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	08/28/2024

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 49272 Based on interview and record review, the facility failed to administer and/or document administration of scheduled medications according to professional standards for ten (R905, R906, R907, R908, R909, R912, R913, R914, R915, R916) of fifteen residents reviewed for medication administration. Finding include: R905 Review of R905's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/6/24 1800 GenTeal Tears Severe Day/Night Ophthalmic Gel 0.4-0.3%, instill 1 drop in both eyes at bedtime 8/6/24 1800 Senna Oral Tablet 8.6mg, give 1 tablet by mouth at bedtime 8/6/24 bedtime dose Cyclosporine Emulsion 0.05%, Instill 1 drop in both eyes two times a day 8/6/24 2100 Eliquis 5mg, Give 1 tablet by mouth two times a day 8/6/24 2000 House/High Protein three times a day 8/7/24 0600 Levothyroxine Sodium Oral tablet 100 mcg, give 1 tablet by mouth one time a day every Mon, Tue, Wed, Thu, Fri, Sat 8/7/24 0600 Menthol-Zinc Oxide External Ointment 0.44-20.6%, Apply to buttock topically one time a day R906 Review of R906's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/7/24 0600 Levothyroxine Sodium Oral Tablet, Give 75 mcg by mouth one time a day every Mon, Tue, Wed, Thu, Fri (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/6/24 2100 Gabapentin Oral Capsule 100mg, Give 1 capsule by mouth three times a day R907 Review of R907's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/6/24 bedtime dose Senna Oral Tablet, Give 1 tablet by mouth at bedtime 8/6/24 2000 and 8/7/24 0600 Ativan 2mg, Benadryl 25mg, Haldol 2mg gel three times a day R908 Review of R908's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/6/24 bedtime dose Atorvastatin Calcium 40mg, Give 1 tablet by mouth at bedtime 8/6/24 bedtime dose Citalopram Hydrobromide Oral Tablet 10mg, Give 1 tablet by mouth at bedtime 8/6/24 bedtime dose Magnesium 400mg, Give 1 tablet by mouth at bedtime 8/6/24 bedtime dose Trelegy Ellipta Inhalation Powder 100-62.5-25mcg, 1 puff inhale orally two times a day 8/7/24 0600 Pantoprazole Sodium 40mg, Give 1 tablet by mouth one time a day 8/7/24 0600 Levothyroxine Sodium 150mcg, Give 150mcg by mouth one time a day R909 Review of R909's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/6/24 bedtime dose Atorvastatin Calcium Oral Tablet 40mg, Give 1 table by mouth at bedtime 8/6/24 bedtime dose Melatonin Tablet 3 mg, Give 2 tablets by mouth at bedtime 8/6/24 bedtime dose Acetaminophen Tablet 325mg, Give 2 tablets by mouth two times a day 8/6/24 bedtime dose Famotidine Oral Tablet 20mg, Give 1 tablet by mouth two times a day 8/6/24 2100 Gabapentin Oral Capsule 100mg, Give 2 capsules by mouth two times a day R912 Review of R912's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	8/7/24 0600 Levothyroxine 50mcg, Give 50mcg by mouth one time a day R913 Review of R913's Medication Administration Record (MAR) revealed that the following scheduled medication was not documented as being administered: 8/7/24 0600 Insulin Glargine Subcutaneous Solution 100 unit/ml, Inject 15 units subcutaneously one time a day R914 Review of R914's Medication Administration Record (MAR) revealed that the following scheduled medication was not documented as being administered: 8/7/24 0600 Bumetanide Tablet 0.5mg, Give 1 tablet by mouth one time a day On 8/27/24 at 2:33 PM an interview was conducted with R914, when asked about the missing dose of Bumex, R914 reported they messed it up, it is fixed now and that the facility staff did not offer him an explanation for the missed dose. R915 Review of R915's Medication Administration Record (MAR) revealed that the following scheduled medication was not documented as being administered: 8/7/24 0600 Levothyroxine Sodium Oral Tablet 50mcg, Give 1 tablet by mouth one time a day R916 Review of R916's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/6/24 2200 and 8/7/24 0600 Gabapentin Oral Tablet 800mg, Give 1 tablet by mouth every 8 hours 8/7/24 0000 and 0600 Hydrocodone-Acetaminophen (Norco) Oral Tablet 10-325mg, Give 10mg by mouth every 6 hours 8/7/24 0600 Levothyroxine Sodium Oral Tablet 137mcg, Give 137mcg by mouth one time a day On 8/28/24 at approximately 3:30 PM, an interview was conducted with R916 regarding the Norco doses that were not documented as administered on 8/7/24 (midnight and 6 AM doses). R916 reported waking up occasionally with increased pain in the morning and felt that indicated that they did not receive scheduled doses throughout the night. R916 further reported that they felt their pain was not adequately managed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A record review was completed for R905, R906, R907, R908, R909, R912, R913, R914, R915, R916 and no documentation was found in the progress notes or within the MAR's indicating an electronic medical record (EMR) outage or any late entry notes reflecting the medications that were not documented as given (as described above). On 8/27/24 at 2:16 PM an interview was conducted with Regional Nurse A (the Director of Nursing (DON) was out of the building at the time). When asked how the facility ensures medications are passed in a timely manner they reported they could pull up the policy and let me know (no policy or additional information was received prior to the conclusion of the survey). When informed that multiple medications were not passed and/or documented for several residents for the shift covering the night of 8/6/24 through the morning of 8/7/24, they stated that they did not know why but they should be administered and their policy is to notify the physician if medications are not administered as ordered. On 8/27/24 at 2:49 PM an interview was conducted with the DON. The DON reported that their EMR system was glitching on 8/6/24 and was completely down until after shift change for the nurses (on 8/7/24). When asked what their downtime policy/procedure was, the DON stated they would have to get that information and was unable to provide an answer at that time. The DON was asked if it is reasonable to expect that if the medications were not documented on the MAR that they would be documented somewhere within the EMR and they confirmed that any medications given should be documented. On 8/27/24 at 2:59 PM, the DON and Regional nurse A re-entered the conference room and reported that their downtime system was down on 8/7/24 in addition to their main EMR system. They provided conflicting information regarding whether or not the undocumented medications from 8/6/24 and 8/7/24 were given or not.The DON reported that the medications were given and Regional nurse A stated that they were unsure if the medications were given or not. On 8/28/24 at 8:41 AM an interview was conducted with LPN J (nurse assigned to several residents whose MAR's indicated they did not receive medications the night of 8/6/24 and morning of 8/7/24). When queried about the medications not documented as given on the night of 8/6/24 and the morning of 8/7/24, LPN J stated that medications were given based on the medications in the resident's medication drawers. They reported that they kept the packets from the medications that she was unable to document in the EMR, gave them to the oncoming nurse and let the DON know that they were unable to document them in the EMR. When asked what the expectation was for ensuring the medications were documented appropriately in EMR once the system was available, they reported that it wasn't discussed. They reported that they didn't go back and document them but they could have, for sure. LPN J reported that a paper chart was not available and she was not aware of what the downtime policy/procedure was for the facility. On 8/28/24 at 9:55 AM an interview was conducted with LPN F (nurse assigned to several residents whose MAR's indicated they did not receive medications the night of 8/6/24 and morning of 8/7/24). When queried about the night of 8/6/27 LPN F reported that they recalled a night when their EMR system went completely out but that she was able to administer and document all of the medications for her residents on the night in question. LPN F was unsure which day the EMR was down but reported that the DON was made aware the night it was down. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at 1:46 PM a second interview was conducted with DON. The DON reported that audits of MAR's are periodically completed. When asked to clarify what their understanding is related to whether or not the undocumented medications were given or not given, the DON reported both LPN F and LPN J reported to her that the medications in question were given but not charted. When asked if it was discussed how or when the medications would be charted, the DON reported it was not discussed but reported that it should have been. The DON reported that to her knowledge the medications that were not able to be documented during the EMR downtime were not documented once the system was fully functional again. Review of the facilities policy titled DISRUPTION IN THE ELECTRONIC MEDICAL RECORD updated 8/9/24, documented in part Nexcare Health Systems and Managed Communities will have a back up plan in place for any situation that would cause a disruption in the electronic medical record longer than 2 hours . Floor staff should notify the Administrator and Director of Nursing. At this time the Administrator and Director of Nursing should start investigating to find out what is the root case of the disruption. The Administrator and/or Director of Nursing should notify their Regional team for additional assistance if needed. If the facility is still unable to find a solution to why there was a disruption in the electronic medical record the facility should call IWER (the IT company) .Call your closest facility within the company to see if they have Internet. If they have Internet then you can go to the additional facility or have that facility print your EMARs and bring them to you. Have the Administrator/DON try to access the electronic medical record on their phone. If [EMR system] is available then this is a local facility issue where you can print the EMAR from another location or contact [local] office and the EMAR can run off of a hot spot . It should be noted that the above mentioned policy was updated two days after the reported EMR outage and reported downtime system outage. Review of the facility policy titled Medication Administration General Guidelines updated 1/21, documented in part The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of medications.

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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** 47283 This citation pertains to intakes: MI00146401 and MI00146531 This citation had two Deficient Practice Statements (DPS). DPS #1 Based on observation, interview, and record review the facility failed to provide adequate supervision for one Resident (R903) of two Residents reviewed for accidents resulting in an unbeknownst exit of a cognitively impaired, wheelchair bound resident from the facility and a fall with injury. Findings include: A record review revealed that R903 was admitted to the facility on [DATE] after a hospitalization , for skilled nursing and rehabilitation services. R903 was recently hospitalized and readmitted back to the facility on [DATE]. R903's admitting diagnoses included Schizophrenia, anxiety disorder, Chronic Obstructive Pulmonary Disease (COPD), Parkinson's disease, end stage renal disease, (on hemodialysis) with history of falls and syncopal (fainting) episodes. R903 had a guardian who handled R903's medical, legal, and financial decisions. Based on the Brief Interview for Mental Status (BIMS), R903 had a score of 11/15, indicative of moderate cognitive impairment. R903 needed limited staff assistance with their Activities of Daily Living (ADLs) such as dressing, bathing etc. A complaint received by the State Agency revealed that a resident fell of their wheelchair in the middle of the road at 9 PM and the facility staff were unaware that R903 was outside of the facility. The facility's front doors were locked and resident was observed on the ground with their wheelchair by a visitor who had notified the facility staff. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An initial observation was completed on 8/27/24 at approximately 11:05 AM. R903 was observed sitting in their wheelchair, in the room doorway. When this surveyor asked to meet with the R903, they were trying to back up into the room from the doorway and reported that they may need help and started backing up in their wheelchair. R903 took approximately two minutes to back into their room with verbal cues from the surveyor to back up the wheelchair. R903 had a dressing on the left lateral (outside) elbow area. R903 reported that they had pain on their left hip/groin area. When the surveyor asked how severe their pain was, R903 stated 10/10 and added I have never had this kind of pain. R903 added they were getting pain medication that was just started a few days ago. They had pain medication this morning and it was not helping and they needed something more. LPN C was notified by the surveyor. R903 was queried if the pain started after their fall, they reported that it started days after the fall and they did not remember the time frame. R903 was queried if they had seen a physician, R903 reported that a woman, not a doctor, not sure about the time frame, who was going to order an ultrasound (test) for the pain. LPN C' who was assigned to care for R903 came in; R903 reported that their pain was 10/10 and nurse reported that it was too soon to get another dose of Tramadol and they would get them a Tylenol. R903 was queried about their fall. R903 reported that they fell outside of the facility in the parking lot area. R903 confirmed that they were outside the building and there were no staff members with them. R903 stated, I scrapped my left arm, not sure if they hit their head. R903 reported that the Emergency Medical Services (EMS) came and they did not want to go to hospital. When asked about the details of the incident, R903 reported that they were in their wheelchair and thought they might have dozed off and fell . When queried further about the specifics of the fall, they reported that they did not remember. R903 added that they were not allowed to go out on their own anymore after the fall. R903 reported that they had a guardian for a few years who handled their businesses and they were able to provide the name of their guardian. R903 had asked the surveyor to check on the test that was ordered for them. Later that day a follow up observation was completed at approximately 1:40 PM. R903 was in their room and they reported that their left hip/groin pain was little better than the morning and stated it was 7/10 and they did not go to dialysis because of pain. R903 was queried about the fall time, approximately 8:30 PM (based on the visitor and staff witnesses) and how they had left through the main entrance door that was set to lock at 6 PM and if they knew the code to unlock the front door. R903 reported that they did not know the code and thought they went outside before the doors were locked (6 PM), but they were not sure. They added that they were not sure how long they were sitting outside before they fell out of their wheelchair. On 8/28/24 at approximately 10:05 AM, R903 was observed in their bed and x-ray technician was in the room. This surveyor met with R903 in their room after. R903 reported that they had an x-ray of their hip. They added that they still had left hip/pain, it was 6/10 and they had constant pain. R903 also added that they were in pain all weekend (last weekend) and they had asked the staff to get some medication for pain; they had been getting the tramadol for the last few days. R903 reported that they were not able to take their shower last night because of their pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of R903's Electronic Medical Record (EMR) revealed a nursing progress note dated 8/8/24 at 20:30 read in part, At approximately 2030, guest was observed outside of the facility, on the ground. Guest stated that she was sitting in her wheelchair when she tipped over, with her wheelchair falling on top of her. Guest stated that she did hit her head on the ground. Guest has a new skin tear on the back of the left forearm writer called EMS to transport guest to hospital due to possible head injury .EMS refusing to take her to hospital stating she can make her own decisions. Director of Nursing (DON) and on call provider notified. Writer attempted to call guest's guardian but could not get in touch with her. Incoming nurse will reattempt during business hours . Further review of nursing progress note revealed a note titled skilled charting' dated 8/9/24 at 9:59 read in part, Transfer and ambulation 1-person assist (PA) with 2-wheeled walker. BIMS of 11, moderate cognitive impairment .Intervention: Offer resident to sit outside in front while waiting for dialysis. Resident can sit outside in front on patio on non-dialysis days and in the afternoon/evening. Root cause: poor trunk control. Inter Disciplinary Team (IDT) reviewed incident, root cause analysis, and new intervention and agree with plan of care. Review of R903's progress notes revealed a care transition (social services) note dated 7/26/24 that read in part, guest has a guardian named 'name of guardian omitted' .BIMS score 11/15 indicating cognition is moderately impaired .plan is for guest to remain Long Term Care (LTC) at 'name of the facility' omitted . Further review of progress notes did not reveal any evidence of follow-up evaluation by a physician or practitioner note after the fall incident on 8/8/24. There was no evidence that there were follow-up radiology/other diagnostic tests were ordered despite the nature of the incident: an unwitnessed fall incident outside of facility, with R903 reporting of hitting their head, R903's cognitive impairment and nursing observation/assessment that warranted a 911 call. Further review of the EMR revealed a physician progress note dated 7/19/24, (prior to recent admission to hospital). The surveyor confirmed with the DON on 8/27/24 that all physician documents were entered in EMR except for a practitioner visit note from 8/26/24. Review of R903's Electronic Medical Record (EMR) revealed physician orders that included: hemodialysis on Monday, Wednesday and Friday and a scheduled pick up at 11:30 AM; vital signs twice daily dated 7/25/24; acetaminophen tablet 325 milligrams (mg) - 2 tablets by mouth every 4 hours as needed for pain dated 7/25/24; and tramadol HCL 50 mg - 1 tablet every 6 hours as needed for pain. Review of R903's care plan revealed that R903 was at risk for falls due their diagnoses and co-morbidities with their physical and cognitive limitations. Review of physical therapy discharge summary dated 7/2/24 revealed that R903 needed minimal staff assistance with their wheelchair mobility in a corridor or similar space. Resident's functional wheelchair mobility on outside terrain, patios and or sidewalk were not assessed or addressed. Standing balance at discharge indicated that R903 was a high risk for falls and they needed staff supervision with their transfers. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A request was sent via e-mail on 8/27/24 at 12:48 PM and verbally to the DON and Administrator to provide the incident/accident report and investigation/facility follow-up for R903's incident/accident from 8/8/24. The facility provided an incident report completed on 8/9/24 that revealed the predisposing factors for the incident were impaired memory and weakness/fainted. The section under statements read no statements. Section under agencies people notified read that R903' s guardian was notified on 8/8/24 at 20:45. There was no investigation and root cause analysis of an unbeknownst exit of a cognitively impaired, wheelchair bound resident from the facility into a secluded area of the parking lot and sustained an unwitnessed fall with skin tear that was brought to the attention of facility staff by a visitor (at 8:30 PM). On 8/27/24 at approximately 2:15 PM Regional Nurse Consultant (RC) A was queried about the investigation file for R903's incident from 8/8/24 as the DON was out of facility. RC A reported that they just found out about the incident and they would check with the DON and Administrator. On 8/27/24 at approximately, 2:35 PM facility Administrator was queried about the incident and investigation report. They reported that they were not involved in investigating the incident. They were notified of R903's fall and the DON completed the fall investigation. They did not provide any further explanation. An interview with the visitor who observed R903 in the parking lot was completed on 8/27/24 at approximately 3:45 PM. The visitor reported that they were leaving the facility with their spouse after visiting a family member it was approximately 8:45 PM. They observed R903 lying on the ground with their wheelchair on top of R903 and they were unsure if that was resident or a visitor. They reported that they had asked R903 if they had hit their head and R903 responded yes. The visitor added that R903 had gash on her arm and it was bleeding. The visitor reported the facility front door was locked when they had left. Their spouse went in and alerted the staff member while they had stayed with R903. There were two nurses who came and assisted the resident. The visitor added that staff members thanked them the next day for and bringing the incident to their attention and helping with the situation. An interview with Licensed Practical Nurse (LPN) B was completed on 8/27/24 at approximately 1:45 PM. They were queried if they remembered about R903's incident on 8/8/24. LPN B reported that they remembered the incident. They had finished their shift and they were charting on the receptionist's computer near the main entrance. A family member came to the facility between 8:30 and 8:45 PM and reported that a resident was hurt and they were on the ground and needed help. When queried how the family member had entered the facility, LPN B reported that the door was locked the family member was regular visitor and they had the code to enter and they had to use the code to exit the building. LPN C who was also at the desk, was completing their charting after their shift. They both went out and saw R903 on the ground in back. LPN B confirmed that there was no one outside and the area where R903 was not visible from the inside. LPN B stated, We assessed [R903] notified [LPN F] (who was assigned to care for R903 on that shift). When they had reported that R903 was outside on the ground LPN F was not aware that R903 was outside the facility. They had called 911. This surveyor asked LPN B to show the area where they had found R903. This surveyor walked with LPN B from the front entrance to approximately three hundred feet away towards the secluded area (West side parking). There was turn on a sidewalk with an incline closer the [NAME] end parking where R903 was located, on the road next to sidewalk. The location of incident was also confirmed by the visitor. The surveyor queried if this was safe area for a wheelchair bound resident with impaired cognition to be alone at 8:30 PM, LPN B stated, No. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An interview was completed with LPN C on 8/27/24 at approximately 2 PM. LPN C also witnessed the incident and assisted LPN B on 8/8/24. LPN C was also the nurse who worked on R903's unit on the morning shift (7 AM - 7 PM). When queried if they remembered the incident and they reported that they did. It was between 8:30 - 8:45 PM a family member came in when they were at the receptionist desk charting after their shift. The family member reported that there was someone one on the ground outside in a wheelchair and they were not sure if that was resident or visitor. They went to check with LPN B and observed R903 on the road next to sidewalk walk and they had notified LPN A who was nurse assigned to R903's unit. LPN A was not aware that R903 was outside of the facility. When they had asked R903 what happened, the Resident reported that they were trying to go around the curve and their wheelchair tipped over. They had assisted with the situation, EMS was called and R903 did not want to go to hospital and the DON spoke with EMS. This surveyor queried LPN C when they had last seen R903 and they reported that R903 was in the room when they had signed off from their shift. The surveyor queried about their signoff process, LPN C reported that they were supposed to see the resident when doing the recap with the oncoming nurse. This surveyor asked if R903 was allowed to go out on their own, LPN C reported that the Resident used to sit outside in the front prior to the fall. When queried how did they monitor when they were sitting outside and what was their process, LPN C reported that they did not have any issues prior; the receptionist left around 8 PM and they would let the charge nurse know if a Resident was sitting outside. It must be noted that the area where R903 was observed was not visible from the front entrance, unless someone did a walk through to the west side of the facility or had parked on this end and walked towards their car. Calls were made to Certified Nurse Assistant (CNA) who was assigned to R903 on 8/8/24 and they were not returned prior to survey exit. An interview with Maintenance Director (DM) D was completed on 8/27/24 at approximately 2:20 PM. DM D was queried about the main door lock time frames and the process. They reported that the doors were set to lock between 6 PM - 7 AM. If anyone needed to exit outside these times frame, the instructions are posted. If they needed to exit, staff were assisting them. DM D was queried about the camera and monitoring. They reported that they had camera in the hallways, but not outside. This surveyor went to check the cameras with DM D at approximately 2:30 PM. DM D had to get the assistance from the Administrator. At approximately 2:35 PM, the Administrator came in. This surveyor explained that they wanted to check the front door camera for 8/8/24 and Administrator reported that they did not have any cameras monitoring the front (main) entrance. An interview was conducted with Receptionist (RE) E on 8/27/28 at approximately 2:50 PM. Receptionist E reported that they had worked till 5 PM and they had two other staff members who took turns to cover the weekends and afternoons, till 8 PM. They had reported that the front door locks at 6 PM to 7 AM. They were queried about the facility process on who is allowed to sit outside and how they were monitoring. RE E reported that they checked with the resident if they had let their nurse know and if they were their own person they had let them sit outside and they were not monitoring the residents. They added if they had wander guard they were not allowed. (continued on next page)

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	235668	A. Building B. Wing	08/28/2024

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An initial interview was conducted with the DON on 8/27/24 at approximately 3 PM. The DON was queried about the incident and why they did not investigate. The DON reported that they were notified of the incident by the charge nurse, that it happened right outside the door and it did not need an investigation so they had just completed a fall investigation and did not provide any further explanation. An interview was completed with R903's guardian on 8/27/24 at approximately 3:25 PM. The guardian was queried about the incident on 8/8/24. They had checked the call notes and checked with their assistant and reported that they did not receive any calls about the incident. When explained the incident the guardian asked, What was she doing at 8:45 PM in the parking lot?. They added that residents should not be in an area where employees cannot monitor them. They added that they never gave permission and R903 was not safe to be outside unsupervised. They noted that should have been notified of this incident. If it is after hours, staff could leave a voicemail and they should receive a call back for this incident. An interview was completed with the Administrator on 8/27/24 at approximately 5 PM. The Administrator was notified of the concerns with supervision for R903, how they had exited and the unknown timeframe they were outside the facility, the fall outside the facility with no investigation, and not notifying the guardian. The Administrator reported that they understood the concerns. An interview was completed with LPN F who was assigned to R903's unit at the time of the incident on 8/28/24 at approximately 6:55 AM. LPN F was queried about R903's incident. They reported that their shift started at 7 PM and they regularly worked that unit and they were familiar with the residents. LPN F added that they received the report from LPN C that R903 was in their room, but they did not physically see the resident after their shift started. They were getting ready to gather supplies and start to pass the medications. At approximately 8:30 PM they were alerted by LPN B that R903 was observed outside the facility on the floor. It must be noted that R903 was on the front end of the unit (1st room) and LPN F failed to explain how they had not seen the Resident for over an hour and a half since the start of their shift. They added that they went outside and LPN C was with R903. They reported that they had called 911 and R903 did not want to go to hospital so EMS did not take the resident. They added that R903 had periods of confusion and had a guardian, also the resident reported that they might have hit their head and the fall was unwitnessed. They did not want to take any chances and had called EMS. They added that they had communicated with the DON and had called the guardian and left a brief message. They had notified the oncoming nurse to call the guardian during business hours. The surveyor queried if R903 was safe at the location without staff supervision/assistance at that time, LPN F' stated nobody would be safe at the location. When queried about the time frame they reported that they did not know. When this surveyor asked what could have prevented the event, LPN F reported better communication between the nursing staff, walking rounds while receiving report at the start of their shift and communication between the receptionist and nursing staff would have prevented the incident. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A follow-up interview with the DON was completed on 8/28/24 at approximately 11:35 AM. The DON reported that they were notified that R903 had a fall from the wheelchair as it tipped, right outside the main entrance and that is why they had not completed any investigation. The DON was queried if they had seen where R903 was on the ground and they reported they had not. The DON agreed to see the location. This surveyor and DON went to see the area where R903 was located. This surveyor queried if that area was safe for R903 to be unsupervised at 8:30 PM? The DON agreed it was not safe. The DON was queried how the facility determined that a Resident was safe to be outside unsupervised? The DON reported that it was based on cognitive assessment and their physical functioning. This surveyor queried about R903's cognitive impairment and physical limitations and how they were safe. The DON reported that R903 usually sat at the main entrance by the door. When they were queried R903 was supervised, they reported that the receptionist and care transition staff can monitor from their desk/office. When queried further how the receptionist could visually see through the walls and vestibule in the front and what happened if they left the desk/office? No further explanation was provided. When queried further about the process, The DON reported that the best practice" for both nurses and CNAs was to do walking rounds during shift change. They reported that they understood the concerns. Review of facility provided document titled Elopements with a revision date of December 2008 read in part, 1. Staff shall promptly report any resident who tries to leave the premises or is suspected of being missing to the Charge Nurse or Director of Nursing. 2. If an employee observes a resident leaving the premises, he/she should: a. Attempt to prevent the departure in a courteous manner. b. Get help from other staff members in the immediate vicinity, if necessary; and c. Instruct another staff member to inform the Charge Nurse or Director of Nursing Services that a resident has left the premises. 3. When a departing individual returns to the facility, the Director of Nursing Services or Charge Nurse shall: a. Examine the resident for injuries. b. Notify the Attending Physician. c. Notify the resident's legal representative (sponsor) of the incident. d. Complete and file Report of Incident/Accident; and e. Document the event in the resident's medical record . The facility's elopement policy that was revised approximately [AGE] years ago did not address facility process on identification and assessment of at-risk residents, facility process to provide supervision in the facility premises such sitting outside the front door, patio etc. DPS #2: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Based on interview and record review the facility failed to provide a thorough root cause analysis after fall(s) and provide resident specific intervention(s)/supervision for one (R902) of two Residents reviewed for falls. Findings include: A complaint received by the State Agency reveled that R902 had multiple falls after admission to facility and the facility failed to provide appropriate interventions. A review of the medical record revealed that R902 was a long-term resident of the facility, admitted to the facility on [DATE]. R902's admitting diagnoses included: Fracture of left Femur (after fall in the hospital), sepsis, heart failure, dementia, anxiety and history of stroke. Based on the MDS (minimum data set) assessment dated [DATE], R902 had a BIMS of 6/15, indicative of severe cognitive impairment. An initial observation was completed on 8/27/24 at approximately 10:30 AM. R902 was observed sitting up in their wheelchair. A family member was in the room. The right side of the bed was against the wall. R902 had nightstand that was partially blocking the bathroom doorway. When the surveyor queried about how the family member reported that they had placed it (the night stand) the night before so R902 would not attempt to go bathroom on their own. The Family member also reported that R902 had to wait longer for assistance when they needed to be changed, especially on weekends and later in the afternoons. They added that R902 was soiled and was changed around 11 AM yesterday after they had come in and had requested the staff to assist. An interview was completed with the complainant on 8/26/24 at approximately 4 PM. The complainant reported that R902 was a high fall risk when they admitted to the facility. R902 did not have the supervision and timely assistance with toileting; had multiple falls in the last few weeks. Review of R902's hospital discharge summary dated 5/28/24 reveled that R902 had a fall in the hospital on 5/25/24 and had fracture of left femur (thigh bone) and had surgery and they were unable to bear weight on left leg and they were admitted to the facility for skilled nursing and rehabilitation services. Review of R902's Electronic Medical record (EMR) revealed that R902 had a recent room and unit change on 8/26/24. Prior to this, R902 was in a different unit in room [ROOM NUMBER], which was on the farther down, closer to the end of the hallway. Review of progress notes revealed a Care Transitions note dated 7/3/24 at 12:53, that read, reached out to family via e-mail and phone call regarding transferring guest to semi-private room on LTC (Long-Term Care) side A follow up note dated 7/3/24 at 13:06 read, Received notice from family that we can move guest to semi-private room on LTC side. No concerns at this time. Based on resident census record R902 was moved to room [ROOM NUMBER], a room closer towards the end of hallway. Facility was requested to provide the Incident & Accident (I&A) reports for R902 from July through current date and was received via e-mail. Review of I&A reports and progress notes revealed the following: R902 was high risk for falls, related to their recent fall history, co-morbidities with impaired cognition and functional mobility related to recent fracture of femur. R902 had falls on: 5/30/24, 6/14/24, 7/11/24, 7/15/24, 8/4/24, and 8/16/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of I&A reports and investigative summaries revealed R902 had 3 falls between 8PM and 10:15 PM and 3 falls between 3 AM and 6 AM. R902 had 3 falls related to incontinence episodes and R902 attempting to get out of bed. Review of investigative summary for 5 out 6 falls for a resident with severe cognitive impairment revealed the root cause analysis as poor safety awareness for 5 out 6 falls and for other fall it read poor impulse control r/t (related to) cognition and an intervention dated 8/16/24 read, re-orientate resident to environment during rounds. Review of care plan included the following interventions: check for incontinence episode around 3 AM dated 5/30/24, offer toileting before and after meals dated 6/28/24, and check for incontinence episode during early morning rounds. An interview with the DON was completed on 8/28/24 at approximately 12:25 PM. The DON was queried about the falls for R902 and their root cause analysis that read poor safety awareness for R902, how that was a root cause for a resident with severe cognitive impairment and history of falls. The DON reported that R902 had multiple falls related to her restlessness due to incontinence episodes and they were working con improving their root cause analysis process with someone from corporate. The DON was queried if it was appropriate to have the high fall risk resident with recent fall and femur fracture to be farther at the end of the hallway and how re-orientation is an appropriate intervention. The DON reported that they understood the concerns and they were working on it. Review of facility provided document titled Falls and Fall Risk, Managing with a revision date of December 2007 (revised approximately [AGE] years ago) read in part, Based on previous evaluations and current data, the staff will identify interventions related to resident specific risks and causes to try to prevent resident from falling and try to minimize complications from falling.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 This citation pertains to Intakes: MI00146401 and MI00146565 Based on observation, interview and record review the facility failed to assess for pain and administer pain medications as ordered by the physician for two (R903 and R916) of two residents reviewed for pain, resulting in unrelieved pain, feelings of frustration, and helplessness. Findings include: R903 A record review for R903 revealed they were admitted to the facility on [DATE] after a hospitalization for skilled nursing and rehabilitation services. R903 was recently hospitalized and readmitted back to the facility on [DATE]. R903's admitting diagnoses included Schizophrenia, anxiety disorder, Chronic Obstructive Pulmonary Disease (COPD), Parkinson's disease, end stage renal disease (on hemodialysis) with history of falls and syncopal (fainting) episodes. R903 had a guardian who handled R903's medical, legal, and financial decisions. The Brief Interview for Mental Status (BIMS) revealed a score of 11/15, indicative of moderate cognitive impairment. R903 needed limited staff assistance with their Activities of Daily Living (ADLs) such as dressing and bathing. An initial observation was completed on 8/27/24 at approximately 11:05 AM. R903 was observed sitting in their wheelchair, in their room doorway. This surveyor asked to meet with R903, they were trying to back up into the room from the doorway and reported that they may need help and started backing up in their wheelchair. R903 took approximately two minutes to back into room with verbal cues from the surveyor to back into the room. R903 had a dressing on the left lateral (outside) elbow area. R903 reported they had pain on their left hip/groin area. When this surveyor asked how severe their pain was, R903 stated 10/10 and added I have never had this kind of pain. R903 added they were getting pain medication that was just started a few days ago. They had pain medication this morning and it was not helping and they needed something more. Nurse was notified. R903 was queried if the pain started after their fall, they reported that it started days after the fall and they did not remember the time frame. R903 was queried if they had seen a physician, R903 reported that they a woman, not a doctor, was not sure about the time frame, who was going to order an ultrasound (test) for the pain. LPN C who was assigned to care for R903 came in and R903 reported that their pain was 10/10. LPN C reported that it was too soon to get another dose of Tramadol as they received one 2 hours ago and they would get them a Tylenol. R903 was queried about their fall. R903 reported that they fell outside of the facility in the parking lot area. R903 stated, I scrapped my left arm, and was not sure if they hit their head. R903 had asked the surveyor to check on the test that was ordered as their pain was so severe. Later that day a follow up observation was completed at approximately 1:40 PM. R903 was in their room and they reported that their left hip/groin pain was a little better than the morning and stated it was 7/10 and they did not go to dialysis because of pain. When queried about the showers, they reported that they were able to do it minimal staff help and they were going to take a shower later that evening. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at approximately 10:05 AM, R903 was observed in their bed and x-ray technician was in the room. Surveyor met with R903 in their room after. R903 reported that they had x-ray of their hip. They added that they still had left hip/pain, it was constant pain, graded the pain as 6/10. R903 also added that they were in pain all weekend (last weekend i.e. 8/24/24 - 8/25/24) and they had asked the staff to get some medication for pain. They had been getting the tramadol for the last few days. R903 reported that they were not able to take their shower last night because of their pain. R903 reported that the pain was so severe and they never had that kind of pain and did not know what it was. They were not sure if they would be able to go to dialysis on Wednesday if they continue to have this pain. Two more observations were completed later that day at approximately 11:30 AM and approximately 1 PM. R903 was observed in their bed. Review of R903's Electronic Medical Record (EMR) revealed a nursing progress note dated 8/8/24 at 20:30 read in part, At approximately 2030, guest was observed outside of the facility, on the ground. Guest stated that she was sitting in her wheelchair when she tipped over, with her wheelchair falling on top of her. Guest stated that she did hit her head on the ground. Guest has a new skin tear on the back of the left forearm writer called EMS to transport guest to hospital due to possible head injury .EMS refusing to take her to hospital stating she can make her own decisions. Director of Nursing (DON) and on call provider notified. Writer attempted to call guest's guardian but could not get in touch with her. Incoming nurse will reattempt during business hours . Review of R903's pain assessment revealed on 8/8/24 at 21:06 (9:06 PM), after the unwitnessed fall (outside the facility) 8/10. An assessment was completed on 8/9/24 at 6:40 AM. There was no further pain assessment completed after until 8/26/24 at 8:18 AM, pain level 8/10. There were no pain assessments completed for 8/24/24 and 8/25/24 when R903 had reported that they were in and had asked for staff to assist them. After the concern was brought to the facility's attention there were follow up pain assessments completed on 8/27/24 and 8/28/24. Review of R903's physician order on 8/27/24 at 12:56 PM did not reveal any physician orders for any tests related to R903's complaints of left groin/hip pain. R903 had an order that read, Acetaminophen (Tylenol) tablet 325 MG (Milligram) - Give 2 tablets by mouth every 4 hours as needed for pain dated 7/25/24 and Tramadol HCL oral tablet 50 MG - give one tablet by mouth every 6 hours as needed for pain dated 8/26/24. Review of R903's Medication Administration Record revealed that R903 did not receive any pain medication on 8/8/24 after the fall incident when they had a reported a pain level of 8/10. There was no evidence that R903 received any pain medication from 8/8/24 until 8/26/24 at 8:18 AM despite their complains of pain prior. R903 was ordered to receive tramadol on 8/26/24 and did not receive until 8/27/24 at 9:23. On 8/26/24 R903 received their first dose of Tylenol at 8:18 AM and reported a pain level of 8/10. There was no evidence of pain assessment after and there was no evidence that R903 received any pain medication later that day. On 8/27/24, R903 received one dose of tramadol at 9:23 AM and reported a pain level of 8/10, pain medication was not effective. They received their next dose of Tylenol at 11:13 AM and reported a pain level of 10/10. The next dose of pain medication (tramadol) was administered at 18:54 (6:54 PM), approximately 7 hours after. There was no evidence in R903's clinical record that a timely follow up was completed physician/mid-level providers (nurse practitioner/physician assistant) after the 8/8/24 unwitnessed fall incident and when R903 had reported had complaints of pain over the weekend. Review of R903's progress notes did not reveal any documentation after 8/12/24. There was no documentation on pain on 8/26/24 and why tramadol was ordered. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R903's care plan for revealed the goals that were updated on 7/5/24, that read will not have signs and symptoms of unrelieved pain; will have individualized pain medication does titration achieve adequate pain relief; and decrease pain to a tolerated level so resident can function in daily life with no interventions. There were multiple interventions listed under pain management dated 11/22/23 with no follow up/update after the recent readmission and or after the unwitnessed fall incident or after recent complaints of pain in left groin/hip area. An interview was completed with LPN F who was assigned to R903's unit at the time of incident on 8/28/24 at approximately 6:55 AM. They were just finishing up their shift and reported they had just left the facility. LPN F was queried about R903's incident and their follow-up. They reported that their shift started at 7 PM and they regularly worked that unit and they were familiar with the residents. LPN F added that they received the report from LPN C that R903 was in their room, but they did not physically see the resident after their shift started. At approximately 8:30 PM they were alerted by LPN B that R903 was observed outside the facility on the floor. LPN F explained that they had called the EMS and their follow up with the DON. LPN F did not explain why they did not administer any pain medications for R903 when they had reported a pain level of 8/10 on 8/8/24. When queried if they had worked with R903 on the night of 8/27/24 and how the resident was, LPN F reported they worked with R903 on 8/27/24. Reported that R903 was complaining of pain and stated, excruciating pain. Reported that R903 refused dialysis on Monday (8/26/24) because of her pain and they were ordered Tramadol. On 8/28/24 at approximately 11:05AM, the surveyor was outside R903's room and overheard the conversation. R903 was speaking with CNA H and reported that they were hurting and needed pain medication and CNA H reported that they would check with the nurse to find out when the next dose is due. An interview with CNA H was completed 8/28/24 at approximately 11:20 AM and they reported that R903 complained of pain and they had notified the nurse. An interview was completed with Director of Nursing (DON) on 8/28/24 at approximately 11:35 AM. The DON was queried about the facility's pain assessment and management following an incident. The DON reported that they would do an initial pain assessment every shift, twice a day (as nurses worked 12-hour shifts) for 3 days and they would follow up as needed with any new onset of symptoms. The DON was queried about the pain assessment and management for R903. The DON reviewed the clinical records and reported that they did not see any pain assessment for three days after the incident and confirmed that R903 did not receive any pain medication after fall when they had complained of pain of 8/10. The DON also confirmed that there were no physician/mid-level provider visits following the fall. The DON added if the pain medications were ineffective staff should have attempted non-pharmacologic interventions such as positioning, ice etc. and should have contacted the covering provider on after hours. The DON added that they had after hour providers available 7 days/week and they did not see any evidence in the clinical record. They reported that on 8/26/24 the nurse practitioner was at the facility and they would check on the progress note was not on R903's EMR. Later that day the DON came and reported that practitioner visit note from 8/26/24 was completed in EMR. Also, added that x-rays result for left hip and pelvis that were completed on 8/28/24 were available pending provider review and R903 did not have any acute fracture. The DON was notified of the concerns with pain assessment and management, and they reported that they understood the concerns. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility provided document titled Pain Assessment and Management with a revision date of October 2010 (revised approximately [AGE] years ago) read in part, .Pain management is defined as the process of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established clinical goals. 49272 R916 Review of R916's Medication Administration Record (MAR) revealed an order for Norco (also known as hydrocodone-acetaminophen 10-325mg a narcotic pain medication) to be given by mouth every six hours related to aftercare following joint replacement surgery. Further review showed no documentation of administration for scheduled midnight and 6 AM doses on 8/7/24. On 8/28/24 at 9:35 AM a request was made via email for the narcotic log for R916's hydrocodone-acetaminophen 10-325mg which included midnight and 6 AM scheduled doses for 8/7/24. The NHA (nursing home administrator) provided a copy of a Narcotic log for August 6th in error. On 8/28/24 at 12:22 PM, the DON (director of nursing) reported that they were unable to locate the requested narcotic log. It was confirmed (by the NHA and DON) at the exit conference that the facility was unable to locate the requested narcotic log. On 8/28/24 at approximately 3:30 PM, an interview was conducted with R916 regarding the Norco doses that were not documented as administered on 8/7/24 (midnight and 6 AM). R916 reported waking up occasionally with increased pain in the morning and felt that indicated that they did not receive scheduled doses throughout the night. R916 further reported that they felt their pain was not adequately managed and staff have made them feel like they do not believe the level of pain being reported. Review of the clinical record for R916 revealed they were admitted into the facility on [DATE] with diagnoses that included: muscle weakness, aftercare following joint replacement surgery and difficulty walking. According to the Minimum Data Set (MDS) assessment dated [DATE], R916 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition).

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	235668	A. Building B. Wing	08/28/2024

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49272 Based on interview, and record review, the facility failed to ensure there was thorough record keeping to accurately account for administration of controlled substances for one (R916) of one resident reviewed for pharmacy services. Findings include: Review of the clinical record for R916 revealed they were admitted into the facility on [DATE] with diagnoses that included: muscle weakness, aftercare following joint replacement surgery and difficulty walking. According to the Minimum Data Set (MDS) assessment dated [DATE], R916 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). Review of R916's Medication Administration Record (MAR) revealed an order for Norco (also known as hydrocodone-acetaminophen 10-325mg a narcotic pain medication) to be given by mouth every six hours related to aftercare following joint replacement surgery. Further review showed no documentation of administration for scheduled midnight and 6 AM doses on 8/7/24. On 8/28/24 at 9:35 AM a request was made via email for the narcotic log for R916's hydrocodone-acetaminophen 10-325mg which included midnight and 6 AM scheduled doses for 8/7/24. NHA (nursing home administrator) provided a copy of a Narcotic log for August 6th in error. On 8/28/24 at 12:22 PM it was DON (director of nursing) reported that they were unable to locate the requested narcotic log. It was confirmed (by the NHA and DON) at the exit conference that the facility was unable to locate the requested narcotic log. On 8/28/24 at 1:46 PM an interview was conducted with DON. When asked if audits are completed of the MAR's they stated that they are completed periodically and not on a scheduled basis. No explanation was given as to why the medications were not documented or what happened to the requested narcotic log. On 8/28/24 at approximately 3:30 PM, an interview was conducted with R916 regarding the Norco doses that were not documented as administered on 8/7/24 (midnight and 6 AM). R916 reported waking up occasionally with increased pain in the morning and felt that indicated that they did not receive scheduled doses throughout the night. R916 further reported that they felt their pain was not adequately managed and staff has indicated they do not believe the level of pain they are reporting.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 49272 Based on interview and record review the facility failed to maintain complete and accurate medical records for ten (R905, R906, R907, R908, R909, R912, R913, R914, R915, R916) of fifteen residents reviewed for medication administration. Findings include: R905 Review of R905's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/6/24 1800 GenTeal Tears Severe Day/Night Ophthalmic Gel 0.4-0.3%, instill 1 drop in both eyes at bedtime 8/6/24 1800 Senna Oral Tablet 8.6mg, give 1 tablet by mouth at bedtime 8/6/24 bedtime dose Cyclosporine Emulsion 0.05%, Instill 1 drop in both eyes two times a day 8/6/24 2100 Eliquis 5mg, Give 1 tablet by mouth two times a day 8/6/24 2000 House/High Protein three times a day 8/7/24 0600 Levothyroxine Sodium Oral tablet 100 mcg, give 1 tablet by mouth one time a day every Mon, Tue, Wed, Thu, Fri, Sat 8/7/24 0600 Menthol-Zinc Oxide External Ointment 0.44-20.6%, Apply to buttock topically one time a day R906 Review of R906's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/6/24 2100 Gabapentin Oral Capsule 100mg, Give 1 capsule by mouth three times a day 8/6/24 1800 Senna Oral Tablet 8.6mg, give 1 tablet by mouth at bedtime 8/6/24 bedtime dose Cyclosporine Emulsion 0.05%, Instill 1 drop in both eyes two times a day 8/6/24 2100 Eliquis 5mg, Give 1 tablet by mouth two times a day 8/6/24 2000 House/High Protein three times a day 8/7/24 0600 Levothyroxine Sodium Oral Tablet, Give 75 mcg by mouth one time a day every Mon, Tue, Wed, Thu, Fri (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R907 Review of R907's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/6/24 bedtime dose Senna Oral Tablet, Give 1 tablet by mouth at bedtime 8/6/24 2000 and 8/7/24 0600 Ativan 2mg, Benadryl 25mg, Haldol 2mg gel three times a day R908 Review of R908's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/6/24 bedtime dose Atorvastatin Calcium 40mg, Give 1 tablet by mouth at bedtime 8/6/24 bedtime dose Citalopram Hydrobromide Oral Tablet 10mg, Give 1 tablet by mouth at bedtime 8/6/24 bedtime dose Trelegy Ellipta Inhalation Powder 100-62.5-25mcg, 1 puff inhale orally two times a day 8/6/24 bedtime dose Magnesium 400mg, Give 1 tablet by mouth at bedtime 8/7/24 0600 Pantoprazole Sodium 40mg, Give 1 tablet by mouth one time a day 8/7/24 0600 Levothyroxine Sodium 150mcg, Give 150mcg by mouth one time a day R909 Review of R909's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/6/24 bedtime dose Atorvastatin Calcium Oral Tablet 40mg, Give 1 table by mouth at bedtime 8/6/24 bedtime dose Melatonin Tablet 3 mg, Give 2 tablets by mouth at bedtime 8/6/24 bedtime dose Acetaminophen Tablet 325mg, Give 2 tablets by mouth two times a day 8/6/24 bedtime dose Famotidine Oral Tablet 20mg, Give 1 tablet by mouth two times a day 8/6/24 2100 Gabapentin Oral Capsule 100mg, Give 2 capsules by mouth two times a day R912 Review of R912's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/7/24 0600 Levothyroxine 50mcg, Give 50mcg by mouth one time a day (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R913 Review of R913's Medication Administration Record (MAR) revealed that the following scheduled medication was not documented as being administered: 8/7/24 0600 Insulin Glargine Subcutaneous Solution 100 unit/ml, Inject 15 units subcutaneously one time a day R914 Review of R914's Medication Administration Record (MAR) revealed that the following scheduled medication was not documented as being administered: 8/7/24 0600 Bumetanide Tablet 0.5mg, Give 1 tablet by mouth one time a day On 8/27/24 at 2:33 PM an interview was conducted with R914, when asked about the missing dose of Bumex, R914 reported they messed it up, it is fixed now and that the facility staff did not offer him an explanation for the missed dose. R915 Review of R915's Medication Administration Record (MAR) revealed that the following scheduled medication was not documented as being administered: 8/7/24 0600 Levothyroxine Sodium Oral Tablet 50mcg, Give 1 tablet by mouth one time a day R916 Review of R916's Medication Administration Record (MAR) revealed that the following scheduled medications were not documented as being administered: 8/6/24 2200 and 8/7/24 0600 Gabapentin Oral Tablet 800mg, Give 1 tablet by mouth every 8 hours 8/7/24 0000 and 0600 Hydrocodone-Acetaminophen (Norco) Oral Tablet 10-325mg, Give 10mg by mouth every 6 hours 8/7/24 0600 Levothyroxine Sodium Oral Tablet 137mcg, Give 137mcg by mouth one time a day On 8/28/24 at approximately 3:30 PM, an interview was conducted with R916 regarding the Norco doses that were not documented as administered on 8/7/24 (midnight and 6 AM doses). R916 reported waking up occasionally with increased pain in the morning and felt that indicated that they did not receive scheduled doses throughout the night. R916 further reported that they felt their pain was not adequately managed. A record review was completed for R905, R906, R907, R908, R909, R912, R913, R914, R915, R916 and no documentation was found in the progress notes or within the MAR's indicating an EMR (electronic medical record) outage or any late entry notes reflecting the medications that were not documented as given (as described above). (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 2:16 PM an interview was conducted with Regional Nurse A (the DON was out of the building at the time). When asked how the facility ensures medications are passed in a timely manner they reported they could pull up the policy and let me know (no policy or additional information was received prior to the conclusion of the survey). When informed that multiple medications were not passed and/or documented for several residents for the shift covering the night of 8/6/24 through the morning of 8/7/24, they stated that they did not know why but they should be administered and their policy is to notify the physician if medications are not administered as ordered. On 8/27/24 at 2:49 PM an interview was conducted with the DON. The DON reported that [EMR system] was glitching on 8/6/24 and was completely down until after shift change for the nurses (on 8/7/24). When asked what their downtime policy/procedure was, the DON stated they would have to get that information and was unable to provide an answer at that time. The DON was asked if it is reasonable to expect that if the medications were not documented on the MAR that they would be documented somewhere within the EMR and they confirmed that any medications given should be documented within the EMR. On 8/27/24 at 2:59 PM, the DON and Regional nurse A re-entered the conference room and reported that their downtime system was down on 8/7/24 in addition to their main EMR system. They provided conflicting information regarding whether or not the undocumented medications from 8/6/24 and 8/7/24 were given or not. The DON reported that the medications were given and Regional nurse A stated that they were unsure if the medications were given or not. On 8/27/24 at 8:41 AM, an interview was conducted with LPN J (nurse assigned to several residents whose MAR's indicated they did not receive medications the night of 8/6/24 and morning of 8/7/24). When queired about the medications not documented as given on the night of 8/6/24 and the morning of 8/7/24, LPN J stated that medications were given based on the medications in the resident's medication drawers. They reported that they kept the packets from the medications that she was unable to document in the EMR, gave them to the oncoming nurse and let the DON know that they were unable to document them in the EMR. When asked what the expectation was for ensuring the medications were documented appropriately in the EMR once the system was available, they reported that it wasn't discussed. They reported that they didn't go back and document them but they could have, for sure. LPN J reported that a paper chart was not available and she was not aware of what the downtime policy/procedure was for the facility. On 8/28/24 at 9:55 AM, an interview was conducted with LPN F (nurse assigned to several residents whose MAR's indicated they did not receive medications the night of 8/6/24 and morning of 8/7/24). When queired about the night of 8/6/27, LPN F reported that they recalled a night when the EMR went completely out but that she was able to administer and document all of the medications for her residents on the night in question. LPN F was unsure which day the EMR was down but reported that the DON was made aware the night it was down. On 8/28/24 at 1:46 PM, a second interview was conducted with the DON. The DON reported that audits of MAR's are periodically completed. When asked to clarify what their understanding is related to whether or not the undocumented medications were given or not given, the DON reported both LPN F and LPN J reported to her that the medications in question were given but not charted. When asked if it was discussed how or when the medications would be charted, the DON reported it was not discussed but reported that it should have been. The DON reported that to her knowledge the medications that were not able to be documented during the downtime were not documented once the system was fully functional again. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facilities policy titled DISRUPTION IN THE ELECTRONIC MEDICAL RECORD updated 8/9/24, documented in part Nexcare Health Systems and Managed Communities will have a back up plan in place for any situation that would cause a disruption in the electronic medical record longer than 2 hours . Floor staff should notify the Administrator and Director of Nursing. At this time the Administrator and Director of Nursing should start investigating to find out what is the root case of the disruption. The Administrator and/or Director of Nursing should notify their Regional team for additional assistance if needed. If the facility is still unable to find a solution to why there was a disruption in the electronic medical record the facility should call IWER (the IT company) .Call your closest facility within the company to see if they have internet. If they have internet then you can go to the additional facility or have that facility print your EMARs and bring them to you. Have the Administrator/DON try to access the electronic medical record on their phone. If [EMR system] is available then this is a local facility issue where you can print the EMAR from another location or contact [local] office and the EMAR can run off of a hot spot . It should be noted that the above mentioned policy was updated two days after the reported the (EMR) outage and reported downtime system outage. Review of the facilities policy titled Medication Administration General Guidelines updated 1/21, documented in part The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given. In no case should the individual who administered the medications report off-duty without first recording the administration of medications.