STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235702	A. Building B. Wing	04/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Novi, LLC	48300 11 Mile Road Novi, MI 48374

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 intake: MI00144138. Based on interviews and record review, facility failed to implement interventions and or provide adequate supervision to prevent injuries/falls for one (R901) of two Residents reviewed for falls, resulting in hospitalization for left hip fracture, preceded by emergency room visits, with subsequent decline in overall condition, pain (per the reasonable person concept) and death. Findings include: Review of the complaint received by the State Agency read in part, (relationship omitted) has had multiple falls, with the most previous breaking (gender omitted) hip. A review of R901's death certificate dated 3/6/24 read manner of death Accident; Describe how the injury occurred Fall; place of injury nursing home. R901 was admitted to the facility for skilled nursing care and rehabilitation after hospitalization . R901's admitting diagnoses included respiratory failure, heart failure, acute urinary tract infection, anxiety, and depression. R901 had dysphagia (difficulty with swallowing) and they were receiving their nutrition and hydration through a Percutaneous Endoscopic Gastrostomy (PEG) tube. Based on the Minimum Data Set (MDS) assessment dated [DATE], R901 had severe cognitive impairments. R901 was transferred to the hospital on 2/11/24 after a fall at the facility and they were admitted to the hospital with a hip fracture. A nursing progress note dated 2/11/24 at 8:12 read, New order in place to transfer resident to ER (emergency room) for further evaluation due to SPO2 (oxygen level) desaturations, increased confusion, and restlessness. Transferred a resident to ER via 911 at 6:40. DON (Director of Nursing) notified. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Further review of the nursing progress note dated 2/11/24 at 5:04 read in part, At approx 0030, 2/11/24, CNA (Certified Nursing Assistant) assigned to 500 hall alerted writer into the room. Writer noted resident in sitting position on the floor with back against the bed, legs extended to full length, CNA states that resident was lying in prone position when she entered the room at first, she assisted him in sitting position for comfort prior to alerting writer. Resident assessed for injuries; Discomfort observed with ROM (range of motion) assessment. Assisted back in bed with the help of CNA New orders for stat-x-ray and PRN (as needed) pain medication in place. PRN Ativan 0.5 mg given r/t (related to) restlessness. Review of R901's discharge summary from the hospital dated 1/30/24 (prior to admission to facility), revealed R901 was nonverbal and they were receiving intra-venous (IV) antibiotics for a urinary tract infection and they had altered mentation. The History & Physical note by the attending physician at the facility dated 1/31/24 revealed an assessment section that included R901 had gait instability and ataxia (unsteady walking) and they were under fall precautions. Further review of R901's Electronic Medical Record (EMR) revealed a Speech Language Pathology (SLP) evaluation dated 1/31/24. Cognitive-communicative skills section of SLP evaluation read in part: Ability to understand others = rarely/never understands; follows 1-step direction= usually, with prompts/cues; ability to express ideas/wants=rarely/never understood clearly indicating that the R901 had poor insight about their current physical and medical condition with severely impaired safety awareness primarily due to their cognitive impairments that was exacerbated by their communication deficits. SLP evaluation assessment summary section read, Barriers likely to impact discharge to next level = Exacerbation of cognitive impairment; Patient characteristics that may impact treatment = lacks insight into condition and risk factors. Review of R901's admission fall risk assessment dated [DATE] revealed a score of 13, indicative of moderate risk for falls. A care transition/social services progress note dated 1/31/24 also revealed that R901 was alert and oriented x1, indicting severe cognitive impairment and they were non-verbal. A review of R901's fall care plan initiated on admission, dated 1/30/24, revealed the following interventions: Administer medications, encourage and assist to bed after therapy, evaluate lab tests, evaluate x-rays, neuro checks per protocol, reinforce need to call for assistance. R901's care plan did not have any safety interventions based on their cognitive impairments, communication deficits and their overall functional impairments/health condition during the admission to the facility. A nursing progress note dated 2/1/24 at 07:18 read, Resident AxOx0, unable to express concerns. PICC (Peripherally Inserted Central Catheter) was placed around 19:00. Patient was combative and pulling at PEG tube and trying to get out of bed. PEG tube was secured. Safety measures, patient bed was lowered to ground and call light within reach. Review of Kardex (electronic patient care information sheet) for Certified Nursing Assistants (CNA) had the following interventions under safety section: Encourage and assist resident into bed after therapy and Reinforce need to call for assistance. There were no other resident specific safety interventions that were in place for R901 from admission to discharge. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing progress note dated 2/1/24 at 15:30 read, Writer was notified of patient noted on the floor.patient was assisted to bed .patient unable to state why he was on the floor. A change of condition progress note dated 2/1/24 at 10:40 revealed that R901 had a fall (approximately 3 hours) after the initial observation of R901's combative behavior/restlessness. Further review of the note revealed a section that read nursing observation, evaluation, and recommendation and the section was blank. The section that read Primary care Provider Feedback was blank. Review of R901's incident/accident report received via e-mail from the facility administrator revealed the following information: R901 had an unwitnessed fall on 2/1/24 and predisposing physiological factors were confusion and unsteady gait. The note read patient unable to state why he was on the floor. It must be noted that R901 was non-verbal and had severe cognitive deficits. Further review of the incident and accident report did not reveal a thorough follow-up and root cause analysis of the fall with an appropriate/resident specific post fall intervention to prevent any further falls/injuries on R901's care plan. A nursing progress on 2/2/24 at 7:09 read in part, unable to express concerns or communicate needs Resident continues making effort to dislodge PEG tube and attempts to get out of bed. CNA assigned to Resident found him in the bathroom at approx 03:25. No evidence of fall . There was no evidence of any interventions based on EMR and timeline of interventions document provided by the facility despite resident making attempts for unassisted and unsafe transfers. A nursing progress note on 2/2/24 at 10:07 (approximately 3 hours later) revealed R901 had a fall. The note read Writer notified by staff that resident was on the floor. Writer went to the room and noticed the patient was on the floor on the side of his bed sitting on his bottom. Patient had a skin tear on each arm that was bleeding and a small gash in the back of his head. Patient is nonverbal and unable to express if he was in any pain. Patient went to hospital at 9:20 for further evaluation . R901 returned from the emergency roiagnom on [DATE]. Review of R901's fall risk assessment dated , d+[DATE] at 17:14 revealed a score of 20, (increase by 7 points from the previous score), indicative of high risk for falls. There was no change in R901's care plan despite the increase in risk with a recent fall and injury. There were no nursing progress notes for 2/2/24 and 2/3/24 after R901 had returned from the emergency room . A progress note dated 2/4/24 at 18:35 revealed that R901 was attempting to ambulate unassisted and had a fall. The note read Skin laceration and bleeding noted on left forearm. Resident appeared to be alert after hitting his head .NP (name omitted) ordered writer to send resident for further evaluation for PICC line insertion due resident current medical status. The night nurse informed the writer that PICC line was pulled out by the resident earlier this morning . A change in condition note dated 2/4/24 at 18:15 revealed that R901 had fall and altered level of consciousness. Nursing observation, evaluation and recommendations read Resident has chronic confusion with poor safety awareness. R901 was sent to ER for further evaluation. R901 returned from the ER the same day. Discharge summary from the ER read, you have a head injury. It does not appear serious this time. But, symptoms of more serious problem, such as a mild brain injury (concussion) or bruising or bleeding in the brain may appear later. For this reason, you or someone caring for you will need to watch for the symptoms listed . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	An investigative summary note dated 2/5/24 at 10:10 read, Root cause analysis was completed and identified that guest incident occurred despite a fall plan in place and followed. Contributing safety factors for this guest for this guest included: anxiety, depression, malnutrition .The root cause of this event was guest attempting to self-transfer. Conclusion: Follow-up assessments support that guest did not experience any functional decline in his conditions. Safety measures are in place per plan of care .There were no lasting effects from the incidents and resolved without complications. No changes in neuro status. It must be noted that R901 had multiple staff observations of attempts for unassisted transfers/ambulation with 3 falls. Review of R901's fall care plan revealed a note under the focus regarding the fall incident on 2/4/24. There were no additional fall preventions/supervision measures implemented despite 3 falls since admission and 2 ER visits, in less than 72 hours. The fall prevention intervention under fall care plan that was added after admission was transfers/ambulates with 2-person assist with assistive device on 1/31/24. A progress note dated 2/6/24 at 3:46 read, During start of shift patient was agitated. Patient was pulling at his PEG tube, trying to get out of bed. Patient's son was called and advised to come and sit with son due to his behaviors and was told no 'That is our f .g job' .Patient would benefit with one-on-one care. A progress note dated 2/7/24 at 00:13 read in part, Resident received on shift fully naked standing without assistance .Resident constantly up without assistance and reminded to use walker . Resident appears to be confused . There was no evidence that R901 received the supervision/additional interventions they needed after multiple falls. R901 was in their room during all the fall events based on the medical records. Nursing progress notes revealed that R901 was agitated on 2/8/24 and 2/9/24. R901 was transferred out to the hospital on 2/8/24 for a dislodged PEG tube and PICC line. The nursing progress note read Resident very agitated tonight. He was constantly trying to get out of bed . R901 was seen by the practitioner on 2/9/24 due to anxiety, restlessness and agitation and they were ordered to have Ativan (a narcotic anti-anxiety) medication as needed. On 2/11/24, R901 sustained another unwitnessed incident in the room when they were observed in the prone position by the CNA. R901 was transferred to hospital and admitted with a hip fracture. An e-mail request was sent to the facility administrator to provide the fall prevention/supervision intervention that were provided for R901. The document received had the following details: Fall: 2/1/2024 - 10:40am - unwitnessed fall in room - no injury noted - offer and assist with transfer back to bed after therapy. Fall: 2/2/2024 - 17:07 - unwitnessed fall in room - abrasion and 2 skin tears - sent to ED for further evaluation. Fall: 2/4/2024 - 11:40 - witnessed fall in room - laceration - sent to ED for further evaluation Fall: 2/11/2024 - :30 - unwitnessed fall in room - left hip pain - sent to ED for further evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview with the complainant on 4/29/24 at approximately 4:50 PM, they reported that R901 had multiple falls during the stay at the facility. The complainant reported that R901 did not have the staff supervision they needed during their stay and they had expressed their concerns, and that after the last fall R901, was admitted to hospital. R901 had a hip fracture and they had hip surgery. The complainant added that R901 went home with family. Their condition had worsened and they had passed away on 3/6/24. An interview was completed with staff member A on 4/30/24 at approximately 9:45 AM. Staff member A was queried how they had received information on the resident care and staff member Areported that they had received information from their electronic medical record (EMR). An interview was completed with the DON on 4/30/24 at approximately 3:55 PM. During the interview the DON was queried what was facility protocol if a resident were a high fall risk. The DON reported that they would order fall prevention interventions like: make sure that wheelchair brakes were locked, low bed, fall mat etc. The DON was queried specifically on R901's fall prevention interventions who had severe cognitive impairment and a communication deficit. The DON reported that R901 was weak when they were admitted . When queried about the multiple falls and ER visits why R901 and the intervention/supervision the facility had in place after every incident, the Administrater and DON provided a copy of the care plan that was in the EMR under mood and activity sections for leisure activities, family support etc. No further information was provided prior to the exit of the survey. A facility provided document titled Falls and Fall Risk, managing with a revision date of December 2007 read in part, Based on previous evaluations and current data the staff will identify interventions related to residents' specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Prioritizing approaches to managing falls and fall risk: 1. Staff with the input of the attending physician will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident form risk identifies several possible interventions the staff may choose to prioritize interventions. (i.e. to try one or a few at a time rather than many at once). 2. Examples of initial approaches might include exercise and balance training or a rearrangement of room furniture. If a medication is suspected as a possible cause of a residence falling the initial intervention might be to taper or stop that medication. 3. In conjunction with the consultant pharmacist and nursing staff the attending physician will identify and adjust medications that may be associated with an increased risk of falling or indicate why those medications could not be tapered or stopped even for a trial period. 4. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. 5. If underlying causes cannot be readily identified or corrected staff will try various interventions. Based on the assessment and of the nature or category of falling until falling is reduced or stopped or until the reason for the continuation of the falling is identified as unavoidable .