmission and prevent worsening of skin condition on the extremities for one (R#700) of three residents reviewed for quality of care, resulting in worsening of skin conditions, multiple refusals of care, lack of coordinated care amongst the wound nurse practitioner, consulted behavioral group and medical physician and resulting in a consultation that documented the need for bilateral (below the knee) major amputations. Findings include: A complaint was submitted to the State Agency on 3/6/20 at 16:39 (4:39 pm) which documented in part, . Patient's skin is extremely dry, appearing to not have been cleansed in a long time, and has gangrene (a lack of oxygen rich blood causes tissue to die) with (sic) on feet and hands (contracted) with ischemic black tissue . after viewing the patient, feels that he has been grossly neglected . On 3/10/20 to 3/12/20 an onsite investigation into the complainant's allegations was conducted. A review of R#700's clinical record revealed the following: R#700 was admitted into the facility on [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 5 out of 15, indicating severely impaired cognition. R#700 was dependent on staff for all activities of daily living. A Nursing Comprehensive Evaluation- admitted d 1/16/19 at 19:01 (7:05 pm) documented in part . Right lower leg (front)- Scrapings and dark bruises present, Left lower leg (front)- scrapings, and scars. Dark discolored dry skin, Right lower leg (rear)- Right lower leg small open wound, Right toe(s)- Dark discolored right toes and foot with dry skin, Left toe(s)- Toes dark, discolored and dry, Other (specify)- Fingers on left hand noted abnormalities, Other (specify)- Fingers on right hand without function on movement with abnormalities present . A Wound Consultation with Wound Nurse Practitioner (WNP D) dated 1/22/19 documented in part, . Chief Complaint: regarding this patient's feet . At the time of admission, he was noted to have some discoloration on his toes . He does state that his feet hurt . On his toes and his feet, he is found to have numerous scattered darkened ischemic (poor blood flow to an area, which causes cells to die and damages to tissue) patches. Again, these are scattered amongst his toes and his dorsal lateral feet. Currently there are no open areas, no drainage, no [MEDICAL CONDITION], borders are closed, no fluctuance noted . There are no treatments necessary to the ischemic areas on his feet since there are no openings drainage or [MEDICAL CONDITION] . A Wound Consultation with WNP D dated 1/29/19 documented in part, . On his toes and his feet he is found to have numerous scattered darkened ischemic patches. Again, these are scattered amongst his toes and his dorsal lateral feet. Currently there are no open areas no drainage, no [MEDICAL CONDITION] borders are closed, no fluctuance noted . There are no treatments necessary to the ischemic areas on his feet since there are no openings, drainage or [MEDICAL CONDITION] . A Social Services Note dated 1/30/19 documented in part, Resident seen by psychiatrist . on this date for evaluation/behaviors, confusion, depression . A Wound Consultation with WNP D dated 2/5/19 and 2/13/19 were identical and documented in part, . On his toes and his feet he is found to have numerous scattered darkened ischemic patches. Again, these are scattered amongst his toes and his dorsal lateral feet. Currently there are no open areas no drainage, no [MEDICAL CONDITION] borders are closed, no fluctuance noted . There are no treatments necessary to the ischemic areas on his feet since there are no openings, drainage or [MEDICAL CONDITION] . A Social Services Note dated 3/9/19 at 20:03 (8:03 pm) documented in part, . Resident has episodes of refusing care and treatment, presents with signs/symptoms of depression including sleep/appetite disturbance, increased fatigue. Resident referred for psych support services . A Total Body Skin assessment dated [DATE] at 16:45 (4:45 pm) completed weekly by the facility nursing staff documented, Skin Assessment- 1. Turgor- Good Elasticity, 2. Skin Color- Normal for ethnic group, 3. Temperature- Cool, 4. Moisture- Normal, 5. Condition- Extremely Dry, 6. New Wounds- 0. A Wound Consultation with WNP D dated 3/12/19 documented in part, . At the time of admission he was noted to have some discoloration on his toes . I was told that (R#700 name redacted) can be very resistive to care . Left heel darkened non-blanchable area 5.3 x 3.3 cm (centimeter) currently no open, Right heel wound 0.5 x 0.5 x 0.2 cm minimal amount of drainage no clinical evidence of infection surrounding tissue is intact the base is granular with some scattered coagulum (mass/clump/clot) . His toes and fingers have scattered stable ischemia no drainage no [MEDICAL CONDITION] . Discontinue treatment to his toes and his fingers. The areas can be left open to air. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . It should be noted that the total body skin assessment on 3/11/19 did not identify the new left and right heel wounds documented on the next day (3/12/19) by the Wound Nurse Practitioner (WNP) D. A behavioral consultation dated 3/12/19, documented in part, . no noted behaviors by staff . he reports pain in his back . discussed starting an antidepressant that could also help with pain . [MEDICATION NAME] 30mg capsule, delayed release, take 1 capsule by oral route, QAM (every morning) . Patient seen and evaluated. Patient admitted he was feeling depressed . A behavioral consultation dated 3/21/19, documented in part, . Resident has episodes of refusing care and treatment and presents with signs/symptoms of depression. Resident reports feeling down/depressed, fatigued, and having sleep/appetite disturbance . Nursing staff reports depression as evidence by patient refusing care, tube feeds, etc. [MEDICATION NAME] was recently started to help with depression (3/12/19) therefore writer is not making any changes today and will give time for medication to take effect . A Wound Consultation with WNP D dated 3/26/19 documented in part, . Left heel darkened non-blanchable area 4.2 x 3.5 cm currently not open, Right heel wound 0.5 x 0.4 x 0.1 scant drainage no clinical evidence of infection surrounding tissue is intact the base is scab with opening granular . His toes and fingers have scattered stable ischemia no drainage no [MEDICAL CONDITION] . Treat left heel, right heel areas wipe with skin prep apply dry bulky wrap 3 time a week and as needed . Discontinue treatment to his toes and his fingers. These areas can be left open to air. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . A Wound Consultation with WNP D dated 4/2/19 documented in part, . I continue to see this patient for his . heel . He continues to be very resistant to care . Left heel darkened non-blanchable area resolved, Right heel wound resolved . His toes and fingers have scattered stable ischemia, no drainage, no [MEDICAL CONDITION] . D/C (discontinue) Treatment to left heel, right heel areas. D/C treatment to his toes and his fingers. These areas can be left open to air. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . A Wound Consultation with WNP D dated 4/9/19 documented in part, . His toes and fingers have scattered stable ischemia no drainage, no [MEDICAL CONDITION] . Discontinue treatment to his toes and his fingers. These areas can be left open to air. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . A Wound Consultation with WNP D dated 4/16/19 documented in part, . His toes and fingers have scattered stable ischemia no drainage, no [MEDICAL CONDITION] . Discontinue treatment to his toes and his fingers. These areas can be left open to air. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . A Total Body Skin assessment dated [DATE] at 13:45 (1:45 pm) completed weekly by the facility nursing staff documented, Skin Assessment- 1. Turgor- Good Elasticity, 2. Skin Color- Normal for ethnic group, 3. Temperature- Warm

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

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.

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) (normal), 4. Moisture- Normal, 5. Condition- Normal, 6. New Wounds- 0 A Wound Consultation with WNP D dated 4/23/19 documented in part, . Unfortunately the treatment nurse states that yesterday she noted some turbid (cloudy) drainage coming from his right toe and I have been asked to evaluate the area . His right great toe ischemic cap is significantly destabilized. My concern is that this toe is going to Autolytically amputate (spontaneuous detachment) without mummifying, there is minimal drainage currently no [MEDICAL CONDITION]. His remaining toes and fingers have scattered stable ischemia, no drainage, no [MEDICAL CONDITION] . Treat right great toe wound with [MEDICATION NAME] gauze covered with dry gauze change daily and as needed. His remaining toes and his fingers can be left open to air. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . The total body skin assessment completed on 4/22/19 did not identify the new right great toe wound and drainage documented on the next day (4/23/19) by the WNP D. A Wound Consultation with WNP D dated 4/30/19 documented in part, . His right great toe ischemic cap is significantly destabilized. There is minimal drainage currently, no [MEDICAL CONDITION]. There is a rim of granular tissue, the rest still has the darkened Ischemic cap. His remaining toes and fingers have scattered stable ischemia, no drainage, no [MEDICAL CONDITION] . Treat right great toe wound with [MEDICATION NAME] gauze covered with dry gauze change daily and as needed. His remaining toes and his fingers can be left open to air. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . A behavioral consultation dated 5/2/19, documented in part, . Patient presents as calm and cooperative. Patient denies mood or anxiety sx. (symptoms) Patient denies issues with sleep or appetite. Continue [MEDICATION NAME] as described . It appears that the benefit resident is getting from the residents medication regimen is outweighing the risk of potential side effects . A Wound Consultation with WNP D dated 5/7/19 documented in part, . His right great toe ischemic cap is significantly destabilized. There is minimal drainage currently, no [MEDICAL CONDITION]. There is a rim of granular tissue, the rest still has the darkened Ischemic cap. His remaining toes and fingers have scattered stable ischemia, no drainage, no [MEDICAL CONDITION] . Treat right great toe wound with [MEDICATION NAME] gauze covered with dry gauze change daily and as needed. His remaining toes and his fingers can be left open to air. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . A Total Body Skin assessment dated [DATE] at 9:45 am) completed weekly by the facility nursing staff documented, Skin Assessment- 1. Turgor- Good Elasticity, 2. Skin Color- Normal for ethnic group, 3. Temperature- Warm (normal), 4. Moisture- Normal, 5. Condition- Normal, 6. New Wounds- 0 A Wound Consultation with WNP D dated 5/21/19 documented in part, . I have been seeing this patient for his . toe and finger wounds. They were all responding favorably to treatment. Unfortunately, the ischemic on his left third fourth and fifth fingers prematurely separated and we now have open areas . His right great toe ischemic cap is restabilizing , there is minimal drainage currently no [MEDICAL CONDITION]. There is a rim of granular tissue. The rest still has the darkened ischemic cap . his left third fourth and fifth fingers have open areas 1.0 x 0.8 x 0.1 cm minimal amount of serous sinus drainage no clinical evidence of infection surrounding tissue is intact bases are granular . Treat right great toe wound with [MEDICATION NAME] gauze change daily and as needed. His remaining toes can be left open to air. Single layer Xeroform gauze cut to fit applied to open areas on his left third, fourth and fifth fingers cover with gauze change daily and as needed. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . The total body skin assessment completed on 5/20/19 did not identify the new open areas to the left third, fourth and fifth fingers and drainage as documented on the next day (5/21/19) by the WNP D. A Wound Care Consultation with WNP D dated 5/28/19 documented in part . His right great toe ischemic cap is restabilizing , there is minimal drainage currently no [MEDICAL CONDITION]. There is a rim of granular tissue. The rest still has the darkened ischemic cap . his left third fourth and fifth fingers have open areas 1.0 x 0.8 x 0.1 cm minimal amount of serous sinus drainage no clinical evidence of infection surrounding tissue is intact bases are granular . Treat right great toe wound with [MEDICATION NAME] gauze change daily and as needed. His remaining toes can be left open to air. Single layer Xeroform gauze cut to fit applied to open areas on his left third, fourth and fifth fingers cover with gauze change daily and as needed. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . A Wound Care Consultation with WNP D dated 6/4/19 documented in part, . His right great toe ischemic cap is restabilizing. There is minimal drainage currently no [MEDICAL CONDITION]. There is a rim of granular tissue the rest still has the darkened ischemic cap . his left, third, fourth and fifth fingers are beginning to cover over with ischemic caps. There is still some scattered open areas with granular tissue. Scant drainage no [MEDICAL CONDITION] . Treat right great toe wound with [MEDICATION NAME] gauze change daily and as needed. His remaining toes can be left open to air. Single layer Xeroform gauze cut to fit applied to open areas on his left third, fourth and fifth fingers cover with gauze change daily and as needed. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . A behavioral consultation dated 6/5/19, documented in part, . Patient was seen and evaluated. Patient presents as calm and cooperative. Patient denies issues with sleep or appetite. Patient denies mood or anxiety sx. Continue [MEDICATION NAME] at current dose . A Wound Consultation with WNP D dated 6/11/19 documented in part, . His right great toe ischemic cap is restabilizing, there is minimal drainage, currently no [MEDICAL CONDITION]. There is a rim of granular tissue is drying out the rest still has the darkened Ischemic cap . His left third, fourth and fifth fingers are beginning to cover over with ischemic caps. There is still some scattered open areas with granular tissue. Scant drainage no [MEDICAL CONDITION] . Treat right great toe wound with [MEDICATION NAME] gauze covered with dry gauze change daily and as needed. His remaining toes can be left open to air. Single layer Xeroform gauze cut to fit applied to open areas on his left third, fourth and fifth fingers cover with gauze change daily and as needed. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . A Nurses Note dated 6/13/19 at 22:15 (10:15 pm), documented in part Pt was sent out to (hospital name redacted) via ambulance. Pt BP (blood pressure) was 121/94 and HR (heart rate) 115. These are abnormal vitals for the pt baseline . The resident returned on 6/17/19, however their [MEDICATION NAME] medication was not restarted upon admission. The Director of Nursing (DON) was asked to confirm the discontinuation of R#700 [MEDICATION NAME] upon readmission on 6/17/19 and confirmed that the medication was not restarted. A Social Services Note on 6/20/19 at 16:07 (4:07 pm) documented in part, Resident seen by psychiatrist . on this date for follow up, medication review . [MEDICATION NAME]. Risks vs benefits of continued medication use reviewed . (It was noted the resident was not on [MEDICATION NAME] at this time, as indicated by the Social Worker.) On 3/11/20 at 3:49 pm, the DON and Corporate Staff Member (CSM) A were queried on why R#700's [MEDICATION NAME] was not restarted upon admission back into the facility on [DATE], considering the facility's documentation noted improvement and the decrease in refusals of care while on the medication. The DON and CSM A were unable to provide any further explanation or documentation on why the [MEDICATION NAME] was discontinued. When queried on why the Interdisciplinary team didn't address or consult with the medical physician and consulted behavior group regarding the discontinuation of the [MEDICATION NAME] medication, no further explanation or documentation was provided. A Wound Consultation with WNP D dated 6/18/19 documented in part, . His right great toe ischemic cap is restabilizing, there is minimal drainage, currently no [MEDICAL CONDITION]. There is a rim of granular tissue is drying out the rest still has the darkened Ischemic cap . His left third, fourth and fifth fingers are beginning to cover over with ischemic caps. There is still some scattered open areas with granular tissue. Scant drainage no [MEDICAL CONDITION] . Treat right great toe wound with [MEDICATION NAME] gauze covered with dry gauze change daily and as needed. His remaining toes can be left open to air. Single layer Xeroform gauze cut to fit applied to open areas on his left third, fourth and fifth fingers cover with gauze change daily and as needed. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . A Wound Consultation with WNP D dated 6/25/19 documented in part, . His right great toe ischemic cap is stable currently no [MEDICAL CONDITION]. There is a rim has dried out the rest still has the darkened Ischemic cap . his left, third, fourth and fifth fingers are covered over with ischemic caps. No [MEDICAL CONDITION] . Treat right great toe wound wipe [MEDICATION NAME] QD (every day) can be left open to air. Left third, fourth and fifth fingers wipe with [MEDICATION NAME] QD can be left open to air. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . A Social Services Note on 6/27/19 at 15:23 (3:23 pm), documented in part . Resident continues to have fewer episodes of refusing care/treatment. Resident reports feeling down/depressed, fatigued, and having sleep/appetite disturbance. Resident has rx (prescription) antidepressant and is followed by psych support services . (It was noted the resident was not on [MEDICATION NAME] at this time, as indicated by the Social Worker.) A Wound Consultation with WNP D dated 7/2/19 documented in part, . Right great toe ischemic is stable, left third, fourth and fifth fingers are stable . Treat right great toe wound wipe [MEDICATION NAME] QD can be left open to air. Left third, fourth and fifth fingers wipe with [MEDICATION NAME] QD (everyday) can be left open to air. Monitor regions for further ischemia, drainage, [MEDICAL CONDITION] . On 3/11/20 at 8:34 AM, the Director of Nursing (DON) was queried and asked to provide the Wound Care Consults from July of 2019 until November of 2019. Originally all Wound consultations was requested regarding R#700 on 3/10/20 at 3:04 pm. A Progress note sheet documented the dates of: 10/15/19, 10/9/19, 10/1/19, 9/24/19, 9/17/19 and 9/10/19 as a refusal of assessment by the resident from the wound nurse practitioner. By the end of survey, no further wound care consultations from the months of July 2019 to November 2019 was provided. On 3/11/20 at 11:40 AM, Wound

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F 0684 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) Care Licensed Practical Nurse (WCLPN) C (the facility wound nurse) was queried and asked to provide R#700's wound consultations from July 2019 to November of 2019 and nothing was provided by the end of survey. A behavioral consultation dated 9/11/19, documented in part, . Resident continues to have fewer episodes of refusing care/treatment . presents as calm and cooperative. Resident states he is doing alright . Unable to determine level of competency . A behavioral consultation dated 10/2/19, documented in part, . Patient noted with multiple med (medication) refusals and refusals of care . Continue to document changes in bx (behavior)/mood . A Social Services Note dated 11/20/19 at 18:44 (6:44 pm), documented in part . Resident has episodes of refusing care and treatment including skin checks and wound care. Resident presents with signs/symptoms of depression including sleep disturbance. Resident has recently started asking staff to cover his feet with pillowcases and making statements that he is putting them to sleep. Resident is followed by psych support services . A behavioral consultation dated 11/20/19, documented in part, . Patient noted with refusal of care multiple times. Pt is noted with confusion on numerous occasions. 11/15/19: skin care note pt (patient) is refusing changing of dressings . Pt states that he wants to go home. Pt denies pain. Pt states that he is being mistreated and states they are doing everything- pt states he doesn't want to explain . Pt is angry, agitated, and continues to be uncooperative . was previously on [MEDICATION NAME] which was discontinued by PCP (primary care physician) for unknown reasons . Pt has been noted to refuse meds, was previously on [MEDICATION NAME] which was later discontinued for unknown reasons . Will continue to monitor . A Wound Consultation with WNP D signed on 11/26/19 at 9:53 am documented in part, . (R#700 name redacted) is a long-term resident of this facility. He has been refusing almost anything related to his care including bathing, taking medications, staff to perform his treatments. He has not allowed me to assess his wound since always (sic) back here except for right (sic) 8/27. Staff is (sic) been attempting to do his treatments with him refusing most times . significant ischemia on his fingers and toes. He will allow me to look at the areas however he will not allow me to do a thorough assessment or touch him. Most of his toes are mummified and stable except the right great toe. At the proximal, and there is an open area that is granular minimal drainage no [MEDICAL CONDITION]. His left heel also has an open area he will not allow me to measure the region has been 0.1 depth minimal drainage the base is granular. He will not allow me to assess his fingers . Right great toe: Xeroform gauze to open area cover with dry gauze change twice a week and as needed, left heel: Silver impregnated calcium alginate covered with foam dressing change twice a week and as needed . His left heel was previously covered with ischemic eschar. This has destabilized. There is minimal slightly turbid drainage. No [MEDICAL CONDITION] right and left toes are slowly modifying. On his right plantar foot there are scattered open areas there is turbid drainage noted. There is the underlying fluctuance noted. He would not allow me to thoroughly cleanse the area provide the care that is necessary. His right lateral leg is now open there was turbid drainage the base is granular . I have asked the treatment nurse to contact his medical doctor and update her regarding her findings . A Nurses Note dated 11/26/2019 at 14:15 (2:15 pm) documented in part, Resident allowed writer and wound NP (Nurse Practitioner) to assess BLE (Bilateral lower extremities) gangrene. His left heel was previously covered with ischemic eschar. This has destabilized. There is minimal slightly turbid (cloudy) drainage. Right and left toes are slowly modifying. On his right plantar foot there are scattered open areas there is turbid drainage noted. There is the underlying fluctuance noted. He would not allow to thoroughly cleanse the area provide the care that is necessary . Discussed with MD (Medical Doctor) and guardian and new order to send to (hospital name redacted) for destabilization of gangrene. A hospital Discharge Summary (admitted : November 27, 2019, discharge date : December 2, 2019) documented in part, . patient presented to emergency department [MEDICAL CONDITION] to 118, with leukocytosis of 17 . Additionally patient has potential sources on scan due to wounds on lower extremities with evidence of osteo[DIAGNOSES REDACTED] in bilateral feet with concern of dry gangrene as well as right index finger concerning for dry gangrene . patient is [MEDICAL CONDITION] as well as hypotensive . dry gangrene seen on bilateral lower extremities on toes, right foot as well as left foot x-ray well emergency department were concerning for chronic osteo[DIAGNOSES REDACTED], suspicion for dry gangrene versus osteo[DIAGNOSES REDACTED] in right index finger . recommended [MEDICATION NAME] dressing changes . no acute surgical intervention . A Physician Note dated 12/6/2019 at 15:41 (3:41 pm), documented in part . C/O (complaints of) LE (lower extremity) pain, wants an appointment with vascular surgery for [REDACTED]. A Wound Consultation with WNP D signed 12/17/19 at 9:33 PM, documented in part, . I have not seen his wounds since 29 October. Today he is finally agreeing to allow us to assess his foot wounds. Not surprisingly, due to his refusals these areas have deteriorated . We have more than adequately documented his refusals and noncompliance regarding his wound care and treatments. He recently went out to the hospital and was treated for [REDACTED]. He was seen by plastic surgery. Patient had requested an amputation however he is too high of a risk secondary to his [DIAGNOSES REDACTED] . Plantar feet, toes on bilateral feet all stable gangrene in the process of mummifying (skin becomes dry, shriveled, dark in color and cold to touch). There is scant drainage no [MEDICAL CONDITION] . right and left plantar foot, left and right toes: Wipe areas with [MEDICATION NAME] cover with ABD (abdominal) pad change 3x/week (three times a week) and as needed . A Wound Consultation with WNP D signed 1/7/20 at 11:06 AM, documented in part . Gangrenous areas on his toes and his feet are stable. There is no drainage no [MEDICAL CONDITION]. He would not allow assessment of his hands . right and left plantar foot, left and right toes: Wipe areas with [MEDICATION NAME] cover with ABD pad change 3x/week and as needed . A Wound Consultation with WNP D signed 1/14/20 at 11:21 AM, documented in part . I am seeing this patient again today regarding his right leg foot toe and hand wounds. I been told by the treatment nurse that he is become much more cooperative with allowing dressing changes to be performed to his legs. He still is refusing to allow treatments to be performed as ordered to his hands . Recommend: right and left plantar foot, left and right toes: Wipe areas with [MEDICATION NAME] cover with ABD pad change 3x/week and as needed . A Wound Consultation with WNP D signed 1/21/20 at 12:03 PM, documented in part, . I am seeing this patient again today regarding his right leg, foot toe and hand wounds. I been told by the treatment nurse that he is become much more cooperative with allowing dressing changes to be performed to his feet and to his hands. He does not appear to be in any pain. He has developed significant finger contractures to the point where his nails are starting to digging (sic) into his palms of his hands . Gangrenous areas on his toes and his feet and his fingers are stable . There is no drainage, no [MEDICAL CONDITION] . A Wound Consultation with WNP D signed 1/28/20 at 11:52 AM, documented in part, . I am seeing this patient again today regarding his right leg, foot, toe and hand wounds. He is much more cooperative with allowing dressing changes to be performed to his feet and to his hands. He does not appear to be in any pain. He has significant finger contractures to the point where his nails are starting to digging (sic) into the palms of his hands . Recommend: right and left plantar foot, left and right toes: Wipe areas with [MEDICATION NAME] cover with ABD pad change 3x/week and as needed . A Wound Consultation with WNP D signed 2/4/20 at 9:19 PM, documented in part, . Chief Complaint/Nature of Presenting Problem: Finger toe foot right leg and left heel wounds . Recommend: right and left plantar foot, left and right toes: Wipe areas with [MEDICATION NAME] cover with ABD pad change 3x/week and as needed . Hand Surgeon Consult . A Wound Consultation with WNP D signed 2/26/20 at 2:56 PM, documented in part, I am seeing this patient again today regarding his right left foot toe and hand wounds. He is much more cooperative with allowing dressing changes to be performed to his feet and to his hands. He does not appear to be in any pain. He has significant finger contractures to the point where his nails are starting to digging (sic) into the palms of his hands . Hand surgeon consult/vascular surgery consult- I will leave the decisions regarding his request for amputations to his medical team . A Wound Consultation with WNP D signed 3/05/20 at 7:05 PM, documented in part, . I am Seeing this patient again today regarding his gangrenous toes and fingers . We have been documenting the issues regarding his refusals for almost every aspect of his care. He has finally been allowing staff to treat his toes, however he is still rarely allowing any treatments or interventions to his fingers . Most recently he has been requesting a vascular surgery consult so he can get his feet and fingers amputated . Gangrenous areas on his toes and his feet and his fingers are stable. There is scant drainage. From his right gt (great) toe. No [MEDICAL CONDITION]. The blister on his abdomen has resolved . Recommend: right and left plantar foot, left and right toes: Wipe areas with [MEDICATION NAME] cover with ABD pad change 2x/week and as needed . A Nurses Note dated 3/5/20 at 17:28 (5:28 pm) documented R#700 was transferred to the hospital for other medical concerns. A (hospital name redacted) consultation dated 3/6/20 at 16:57 (4:57 pm) documented in part, .Patient with bilateral dry gangrene of the forefeet and the lateral portion of the plantar surface up to mid foot level patient does have good perfusion into the foot palpable DP's (Dorsalis Pedis) bilaterally. Going by how the feet affected by gangrene, limb salvage is probably not an option and he (sic) need bilateral major amputations . A hospital Palliative Medicine Consult filed on 3/9/20 at 11:53 am, documented in part . Vascular consulted for gangrene of bilateral feet and recommend bilateral BKA ([MEDICAL CONDITION]) . Vascular team will contact patient's legal guardian to discuss further regarding procedure . On 3/11/20 at 11:40 am, Wound Care Licensed Practical Nurse (WCLPN) C was queried on the inaccurate weekly nursing skin assessments (on 3/11/19, 4/22/19 and 5/20/19) and explained the wound may not have been present when the skin assessment

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	235663	A. BUILDING _____ B. WING _____	03/12/2020

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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	(continued... from page 3) was performed and may have developed the next day. WCLPN C was further queried on the worsening of R#700's skin condition and stated the resident had so many refusals of care. When asked what the facility was doing about the constant refusals of care and why wound care staff didn't take advantage of completing the wound assessments during the weekly nursing skin assessments or bath days since the resident allowed the staff to complete these tasks weekly, WCLPN C did not offer any further explanation. On 3/12/20 at 9:55 am, WNP D was queried regarding R#700's worsening of skin condition and stated in part . we have more than enough documentation of his refusals. When asked about the coordination of care with the medical physician (MP B) and the WNP D stated in part the doctors have access to my notes in the system . On 3/12/20 at 10:01 am, Medical Physician (MP) B was queried regarding R#700's wound care and stated in part, . There was a communication problem when it came to his care . No, (Wound Nurse Practitioner name redacted) needs to talk to me directly if there is an issue. We need to have a meeting about this and improve the communication there . A facility policy titled Skin Management dated 10/2019 documented in part, . Guests/residents with wounds . and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitor
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: MI 561 Based on interview and record review the facility failed to investigate the root cause analysis of a fall and implement care planned interventions for one (R#702) of three residents reviewed for accidents, resulting in the resident falling and hitting their head on the sink, obtaining a hematoma above the right eye and being sent to the emergency department for further evaluation. Findings include: A review of a ED (emergency department) Provider Notes dated 10/04/19 at 22:48 (10:48 pm) documented in part, . She presents after unwitnessed fall at nursing home. Per staff, they heard a thump and found patient on the ground and assisted her back to her bed. The patient has a hematoma above her right eyebrow. The patient c/o (complaints of) mild neck pain . Pt (patient) with multiple recurrent falls over last several months, seem to be related to her not being supervised well at her facility (per family at bedside). She gets up when no one answers the call light, and with her dementia, she's a fall risk . On 3/10/20 to 3/12/20 an onsite investigation was completed at the facility and revealed the following: R#702 was admitted into the facility on [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) with a score of 6 out 15, indicating severely impaired cognition. R#702 was documented as a two-person transfer and a one-person assistance for ambulation, dressing and bowel/bladder. A Incident and Accident Report dated 3/23/19 documented in part, . Resident states she tried to get up and answer her phone and lost her balance . Interventions Implemented- Placed personal items at bedside . A Post Fall Evaluation dated 3/23/19 documented in part, . Describe initial intervention to prevent future falls: Keep call light and all personal items within reach of the resident . A Incident and Accident Report dated 5/23/19 documented in part, . Resident was observed on floor, she states she lost her balance while walking . Interventions Implemented- Non-skid socks provided, pt (patient) reminded to always use call light for assistance . A Post Fall Evaluation dated 5/24/19 documented in part, . What did the resident say they were trying to do just before they fell ? She was walking to her closet . Footwear at time of fall: regular socks . Describe initial intervention to prevent future falls: provided resident with non-skid socks and reminded pt to always use call light for assistance . frequently check/offer + encourage assistance w (with) HS (hour of sleep) bedtime ADL (activities of daily living)/ laydown as resident prefers . A Incident and Accident Report dated 10/4/19 at 4 PM, documented in part . Location of Injury: Bump, around right eye and frontal lobe . Resident noted on the bathroom floor. She was laying between the sink and the toilet seat when she was noted . The doctor called and notified of the fall and injuries sustained. She (doctor) ordered for the resident to be transferred to (hospital name redacted) . Interventions Implemented- Dress resident in appropriate footwear while out of bed. Continue to encourage resident to wear non-skid socks . A Post Fall Evaluation dated 10/4/19 documented in part, . observed on the floor (unwitnessed) . brief noted wet . Footwear at time of fall: was wearing regular socks . Time last toileted and/or changed . 3:50 (a 3 is written over the 5, making the documented time appear to be 3:30 pm) . Where there any changes in the resident's normal routine? Per assigned CNA (certified nursing assistance), resident ambulates to the bathroom using a walker regularly . Re-enactment of fall . Resident ambulated to the rest room with inappropriate footwear. Did not have gripper socks on . Fall Huddle (what was different this time?): Resident was wearing socks that have no grippers; just regular socks. Needs to wear gripper socks at (sic) comfortable shoes while ambulating . A review of R#702's clinical record revealed the following Resident at Risk progress notes: A Resident At Risk noted dated 10/11/19 at 10:25 am, documented in part . Resident had a fall on 10/4 . Staff to offer and encourage toileting after meals . No fall since 10/4 . IDT (Interdisiciplinary team) to follow up prn (as needed). Further review of R#702's clinical record revealed no additional Resident at Risk assessments documented in 2019. A care plan titled . is at risk for fall related injury and falls R/T: Generalized weakness . decline in mobility (Initiated: 9/16/19 and revised on 11/20/19), documented in part . will be free from injury related to falls through the review date . Interventions . Do not leave resident unattended in bathroom . Dress resident in non-skid footwear when out of bed . Encourage the resident to wear appropriate footwear as needed . A care plan titled Resident requires assistance with ADL's R/T (related to) Decreased mobility and generalized weakness (Initiated: 9/16/19 and revised on 11/20/19) . Interventions . Resident requires 1 person assistance to dress . Resident requires 1 person assistance with personal hygiene and oral care . On 3/12/20 at 9:20 AM, the Director of Nursing (DON) was queried what type of supervision was provided to R#702 prior to their fall on 10/4/19. The DON was further queried on why R#702 who required assistance from the facility staff to get dressed, didn't have the appropriate non-skid socks for safety as documented in the resident's care plan? The DON stated they were not employed at the facility in October of 2019 and will consult with their team to find out the answers. At 9:47 am, the DON returned and was unable to provide any further information. A facility policy titled Fall Management dated 10/2019 documented in part, . The facility will identify hazards and guest/resident risk factors and implement interventions to minimize falls and risk related to falls . Each guest/resident is assisted in attaining/maintaining his or her highest practical level of function by providing the guest/resident adequate supervision, assistive devices, and/or functional programs as appropriate to minimize the risk for falls . A plan of care developed and implemented based on this evaluation with ongoing review . If a fall occurs, the interdisciplinary team conducts an evaluation to ensure appropriate measures are in place to minimize the risk of future falls . A Guest/resident at Risk meeting will be conducted at least monthly by the Interdisciplinary Team. Guests/residents reviewed during the meeting are as follows: Guests/residents that had a fall since the previous meeting, New admission at risk for falls since the previous meeting .
F 0690 **Level of harm -** Actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: MI 825 Based on interview and record review the facility failed to follow up with the urologist after the insertion of a left [MEDICAL CONDITION] stent (a soft tube about 10-12 inches long, used to hold ureter open and maintain drainage of urine) and monitor for renal/[MEDICAL CONDITION] calculous/calculus (stones) obstructions for one (R#700) of three residents reviewed for a urinary catheter, resulting in the lack of coordination of care with the urologist, a missed urology appointment, the lack of straining/collecting stone fragments from urine,[MEDICAL CONDITION], pain and resulting in a transfer to the hospital for a surgical consultation to remove a urinary catheter. Findings Include: A complaint was submitted to the State Agency on 3/6/20 at 16:39 (4:39 pm) which documented in part, . Patient arrived at (hospital name redacted) . because the staff at (facility name redacted) was attempting to take out his foley, but it got stuck. Urology was consulted and they were unable to remove the foley, even after flushing it. Patient was admitted for a Cystoscopy (a procedure that allows a urologist to view the inside of the bladder and urethra). Foley was removed and found to be severely encrusted . A review of R#700's clinical record revealed the following: R#700 was admitted into the facility on [DATE] with a readmission date of [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 5 out of 15, indicating severely impaired cognition. R#700 was dependent on staff for all activities of daily living. R#700 was not admitted with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0690 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) a urinary catheter. Continued review of R#700's clincial record revealed the following: A Nurses Note dated 9/3/19 at 5:20 AM, documented in part . Resident observed during care rounds to be diaphoretic (excessive sweating). VS (vital signs) obtained T (temperature)-103.1, BP (blood pressure) 112/81, P (pulse)-163 R (respiration)-22. Attempted to give Tylenol peg tube clogged. Cold cloths placed on resident forehead. MD (Medical Doctor) notified of condition and ordered to send out 911 . A hospital discharge summary (admitted date: September 3,2019, discharge date : September 6, 2019), documented in part, . Insertion of [MEDICAL CONDITION] stent (left) . [MEDICAL CONDITION] stone with hydro[DIAGNOSES REDACTED] . [MEDICAL CONDITION] with a 8mm (millimeter) calculus in the distal L (left) ureter . 1.1 x1.9 cm (centimeter) rim-enhancing collection . which may represent a psoas muscle abscess . f/u (follow up) in 4 weeks with low dose CT scan prior to f/u with (urologist doctor name redacted) .[MEDICAL CONDITION] . On admission febrile (fever) 103.1 and [MEDICAL CONDITION] (110) .Continue to strain all urine with strainer to collect any stone fragments . Collect the stone and bring to your appointment if you pass them . Stent MUST be removed after stone is resolved. Please ensure follow-up with (Urologist name redacted) . A review of R#700's clinical chart revealed no follow up outpatient consultations completed with the urologist, Per R#700 discharged paperwork which documented in part to follow up on [DATE] 10:00 AM. A Nurses Note dated 11/26/2019 at 15:45 (3:45 PM) documented the resident was transferred to the hospital. A hospital Discharge Summary (admitted date: November 27, 2019, discharge date : December 3, 2019) documented in part, . Foley replaced on admission . presented with [MEDICAL CONDITION] 2/2 (secondary to) [MEDICATION NAME] bacteremia with source likely being GU ([MEDICAL CONDITION]- genital and urinary organs) . UC (urinary catheter) showing gross contamination . patient presented to emergency department [MEDICAL CONDITION] (fast heart rate) to 118, with leukocytosis (high white blood cell count) of 17 with likely source urinary tract . It was noted the resident was readmitted on [DATE] with a foley catheter and remained at the facility until March 5, 2020, when the resident was transferred back into the hospital. Per the DON, 11/27/19 was the last time R#700's foley [MEDICATION NAME] was documented as changed (by the hospital.) A Nurses Note dated 3/5/20 at 17:28 (5:28 pm) documented in part, . Resident's foley balloon was deflated and foley unable to be removed. B/P (Blood Pressure) 102/64, HR (heart rate) 52 . MD (Medical Doctor) notified: and ordered to send resident to the hospital . A (hospital name redacted) urology surgery consult dated 3/5/20 documented in part, . Stuck foley . he has complaints of urethral pain when catheter is manipulated. Once in the ED (emergency room department), the foley was attempted removal without success. Urology surgery is consulted to assess the removal and replacement of the foley . Patient has suprapubic (lower abdomen) pain when catheter being flushed . presented today from his nursing facility due to inability to remove his foley cath . Case has been reviewed and discussed in detail with supervising physician . for surgical consultation . purulent (milky) drainage out of foley . Urology consulted and they were also unable to remove the foley despite flushing. Urology requests CT (computed tomography) pelvis for better imaging. They request the patient be placed in observation with plan for possible cystoscopy (a procedure that allows a urologist to view the inside of the bladder and urethra) in a.m . A (hospital name redacted) CT of pelvis report dated 3/6/20 at 12:14 AM, documented in part . The tip of the patient's foley catheter is located within the urinary bladder with multiple coarse calcifications (accumulation of calcium salts) seen along the course of the foley catheter, most prominent near the foley catheter tip . additional layering calcifications within the urinary bladder . A hospital Palliative Medicine Consult filed on 3/9/20 at 11:53 am, documented in part, . Pt (patient) had foley catheter removed 3/6/20 with Urology and did not replace foley catheter. Urology recommending to leave foley catheter out with checks PVRs (post-void residual) . A review of R#700's care plans revealed one urinary care plan titled R#700 has an Indwelling Catheter d/t (due to) [MEDICAL CONDITION] (Date Initiated and Revised on 1/28/20). Is at risk for urinary tract infection and catheter related trauma R/T (related to) Indwelling Catheter . Goal- Catheter will remain patent and without complications through the review date . Interventions- Change R#700 catheter and tubing per facility policy, Foley catheter securement device in place every shift, Observe and document output every shift, Position catheter bag and tubing below the level of the bladder. Check tubing for kinks each shift, Privacy bag to foley drainage bag every shift, provide catheter care every shift and as needed . This care plan did not inform the staff to monitor for the signs and symptoms of renal/[MEDICAL CONDITION] calculous (calculus), pain or straining the urine to collect stone fragments for the urologist as the physician documented. On 3/11/20 at 8:32 AM, the DON was asked to provide the facility policy on changing catheter and tubing (as documented in R#700's care plan) and stated the facility did not currently have a policy for the changing of a resident's urinary catheter and tubing. On 3/11/20 at 9:51 AM, the Director of Nursing (DON) and Corporate Staff Member (CSM) A was queried about R#700's urology appointments and provided an appointment reminder from R#700 discharged paperwork which documented in part . Follow up in 1 week(s) . [DATE] 10:00 AM . Follow-Up Visit with (Urologist name redacted) . When queried on why the facility did not ensure that R#700 made it to the appointment, both the DON and CSM A could not provide an explanation. The DON and CSM A were queried further on why the low dose CT scan was not completed as directed by the Urologist and no further explanation was given. On 3/12/20 at 10:02 AM, Medical Physician (MP) B (R#700's attending physician at the facility) was interviewed via telephone. When asked if the Urologist follow up would have been beneficial to R#700's care, MP B stated in part . Yes, if they would have followed up with the Urologist it would have equipped the facility to be able to better monitor him and his urological condition . There was a big miscommunication with his care . We all need to have a meeting about this and work on improving the communication there (at the facility) . On 3/12/20 at 12:02 PM, the DON and CSM A was asked to provide any additional documentation regarding R#700's urological care and no additional documentation or information was provided by the end of survey. The DON and CSM A were asked to provide any policies on following up on appointments after a hospital discharge and implementing a physician directive. The DON and CSM A provided policies on physician's orders [REDACTED]. All policies were reviewed, however contained no relevant information to the above deficient practice.