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	03/14/2025

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.

(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 - Some	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** 47283 This citation pertains to Intake #: MI00150503. Based on observation, interview, and record review facility failed to investigate an incident of hot liquid spill (unknown resident) and failed to implement interventions/supervision related to falls for two (R801 and R803) of four residents reviewed for accidents resulting in a fall with major injury and hospitalization (R803); with potential for continued falls for R803. Findings include: A complaint received by the State Agency read in part, (R801- name omitted) had a fall and sustained a hip fracture. Complainant also states the (R801- name omitted) had a laceration on head .was found in the lunch area after fall. R801 R801 was admitted to the facility on [DATE] after a hospital stay from 11/4/24 to 11/10/24. R801 was living at home with their family member prior to admission to the hospital and was admitted to hospital after a fall. R801's admitting diagnoses included wedge compression of lumbar spine due to fall, mixed Alzheimer's disease and vascular dementia, mood disorder, anxiety, and history of mini strokes and falls. Based on the Minimum Data Set (MDS) assessment dated [DATE], the Brief Interview for Mental Status (BIMS) assessment was scored a 1/15, indicative of severe cognitive impairment (when manually added the assessment scores). Review of MDS assessment dated [DATE] did not reflect R801's fall history and their fracture prior to recent admission to facility. An interview with the complainant was completed on 3/13/25 at approximately 1:15 PM. During the interview the complainant reported that R801 sustained a left hip fracture after their fall in the facility lunchroom on 2/20/25 and they were transferred to the hospital, after their request. Staff were not going to send their mother to the hospital until they had insisted to transfer them. They added that their mother had multiple falls at the facility, in their room and in the dining room. They added that their mother kept trying to stand up; that facility knew that they were a fall risk. They added that there were no staff members watching their mother when they were in dining room and their mother had fallen in the dining room prior to this incident on 2/20/25. They reported that their mother was receiving hospice services during their stay at the facility. They also added that they started taking their mother to an adult day care facility on Fridays approximately 3 weeks prior to the transfer to the hospital and their mother was staying at the other facility for about 6 hours at a time. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A follow up interview was completed with a family member was completed on 3/13/25 at approximately 1:45 PM. The family member reported that they visited their family member regularly at the facility. They added the residents would sit in the dining room after lunch and the facility staff were not monitoring them. They reported that in December (approximately before Christmas) they were in the lunchroom and a resident spilled coffee on themselves and they had to find a staff member and got assistance as there were no staff in the dining room. They identified the staff member as the therapist, who came and assisted the resident. (This incident was confirmed by a facility staff member). Review of R801's hospital records dated 2/20/25 revealed that they were admitted to the hospital after a fall at the facility and they were diagnosed with a closed and displaced fracture of the left femur and head injury to the left forehead. Review of R801's admission fall risk assessment dated [DATE] reveled a score of 16, indicative of high risk for falls. Review of R801's care plan revealed the following interventions that were initiated on 11/10/24 and read: Administer medications as ordered by physician; evaluate lab test and x-ray PRN (as needed); neuro-checks per protocol; reinforce the need to call for assistance; requires 1-person assist with transfers, non-ambulatory. It must be noted that R801 had significant cognitive deficits. R801 did not have any other resident specific fall prevention interventions in place based on their admission fall risk assessment, their diagnosis, cognitive and physical limitations with history of falls. Review of R801's hospital records (prior to admission to hospital) revealed a care management note dated 11/5/24. The note read patient currently has a sitter for safety .referral sent to (Skilled Nursing Facility name omitted) - will need 24-hour sitter for acceptance . Review of R801's physical and occupational therapy evaluation dated 11/8/24 revealed significant deficits with safety due severe cognitive impairment. Review of R801's Electronic Medical Record (EMR) revealed the nursing progress note dated 2/20/25 at 17:17 (5:17 PM) that read in part, CENA (Certified Nursing Assistant) approached the writer asking for assistance with change in elevation in the dining room. Writer entered the dining room and observed a staff member supporting guest .laceration noted to left temple, blood beginning to clot .left lower extremity (LLE) range of motion (ROM) impaired with decrease ROM noted .son arrived and requested guest to go to hospital. At that time multiple nurses notified the son (name omitted) that hospice would be sending someone to evaluate. Son insisting guest to go to hospital . Review of the fall care plan dated 2/20/25 included the intervention that read Activities to notify nursing when activity has ended and guest will be unattended in the dining room. A request was sent to facility administrator to provide all the incident and accident (I&A) reports for R801 from 11/10/24 to 2/20/25. Received I&As for the following dates: 11/24/24, 12/16/24, 1/2/25, 2/25/25, and 2/20/25. Review of I&A reports revealed that R801 had falls in the common area (s) on 12/16/24, 2/5/25 and 2/20/25. I&A dated 12/16/24 read, Guest was observed lying on her left side on the floor in front of her w/c (wheelchair) next to the couch in the common area outside of the north team room, it appears that the guest was trying to self-transfer from the w/c to the couch . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	I&A dated 2/5/25 read, Nurse was notified by activities aide that resident was on the floor in the dining room. She states that she did not see her fall. Resident observed on the floor in the dining room lying on her left side between the tables . I&A dated 2/20/25 read, CENA approached writer asking for assistance w/ (with) change in elevation in dining room. Writer entered dining room and noted staff member supporting guest who was positioned on buttock w/ legs stretch outward and flat. Wheelchair w/in reach and to the front/left of guest. Dining room chair to the right of guest . Review of the statement from the facility administrator dated 2/21/25 read, I was rounding the north side of the building just before 4pm on Thursday 2/20 and was walking through the dining room coming from the 700-hallway side and just finished talking to (name omitted) briefly. When walking through the dining room I saw a blur out of my peripheral and heard a thud. I turned and (R801's name omitted) was on the floor and her dining room chair was fallen over backwards. I went to her and kneeled down behind her and tried to prop her head up off the ground I called out for (CNA) A and LPN B- name omitted). Both came to the north dining room and assisted with getting (R801) back into the wheelchair. An interview with LPN B was completed on 3/14/25 at approximately 10:30 AM. LPN B was called to complete the assessment on R801 after their fall in the dining room on 2/20/25. LPN B reported that they recalled the incident and they were notified by the Certified Nursing Assistant (CNA) that R801 was on the floor in the North dining room and they completed the initial assessment. They were not assigned to the unit and they were notified of the fall and they did the assessment. An interview with CNA A was completed on 3/14/25 at approximately 12:20 PM. They reported that they had been working at the facility for 2 years. They were queried about R801's fall on 2/20/25. They reported that they remembered the incident. They reported that they were walking down the dining room and they heard someone calling. They observed R801 was on the floor in the dining room and the administrator was holding R801 in back. They went and notified LPN B and they had both assisted R801. R803 R803 was a long-term resident of the facility. R803 was originally admitted to the facility on [DATE]. R803's admitting diagnoses include dementia, stroke, visuo-spatial neglect after stroke, history of falls, mood disturbance and anxiety. Based on the Minimum Data Set (MDS) assessment dated [DATE] R803 had a BIMS score of 2/15, indicative of significant cognitive impairment. An initial observation was completed on 3/13/25 at approximately 3:05 PM. R803 was observed sitting in their wheelchair in the room. R803's bedside table was in front of their wheelchair. R803's call light was laying on their lap and the clip to secure call light was broken. R803 had their bed against the wall on the right side and had perimeter mattress. R803 was sitting in a regular wheelchair with a cushion. The wheelchair did not have any safety devices (anti-tip and dycem - nonslip sheet). The back of the wheelchair had rubber tips on both sides (which had to be removed to install the anti-tips). R803 was sitting on a cushion and there was no dycem visible on top or below the cushion on the corner. R803 was able to answer simple questions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	UM F was queried about what generic interventions were ordered for their new residents. They checked the EMR and shared the following interventions: administer meds, evaluate labs and test x-rays, transfer status, neuro check per protocol, ambulation/transfer. They added that additional interventions were added after root cause analysis after an incident. UM F was queried about R801's (who was a high-risk for falls on admission, with diagnosis of fracture and severe cognitive impairment) fall preventions interventions upon admission to facility. They checked the EMR and reported that R801 had the generic interventions (as above) were ordered upon admission in addition to an intervention reinforce need to call for assistance. It must be noted that R801 had severe cognitive deficits and may not be able to call for assistance due to confusion. A follow up interview was completed with the DON on 3/14/24 at approximately 12:30 PM. The DON was queried about their staff expectations for fall risk assessments and implementation of interventions upon admission. The DON reported that admitting nurses were completing admission fall risk assessments and implemented standard interventions for residents who were at risk. They were queried if the fall preventions interventions were resident specific based on their admission risk assessment and they reported that admission interventions were only generic/standard regardless of their risk level and they added additional resident specific interventions were added as need based on root cause analysis if they had any incidents during their stay. The DON was queried about the purpose of the admission fall risk assessment if admission interventions were generic; not resident specific, they did not provide any explanation. The DON was queried about R801 who had a sitter in the hospital prior to discharge and why they did have any additional resident specific interventions. The DON reported that they were not aware R801 had a sitter at the hospital and usually their admissions team reviewed hospital documentation, not the clinical team. The DON was queried on what their expectations were to ensure all fall prevention intervention(s) were in place as ordered/recommended. They reported that the nurses, unit managers, and clinical leaders were supposed to check during their daily rounds.The DON was notified of concern related to R801's resident specific fall prevention interventions and R803's interventions that were not in place. They reported that they understood the concerns. A follow-up interview with RC C was completed on 3/14/25 at approximately 1 PM. RC C confirmed that their team was unaware of staff witnessed incident of an unknown resident who had spilled coffee in the dining room that was also witnessed by another family member. RC C was notified of the concerns with R801's fall prevention interventions that were not resident specific and R803's fall prevention interventions that were not in place. They reported that they understood the concerns and they would follow up. Review of facility provided document titled Accidents and Incidents - Investigating and Reporting with a revision date of 2011 (revised approximately [AGE] years ago) read in part, All accidents or incidents involving residents, employees, visitors, vendors, etc. occurring on our premises shall be investigated and reported to the administrator. The document did not address facility process on fall risk assessment on admission, implementation of resident specific meaningful interventions, and process to monitor the implemented interventions were in place.