

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235171	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2024
NAME OF PROVIDER OR SUPPLIER Wellbridge of Grand Blanc		STREET ADDRESS, CITY, STATE, ZIP CODE 3139 East Baldwin Road Grand Blanc, MI 48439	

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592</p> <p>Based on observation, interview and record review, the facility failed to ensure that narcotic medications were accurately documented according to professional standards of practice for one resident (Resident #901).</p> <p>Findings include:</p> <p>Resident #901 (R901):</p> <p>On 7/1/24 at 11:40 AM, R901 was observed lying in bed. R901 was asked about care at the facility. R901 explained they did not think they were getting their Norco (a narcotic pain medication) correctly.</p> <p>Review of the clinical record revealed R901 was admitted into the facility on [DATE] with diagnoses that included: peripheral vascular disease, polyneuropathy (damage to multiple nerves) and anxiety disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R901 was cognitively intact.</p> <p>Review of R901's July 2024 Medication Administration Record (MAR) revealed a physician order for, HYDROcodone-Acetaminophen (Norco) Oral Tablet 5-325 MG (milligrams) . Give 1 tablet by mouth every 6 hours for CHRONIC PAIN with a start date of 3/3/23. The times of medication administration listed on the MAR were: 12:00 AM, 6:00 AM, 12:00 PM and 6:00 PM.</p> <p>On 7/2/24 at 9:26 AM, observation of R901's Controlled Substance Proof-Of-Use Record with Licensed Practical Nurse (LPN) C revealed documentation that the last pill removed had been on 7/1/24 at 11:00 PM by Registered Nurse (RN) D, and that there were seven pills left. Observation of R901's blister pack of the Hydrocodone-Acetaminophen 5/325 mg revealed there were six pills left in the blister pack. When asked about the discrepancy, LPN C had no answer.</p> <p>On 7/2/24 at 9:36 AM, the Director of Nursing (DON) was informed of the discrepancy of R901's narcotic medication.</p> <p>On 7/2/24 at 9:41 AM, a phone call was made to RN D, but the voice mailbox was full and a message could not be left.</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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/2/24 at 9:50 AM, the DON explained she herself had counted the narcotic medications at shift change with RN D, and RN D had forgotten to sign the Proof-Of-Use Record when she had given the medication at 6:00 AM, and must have forgotten to sign it when they were counting the narcotics. The DON was asked when should the Proof-Of-Use Record be signed. The DON explained it should be signed when the narcotic medication is removed from the supply. When asked if a nurse should ever wait until the end of their shift to document they removed a narcotic medication, the DON said no. The DON was asked why she did not ensure RN D signed the Proof-Of-Use Record when they were counting the narcotics. The DON explained it was very chaotic at the time, there were three residents around where they were counting and RN D must have forgotten to sign. The DON explained she and another nurse, Clinical Care Coordinator (CCC) G had called RN D and asked if she had given R901 their medication, then they both signed the Proof-Of-Use Record for RN D.</p> <p>On 7/2/24 at 10:02 AM, a request was made for R901's Hydrocodone-Acetaminophen Proof-Of-Use Record.</p> <p>Additional review of R901's Hydrocodone-Acetaminophen Proof-Of-Use revealed an additional line that documented one tablet given on 7/2/24 at 6:00 AM by RN D and that there were six tablets left. It was signed by the DON and CCC G and had via phone written on it.</p> <p>Review of a One to One Educational Opportunity document dated 7/2/24 read in part, .At the time of count with off going nurse ensure accuracy with narc (narcotic) sheets. Ensure nurse & educate nurse signed out MAR & narc sheet at the time of administration . The Administrator had signed on the Instructor Signature line, and the DON had signed on the Employee's Signature line.</p> <p>Review of a One to One Educational Opportunity document dated 7/2/24 read in part, .At the time medication is administered MAR & narc count sheets are to be signed out by nurse giving medication . The DON had signed on the Instructor Signature line, and the Administrator had signed on the Employee's Signature line with witness and via phone written.</p> <p>On 7/2/24 at 2:25 PM, a request was made for a facility policy regarding medication administration of controlled substances. The policy provided was titled, Controlled Substance Medication Orders dated 1/2020 and did not address documentation of administered narcotic medications.</p>		