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	10/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Novi	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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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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(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 - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2634191.Based on interview and record reviews the facility failed to timely implement orders as directed by the Provider for one (R702) of one resident reviewed for a change of condition. Findings include:A review of the medical record revealed R702 was re-admitted to the facility on [DATE] with a primary diagnosis of acute on chronic diastolic (congestive) heart failure and additional diagnoses of edema, paroxysmal atrial fibrillation and acute embolism and thrombosis of unspecified deep veins of lower bilateral extremity. A Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. A review of the progress notes revealed the following: A nursing note dated 4/25/25 at 6:15 AM, documented . Resident stated she was having chest pain. Given Nitroglycerin x3. She then stated that her whole body is hurting . given.pain medication. She then began to ask where her daughter is & where is she at. Stated that she is lost. Resident is now stating that pain is decreasing.A review of a Physician progress note dated 4/28/25 at 1:57 PM, documented in part . Reason for visit: request by patient/family/nurse regarding weakness, fatigue, pain. Patient seen and examined. C/O (complaints of) increased weakness and fatigue. Also C/o generalized joint pain. States she is feeling weakness than when she was admitted . C/o dysuria (pain with urination), urgency, urinary frequency. Also c/o SOB (shortness of breath). chronically ill appearing, weak. Diminished BS (breath sounds) with crackles at bases. + (positive) trace BLE (bilateral lower extremities) edema. Assessment SOB, suspect secondary to CHF (congestive heart failure). decompensated CHF, Fatigue, Urinary . UTI, Persistent atrial fibrillation with RVR (rapid ventricular response), BLE edema. Plan. check UA (urinalysis), C&S (culture & sensitivity), CHF - with SOB. Check CXR (chest x-ray) PA (posterior - anterior)/lat (lateral) STAT (immediate). Give extra 20 mg (milligram) Lasix QD (every day) x3 days-1st dose today. Begin duoneb (Ipratropium-Albuterol Solution via nebulizer) QID (four times a day). Continue Lasix. A review of the Physician orders and medical record revealed the extra 20 mg of Lasix to be administered once a day for three days was not implemented as directed for the first dose to be administered on 4/28/25. The duoneb nebulizer treatment was implemented incorrectly and ordered three times a day instead of four times a day. Further review of the Physician orders revealed on 5/7/25, more than a week later the extra 20 mg of Lasix was administered as initially directed by the Provider on 4/28/25. The duoneb (Ipratropium-Albuterol nebulizer treatment) was implemented four times a day as initially directed by the Provider on 5/7/25, more than a week after the directive.On 10/7/25 at 1:37 PM, the Unit Manager (UM) A was interviewed and asked about the facility's practices when a nurse practitioner, physician assistant or physician (Provider) examines a resident and orders new medications to be implemented whose responsibility it was to ensure the orders are implemented in the electronic medical system and administered. UNM A replied the provider would inform the floor nurse to put in the orders or the Provider would usually tell them (the unit manager) and they would ensure the orders are put in the system. UNM A was then asked why R702's extra 20 mg of Lasix x3 days was not implemented and administered timely and why the nebulizer treatment was not implemented correctly initially causing a delay in the correct administration/dose of the treatment. UNM A stated they would look into it and follow back up. At 2:41 PM, UNM A stated they reviewed the medical record and they were unable to provide further information or documentation on why the extra 20 mg of Lasix was not implemented/administered timely or why the nebulizer treatment was not implemented as ordered by the Provider. No further explanation or documentation was provided by the end of the survey.

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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. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #2634191Based on interview and record review the facility failed to ensure a resident's safety to prevent a fall and ensure x-rays pertaining to the fall were completed timely for one (R702) of one resident reviewed for falls resulting in R702 falling out of bed, sustaining a fracture to the right femur that required hospitalization, surgery and led to their death. Findings include:Complaints were filed with the State Agency (SA) that alleged R702 fell out of their bed trying to attempt to grab their food tray and feed themselves. The complainant reported R702 required 1:1 feeding assistance for all meals/snacks as they suffered from severe Rheumatoid Arthritis (an inflammation that causes swollen joints causing difficult performing daily activities) and Osteoarthritis (joint disease that causes pain, stiffness and loss of function). The complainant noted that a full lunch tray was placed out of reach of R702 on or about 5/13/25. The resident was sitting on the side of their bed and allegedly tried to reach for their meal tray and fell out of bed. R702 was sent to the Hospital the next evening (5/14/25). It was determined the resident had sustained a fracture on their left femur that required surgery. Continued review of the complaint noted that despite the surgery, R702's death certificate noted that the resident died due to Left femur fracture with complications on 5/27/25.A review of R702's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: urinary tract infection, morbid obesity, rheumatoid arthritis and congestive heart failure. A review of the resident's Minimum Data Set (MDS) dated [DATE] noted R701 had a Brief Interview for Mental Status (BIMS) score of 13/15 (cognitively intact). However, additional record reviews noted that R702 had a decline in cognition after 4/26/25.Continued review of R702's record revealed the following:4/18/25: Hospital Assessment OT(Occupational Therapy): .DC (discharge) recommendations:. Patient requires extra time and encouragement to participate, with mod (moderate) x2 assist with ADLs (activities of daily living) secondary to pain.Patient is easily distracted.Precautions to Rehabilitation Treatment: falls.Functional Mobility: Roll-Right: Max PA (Patient Assist)=Maximal Assist.Supine to Sit: Max PA.Sit to Stand=Moderate 2 Person Assist.Stand to Sit: Moderate 2 Person Assist.OT Problem List: Balance deficits.decreased functional ability.Fall risk.Assessment details.Patient requires extra time and encouragement to participate with mod x2 assist with ADLs.4/20/25: admission Summary: .Patient has pain all over her body due to arthritis. Patient is a one-to-one feed hydration.4/21/25: Physician Progress Note:. Patient presented to ED (emergency department) for SOB (shortness of breath) and BLE (bilateral lower extremities).PT (patient) has acute metabolic encephalopathy due to pain medication. Palliative care was consulted.Physical Exam:.Chronically ill appearing weak, obese.Plan:.PT (Physical Therapy)/OT.Fall precautions.Rehab Potential: Fair.4/23/25: Skilled Charting: .Guest resting in bed. Ax0x1-2 (alert and oriented) to name and date.4/25/25: Skilled Charting: .Resident stated she was having chest pain.whole body is hurting.She then began to ask where daughter is.stated that she is lost. This appears to be resident's baseline.4/26/25: Skilled Charting: .Resident calls out for daughter and stating she wants to die.Assisted with transfers as needed, 2 PA.non-ambulatory.4/29/25: Order: .Regular texture, thin consistency, 1:1 assistance at meals. Created by Nurse E.5/2/25: Physician Progress Note: .Patient seen.somewhat increased anxiety today. Does not know why she can't walk.Tolerating Keflex (antibiotic) for suspected UTI (urinary tract infection).5/8/25: Skilled Charting: .Resident a/o x 1-2.5/12/25: Order Note: .Late entry.Follow-up UTI. chronically ill, weak.5/13/25 (12:54 PM): INTERACT SBAR (Situation, Background, Assessment, Recommendations): .Evaluation: Fall.Does resident have pain: Yes.Nursing observations.was charting when writer heard a faint help me from room (number redacted). Writer then went to assist resident when writer enter room resident was on floor by the bed with upper body against the bed, resident stated she [sic] slip out of bed trying [sic] get her food tray close to her as she set [sic] on the side of the bed.resident stated her left knee was in pain.Manager came and assist resident back on bed with writer.5/13/25 (2:38 PM): Nursing Note: .Writer was charting when writer heard a faint help me from room.Writer then went to assist resident, when writer enter room resident was on floor by the bed with her upper body against the bed, resident stated she slip out <sic> out of bed trying to get her food tray close to her as she set on the side of the bed. Manager came and assist resident back on bed with writer. *It should be noted that the writer was Nurse D and is no longer is employed at the facility.5/13/25 (2:50 PM): (Facility) Fall Assess: .R702.History of Fall. doing unusual activity 7.Reaching up or reaching down.Contributing Factors: 1. Difficulty maintaining sitting balance 3. Gait Problem , such as unsteady gait Intervention/Comment: Resident should always be in bed

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2634191.Based on interview and record reviews the facility failed to ensure a STAT (immediate) chest x-ray was ordered and completed as noted by the physician assistant for one (R702) of one resident reviewed for radiology services. Findings include:A review of the medical record revealed R702 was re-admitted to the facility on [DATE] with a primary diagnosis of acute on chronic diastolic (congestive) heart failure and additional diagnoses of edema, paroxysmal atrial fibrillation and acute embolism and thrombosis of unspecified deep veins of lower bilateral extremity. A Minimum Data Set (MDS) assessment dated [DATE] noted a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. A review of a Physician progress note dated 4/28/25 at 1:57 PM, documented in part . Reason for visit: request by patient/family/nurse regarding weakness, fatigue, pain. Patient seen and examined. C/O (complaints of) increased weakness and fatigue. Also C/o generalized joint pain. States she is feeling weakness than when she was admitted . C/o dysuria (pain with urination), urgency, urinary frequency. Also c/o SOB (shortness of breath). chronically ill appearing, weak. Diminished BS (breath sounds) with crackles at bases. + (positive) trace BLE (bilateral lower extremities) edema. Assessment SOB, suspect secondary to CHF (congestive heart failure). decompensated CHF, Fatigue, Urinary . UTI, Persistent atrial fibrillation with RVR (rapid ventricular response), BLE edema. Plan. check UA (urinalysis), C&S (culture & sensitivity), CHF - with SOB. Check CXR (chest x-ray) PA (posterior - anterior)/lat (lateral) STAT (immediate). Give extra 20 mg (milligram) Lasix QD (every day) x3 days-1st dose today. Begin duoneb (nebulizer treatment) QID (four times a day). Continue Lasix. A review of the physician orders revealed no order implemented for the STAT chest x-ray until 5/6/25, more than a week later. On 10/7/25 at 1:37 PM, the Unit Nurse Manager (UNM) A (the nurse manager for the unit R702 resided on) was interviewed and asked the facility's practices when a nurse practitioner, physician assistant or physician examines a resident and orders new medications and test to be completed whose responsibility was it to put in the orders for the new medications and tests. UNM A stated the provider would tell the floor nurse to put in the order or they would usually tell them (the unit manager) and they would put in the orders. When asked why R702's STAT chest x-ray was ordered more than a week after the provider examined and noted to have the STAT chest x-ray completed, UNM A stated the ordered probably did not hit the board (electronic medical system notification) delaying the implementation. UNM A stated they would look into the concern and follow back up. At 2:41 PM, UNM A stated they reviewed the medical record and they were unable to provide further information or documentation on why the STAT chest x-ray order was not implemented and completed timely. No further explanation or documentation was provided by the end of the survey.