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	10/16/2024

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview, and record review the facility failed to ensure medications were administered per the facility's policy and professional standards of practice for two (R's 41 & R78) of four residents observed for medication administration and provide wound care treatment and documentation of treatment changes according to professional standards of practice for one (R3) of one resident reviewed for non-pressure wounds. Findings include: The facility was previously determined to be out of compliance for concerns with administration and documentation of administration of scheduled medications according to professional standards of practice during an abbreviated survey conducted on 8/28/24 with an alleged compliance date of 9/18/24. R78 On 10/14/24 at 9:04 AM, Licensed Practical Nurse (LPN) F was observed opening the medication cabinet of R78. A clear medication cup was observed in the cabinet with three pills in the cup. When LPN F was asked what the pills were, LPN F stated they did not know. LPN F then reviewed the morning medication packets and confirmed that two of the pills inside the medication cup were identical to R78's other morning medications packets. LPN F was asked if they prepared the three medications in the clear medication cup and LPN F stated they did not. LPN F reviewed R78's medical record and noted the resident was also due for an 81 mg (milligram) Aspirin and identified that as the third pill in the medication cup. LPN F opened the Aspirin 81 mg bottle to show the surveyor that the third pill was identical to the Aspirin. LPN F then stated the night shift nurse must have prepared the three pills inside of the clear medication cup. LPN F obtained the medication cup with the three pills and administered it to R78. Review of a facility policy titled Administering Medications revised December 2012, documented in part . Medications shall be administered in a safe and timely manner, and as prescribed .The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . LPN F was unable to follow the protocol of the facility, as the packet had been discarded and the three pills that were left in the medication cup was not prepared by LPN F, however LPN F administered the three pills to R78. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R41 On 10/14/24 at 9:43 AM, LPN E was observed administering R41's morning medications. LPN E was then observed administering one spray of R41's Fluticasone Propionate Nasal Suspension allergy medication in to the right nostril (without holding down the left nostril simultaneously) and then administered one spray in to R41's left nostril (without holding down the right nostril simultaneously). Review of a facility policy titled Nasal Administration dated 9/1/23, documented in part .Purpose to administer nasal medications in a safe, accurate, and effective manner .Use a finger of your other hand to gently press and close the nostril that is not receiving medication .Press the actuator or spray tip firmly and quickly . On 10/14/24 at 12:40 PM, the Director of Nursing (DON) was interviewed and informed of the observation made of R41's nasal medication administration by LPN E and asked the facility's protocol. The DON confirmed that LPN E should have held down the opposite nostril while administering nasal medication into each nostril. The DON was then informed of the observation with LPN F and R78's medications and asked the facility's protocol on the administration of medications that were not prepared by the administering nurse. The DON replied LPN F should have not administered medications that they did not prepare. The DON stated they would check into it and follow back up. No further explanation or documentation was provided by the end of the survey. 30675 R3 On 10/15/24 at 9:29 AM, the resident was observed seated in an adaptive chair in the main lounge near the 200/300 hallways. A square foam bandage was observed to their left outer arm near the elbow that was dated 10/11/24. Review of R3's physician orders included a current order started on 10/7/24 that read, Left lateral elbow cleanse with wound cleanser pat dry apply foam dressing Q (every) 3 days and PRN (as needed) Monitor for signs of infection. At bedtime for skin protectant. Review of the Medication Administration and Treatment Administration records revealed the documentation for R3's left lateral elbow was documented with a check mark (as treatment completed) for each day from 10/7/24 through 10/14/24. Despite the order being written for every three days, Nurse 'A' and Nurse 'T' both documented treatments were being completed daily. Further review of the clinical record revealed R3 was admitted into the facility on [DATE] with diagnoses that included pneumonitis due to inhalation of food and vomit, autistic disorder, and restless leg syndrome. According to the Minimum Data Set (MDS) assessment dated [DATE], R3 had communication deficit (no speech), had severe cognitive impairment, was dependent upon staff for all aspects of care, and received hospice care. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/15/24 at 11:10 AM, an interview was conducted with Unit Manager (UM 'U'). When asked about the treatment to R3's left arm, UM 'U' went to R3 who was seated in a group activity, and removed the treatment with their bare hands and stated, Actually it's all healed up. When asked about the documentation that the treatment was being changed daily and most recently documented as completed on midnight shift for 10/14 when they confirmed the treatment they just removed was dated 10/11, UM 'U' reported the order had never been clarified and was unable to explain why Nurse 'A' and Nurse 'T' documented the treatment as being done, when it was not. On 10/15/24 at 11:55 AM, an interview was conducted with the Director of Nursing (DON). When asked if they had been informed of R3's concerns with documentation and treatment of their wound to the left elbow, the DON reported they were not. The DON was informed of the observation and interview and reported that should not have occurred. The DON reported they did random audits and have not identified that as an issue. On 10/15/24 at 2:05 PM, and 2:32 PM, attempts were made to contact Nurse 'A' but the voicemail was full and unable to leave a message. A SMS (Short Message Service) was left, but there was no response by the end of the survey.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to ensure effective interventions were implemented for one (R44) of one resident reviewed for communication. Findings include: On 10/14/24 at 9:15 AM, R44 was observed sitting up in bed. When spoken to, R44 appeared to understand the questions asked, but had difficulty speaking. R44 spoke softly and speech was unclear. R44 became tearful when she was not understood. A sign was posted in R44's room that noted R44 was able to understand others. R44 said she had Parkinson's Disease. It was difficult to understand most words R44 said. On 10/14/24 at approximately 9:30 AM, an interview was conducted with a staff member who was familiar with R44 (Staff 'V'). When queried about how staff communicated with R44, Staff 'V' reported it was difficult and they could sometimes understand what she said. On 10/14/24 at 12:25 PM, a second interview was conducted with R44. R44 answered Yes, No, and Sometimes to questions regarding her care, but when further inquiry was made to get more information, it was difficult to understand the resident's speech. R44 became tearful when not understood. On 10/15/24 at 2:00 PM, R44 was observed sitting up in bed. R44 was drooling with excessive saliva pooled in her mouth. When asked questions about her care, R44 grabbed a pen and attempted to write what she wanted to say, but it was illegible. R44 tried to speak, but her voice was soft and difficult to understand. R44 became tearful. On 10/15/24 at approximately 2:10 PM, an interview was conducted with Licensed Practical Nurse (LPN) 'F'. LPN 'F' was queried about how staff communicated with R44. LPN 'F' reported R44 had intact cognition and understood what was said to her. LPN 'F' reported they just asked Yes or No questions and said sometimes staff could understand her. When queried about any additional techniques, devices, and interventions that were used to ensure staff knew what her expressed needs were, LPN 'F' reported they were not aware of anything. On 10/16/24 at approximately 12:40 PM, an interview was conducted with Speech Language Pathologist (SLP) 'W'. SLP 'W' reported working with R44 since January 2024. When queried about what recommendations were made by SLP to improve or maintain R44's verbal communication or if any alternative methods of communication were used, SLP 'W' reported they spent time training nursing staff and R44 to ensure R44's communication needs were met. SLP 'W' reported R44 was able to understand others, but had difficulty speaking clearly due to Parkinson's Disease. SLP 'W' reported she made a laminated guide with techniques for both R44 and staff to use to ensure R44 was understood. On 10/16/24 at approximately 12:45 PM, R44 was observed with family who assisted her with eating. SLP 'W' located the guide mentioned above which was located in a basket near R44 on the over bed table. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the guide revealed a page titled, Tips and Tricks for Others and documented the following interventions: Be patient and focus on response. If you are distracted, you may miss a lot of words. Watch/read lips. Ask for Clarification. Repeat the words you understood, ask to repeat. Remind to slow down/restart. Ask for spelling of key word that may be missed. Ask for single words to get context clues at start. Ask yes/no for clarification. Give time to collect thoughts/respond. Think about environment/sounds. At that time, the guide was reviewed with R44. When asked if staff referred to the guide and/or utilized the techniques noted to ensure adequate communication, R44 shook her head and said they did not. A review of Speech Therapy Treatment Encounter Notes for R44 revealed the following notes: On 8/16/24, .Assisted (CNA) w/(with) pt ADLs (activities of daily living). Assisted (CNA) w/ pt (patient) communication. Pt required mod cueing for repetition, utilizing loud voice, and over exaggeration of consonants for increased intelligibility . On 8/23/24, .Created visual handout personalized to pt (patient) techniques to increase intelligibility w/(with) other communication partners . 9/4/24, .Establishment of compensatory strategies/creation of external environmental aid for communication techniques for pt family members and staff to utilize to increase comprehension and socialization of speech . A review of R44's care plans revealed a care plan initiated on 1/30/24 and revised on 5/16/24 that noted, The resident has Parkinson's. Interventions initiated on 1/30/24 included, .Allow sufficient time for speech/communication. Follow ST (speech therapy) recommendation to assist resident with communication. There were no specific interventions as recommended by SLP included on the care plan, including instructions to refer to the guide made by SLP 'W' or specific techniques recommended by SLP 'W'. A review of R44's clinical record revealed R44 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Parkinson's Disease. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R44 had intact cognition, unclear speech, was able to understand others, was dependent on staff for bed mobility and transfers, and required substantial/maximum assistance for all activities of daily living (ADLs). On 10/16/24 at 2:17 PM, an interview was conducted with the Director of Nursing (DON). When queried about what was in place to ensure adequate communication with R44, the DON reported she was not sure and would have to look into it. The DON reported communication interventions should be in the care plan and Kardex (guide for CNAs).

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to ensure accuracy of assessments, coordination of care with a wound care clinic, and ensure recommended interventions were followed for one (R18) of four residents reviewed for pressure ulcers, resulting in R18 being sent to the hospital from the wound care clinic for surgical debridement and intravenous (IV) antibiotics of an infected Unstageable (full-thickness skin and tissue loss in which the wound bed is obscured by slough or eschar) Pressure Ulcer. Findings include: On 10/14/24 at 9:26 AM, R18 was observed sitting up in bed eating breakfast. A low air loss mattress (group 2 mattress) was observed on R18's bed and a ROHO (individual air cells) cushion was observed in R18's wheelchair. R18 was asked if they had any wounds. R18's spouse explained R18 had a bad wound on their bottom and they were going to a wound care clinic for it. Review of the clinical record revealed R18 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: acute and chronic respiratory failure, cervical disc disorder and atrial fibrillation. According to the Minimum Data Set (MDS) assessment dated [DATE], R18 had severely impaired cognition and required substantial/maximal assistance of staff for mobility in bed. The MDS assessment also indicated R18 had two facility acquired Stage 2 (partial-thickness loss of skin with exposed dermis) pressure ulcers. Review of R18's wound assessments documentation revealed: A Skin & Wound Evaluation dated 7/17/24 read in part, .Type: Pressure - Kennedy terminal ulcer (skin failure during the final weeks of life) .Stage: Stage 1: Non-blanchable erythema (redness) of intact skin .Location: Sacrum, Lateral .In-House Acquired .Exact Date: 7/17/24 . A Wound Evaluation dated 7/17/24 read in part, #18 - Pressure - Kennedy terminal ulcer - Stage 1 .Sacrum - Lateral . The evaluation also included a picture of R18's wound. A Skin & Wound Evaluation dated 8/31/24 read in part, .Type: Pressure - Kennedy terminal ulcer . Stage 2: Partial-thickness skin loss with exposed dermis .Progress: Resolved . A Wound Evaluation dated 8/31/24 read in part, .#18 - Pressure - Kennedy terminal ulcer - Stage 2 .Sacrum - Lateral . The evaluations included a picture that showed R18's wound that had an open wound, not a resolved wound. A Skin & Wound Evaluation dated 9/13/24 read in part, .Type: Pressure - Kennedy terminal ulcer .Stage: Unstageable: Obscured full-thickness skin and tissue loss . Location: Coccyx . In-House Acquired .Exact Date: (left blank) . A Wound Evaluation dated 9/13/24 read in part, .#21 - Pressure - Kennedy terminal ulcer - Unstageable . Coccyx . The picture showed the wound in the same place on R18's body as the previous sacrum evaluations. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A Wound Evaluation dated 10/15/24 read in part, .#16 - Pressure - Unstageable .Coccyx . This evaluation was documented in a previously resolved wound thread however, the picture was consistent with R18's current wound. Review of R18's wound care consultation documentation available in the electronic clinical record included only two from 9/10/24 and 9/17/24, and revealed only treatment recommendations for R18's wounds. No consultation notes or description of R18's wound were included in the documentation. On 10/15/24 at 10:06 AM, the Director of Nursing (DON) was interviewed and asked about the apparent discrepancy in the documentation of R18's wounds. The DON explained she had not been at the facility when R18 acquired their wounds. The documentation and pictures of R18's wounds was reviewed with the DON. The DON agreed the wound labeled as Sacrum - Lateral and Coccyx and receiving the numbers 18, 21 and 16 were most likely the same wound. The DON was asked who had diagnosed R18's wound as a Kennedy terminal ulcer. The DON explained it is the doctor who diagnoses. When informed according to progress notes, R18's attending physician, Dr. S had last seen R18 on 7/10/24, the DON explained it must have been the Nurse Practitioner (NP R). The DON was asked about the lack of the wound care clinic's consultations and description of R18's wounds. The DON explained she would look into it. Multiple attempts beginning 10/15/24 at 12:31 PM were made to speak via phone or in person with Dr. S. No return call was made prior to the end of the survey. On 10/15/24 at 4:29 PM, a phone interview was conducted with Dr. P, the wound care clinic doctor. Dr. P was asked about R18's wounds. Dr. P explained R18's wounds had deteriorated significantly and were infected, they had sent R18 directly from the clinic to the Emergency Department (ED) from the clinic for surgical debridement and antibiotics .it had appeared the recommended interventions had not been done. Dr. P was asked if they had ever diagnoses R18's wounds as Kennedy terminal ulcers. Dr. P explained they had not. Dr. P was asked to provide the consultation notes for R18. Review of R18's wound care clinic consultation notes revealed: 9/10/24 .Note: The sacral wound cannot be examined today because the patient did not arrive seated in (their) Hoyer Lift (mechanical lift) sling. Therefore, the staff cannot safely transfer (them) for examination . 9/17/24 .Wound #4 Coccyx is a chronic Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer .The patient's wounds have worsened despite offloading on a group 2 alternating low are loss pressure reducing surface. (in bold type) (They) is a candidate for a group 3 air-fluidized bed (powered support surface that circulates air through ceramic beads to reduce pressure, friction and shear). The prognosis for healing is extremely poor unless offloading can be optimized . 10/1/24 .The coccygeal ulcer has further worsened due to suboptimal offloading .A group 3 air-fluidized bed is strongly recommended. The prognosis for healing is extremely poor unless offloading can be optimized . Offloading: .Sleep on group 2 alternating low air loss pressure reducing surface and turn q2 (every 2 hours) hours alternating between sides until group 3 air-fluidized bed procured . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	10/15/24 .The coccygeal wound has further deteriorated .suggesting inconsistent adherence to the offloading directives Nor, as far as I can tell, have my strong recommendation for a group 3 air-fluidized bed been pursued. The prognosis for healing is extremely poor unless offloading can be optimized .Wound #4 (coccyx) .New circumferential undermining .Except for a narrow peripheral rim of inflamed, red subcutaneous tissue, the wound surface is entirely obscured by grossly necrotic (dead) tissue undergoing liquefactive necrosis. No viable tissue is visible .Large amount of serosanguineous (blood and serum fluid) drainage with strong malodor. The wound is grossly infected .I disagree with the classification of the ulcer as a terminal Kennedy ulcer .the patient is not imminently or actively dying; however, given the current condition of the wound, he is at high risk for sepsis and death without urgent intervention, including hospital admission, IV (intravenous) antibiotic therapy, and aggressive debridement . Review of R18's progress notes revealed a Plan of Care Note dated 10/15/24 at 8:26 PM that read in part, . wound care provider was admitting guest to (local) hospital for debridement of (their) coccyx wound . Further review of R18's progress notes revealed: A Skilled Charting note dated 9/17/24 at 3:19 PM read in part, .Guest encouraged to turn and reposition. Guest favors laying on back . A Plan of Care Note dated 9/26/24 at 7:31 PM read in part, .Staff continues to encourage guest to turn and reposition frequently, guest does decline, states 'I don't like laying on my sides.' Guest prefers laying on (their) back . *It should be noted turning and repositioning is not necessary when using a group 3 air-fluidized bed. On 10/16/24 at 10:49 AM, NP R was interviewed and asked if they had diagnosed R18's wounds as Kennedy terminal ulcers. NP R explained they had agreed with the nurse's assessment, that it was a collaboration with nursing. NP R was asked if they were monitoring R18's wounds. NP R explained since R18 went to a wound care clinic, they did not monitor the wounds, they deferred to the doctor at the clinic. On 10/16/24 at 1:33 PM, the Administrator was interviewed and asked if they had ever been notified that the doctor at R18's wound care clinic had recommended R18 have an air-fluidized bed. The Administrator explained it had never been brought to their attention. On 10/16/24 at 12:49 PM, Licensed Practical Nurse (LPN) Q, who had taken the picture of R18's wound on 10/15/24, was interviewed and asked if there had been drainage and an odor when she changed the dressing on R18's coccyx. LPN Q explained there was drainage and an odor. Further review of the Wound Evaluation of R18's coccyx dated 10/15/24 read in part, .EXUDATE (drainage): Amount: Light; Type: Serous (serum); Odor noted after cleansing: None . (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/16/24 at 1:54 PM, the DON was informed of the findings from the wound care clinic consultation notes and asked why the consultation notes had not been requested after each visit to the wound clinic since the clinic's doctor was the one who was managing the resident's wound. The DON had no explanation. Review of a facility policy titled, Prevention of Pressure Ulcers revised 10/2010 read in part, .The facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognize, evaluated, reported to the practitioner, physician, and family, and addressed .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review the facility failed to ensure orders were implemented for a CPAP (continuous positive airway pressure) machine for one (R231) of one resident reviewed for respiratory equipment. Findings include: On 10/24/24 at 9:16 AM, R231 was observed sitting in a wheelchair in their room. R231 was asked about the care at the facility. R231 explained they did not understand why they had to almost beg someone to put on their CPAP machine at night. R231 pointed to their CPAP machine sitting on a dresser next to the bed. R231 explained they could not put it on themselves, but no one would put it on unless he asked. Review of the clinical record revealed R231 was admitted into the facility on [DATE] with diagnoses that included: acute pyelonephritis (kidney infection), Parkinson's and obstructive sleep apnea. According to a Brief Interview for Mental Status (BIMS) exam dated 10/11/24, R231 scored 12/15 indicating moderately impaired cognition. An admission nursing assessment dated [DATE] indicated R231 required the extensive assistance of staff for activities of daily living. Review of R231's physician orders revealed no CPAP orders. Review of R231's hospital referral paperwork read in part, .Past Medical History: .OSA (obstructive sleep apnea) on CPAP . On 10/15/24 at 9:25 AM, R231 was observed in the doorway of their room. R231 was asked if they had used their CPAP during the night. R231 explained sometime in the middle of the night, they had asked someone and they had put it on for them. On 10/15/24 at 3:14 PM, the Director of Nursing (DON) was asked if a resident had their CPAP machine at the facility, and if staff were putting it on a resident, should the doctor be called and an order be obtained. The DON explained there should be a physician order for CPAP. When informed R231's hospital referral listed CPAP, and R231 wanted to use their CPAP, but there were no orders for it. The DON explained she would look into it. No further documentation was provided by the end of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interviews and record reviews the facility failed to ensure expired medications were discarded and medications were stored securely for three Residents (R37, R61 and R70) of four residents reviewed for medication storage. Findings include: On 10/14/24 at 8:51 AM, Licensed Practical Nurse (LPN) G was observed preparing the morning medications for R37. Included in the medications was a Docusate Sodium Capsule 100 mg (milligram) obtained from a bottle with an expiration date of 9/2024 and a Multivitamin obtained from a bottle with an expiration date of 8/2024. LPN G did not identify that the medications were expired and administered both medications to R37. LPN G was asked to open the medication cabinet of R37 and obtain the Docusate Sodium and Multivitamin bottle. LPN G was asked to review the expiration date. LPN G reviewed the date and stated they usually would check the expiration date. LPN G stated the expired medication should have not been administered to R37. LPN G stated they were removing both medications from the residents medication cabinet to discard. On 10/14/24 at 9:50 AM, LPN E was observed preparing the morning medications for R61. Included in the medications was a Multivitamin pill obtained from a bottle with an expiration date of 8/2024. LPN E did not identify that the medication was expired. LPN E was observed to administer the expired multivitamin to R61. LPN E was asked to obtain the Multivitamin bottle from R61's medication cabinet and to review the expiration date. LPN E reviewed the date and stated they were discarding the expired medication. On 10/14/24 at 11:35 AM, an observation was conducted with the Director of Nursing (DON) of the 600 & 700 medication storage room. The first five bottles observed was a b complex B-12 full medication bottle that expired on 9/2024. Additional bottles of Vitamin C, Aspirin 81 mg and Vitamin B6 were all found to be expired with dates of expiration ranging from 2/2024 to 9/2024. The DON was asked the facility's process to ensure inventory is being done on the medications in the resident's medication cabinets and the facility's medication storage rooms. The DON stated they were recently hired at the facility and planned to look into the current system and implement a more effective system. The DON obtained all of the identified expired medications and stated they would discard them from the facility's supply. Review of a facility policy titled Storage of Medications dated June 2019, documented in part . Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled or without secure closures are immediately removed from inventory, dispose of according to procedures for medication disposal . The facility staff failed to follow the protocol of the facility policy. No further explanation or documentation was provided by the end of the survey. 39592 (continued on next page)

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	235668	A. Building B. Wing	10/16/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/14/24 at 9:46 AM, R70 was observed lying in bed. A bottle of Systane eye drops was in it's packaging box with the top removed and observed sitting on R70's bed. R70 was asked about the eye drops. R70 explained it was supposed to be locked in the medicine cabinet on the wall, but sometimes the staff left it out. Review of the clinical record revealed R70 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: congestive heart failure, atrial fibrillation and macular degeneration. According to the Minimum Data Set Assessment (MDS) assessment dated [DATE], R70 was cognitively intact. Review of R70's physician orders revealed no order for Systane eye drops. Review of R70's September 2024 Medication Administration Record (MAR) revealed Systane eye drops had bed discontinued on 9/27/24. On 10/15/24 at 2:03 PM, R70 was observed sleeping in their bed. The bottle of Systane in it's box was observed sitting on R70's bed. On 10/16/24 at 2:58 PM, the Director of Nursing (DON) was interviewed and asked if medications should just be left on a resident's bed. The DON explained they should be locked in the medicine cabinet. The DON was informed the Systane had been discontinued on 9/27/24. The DON explained the medicine should have been removed from the cabinet when it was discontinued.

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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. 30675 Based on observation, interview, and record review, the facility failed to maintain the main kitchen and the south satellite kitchen in a sanitary manner. This deficient practice had the potential to affect all residents in the facility that consume food. Findings include: On 10/14/24 between 9:40 AM-10:10 AM, during an initial tour of the kitchen with Dietary Manager (DM 'D'), Culinary Specialist (CS 'B'), and the Assistant Dietary Manager (ADM 'C'), the following items were observed: In the dry food storage room, there was a package of sweet cornbread muffin mix on a metal wire shelf that was not sealed and exposed to air. In the walk-in refrigerator, there was a large package of full-size fresh carrots that were not sealed and exposed to air. In the south kitchenette, there were multiple concerns identified, including: The countertop was observed to have dried debris on the surfaces, and in the cracks. The glass enclosure was soiled with debris on the glass surfaces both inside and out. There was debris imbedded in the cracks and crevices and missing portions of the seal that connected the glass to the countertop. The walls of the kitchenette along were soiled with dried dark colored food debris and stains. The flooring underneath the sink was observed to be covered with a thick, black debris. The microwave was heavily soiled on the inside with splattered food particles. The lower countertop area directly under the steam table was observed to have a laminate bottom shelf that was chipped, worn, and the edges were swollen from water damage. There were several trays and other food equipment stored directly on the laminate shelf. CS 'B' reported that area of the shelving was going to be replaced. CS 'B' was asked to provide documentation of an invoice regarding the shelving repair. When asked about the above concerns, CS 'B' , DM 'D' confirmed and reported they would address those concerns immediately. When asked who was responsible to ensure the satellite kitchens were maintained, CS 'B' reported they had a closing night checklist and after every shift, those areas should've been cleaned. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/15/24 at 8:25 AM, the Administrator was requested to provide any documentation such as an invoice of repairs needed for the satellite kitchens prior to concerns identified during the survey. They were informed this was requested from CS 'B' on 10/14/24, but there was no invoice provided. The Administrator reported they would look into that further. Review of the documentation provided by the facility regarding the invoice request included a facility email request on 10/14/24 at 10:32 AM (following the concerns identified during the survey) and a document dated 9/27/24 from CS 'B' that identified a maintenance need for the south serving kitchen laminate board repair and to fix laminate underneath the main wells (on the steam table). On 10/15/24 at 1:30 PM, the Administrator confirmed there was no invoice for repairs and reported someone was coming on 10/17/24 to make repairs. According to the 2017 FDA (Food and Drug Administration) Food Code section 3-305.11 Food Storage, (A) Except as specified in (B) and (C) of this section, food shall be protected from contamination by storing the food: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination . 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. According to the 2017 FDA Food Code section 4-602.13 Nonfood-Contact Surface, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. According to the facility's policy titled, Sanitation of Kitchen dated 8/13/2022: .All utensils, counters, shelves and equipment shall be kept clean maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use for proper cleaning. Seals, hinges and fasteners will be kept in good repair .All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on interview and record review, the facility failed to maintain complete and accurate medical records for one (R18) of one residents reviewed for medical records. Findings include: The facility was previously determined to be out of compliance for concerns with maintaining complete and accurate medical records during an abbreviated survey conducted on 8/28/24 with an alleged compliance date of 9/18/24. Review of the clinical record revealed R18 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: acute and chronic respiratory failure, cervical disc disorder and atrial fibrillation. According to the Minimum Data Set (MDS) assessment dated [DATE], R18 had severely impaired cognition and required substantial/maximal assistance of staff for mobility in bed. The MDS assessment also indicated R18 had two facility acquired Stage 2 (partial-thickness loss of skin with exposed dermis) pressure ulcers. Review of R18's wound assessments documentation revealed: A Wound Evaluation dated 7/17/24 read in part, #18 - Pressure - Kennedy terminal ulcer - Stage 1 . Sacrum - Lateral . The evaluation also included a picture of R18's wound. A Skin & Wound Evaluation dated 8/31/24 read in part, .Type: Pressure - Kennedy terminal ulcer . Stage 2: Partial-thickness skin loss with exposed dermis . Progress: Resolved . A Wound Evaluation dated 8/31/24 read in part, .#18 - Pressure - Kennedy terminal ulcer - Stage 2 . Sacrum - Lateral . The evaluations included picture showed R18's wound that had an open wound, not a resolved wound. A Wound Evaluation dated 9/13/24 read in part, .#21 - Pressure - Kennedy terminal ulcer - Unstageable . Coccyx . The picture showed the wound in the same place on R18's body as the previous sacrum evaluations. A Wound Evaluation dated 10/15/24 read in part, .#16 - Pressure - Unstageable . Coccyx . This evaluation was documented in a previously resolved wound thread however, the picture was consistent with R18's current wound. Review of R18's wound care consultation documentation from 9/10/24 and 9/17/24 revealed treatment recommendations for R18's wounds. No consultation notes or description of R18's wound was in the documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/15/24 at 10:06 AM, the Director of Nursing (DON) was interviewed and asked about the apparent discrepancy in the documentation of R18's wounds. The DON explained she had not been at the facility when R18 acquired their wounds. The documentation and pictures of R18's wounds was reviewed with the DON. The DON agreed the wound labeled as Sacrum - Lateral and Coccyx and receiving the numbers 18, 21 and 16 were most likely the same wound. The DON was asked why the same wound was not consistently in the same place but in multiple places with multiple wound numbers. The DON explained they had realized the nurse had put the Wound Evaluation on 10/15/24 in the wrong place, but had no explanation for the Sacrum-Lateral and Coccyx difference. The DON was asked about the lack of the wound care clinic's consultations and description of R18's wounds. The DON explained she would look into it. On 10/15/24 at 4:29 PM, a request was made to R18's wound care clinic to provide the consultation notes for R18. Review of R18's wound care clinic consultation notes revealed: 9/10/24 .Note: The sacral wound cannot be examined today because the patient did not arrive seated in (their) Hoyer Lift (mechanical lift) sling. Therefore, the staff cannot safely transfer (them) for examination . 9/17/24 .Wound #4 Coccyx is a chronic Unstageable Pressure Injury Obscured full-thickness skin and tissue loss Pressure Ulcer . The patient's wounds have worsened despite offloading on a group 2 alternating low are loss pressure reducing surface. (in bold type) (They) is a candidate for a group 3 air-fluidized bed. The prognosis for healing is extremely poor unless offloading can be optimized . 10/1/24 .The coccygeal ulcer has further worsened due to suboptimal offloading . A group 3 air-fluidized bed is strongly recommended. The prognosis for healing is extremely poor unless offloading can be optimized . Offloading: .Sleep on group 2 alternating low air loss pressure reducing surface and turn q2 (every 2 hours) hours alternating between sides until group 3 air-fluidized bed procured . On 10/16/24 at 12:45 PM, Unit Manager (UM) M was interviewed and asked about consultation notes. UM M explained when a resident went to an outside appointment, the assigned nurse would get the consultation report from the resident and enter the orders, then it went to the Unit Managers for review and was scanned into the clinical record. UM M was asked about R18's wound care clinic consultation from 10/1/24. UM M explained she would look for it. On 10/16/24 at 1:33 PM, the Administrator was interviewed and asked if she had ever been notified the doctor at R18's wound care clinic had recommended R18 have a air-fluidized bed. The Administrator explained it had never been brought to her attention. On 10/16/24 at 1:54 PM, the DON was informed of the recommendations from the wound care clinic consultation notes. The DON explained they had also called the clinic and received the consultation notes. When asked why when the facility had only the treatment recommendation from 9/10/24 and 9/17/24 and nothing from 10/1/24 that the consultation notes had not been requested prior, the DON had no explanation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41415 Based on observation, interview, and record review the facility failed to ensure the facility maintained proper infection control practices regarding the cleaning and disinfecting of glucometers per the facility's policy and manufacturer's instructions for two (R's 41 & 61) of four residents observed for the medication administration task. Findings include: R41 On 10/14/24 at 9:43 AM, Licensed Practical Nurse (LPN) E was observed administering R41's morning medications. Once R41 consumed their pills LPN E was then observed to obtain R41's blood glucose level via a fingerstick and glucometer. Once completed, LPN E was observed cleaning the glucometer with an alcohol prep pad and placed the glucometer in R41's medication cabinet and locked it. R61 On 10/14/24 at 9:55 AM, LPN E was observed obtaining the blood glucose level of R61 via fingerstick and the use of a glucometer. Once completed, LPN E was observed cleaning and disinfecting the glucometer with an alcohol pad and placed the glucometer in R61's medication cabinet and locked it. Review of a facility policy titled Blood Sampling revised April 2012 documented in part, . Obtain the blood sample, following the manufacturer's instructions for the device . Following the manufacturer's instructions, clean and disinfect reusable equipment, parts, and/or devices after each use . Review of the manufacturer's booklet provided by the Director of Nursing (DON) for the facility's glucometer documented in part . The disinfection procedure is needed to prevent transmission of blood-borne pathogens . The meter should be cleaned and disinfected after use . Two disposable wipes will be needed for each cleaning and disinfection procedure: one wipe for cleaning and a second wipe for disinfecting . The booklet documents multiple approved cleaning and disinfecting wipes and an alcohol prep pad was not listed. On 10/14/24 at approximately 12:43 PM, the Director of Nursing (DON) was interviewed and asked about the facility's protocol to clean the glucometers after obtaining a resident blood glucose level and the DON stated they would look into it and follow back up. The DON was informed of the observations of LPN E obtaining the blood glucose levels of R's 41 & 61 and the concern of improper infection control practices regarding the cleaning and disinfecting of the facility's glucometers and the DON stated they understood and would follow back up. At 1:05 PM the DON provided a one-step cleaner and disinfectant wipe bottle and stated the staff are supposed to use it after the resident is discharged , however staff can use alcohol swabs after each use of the glucometer. The DON was then asked about the directive in their facility policy and the manufacturer's directive regarding the cleaning and disinfecting of the glucometer device and the fact that an alcohol prep pad is not listed as an approved cleaning and/or disinfectant agent. The DON acknowledged the concern and provided no further explanation.