STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235470	A. Building B. Wing	12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bellbrook	873 W Avon Rd Rochester Hills, MI 48307

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review the facility failed to thoroughly and accurately investigate allegation(s) of staff to resident physical/verbal abuse for one (R91) of two residents reviewed for abuse. Findings include: On 12/16/24 at approximately 11:02 AM, R91 was observed sitting in a wheelchair in their room. The resident was alert and able to answer questions asked. R91 noted that they were at the facility to obtain physical therapy following a fall at their assisted living home located on the same property as the facility. R91 reported that they wanted to get back to their assisted living home and was not happy at the facility. They noted that a male staff member (herein after Certified Nursing Assistant/CNA D) was very rude, disrespectful and grabbed their wrist. R91 noted that the incident happened about two weeks ago, possibly the first week in December. When asked if they reported the incident to any staff members, R91 reported that they had talked with the Administrator/Abuse Coordinator and pulled out a piece of paper that noted CNA D's first name and also the name of the Administrator. A review of R91's clinical record noted the resident was initially admitted to the facility on [DATE] with diagnoses that included: fracture of left femur and history of falls. A review of resident Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 13/15 (cognitively intact cognition). *It should be noted that there were no documents in the resident's clinical record that addressed any allegations regarding rough and/or rude treatment. A request for all IA (investigation/accident) reports and/or grievances was made on 12/16/24 at approximately 3:38 PM. On 12/16/24 at approximately 3:58 PM, the facility responded with two grievances and two IAs. Neither mentioned anything regarding the allegation pertaining to CNA D being rude, disrespectful and grabbing R91's wrist. Nothing else was provided on 12/16/24. On 12/17/24 at approximately 2:35 PM, an interview was conducted with the Administrator/Abuse Coordinator. The Administrator was asked again if there were any additional IA/Grievances pertaining to R91. They responded No. At that time the Surveyor reported that R91 had made an allegation that CNA D was rude, disrespectful and grabbed their wrist. It was also reported to the Administrator that R91 had a piece of paper that noted CNA Ds name as well as their signature. Again, the Administrator noted that they did not recall the actual incident and noted that perhaps they missed a concern form. The Administrator could only recall that at times R91 makes inappropriate racial slurs. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 12/17/24 at approximately 3:36 PM, the Administrator provided an additional Grievance/Complaint report that documented, in part, the following: Date received: 12/5/24 .Resident name (R91) .Grievance/complaint reported to .Administrator . other: Clinical Coordinator (CC)A . Describe grievance/complaint: Customer service/care concerns with CNA D .Documentation of follow-up by CC A: Date assigned: 12/5/24 .What actions was/were taken to resolve grievance/complaint (be specific) .Removal of CNA from care of elder per elder request .Resolution: CNA A removed from elder care per elder request .Form completed by: CC A and Grievance officer/ Administrator on 12/5/24. On 12/17/24 at approximately 3:49 PM, an interview was conducted with Clinical Coordinator A regarding the grievance noted above, what was alleged by R91 and what Customer service/care concerns referred to. CC A reported that they recalled talking to R91 who noted that CNA D did not have a good attitude and was rough and rude. CC A could not recall as to the specifics regarding rough and rude. CC A did note that R91 asked that CNA D not work with them. CC A noted that they spoke with CNA D who did not recall any issues with R91 on or about 12/5/24 but noted that the CNA noted that R91 made rude comments to them, and they did not like it. CNA Ds personnel record was reviewed there was no indication in the record that detailed R91's allegation, no documents that noted they should not work with R91 or further education regarding Customer/Service Care. The facility schedule for the month of December 2024 noted that CNA D worked on 12/6/24 the day after the allegation. An attempt to contact CNA D was made on 12/17/24 at approximately 5:43 PM. A voice message was left. No return call was made prior to the end of the Survey. The facility policy titled Abuse, Neglect (Revised August 2022) was reviewed and documented, in part, the following: .Policy: This Community will not tolerate verbal .physical, or mental abuse .Any resident .may file a complaint with this Community's Administrator .or with any other officials .Alleged Violation .is a situation or occurrence that is observed or reported by staff, resident .but has not been investigated .Identification of inappropriate behavior of staff, such as derogatory language, rough handling .Protection: .The Community will take all action necessary to prevent the abuse .while it is conducting its investigation of the incident .if Staff is accused or suspected: immediately remove from the Community and the work schedule pending the outcome of the investigation .Investigation .The investigation shall be completed, whenever possible, within twenty-four (24) hours after the Administrator has knowledge of the incident, but the investigation should not take longer than five (5) working days .

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on interview and record review the facility failed to timely transmit Minimum Data Set (MDS) assessments to the Centers for Medicare and Medicaid Services (CMS) within 14 days after completion for two (R311 and R333) of three residents reviewed for resident assessments. Findings include: According to the CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 Manual v1. 17.1, effective 10/1/2019, .Submission files are transmitted to the QIES (Quality Improvement and Evaluation System) ASAP (Assessment and Submission and Processing) system using the CMS wide area network .Transmission requirements apply to all MDS 3.0 records used to meet both federal and state requirement .must be submitted with 14 days of the MDS Completion Date (Z0500B + 14 days) .For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by the QIES ASAP system. This confirmation information includes the files submission identification number (ID), the date and time the file was received for processing as well as the file name . The facility reported there was no actual policy for MDS transmitting. Review of R311's clinical record revealed the resident was initially admitted to the facility on [DATE], with diagnoses that included: Atrial Fibrillation and diabetes type II. The resident was discharged from the facility on 8/13/24. Review of the MDS dated [DATE] documented sections C, D, E, Q and Z had not been completed and the MDS was 120 days overdue. Review of R333's clinical record revealed the resident was initially admitted to the facility on [DATE], with diagnoses that included: acute fracture and Atrial Fibrillation. Review of the MDS dated [DATE] revealed section Z was not signed/completed. On 12/17/24 at approximately 6:40 PM, the facility MDS Nurse E, was interviewed and asked why R311 and R333 MDS was not completed and submitted to CMS in a timely manner. MDS Nurse E noted that with respect to R311, Social Services failed to complete their portions of the MDS and for R333 there was a failure to sign and submit.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview and record reviews the facility failed to ensure an Annual Resident Review (ARR) level I screening was completed and submitted annually for a level II OBRA (Omnibus Budget Reconciliation Act of 1993) evaluation for one (R2) of one resident reviewed for PASARR's (Preadmission Screening Annual Resident Review). Findings include: On 12/15/24 at 10:08 AM, R2 was observed sitting in their wheelchair sleeping. With verbal stimuli R2 was easily awakened. A brief interview was attempted with the resident at that time. A review of the medical record revealed R2 was admitted to the facility on [DATE], with diagnoses that included: dementia, dysthymic disorder, anxiety disorder, psychotic disorder with delusions, major depressive disorder, adjustment disorder and hoarding disorder. Further review of the medical record contained a Level I Screening (ARR) dated 7/26/2023. A Level II screening exemption criteria document was noted with the physician electronic signature and dated 7/26/2023. The medical record did not contain a completed and submitted Level I or Level II screening for the year of 2024. On 12/17/2024 at 9:10 AM, Social Worker Technician (SWT) G and Social Worker Helper (SWH) H was interviewed and asked to provide the Level I and Level II PASARR screening for R2. SWH H stated they had a bunch of PASARR's that needed to be scanned in the resident charts. SWH H stated they would look through the pile and provide R2's PASARR's for review. At 11:36 AM, the Level I and Level II exemption documents from 2023 was provided by the Administrator and Director of Nursing (DON). At 11:51 AM, the Administration team (Administrator and DON) was asked if they had any Level I or Level II PASARR screening for the year of 2024. At 12:44 PM, the Administrator stated R2's annual was submitted to OBRA and the facility had not received a response for the Level II determination. At this time the Administrator was asked to provide the Level I (annual) screening submitted. Review of a Level I screening dated 12/17/2024 was provided. This indicated the facility failed to ensure a Level I screening was completed timely and before being requested by the surveyor. No further explanation or documentation was provided by the end of the survey.

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00148291. Based on interview and record reviews the facility failed to timely notify the Physician and/or practitioner of an identified change of condition and failed to monitor/assess the resident once the change of condition was identified for one (R140) of one resident reviewed for a change of condition, resulting in a delayed notification to the physician and delayed interventions and care/treatment. Findings include: A review of a complaint submitted to the State Agency (SA) included concerns of the facility staff to have failed to properly assess and seek appropriate treatment following a change in R140's condition. Review of the medical record revealed R140 was initially admitted to the facility on [DATE] with diagnoses that included dementia and the need for personal care assistance. Review of the progress notes documented the following: On [DATE] at 10:43 AM, a Nursing note documented in part . had episode at breakfast this am (morning)- took spoonful of oatmeal and started to cough was able to spit oatmeal out with encouragement and took some orange juice. Vss (vital signs stable) and lungs are clear-elder is in no distress. Will monitor . On [DATE] at 10:17 PM, a Nursing note documented in part . appetite poor for supper, drank approx. 50% of ensure . On [DATE] at 2:21 PM, a Nursing note documented in part . seen by speech therapist- no coughing episodes noted ate few bites of oatmeal and little bit of orange juice. No appetite for lunch . On [DATE] at 1:39 PM, a Nursing note documented in part . Patient asleep most of the shift. Patient not able to arouse during meals ate 0% of breakfast and lunch. Medication not given due to the patient not being able to awake throughout the shift . The above note was modified twice. The first modification of the [DATE] Nursing note completed at 2:44 PM, inserted the following . Patient family has been aware of moms condition today bp (blood pressure) ,d+[DATE], [NAME] <sic> 96.8, spo2 (oxygen saturation level) 96%, hr (heart rate) 94, resp (respirations) 14 . The second modification of the [DATE] Nursing note completed at 2:51 PM, changed the previous respiration rate of 14 to 20. The [DATE] note was documented and modified by Licensed Practical Nurse (LPN) I. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the medical record revealed no documented time the above vitals were obtained on [DATE] and no documentation of additional vitals obtained or monitoring conducted after the identified change of condition for R140. Further review of the medical record revealed no immediate notification to the physician or practitioner regarding the identified change of condition for R140. Review of a facility policy titled Change in Resident's Condition updated [DATE], documented in part . The community will promptly notify the resident, his/her attending physician . of changes in the resident's medical/mental condition and/or status . The nurse supervisor/charge nurse will notify the resident's attending physician or on-call physician when there has been . a significant change in condition: physical/emotional/mental . refusal of treatment or medications (two consecutive times) . a need to transfer the resident to a hospital/treatment center . The nurse caregiver will record pertinent changes in the resident's medical record and whom was contacted to these changes . A Nursing note dated [DATE] at 3:29 PM, documented in part . Physician contacted with elders status change. Physician ordered stat (immediate) chest x-ray, stat cbc (complete blood count) and bmp (basic metabolic panel) and to monitor vitals. Blood drawn from left antecubital with no adverse effects noted . labs call in stat for pick up . A Nursing note dated [DATE] at 3:56 PM, documented in part . Elder noted with absence of breath sounds and heartbeat at 16:40 (4:40 PM) . Both of the notes above was documented by Unit Manager (UM) F. This indicated LPN I failed to notify the physician/practitioner timely after the identification of the change of condition for R140. As documented by LPN I of not being able to awake the resident throughout their shift, unable to arouse resident for breakfast and lunch and unable to administer the resident's medications throughout their shift. This revealed hours in the delay of notification to the physician and a delay in timely care. Review of a Physician Discharge Summary dated [DATE], documented in part . Rapid decline with decrease po (by mouth) intake, lethargy x 1 day - CBC, BMP, C-XRY (chest x-ray) ordered STAT . Patient expired before results obtained . Review of the cbc and bmp labs with the collection date of [DATE], revealed the following abnormal levels: Sodium 156 H (high) - Range ,d+[DATE] Chloride 114 H - Range ,d+[DATE] BUN (blood urea nitrogen) 71 H - Range ,d+[DATE] Creatinine 2.88 H - Range 0.60 - 1.20 eGFR (estimated glomerular filtration) 15 L (low) - Range >60 WBC (white blood cell) 15.5 H - Range 3XXX,d+[DATE].0 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Hematocrit 46.9 H- Range 35XXX,d+[DATE].0 Review of a chest x-ray dated [DATE], documented in part . IMPRESSION . early interstitial infiltrates in the right lung base . On [DATE] at 1:42 PM, LPN I was interviewed via telephone and asked about R140's change of condition documented on [DATE]. LPN I was asked why they modified their note twice and why the respirations were changed from 14 to 20 in the final modification. LPN I stated they go back to their notes throughout their shift and make changes. LPN I stated they were unsure but the wrong vitals could have been noted and they went back to correct it. LPN I was asked why there were no additional vitals obtained or additional monitoring of R140 after the identified change of condition. LPN I replied they had checked on R140 throughout the day but was unsure of the documentation of the additional vitals obtained or any noted documentation of the monitoring conducted. LPN I was asked what exactly did check on mean when monitoring R140 and LPN I stated there were moments that R140 did not want to eat or take medications in the past. LPN I was asked was it normal that the resident could not be awakened for an entire shift and could not be aroused to eat or take their medications for an entire shift? And LPN I did not respond. LPN I was asked why there was a delay in notification to the physician after an entire shift of an identified change of condition with R140 and LPN I replied they did notify UM F and the physician. On [DATE] at 2:22 PM, UM F was interviewed and asked about the change of condition identified for R140 on [DATE]. UM F stated they were informed by LPN I that the resident did not eat breakfast. UM F stated R140 was up that morning because they were the one that put the resident back to bed after breakfast. UM F was asked if R140's eyes were opened and UM F confirmed they were not. UM F stated at that time LPN I was taking R140's vitals and UM F went to their morning meeting. UM F stated they had meetings scheduled for most of that day. UM F stated after their meetings they assisted LPN I with obtaining the vitals for R140. UM F was unable to recall the value of each vital, however stated the vitals were normal for R140. UM F stated after obtaining the vitals they were the one to notify the Physician of R140's change of condition and the Physician ordered the STAT labs and chest x-ray. UM F stated soon after they pronounced the death of R140. The Director of Nursing (DON) who was employed with the facility on [DATE], was no longer employed with the facility at the time of the survey. On [DATE] at 4:42 PM, the Administrator and [NAME] President of Operations (VPO) J was interviewed and informed of the concern of the delay in addressing an identified change of condition. No further explanation or documentation was received by the end of the survey.

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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** 41415 Based on observation, interview and record reviews the facility failed to implement a resident centered care plan with individualized interventions that identified behaviors and/or mood concerns for one (R13) of five residents reviewed for unnecessary medications. Findings include: On 12/15/24 at 10:11 AM, R13 was observed laying on their back in bed. During a brief interview conducted with the resident, R13 was asked if they had any concerns with their care at the facility and R13 responded in part . I'm not sure. I can't really remember things . A review of the medical record revealed R13 was initially admitted to the facility in June 2024 with a readmitted [DATE] with diagnoses that included: dementia without behavioral, psychotic or mood disturbances, Alzheimer's disease and anxiety disorder. Review of the physician orders and Medication Administration Record (MAR) revealed the following medications: Sertraline 25 mg (milligram) tablet, one time daily for depression. Trazodone 50 mg tablet, at hour of sleep for depression. Memantine 5 mg tablet, one time daily for Alzheimer's disease. A review of the behavioral consultations noted the following: 6/21/24 consultation documented in part . According to pt (patient), resident has had depression over 1-2 years . pt (patient) has C/O (complaints of) depression with emotional distraught due to medical change and, get worse due to debility . pt look alert and verbal response, sadness with tearful when talking about his depression a+o x 2-3 (alert and oriented times two/three) . + (positive) Anxious; +Depressed; +Sad . Generalized anxiety disorder . (chronic) . Psychosocial support, Monitor mood change . Adjustment disorder with mixed anxiety and depressed mood . (acute) . Dysthymic disorder . (chronic) . 11/25/24 consultation documented in part . Dx (diagnosis) of anxiety depression stay with Desyrel Zoloft as well as Namenda HX (history) of Remeron, and monitor today any mood change and medication evaluated for benefit vs risk . pt seen in his room pt look alert and verbal response, there are no c/o medication after a trial of Desyrel but pt still with confused . pt's psychotropic medication has change pt has taken Namenda and Zoloft and Seroquel now . Mood: +Anxious; +Depressed; +Sad . Affect: +Flat . Delirium: +Present . Generalized anxiety disorder . stay with Desyrel for anxiety depression insomnia . stay Zoloft for depression, Stay Namenda for dementia to delay progression of cognitive . Psychosocial support, Monitor mood change . Dysthymic disorder . Dementia . moderate, with psychotic disturbance . pt's Namenda and Desyrel benefit to pt . (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plans revealed no individualized behaviors, mood or stressors identified for the resident or person centered interventions implemented. Further review of the care plans revealed no implementation of resident specific non-pharmacological interventions noted. Review of the medical record revealed no documentation of identified behaviors or specific mood changes identified. Further review of the medical record revealed no documentation for the monitoring of the residents identified behaviors or specific mood changes. A review of a facility policy titled Behavior Monitoring/Management revised July 2018, documented in part . Outline and Best Practice Suggestions for the Behavior team would be the following . What behavior(s) is the resident exhibiting? (Review target behaviors) . Is there documented behavior monitoring in place that identifies the following criteria . target behavior, specific and individualized interventions to decrease or eliminate behavior, method of determined outcome if interventions were successful . A care plan is in place to demonstrate the target behavior, interventions that are most successful and goals . On 12/17/24 at 12:20 PM, Unit Managers (UM) - UM F and Clinical Coordinator (CC) CC A was interviewed and asked what the targeted behaviors and/or identified mood concerns were for R13. UM F and CC A was also asked to provide documentation of identified behaviors or mood concerns for R13. UM F and CC A stated they would look into it and follow back up. No additional explanation or documentation was provided that identified targeted behaviors or mood concerns for R13.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 12/15/24 between 8:50-9:35 AM, during an initial tour of the kitchen, the following items were observed: In the walk-in cooler, there was a pan of cooked corned beef, uncovered and undated. The Internal temperature of the corned beef ranged from 99-102 degrees Fahrenheit. When queried at that time, Dietary Staff C stated the corned beef had been cooked sometime this morning. When queried about a cooling log, Dietary Staff C checked the log and stated that the corned beef had not been placed on the cooling log. No explanation was given for why the cooling log had not been utilized. According to the 2017 FDA Food Code section 3-501.14 Cooling, 1. (A) Cooked POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be cooled: 1. (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); P and 2. (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. There were 6 cans of various food items on the floor behind the can racks. According to the 2017 FDA Food Code section 3-305.11 Food Storage, 1. (A) Except as specified in (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: 1. (1) In a clean, dry location; 2. (2) Where it is not exposed to splash, dust, or other contamination; and 3. (3) At least 15 cm (6 inches) above the floor. In the dry storage room, there were crumbs, food debris, packages of crackers and condiment packages on the floor underneath the racks. The floor underneath the dish machine was observed with standing water, and a slimy surface. According to the 2017 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean. There was a red sanitizer bucket in the main kitchen area. The concentration of the sanitizer solution was tested with a smart power test strip. The strip did not change color to detect any level of sanitizer. According to the 2017 FDA Food Code, Section 3-304.14 Wiping Cloths, Use Limitation, .(B) Cloths in-use for wiping counters and other equipment surfaces shall be: (1) Held between uses in a chemical sanitizer solution at a concentration specified under S 4-501.114; (continued on next page)

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	There was a bin of thickener with the scoop stored inside, and the handle was resting in the thickener powder. According to the Food & Drug administration (FDA) 2017 Model Food Code, Section 3-304.12 In-Use Utensils, Between-Use Storage, During pauses in food preparation or dispensing, food preparation and dispensing utensils shall be stored: .(B) In FOOD that is not TIME/TEMPERATURE CONTROL FOR SAFETY FOOD with their handles above the top of the FOOD within containers or EQUIPMENT that can be closed, such as bins of sugar, flour, or cinnamon; On 12/15/25 at 10:00 AM, DM B was queried about the corned beef not being logged on the cooling log. DM B confirmed the corned beef should have have documented on the cooling log. DM B was also queried about the housekeeping concerns in the dry storage area and underneath the dish machine, and stated that on weekends they don't have their strongest porters on the schedule.