

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 04/29/2025
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348</p> <p>This Citation pertains to Intake Number MI00152519.</p> <p>Based on interviews and record review, the facility failed to ensure that the GLP-1 (Glucagon-like peptide-1) injection medication was protected from staff misappropriation for one resident (Resident #601) of three residents reviewed for misappropriation of medication.</p> <p>Findings include:</p> <p>According to Cleveland Clinic, myclevelandclinic.org, dated 7/3/23, the prescribed GLP-1 medication states, GLP Agonists are medications that help lower blood sugar levels and promote weight loss .They mainly help manage blood sugar levels in people with Type 2 diabetes. Some GLP-1 agonists can help treat obesity.</p> <p>Resident #601 (R601):</p> <p>A review of R601's medical record conducted on 4/29/25 at 11:30 AM revealed an admission into the facility on [DATE], with the diagnosis of Type 2 Diabetes Mellitus, Chronic Kidney Failure, Heart Failure, and Obesity in addition to other diagnoses. R601 Physician's order for R601's Type 2 diabetes regimen revealed: Insulin Lispro Injection Solution-Humalog Injection Solution 100 units/ML inject 30 units subcutaneously three times a day (Injected as per sliding scale), Ozempic (1mg dose) subcutaneous solution pen-Injector 4mg/3 ml (Semaglutide) inject subcutaneously in the morning every Monday, Insulin Glargine Solution, 100 unit per ML (Inject 30 unit subcutaneously at bedtime). R601's daily blood sugar readings from 3/15/25 to 4/29/25 indicated that R601 remains stable and on her baseline. A review of the Minimum Data Set (MDS) assessment revealed a Brief Interview of Mental Status (BIMS) score assessed on 3/25/2025, indicating a BIMS score of 11/15. A score of 11 indicates moderate impairment. This suggests the individual may need extra assistance with daily tasks and activities and may be experiencing cognitive decline.</p> <p>R601 Blood Sugar (BS) on 4/14/25 when the injection was found missing, R602 's Blood Sugar testing remained in her baseline, and the Medication Administration Record (MAR) revealed that R601 received Ozempic at 1700 (at 5:00 PM) instead of the order to be administered every Monday morning as ordered.</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
---	-------	-----------

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 04/29/2025
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R601 was interviewed on 4/29/25 at 2:00 PM. She was well groomed and in good affect, interacting with her husband in her room. She stated she was receiving excellent care at the facility, and she believed that her medications were given too soon and more than what she needed. She did not recall missing any of her medications and had no blood sugar complications during her stay.</p> <p>R601's Family interview on 4/29/25 at 2:05 PM revealed that he disagreed with R601's opinion regarding her insulin medication regimen. He expressed that as a caregiver at home, she was not receiving the same prescriptions that R601 had at home. He stated that She is getting less here. R601 's husband presented the surveyor with his home medication orders and gave the surveyor a copy to evaluate. The surveyor explained that the Physician's orders at the facility are the ones followed because he is the current attending Physician. The list you submit will be given to the Director of Nursing for reconciliation. R601's husband indicated that R601 is getting the care she needs and is looking forward to her returning home.</p> <p>The Director of Nursing (DON) was interviewed on 4/29/25 at 11:22 AM. She revealed that they went back to the staff who gave the last dose, and the video was installed in the secured med room, and found suspicious activity with one of the RNs who was not the nurse responsible for the insulin administration that day, taking the Ozempic Pens from the supplies. On the day of 4/7/25, the RN W was seen on video taking the two Ozempic pens. RN W at first denied taking them, but when the DON mentioned the video, Nurse W sobbed and admitted taking them. Nurse W admitted and returned the pens. She was terminated instantly by phone. We reported the incident to the local authorities and reported the incident to the state.</p> <p>The Facility Administrator was interviewed on 4/29/25 at 10:15 AM During the interview, she revealed that on 4/14/25, the nurse on duty could not locate R601's Ozempic inj due to the secured medication room refrigerator. She immediately reported after knowledge of the missing GLP-1 and search and investigation started. After a full investigation and a review of the video installed in the medication room, the administrator revealed that they reported the incident to the local police department, reported the case to the State of Michigan, and the Bureau of Health Professionals to report her actions. RN W took the Ozempic medication, admitted taking the Ozempic Pens, wrote a statement, and returned the pens to the facility.</p> <p>A review of the investigation report for R601 revealed the summary of the incident, which revealed the following:</p> <p>Facility Incident Report</p> <p>(continued on next page)</p>		

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 04/29/2025
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Incident Summary on April 14, 2025, the nurse supervisor was notified that missing medication from a guest's (R601) prescribed GLP-1 agonist medication, Ozempic (Semaglutide), from the secured medication refrigeration unit located in the North Team Room of the facility. The medication in question was ordered and stored per protocol in the team room's refrigeration unit designated for injectable, multi-use, and temperature-sensitive medications. A discrepancy was noted when the medication could not be located in the designated storage area during routine preparation for administration. Verification of medication administration record (MAR) and narcotic log entries related to the Ozempic pen in question. Interview with the last administering nurse, who affirmed that she had administered the medication per MAR on her assigned shift and returned the Ozempic pen to the medication refrigerator in accordance with facility protocol. Subsequent interview with a night shift RN who reported that the Ozempic was present in the refrigerator as of the early morning hours of Wednesday, April 9, narrowing the timeframe of disappearance. Video surveillance review security surveillance footage from the North Team Room camera was reviewed covering the timeframe from Monday, April 7, 2025, at 08:00 hours through Thursday, April 10, 2025, at 17:07 hours. The following actions were captured on camera: On Thursday, April 10, 2025, between 17:04 and 17:07, RN JW (Full name mentioned) is visibly observed entering the North Team Room and proceeding to the medication refrigeration unit. At approximately 17:04, RN JW is seen opening the refrigerator and removing two manufacturer-labeled Ozempic boxes. She is then observed withdrawing the injectable pen device from one of the boxes, obtaining corresponding injection needles, and placing the empty cardboard packaging back into the refrigerator, a behavior inconsistent with standard disposal procedures. Immediately thereafter, she removed the second Ozempic box from the refrigerator and exited the medication room with it in her possession at precisely 17:07. These actions were not contemporaneously documented in any medication administration record or shift count sheet. No corresponding guest MARs indicated a need for administration of the second dose, nor was there documentation of a medication return or disposal consistent with policy.</p> <p>Based on the findings of the internal review, which included: Video evidence demonstrating unauthorized removal of controlled medication; Lack of MAR or narcotic log entries justifying the dual removal the facility concludes that there is substantial and substantiated evidence suggesting diversion or misappropriation of a controlled injectable pharmaceutical by RN [NAME] Wartella on April 10, 2025. Immediate actions were taken to: Remove RN JW from active duty pending further investigation; call the local police department. Husband and resident notified. Initiate this mandatory report to [NAME] pursuant to regulatory obligations regarding suspected drug diversion by a licensed healthcare provider.</p> <p>Investigation Summary and Plan</p> <p>On April 14, 2025, the nurse supervisor was notified that missing medication from a guest's (R601) prescribed GLP-1 agonist, Ozempic (Semaglutide), from the secured medication refrigeration unit in the facility's North Med Room. After reviewing video surveillance that viewed RN JW removing medication, a call to RN JW took place in which she admitted to taking medication.</p> <ul style="list-style-type: none"> > Police authorities were notified and arrived at the facility for investigation. > On 4/14/2025, RN JW admitted to taking medication and also arrived at the facility to return the medication. > The police officer NL (Fullname mentioned) arrested RN JW. <p>(continued on next page)</p>		

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 04/29/2025
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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>> On April 14, 2025, the facility completed a one-time audit of guests prescribed GLP-1 agonist medication, Ozempic (Semaglutide), including antidiabetic medications, to ensure no other medications were missing. We also checked the blood sugar levels for the last seven days to ensure no abnormalities were noted.</p> <p>> On 4/14/25 and 4/15/25, a facility-wide education on System change: Ozempic and Like Medications will be locked and counted like narcotics and treated was conducted. The education was delivered by phone or live to all licensed and registered nurses.</p> <p>> A process change was implemented effective 4/14/2025: All GLP-1 agonist medications will follow the narcotic double lock protocol and sign-out process.</p> <p>> On April 17, 2025, RN JW was terminated.</p> <p>> The date of completion of the plan of correction was dated 4/17/2025.</p> <p>On 4/29/2025, the State Surveyor verified the documentation provided by the facility and conducted interviews with facility staff. During the interviews, staff reported that they had been educated on the facility's policy for abuse and misappropriation of medications, including reporting, and were knowledgeable about the facility's policies.</p> <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included the Investigation Summary and Plan, listed above. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p> <p>The Compliance Date is 04/17/2025.</p>		