STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235716	A. Building B. Wing	04/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Rochester Hills	252 Meadowfield Drive Rochester Hills, MI 48307

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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** 32568 This citation pertains to Intake Number(s): MI00143710. Based on observation, interview, and record review, the facility failed to identify and treat a wrist fracture in a timely manner for one (R701) of three residents reviewed for changes in condition. Findings include: A review of a complaint submitted to the State Agency revealed allegations that R701 fell and the facility did not seek timely treatment afterwards. On 4/15/24 at 11:35 AM, R701 was observed lying on his back, sleeping. A cast was observed on R701's left arm. On 4/15/24 at 2:00 PM, an interview was conducted with R701. When queried about what happened to his left arm, R701 stated, I fell . When asked it was painful, R701 reported he experienced pain when he did not take pain medication. A review of R701's clinical record revealed R701 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: a fracture of the left wrist and hand (dated 4/10/24) and a displaced fracture of the left ulna (the long bone in the forearm) (dated 4/10/23). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R701 had moderately impaired cognition, a pain level of three (out of 10 with 10 being the most severe pain), and no history of falls. A review of a Skilled Charting progress note dated 2/6/24 revealed R701 fell from the bed. A review of a Physician Note dated 2/7/24 revealed R701 was forgetful and does not recall multiple falls. A review of a eMAR (Electronic Medication Administration Record) note revealed R701 received two tablets of acetaminophen after he complained of pain to the left upper extremity. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a Facility Reported Incident (FRI) submitted to the State Agency by the facility for R701 revealed on 2/24/24 at 12:38 PM, R701 alleged he was abused over night during his care (on the midnight shift of 2/23/24. A review of the Investigation Summary revealed R701 told the Administrator he was hit and fell to the floor hurting his wrist. A review of a written and signed statement by Licensed Practical Nurse (LPN) 'B' revealed, Guest told aide he was picked up and slammed by a tall big guy the night before and that his arm hurt. I went into room to assess guest and some swelling was present to his left lower arm but no bruising. When asked what happened, patient states he stood up and a guy pulled him down by his arms back into the bed. Patient was unable to give any other details. A review of a statement given by Certified Nursing Assistant (CNA) 'H' on 2/24/24 revealed R701 told her he got his ass beat last night. By some tall guy . A review of a Physician Note dated 2/25/24, written by Physician 'D', revealed R701 had left wrist bruising and swelling. It was documented R701 did not recall any trauma or injury. However, it should be noted that the previous physician evaluation on 2/7/24 revealed documentation that R701 was forgetful and did not recall a fall he had the day prior. The 2/25/24 note revealed, Large bruise on the left hand/wrist dorsal (back) side noted with edema (swelling) but no tenderness. Range of motion of the left wrist is normal and no pain with deep palpation or range of motion. Unclear etiology, patient does not recall trauma or injury but cannot rule out patient bumping his hand into the bed railing or furniture leading to possible small hematoma and bruising. Clinically do not suspect fracture and do not think patient needs x-ray, continue monitors closely . There was no documentation in that note that indicated the physician was aware that R701 made an allegation of physical abuse or that he may have fell . A review of a Skilled Charting progress note dated 3/9/24 revealed R701 was observed on the floor during breakfast. The following was documented, Left wrist appears to be swollen, guest states it was from him falling previously. No new orders. A review of a Skilled Charting progress note dated 3/10/24 revealed R701 fell in his room. There was no documentation of the appearance of R701's left wrist. A review of a Skilled Charting progress note dated 3/30/24 revealed R701 complained of pain to his left wrist which was five out of 10 pain level. R701 requested Motrin instead of Tylenol. It was documented by the nurse that Wrist is visibly swollen. Guest denies injury to wrist. On call physician notified. New order received for Motrin . A review of a Physician Progress Note dated 4/1/24 revealed the following, Patient is complaining of left wrist pain, denies any recent fall/trauma or injury (It should be noted that R701 had three previous falls prior to that date and made an allegation of abuse). On exam swelling the left wrist noted but no bruising or signs of trauma noted. Unclear etiology but most probably osteoarthritis .Will do X-ray of the left wrist but clinically do not suspect fracture . A review of a Skilled Charting progress note dated 4/2/24 revealed R701 had an X-ray done for his left wrist on 4/1/24 which was positive for a radial fracture (wrist). R701 was sent to the hospital. A review of R701's hospital records revealed the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An ED (Emergency Department) Note dated 4/2/24 documented, .presents to the Emergency Center today for evaluation after a fall. Patient reports he fell a few days ago and landed on his left wrist .He currently has left wrist pain .He has an obvious deformity and edema to the left wrist .No ecchymosis to left forearm or wrist .Left wrist and forearms x-rays .IMPRESSION: Comminuted (broken into multiple fragments), impacted (when the bone gets compressed or squashed causing the broken ends to push into each other), and angulated (a specific type of fracture where the normal axis of the bone has been altered, causing the distal portion of the bone to point off in a different direction. It is usually caused by landing on the bone at an angle after a fall or being hit suddenly from an angle) fracture distal radius .Displaced fracture ulnar styloid (injury involving the end of the bony part of the wrist) .Multiple attempts to reach ECF (extended care facility) unsuccessful, did reach receptionist once but was unable to speak with nursing/care staff. Spoke with pt's (patient's) son who states he saw pt on Saturday (3/30/24) noted wrist deformity and was told by nurse who reviewed records last fall was March 10th, son noted wrist was deformed with no bruising or redness . A History and Physical evaluation noted, .patient was found to have a left wrist fracture .insist that he does not have any fracture patient has dementia and is poor historian .: Further review of R701's clinical record revealed he was readmitted into the facility on [DATE]. The Admission Summary noted, .Guest has c/o (complained of) pain being a 10 on a scale of 0-10 in his wrist. Guest describes the pain as sharp and the pain is constant. Guest states that moving his wrist makes it worse and resting and ice helps it feel better . A review of R701's physician orders and MAR revealed he had an order for hydrocodone-acetaminophen (a narcotic pain medication used to relieve moderate to severe pain) 5-325 milligrams every 6 hours as needed which was started on 4/10/24. R701 received the pain medication one time on 4/11/24, 4/12/24, 4/13/24, and 4/15/24 and two times on 4/14/25 with pain levels between three and eight. On 4/15/24 at 1:34 PM, a telephone interview was conducted with LPN 'B'. When queried about what happened with R701 on 2/24/24, LPN 'B' reported that the day shift CNA said R701 alleged a big guy kicked my ass last night. When LPN 'B' assessed R701, he complained of pain to his left wrist which originally did not have any bruising but explained by the following day He definitely had bruising and swelling, but I wasn't his nurse that day. On 4/15/24 at 1:38 PM, a telephone interview was conducted with R701's family member who reported on 3/30/24 he visited R701 and immediately noticed his right forearm was deformed and swollen. When R701's family member asked R701 what happened, R701 said he fell and he thought his wrist was broken. R701's family member addressed the issue with the assigned nurse who went to the room to assess R701's arm. At that time, R701 told the nurse that his arm hurt. The nurse reviewed R701's clinical record and told R701's family member that R701 fell , but it was on 3/10/24 which would have been 20 days earlier. When R701 inquired about whether an X-ray was done, the nurse told him he had to talk to Administration who was not available that day. R701's family member explained that R701 was discovered to have a wrist fracture and the ER doctor was concerned that the injury appeared to have gone on for a significant amount of time. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/24 at 2:40 PM, a telephone interview was conducted with LPN 'C', the nurse who was assigned to R701 on 3/30/24 when R701's family member was visiting. When queried about what occurred with R701's wrist on 3/30/24, LPN 'C' reported R701 complained of pain in his wrist and R701's family member reported pain to her. LPN 'C reported she contacted the physician and reported that R701's wrist was swollen and painful and the physician changed R701's Tylenol order to Motrin per the resident's request, but did not order an X-ray. On 4/15/24 at 3:26 PM, a telephone interview was conducted with Physician 'D'. Physician 'D' was familiar with R701. When queried about whether he was aware of R701's falls that occurred on 2/6/24, 3/9/24, and 3/10/24 and that R701 made an allegation of abuse on 2/24/24, the day before he documented bruising and swelling to R701's wrist, Physician 'D' reported he did not remember the abuse allegation and knew that he had multiple falls. When queried about why no X-ray was done to rule out a fracture when there was bruising, swelling, and deformity (according to the hospital records), Physician 'D' reported there was swelling, but no bruising, and he could not produce any palpable pain. Physician 'D' reported he was surprised R701's wrist was fractured when he received the results on 4/2/24 because he has never seen a fracture that did not produce some kind of pain. On 4/15/24 at approximately 3:45 PM, an interview was conducted with the Director of Nursing (DON) who reported she was aware of R701's wrist being swollen, his falls, and the allegation of abuse. When queried about the lack of X-ray completed, the DON reported they followed the physician's orders and he did not think R701 needed an X-ray. A review of a facility policy titled, Acute Condition Changes - Clinical Protocol revealed, in part, the following: . Before contacting a physician about someone with an acute change of condition, the nursing staff will make detailed observations and collect pertinent information to report to the Physician .The nursing staff will contact the Physician based on the urgency of the situation .The Nurse and Physician will discuss and evaluate the situation .The Physician should ask questions to clarify the situation .The nursing staff and physician will discuss possible causes of the condition change based on factors including resident history, current symptoms, medication regimen, and existing test results .If necessary, the Physician will order diagnostic tests or evaluate the resident directly .The Physician will help identify and authorize appropriate treatments .

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 This citation pertains to Intake MI00143662 Based on interview and record review, the facility failed to ensure a physician and/or physician extender evaluated and assessed pressure ulcers for one (R702) of three residents reviewed for pressure ulcers. Findings include: Review of the closed record revealed R702 was admitted into the facility on [DATE] with diagnoses that included: fracture of right femur, encounter for other orthopedic aftercare and hypertension. According to the Minimum Data Set (MDS) assessment dated [DATE], R702 was cognitively intact and had no pressure ulcers upon admission. Review of R702's admission wound progress note dated 7/2/23 at 7:39 AM read in part, Guest has red slow to blanch boggy heals bilaterally . sacrum and coccyx are red and blanching . Review of R702's July 2023 Medication Administration Record (MAR) revealed an order with a start date of 7/2/23 for, Skin Prep to bilateral heels r/t (related to) redness/boggy, two times a day for protection. Review of wound evaluations revealed R702 developed a Stage 2 (partial-thickness loss of skin with exposed dermis) sacrum pressure ulcer and a Deep Tissue Injury (DTI - intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration due to damage of underlying soft tissue) pressure injury to the right heel on 7/9/23. Review of a Skin & Wound Evaluation for R702 dated 7/12/23 a DTI to the left heel that was documented as Present on Admission. It should be noted, there was no documentation of a DTI, order for treatments, or heel lift protectors put into place before 7/12/23. Review of physician progress notes revealed: A History and Physical note dated 7/1/23 by Dr. J read in part, .Here for physical therapy needs . main complaint is generalized weakness . REVIEW OF SYSTEMS: Full 14-point review of systems was done . SKIN: Warm and dry. EXTREMITIES: Decreased range of motion of the right hip . A Physician Note dated 7/10/23 at 3:47 PM by Nurse Practitioner (NP) K read in part, .Patient seen and examined . Skin: Inspection and palpation: no rash or lesions . Physician Visits dated 7/11/23 at 12:35 PM, 7/18/23 at 6:41 AM and 7/20/23 at 9:48 AM by Dr. J contained no mention of R702's pressure ulcer/injuries, they all documented in part, .SKIN: Warm and dry . Physician Notes dated 7/12/23 at 3:00 PM, 7/14/23 at 4:41 PM, 7/17/23 at 4:06 PM, and 7/19/23 at 4:07 PM, by NP K contained no mention of R702's pressure ulcer/injuries, they all documented in part, .Skin: Inspection and palpation: no rash or lesions . (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/24 at 4:25 PM, Dr. J was interviewed by phone and asked about the lack of documentation of a physician assessing and evaluating R702's pressure ulcer/injuries. Dr. J explained he was an Internal Medicine specialist, not a wound doctor and his visits were very focused on the medical necessity reason he was there for. Dr. J was asked when would he normally assess and/or evaluate a pressure ulcer or injury. Dr. J explained the nurse would have to specifically notify him that a wound was infected or needed debridement (removed debris or infected/dead tissue from wound) for him to evaluate them. When questioned how he knew what orders to put in for wound care if he had not seen the wounds, Dr. J explained the wound orders were basically nursing orders entered by nursing and he just signed off on whatever order they wrote for. On 4/15/24 at 4:49 PM, NP K was interviewed by phone and asked about the lack of documentation of R702's pressure ulcer/injuries. NP K explained that basically she focuses on what the resident was admitted for , and since R702 was admitted for surgical aftercare, she was focused on ensuring the correct orders were entered. Review of a facility policy titled, Physician Services revised 8/2006 read in part, .The resident's Attending Physician participated in the resident's assessment and care planning, monitoring changes in resident's medical status, and providing consultation or treatment .