STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235715	A. Building B. Wing	03/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Fenton	901 Pine Creek Drive Fenton, MI 48430

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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake #'s: MI00142837, MI00142926 Based on observation, interview and record review, the facility failed to ensure communication between clinical services and social services to develop a person-centered care plan for one resident (Resident #501) of 4 residents reviewed for behavioral care, resulting in unmet care needs and a lack of individualized approaches to care with the likelihood of emotional and behavioral care needs being unassessed. Findings Include: Resident #501: A review of the Face sheet and Minimum Data Set (MDS) assessment for Resident #501 revealed the resident was admitted to the facility on [DATE] with diagnoses: history of a brain bleed, schizophrenia, GERD, visual loss, urinary retention and hypertension. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 14/15 and the resident needed some assistance with most care. A record review of the progress notes revealed Resident #501 was transferred to the hospital on 2/17/2024: 2/17/2024 at 4:22 AM, a skilled charting note, Resident does not allow the healthcare staff to care for her. Guest has upcoming appointment with psychology. She is combative with care. Resident screams, kicks and scratches when the nursing staff attempts to change her . she still believes the nursing staff is out to get her. I will continue to offer care for this patient throughout my shift. 2/17/2024 at 5:47 AM, a skilled charting note, Resident is not cooperative with care. She is highly agitated and continues to yell, punch and scratch at nursing staff. Guest has feces on her body . will continue offering assistance to this resident. 2/17/2024 at 8:10 AM, a skilled charting note, On call MD (physician) was notified of the guests behavior throughout the night. MD advised us to call 911 and send her out to the hospital . 2/17/2024 at 8:30 AM, a skilled charting note, Care passed over from nursing staff to EMT's. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235715	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2024
NAME OF PROVIDER OR SUPPLIER Wellbridge of Fenton		STREET ADDRESS, CITY, STATE, ZIP CODE 901 Pine Creek Drive Fenton, MI 48430	

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/17/2024 at 12:45 PM, a skilled charting note, Guest returned to facility via EMS . 2/18/2024 at 8:00 PM, a skilled charting note, CNA (certified nursing assistant) approached guest to assist to (bathroom) . Guest (resident) yelling at CNA to stay away from her and yelling for her to get out of room. Guest yelling this nurses name . Guest upset and yelling that only a nurse can help her . 2/19/2024 at 6:56 AM, Guest is walking around room moving wheel chair, opening closet door, bending down refusing care, tried to redirect . She closed her door. I reopened it for her safety and she got upset. 2/20/2024 at 2:08 PM, a physician progress note, Medical management, (follow up) ED visit. Pt (patient) is a [AGE] year old female . (after) hospitalization for fall at home with unspecified down time. Was found to have left parietal hemorrhage (brain bleed) . Patient is alert and oriented but does not process with a linear thought process . Pt did go to ED over the weekend for AMS (acute mental status change). Pt returned with no new orders. Psych to follow . Schizophrenia, stable but not at treatment goal psych to follow . 2/21/2024 at 11:52 AM, a skilled charting note, Guest left facility with Sister. Resident #501 was returned to the facility on [DATE] from the emergency room and was transferred to another facility per her and her Guardian's request on 2/21/2024. During an interview with Nurse K, on 3/12/2024 at 1:15 PM, she said she had cared for Resident #501 at times, during the residents stay at the facility. She said the resident liked her and would ask for her and let her care for the resident. She said the resident would often ask for a Nurse to care for her, not an aide or other caregivers, but she also wouldn't allow all nurses to care for her. Nurse K said the resident had difficulty seeing and needed assistance with all ADL's but could feed herself when you handed her the silverware. The nurse said sometimes the resident would say her food was poisoned. Nurse K said several days prior to Resident #501 transferring to the hospital, she had been repeatedly refusing care. She wouldn't let anyone touch her. She said it wasn't the first time the resident had feces on her, but she would let Nurse K or a few other staff help her if the were working that day. On 3/12/2024 at 2:39 PM, the Director of Nursing/DON was interviewed about Resident #501 she said the resident would take off her clothes, walk around her room, try to scratch, bite, hit staff. The DON said the staff would try to reapproach, use 2 aides with care, if one aide had issues they would try another aide. She said Resident #501 would specifically ask for a nurse to care for her and stated, We set her up to be seen by psych. We were waiting for psych to see her. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/2024 at 9:42 AM, during a phone interview with Confidential Person H, she said Resident #501 was diagnosed with schizophrenia at age [AGE] years old and had lived at home with her parents and didn't go anywhere. She said after that, for the past [AGE] years, she lived in an apartment by herself and never left the apartment. Resident #501 would not leave the apartment. She had everything that she needed brought in to her. The Confidential Person H said the resident had fallen at her apartment and was taken to the hospital where they found she had a brain bleed/stroke. She was then transferred to the nursing home/facility. She said the resident was having a very hard time at the facility, because she was not used to being out of her home or around all of the people that she didn't know. She said the resident had limited vision after the stroke and acted differently. She said her short term memory was poor after the stroke. Confidential Person H said the resident would walk around on her own at the facility and was refusing care at times. On 3/13/2024 at 9:56 AM, Confidential Person I was interviewed on the phone, she said Resident #501 arrived in the ER from the facility and the resident was saying she was in the bathroom and couldn't get out. She said she couldn't see. She said the EMS personnel had assisted the resident with care prior to the arrival in the ER and the resident did not have feces on her when she arrived. On 3/13/2024 at 10:15 AM, Nurse Aide D was interviewed and said the resident would often refuse care from the staff and would ask for a nurse or doctor. She said the staff would try to come back at a later time and approach the resident again and she would refuse. There were no additional interventions tried. On 3/13/2024 at 11:00 AM, Nurse B was interviewed and said she usually worked on the 500 and 600 halls and had cared for Resident #501. Nurse B stated, She didn't like a whole lot of people. She was blind and didn't trust anybody. She didn't want other people toileting her, but she did like me. Nurse B said it depended on the resident's mood. She stated, She sometimes let me and not the aides. Sometimes she had it in her head that she wanted an RN. She said she worked the morning the resident was sent to the hospital and the Night Nurse A was in the process of completing the paperwork to send her to the hospital, because she wouldn't let anyone care for her. She said shortly after EMS arrived and were in the resident's room a long time. On 3/13/2024 at 11:30 AM, Nurse C was interviewed, she said she worked on the unit Resident #501 was on and was familiar with her. Nurse C stated, (Resident #501) was blind. She was here for skilled care. She had behaviors. I spoke with the doctor and asked if we could refer her to (behavioral services). She would scream, refuse care and treatment and kick people out of her room. She was very angry. She liked Nurse K. She didn't do well with most of the staff. Nurse C said she worked the morning Resident #501 was transferred to the hospital, I came into her hall and the CNA's said she had feces all over her and refused care. The next shift CNA's came on and tried to help her and she refused. (Nurse A) seemed frustrated. I went in the room and (Resident 3501) was in the bathroom with the door open. She was standing in the bathroom. She said she didn't feel safe. On 3/13/2024 at 11:50 AM, during an interview with Social Services F, she said during the admission process she got to know the resident a little bit. She said the resident really wanted to go home. Social Services F stated, I knew she had some quirks, was argumentative, but no behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/13/2024 at 12:15 PM, Social Worker G was interviewed about Resident #501, she said Social Services F saw Resident #501 more than she did. She said she read in the medical record that Resident #501 was having behaviors. She said she made a referral for behavior services for the resident, but they usually came to the facility every 2 weeks. A review of the physician orders revealed there was no order for a referral for behavior services. Further review of the progress notes identified a social services note dated 2/16/2024 at 1:28 PM, . SW (social worker) referred guest to (behavioral health services) for eval regarding safety awareness and untreated schizophrenia . Resident #501 had resided in the facility for 10 days with continued behavioral issues, prior to mention of a behavioral health evaluation. Additionally, there were progress notes almost daily referencing the residents behaviors, not wanting certain staff in her room, refusing care and combativeness. The resident discharged to another facility on 2/21/2024. A review of the Care Plans for Resident #501 provided the following: Actual ADL/Mobility deficit related to intracerebral hemorrhage, fall . schizophrenia . visual loss . date initiated 2/7/2024 with interventions that identified the resident needing assistance with hygiene, toileting, bathing/showers, dressing, nail care, oral care. All interventions dated 2/7/2024. Bowel elimination . date initiated 2/7/2024 with interventions: encourage fluids .treatment per physician orders .notify physician of any changes in bowel function . all interventions dated 2/7/2024. Independent leisure pursuits only . date initiated 2/7/2024 with interventions that were all generic and not specific for the residents such as: Encourage resident to eat meals in the dining room to engage in social opportunities . Encourage residents to participate in common area activities for group activities . At risk for behavior symptoms r/t new environment . dated 2/7/2024 with interventions: Inform of ADL (activities of daily living) that is required ahead of time; Observe for mental status/behavior changes, notify physician if noted; Obtain labs as ordered; Psych referral as needed; all dated 2/7/2024; Resident assessed on admission for Trauma care needs and does not have any concerns (dated 2/9/2024). Potential for alteration in psychosocial well-being related to, new environment, dated 2/7/2024 with interventions including, Offer words of encouragement and positive feedback . Guest can appear agitated if questions are too fast, personal or numerous. Dated 2/9/2024. All other interventions were generic. At risk for changes in mood related to new environment with recent hospitalization , schizophrenia, date initiated 2/7/2024 with interventions: 1:1 conversation with social worker, per guest request; Encourage out of room activities; Guest responds well to calm, reassuring conversation. Can appear agitated if questions are too fast or numerous. (date initiated 2/9/2024); Psychiatric evaluation for changes in mood, date initiated 2/7/2024. (continued on next page)

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