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	06/04/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number(s): MI00152206. Based on observation, interview, and record review, the facility failed to provide care according to the preference of the resident's legal decision maker for one (R901) of two residents reviewed for care planning and activities of daily living. Findings include: A review of a complaint submitted to the State Agency (SA) revealed an allegation that R901 was not getting two showers per week. On 6/4/25 at 9:10 AM, R901 was observed sitting up in bed. R901 appeared to have a language barrier, but seemed to understand some questions. When queried about when she received showers, R901 asked on which days was she was supposed to get them and said she thought Monday and Thursday. R901 was unable to clearly answer questions regarding showers and bathing. On 6/4/25 at 10:05 AM, an interview was conducted with R901's family member (FM), FM 'A'. FM 'A' reported they were the legal decision maker for R901 and they wanted R901 to get full showers at least two times a week and bed baths were not to be given in place of a shower. R901 reported on Monday, 6/2/25, R901 received a bed bath instead of a shower. R901 further explained they reported their concern to the Administrator and they arranged a time for FM 'A' to be present in the facility the following day, 6/3/25 at 2:00 PM to ensure R901 received a shower. FM 'A' reported they arrived at the facility at 2:00 PM and was informed R901 received a shower before lunch. FM 'A' reported the facility told her R901 refused showers at times, but FM 'A' told them to contact her so that she could attempt to communicate with R901 in her language to help convince her to shower, as she may not understand what the staff wanted to do. On 6/4/25, the Administrator was asked to provide any grievance/concern forms for R901 since March 2025. The Administrator reported he talked to R901's family on a daily basis and did not document all concerns on forms, but would provide evidence of other forms of communication. A review of copies of email conversation between FM 'A' and the facility provided by the Administrator revealed the following: (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/2/25 at 7:48 PM, an email was sent to the Director of Nursing (DON) by FM 'A' and it read, Why is my grandma (R901) still getting bed baths? I was told she got a bed bath today by the nurse because you guys are short staffed! I don't know how much more clear I need to be that my grandma is to always get a full shower not bed baths for any circumstance or I need to be called. I am sick and tired of her not getting her full showers . The DON responded and said they would look into the concern. On 6/3/25 at 5:09 PM, an email was sent to the DON by FM 'A' and it read, .I have also spoke with the new u it <sic> manager and made it very clear to him that we want her to get full showers twice a week and no bed baths if there are any issues I'm always available to call or Face Time via her phone . A review of R901's clinical record revealed R901 was admitted into the facility on 7/5/24 and readmitted on [DATE] with diagnoses that included: End Stage Renal Disease (ESRD) and Parkinson's Disease. A review of R901's Minimum Data Set (MDS) assessment dated [DATE] revealed R901 had severely impaired cognition, was dependent on staff for showers and baths, and was not assessed for tub/shower transfers due to it being not applicable. A review of R901's Tasks (where the Certified Nursing Assistants - CNAs document the care they provided) revealed a task for Bathing/Showers: Monday and Friday AM Shift NO BED BATHS. The last documented shower for R901 was on 5/26/25. It was documented on 5/30/25 that R901 refused a shower. However, there was no further documentation of a shower after that date. According to R901's Monday and Friday schedule, R901 should have received a shower on 6/2/25. A review of R901's care plans revealed no intervention to specify R901 should receive full showers and not bed baths on their scheduled shower days. An intervention was initiated on 7/5/24 that read, Assist the pt (patient) with showers/bed baths. A review of a Skilled Charting progress note dated 5/30/25 at 2:00 PM revealed, Guest refused shower x 2. Unit manager and 2 CNAs present. Guest stated she got cleaned up in the morning and would take a shower on Monday. On 6/4/25 at 2:30 PM, an interview was conducted with the Administrator. When queried about how the facility ensured R901 received full showers instead of bed baths per the family's preference, the Administrator reported they initially switched the showers to be scheduled on days R901 did not go to dialysis and continued to educate staff. The Administrator reported the staff on R901's hallway were not always consistent so they offered a room change to a different hallway but FM 'A' refused. The Administrator reported the plan of care should be followed regardless of whether the staff think they are short of staff. The Administrator reported on 6/2/25, the CNA gave R901 a bed bath instead of a shower and CNA was provided with education. The Administrator stated, We try our best and if a shower cannot be given, a bed bath should always be offered. When queried about where showers were documented, the Administrator reported in the CNA Task. When queried about what happened on 6/3/25 with R901's shower, the Administrator reported they scheduled a time with the family so they could come to the facility when R901 received her shower, but the nurse had an opportunity to give her a shower and did it before the family got there. When queried about where that shower was documented, the Administrator did not offer a response. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an Employee Corrective Action form dated 6/2/25 revealed CNA 'D' received education regarding the following: .Guest received bed bath on 6/2 .Guest .is to have showers only as stated in the Kardex (CNA care guide) and shower schedule .

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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** This citation pertains to Intake Number(s): MI00153363. Based on interview and record review, the facility failed to treat the resident's high blood sugar in a timely manner for one (R902) of one resident reviewed for diabetes management. Findings include: A review of a complaint submitted to the State Agency (SA) revealed an allegation that R902's blood sugar was 452 at 9:00 PM, he needed an insulin shot, and did not receive treatment until 2:00 AM the next day. On 6/4/25 at 9:15 AM, an interview was conducted with R902. When queried about any concerns about his care in the facility, R902 reported a recent issue with his blood sugar. R902 explained his blood sugar was 452 one evening at 9:00 PM. He pressed the call light and a nurse came in. He informed the nurse he needed insulin and she told him she could not give it without a physician's order. R902 further explained at 12:00 AM, the nurse came back and said the physician never called back so she could not give him additional insulin. R902 reported he was irritated because at home he managed his own insulin and the doctor who managed his diabetes gave him specific instructions on how to monitor his blood sugar and administer insulin when needed. R902 reported the facility was not following the same regimen. R902 had his own personal glucose monitoring device in his room and reported he checked his own blood sugar levels in addition to the nurse. R902 said on the evening when his blood sugar was high, he was not able to receive additional insulin until 2:00 AM and then his blood sugar started to come down. R902 reviewed some notes he had and said the date of the event was 5/24/25 and he discussed his concerns with the Administrator. A review of R902's clinical record revealed R902 was admitted into the facility on 5/16/25 with diagnoses that included: type 2 diabetes. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R902 had intact cognition. A review of R902's Physician's Orders revealed the following orders: Insulin Aspart (fast acting insulin) 100 units/milliliter (ml) - inject 12 units subcutaneously four times a day (QID) Insulin Glargine (long acting insulin) 100 unit/ml - inject 16 units in the morning A one time order for Insulin Aspart ordered on 5/25/25 at 2:16 AM A review of R902's Medication Administration Record (MAR) for May 2025 revealed on 5/24/25 at 9:00 PM, R902's blood sugar was recorded as 420 mg/dl (milligrams per deciliter) by Licensed Practical Nurse (LPN) 'C', which indicated R902's blood sugar was very high. (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 R902's progress notes revealed a Skilled Charting progress note dated 5/25/25, written by LPN 'C' that read, .He had c/o (complained of) a high BS (blood sugar). Writer collected guest BS, results were 420, writer administered 12 units long-acting insulin as ordered. Writer notified on call HCP (Health Care Provider), after an hour no response. Writer recheck guest BS results were 412. Guest was insisting writer give him more insulin. Writer as well as the supervisor informed guest that the HCP was notified and we were waiting on a response. Writer and supervisor also explained that he was given a long-acting insulin and we could not just inject him with more because it could drop his sugar too low (R902's order for long acting insulin was for the morning). The supervisor than <sic> called the HCP, no answer. Writer rechecked guest BS at (1:24 AM) reading was 337. A review of a Skilled Charting progress note dated 5/25/25 at 2:21 AM revealed, On call HCP gave order for 6 units of Novolog (insulin aspart), recheck BS in 2 hours. It should be noted that that order was received five hours after R902 first notified the nurse of the high BS and it was recorded on the MAR as 420 mg/dl. A review of R902's care plan for diabetes mellitus revealed interventions initiated on 5/16/25 that read, Obtain blood sugar results, sliding scale as ordered by MD (physician). Notify MD of any abnormal results (It should be noted R902 did not have sliding scale insulin ordered) and Follow diabetic protocol as per MD order. Notify MD if any abnormals occur (It should be noted there were no specific parameters included in the physician's orders). On 6/4/25 at 3:16 PM, an interview was attempted with LPN 'C' via the telephone. However, LPN 'C was not available for interview prior to the end of the survey. On 6/4/25 at 3:20 PM, an interview was conducted with the Administrator. When queried about what R902 told him about his concerns regarding the way his high blood sugar was managed on 5/24/25, the Administrator denied R902 reported anything to him and said Unit Manager, Registered Nurse (RN) 'B' talked to R902 regarding his medications before. On 6/4/25 at 3:36 PM, an interview was conducted with RN 'C'. When queried about the process for addressing a resident's high blood sugar, when all ordered insulin had already been administered, RN 'C' reported the medical providers were typically very responsive and it would be expected that the nurse contacted the provider via the facility's text messaging system. RN 'C' reported there was always an on-call provider available after hours. When queried about what timeframe would be reasonable to wait for the provider to call back, RN 'C' reported about 30 minutes. When queried about what the nurse should do if the provider did not call back, RN 'C' reported they could always contact the provider again or contact another provider. RN 'C' denied having knowledge of R902's concern about his blood sugar management on the evening of 5/24/25. When queried about whether five hours was a reasonable amount of time to wait for the provider to call back, RN 'C' reported it was a long time, but he wasn't symptomatic. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/4/25 at 4:00 PM, an interview was conducted with the Director of Nursing (DON). When queried about what would be considered a timely response in regards to a physician calling back after being notified of a change in resident's condition, specifically, an elevated blood sugar that potentially needed to be treated with insulin, the DON stated, A half hour to an hour. When queried about the process for notifying the medical provider, the DON reported the facility had an on-call Nurse Practitioner (NP) after 7:00 PM and the attending physicians were included in the text messages that were sent out. When queried about the five hour delay in getting a hold of the medical provider when R902's blood sugar was high, the DON stated, They could have contacted the provider. A review of a facility policy titled, Nursing Care of the Resident with Diabetes Mellitus (undated) revealed, in part, the following, .Glucose Monitoring .Normal ranges are approximately 70-130 mg/dl before meals and (less than) 180 mg/dl after meals . A review of a facility policy titled, Acute Condition Changes - Clinical Protocol (undated) revealed, in part, the following, .The Attending Physician (or a practitioner providing backup coverage) will respond in a timely manner to notification of problems or changes in condition and status .The staff will notify the Medical Director for additional guidance and consultation if they do not receive a timely or appropriate response .