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	08/22/2024

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 0689 Level of Harm - Minimal harm or potential for 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** 38471 This Citation pertains to Intake Numbers MI00143332 and MI00146115. Based on interview and record review the facility failed to document post-fall monitoring, complete neurological checks and implement appropriate interventions for two residents (Resident #701 and Resident #703) of two residents reviewed for falls, resulting in, Resident #701 sustaining a fall without facility post-fall monitoring and neurological checks and Resident #703 sustaining three falls with subsequent injuries, one day apart, without meaningful interventions implemented, consistent neurological checks and post-fall monitoring/documentation. Findings Include: Resident #701: On 8/21/2024 at approximately 2:00 PM, a review was completed of Resident #701's medical record. It revealed the resident completed a hospice respite stay from 1/12/2024 to 1/15/2024 with diagnoses that included, Alzheimer's Disease, Dementia, Seizures and Anorexia. Resident #701 required the assistance of staff for ADL (Activities of Daily Living)'s and had severe cognitive impairment. Further review revealed the following: Progress Notes: 1/12/2024 at 19:47: Guest admitted for 5 day respite care, Skin intact and bony prominences checked with no skin breakdown or wounds noted. Call light in reach, water placed within reach and diet order in. Assessments completed, VSS. Resident resting comfortably in bed at this time with no signs of distress noted. 1/15/2024 at 19:29: Guest picked up by ems (Emergency Medical Services) at 7 PM. discharged to home with hospice. All belongings and medications sent with guest. There was no denotation of any falls that may have occurred with the resident or subsequent monitoring documented in the resident's chart (that this writer had access too). On 8/21/2024 at approximately 3:45 PM, the DON (Director of Nursing) provided the fall incident ad accident report for Resident #701. The document indicated the following: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident fell on [DATE] at approximately 16:07. CNA (Certified Nursing Assistant) informed nurse that the resident was found on left side of bed. Resident appeared to have rolled out of bed. Last seen napping in bed approx. 1 hour prior, bed in transfer position .no injuries observed post incident . It can be noted there were no neurological checks completed post fall, progress notes entered, or documentation related to any marks/bruises that may have appeared prior to the resident's discharge home on 1/15/2024. Resident #703 On 8/21/2024 at approximately 9:30 AM, an interview was conducted with Family Member J regarding Resident #703's falls at the facility. Resident #703 had three falls back-to-back at the facility as they were not toileting her appropriately. From one of the falls the resident sustained a lump that protrudes from her head, and still has multiple bruises in different stages of healing, and a cut by her right eye. Each fall Resident #703 was attempting to go to the bathroom, as even with her dementia she recognized when she had the urge, but the facility failed to toilet her and would direct her to urinate in her brief. On 8/21/2024 at approximately 10:00 AM, a review was completed of Resident #703's records that revealed she readmitted to the facility on [DATE] with diagnoses that included, Diabetes, Alzheimer's Disease, Dementia, Anxiety and Macular Degeneration. She required the assistance of staff for ADL's and was severely cognitively impaired. Further review was completed of Resident #703's August 2024 falls and yielded the following: 8/2/2024 at 5:15 AM: .guest observed laying on floor next to bed while in rounds. Guest stated that she was trying to go to the bathroom. [NAME] was at bedside .I just fell when I was trying to get up and go to the bathroom .bruising to head .Neuro checks initiated. Intervention added after fall was to clip call light to blanket. Neuro's were not completed within the appropriate timeframe's. Resident #703 sustained a bruise on her front scalp that was 1.97cm (centimeters) x 2.2cm x 1.18cm and deep purple in color. 8/3/2024 at 2:30 AM: Writer observed guest laying on floor next to bed during med pass. Room was free from clutter and brief was clean and dry. [NAME] was next to bed .Overbed light was not on. Trying to go to bathroom it was dark and I just couldn't see where I was going . Knot was forming on guest head . orders given to send to ED (Emergency Department) for further evaluation . Intervention add was to ensure adequate lighting. Resident #703 sustained a goose bump to the right side of her forehead that was 3.62cm x 2.55cm x 1.88 cm in size. She returned from the emergency room and there was no documentation located regarding monitoring of the sustained injures or details regarding her return from the hospital and any further follow up required. 8/4/2024 at 12:15 PM: Upon entering the room guest was at the foot of bed in- between the med cabinet and the bed. Guest had bowel movement on the floor and on her clothing. Guest asking for help to get up . Guest then assisted off of the floor back to bed to get cleaned up . Neuro checks began .guest educated on the importance of using call light when in need of assistance. There were no neuro checks completed after this fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #703 sustained three falls, three days in a row and sustained injuries with two of the falls. With each fall the resident was attempting to go to the bathroom and the facility failed to implement meaningful interventions post fall, consistent neuro checks and monitoring of sustained injuries. On 8/22/2024 at 12:08 PM, an interview was conducted with the DON and Unit Manager L regarding Resident #703's falls. They reported on 8/2/2024 the resident was attempting to go to the bathroom and sustained a scalp bruise and was transferred to the emergency room later that morning and they implemented clipping her call light to her blanket. The Unit Manager was asked the frequency of neuro checks post fall and she advised they are Q(every)15 minutes x 1 hour, Q hour x 4 hours, Q 2 hours x 4 hours and Q shift x 24 hours. We reviewed the neuro checks from this fall from 5:15 AM until transfer to hospital and many were not able to be located in the chart. On 8/3/2024, the resident was again attempting to go to the bathroom when she fell and sustained a goose egg on her forehead. The facility implemented leaving her overhead sink light on at night. Resident #703 was transferred to the hospital and upon their return there were no progress notes or any monitoring regarding her sustained injuries. On 8/4/2024, the resident for the third time fell while attempting to go to the restroom and was found to have bowel movement on her feet, legs and clothing. Upon review of the neuro's, it was found there were none completed for this fall. It was discussed with the DON and Unit Manager L that accessibility to the call light is not a meaningful intervention given that it was already an expectation of the facility. Furthermore, the lack thereof of monitoring and documentation following Resident #703's falls with sustained injuries and inconsistency of neuro's were discussed. They expressed understanding of the above concerns. On 8/22/2024 at approximately 3:30 PM, a review was conducted of the facility policy entitled, Falls Reduction Program, revised 9/25/2016. The policy stated, To provide a safe environment for residents, modify risk factors, and reduce risk of fall- related injury . If fall occurs Charge Nurse to complete the following . Neurological Assessment, as applicable with any known or suspected head trauma . Charge nurse to monitor for delayed consequences of incident utilizing the following. Physical assessment and documentation .