STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235704	A. Building B. Wing	10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Romeo, LLC	375 South Main Street Romeo, MI 48065

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on interview, and record review, the facility failed to ensure a responsible party (RP)/family member/Durable Power of Attorney (DPOA) was notified when a resident left the facility against medical advice (AMA) for one resident (R111) of one reviewed for notification of changes. Findings include: A record review of R111's electronic medical record revealed the following progress note, 8/13/24 02:53 AM: 8/12/24, around 20:40 (8:40 PM) [R111] stated to writer that [they] [were] leaving [Nursing Home] tonight with [their two friends]. [R111] stated that [they] [were] going to the [Upper Peninsula] and [they] will not be returning to [nursing home]. Conversation had with [R111] encouraging [them] to stay at facility and [they] continued to refuse. [R111] asked plans for transportation, where [they] will be staying once [they] left the facility as well as who is going to provide care for [them] when needed. [R111] stated that [their] friend [had] transportation, provides shelter and her two friends will help care for [R111] DON (Director of Nursing) contacted regarding situation and spoke directly with [R111] about [their] decision to leave AMA. DON suggested to [R111] that [they] stay tonight so our team can speak with [them] in the morning, make proper arrangements for possible homecare and provide all available resources to guest before leaving against medical advice and [R111} continued to refuse. [R111] made aware of the importance of medication compliance and that [they] [had] prescription medications that will need to be filled by a doctor. [R111] made aware that [they] need a physician overseeing [their] care and also made aware that [they] need someone to help provide care for [their] basic needs and medical needs. [R111] claimed [that their] pain medications [they] received here do not work for [them] anyway's and [that they] do not need a doctor. [R111] also claims that [they] have [their] two friends that can help with [their] care and [they] can also provide [their] own care for [themselves], as [they] [have] always done so before. [R111] continued to refuse to stay at [nursing home] despite multiple attempts and conversations with writer and DON. MD (Medical Doctor) contacted by DON, notified of situation and said 'Okay it is AMA.' [R111] signed face sheet stating [they were] leaving against medical advice on 8/12/2024 at 21:20. Further record review revealed the following email sent to R111's designated responsible party (RP) C by Social Services Director (SSD) A on 8/13/24 at 9:39 AM, Wanted to let you know that to my surprise, found out this morning that [R111] is no longer at the facility. I'm not sure if you were aware of that. [R111] checked [them self] out last night, stated [they] [were] going to live with friends. Several staff members had discussions with [R111] but [R111] [insisted] on leaving . (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R111's progress notes revealed the following, On 8/16/24 1421 (2:21 PM) Phone call received from [Social Worker] from an [out of state hospital] stating that [R111] had arrived at the emergency room (ER), 'caked in urine and feces' with [their] [friend]. [Friend] stated that [R111] was unable to transfer from vehicle to the restroom and [that they] [were] unable to transfer [R111]. [R111] had not exited vehicle since leaving [nursing home] [Social Worker] stated that [R111] provided phone number for [RP/Family member] and requested writer to confirm phone number. [Social Worker] also requested rx (prescription) list and DPOA (durable power of attorney) papers to assist w (with)/ initiation of care and discharge planning. Writer sent information to [Social Worker]. Continued review of R111's EMR revealed family member C was indicated in R111's record to be the responsible party and DPOA. A document titled, .DPOA For Healthcare was signed by family member C and dated 7/19/22. Per review of R111's EMR, R111 was originally admitted to the facility on [DATE] with diagnoses that included Multiple sclerosis (autoimmune disease) and Chronic obstructive pulmonary disease (COPD) (lung disease). R111's most recent quarterly minimum data set assessment (MDS) dated [DATE] revealed that R111 had a moderately impaired cognition, was dependent for toileting, and required assistance with showering, bathing, and dressing. On 10/9/24 at 4:04 PM, Registered Nurse (RN) B was interviewed by phone and asked about the discharge of R111 from the facility on 8/12/24. RN B indicated that R111 made the decision to leave the facility and discharge with a friend on, the spur of the moment. RN B was asked if R111's RP/DPOA/Family member C was contacted regarding R111's discharge from the facility. RN B' was not able to provide an answer to this question. On 10/10/24 at 12:12 PM, R111's RP/DPOA/Family member C was contacted by phone and asked about R111's discharging from the facility on 8/12/24. Family member C stated, This is a messed up situation. They shouldn't have let [R111] go without notifying me. [R111] left with someone I consider to be a stranger. Family member C indicated that they had not spoken to [R111] in over three weeks and were unaware of [R111's] current whereabouts. Family member C indicated that [R111] was incontinent and dependent upon others for their care. Family member C stated, I'm very upset that the [nursing home] let [R111] leave their facility without notifying me. On 10/10/24 at 12:47 PM, The Social Service Director (SSD) A was interviewed about R111 leaving the facility AMA and asked if the RP/Family Member/DPOA should have been contacted upon R111 leaving the facility. SSD A stated, [R111] was her own RP when they left the facility. The business office changed it, I had nothing to do with it. SSD A was further interviewed and asked if they had any documentation to provide which indicated that R111 was their own RP on 8/12/24 when they left the facility AMA. SSD A was unable to provide any documentation to the surveyor regarding this issue. On 10/10/24 at 1:16 PM, the Director of Nursing (DON) was interviewed about R111 leaving the facility AMA and asked if the RP/Family Member/DPOA should have been contacted upon R111 leaving the facility. The DON stated, [R111] was cognitively intact. The DON further indicated that they felt that it was unnecessary to contact [R111's] RP/Family Member/DPOA regarding [R111] leaving the facility AMA. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled, Discharge or Transfer of Resident Effective: 10/24/17 was reviewed and revealed the following, Purpose: To provide safe departure from the center .To provide guidelines to ensure the proper steps are taken should a resident .request to be discharged from the center against medical advice (AMA). Discharge Against Medical Advice: 1. The resident/guest/and/or family legal representative should be informed of the risk involved, the benefits of staying at the facility and alternatives to do both .2. Document in the Medical Record regarding the information was presented to .the family responsible party if needed. 3. Notify Adult Protective Services .if self-neglect is suspected and document as needed. A facility policy titled, Change of Condition Resident Family/Responsible Party Notification Revision Date: 4/12/16 was reviewed and revealed the following, Purpose: Family and/or responsible party are notified anytime there is a change in the resident's condition or plan of care. Procedure: 1. Notification of any change in the resident's condition will be done in a timely manner .Check the medical record for specific family/responsible party instructions regarding notification. 2. Notify appropriate party and record in resident's medical record.

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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 0686 Level of Harm - Minimal harm or potential for 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** 32220 Based on observation, interview, and record review, the facility failed to ensure interventions for repositioning were implemented for care of a pressure injury (skin impairment) for one resident (R35) of three reviewed for pressure ulcer care. Findings include: On 10/08/24 at 10:38 AM, R35 was observed to be on their back in bed with the head of the bed elevated around thirty degrees; their lower legs were elevated on a pillow and an active low air loss mattress was in place. On 10/08/24 at 12:07 PM, R35 was observed to be in bed as before, legs elevated, and the head of the bed elevated around thirty degrees. At 12:43 PM, R35 appeared positioned in bed as before. Licensed Practical Nurse (LPN) D nurse raised the bed a little higher to around 45 degrees and stood next the bed to assist R35 to eat. On 10/08/24 at 1:33 PM, resident observed to be awake, eyes open with the TV on. R35 was observed to be in bed on their back with the head of the bed elevated around 30 to 45 degrees. The legs appeared elevated. R35 reported they were generally not feeling well. At 4:21 PM and 4:40 PM, R35 was observed to be in bed on their backside with the legs elevated. R35 appeared positoned in bed as before. A review of the progress notes revealed no documented refusal to be repostioned. On 10/09/24 at 8:35 AM, 9:06 AM, 10:36 AM, 10:48 AM, and 11:29 AM, R35 was turned toward they're right side with a pillow on the left side behind the torso. R35 appeared asleep with their head toward the right side of pillow. At 10:48 AM and 11:29 AM the heels were on the bed surface. Review of the record for R35 revealed R35 was admitted into the facility on [DATE]. Diagnoses included Falls and Stroke with weakness and paralysis which affected the left side. The Minimum Data Set (MDS) assessment dated [DATE] indicated impaired cognition and the need for partial/moderate assistance for toileting hygiene and total dependence for transfer, toilet transfer, sit to stand, and walking. The nursing care plan Actual skin impairment (related to) terminal pressure injury on sacrum (buttocks) and DTI (deep tissue injury) left heel. Revised 10/06/24 indicated, .turn side to side to stay off sacral wound as tolerated . Also indicated were PRAFO (Pressure Relief Ankle Foot Orthosis) boots while in bed A review of the October 2024 Treatment Administration Record (TAR) and Medication Administration Record (MAR) documented, Turn side to side to stay off sacral wound as tolerated and use positioning device if needed for support as tolerated two times a day. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a physician note dated 09/30/24 documented, .Pressure induced deep tissue damage left heel, Patient with noted DTI (non-blanchable deep red, purple, or maroon areas of intact skin) of left heel and stage I pressure ulcer (non-blanchable reddened areas of intact skin) right heel also sacral [NAME] (non healing) ulcer. Patient has declined significantly under hospice care, patient with end-stage skin breakdown/failure. Continue with the frequent position change and also try to keep pressure off of both heels by floating. On 10/10/24 at 8:31 AM, Licensed Practical Nurse (LPN) G indicated R35's sacral area appeared to have improved and did not feel R35 would reposition independently. On 10/10/24 at 11:40 AM, the Director of Physical Therapy reviewed the most recent therapy notes and reported R35 was max assist for transfer, walking and bed mobility. On 10/10/24 at 3:25 PM, the identified concerns were reviewed with the Director of Nursing (DON). The wound pictures of the sacral area were reviewed and indicated the wound had been open and closed but the purple discoloration remained. The DON reported the aide should attempt to reposition the resident on rounds which should be at least every two hours. A review of the Pressure Ulcer Risk Assessment policy revised October 2010 revealed, .Pressure ulcers are usually formed when a resident remains in the same position for an extended period of time .Pressure ulcers are often made worse by continual pressure .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32220 This citation pertains to Intake MI00146218. Based on observation, interview, and record review, the facility failed to document targeted behavior and non-pharmacological intervention attempts and prior to use of a psychotropic medication (ativan/lorazepam) for one resident (R35) of three reviewed for medication use. Findings include: On 10/08/24 at 10:38 AM, R35 was observed to be awake and alert and easily answered yes and no questions and provided detail to answers. At 1:33 PM, R35 was observed to be awake, eyes open with the TV on. R35 reported they were generally not feeling well but was awake and alert. At 4:21 PM and 4:40 PM, R35 was observed to be in bed. At 4:40 PM, R35 had two visitors and was engaged in a conversation. On 10/09/24 at 4:50 PM, R35 appeared asleep on each encounter and did not remain awake or with eyes open after query. On 10/10/24 R35 appeared asleep and did not open their eyes to a knock on the door or a call of their name. At 11:24 PM, the visitor indicated R35 did not awaken to their voice. R35 did not awaken to a knock on the door or a call of their name. R35 appeared to remain asleep and did they open their eyes nor move during the conversation with the visitor. A review of the physician orders for R35 revealed: An order dated 09/05/24 which documented, Lorazepam Oral Tablet 0.5 (milligrams) MG (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for anxiety. The order did not have a 14 day stop date. An order with start date of 09/23/24 for Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for anxiety for 6 Months. Document 3 non-pharm interventions prior to giving. An order with start date of 10/07/24 documented, Ativan oral tablet, 0.5 MG Lorazepam, Give one tablet four times daily for anxiety. A review of the September 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed: The Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for anxiety did not have a 14 day stop date. The progress notes indicated upon a pharmacy review dated 09/23/24 the order was discontinued on 09/23/24. No as needed administrations were documented during this time. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for anxiety for 6 Months Document 3 non-pharm interventions prior to giving was documented as given two times on 09/29/24. A review of the progress notes and September 2024 MAR and TAR revealed no indications of anxiety or non-pharmacological interventions attempted. Further review of the September 2024 MAR documented, (Ativan) Lorazepam Tablet 0.5 MG Give 1 tablet by mouth at bedtime related to Anxiety Disorder was last given 09/16/24. A review of the October 2024 MAR revealed, Lorazepam Oral Tablet 0.5 MG (Lorazepam) Give 1 tablet by mouth every 4 hours as needed for anxiety for 6 Months Document 3 non-pharm interventions prior to giving was documented as given on 10/03/24 and 10/07/24. A review of the progress notes and October 2024 MAR and TAR revealed no indications of anxiety or non-pharmacological interventions attempted. A physician note was dated 09/30/24 and did not indicate increased episodes of anxiety. A nurse note dated 10/07/24 documented weight warning and the request to have the ativan scheduled. It was was further documented the Ativan scheduled four times a day was given on 10/07/24 and had continued four times a day on 10/08/24 and 10/09/24 and had been given at midnight and six AM on 10/10/24. A progress note date 10/07/2024 at 10:44 AM by Licensed Practical Nurse (LPN) E revealed, .Family requesting Ativan to be ordered scheduled as well as (as needed) PRN due to guests recent agitation. Hospice aware. Order ok by (Nurse Practitioner) NP and (doctor) Dr. and hospice. Placing order at this time . The prior note was a weight change warning note dated 10/03/24. No indication of restlessness or anxiety was noted. A review of the hospice note dated 09/26/24 documented, has been more awake and talking since reducing meds .speech has been easier for (R35) . Further review of the Nurse Practitioner and Physician notes dated 07/11/24, 08/02/24 and 08/07/24 documented the chief complaint as fatigue. The 08/07/24 visit note documented a daughter's concern for medication related sedation. A review of the record for R35 revealed R35 was admitted into the facility on [DATE]. Diagnoses included Anxiety Disorder, Bipolar Disorder, Falls and Stroke. The Minimum Data Set (MDS) assessment dated [DATE] indicated impaired cognition and the need for partial/moderate assistance for toileting hygiene and total dependence for transfer. The nursing care plan At risk for changes in mood (related to) r/t Adjustment (Disorder) d/o with anxiety and depressed mood initiated 09/24/21, revised 08/21/24 revealed, .Observe for potential side effects of psychotropic medication prescribed for anxiety, such as drowsiness, fatigue, headache, dizziness, and weight changes. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/10/24 at 3:25 PM, the identified concerns were reviewed with the Director of Nursing (DON). The DON was asked about the ativan scheduled four times a day when the as needed had only been used three times and indicated it was related hospice care and the family concerns. The DON was also asked about the missing documentation for the indication for use of a psychotropic medication and documentation of non pharmacological interventions prior to as needed administration of the ativan. The DON indicated they would look into it. No further documentation or information was provided prior to exit. On 10/10/24 at 3:52 PM, the observed sedation of R35 was noted to the Hospice Registered Nurse (RN) F. RN F was asked about the scheduled ativan four times a day and the indications for administration of the as needed Ativan as only three Ativan administrations had been documented. RN F noted the recent discontinuation of many of R35's psych medications and they try to consider resident and family requests to provide comfort for the resident. A review of the policy titled, Palliative/End of Life Care - Clinical Protocol revised October 2010 revealed, . The hospice and facility will communicate with each other when any changes are indicated or made to the plan of care .