

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235716	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/16/2024
NAME OF PROVIDER OR SUPPLIER  Wellbridge of Rochester Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from the wrongful use of the resident's belongings or money.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39592</p> <p>This citation pertains to Intake MI00145482</p> <p>Based on interview and record review the facility failed to prevent misappropriation of a controlled substance medication for one (R401) of three residents reviewed for misappropriation of resident property.</p> <p>Findings include:</p> <p>A Facility Reported Incident (FRI) was filed with the State Agency that alleged in part, .there was a discrepancy with the count of a controlled substances that belonged to the resident . the 400-hall controlled count sheet was off for (R401's) klonopin (a Schedule IV anti-anxiety medication). The count went from 25 to 22 with no signature accounting for its administration .</p> <p>Review of a facility policy titled Abuse, Neglect and/or Misappropriation of Resident Funds or Property revised 3/15/23 read in part, .Misappropriation means the deliberate misplacement, exploitation, or wrongful temporary or permanent user [sic] of a resident's belongings or money without the resident(s) consent .</p> <p>Review of the clinical record revealed R401 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: generalized anxiety disorder, dementia with behavioral disturbance and bipolar disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R401 had moderately impaired cognition and received anti-anxiety medications.</p> <p>Review of R401's physician orders revealed an order with a start date 5/13/24 for clonazepam (klonopin) 0.5 MG (milligrams), give 1 tablet by mouth at bedtime.</p> <p>Review of a Controlled Substance Proof-Of-Use Record (count sheet) for R401's clonazepam 0.5 MG revealed there were 29 tablets dispensed by the pharmacy on 6/11/24. One tablet was removed on 6/14 at 8:00 PM for a count of 28 tablets. One tablet was removed on 6/15/24 at 9:00 PM for a count of 27 tablets. One tablet was removed on 6/16/24 at 9:00 PM for a count of 26 tablets. One tablet was removed on 6/17 at 9:00 PM for a count of 25 tablets. One tablet was removed on 6/18 at 9:30 PM for an unknown amount of tablets. The next line on the count sheet was dated 6/19 at 7:17 PM had actual count written twice then had 22 circled with two initials next to it. There was no documentation on how the number of tablets remaining went from 25 to 22 with only one line in between.</p> <p>(continued on next page)</p>

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
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<p>F 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the count sheet for R401's clonazepam 0.5 MG revealed on 6/18/24 the amount of tablets remaining difficult to verify as a possible 22 appeared to have been written over another number that could not be deciphered.</p> <p>On 7/16/24 at 1:17 PM, Licensed Practical Nurse (LPN) A was interviewed and asked about R401's clonazepam count sheet. LPN A explained she had been R401's assigned day shift nurse on 6/18/24 and 6/19/24 and had counted the controlled substances with the midnight shift nurse, Registered Nurse (RN) G at the end of her shift on 6/18/24 and the count was correct . then when she came in the next morning and counted with RN G, she had the blister pack with the tablets in it and RN G had the count sheet . RN G read there were 22 tablets and that is what was in the blister pack . then when she counted at the end of her shift on 6/19/24 with LPN B she had the count sheet and could not make out the number of tablets remaining, there should have been 24, but there were 22 in the blister pack. When asked why she had not noticed the discrepancy during her 12 hour sift, LPN A explained she never gave any of the medication as R401 only gets the clonazepam at night.</p> <p>On 7/16/24 at 1:57 AM, LPN B was interviewed by phone and asked about R401's clonazepam count sheet. LPN B explained when she and LPN A were counting the controlled substances at the beginning of her midnight shift on 6/19/24, LPN A said she could not read the number on the sheet, so she looked at it, and could not read it either and wrote the actual count of tablets remaining on the count sheet and she and LPN A signed their initials on the sheet and notified the Director of Nursing (DON).</p> <p>On 7/16/24 at 2:49 PM, RN G was interviewed by phone and asked about R401's clonazepam count sheet. RN G explained she had not noticed the number was off when she gave R401 the tablet, she just wrote the number down . she did not notice the count was off until she and LPN A were counting the medications RN G was asked what she did when she saw the count was off from the count sheet. RN G explained she had told LPN A to report it to the DON, but she had not stayed because she was going on vacation.</p> <p>Review of a 6 Panel urine drug test that had been performed for RN G on 6/21/24 at 10:11 AM revealed the 6 Panel test did not include testing for benzodiazepine (drug classification of clonazepam).</p> <p>Review of the facility's FRI investigation of R401's missing clonazepam revealed the investigation was inconclusive as to who diverted R401's medication, however, it was concluded there were two clonazepam tablets that were unaccounted for.</p> <p>On 7/16/24 at 3:43 PM, the Administrator and DON were interviewed and asked why the urine drug test ordered for RN G did not test for benzodiazepine. The Administrator explained somehow the test had not been ordered correctly. The Administrator was asked if there was any further investigations or documents related to R401's missing clonazepam. No additional information was provided before the end of the survey.</p> <p>Review of a facility policy titled, Medication Storage In The Facility dated 9/1/23 read in part, .A controlled substance count sheet is prepared by (Contracted Pharmacy) or the facility for all Schedule II-V medications . At each shift change or when keys are transferred, a physical inventory of all controlled substances, including refrigerated items, is conducted by two licensed nurses and is documented .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>39592</p> <p>This citation pertains to Intake MI00145482</p> <p>Based on interview and record review, the facility failed to ensure controlled substances were stored in locked compartments in the 400-Hall. This deficiency had to ability to affect all residents with prescribed controlled substances residing on the 400-Hall.</p> <p>Findings include:</p> <p>A Facility Reported Incident (FRI) was filed with the State Agency that alleged in part, .there was a discrepancy with the count of a controlled substances . the 400-hall controlled count sheet was off for (room) 402 klonopin (a Schedule IV anti-anxiety medication). The count went from 25 to 22 with no signature accounting for its administration . The date of the occurrence was documented as 6/18/24.</p> <p>Review of facility provided nursing schedules for 6/18/24 and 6/19/24 revealed for the 400 Hall Licensed Practical Nurse (LPN) A had been the day shift (7:00 AM-7:00 PM) nurse on 6/18/24 and 6/19/24, Registered Nurse (RN) G and RN E had been the midnight shift (7:00 PM-7:00 AM) on 6/18/24, and LPN B had been the midnight shift nurse on 6/19/24.</p> <p>On 7/16/24 at 12:48 PM, RN E was interviewed by phone and asked about the controlled substances in the 400-Hall on 6/18/24. RN E explained that was the one and only shift she had worked at the facility . before her shift started, she was talking to the day shift nurse who told her the lock was broken on the controlled substance box and the Director of Nursing (DON) was aware and a work order had been put in . but all the controlled substances were still in the box, they were not moved to a box that would lock . she decided then she would just get through that 12-hour shift, but this facility was not the place for her. RN E was asked if she had given any controlled substances that night. RN E explained RN G did not let her remove any controlled substances, RN G would remove them then give the medication to her to give to the residents.</p> <p>On 7/16/24 at 1:17 PM, LPN A was interviewed and asked if the lock on the controlled medication box had been broken on 6/18/24 and/or 6/19/24. LPN A explained she knew it had been broken, but did not remember when. LPN A was asked if she had told RN E or RN G that the lock was broken. LPN A denied she had told either RN E or RN G the lock was broken. When asked if she had talked to RN E before RN G got there, LPN A explained she had chatted with RN E.</p> <p>On 7/16/24 at 1:57 PM, LPN B was interviewed by phone and asked if the controlled medication lock box had been broken when she worked on 6/19/24. LPN B explained she could not remember if it was broken or not.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 7/16/24 at 2:44 PM, the Maintenance Director was interviewed and asked if the lock on the controlled box had been reported as broken. The Maintenance Director explained he had replaced the lock on that box . The Maintenance Director was asked for the work order that had been put in for that lock.</p> <p>Review of a work order created by the DON on 6/20/24 at 5:00 AM read in part, .400 hall control cabinet lock is broke . The work order documented I replaced both of the locks on 6/20/24 at 3:50 PM.</p> <p>On 7/16/24 at 2:49 PM, RN G was interviewed by phone and asked if the lock on the controlled substance box was broken on 6/18/24. RN G explained she had gotten in report when she came on that the lock on the box was broken and that the DON had said to just keep an eye on the box.</p> <p>On 7/16/24 at 3:43 PM, the DON was interviewed and asked when she had been informed the lock on the controlled substance was broken in the 400 Hall. The DON explained she put in a work order when she heard about the lock being broken. The DON was asked where should the controlled substance medications be kept if the lock on the box was broken. The DON explained if the lock was broken, all the medications should be moved to a box that had a working lock.</p> <p>Review of a facility policy titled, Medication Storage In The Facility dated 9/1/23 read in part, .Schedule II-V controlled substances and other medications subject to abuse or diversion are stored in a permanently affixed, double-locked compartment separate from all other medications .</p>		