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	12/11/2024

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 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** 22347 Based on observation, interview and record review, the facility failed to ensure dignity for 4 residents (Resident's #66, #73, #68, and #281) and 5 of 7 confidential Resident Council group meeting (held on 12/10/24) residents, regarding call lights within reach and the timely answering of the call lights. Findings Include: Resident #73: Review of the Face Sheet, care plans dated 10/29/24, nursing note's dated 11/24 through 12/10/24, and physician orders dated 12/24, revealed Resident #73 was [AGE] years-old, alert with memory deficient and confusion, and had a feeding tube; he was admitted to the facility on [DATE]. The resident was an 1 person assist with 2 persons for walker, and he has a history of falls at the facility and respiratory impairments with oxygen dependency. The resident's diagnosis includes, stroke, Aphasia (communication deficit), hemiplegia, hemiparesis with left sided weakness, Dysphagia (swallowing deficit), chronic respiratory failure, diabetes, congestive heart failure, Dementia, memory deficit, major depression, pneumonia, and dependent on oxygen. Observation was made on 12/9/24 at 11:14 a.m., of residents call light hanging over the breathing machines black tubing on the dresser next to the residents bed, When this surveyor asked him if he knew were his call light was and could he reach it, he could not find it and when location pointed out, he was not able to reach it. At the time the resident was sitting in his recliner chair. Confidential Resident Council group meeting: During the confidential Resident Council group meeting that was held on 12/10/24 at 10:07 a.m., 5 of 7 alert resident's verbally complained of staff taking an excessive amount to time to answer call lights on second shift primarily. One alert confidential resident stated I soiled myself because it took them (staff) over an hour to answer my light. Another confidential resident stated I had 2 aides this morning (on 12/20/24, first shift) come in my room and they were talking to each other and I did not get dressed, had to go to breakfast not dressed. A resident stated They (staff) talk on their phones in my room. 3 of 7 resident's revealed they had accident's because staff would not answer their call lights timely. (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235715	A. Building B. Wing	12/11/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Dignity policy dated 10/2009, stated Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individually. Treated with Dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Promptly responding to the resident's request for toileting assistance. Review of the facility Call Light policy dated 11/2019, stated Be sure the call light is within easy reach of the resident; answer the resident's call as soon as possible, 37668 Resident #66: On 12/10/24 at 3:11 PM, while walking down the hallway in the facility with Unit Manager Registered Nurse (RN) U, a visitor was observed standing in the center hub area of the hallway near the 600-hallway entrance. The visitor was loudly requesting staff assistance and stated, Who's (Resident #66's) aide? Several staff were observed standing on the other side of the hub area of the hallway talking to each other. The staff did not respond to the visitor. Unit Manager RN U got the staff attention and asked who (Resident #66's) aide was. One of the staff standing in the hub replied, Not me, I just got here. None of the staff who were standing in the hub area went to assist the visitor. The Visitor then loudly stated, (Resident #66's) been in the bathroom for 16 minutes and I had to help put her on the toilet. Is there no body working down here? A corporate clinical staff went to assist the visitor at this time. RN U was queried why the staff standing in the hub had not assisted the visitor/Resident and an explanation was not provided. Record review revealed Resident #66 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease, dementia, cerebral infarction (stroke), and lower extremity fractures. Review of the MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required substantial/maximum assistance to complete toileting hygiene. Review of Resident #66's Electronic Medical Record (EMR) revealed a care plan entitled, Risk for falls r/t left ankle fracture, neck muscle strain, fall . (Initiated: 1/25/24; Revised: 8/2/24) included the intervention, Transfers: 2PA (Person Assist) with 2WW (Wheeled walker) WBAT (Weight Bearing As Tolerated); Ambulation: Non-ambulatory (Initiated: 1/25/24; Revised: 8/2/24). 49944 Resident #68 (R68): R68 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include a femur fracture, falls, type two diabetes and benign prostatic hyperplasia (BPH). R68 has a brief interview for mental status (BIMS) score of 12, indicating moderate cognitive impairment. On 12/09/24 at 01:38 PM, an interview was conducted with R68. R68 was asked if their call light is in reach and if the staff answers it in a timely fashion. R68 stated the call light is in reach at all times. R68 stated that they don't use the call light a lot, but they are really slow to answer when they do use it. Resident #281 (R281): (continued on next page)

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	12/11/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R281 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include pulmonary embolism, chronic obstructive pulmonary disease, congestive heart failure and depression. On 12/09/24 at 11:35 AM, an interview was conducted with R281. R281 was asked if their call light is in reach and if the staff answer it timely. R281 stated the call light is always in reach, sometimes they might answer in 20 minutes or it might be 12 hours. R281 stated you never really know how long it will be, but it is a long time.

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	12/11/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 Based on interview and record review, the facility failed to ensure that two resident's (Resident's #28, and #55) care plans were updated and individualized, resulting in the potential for unsupervised outdoor activity, falls, and not meeting residents' needs. Findings Include: Resident #28: Review of the Face Sheet, fall report dated 1/22/24, nurse's note's dated 6/24 through 12/10/24, and care plans dated 10/23, revealed Resident #28 was [AGE] years old, alert with confusion, admitted to the facility on [DATE], had an extensive history of falls at the facility and required staff assistance with all Activities of Daily Living, and transfers. The resident's diagnosis included vascular dementia with cognitive, cancer of breast and uterine, and undergoing treatment, intracerebral bleed, malnutrition, chronic lung disease and dependent on oxygen, cystic disease of liver, chronic pain, anemia (low iron), back fracture, osteoporosis, osteoarthritis, muscle wasting, major depression, adjustment disorder, anxiety disorder, limited activities due to disability and double vision wearing an eye patch which limited vision field. On 3/16/24, the resident tipped over her wheelchair outside while alone on the sidewalk and was hospitalized with a left hip fracture. Review of the hospital emergency room note dated 3/16/24, stated She was using her wheelchair to go outside when she caught her wheel on something resulting in her wheelchair flipping, causing her to land on her left side; at this time, she endorses left hip pain. Hip is shortened and extremely rotated. X-ray of the left hip, there is a displaced intertrochanteric femur fracture. The resident was admitted to the hospital for treatment. Review of the nursing notes, Incident Report and resident statement dated 3/16/24, revealed the resident went outside to smoke without supervision, fell on the ground in the parking lot off the curb and was found by a visitor walking in the parking lot. Review of the facility Occupational Therapy Evaluation notes dated 3/21/24, stated Functional Cognition=Needed Some Help, Mobility Performance Raw Score=4 (Poor mobility). Review of the facility Physical Therapy Evaluation notes dated 1/23/24, stated Eye patch R (right) eye due to double vision, fall risk, no ambulation due to risk for fx (fracture). During an interview done on 12/10/24 at 2:00 p.m., Occupational Therapist/Rehab Manager L stated She (Resident #28) needs to be kept an eye on; given her history of fall's she should not be outside by herself. She has poor mobility, that includes wheelchair, a very low functional mobility. During an interview done on 12/10/24 at 2:10 p.m., Administrative Assistant K who is at the front desk during first shift, stated She (Resident #28) can go outside, she is her own person. (continued on next page)

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	12/11/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of all facility care plans dated 11/9/22 through 11/13/24, including the Risk for Falls (dated 11/9/22) revealed no documentation of Resident #28 requiring assistance or supervision when going outside the facility. Review of the Cognitive loss care plan dated 11/13/24, stated CVA (stroke), vascular dementia, BIMS (cognitive assessment tool) score 3/13 (decreased cognitive score). After the incident on 3/16/24, no intervention was added regarding supervision or visualization while outside the facility with no family member with her. During an interview done on 12/10/24 at 3:15 p.m., MDS Coordinator G and this surveyor went through all of the resident's care plans together and no documentation of supervision while outside was found. MDS Coordinator G stated When she came back (from the hospital after her fall outside on 3/16/24), when she was readmitted we should have caught it in the morning meeting, I am going to change the care plan. Review of the facility Comprehensive Care Plans policy dated 2001, stated As individualized comprehensive care plan that includes measurable objectives and timelines to meet the resident's medical, nursing, mental and psychological needs is developed for each resident. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. 22348 Resident # 55 (R55): R55 was [AGE] years old, admitted to the facility on 4//26/24 with the diagnosis of Chronic Diastolic Congested Heart Failure (CHF), Severe Morbid Obesity, Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure with hypoxia in addition to other diagnoses. R55's Minimum Data Set (MDS), dated [DATE], revealed a BIMS (Brief Interview for Mental Status) score of 13/15, which indicates that a person's cognition is intact. Section GG of the MDS, dated [DATE], revealed that R55 required Substantial/ Maximal assistance with the following activities: Toileting Hygiene, shower, and upper body dressing. However, the assessment dated [DATE] also revealed that R55 was dependent on lower body dressing, bed mobility, toilet transfers, and wheelchair ambulation. Dependent means that the helper does all of the effort to complete the task or activity. During a wound care observation on 12/10/24 at 1:45 PM, five nursing staff were inside R55's room to assist. R55 was found to have developed an excoriation on the folds that measured approximately 14 inches across her lower back from the left side to the right side of the lower lumbar area of R55's back. The area appeared extremely red, raw, raised, irritated, and tender to the touch. When NurseU was asked, he described the area as having MASD (Moisture-Associated Skin Damage) and was newly developed. Nurse U provided the standard treatment per facility skin care protocol. On 12/10/24 at approximately 2:10 PM, after the skin care observation, A review of R55's clinical record revealed no treatment, assessment, or updated care plan related to the lower back area skin impairment observed. It was a newly observed skin impairment. However, the following morning, on 12/11/24 at 10:30 AM, R55's clinical record revealed no nurse's notes indicating the skin assessment of the lower back skin excoriated MASD, no treatment entry from 12/10/24 was documented, and no physician order was documented for the lower back skin impairment. No updates in the care plan were found related to the lower back MASD. (continued on next page)

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	12/11/2024

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following day, on 12/11/24 at 11:32 AM, R55's nurse's notes, skin/wound assessment, and treatment record (TAR) were reviewed. No documentation was found in the nurse's notes, and no updated skin assessments or treatment orders for the observed skin impairment were found on 12/10/24. The care plan was reviewed on 12/10/24 and 12/11/24, and no updates nor revisions of the lower back excoriation were found by the facility staff on 12/10/24. On 12/11/24 at 11:35 AM, CRN W and CRNX were queried regarding why there was no documentation of R55's lower back excoriated area observed on 12/10/24. CRN W and CRN X agreed that the observed skin impairments should have been documented. However. Both CRNW and CRN' X indicated that they thought the Nurse Manager (Nurse V) would do the documentation and stated: We will get them there. The Nurse Manager (Nurse V) was queried on 12//11/24 at 12:11 PM. She stated that I assumed Nurse U did the follow-up documentation because he did the assessment and provided the care that day. Nurse V revealed that she left the room before R55's skin evaluation on 12/10/24. Nurse U was queried on 12/22/24 at 1:30 PM. He did not explain why the assessment and treatment on 12/10/24 were not documented.

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	12/11/2024

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 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 Based on observation, interview, and record review, the facility failed to ensure comprehensive skin care (assessments, treatment order, and documentation) for one resident (R#55) of 2 residents reviewed for skin and wound care of 41 total samples, resulting in the potential for severe pain, infection, and further delay in appropriate treatment. Findings include: Resident# 55 (R55): R55 was [AGE] years old, admitted to the facility on 4//26/24 with the diagnosis of Chronic Diastolic Congested Heart Failure (CHF), Severe Morbid Obesity, Chronic Obstructive Pulmonary Disease, Acute Respiratory Failure with hypoxia in addition to other diagnoses. R55's Minimum Data Set (MDS), dated [DATE], revealed a BIMS (Brief Interview for Mental Status) score of 13/15, which indicates that a person's cognition is intact. Section GG of the MDS, dated [DATE], revealed that R55 required Substantial/ Maximal assistance with the following activities: Toileting Hygiene, shower, and upper body dressing. However, the assessment dated [DATE] also revealed that R55 was dependent on lower body dressing, bed mobility, toilet transfers, and wheelchair ambulation. Dependent means that the helper does all of the effort to complete the task or activity. On 12/9/24 at approximately 12:15 PM, R55 was interviewed during an initial tour. R55 complained of pain and discomfort because her bed was too small and not comfortable. R55 indicated she had a sore but did not know how it looked because she could not see what the staff did behind her. Among her complaints was that her bed was too small, which caused her to limit her movement from side to side because she was afraid to fall out of bed. R55 explained that because of her limited movement, R55 indicated she developed a sore on her back and is currently receiving treatments. R55 revealed that she had complained about the bed being too small, but nothing had been done. She expressed difficulty with repositioning and was not comfortable. During a wound care observation on 12/10/24 at 1:45 PM, five nursing staff were inside R55's room to assist. The five staff members that were present consisted of one nurse (Nurse U), one (nursing assistant, one (1) nurse manager (NURSE V), and two (2) corporate clinical staff (CRN W and CRN X). The four positioned themselves on each side of the standard bed (42 inches), and the nurse manager (Nurse V) left the room. R55 was turned by staff from side to side to assess and provide treatment. R55 was found to have developed an excoriation on the folds that measured approximately 14 inches across her lower back from the left side to the right side of the lower lumbar area of R55's back. The area appeared extremely red, raw, raised, irritated, and tender to the touch. When NurseU was asked, he described the area as having MASD (Moisture-Associated Skin Damage) and was newly developed. Nurse U provided the standard treatment per facility skin care protocol. During the wound/skin care observation on 12/10/24 at 2:40 PM, Corporate Nurse 1 (CRN W) confirmed that R55 skin condition on the lower back was extremely red, painful, and raw that runs across her lumbar area of the back from one side to another. (continued on next page)

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	12/11/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at approximately 2:10 PM, after the skin care observation, A review of R55's clinical record revealed no treatment, assessment, or updated care plan related to the lower back area skin impairment observed. It was a newly observed skin impairment. However, the following morning, on 12/11/24 at 10:30 AM, R55's clinical record revealed no nurse's notes indicating the skin assessment of the lower back skin excoriated MASD, no treatment entry from 12/10/24 was documented, and no physician order was documented for the lower back skin impairment. No updates in the care plan were found related to the lower back MASD. On 12/10/24 at 02:30 PM, the nurse manager was interviewed and stated a bariatric bed was available now, and we could switch it if R55 wanted it. We offered it to her before, but she refused it. When the nurse manager was queried whether she knew why R55 refused it, the nurse manager stated that she was in the smaller room and would be too tight for the bariatric bed and the Hoyer lift to fit. Now she is in a bigger room by herself. We have not offered it to her since she moved to a wider room. The following day, on 12/11/24 at 11:32 AM, R55's nurse's notes, skin/wound assessment, and treatment record (TAR) were reviewed. No documentation was found in the nurse's notes, and no updated skin assessments or treatment orders for the observed skin impairment were found on 12/10/24. The care plan was reviewed on 12/10/24 and 12/11/24, and no updates nor revisions of the lower back excoriation were found by the facility staff on 12/10/24. On 12/11/24 at 11:35 AM, CRN W and CRNX were queried regarding why there was no documentation of R55's lower back excoriated area observed on 12/10/24. CRN W and CRN X agreed that the observed skin impairments should have been documented. However. Both CRNW and CRN X indicated that they thought the Nurse Manager (Nurse V) would do the documentation and stated: We will get them there. The Nurse Manager (Nurse V) was queried on 12//11/24 at 12:11 PM. She stated that I assumed Nurse U did the follow-up documentation because he did the assessment and provided the care that day. Nurse V revealed that she left the room before R55's skin evaluation on 12/10/24. Nurse U was queried on 12/22/24 at 1:30 PM. He did not explain why the assessment and treatment on 12/10/24 were not documented. A written request sent to the administrator for the facility policy for Skin Care and Wound Management and Standing Orders on 12/11/24 at 8:57 AM. The facility did not provide the policy requested at the date and time of exit.

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	12/11/2024

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** 37668 Based on observation, interview and record review, the facility failed to implement policies and procedures to mitigate risk of injury during wheelchair transport for one resident (Resident #45) of five residents reviewed for accidents resulting in the potential for injury. Findings include: Resident #45: On 12/11/24 at 1:30 PM, Resident #45 was observed being pushed down the hallway in a wheelchair by Certified Nursing Assistant (CNA) S. The wheelchair did not have footrests, and the Resident was attempting to hold their legs up. Resident #45's feet were observed getting closer to the floor the further they were pushed. An interview was completed with CNA S on 12/11/24 at 1:40 PM. When queried if they were pushing Resident #45 in the hallway without footrests, CNA S confirmed they were. CNA S was then asked about the facility policy/procedure related to pushing residents in wheelchairs without footrests and replied, We do. CNA S then stated, Not really supposed to but they (residents) want help and don't have footrests. With further inquiry, CNA S verbalized most residents do not have footrests available for their wheelchairs and will ask to be pushed in their wheelchair due to the size of the facility. CNA S stated they were surprised when they came to work at the facility because of the lack of wheelchair footrest availability and use when being pushed by staff. When asked why they were surprised, CNA S revealed it was a requirement at other facilities they had worked at because of resident safety. Record review revealed Resident #45 was admitted to the facility on [DATE] with diagnoses which included dementia, chronic kidney disease, hallucinations, and repeated falls. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required moderate assistance from staff to stand and transfer from a sitting position. Review of Resident #45's Electronic Medical Record (EMR) revealed the Resident fell seven times in the facility on 7/13/24, 8/11/24, 8/28/24, 9/1/24, 10/21/24, 11/4/24, and 12/5/24 and was a moderate risk for falls. Resident #45 had a care plan entitled, Risk for falls r/t (related to) dementia with behavioral disturbance . fall . (Initiated: 7/8/24; Revised: 10/24/24). The care plan included the intervention, Transfer/Ambulation: 1 PA (Person Assist) with 2ww (wheeled walker); WBAT (Weight Bearing As Tolerated) (Initiated: 7/8/24, Revised: 9/26/24). Resident #45 did not have a care plan in place pertaining to footrest use while being pushed in a wheelchair by staff. (continued on next page)

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	12/11/2024

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	An interview was completed with Clinical Registered Nurse (RN) F on 12/11/24 at 1:55 PM. When queried regarding facility policy/procedure related to pushing residents in wheelchairs without footrests, RN F revealed the need for footrests while being pushed was based on each individual resident. When queried if the facility had a policy/procedure related to wheelchair mobility and foot pedal use, RN F replied, No. A policy/procedure pertaining to wheelchair transport of residents was requested from the facility Administrator on 12/11/24 at 1:50 PM but not received by the conclusion of the survey.

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	12/11/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on interview and record review the facility failed to ensure that a physician's order was in place for indwelling catheter changes and that the indwelling catheter changes were documented for one resident (R69) of one resident reviewed for catheters, resulting in the absence of a physician's order for indwelling catheter changes and the absence of documentation of indwelling catheter changes. Findings include: Resident #69 (R69): R69 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include kidney failure, depression, hypertension and encounter for surgical aftercare following surgery on the genitourinary system. On 12/10/24 at 03:37 PM, record review revealed that there was a care plan in place for the use of the catheter, an order is present to care for the catheter every shift with the size of the catheter and catheter balloon size. There was no order present for intervals for changing the catheter. On 12/10/24 at 03:50 PM, R69 was asked when the last time their catheter had been changed. R69 stated that they believed the catheter was changed last week. R69 stated they were in the therapy gym and the staff noticed the catheter was leaking. R69 stated they were returned to their room and had the catheter changed. On 12/11/24 at 09:20 AM, record review revealed there was no documentation present in the electronic medical record (EMR) to indicate the catheter had been changed. On 12/11/24 at 09:34 AM, an interview was conducted with registered nurse (RN) F. RN F was asked if there should be a physician's order to change catheters in the EMR and should the nursing staff document when a catheter had to be changed, if it was necessary to change the catheter. RN F stated that at minimum, there should be an as needed order to change the catheter. RN F also stated, yes, there should be a progress note or an area to document that the catheter has been changed if it was needed and why it had to be changed. Review of the policy titled, Catheter Care, Urinary, revised October 2010 revealed: Changing Catheters: 1. Changing indwelling catheters or drainage bags at routine, fixed intervals is not recommended. Rather, it is suggested to change the catheters and drainage bags based on clinical indications such as infection, obstruction, or when the closed system is compromised. Documentation: (continued on next page)

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	12/11/2024

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The date and time that catheter care was given. 2. The name and title of the individuals giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Character of urine such as color, clarity and odor. 5. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain. 6. Any problems or complaints made by the resident related to the procedure. 7. How the resident tolerated the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken. 9. The signature and titled of the person recording the data.

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	12/11/2024

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on interview and record review the facility failed to enter a physician's order timely for dialysis perma-cath care and follow a physician's order to complete dialysis documentation for one resident (R289) of one resident reviewed for dialysis care, resulting in incomplete and missing dialysis record forms and the absence of documentation of the dialysis perma-cath site being monitored. Findings include: Resident #289 (R289): R289 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include, acute kidney failure, chronic kidney disease, congestive heart failure and dependence on renal dialysis. R289 has brief interview for mental status (BIMS) score of 14, indicating that R289 is cognitively intact. On 12/09/24 at 03:27 PM, record review revealed that R289 attends dialysis at [NAME] Davita on Tuesdays, Thursdays and Saturdays with a chair time of 02:15 PM. On 12/10/24 at 01:48 PM, record review revealed a physician's order to monitor the dialysis perma-cath to the right chest wall every shift. The order was entered on 12/09/24 at 14:14 PM. R289 admitted to the facility on [DATE] and R289 attended dialysis on 12/05/24 and 12/07/24 prior to order entry. On 12/10/24 at 01:51 PM, record review revealed a physician's order to complete the Wellbridge Dialysis Assessment, the top portion of the form is to be completed and sent with the guest to Davita [NAME] Dialysis, upon returning, fill out the bottom portion under the assessment, sign and lock. The order is dated 12/04/24. On 12/10/24 at 01:54 PM, record review revealed that a Wellbridge Dialysis Assessment was started on 12/05/24 at 09:45 AM and was incomplete on the bottom of the form, not signed or locked. There was no evidence of a form from 12/07/24 when R289 would have attended dialysis as well. On 12/10/24 at 01:57 PM, an interview was conducted with Infection Control Nurse (IC) M. IC M was asked if R289 should have had the Wellbridge Dialysis Form completed for 12/05/24 and 12/07/24. IC M stated, yes, R289 should have had both been completed. IC M was asked if R289 should have had a physician's order to monitor the dialysis perma-cath site prior to 12/09/24, after already receiving dialysis. IC M stated, yes, the order should have been entered and was missed. Record review of the policy titled, End-Stage Renal Disease, Care of a Resident with, revealed: Scope of Training: 2. Education and training of staff includes, specifically: a. The nature and clinical management of End Stage Renal Disease (ESRD) (including infection prevention and nutritional needs) (continued on next page)

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	12/11/2024

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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis. c. Signs and symptoms of worsening condition and/or complications of ESRD. d. How to recognize and intervene in medical emergencies such as hemorrhages and septic infections. e. How to recognize and manage equipment failure or complications (according to the type of equipment used in the facility) f. Timing and administration of medications, particularly those before and after dialysis: g. The care of grafts and fistulas: and h. The handling of waste.

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	12/11/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 37668 Based on observation, interview and record review, the facility failed to ensure that the medication error rate was less than 5% when six medication errors were observed from a total of 29 opportunities for three residents (#'s 28, 34, and 288) of six residents reviewed. This deficient practice resulted in a medication error rate of 20.69% and the potential for adverse medication effects and decreased medication efficacy. Findings include: Resident #34: On 12/11/24 at 7:52 AM, medication pass observation for Resident #34 was completed with Licensed Practical Nurse (LPN) O. Upon entering Resident #34's room, a breakfast food tray with all food eaten was observed in the room. LPN O was observed checking the Resident's blood glucose level at the bedside. The blood glucose level result was 428. LPN O reviewed the Resident's Medication Administration Record (MAR) and verbalized the Resident needed 10 units of insulin based on the blood glucose level. The MAR showed Resident #34 had a documented blood glucose level of 254 on 12/11/24 at 5:19 AM. LPN O obtained the Resident's Insulin Aspart (short acting insulin) pen, set it to administer 10 units of insulin without priming the pen, and prepped the skin with an alcohol pad. Prior to administering the insulin, LPN O was stopped. When asked if they had primed the insulin pen, LPN O responded, No. LPN O then primed the insulin pen and reset the pen to administer 10 units of insulin. LPN O administered the insulin into the Resident's left abdomen and held the pen in place for four seconds prior to removing from the skin. Review of Resident #34's Health Care Provider Orders and MAR was completed with LPN O following medication administration. The MAR revealed: - NovoLOG Injection Solution 100 unit/mL (Insulin Aspart) Inject as per sliding scale . subcutaneously before meals and at bedtime (Start Date: 12/10/24) Resident #288: A medication pass observation for Resident #288 was completed with LPN O on 12/11/24 at 8:36 AM. LPN O was observed preparing a Lidocaine 4% and Menthol 1% topical patch for administration by writing their initials and date on the patch. When LPN O lifted the Resident's shirt to place the patch on the Resident's back, the prior patch was observed on the Resident's back. The prior patch was not fully adhered to the Resident's skin and was dated 12/11/24 with no initials. LPN O removed the prior patch and placed the new patch. LPN O was then observed handing Resident #288 a Symbicort inhaler (inhaled medication used to treat asthma and chronic obstructive pulmonary disease [COPD]) for the Resident to self-administer. After inhaling two puffs of the medication, Resident #288 handed the inhaler back to LPN O. LPN O did not assist and/or instruct the Resident to rinse their mouth following administration of Symbicort. Review of Resident #288's Health Care Provider Orders and MAR was completed with LPN O following medication administration. The MAR revealed: (continued on next page)

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	12/11/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Lidocaine External Patch 4% . Apply to back topically one time a day for pain and remove per schedule (Start: 12/4/24). The MAR detailed the patch was to be applied at 8:00 AM and removed at 8:00 PM. Per the MAR, the patch was removed on 12/10/24 at 8:00 PM and LPN O applied the patch on 12/11/24 during the medication pass observation. - Symbicort Inhalation Aerosol 160-4.5 mcg (micrograms)/Act (actuation) 2 puff inhale orally two times a day. Oral rinse and spit after medication administration (Start: 12/3/24) When queried regarding the patch they removed from Resident #288's back, LPN O verbalized it was a Lidocaine patch. With further inquiry, LPN O revealed the patch was supposed to have been removed the prior night. LPN O confirmed the patch was dated 12/11/24 and indicated the staff who applied the patch on the previous day must have written the wrong date on the patch. When queried why they administered a Lidocaine 4% with Menthol 1% patch when the order was for a Lidocaine 4% patch with no menthol, LPN O revealed the facility did not have plain Lidocaine 4% patches. When queried what Resident #288 was supposed to receive per their order, LPN O verbalized the Resident's order was for Lidocaine only. When queried regarding rinsing and spitting following Symbicort administration, LPN O confirmed they did not instruct/assist the Resident to rinse and spit following administration. LPN O was then queried how long an insulin pen should be held in place during administration and replied, 10 seconds. When asked if they knew how long they held the insulin pen in place during administration for Resident #34, LPN O revealed they were not sure. When asked why they only held the insulin pen in place for four seconds and did not prime the pen prior to being stopped by this surveyor, LPN O responded that they were nervous. When queried why Resident #28's blood glucose was checked and insulin administered after they already ate their breakfast, LPN O revealed they did not have an opportunity to check the Resident's blood glucose previously because they were assisting to pass breakfast trays. Resident #28: On 12/11/24 at 9:12 AM, a medication pass observation was completed with Registered Nurse (RN) P for Resident #28. RN P administered one drop of Dorzolamide HCl 2% Ophthalmic Solution (medication used to treat increased pressure in the eye) into the Resident's right eye at 9:13 AM. RN P immediately proceeded to administer one drop of Prednisolone Acetate 1% Ophthalmic (medication used to reduce inflammation in the eye) solution into the Resident's right eye at 9:13 AM. Directly after, RN P administered 1 drop of Brimonidine Tartrate 0.2% ophthalmic solution (medication used to reduce pressure in the eye) into Resident #28's right eye directly. RN P did not apply pressure to the tear duct and/or instruct the Resident to close their eyes following administration of any of the three eye drop medications. An interview was completed with RN P after exiting Resident #28's room. When queried if different medication eye drops are supposed to be administered back-to-back, RN P replied, They are all scheduled for the same time (on the MAR). RN P was queried regarding procedure and technique for eye medication administration, RN P did not provide further explanation. (continued on next page)

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	12/11/2024

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was completed with Clinical RN F on 12/11/24 at 11:23 AM. When queried regarding administration of different eye drop medications, RN F stated, Have to wait between different eye drop medication administration. RN F verbalized they heard about that and would address with education. When queried what should occur following administration of Symbicort inhaler, RN F stated, Rinse and spit. RN F was informed of observation of Resident #288 not being instructed/assisted to rinse and spit following administration of Symbicort, RN F verbalized understanding of error. When queried if insulin pens have to be primed prior to administration, RN F confirmed they did. When asked how long insulin pens have to be held in place to ensure administration of intended dose, RN F verbalized insulin pens needed to be held in the skin for 10 seconds. When queried regarding observation of insulin pen not being primed and being held in place for four seconds, RN F verbalized understanding. RN F revealed the staff needed and would receive education. Review of facility policy/procedure entitled, Specific Medication Administration Procedures . Eye Drop Administration (Dated: 9/1/23) revealed, To administer ophthalmic solution/suspension into the eye in a safe, accurate, and effective manner . Procedures . H. Instruct resident to close eyes slowly to allow for even distribution over surface of the eye . should also refrain from blinking or squeezing eyes shut. I. While the eye is close, use one finger to compress the tear duct in the inner corner of the eye for 1-2 minutes . Alternately, the resident may keep his/her eyes closed for approximately three minutes . K. If another dop of the same or different medication is prescribed for administration in the same eye at the same time, wait 10 minutes, then repeat procedure . Upon request for a policy/procedure related to insulin pen administration, a policy/procedure entitled, Specific Medication Administration Procedures . Injectable Medication Administration (Dated: 9/1/23) did not include insulin pen administration.

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	12/11/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation and interview, the facility failed to implement and operationalize policies and procedures to ensure appropriate labeling, storage, and disposal of medications and medical supplies, per professional standards of practice for two of two medication storage rooms in the 400 hallway and in two residents' rooms, resulting in medications left unattended and unsecured, lack of dating of medications with a shortened expiration date after opening, storage of contaminated medications and medical supplies with new medications and medical supplies. Findings include: On [DATE] at 1:45 PM, an interview was completed with Registered Nurse (RN) Q. When queried regarding storage of resident controlled and narcotic medications, RN Q revealed all controlled substances are stored in a locked cabinet at the front of the hall, near the center hub. An observation and tour of the 500-hall narcotic locked storage wall box was completed with RN Q at this time. Upon opening the wall box, two oral medication syringes were observed on the top shelf. There was a pink colored substance present in end of the syringe. When queried if the syringes had been used, RN Q responded they were, and that staff will sometimes use the oral syringe again as it is for a hospice resident who is frequently receiving liquid morphine. RN Q was asked if the facility did not have an adequate supply of oral syringes to use a new one for each medication administration and indicated they did. RN Q proceeded to dispose of the two used syringes. When queried regarding infection control considerations, due to multiple resident medications being contained in the narcotic cabinet, RN Q did not provide an explanation. A tour of the 500 and 600 Hall Medication Storage Room was completed with RN Q on [DATE] at 2:04 PM. The following items were present in the medication storage room: - A vial of CoaguChek XS PT Test strips was noted to be open - Seven Addipak 5 mL containers of 0.9% sterile saline solution, Expired ,d+[DATE] - Open 8 fluid ounce (fl. oz.) container of Iodine. The top of the container was visibly soiled with dark brown colored, crusted material. A tour of the Main (400 hall) medication room was completed with Unit Manager RN R. A box of call bells and an empty plastic container were noted in the cabinet under the sink. When queried regarding storage of items under the sink, RN R stated nothing should be stored under the sink. The following items were observed: - Open and undated vial of Tuberculin purified protein it 5 TU (Tuberculin Unit)/ 0.1 mL testing solution (continued on next page)

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	12/11/2024

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Multiple open and undated bottles of over-the counter medications were present in the medication room. When queried regarding facility policy/procedure related to dating and storage of over-the-counter medications, RN R revealed over the counter (OTC) medications are not dated when opened and the manufacturer expiration date is used. When asked if opened OTC medications are supposed to be stored in the medication room, RN R stated, No. They are in the in-room med cabinets. You can't but them back (in med room). That's gross. When queried regarding the open OTC medications in the medication room, RN R stated, I'm so upset because we have trained them (nursing staff) to not put med's back and to send them home with the resident. When asked about the training which had been completed, RN R revealed facility staff had received training to not return medications to the med room previously because of prior concerns. On [DATE] at 4:10 PM, RN R indicated they wanted to discuss the open medications in the medication room and an interview was completed. RN R stated, I was told they pulled them (open OTC med's) from the hall cabinets. When queried who told them that, RN R verbalized they were informed by facility corporate staff. RN R was asked what hall cabinets they were referring to and revealed there are in wall locked cabinets in each the open room/cubby on each hall which are no longer used. With further inquiry, RN R stated, We shut those down a year ago. I didn't think anyone was still using them. When asked what medications were removed from the hallway cabinets, RN R revealed they did not know. When asked if there was a list, RN R stated there was not. When queried if some of the open medications may have been from resident in room cabinets, as there was not a list and/or documentation of the medications removed from in hall cabinets, RN R confirmed but did not provide further explanation. A policy/procedure related to all medication storage including testing equipment and vaccine solutions was requested from the facility Administrator on [DATE] at 10:46 AM but not received by the conclusion of the survey. 49944 Resident #34 (R34): R34 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include acute kidney failure, major depressive disorder, paraplegia and hypertension. R34 has a brief interview for mental status (BIMS) score of 6, indicating severe cognitive impairment. On [DATE] at 11:05 AM, a bottle of iodine was observed sitting on the dresser of R34. R34 was asked if they knew why the bottle of iodine was sitting out in the room. R34 stated it didn't belong to them and they are not sure how it got there. This surveyor located the nurse that was working on the hall and had them come to R34's room. Licensed Practical Nurse (LPN) N was asked if the iodine should be locked up in a secure medicine cabinet and not left out in the room. LPN N stated, yes it should be. LPN N stated they did not know why the iodine was left out, but that the night nurse must've left it in there after wound care from the previous shift. LPN N placed the iodine in a secure medicine cabinet in the room.

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	12/11/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22347 Based on observation, interview and record review, the facility failed to 1) Maintain food preparation and kitchen equipment in a sanitary and good working condition, and 2) Ensure proper maintenance of kitchen equipment (dishwasher), resulting in an increased likelihood for food borne illness with hospitalization , and cross contamination affecting 81 residents who consumed oral nutrition from the facility kitchen of a total census of 82 residents. Findings Include: Review of the Public Health Service 2009 Food Code, adopted by the Michigan Food Law, effective October 1, 2012, Chapter 4-501.14 directs that equipment cleaning frequency is to be throughout the day at frequency necessary to prevent recontamination of equipment and utensils. On 12/9/24 at 10:05 a.m., during the initial tour of the kitchen accompanied by Culinary Specialist H and Executive Chief I, the following was observed: -At 10:07 a.m., the inside door of the ice machine was found to have a build-up of calcium-like hard white substance coating the door gasket on the left side, directly over the ice when the door was shut. Review of the Service Invoice dated 10/25/24, revealed the facility identified the ice machine door gasket concern and had ordered new ones; however, the ice machine door gasket was still a concern on 12/9/24. -At 10:09 a.m., two clean and ready for use knifes were found in the knife rack with dried on food particles on the blades. -At 10:15 a.m., four clean and ready for use silver metal pans were found on the clean pan rack with water inside and dried food particles inside. The pans were stacked inside of one another. Chief I immediately removed them and directed staff to re-wash them and stated, they should not be wet. Review of the handwritten Employee Corrective Action sheet dated 12/9/24, stated It is expected that pans are dry before being stacked and put on shelves. Review of the facility kitchen education given on 12/9/24 at 11:45 a.m., revealed staff were inservice on wet nesting, the practice of stacking wet dishes, pots or pans on top of each other, which prevents them from drying and can lead to the growth of microorganisms. -At 10:25 a.m., in front of the dishwasher was observed an excessive amount of standing water on the floor. Culinary Specialist H took a large squeegee and push the water toward the drain under the dishwasher. When requested to turn the dishwasher on, a constant dripping/leaking was noted under the dishwasher from the drain trap. (continued on next page)

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	12/11/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview done on 12/9/24 at 10:28 a.m., Dietary Aide J stated Sometimes it leaks all over, bothers me. -At 10:35 a.m., a large silver spatula was observed in with clean silverware, and it had dried on food particles on it. During an interview done on 12/11/24 at approximately 10:15 a.m., the cooperate Infection Control Consultant A was asked if the facility Infection Control Nurse toured the kitchen and she stated, I totally trust my staff, I one hundred percent trust my staff: Infection Control Consultant A said she did have Infection Control nurse do the walk through in the kitchen. During an interview done on 12/11/24 at approximately 2:10 p.m., the facility Infection Control Nurse M was asked if she was shown or given directions on how to do a kitchen infection control tour, and she stated, I didn't get shown what to look for. Infection Control Nurse M was new to the role of Infection Control at the facility. Review of the facility Interdepartmental Infection Control Rounds sheets dated 9/24, 10/24, and 11/24, revealed no documentation (check list questions) of dishwasher, nor ice machine.

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	12/11/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37668 Based on observation, interview and record review, the facility failed to implement and ensure hand hygiene per professional standards of practice during medication administration for two residents (#32 and #48) of six residents reviewed during medication pass observation resulting in the potential for cross contamination and spread of microorganisms. Findings include: A medication pass observation for Resident #32 was completed with Registered Nurse (RN) Q on 12/10/24 at 1:50 PM. RN Q did not perform hand hygiene prior to entering Resident #32's room and/or preparing the Resident's medications. Following completion of medication pass administration, RN Q exited Resident #32's room without completing hand hygiene. RN Q did not complete hand hygiene prior to entering Resident #48's room at 2:00 PM on 12/10/24. RN Q was observed obtaining Resident #48's medications from the in-room medication cabinet and then administering the medications without performing hand hygiene. An interview was completed with Clinical RN F on 12/11/24 at 11:23 AM. When queried regarding hand hygiene prior to and after medication administration, RN F stated, They (staff) should do their hand hygiene. RN F was informed of observations of RN Q not performing hand hygiene and confirmed hand hygiene should have been completed. Review of facility policy/procedure entitled, Preparation and General Guidelines . Medication Administration . (Dated: 9/1/23) revealed, Procedures: A. Preparation . Handwashing and hand Sanitization. The person administering medications adheres to good hand hygiene which includes washing hands thoroughly: - before beginning a medication pass, - prior to handling any medication, - after coming into direct contact with a resident, - before and after administration .