STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235668	A. Building B. Wing	05/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Brighton	2200 Dorr Road Howell, MI 48843

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 This citation pertains to Intake Number: MI00144507. Based on interview and record review, the facility failed to ensure multiple allegations of abuse and mistreatment were reported to the Abuse Coordinator and the State Agency for one (R801) of two residents reviewed for abuse. Findings include: A review of a complaint submitted to the State Survey Agency revealed R801 alleged being sexually abused by an unnamed staff member two times. It was alleged the male staff member grabbed (R801's) penis area and played with (R801's) penis. It was noted that the abuse occurred sometime last month (April 2024) during the nighttime. On 5/20/24 at 11:33 AM, a telephone interview was conducted with R801 (who no longer resided at the facility). R801 had some difficulty getting his words out and became frustrated. R801 reported there were two sexual incidents by the same male staff member who worked the midnight shift. R801 stated, I didn't ask for abuse, but he was willing to give it to me. R801 reported the first time it happened, He played with me, my penis. I had to sit down on the floor to stop him. R801 stated, The second time, he manhandled me. I lost balance so I sat down. Then he took my shorts off and I wasn't having any of it. When queried about what he meant by manhandled, R801 stated, He molested me! He touched me sexually!. R801 explained that he gave a statement to a staff member who watched the front door immediately in the morning following the incident. R801 stated, I heard the assistant director didn't believe me. R801 further reported no police officers were involved and if they had been he would have wanted to press charges. R801 explained there were two incidents of sexual battery and one incident of the same staff member threatened to hit me. R801 reported he went to the hospital the day after he told the staff about the abuse and went to another facility to get away from that guy. R801 could not remember if he reported the abuse to anyone at the hospital. On 5/20/24 and 5/21/24, an unannounced, onsite investigation was conducted. A review of R801's clinical record revealed R801 was admitted into the facility on [DATE], readmitted on [DATE], and discharged on [DATE] with diagnoses that included: congestive heart failure, diabetes, hemiplegia affecting the right side, anxiety disorder, and major depressive disorder. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had moderately impaired cognition and no behaviors. (continued on next page)

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R801's progress notes revealed the following: A Plan of Care Note dated 4/7/24 noted, .Guest c/o (complained of) 'No one is taking care of me. I'm sick .' Guest very upset and verbally abusive .Guest then got on his cellphone calling (emergency contact), telling (emergency contact) to call (news networks) to report 'no one is doing anything' for him .just transferred to this new room . A Plan of Care Note dated 4/9/24, written by the Director of Nursing (DON) noted, Followed up with resident regarding concerns documented. Resident denied specific incident or specific staff member. Replied to questions with 'I don't know', became irritable with writer. A review of progress notes prior to 4/7/24 revealed no documented verbally abusive or irritable behavior. It was documented R801 was cooperative and pleasant with staff. An Incident Note dated 4/30/24 revealed R801 was transferred to the hospital per his request on that date after being observed on the floor in a fetal position. On 5/20/24 at 5:09 PM, an interview was conducted with Licensed Practical Nurse (LPN) 'A'. When queried about the day R801 was transferred to the hospital (4/30/24), LPN 'A' reported he was on the floor, they assessed him, but he refused to allow staff to move him and asked to be sent to the hospital and did not tell them why. When queried about any allegations of abuse made by R801, LPN 'A' reported nothing was every directed reported to her, but remembered a vague report from LPN 'C' but LPN 'C' did not elaborate and LPN 'A' did not remember the date or what the allegation was. On 5/21/24 at 9:15 AM, an interview was conducted with LPN 'C' When queried about any abuse allegations made by R801, LPN 'C' reported one day R801 was on the phone with a friend and was making allegations. LPN 'C' reported that she confronted R801 and his story changed and he didn't give a name. When queried about what R801's allegations were, LPN 'C' reported R801 alleged one of the Certified Nursing Assistants (CNA) at night was being rough with him. LPN 'C' stated, When I confronted him about it, he didn't give me the name or the description so in my opinion it probably didn't happen. LPN 'C' further reported R801 went between saying the CNA picked me up roughly and he beat me, but that his story changed. LPN 'C' reported she notified the DON, but the DON said it was already reported to her. LPN 'C' further reported she was not sure if she reported it to the DON or the other DON (referring to Unit Manager, LPN 'E'). When queried about who the facility's Abuse Coordinator was, LPN 'C' reported she did not know and said, It's one of the three DONs and named the DON, LPN 'E', and the Administrator. On 5/21/24 at 8:30 AM, the Administrator was asked to provide all incident reports, grievance/concern forms, and any investigations conducted by the facility for R801 for the duration of his stay at the facility. A review of a Resident Grievance/Complaint Form dated 4/29/24 and completed by Receptionist 'B' revealed R801 alleged the following occurred on Sunday (4/28/24) late PM, after dinner: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.'Ignored for so long' by director re: (regarding) incident aware of .'Manhandled' by aide and 'threatened' by (illegible handwriting) to roommate who is (illegible handwriting) . It was documented the other person involved was aide-male. The form was signed by the Administrator on 4/29/24 and a hand written Investigation Summary was written on the backside of the form. The handwritten investigation documented the following: ED (Executive Director - Administrator) met with patient on 4/24/24 to discuss concerns about male staff member making him remove his clothing, including socks after he was already dressed .It was identified that he had wounds that needed to be assessed and cared for. (R801) did not say that the staff member threatened him. he understood that his wound needed care and that the staff member was doing his job . .The night of 4/28/24, (R801) said that a 'mountain man' kind of white looking picked him up and he was just swinging so he lay himself down and the nurse didn't lock his chair. He said the nurse told him to 'fly right' because of his roommate. He could not say why. S/W (spoke with) the roommate who reported that the aide was (CNA 'D') who did nothing wrong . On 5/21/24 at 9:30 AM, an interview was conducted with Receptionist 'B'. When queried about how allegations of abuse were addressed in the facility, Receptionist 'B' reported an allegation of abuse or missing items is reported to her, she immediately completed the grievance form and notified the Administrator in person or by phone. Receptionist 'B' reported the grievance form was given to the Administrator. When queried about the grievance made by R801 on 4/29/24, Receptionist 'B' reported she recalled R801 was very upset and hard to redirect to get the information. R801 did not want to fill out the grievance form himself so Receptionist 'B' completed it for him the best she could. Receptionist 'B' reported she was instructed to only write down the facts without asking too many questions so she wrote down what R801 said. Receptionist 'B' did not recall what time R801 made the allegations and did not recall if the Administrator was in the building at the time. Receptionist 'B' reported she notified the Administrator and/or the DON because she definitely considered those allegations of abuse. On 5/21/24 at 9:53 AM, an interview was conducted with the DON. The DON reported she was not aware of any allegations of abuse made by R801. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/21/24 at 9:58 AM, an interview was conducted with the Administrator, who was the facility's Abuse Coordinator. When queried about the facility's protocol for reporting allegations of abuse, the Administrator reported once she became aware of an allegation, there was a two hour window to report to the State Agency if there was any type of injury and a 24 hour window to report to the State Agency if no injury. The Administrator reported regardless she tried to report allegations within the two hour timeframe. The Administrator reported if staff were made aware of an allegation of abuse, they were required to immediately notify her and if she was not in the building, the DON, who then would contact the Administrator. When queried about whether the allegations documented on the grievance form on 4/29/24 made by R801 and whether they were reported to the State Agency, the Administrator reported they were not because once she went to the room and talked to the roommate it was determined there was no abuse. When queried about the time the allegations were reported to her and the time she went to the room, the Administrator did not know. When queried about the handwritten statement that referred to 4/24/24, the Administrator reported she added that because of a previous allegation, but did not have it on a grievance form. The Administrator remembered being notified that R801 said someone threatened him and made him remove his clothing. The Administrator reported that allegation was not reported to the State Agency because he denied it when he was talked to about it. When queried about whether she was aware of an allegation made by R801 that a staff member was rough with him or beat him (as reported by LPN 'C' during the above documented interview), the Administrator reported she was not aware. The Administrator explained that if she would have been notified, it would have been reported to the State Agency. A review of a facility policy titled, Abuse, Neglect and/or Misappropriation of Resident Funds or Property, revised on 3/15/23, revealed, in part, the following: .For the alleged violation involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, the Center will report immediately but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .to the administrator of the facility and to other officials (including the state survey agency .