STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235171	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Grand Blanc	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)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 22927 Based on interview and record review, the facility failed to ensure that a comprehensive person-centered care plan was established for two residents (Resident #32, Resident #41) of twenty-five residents reviewed for care planning, resulting in Resident #32, a hemodialysis resident, to continue to gain weight with no updated care plan interventions and the likelihood for unmet care needs. Findings include: Record review of the facility 'Care Plans-Comprehensive' 2001 MED-PASS, Inc. (revised October 2010) policy revealed an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, and psychological needs is developed for each resident. Policy Interpretation and Implementation: 3.) Each resident's comprehensive care plan is designed to: incorporate identified problem areas, incorporate risk factors associated with identified problems. #5.) Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes Record review of the facility 'Policy: Obtaining Weights and Re-weight Policy' undated, revealed each individual's weight will be determined and documented upon admission to the facility. Procedure: 1.) Nursing will be responsible for the initial determination of each individual's weight. Subsequent measurements for weight will be documented on the appropriate designated form or tracker in the computer database. Weight will be documented on the individual assessment instrument (MDS) for nursing facilities), and in the medical nutrition therapy (MNT) assessment. Weight will be obtained weekly for 4 weeks after admission. Subsequent weights will be obtained monthly. unless physician orders or individual condition warrants frequent determinations. Re-weights will be done for a weight change of +/- (gain/loss) of 3# (pounds) for anyone under 100# pounds and for +/- (gain/loss) of 5# (pounds) for anyone 100 pounds and over. (2.) The Registered Dietitian (RD) or designee will be responsible for determining the desirable weight range Resident #32: Observation and interview on 09/30/24 at 10:03 AM with Resident #32, while the resident was seated at the edge of her bed, revealed a left upper arm hemodialysis graft with dressing in place. Resident #32 stated that she had been getting hemodialysis treatments for 3 years and goes to dialysis on Tuesdays-Thursdays and Saturdays. Observation of bedside table noted two glasses of beverages. Observation of Resident #32's lower extremities noted skin tightness and possible edema. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #32's medical diagnosis list revealed: acute and chronic Respiratory failure with hypoxia, hypertension, metabolic encephalopathy, falls, seizures, end stage renal disease, cerebral infarction, heart failure, type 2 diabetes, chronic obstructive pulmonary disease, anxiety, Gastrostomy tube, muscle wasting, dysphagia, cognitive communication deficit, mild cognitive impairment, insomnia, dependence on renal dialysis, pneumonia, and anemia. Record review of Resident #32's electronic medical record weight log revealed inconsistent weight monitoring: 9/5/2024 weight 160.8 Lbs. 9/10/2024 weight 166.3 Lbs. that was a gain of 5.5 pounds, no care plan intervention added. 9/12/2024 weight 166.1 Lbs. 9/14/2024 weight 172.9 that was a gain of 6.8 pounds, no care plan intervention added. 9/17/2024 weight 178.9 Lbs. was a gain of 6.0 pounds, no care plan intervention added. 9/19/2024 weight 182.8 Lbs. that was a gain of 3.9 pounds, no care plan intervention added. 9/21/2024 weight 189.9 Lbs. was a gain of 7.1 pounds, no care plan intervention added. The total weight gain in a 17-day period for Resident #32 who received hemodialysis treatment for renal failure was a total of 29.1 pounds. Record review of Resident #32's care plans, pages 1-18, revealed that the 'Alteration in nutritional status related to recent hospitalization , diabetes, heart failure, end stage renal disease and peg tube' initiated on 7/29/2024, with a revision on 7/30/2024 and 9/20/2024 of offer evening snack and then revised after the state surveyor inquired about weight gain on 10/2/2024 with updated intervention of 'No PM/HS (bedtime) water. An interview and record review on 10/02/24 at 08:44 AM with Registered Dietitian (RD) M of Resident #32's weight log revealed that Resident #32 was a hemodialysis resident that received treatment 3 days a week. The state surveyor inquired about Resident #32's estimated weight gain of about 6 pounds weekly, and her fluid status, how much was the resident drinking. The state surveyor and RD M discussed possible health crisis of fluid overload. The RD M stated that she did make the care provider (NP) aware, and each week notify the NP. Discussion of follow-up to the notifications and possible treatments were discussed. RD M stated weights for Resident #32 were taken from her post dialysis weights sent from the dialysis center and documented those in the medical record. RD M agreed that Resident #32 does have around a 6-pound gain weekly. In an interview on 10/02/24 at 10:39 AM, Registered Dietitian (RD) M stated that Resident #32 was aware of the fluid restrictions and that she is gaining weight. RD M stated that she spoke with the Resident #32 in regard to more account ability by the bedside water, we are just going to limit the water amounts and update her care plans. RD M stated that she did put a note in yesterday (10/1/2024) about the weight gain, the re-weigh we don't do because of the dialysis weights. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #41: Observation and interview on 10/01/24 at 08:17 AM with Resident #41 revealed that he had his gall bladder out and lost weight, but he thought that he should be gaining weight back. Observation of Resident #41 was noted to be lying in bed with a breakfast tray still at the bedside with most of the meal left on the plate. Record review of Resident #41's admission Minimum Data Set (MDS), date 6/25/2024, revealed an elderly male cognitively intact. Medical diagnoses: Medically complex conditions, anemia, coronary artery disease, hypertension, gastroesophageal reflux disease (GERD), benign prostatic hyperplasia (BPH), renal insufficiency, pneumonia, septicemia, diabetes, thyroid disorder, anxiety and depression. Section K: Swallowing/Nutritional Status- Weight 185, mechanically altered diet and therapeutic diet were noted. Record review of Resident #41's care plans, pages 1-24, revealed that the 'Alteration in nutritional status related to recent hospitalization , dysphagia, C. diff, pneumonia, diabetes, coronary artery disease, hypertension, chronic kidney disease stage 4, and anemia' initiated on 5/11/2024, with a revision on 8/29/2024 interventions added included: Provide diet as ordered 6/21/2024, Provide diet per physician order; mechanical soft texture, thin liquids, supplements as ordered 8/29/2024. Record review on 10/01/24 at 01:55 PM of Resident #41's weight log electronic medical record weight log revealed inconsistent weight monitoring: 6/4/2024 weight 192.4 Lbs. 6/9/2024 weight 180.6 Lbs. that was a loss of 11.6 pounds, no care plan intervention added. 7/2/2024 weight 169.0 Lbs. that was a loss of 16.2 pounds, no care plan intervention added. There was no re-weight for a week. 7/8/2024 weight 165.9 Lbs. that was a loss of 3.1 pounds, no care plan intervention added. Record review on 10/02/24 at 08:22 AM of the facility re-weigh policy identified that a resident with weight loss of 5 pounds or more would be re-weighed. In an interview and record review on 10/02/24 at 08:41 AM with Registered Dietitian (RD) M of the facility 'weight /Re-weight policy' revealed that Re-weigh policy did not have a time frame for re-weights to be performed. RD M stated that the re-weights should be performed within 48 hours, is what the RD would prefer. Facility Policy states that a re-weight of -/+5 (loss/gain) we should re-weigh. The State surveyor asked why not weighed more than once weekly? RD M stated that after Resident #41's weight went down to 175 pounds, the facility was only going by his weekly weight. An interview and record review on 10/02/24 at 10:43 AM with Registered Dietitian (RD) M of Resident #41's electronic medical records and weight log revealed that in June 2024 weight of 192.6 dropped on July 165.6 with a loss of 27 pounds with an -14.02% percent loss. RD M stated that Resident #41 has been in and out of the hospital and the last time he lost weight. RD M stated that the re-weight was not performed to verify actual resident weights.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to complete timely comprehensive activity assessments and ongoing programming to meet the interests of one resident (Resident #77) one resident reviewed for activities, resulting in, Resident #77's activity assessments not being completed since 03/2023 and a lack of activity programming to meet the resident's independent leisure pursuits. Findings Include: Resident #77: During initial tour on 10/1/2024 at 8:33 AM, Resident #77 was observed resting quietly in her room. When asked about activities she participates in, she stated many of the activities she physically cannot complete due to limited mobility in her hands. Resident #77 expressed prior to being admitted she was very active and always on the go and now she just lays in bed everyday with nothing to do. Resident #77 stated they have asked her to come to activities and watch the others participate as there would have been no adaptations made so she could fully participate. On 10/1/2024 at approximately 3:30 PM, a review was completed of Resident #77's medical records and it indicated she was admitted to the facility on [DATE] with diagnoses that included, Peripheral Vascular Disease, Tinea Unguium, Diabetes, Major Depressive Disorder, Anxiety and Polyneuropathy. Resident #77 is cognitively intact and able to make her needs known. Further review was completed of Resident #77's record and it yielded the following: Care Plan: (Resident #77) will initiate independent leisure activities of interest daily, attend group programs as interested and be provided/offered 1:1 room visits throughout the week until next quarter for increased opportunities of personal enjoyment and socialization . Activities Assessments: Resident #77 only had one Activity Assessment that was completed on 3/3/2023, which was her admission assessment. There were no other documented assessments completed for the resident. On 10/2/2024 at 9:20 AM, an interview was conducted with Activities Director N regarding Resident #77 lack of Activity Assessments and activities offered/adapted for the resident. Director N and this writer reviewed the activity assessments for Resident #77 and saw only one assessment from 3/2023. Director N stated the assessments should be completed every three months. She further explained she initially completes the assessment on paper and will input it into their respective charts within a week. Director N stated there should be assessments documented in the chart from her at this juncture. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director N was further asked what efforts were being made to adapt activities to meet her needs. She explained they spend extra time with her when delivering her meal tray. The director was asked if they have adapted any activities so she can participate fully with the group and she stated they had not. Director N was asked if there is any documentation of leisure purists attempted with the residents, rather its music in her room, an iPad to browse or making more efforts to get her out of bed maybe once a week. The Director state they did not have any documentation of this type. It can be noted Resident #77 did not have any activity assessment in over one year and there was nothing found indicating how they maintained her engagement or found alternative ways to entice and include her in programming at the facility. Review was completed of the facility policy entitled, Life Enrichment Programs, revised 5/23/2013. The policy stated, Activity program designed to meet the needs of each resident are available on a daily basis . individualized and group activities .reflect cultural and religious interests, hobbies, life experiences and personal preferences of the residents .

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F 0689 Level of Harm - 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** 37666 This Citation pertains to Intake Number MI00145400. Based on observation, interview and record review, the facility failed to provide a safe and monitored environment to prevent falls with injuries and fractures for one resident (Resident #30) of 2 residents reviewed for falls, resulting in Resident #30 having three falls with injuries and sustaining fractures with two of the falls. Findings Include: Resident #30: Accidents On 9/30/2024 at 11:01 AM, Resident #30 was observed in his room, lying in a low bed. The call light was in his hand. The resident said he fell in the hallway and once in the bathroom. He said he had hurt his arm and leg. A record review of the Face sheet and Minimum Data Set/MDS assessment indicated Resident #30 was initially admitted to the facility on [DATE] with diagnoses: Parkinsonism, arthritis, peripheral vascular disease, heart disease. The MDS Admission assessment dated [DATE] revealed the resident had severe cognitive decline with a Brief Interview for Mental Status (BIMS) score of 6/10 and had no upper or lower extremity limitation in range of motion. Resident #30 needed substantial-to-maximal assistance with all mobility. Fall on 06/07/2024: An Incident and Accident report dated 6/7/2024 said Resident #30 said, I walked into the hallway and fell in front of a door. A review of a Facility Reported Incident, dated 6/8/2024-6/17/2024, indicated that Resident #30 fell on [DATE] and reported that he was having pain in his right elbow. The resident said he had a fall and thought he broke his arm; his arm was assessed by the nurse to be slightly swollen and spongy. An x-ray was obtained and identified an acute fracture of the right olecranon (a bony prominence of the elbow). The resident was transferred to the emergency room and returned to the facility with a cast on his right arm. Per the facility investigation the incident was not witnessed by a staff member, but was witnessed by a visitor. A review of a Significant Change MDS assessment, dated 6/13/2024, indicated that the resident had fallen at the facility and suffered an injury. MDS section GG identified the resident to have Functional Limitation to one side of the upper extremity and both sides of the lower extremities. A review of the Care Plans for Resident #30 identified the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Risk for falls (related to) Parkinson's, dementia, (osteoarthritis) of bilateral hips, atrial fibrillation, unsteady gait, and muscle weakness. Fall with hip (fracture) (status post hip surgical repair), date initiated 5/1/2024 and revised 9/17/2024 with Interventions: Geri chair in upright position, date initiated 6/8/2024 and revised 6/10/2024; Scoop mattress to bed, date initiated 6/8/2024. The interventions did not address that the resident was walking on his own in the hallway. Fall on 06/29/2024: A review of an Incident and Accident report for Resident #30, dated 6/29/2024, revealed the following: Another guest (resident's) family came to me in the hall and explained that (Resident #30) was on the floor. Guest was on the floor on his bottom in front of the easy chair. Leg of over-the-bed-table was wedged under the heating unit. Guest states he was getting up to answer the door. CENA (nurse aide) explained to him that he doesn't walk anymore. Guest replied 'Oh, yeah' . Guest is very confused . A review of the Care Plans for Resident #30 identified the following: Risk for falls (related to) Parkinson's, dementia, (osteoarthritis) of bilateral hips, atrial fibrillation, unsteady gait, and muscle weakness. Fall with hip (fracture) (status post hip surgical repair), date initiated 5/1/2024 and revised 9/17/2024 with Interventions: Leave room door open, date initiated 7/1/2024 and updated 8/29/2024. Fall on 09/13/2024: A review of the Progress Notes for Resident #30 identified the following: 9/13/2024 at 4:32 PM, . Guest observed on floor at the foot of his bed. Sitting on his right side . abrasion/carpet burn to right elbow area. Recommends that staff continues to place guest bed in lowest position. 9/13/2024 at 4:59 PM, Guest observed on floor at foot of his bed. Guest has a carpet burn to right anterior arm . 9/14/2024 at 10:57 AM Incident Note, . Guest had no complaints of pain at time of fall but later (complained) of left hip pain Left hip x-ray, results show positive for acute fracture, dr made aware of results and gave order to send to ER for further evaluation . Root Cause: guest observed prior to fall safely in wheelchair in room . Guest stood independently and was unable to maintain balance and had a fall . 9/17/2024 at 5:50 PM, Admission Summary, Guest arrived to facility by (ambulance) . via stretcher. Guest has a 16 fr patent foley (urinary catheter) . Guest has an auacel dressing to left hip surgical site . small red area to left knee . (complains of) pain when moving (left lower extremity) . A review of the Care Plans for Resident #30 identified the following: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Risk for falls (related to) Parkinson's, dementia, (osteoarthritis) of bilateral hips, atrial fibrillation, unsteady gait, and muscle weakness. Fall with hip (fracture) (status post hip surgical repair), date initiated 5/1/2024 and revised 9/17/2024 with Interventions including: Encourage guest to participate in group activities, date initiated 9/13/2024. 1:1 activities, date initiated 9/182024; Bed in lowest position, date initiated 9/14/2024; Encourage family visits, 9/18/2024. Resident #30 was admitted to the facility on [DATE]. The basic interventions were not mentioned until the resident had fallen and injured himself numerous times. On 09/30/2024 at 11:08 AM, Nurse H was interviewed about Resident #30 and said she didn't normally work on his hall, but was today. When asked about fall prevention measures for Resident #30, she said she would have to check on it. On 10/1/2024 at 10:00 AM, Confidential Person O was interviewed about Resident #30 falling and suffering multiple injuries and fractures and said that the resident had a different chair previously and seemed to sit in it better. The Confidential Person said the resident looks uncomfortable at times. On 10/01/2024 at 10:26 AM, the Director of Nursing/DON was interviewed related to Resident #30's falls and reviewed the multiple incident reports of falls on 6/7/2024 when he fractured his right elbow; 6/29/2024 when he obtained an abrasion to the right arm that he previously injured and 9/13/2024 when he fractured his left hip. The DON was asked about the interventions to aid in preventing the resident from falling. Supervision of the resident was not identified as an intervention or an updated intervention. The DON said the facility had increased nursing staff overall in the building, as the Resident census had continuously increased throughout the year, but specific supervision and monitoring for Resident #30 was not addressed. The DON said the staffing on the resident's hall had not changed from prior to his falling. Reviewed the Care Plans for Resident #30 as several of the updated interventions after the 3rd fall on 9/13/2024, such as encourage group activities, were addressed in prior activities assessments after the resident was admitted on [DATE]. The interventions reviewed were not necessarily specific to the resident's falls. None of the falls were witnessed by staff and he was identified as at risk for falls and continued to fall and sustain serious injuries. A review of the facility Policy titled, Falls Reduction Program, origination date July 1, 2008 and revision date 9/25/2016, provided, Purpose: To provide a safe environment for residents, modify risk factors, and reduce risk of fall-related injury . Identify/analyze resident risk for fall .Implement and indicate individualized interventions on Care Plan/Kardex . Initiate safety interventions . Determine the need for ongoing assessments/interventions .

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F 0690 Level of Harm - Minimal harm or potential for 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. 39059 Based on observation, interview and record review, the facility failed to ensure that a urinary drainage bag and tubing was properly placed off the floor for one resident (Resident #46) of two residents reviewed for urinary catheters, resulting in the likelihood of cross-contamination and infection. Finding include: Resident #46: On 10/01/24, at 9:34 AM, Resident #46 was resting in their bed. Their urine drainage bag was hooked to bed frame and resting on the floor. A loop of the catheter tubing was on floor as well. On 10/01/24, at 9:40 AM, an observation along with CNA J of Resident #46's drainage bag and tubing was conducted. CNA J was asked if the bag and tubing was supposed to be on the floor and CNA J stated, no. On 10/01/24, at 9:45 AM, CNA J was observed placing a basin under the drainage bag and tubing. On 10/01/24, at 3:30 PM, a record review of Resident #46's electronic medical record revealed an admission on 4/25/2024 with diagnoses that included Dementia, Quadriplegia and stroke. Resident #46 required extensive assistance with all Activities of Daily Living and was severely cognitively impaired. A review of the (the resident) has 16 French indwelling foley catheter with 10 ml retention balloon related to urinary retention . Check catheter system every shift for pateny and integrity Date Initiated: 04/11/2024 . There was no intervention to ensure urine drainage bag and tubing was kept up off the floor. On 10/02/24, at 10:29 AM. Resident #46 was resting in their bed. Their urine drainage bag was hooked to bed resting inside a basin protecting it from the floor. According to the Healthcare Infection Control Practices Advisory Committee GUIDELINE FOR PREVENTION OF CATHETER-ASSOCIATED URINARY TRACT INFECTIONS 2009 . Maintain unobstructed urine flow . Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor .

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 22927 Based on observation, interview and record review, the facility failed to ensure timely re-weighs for weight loss or weight gain for two residents (Residents #32, Resident#41), resulting in a lack of weight monitoring completion, follow-up of abnormal weights, and the potential for unidentified nutritional deficiencies and a decline in overall health. Findings include: Record review of the facility 'Policy: Obtaining Weights and Re-weight Policy' undated, revealed each individual's weight will be determined and documented upon admission to the facility. Procedure: 1.) Nursing will be responsible for the initial determination of each individual's weight. Subsequent measurements for weight will be documented on the appropriate designated form or tracker in the computer database. Weight will be documented on the individual assessment instrument (MDS for nursing facilities), and in the medical nutrition therapy (MNT) assessment. Weight will be obtained weekly for 4 weeks after admission. Subsequent weights will be obtained monthly. unless physician orders or individual condition warrants frequent determinations. Re-weights will be done for a weight change of +/- (gain/loss) of 3# (pounds) for anyone under 100# pounds and for +/- (gain/loss) of 5# (pounds) for anyone 100 pounds and over. (2.) The Registered Dietitian (RD) or designee will be responsible for determining the desirable weight range Resident #32: Observation and interview on 09/30/24 at 10:03 AM with Resident #32 while the resident was seated at the edge of her bed revealed a left upper arm hemodialysis graft with dressing in place. Resident #32 stated that she had been getting hemodialysis treatments for 3 years and goes to dialysis on Tuesdays-Thursdays and Saturdays. Observation of bedside table noted two glasses of beverages. Observation of Resident #32's lower extremities noted skin tightness and possible edema. Record review of Resident #32's medical diagnosis list revealed: acute and chronic Respiratory failure with hypoxia, hypertension, metabolic encephalopathy, falls, seizures, end stage renal disease, cerebral infarction, heart failure, type 2 diabetes, chronic obstructive pulmonary disease, anxiety, Gastrostomy tube, muscle wasting, dysphagia, cognitive communication deficit, mild cognitive impairment, insomnia, dependence on renal dialysis, pneumonia, and anemia. Record review of Resident #32's electronic medical record weight log revealed inconsistent weight monitoring: 9/5/2024 weight 160.8 Lbs. 9/10/2024 weight 166.3 Lbs. that was a gain of 5.5 pounds, no care plan intervention added. 9/12/2024 weight 166.1 Lbs. 9/14/2024 weight 172.9 that was a gain of 6.8 pounds, no care plan intervention added. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/17/2024 weight 178.9 Lbs. was a gain of 6.0 pounds, no care plan intervention added. 9/19/2024 weight 182.8 Lbs. that was a gain of 3.9 pounds, no care plan intervention added. 9/21/2024 weight 189.9 Lbs. was a gain of 7.1 pounds, no care plan intervention added. The total weight gain in a 17-day period for Resident #32 who received hemodialysis treatment for renal failure was a total of 29.1 pounds. Record review of Resident #32's care plans pages 1-18 revealed that the 'Alteration in nutritional status related to recent hospitalization , diabetes, heart failure, end stage renal disease and peg tube' initiated on 7/29/2024, with a revision on 7/30/2024 and 9/20/2024 of offer evening snack and then revised after the state surveyor inquired about weight gain on 10/2/2024 with updated intervention of 'No pm/HS (bedtime) water. Record review of Resident #32's care guide Kardex dated 10/2/2024 revealed eating/nutrition: No pm/HS water, offer evening snacks, provide diet per physician order; Regular, thin liquids- Renal low sodium, diabetic modifications. In an interview and record review on 10/02/24 at 08:44 AM with the Registered Dietitian (RD) M of Resident #32's weight log revealed that Resident #32 was a hemodialysis resident that received treatment 3 days a week. The state surveyor inquired about Resident #32's estimated weight gain of about 6 pounds weekly, and her fluid status, how much was the resident drinking. The state surveyor and RD M discussed possible health crisis of fluid overload. The RD M stated that she did make the care provider (NP) aware, and each week notify the NP. Discussion of follow-up to the notifications and possible treatments were discussed. RD M stated weights for Resident #32 were taken from her post dialysis weights sent from the dialysis center and documented those in the medical record. RD M agreed that Resident #32 does have around a 6-pound gain weekly. In an interview on 10/02/24 at 10:39 AM with Registered Dietitian (RD) M stated that Resident #32 was aware of the fluid restrictions and that she is gaining weight. RD M stated that she spoke with the Resident #32 in regard to more account ability by the bedside water, we are just going to limit the water amounts and update her care plans. RD M stated that she did put a note in yesterday (10/1/2024) about the weight gain, the re-weigh we don't do because of the dialysis weights. Record review of Resident #32's Nurse Practitioner (NP) note dated 9/9/2024 at 1:17 PM noted resident eating most meals and sometimes more, discussion with dietitian, will discontinue bolus (tube feedings) feeds at this time There were no other care provider notes regarding weight gains. Resident #41: Observation and interview on 10/01/24 at 08:17 AM with Resident #41 revealed that he had his gall bladder out and lost weight, but he thought that he should be gaining weight back. Observation of Resident #41 was noted to be lying in bed with a breakfast tray still at the bedside with most of the meal left on the plate. (continued on next page)

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Wellbridge of Grand Blanc	3139 East Baldwin Road Grand Blanc, MI 48439

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #41's admission Minimum Data Set (MDS) date 6/25/2024 revealed and elderly male cognitively intact. Medical diagnosis: Medically complex conditions, anemia, coronary artery disease, hypertension, gastroesophageal reflux disease (GERD), benign prostatic hyperplasia (BPH), renal insufficiency, pneumonia, septicemia, diabetes, thyroid disorder, anxiety and depression. Section K: Swallowing/Nutritional Status- Weight 185, mechanically altered diet and therapeutic diet were noted. Record review on 10/01/24 at 01:55 PM of Resident #41's weight log electronic medical record weight log revealed inconsistent weight monitoring: 6/4/2024 weight 192.4 Lbs. 6/9/2024 weight 180.6 Lbs. that was a loss of 11.6 pounds, no care plan intervention added. 7/2/2024 weight 169.0 Lbs. that was a loss of 16.2 pounds, no care plan intervention added. There was no re-weight for a week. 7/8/2024 weight 165.9 Lbs. that was a loss of 3.1 pounds, no care plan intervention added. Record review on 10/02/24 at 08:22 AM of the facility re-weigh policy identified that a resident with weight loss of 5 pounds or more would be re-weighed. In an interview and record review on 10/02/24 at 08:41 AM with Registered Dietitian (RD) M of the facility 'weight /Re-weight policy' revealed that Re-weigh policy did not have a time frame for re-weights to be performed. RD M stated that the re-weights should be performed within 48 hours, is what the RD would prefer. Facility Policy states that a re-weight of -/+5 (loss/gain) we should re-weigh. The State surveyor asked why not weighed more than once weekly? RD M stated that after Resident #41's weight went down to 175 pounds, the facility was only going by his weekly weight. In an interview and record review on 10/02/24 at 10:43 AM with Registered Dietitian (RD) M of Resident #41's electronic medical records and weight log revealed that in June 2024 weight of 192.6 dropped on July 165.6 with a loss of 27 pounds with an -14.02% percent loss. RD M stated that Resident #41 has been in and out of the hospital and the last time he lost weight. RD M stated that the re-weight was not performed to verify actual resident weights.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review the facility failed follow physician's orders for enteral feeding for one resident (Resident #83) of one resident reviewed for enteral feeding, resulting in the resident not receiving the ordered amount of enteral feeding. Findings Include: Resident #83 (R83): Resident #83 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include, aphasia, dysphagia and history of a transient ischemic attack. On 09/30/24 at 10:04 AM, R83 was observed in bed, well dressed, groomed and free of any odors. Observation revealed that R83 had their enteral feeding infusing, the rate of the infusion on the pump was set at 70 ml/hr, the bottle of Glucerna was dated 09/30/24, dated for a start time of 09/29/24 at 11:00 pm. On 10/01/24 at 09:30 AM, observation revealed that R83 had their tube feeding infusing at 70ml/hr. The bottle of Glucerna was dated 10/01/24 and was dated for a start time of 09/30/24 at 11:00 pm. On 10/01/24 at 02:19 PM, record review of the EMR (Electronic Medical Record) revealed a physician order dated 09/27/24 for two times a day Glucerna 1.5 at 75ml/hr for 16 hours, providing 1200cc total volume, 1800kcal, 98gm of protein and 900cc of free water. Another physician order dated 09/27/24 revealed, two times a day 75cc/hr water flush while tube fee infusing. On 10/01/24 at 02:20 PM, record review in the EMR revealed a care plan for at risk for alterations in nutritional, an intervention in the care plan stated, provide diet per physician order; npo diet and tube feed: Glucerna 1.5 @ 75cc/hr for 16 hours, providing 1200cc total volume, 1800kcal, 98gm of protein, 900cc of free water and 75cc/hr for 16 hours water flush providing total of 2418cc of free water daily. On 10/01/24 at 02:22 PM, record review in the EMR revealed R83 weighed 166 lbs on 9/4/24 and weighed 157.2 lbs on 09/30/24 157.2. This was a 5.6% weight loss in that time span. On 10/02/24 at 10:10 AM, an interview was conducted with the RD (Registered Dietitian). RD M was asked why was the enteral feeding rate changed from 60cc/hr to 75cc/hr? RD M stated that R83 had experienced weight loss recently, so the decision was made to bumped up to 75cc/hr to increase caloric intake. RD M was asked who is responsible for setting the rate on the enteral feeding pumps? RD M stated that the nurses are ultimately responsible for setting the rate on the pump based on the physician's order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/02/24 at 10:21 AM, the DON (Director of Nursing) was made aware the that enteral feeding rate had been set at 70ml/hr for the first two days of survey. instead of the 75ml/hr as ordered. The DON stated they recognized the rate was set at 70ml/hr on 10/01/24 at around 10:00 am and they changed the rate to 75ml/hr as ordered. The DON was asked who is responsible for ensure the correct rate of infusion on the pump. The DON stated that the nurses on the floor are responsible for setting the rate on the pump. Record review of the policy titled; Enteral Nutritional Feeding revised 09/23/19 revealed: Procedure: 5. If continuous feeding is ordered set the feeding pump at the ordered rate.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 Based on interview and record review, the facility failed to provide medications as ordered for one resident (Resident #113) of one resident reviewed for pain management, resulting in Resident #113 experiencing pain and calling 911 and leaving the facility. Findings Include: Resident #113: A record review of the electronic medical record indicated Resident #113 was admitted to the facility on [DATE] at 9:50 PM with diagnoses: recent left knee joint replacement, pain, arthritis, anxiety, hypothyroidism, atrial fibrillation, asthma, claustrophobia, anemia, and essential tremor. The resident discharged back to the hospital a few hours later on 7/30/2024 at approximately 1:23 AM. A record review of the progress notes for Resident #113 revealed the following: 7/30/2024 at 1:23 AM, a Skilled Charting note, Guest alert and oriented and ale to make needs known, guest called 911 to be took back to the hospital because she didn't get her pain medication when she asked. When I tried to explain to her what was going on she started yelling and being very rude. I contacted on call provider and then sent her out. 7/30/2024 at 1:42 AM, a Skilled Charting note by Nurse P, Guest alert and oriented and able to make needs known, guest called 911 to be taken back to the hospital because she didn't get her pan medication when she asked, when I tried to explain to her what was going on she started yelling and being very rude, I contacted on call provider and then sent her out. There were no additional progress notes related to the resident's admission or stay. There was no admission assessment or vital signs. A review of the electronic medical record identified the following: A review of the Pain Level Summary report for Resident #113 identified it was blank. There were no pain assessments for the resident. A review of the Physician orders for Resident #113 revealed the following orders: Tramadol 50 mg, 1 tablet by mouth every 6 hours as needed, (a pain medication), to be started on 7/29/2024 at 11:30 PM. Oxycodone 10 mg, one tablet by mouth every 3 hours as needed for pain, to be started on 7/29/2024 at 11:15 PM. Acetaminophen (Tylenol) 500 mg, 2 tablets four times a day, to be started 7/30/2024 at 8:00 AM. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Buspirone 10 mg, 1 tablet by mouth two times a day for anxiety, to start 7/30/2024 at 7:00 AM. Resident #113 had a variety of additional medications to start on 7/30/2024 in the morning or evening. A review of the July 2024 Medication Administration Record/Treatment Administration Record (MAR/TAR) for Resident #113 revealed the resident did not receive pain medications or any medications during her stay at the facility. Transfer/Discharge Report for Resident #113 indicated the resident was admitted to the facility on [DATE] for Aftercare following Joint replacement surgery and was discharged back to the hospital on 7/30/2024 at 1:07 AM. An Interact Transfer Form, dated 7/30/2024 at 11:48 AM and locked on 7/30/2024 at 3:47 PM revealed Resident #113 was admitted to the hospital on 7/29/2024 at 2150 (9:50 PM) with Primary Diagnosis for Admission to your Facility: Aftercare Following Joint Replacement Surgery. The document indicated the resident was capable of making her own decisions and had requested to leave. On 10/1/2024 at 2:00 PM, the Administrator was interviewed and the surveyor asked to speak with the DON and her to review the Resident #113's stay at the facility and discharge. On 10/2/2024 at 9:05 AM, the Administrator and Corporate Nurse Q were interviewed about Resident #113's admission, stay and discharge, they said they would review the chart and get back with me. On 10/02/2024 at 10:00 AM, the Administrator was interviewed about Resident #113, she said she spoke with the Nurse caring for the resident, and sent all of the chart information. She said the resident was admitted late to facility about 10:42 PM on 7/29/2024, and at 11:45 PM, the resident asked for a pain pill; she wanted oxycodone. The Administrator said the nurse was working on obtaining the physician orders, and was awaiting pharmacy approval for the narcotic. She said she offered the resident Tylenol and she didn't want it; she became upset and called for an ambulance at 1:23 AM. She said the nurses note at 1:45 AM detailed the resident called the ambulance because she didn't receive her pain medication. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	During the interview on 10/2/2024 at 10:00 AM, the Administrator was asked if the facility had the resident's pain medication in the medication dispensing system and she said the oxycodone was in the medication dispense machine, but the nurse was processing the orders and the resident would not wait. The nurse said the resident left AMA (against medical advice) and she provided basic discharge paperwork for the ambulance/ EMS. The Administrator called the resident in the hospital when she was told about her leaving AMA and the resident said the nurse should have known she would need the pain medication. The Administrator was asked why the resident was admitted so late in the evening and she said sometimes patients were admitted late in the day. The Administrator was asked if preparations were arranged to accommodate the resident's needs, as she had recently had surgery and was sent with pain medication orders from the hospital. The Administrator said the resident was very upset that she did not receive pain medication. Reviewed the process for late admissions with the Administrator and if the resident's could receive the medications they needed? She said from the time the resident asked for the pain medication 11:45 PM until the resident left was about 1.5 hours and the nurse was actively trying to get everything ready (the resident admitted to the facility at 9:50 PM and discharged after 1:00 AM: which was a little over 3 hours). The Administrator said the orders for Oxycodone and Tramadol said, On order. The Administrator said she again tried to contact Resident #113, but she transferred from the hospital to a different nursing home.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Post nurse staffing information every day. 22927 Based on observation, interview, and record review, the facility failed to ensure clinical staff posting of licensed and un-licensed staff levels were posted in a visible area for residents and visitors to review, resulting in the inability for residents and visitors to know what clinical staff were working on those days. Findings include: According to the State Operations Manual (SOM) reflected The facility must post the total number and actual hours worked by licensed and un-licensed nursing staff directly responsible for the resident care per shift to include registered nurses Licensed Practical Nurses and Certified Nursing Aides. The SOM guides that the facility must Ensure staffing information is posted in a prominent place readily accessible to residents and visitors Observation on 9/30/2024 at 8:47 AM upon entrance to the facility in the front lobby there was no identified clinical staff level posting visible upon looking around entry. Observation on 9/30/2024 at 10:07 AM review of 100 hall and 600 hall reviewed for clinical nursing staffing hours to be posted for resident review, none were found. On 9/30/2024 at 4:09 PM during the survey team meeting of surveyors revealed that there were no clinical nursing/staffing hours posting found within the resident care areas. Observation on 10/1/2024 at 7:07 AM review of the front reception area revealed there to be no clinical licensed staffing hours posting visible. Review of the 100 and 600 resident living halls revealed that there were no clinical nursing hours public posting found for residents to review. Observation and interview on 10/02/24 at 09:40 AM with the Human Resource (HR) director E The state surveyor had to request the HR Director locate the clinical nursing hours public posting, that was not located by the surveyor. the HR Director took the surveyor to the front lobby seated area and located the 'Staffing Report & Concerns Contact' form dated 10/2/2024 within in a white binder in front lobby, tucked into the back side of the front cover. census 122, on the back side of the form was located the nursing hours: 7 am-3 pm RN's 7/Plans 4, 3 pm-11 pm RN's 3/Plans 10, 11 pm-7 am RN's 1/Plans 6. The public white binder was located on a low-level coffee table located in the front lobby, 'Public Information' on front of binder.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059 Based on observation, interview and record review, the facility failed to care plan an antipsychotic injectable medication (Invega) and to ensure community mental health services coordination of care for one resident (Resident #467) out of one resident reviewed for community mental health services, resulting in feelings of worry and concern with the likelihood of an overall decrease in psychosocial well-being. Findings include: Resident #467: On 10/01/24, at 8:48 AM, Resident #467 was resting in their bed. They voiced a concern about going home and that they needed to talk to their HOPE case manager because they were discharging in a few days. The resident repeated their concern twice and offered the name of their case manager. On 10/01/24, at 2:30 PM, a record review of Resident #467's electronic medical record revealed an admission on 09/16/2024 with diagnoses that included schizoaffective disorder, bipolar disorder and anxiety. Resident #467 required assistance with Activities of Daily Living and had intact cognition. A review of the PREADMISSION SCREENING (PAS) RESIDENT REVIEW (ARR) Date 09/19/2024 revealed the change of condition was check marked. At the time of the initial record review there was no ARR nor a level 2 follow up letter. A review of the physician orders revealed no order to coordinate care with community mental health services. A review of the Discharge Planning has been initiated upon admission. Has 2 ww (wheeled walker) lives alone . Revision on 09/18/2024 . Plans to discharge home alone . PASSAR recommendations are followed as recommended . There was no mention of Resident #467 being involved in community mental health services through the HOPE network. A review of the Potential for alteration in psychosocial well-being related to New environment, tardive dyskinesia, schizoaffective, bipolar, anxiety Date Initiated: 09/17/2024 care plan revealed no mention of community mental health services, HOPE network and or their case manager contact information. A review of the (the resident) is at risk for behavior symptoms r/t (related to) anxiety, bipolar, and schizoaffective disorder with delusions . + Trauma assessment: sexual abuse, physical abuse, human suffering, stressful events, stressful events at home hx (history) of suicide attempt [AGE] years ago Date Initiated: 09/17/2024 . care plan revealed Administer medications as ordered. There was no mention of HOPE network community mental health involvement and the antipsychotic injectable medication Invega and how it was provided. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/01/24, at 1:50 PM, Social Worker L was asked if they had met with or assessed Resident #467 and SW L offered, I have not and that they started in the facility on 9/26/24. On 10/01/24, at 2:01 PM, transitional care coordinator D was interviewed regarding Resident #467's and their community mental health services. TCU D offered that they contacted the case manager and had a meeting scheduled for the afternoon in the residents room. On 10/01/2024, at 2:10 PM, the Administrator was asked who was responsible for the PASSAR's and Level 2 letters and the Administrator stated they were. The Administrator was alerted the PAS for Resident #467 was check marked change of condition and that there was no ARR nor Level 2 in the electronic record. On 10/01/24, at 2:24 PM, Resident #467 was lying in their bed and offered that (HOPE case manager) would be coming by within the hour to visit. Resident #467 was asked how often their case manager visits while they are home and Resident #467 offered weekly and that they have had their case manager for [AGE] years. On 10/01/24, at 2:49 PM, Unit Manager I was interviewed regarding Resident #467's Invega medication and their community mental health services. UM I offered that they got the Invega from the HOPE network case manager and that the resident is due for an injection on 10/7/24. A record review along with UM I of Resident #467's discharge medication list and orders for the Invega revealed that the resident had received two partial doses prior to admission with the last dose given on 8/30/24 and that a full dose would be due on 10/7/24. UM I offered that they have the medication inhouse and that the HOPE network brought it in for the resident and that the facility would be administering the medication. UM I was further questioned regarding psychological services being provided for Resident #467 and UM I offered they initiated the behavior care plan with ongoing management with social work. UM I was asked who initiated the discharge planning and UM I offered, that nursing tells (TCU D) and that the transitional care coordinator does the discharge planning and also communicates with the facility provided psychotherapy services. UM I was alerted the resident was concerned because they were discharging in a few days and was worried about their HOPE network services and UM I pulled up the discharge list in the electronic medical record which revealed the resident was discharging with home health care to an assisted living facility and there was no mention of the HOPE network/community mental health services. UM I was alerted that the resident stated they were going home to their apartment (apartment complex name) and UM I searched the name of the apartment and offered that it is a private apartment and not an assisted living facility. On 10/02/2024, at 1:00 PM, a further record review of the (the resident) is at risk for behavior symptoms r/t (related to) anxiety, bipolar, and schizoaffective disorder with delusions . + Trauma assessment: sexual abuse, physical abuse, human suffering, stressful events, stressful events at home hx (history) of suicide attempt [AGE] years ago Date Initiated: 09/17/2024 revealed an added Focus .Guest receives outside services through Hope Network CMH (community mental health) . Revision on: 10/02/2024 . There was still no mention of the Hope Network case manager name nor contact information and who supplied the antipsychotic medication Invega.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 22927 Based on interview and record review, the facility failed to obtain consent for antipsychotic usage for one resident (Resident #53), resulting in Resident #53 being administered an antipsychotic medication without the appropriate consent and risk-versus-benefit analysis of the medication explained to the resident or the resident's responsible party and the increased likelihood for serious side effects and adverse reactions. Findings include: Record review of the facility 'Use of Psychotherapeutic medications' dated 6/23/2019 revealed a resident will not receive psychotherapeutic medications unless such a medication is needed to treat a specific condition as diagnosis and documented . Assessment and documentation: ii.) Informed consent from the resident and/or responsible party along with education regarding potential side-effects. Record review of the 'Nursing 2017 Drug Handbook' Wolters Kluwer 2017 page 156, Abilify antipsychotic medication adverse reactions included: increased suicide risk, neuroleptic malignant syndrome, seizures, hostility, tardive dyskinesia Resident #53: Record review of Resident #53's medical diagnosis list tab in the electronic medical record revealed diagnoses included: vascular dementia with agitation, psychotic disorder with hallucinations due to unknown physiological condition, major depressive disorder recurrent, dementia in other diseases classified elsewhere, mild, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review on 10/01/24 at 02:02 PM of Resident #53's the physician orders noted Abilify (antipsychotic) was started July 13th, 2024, for depression. Record review of Resident #53's Medication Administration Records, July through October 2024 revealed that the resident did receive the Abilify antipsychotic medication. Record review of Resident #53's nursing progress note dated 7/13/2024 at 7:21 PM noted Brief Interview of Mental status (BIMS) score of 7 out of 15, cognitively impaired. Resident #53 received Aripiprazole (Abilify) 2mg. In an interview on 10/01/24 at 03:04 PM with the Transitional Care Coordinator D who performed social services duties identified the medication 'Abilify' classification as antipsychotic, which needs a consent for use that is obtained by nurses. The Transitional Care Coordinator D Checked the informed consents tab of the electronic medical records and only found consents for medications of trazadone (antidepressant) and Lexapro (antidepressant), there was no Abilify consent found in the medical record. Transitional Care Coordinator D stated that there should be a consent the nurses obtain consent. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235171	A. Building B. Wing	10/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Grand Blanc	3139 East Baldwin Road Grand Blanc, MI 48439

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	In an interview on 10/01/24 at 03:12 PM with unit manager Registered Nurse (RN) C revealed that Abilify is an antipsychotic and that yes it needs a consent. RN C stated that she did not know why nursing would not have gotten a consent. Record review of Resident #53's psych services note dated 8/1/2024 noted Abilify in use. Record review of the informed consent tab noted only trazadone and Lexapro med consents. In an interview on 10/01/24 at 03:24 PM with RN C revealed that she investigated the resident's medical record, and that the facility missed the initial assessment for the Abilify, and that the facility would call the daughter and have an assessment done. Record review of Resident #53's electronic medical record revealed that there was no risk-verse benefit located within the medical record for the antipsychotic medication Abilify.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 22927 Based on observation, interview and record review, the facility failed to ensure that 8 of 19 medication punch cards in the 100 Hall Controlled/Narcotic substance medication cabinet were free of puncture holes, resulting in the likelihood for misappropriation of medication by one narcotic punch card to have 2 tablets with taped over punch holes noted upon inspection and the likelihood of cross contamination and ineffective medications. Findings include: Record review of the facility 'Controlled Substances' 2001 MED-Pass, Inc. (revised December 2012 policy dated) revealed the facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of Schedule II and other controlled substances. Policy Interpretation and Implementation: #8.) Unless otherwise instructed by the Director of Nursing Services, when a resident refuses a non-unit dose medication (or it is not given), or a resident receives partial tablets or single dose ampoules (or it is not given), the medication shall be destroyed and may not be returned to the container. #9.) Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services. Record review of the facility 'Discarding and Destroying Medications' 2001 MED-Pass, Inc. (revised April 2007 policy dated) revealed medications that cannot be returned to the dispensing pharmacy (e.g., non-unit-dose medications, medications refused by resident, and/or medications left by residents upon discharge) shall be destroyed. Medication Storage and Labeling: Observation and interview on 10/01/24 at 07:20 AM with Licensed Practical Nurse (LPN) A of the 100-hallway controlled substance medication storage cabinet revealed that Resident #48's medication Armodafinil 50mg punch card was noted to have two tablets punched with tape covering the holes, to hold the medication into the punch card. LPN A stated that she had not started the morning medication pass yet, stating the shift started at 7:00 AM. LPN A stated that the Armodafinil count looked off because the punch card had clear punches noted and LPN A counted 20 tablets when there were actually 22 tablets in the card. LPN A stated that it must have been the night shift nurse that taped up the holes and did not know why she did not waste the tablets. In an observation and interview on 10/01/24 at 07:26 AM, the Director of Nursing Services (DON) was shown the Armodafinil medication punch card with taped up holes and stated that no we do not tape up the punched holes it should have been wasted. The DON finished punching out the taped over holes and walked the two tablets to her office to waste the tablets with LPN A. There was no Drug buster jug in her office, then the DON walked away with the tablets to the stock room. The Surveyor requesting narcotic storage and administration policies, medication waste policy and the Infection control cross contamination policy with taped up narcotic punch cards. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on 10/01/24 at 07:42 AM, LPN A and the Director of Nursing Services (DON) reviewed the rest of the medication/narcotics in the 100-hallway narcotic cabinet, there were 6 more narcotic punch cards punctured through on medications not administered found. The holes were small in size of either a fingernail puncture or a point of an ink pen that pierced the back of the cards: Unsampled Resident #12 lorazepam 0.5mg, Unsampled Resident #91 lorazepam 0.5mg, Sampled Resident #47 Norco 5/325, Unsampled Resident #56 Norco 5/325, and Sampled Resident #48 had two punctured punch cards of Acte-cod #3 300mg, times 2 punch cards.

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F 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. 38471 Based on interview and record review, the facility failed to employ a qualified social worker on a full-time basis to meet the psychosocial, mental, and behavioral health care needs of the residents. This deficient practice had the potential to affect all 124 residents that reside within the facility. Findings Include: On 10/1/2024 at 12:05 PM, an interview was conducted with Transitional Care Coordinator D regarding her role at the facility. Coordinator D explained while she does assist with social work roles, she is not a qualified Social Worker but is currently enrolled in a Bachelor of Social Work program. She shared a Social Worker from a sister facility does review assessments she completes and sends edits if needed. On 10/1/2024 at 1:15 PM, an interview was conducted with the Administrator regarding fulfilling their social worker position. The Administrator stated their Social Worker resigned with no notice on December 21, 2023. On August 29, 2024, a new social worker was hired with the start date of September 23, 2024, but she never showed up for orientation and informed the facility she accepted another position elsewhere. As of September 26, 2024, two social workers from sister facilities began splitting the full-time status at the facility and are in the building Monday to Thursday. On 10/1/2024 at approximately 4:40 PM, a review was completed of the facility's license which indicated they were certified for 128 beds. Review was completed of the job description for Director of Care Transitions it stated, .Education: Bachelor's degree in a human services field including, but not limited to: social work, sociology, special education, rehabilitation counseling, and psychology. Master's Degree Preferred . On 10/2/2024 at 11:50 AM, the Administrator shared they received a Medicaid Bed Count waiver beginning January 1, 2024, and ending June 30, 2024, which decreased their bed count to 116. The administrator provided the document for this writer to review that indicated on July 1, 2024 their bed count was back to 128 from 116.