

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235702	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/09/2025
NAME OF PROVIDER OR SUPPLIER  Wellbridge of Novi, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Plan the resident's discharge to meet the resident's goals and needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38271</p> <p>This citation pertains to intake #MI00149107.</p> <p>Based on interview and record review the facility failed to involve a court appointed-legal guardian in the discharge process for one resident (R502) of three residents reviewed for discharge planning, resulting in R502 signing themselves out of the facility without the legal guardian's knowledge. Findings include:</p> <p>On 1/9/25 a complaint submitted to the State Agency was reviewed and alleged R502 had signed themselves out of the facility against medical advice (AMA) without the legal guardian being involved in the decision on 11/17/24.</p> <p>On 1/9/25 the medical record for R502 was reviewed and revealed the following: R502 was initially admitted to the facility on [DATE] and had diagnoses including Adult failure to thrive, Cognitive communication deficit and Heart failure.</p> <p>A patient demographics hospital document from R502's initial admission in June 2024 was reviewed and revealed R502 had a legal guardian.</p> <p>A letters of guardianship document signed by the [NAME] County probate court Judge on 9/30/24 indicated R502 had a court appointed legal guardian.</p> <p>A PASARR (Preadmission screening and resident review) dated 10/15/24 completed by the hospital Social Worker was reviewed and indicated R502 had a public guardian and had a history of major depression and psychosis</p> <p>A review of R502's facility census revealed they were discharged on [DATE] and was readmitted on [DATE].</p> <p>A progress note dated 11/17/2024 at 15:05 revealed the following: Writer entered residence room resident was up in bed watching TV, Vitals were assessed , medication was administered. At 1504 Resident became very agitated saying that he wanted to go home, resident called his friend, friend came resident started to get dressed. Writer educated him on the importance of staying and also informed him that he was leaving AMA. Resident still decided to leave , he got in a red car with his friend. On call NP (Nurse Practitioner) notified along with on call manager .</p> <p>(continued on next page)</p>

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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<p>F 0660</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A progress note dated 11/19/24 revealed the following: guest admitted back to facility, .guest admitted with cell phone no charger and clothing. guest was offered lunch and snacks upon arrival. guest consumed meal with no concerns. guest is currently in bed with call light and fluids with in reach.</p> <p>A progress note dated 11/20/24 revealed the following: Spoke with guardian; guardian wanted to make sure resident is not to have any contact with [name of neighbor]-his neighbor; they are pressing charges against him; resident is allowed to speak with [name of brother], his brother, but [brother] can not make any decisions regarding resident ' s care.</p> <p>On 1/9/25 at approximately 10:56 a.m., during a conversation with R502's legal guardian D (LG D), LG D indicated that they were never contacted before R502 signed themselves out on 11/17/24. LG D reported that they were not involved in the discharge planning process until after R502 had been brought back to the facility and reported that it was dangerous that the facility let R502 leave without consulting them to ensure R502 was safe in the community and had an appropriate discharge plan.</p> <p>On 1/9/25 at approximately 1:56 p.m., during a conversation with the facility Administrator, the Administrator was asked why R502 was permitted to leave the facility without notifying the legal guardian and discussing the discharge plan with them. The Administrator indicated that there was little information in the record that identified R502 had a legal guardian and that after they were brought back, they reviewed the PASARR form which gave some information that R502 had a legal guardian. The Administrator indicated they completed a past non-compliance as a result of failing to contact R502's guardian before the discharge and had audited all the PASARR forms to ensure residents that had guardians had updated guardianship information and audits were ongoing. The Administrator indicated that the Social Worker at that time was educated on completing thorough reviews of PASARR forms upon admission and that the facility's compliance date to be back in compliance was 11/28/24.</p>		