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	10/24/2024

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

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37771 This Citation pertains to Intake Numbers MI00146582, MI00146860, and MI00147441. Based on observation, interview and record review, the facility failed to ensure Residents were treated with respect and dignity by not ensuring call lights were in reach and answered timely, ensure respectable customer service and ensure the provision of Resident rights with care planning that included Resident representative input/awareness of resident's care, for Residents (#1, 3, 6, 7, 8, and 10) of eight reviewed for call lights, abuse, and resident rights, resulting in care needs not met timely, lack of Resident/resident representative awareness in Resident's received care, feelings of frustration and anger and the potential for unmet care needs and lack of psychosocial wellbeing. Findings include: Resident #1: A review of Resident #1's medical record revealed an admission into the facility on [DATE] with re-admission on [DATE] with diagnoses that included stroke, hemiplegia and hemiparesis following a stroke affecting the right dominant side, and gastro-esophageal reflux disease. A review of the Minimum Data Set (MDS) assessment revealed Brief Interview of Mental Status (BIMS) score of ,d+[DATE] that indicated intact cognition, and the Resident needed substantial/maximal assistance with toileting hygiene, bathing, lower body dressing, sit to stand mobility and bed to chair transfers. On [DATE] at 1:43 PM, an observation was made of Resident #1 lying in bed with the head of the bed elevated. The Resident was awake, answered questions and engaged in conversation. The Resident had a basin on the bedside table near her and inside the basin was an emesis bag. The Resident indicated she felt sick to her stomach like she was going to throw up. The Resident was asked if she had a call light in reach. The Resident stated, I can't find it. An observation was made of the call light at the top corner of the pillow with the push apparatus of the call light partially covered by the top corner of the pillow. The Resident reported she could not reach up there and could not see it. The Resident stated, It doesn't matter, they don't come to answer it. When asked to explain the Resident reported that it takes a long time or not at all and indicated she has had to wait longer than 30 minutes to have someone come or longer at times when used the call light. Resident #3: (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #3's medical record revealed an admission into the facility on [DATE] and re-admission on [DATE] with diagnoses that included heart failure, chronic respiratory failure, lymphedema and chronic pain. A review of the MDS dated [DATE] revealed the Resident had a BIMS score of ,d+[DATE] that indicated intact cognition and the Resident on admission needed partial/moderate assistance with toileting hygiene, bathing, upper and lower body dressing and with most mobility/transfers. On [DATE] at 2:50 PM, an observation was made of Resident #3 sitting in a wheelchair in his room. The Resident was asked about any issues regarding care at the facility. The Resident reported attitudes of aides. When asked to explain the Resident reported that some of the aides had bad attitudes when they come in to assist the Resident and stated, not very nice to you. The Resident reported call lights not answered timely, and indicated he could get himself to the toilet but needed help with hygiene and getting off the toilet. The Resident reported an aide came in over the weekend to answer the light and stated, she came in and said she was busy and left. The Resident said she didn't come back, and he had to put the light on again. The Resident reported he gave up on having them answer the call light quickly and reported he just started to yell out for help. The Resident stated, They leave me on the toilet too long and my legs go to sleep, legs hurt when left there and Can't stand on them then when getting off the toilet. The Resident stated, they shut it off, ask what I want, leave again and I have to put it back on. The Resident reported having to wait for 30 minutes or more when in the bathroom and ends up yelling out for help. The Resident stated, Biggest issue, damn call light not answered! A review of the document Resident Grievance/Complaint Form for Resident #3 revealed date on ,d+[DATE], Date the incident occurred: during stay, Describe the nature of the grievance/complaint (be specific): Call light times, Document the actions taken to remedy the situation. Call light answered, Investigation Summary: Cena (Certified Nursing assistant) and nurse educated on timely responses needed. Resident #6: A review of Resident #6's medical record revealed an admission into the facility on [DATE] with diagnoses that included aftercare following joint replacement surgery, erosive osteoarthritis and chronic obstructive pulmonary disease. A review of the MDS dated [DATE] revealed a BIMS score of ,d+[DATE] that indicated intact cognition, and the Resident needed partial/moderate assistance with toileting hygiene, bathing and personal hygiene, sit to stand and lying to sitting mobility and needed substantial/maximal assistance with lower body dressing, lying to sitting on side of bed and chair/bed to chair transfers. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:04 PM, an interview was conducted with Confidential Person (CP) G regarding Resident #6's care at the facility. The CP indicated the Resident had complained of the call light not answered timely, she would press the call light, and it took hours before staff would check on her or respond to her, and reported having incontinence, could not hold it, that long. The CP reported that a CNA (Certified Nursing Assistant) was verbally and physically abusive to Resident #6. The CP explained that a CNA had yelled in her face when she was getting up to the bathroom that she was taking too long and stated, She (Resident #6) had never had anyone yell at her like that before. The CP reported that the Resident had reported that a CNA had been physically abusive when she had grabbed her gown and stated, She kicked her out of her room and didn't want her touching her again. The CP reported the Resident had told her about the incident the next day. The CP reported she had tried to get a hold of someone at the Nursing home and had finally got to talk to the Social Worker, and had reported it to her. The CP reported the Resident did not want to stay there, that she didn't feel comfortable or safe. Confidential Person G reported that they had asked for a list of medications to see what the Resident was receiving, and one was not supplied. The CP reported that a care conference was held, and the family was to attend by phone due to living a distance away from the facility. The CP reported that the phone the facility was using kept dropping the call and stated, we were supposed to talk to the nurse, PT (physical therapist) and the social worker. The CP reported they missed the whole meeting and only talked to the social worker afterwards and stated, None of my questions got answered, and reported the Resident was in a lot of pain, was not progressing in therapy, and they did not know what medications were being given. The CP reported talking to the Resident about her medications who told the CP that she did not know what they were giving her and stated, She said they just tell me to take them. Confidential Person G reported that the Resident was to move to a different facility, but the new facility wanted the Resident to be evaluated at the hospital because they felt something was not right. The CP reported they requested the Resident go to the hospital where they found a fracture at the head of the femur and that was causing severe pain. The CP reported they found out at the hospital what medications the Resident was administered at the facility which included a medication the Resident had issues with bleeding when taken before. The CP reported had the facility given the list to the family or the Resident, they would have known that she had been taking the medication Celebrex (Celecoxib-a nonsteroidal anti-inflammatory drug used to treat pain) and reported the Resident had almost died before after taking that medication. The CP reported the Resident had to go for surgery to fix the fractured femur and could not take an anticoagulant due to developing GI (gastrointestinal) bleed and bleeding from the kidneys, and reported the Resident died from complications of bleeding in the bowel and a pulmonary embolism. A review of the facility document titled Resident Grievance/Complaint Form, for Resident #6, dated [DATE], revealed, Date the incident occurred: [DATE], Describe the nature of the grievance/complaint (be specific). Guest stated to SW (Social Worker) the Cena used her shirt to turn and/or reposition her in bed, Investigation Summary: Unable to educate Cena on the appropriate ways to reposition guests. Termed on [DATE] due to attendance. A review of progress notes for Resident #6 included the following: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Dated [DATE] at 7:29 PM, On [DATE] Care conference held with guest in room and teleconference with daughters. Therapy reported Wt (weight) bearing as tolerated. Mod A (moderate assistance) w(with)/transfers/bed mobility. Supervision w/UB (upper body) dressing and Mod A w/LB (lower body) dressing. SW (Social Worker) informed insurance determines length of stay and informed if not ready to dc (discharge) home options of paying privately . Family addressed some care issues and sw addressed with unit manager. Daughters at this point would like to transfer to facility in (name of town) as she was there in May ., author Social Worker F. -Dated [DATE] at 4:11 PM, Guest was discharged to9 (to) the hospital per guest request. Guest stated that her left ankle was in pain, and she needed to be sent out o (to) the hospital. Guest was scheduled to be discharged from facility today. All belongings, medications, and discharge instructions were given to guest before dismissal. On [DATE] at 11:30 AM, an interview was conducted with Social Worker F regarding concerns for Resident #6. The Resident was admitted into the facility on [DATE] and the care conference was held on [DATE]. The Social Worker reported that the initial care conferences were usually held within 48 hours after admission and depended on what was convenient with the Resident's representatives, but did not have documentation of why the care conference was set for the 28th. The Social Worker was asked what happened with the equipment failure during the care conference. The Social Worker reported issues with the phone she had been using and could not connect with the daughters for the care conference, reported she connected with them later and gave an update on what the Resident needed for assistance, managed care, determination of care, length of stay and appeal. When asked if the family requested a list of medication or if one had been given, the Social Worker did not remember giving a list of medications. Review of the medical record revealed no documentation that a list of medications had been given to the Resident or representative. The Social Worker reported they discussed the transfer to another facility. The Social Worker reported the daughter had discussed response of call light time and stated, not in a timely manner, I don't remember the length of time. The Social Worker reported the daughter reported care with how the CNA had handled her to transfer her. When asked if the daughter or Resident had talked about abuse physical and/or verbal, the Social Worked reported for the daughter it was a disappointment of the standard of care, the CNA had grabbed the top of her shirt and did not remember a discussion of verbal abuse. When asked if it was considered abuse, the Social Worker reported she was unsure and went to the Unit Manager at that time to share the information. The Social Worker reported it had upset the Resident and she did not want that CNA taking care of her. On [DATE] at 3:45 pm, an interview was conducted with Clinical Care Coordinator/Unit Manager, Nurse E regarding Resident #6. The Unit Manager reported she had talked to the guest regarding someone had grabbed her shirt to reposition her. The Unit Manager reported she had talked to the daughter who was upset, and the Unit Manager indicated she didn't think it was intentional. When asked if the daughter indicated abuse, the Unit Manager reported that she would have been on top of that, we don't hurt or disrespect people, treat them with dignity. When asked if the Resident was upset, the Unit Manager reported the Resident didn't know why the CNA had grabbed her like that. When asked if the daughter reported verbal abuse, the Unit Manager indicated she had not. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Unit Manager, Nurse E was asked about call lights not answered timely. The Unit Manager reported call lights were to be answered within 10 minutes, they monitor how long call lights were on and reported that during meal pass they tend to be longer, trying to pass out food and at change of shifts and stated, I would expect no more than 15 minutes. The call lights not in reach during the initial tour of the facility was reviewed. The Unit Manager reported all call lights should be in reach for all residents. On [DATE] at 4:17 PM, an interview was conducted with the Unit Manager E regarding medication list being given to Resident #6 and to their Representative. The Unit Manager reported that they would have given the hospital discharge instructions back to the Resident that had the Celebrex listed as a new medication and reported they would reach out to the Resident of POA (power of attorney) for discrepancies if there were any. When asked how allergies were recorded, the Unit Manager reported that they would be taken from the hospital discharge records and indicated they don't ask about allergies but go off the hospital records. The Unit Manager reported the family could have reviewed the medications during the care conference, but the family was not able to be in the conference due to poor phone connection. Resident #7: A review of Resident #7's medical record revealed an admission into the facility on [DATE] with diagnoses that included stroke, dementia, anxiety disorder, contracture and gastrostomy status. A review of the MDS revealed a BIMS score of ,d+[DATE] that indicated severely impaired cognition, and the resident was dependent with activities of daily living and mobility. On [DATE] at 1:46 PM, an observation was made of Resident #7 lying in bed. The Resident was awake, moved her arms and had padding (used for contractures of the hands) inside her hands. The Resident did not engage in conversation. An observation was made of the Resident's call light hung on the bedframe of the bed with the call apparatus positioned under the mattress hanging towards the floor and not in reach for the Resident. Resident #8 A review of Resident #8's medical record revealed an admission into the facility on [DATE] and re-admission on [DATE] with diagnoses that included osteomyelitis of left ankle and foot, diabetes, chronic obstructive pulmonary disease, and anxiety disorder. A review of the Resident's MDS dated [DATE] revealed a BIMS score of ,d+[DATE] that indicated the Resident had intact cognition and the Resident needed partial/moderate assistance with toileting hygiene, upper and lower body dressing and needed substantial/maximal assistance with chair/bed to chair transfer, sit to stand and toilet transfer. A review of the facility document titled Resident Grievance/Complaint Form, for Resident #8, dated [DATE], revealed, Describe the nature of the grievance/complaint (be specific). Reported Cena enters room and says, what do you want, Document the actions taken to remedy the situation. Cena spoken to, Investigation Summary: staff termed for cursing @ (at) the ED (executive director) during conversation. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:35 AM, an observation was made of Resident #8 sitting in her wheelchair in her room. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about the care she received. The Resident discussed some CNAs attitudes as being snotty and mean and stated, They don't have to like me, but they should be kind, and reported she had talked to the Social Worker about it. When asked about call light response times, the Resident reported having some issues with not answering the call light, having diarrhea and sitting too long with bowel movement and stated, I had skin breakdown in my lady parts. It was so painful, and reported more than 30 minutes or longer sometimes to have the call light answered. The Resident reported a Resident across the hall who yells for help, reported the resident will start screaming and people walk by and ignore her screaming, did not know if her call light was on or not, but she screams for a long time, yells her butt hurts and that she has to get off the toilet. On [DATE] at 11:30 AM, an interview was conducted with the Social Worker F regarding Resident #8's concern of how she was addressed by the CNA. The Social Worker reported Resident #8 had come to her with a few issues with some CNAs, the Resident had asked for some towels, they asked to take a minute, and she got upset with them. The Social Worker reported it was the approach, customer service. When asked if it was poor customer service, the Social Worker indicated yes and getting assistance with care. Resident #10: A review of Resident #10's medical record revealed an admission into the facility on [DATE] and re-admission on [DATE] with diagnoses that included senile degeneration of brain, dementia, anxiety disorder and repeated falls. A review the MDS dated [DATE] revealed a BIMS score of ,d+[DATE] that indicated severely impaired cognition, and the Resident was dependent with activities of daily living and mobility. On [DATE] at 1:46 PM, an observation was conducted of Resident #10 sleeping in bed. The call light cord was hanging straight down the wall between the wall and mattress and the call light apparatus was not in reach for the resident. A review of Resident #10's care plan revealed a focus for risk for falls with an intervention Clip call light to guest clothing while in bed, with revision on [DATE]. A review of facility policy titled, Resident Rights, revealed, Policy Statement: Employees shall treat all residents with kindness, respect, and dignity . 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity . A review of facility policy titled, A review of facility policy titled, Answering the Call Light, revealed, Purpose: The purpose of this procedure is to respond to the resident's requests and needs . 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident . 8. Answer the resident's call as soon as possible. 9. Be courteous in answering the resident's call . 49944 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:46am medication administration was observed with LPN D. LPN D entered room [ROOM NUMBER]-A to administer medication. LPN D verified the resident, washed their hands, retrieved the medication and signed the medication out in the EMR (electronic medical record) LPN D then asked the resident if they would like their pills all at once or one at time. The resident stated they would take them one at a time and did so until they were done. LPN D did not explain to the resident what medications they were receiving. Review of the policy titled, Medication Administration revised ,d+[DATE], revealed: Medication Administration: 13. Explain to the resident the type of medication being administered and the procedure.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 This Citation pertains to Intake Numbers MI00146860 and MI00147441. Based on interviews and record review, the facility failed to monitor and inform the physician promptly regarding the declining status post-fall for one resident (Resident #5), resulting in the delay in treatment and hospitalization for Resident #5, who sustained a brain bleed post-fall. Findings include: Resident #5 (R5): According to the review of records conducted on 1023/24 at 10:00 AM, R5 was [AGE] years old and admitted to the facility on [DATE], with the primary diagnosis of Atrial Fibrillation, Anxiety, Depression, and Chronic Respiratory Failure in addition to other diagnoses. R5 was discharged from the hospital after a fall on 8/6/24. The resident was assessed, alert, and oriented according to records on the 8/4/24 Incident Report. The list of medication orders dated August 2024 revealed that R5 was taking an anticoagulant (Eliquis) for a history of Atrial Fibrillation as a diagnosis. R5 Care plan interventions dated 8/31/2023 were noted under anticoagulant therapy: Report to the physician any signs and symptoms of anticoagulant complications: blood tinged of flank blood in urine, black, tarry stools, dark or bright red blood in stools, sudden severe headaches nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (Shortness of breath), loss of appetite, sudden changes in mental status, and significant or sudden changes in v/s (vital signs). Date initiated on 8/31/2023. R5 Fall on 8/4/24 and 8/7/24 was reviewed on 10/23/24 at 3:00 PM. Fall #1: A Fall Incident Report, written, occurred on 8/4/24, at approx. 14:45 (2:45 PM) The nursing Description noted, R5 was found laying on the floor in room by wheelchair and chair in room. The fall was unwitnessed. However, R5 was described as alert and oriented to person and place. No injuries were observed post-incident. Fall # 2: Occurred on 8/6/24, written at approximately 06:19 AM. The incident (I/A) was described: The CENA (nursing assistant) was doing rounds when she noticed guest on the side of the bed. She immediately came to notify me . Guest stated she did not hit her head . No injuries observed at the time of the incident. However, R5's mental status: The nurse indicated that R5 was oriented, with the place was noted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse Manager Z was interviewed on 10/24/24 at 10:50 AM. She stated that R5 was admitted to the facility almost a year ago and at first denied that Nurse Manager Z was not working on 8/6/24. She stated, I was not notified until I got back in. She further stated: I was not working on both falls (8/4/24 and 8/6/24). The Nurse Manager Z, after verifying the nurse's notes documentation, indicated that Nurse Manager Z had entered notes on 8/6/24 regarding the status- post fall. Nurse manager Z continued to describe that R5 fell on [DATE] and went to see R5 in the room with her daughter present in the room. She further explained it was at around 8:00 AM when she assessed and made sure R5 was ok after the fall Nurse Manager Z described what happened during the fall, reading the incident report that stated: R5 rolled out of bed, neuro checks were done, and was normal baseline during interview at that time in the morning at around 8:14 AM on 8/6/24 was when Nurse Manager z assessment was but she documented it at a later time at 15:17 (3:17 PM). From my assessment in the afternoon, compared to the morning, Nurse Manager Z felt something was not right with R5. R5 was more sluggish and lethargic and described as more tired than usual. The nurse practitioner (NP) was notified and made aware of the incident but ordered Covid testing and precautions. Nurse Manager Z denied observing any respiratory distress, coughing, or shortness of breath. However, R5 was declining for months. R5's Covid test was done and was negative. The nurse practitioner recommended a Covid test and put her on precautions for 3 days. The Nurse Manager Z denied testing R5 for UTI because it was not discussed and not recommended to be tested by the NP (Nurse Practitioner). Nurse Manager Z stated that she had assessed R5 just before she left at 3:30 PM that day on 8/6/24. The nurse Manager stated that she had talked to the daughter, who was present in the room at about 8:30 AM on 8/6/24 and discussed hospice services. The daughter said that she would discuss the recommendation with the family. The daughters were hands-on with R5. She must have gotten a call from the nurse about the fall, and she got a call from the nurse, so she immediately came at 8:00 AM. Nurse Manager Z stated she was unsure about Anticoagulant Orders: Eliquis. I observed at around 3:00 PM that something was off on her mental status. R5's family was present in the facility, and they wanted her to be sent out to the hospital. The nurse sent her on 8/6/24 at approximately 6:30 PM because the family insisted. R5 was described in the progress notes as: tired, weak, and a little confused. The family was at the bedside. Something was off, and she was not her usual. R 5 family was present. R5's family triggered her to be sent out. Nurse 2 was interviewed on 10/24/24 at 10:30 AM and stated that she was not R5's nurse but was walking by when the family approached her and asked if she could assess R5. She said she had taken care of R5 and knew R5's baseline. Nurse 2 revealed that the resident was difficult to arouse and had a one-sided weakness. Nurse 2 stated, It was very apparent and definitely not R5's usual state of self and mental state. After assessment, when the family asked if R5 needed to be treated and evaluated at the hospital, Nurse 2 stated: I did say yes after discussing with the nurse assigned to R5. Hospital records dated August 6, 2024 revealed: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5 was received nonresponsive to voice or touch but is breathing and in no acute distress. The Hospital Admission Diagnosis revealed Brain Bleed. CT Brain performed on 8/6/24 at 20:46 (8:46 PM) FINDINGS: Acute intraparenchymal hemorrhage in the left occipital and posterior parietal lobes surrounding low-attenuation edema. The intraparenchymal hemorrhage measures about 3.0 x 5.4 cm in the axial plane and about 3.7 cm in CC length. Mild mass effect in the region, effacement of sulci in the region . IMPRESSION: 3.0 x 5.4 x 3.7 cm intraparenchymal hemorrhage in the posterior left parietal and occipital lobes. Surrounding low-attenuation edema with mild regional mass effect. A posterior parafalcine hemorrhage is also present, probably a thin left parafalcine subdural . A verbal report was called to the emergency room , and the case was discussed at 2050 (8:50 PM) hours. Electronically signed on 8/6/24 at 9:04 PM EDT. Hospital Course indicated: . Patient is a [AGE] year-old female with a past medical history of atrial fibrillation maintained with Eliquis, admitted with hemorrhagic CVA after a fall at her facility. No interventions recommended by neurosurgery, and patient was transitioned to comfort measures in the emergency department 8/7 . The patient is breathing but not responding to voice. Not responsive to touch. No sternal rub as she is comfort measures. Noted notes on Hospital Discharge Summary, dated 8/7/24 at 14:07 (2:07 PM). The nurse's progress note dated 8/6/24 at 6:30 PM revealed: Guest was tired, weak, a little confused. The family was at the bedside. The nurse practitioner (NP) was interviewed on 10/24/24 at 10:35 PM, and she stated that she received a call in the morning regarding R5's fall. There was no indication of any neurological status changes at that time. The NP denied evaluating R5 in person. NP indicated that she was not present at the facility, nor was the primary physician on 8/6/24, to assess R5 post-fall. Instead, she ordered Covid Testing and Precautions for 3 days. The NP did not order her to go to the hospital because she was reported to be in her baseline. She added that regarding R5 taking Eliquis, it is not an indication to be sent to the hospital unless there are signs and symptoms. She was unaware of any changes and did not get a follow-up call. The Fall Policy entitled: Fall Reduction Program, revised on 9/25/2016, revealed the fall program's purpose: To provide a safe environment for residents, modify risk factors, and reduce risk of fall-related injury. Procedure: . 3.1 Initiate safety interventions and update care plan as applicable 3.2 Charge nurse to monitor for delayed consequences of incident utilizing the following. Physical assessment and documentation Neurological Assessment per directions, as applicable .

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Wellbridge of Fenton	901 Pine Creek Drive Fenton, MI 48430

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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** 49944 This Citation pertains to IntakeNumber MI00146582 Based on observation, interview and record review the facility failed to enter a physician's order for wound care and update a skin integrity care plan timely for one resident (Resident #7) of three residents reviewed for pressure ulcers, resulting in late physician's orders for wound care and late revision of a skin integrity care plan. Findings include: R7 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include cerebral infarction, contractures, dementia and age-related physical debility. R7 has a BIMS (Brief Interview for Mental Status) score of 0, indicating R7 has a severe cognitive impairment and during the survey was not observed to communicate with anyone and would occasionally moan out in pain during care. On 10/23/24 at 12:00PM, R7 was observed sleeping in bed, dressings were noted to the left and right elbows. Bilateral elbows were propped up on pillows for pressure reduction, pressure reduction mattress was in place and functioning. On 10/23/24, record review revealed that R7 has a Stage 3 pressure ulcer (full thickness loss of the skin) on the left medial elbow and a Stage 2 pressure ulcer (partial thickness loss of the skin) on the right medial elbow, both are in-house acquired and developed on 10/17/24. Record review revealed a care plan is in place that addresses the pressure ulcers on the bilateral elbows. The care plan was updated on 10/23/24. Orders were not placed for wound care on the bilateral elbows until 10/21/24. Current dressings dated 10/24 on bilateral elbows. On 10/23/24 at 01:25PM, an interview was conducted with LPN (Licensed Practical Nurse) A. LPN A was asked, if you identified a wound, when would you expect a treatment to be put in place. LPN A stated they would enter the order as quickly as possible, preferably the same day that it was identified. LPN A was asked what the process is if you were performing a skin assessment and identified a new wound. LPN A stated they would notify the unit manager, DON (Director of Nursing) and the physician, either in person or via tiger text. LPN A stated they would take pictures of the wound and get them in PCC (Point Click Care, electronic medical record), then I would expect a treatment order to be given by the physician and I would put it in place. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/24/24 at 01:14PM an interview was conducted with RN (Registered Nurse) B. Based on record review RN B is the nurse that identified the new pressure injuries on the bilateral elbows. RN B was asked what the steps are that you take when you identify new wounds. RN B stated there is an algorithm they follow if you identify a wound. RN B was asked when they identified the wound, if they put a treatment in place and if they notified anyone about the new pressure wounds. RN B stated it was near the end of their shift, RN B put a foam dressing in place and passed it on to the next shift and let management know there were new areas. RN B stated they took pictures of the elbows and put them into PCC. RN B was asked if they put an order for the wound care into PCC for the newly identified area. RN B stated they put a dressing on R7, but did not enter an order into PCC. RN B was asked who is responsible for updating the care plans and how quickly they should be updated. RN B stated that nurses on the floor could update the care plans and feels that 24 hours is a reasonable time to update the care plan. RN B states they don't always feel comfortable updating the care plans, so they let management know it needs to be updated. Review of the policy titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol revised October 2010, revealed: Treatment/Management: 1. The physician will authorize pertinent orders related to wound treatments, including pressure reduction surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.) and application of topical agents. Review of the policy titled, Care Plans-Comprehensive revised October 2010, revealed: Revisions: 8. Assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition change. Reviewing and Updating: 9. The care planning/interdisciplinary team is responsible for the review and updating of care plans: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review the facility failed to store nebulizer equipment per facility policy and follow a physician's orders for oxygen administration for two residents (R3, R10) of three residents reviewed for nebulizer equipment, resulting in nebulizer equipment being stored on a bedside table and the medication chamber having fluid in it and not receiving the physician's ordered amount of oxygen administration. Findings include: Resident #3: R3 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include CHF (Congestive Heart Failure) chronic respiratory failure, pulmonary hypertension and major depressive disorder. R3 has a BIMS (Brief Interview for Mental Status) score of 15 indicating they are cognitively intact. On 10/23/24 at 11:30AM, R3 was observed sitting in a wheelchair in the room and watching television. R3 was observed to be receiving oxygen at 3 liters per minute via a nasal cannula and a nebulizer machine was sitting on the nightstand with liquid in the medication chamber. R3 was asked what the liquid was in the medication chamber, and they replied the nurse put it in there at 9am when they gave me my pills, it is my breathing treatment. R3 state they get nebulizer treatments 2-3 times a day. R3 was asked about using oxygen, R3 stated they only use it in the building and that is about it. R3 was asked if they use in continuously in the building and they replied yes. On 10/23/24 at 11:45AM, an interview was conducted with LPN D. LPN D was asked if they could tell me why R3 has fluid in his nebulizer chamber. LPN D stated they took over for another nurse at 9:00am and did not give morning medications to R3, LPN D stated they don't know why there would be fluid in the chamber already. This surveyor and LPN D verified there is fluid in the chamber. LPN D emptied out the chamber and went to retrieve a new nebulizer mask for R3. On 10/23/24 at 12:15PM, record review revealed a physician's order for nebulizer treatments four times a day for chronic respiratory failure. Record review also revealed a physician's order for continuous oxygen at 2 liters per minute and an at risk for respiratory impairment care plan with interventions that included O2 (oxygen) via NC (nasal cannula) at 2 Liters per minute. On 10/24/24 at 12:15PM, an interview was conducted with LPN D. LPN D was asked to verify the current rate of oxygen R3 is supposed to receive. LPN D stated they believe R3 is supposed to be receiving oxygen at 2 liters per minute. LPN D and this surveyor observed the concentrator of R3 running at 3 liters per minute. LPN D stated that sometimes residents will have orders to increase oxygen up to 5 liters per minute to maintain oxygen saturation above 90%. LPN D verified the order and adjusted the oxygen amount to 2 liters per minute. Resident #10: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include pneumonia, anxiety, repeated falls and Alzheimer's disease. R10 has a BIMS score of 4, indicating severe cognitive impairment. On 10/23/24 at 01:12PM, during a tour of R10's room, a nebulizer mask setup was observed sitting on an overbed table with fluid still in the medication chamber. R10 was not present in the room at this time. On 10/23/24 at 01:15PM, an interview was conducted with LPN A. LPN A was alerted by this surveyor the nebulizer sitting on the bedside table with fluid in the medication chamber. LPN A stated you don't have to say anything, I already know what is wrong. LPN A then disposed of the nebulizer and went to retrieve a new one. On 10/23/24, record review revealed a physician's order for nebulizer treatments four times a day. Review of the October MAR (medication administration record) revealed the nebulizer had last been signed out at 0800. Review of the policy titled; Nebulizer, revised 09/25/2016 revealed: Equipment Cleaning: 10. Following medication administration, disconnect nebulizer cup/mask/mouthpiece from tubing, rinse equipment with hot water and place on paper towel to completely air dry. 11. Remove gloves and wash hands. 12. Once nebulizer cup/mask/mouthpiece is completely dried place in storage bag. Review of the policy titled; Oxygen Administration revised October 2010 revealed: Preparation: 1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident. 3. Assemble the equipment and supplies as needed.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 This Citation pertains to Intake Number MI00146860. Based on Interviews and record review, the facility failed to obtain Physician visit documentation of one resident (Resident #5) in a timely manner of three residents reviewed for physician visits, resulting in delayed implementation of treatment orders and the potential for inappropriate physician's orders. Findings include: Resident # 5 (R5): According to the review of records conducted on ,d+[DATE] at 10:00 AM, R5 was [AGE] years old and admitted to the facility on [DATE], with the primary diagnosis of Atrial Fibrillation, Anxiety, Depression, and Chronic Respiratory Failure in addition to other diagnoses. R5 was discharged from the hospital after a fall on [DATE]. R5 medication orders reviewed revealed that she was taking an anticoagulant (Eliquis) for the history of Atrial Fibrillation as a diagnosis. R5 Care plan interventions dated [DATE] were noted under anticoagulant therapy. Resident R5 fell twice on [DATE] and [DATE]. R5 was sent to a nearby emergency room after the fall on [DATE] and returned from the hospital with a diagnosis of brain bleed. R5 was enrolled in hospice services upon her return on [DATE] and expired on [DATE]. A review of R5's Nurse Practitioner and physician progress notes in the Electronic Medical Record (EMR) conducted on [DATE] at 1:0:30 AM revealed that R5 was seen by a provider on the following dates: [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE] R5 was seen by a practitioner on the dates indicated above. There was a noted gap between [DATE] and [DATE] for the physician's visit. The Nurse practitioner was queried during an interview conducted on [DATE]. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Nurse Practitioner (NP) in an interview on [DATE] at 11:50 AM, she tries to see residents alternate with the physician in a routine regulatory visit. On [DATE], she recalled getting a call from a nurse that R5 fell but did not see and examine R5 on [DATE] post-fall. NP recalled ordering a Covid test and Covid Precaution for 3 days. She denied ordering a urine test to rule out UTI post-fall on [DATE]. The family often called for anything and recalled discussing hospice services. NP did not recommend sending her out because the report received because the symptoms described mostly were her baseline. Eliquis was not an automatic criterion for sending the resident out to the hospital after every fall. The NP stated that there were no abnormal neurologic signs and symptoms presented in the report given to her. When the surveyor stated what the nurse had described during the assessment in the afternoon at around 5:00 PM, such as lethargy, nonresponsive and flaccid one-sided weakness, the NP indicated that If there were neurological symptoms that developed later that were reported to her that she would have sent her to the hospital. R5 returned from the hospital on [DATE], and hospice service was considered. The NP was asked if the gap between [DATE] and [DATE] was over 60 days and that R5 did not receive physician services. She explained the protocol and, between the physician and her visits, agreed that there were more than 60 days that the resident did not receive a practitioner visit. The facility's Physician Visit Policy, dated [DATE], was reviewed on [DATE] at 1:30 PM. It revealed: .PURPOSE: To provide physicians services to ensure the availability of attending, consulting, and emergency medical services. PROCEDURE: 1. Accountability: The Attending Physicians are under the supervision and authority of the Medical Director and are responsible to the Medical Director with regard to the quality of medical care and for the ethical and professional provision of medical services in the facility. 2. Appointment: Privileges shall be granted to serve as an Attending Physician by the Medical Director and the Administrator of his/her designee based upon review of appropriate credential/information and in accordance with all state and federal regulations. 3. Review the resident's total program of care, including medications and treatments. 4. Write, sign, and date progress notes. 5. See the resident at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. On [DATE] at approximately 3:00 PM, the NP returned to the surveyor and presented a physician visit note effective [DATE]. However, the note presented was recently dictated with a Dictated Date (DD)on [DATE], and the recently dictated progress note was not reviewed. It also reflected that the late entry visit note was locked on 10 ,d+[DATE]. When the NP was queried about why the dictated date (DD) and locked date were [DATE] and not [DATE], the NP replied, I don't know. You have to ask the doctor about that.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review the facility failed to follow facility policy for EBP (enhanced barrier precautions) for one resident (R7) of one resident reviewed for EBP, resulting in the nurse performing wound care without the required PPE (personal protective equipment) for a resident on EBP. Findings include: Resident #7 (R7): R7 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include cerebral infarction, contractures, dementia and age-related physical debility. R7 has a BIMS (Brief Interview for Mental Status) score of 0, indicating R7 has a severe cognitive impairment and during the survey was not observed to communicate with anyone and would occasionally moan out in pain during care. On 10/24/24, record review revealed a physician's order for Enhanced Barrier Precautions as directed. This includes gowns and gloves for high-contact resident care activities. Specify why: foley, peg tube, pressure wound. The order was dated 9/5/24. On 10/24/24, wound care was observed for R7 with RN B, a hospice caregiver was present as well and provided support to RN B. RN B gathered supplies for wound care, washed their hands, applied gloves, removed the soiled foam dressing on the right trochanter, removed gloves, applied new gloves, cleansed the wound, put the gauze packing in the wound, applied foam dressings and dated the dressing for 10/24 and placed their initials on the dressing. RN B and the hospice aide were not wearing PPE for EBP due to the wound care. Upon completion of the wound care, RN B was informed that R7 is on EBP for high contact care. RN B was asked what they should have done before providing wound care. RN B replied they should have gowned up and put on PPE since the resident was on EBP. On 10/24/24, an interview with IC (infection control) Nurse C. IC Nurse C was asked what their expectations were with EBP and staff providing care. IC Nurse C stated that nursing staff should follow the signs on the doors related to EBP for residents with catheters, wounds, bathing and transfers to therapy. IC Nurse C stated they should have gowns and gloves on for high contact care. IC Nurse C was asked what kind of education the staff receives on EBP. IC Nurse C stated they do education each month, if there is a specific issue such as COVID they will address it. IC Nurse C stated that staff education is completed on donning/doffing PPE, IC Nurse C does spot checks at the rooms of people on EBP and educates staff at that moment if it is necessary. Review of the policy titled, Enhanced Barrier Precautions revised April 1, 2024, revealed: DEFINITIONS: Enhanced Barrier Precautions: Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	High-Contact Resident Care Activities include: -Dressing -Bathing/showering -Transferring -Providing hygiene -Changing linens -Changing briefs or assisting with toileting -Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator -Wound care: any skin opening requiring a dressing