STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235720	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Pinckney	664 South Howell Street Pinckney, MI 48169

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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

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(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 - Actual harm Residents Affected - Few	This citation pertains to Intake#1201757.Based on observation, interview and record review the facility failed to prevent a fall for one (R701) of three residents reviewed for falls, resulting in R701 falling out of bed and sustaining multiple fractures, bruising to their face, eyes, arms and legs that required hospitalization. Findings include: A complaint was filed with the State Agency (SA) that alleged during care R701, who was bedridden, was turned too far to the right and fell out of bed, landed face down resulting in fractures to their nose, right ankle and multiple bruising on their face, arms, legs requiring hospitalization.On 7/9/25 at approximately 8:50AM, R701 was observed lying in bed. The bed was in a high position and did not have enablers bars. The resident had bruising under both the left and right eye. Their left arm was bruised from their wrist up to above their elbow. R701 was queried as to what caused the bruises. R701 reported that a Certified Nursing Assistant (CNA) was changing their brief and asked them to turn over to the right and hold the mattress with their left hand. They did what the CNA asked them to do, but felt the CNA pushed them one more time to assist with the roll over. They could not hold the mattress and fell out of bed and landed on their face. R701 noted that following the fall they were in so much pain, and it took almost an hour to get to the hospital. R701 further reported that their right foot was completely wrapped up as it was fractured following the fall. R701 could not provide the name of the CNA but was able to give a description. R701 was asked how nursing staff generally changes their brief and R701 noted that generally two people assist. They did note that the CNA has changed them by themselves in the past, usually on the midnight shift.A review of R701's clinical record revealed the resident had an original admission date of 12/29/16 with diagnoses that included: cerebrovascular accident (CVA)/stroke, difficulty walking depressive disorder. A view of the resident's Minimum Data Set (MDS) with a date of 6/20/25 noted that the resident had a Brief Interview for Mental Status (BIMS) score of 13/15 (cognitively intact). The MDS noted the resident was incontinent of bowl. Continued review of R701's clinical record revealed, in part, the following:3/17/25: Order: Transfer and ambulation; 2 PA (person assist) with mechanical lift.No ambulation.6/24/25 (1:15 AM): Nurses Note: .Writer was called into resident room by staff stating that resident fell on the floor during his brief change. Upon entering the room, resident was found on the floor face down, resident bed always in a high position.resident stated his neck was hurting, staff assisted writer with turning guest on his back to be further assessed, writer noted a spot of blood on the carpet and blood clot on guest nose, vs (vitals) taken and documented, guest also had a small tear on his L (left) knee and toe. Authored by Nurse D.6/24/25: Prehospital Care Report Summary: .Call received 1:01 AM .Name: R701 .Medical Need: unable to get out of bed .Severe pain: Yes. Mechanism of Injury.Fall.Height of fall: 3 (feet).Events leading up to the call.Prior to EMS (Emergency Medical Services) arrival crews were informed that around 12:45 AM.R701 was being changed in bed.bed was elevated 3-4 (feet) off the ground.Guard Rails to the bed were not in place.Staff states that as the rolled PT(patient) onto his side to facilitate changing pt he continued to roll off the bed falling to the floor below and striking his head. Patient suffered from multiple injuries to the head.Head to toe assessment reveals a contusion to the orbital bone region just superior to PT's left eye.laceration to the medial anterior portion of pts nose. takes anticoagulants.PT states he can't sign because he is right-handed and suffers from hemiplegia to the right side following a CVA (stroke).6/24/25: Hospital Record: .Nose Fracture.Chief Complaint: Patient transported from (name redacted) facility.Patient had a fall. Patient hit his head.Patient has a c-collar in place.Hemiplegia on right side due to a stroke.6/25/25: Hospital Record: .per chart. presented to our emergency department yesterday after a fall. Staff were completing a bed change, and they did not have the rails up, and patient fell out of bed. He did hit his head .displaced nasal bone fracture on both sides.today, patient presents to the emergency department.appears patient complaining of occipital headache.confusion this morning.x-ray of the right lower extremity revealed an acute impacted fracture of the distal tibia .extending into the medial malleolus with associated moderate swelling.Care Plan: Focus: ADL(activities of daily living)/Mobility deficit r/t (due to) R(right) sided hemiplegia following CVA (12/20/16). Interventions: .Transferring 2 PA with mechanical lift Hoyer (extra-large sling)- Initiated 7/3/25.Focus: Risk for falls r/t R sided hemiplegia(date initiated: 9/28/22.Revision 7/9/2025.Interventions:.Transfer & Ambulation: 2 PA with mechanical lift.Non-Ambulatory.1 PA for bed mobility (date initiated 7/9/25).Enabler bar on Right side of bed (7/9/25).Floor mat to Right side of bed. *It should be noted that changes/interventions were made to R701's care plan during the Survey (7/9/25). An enabler bar was not observed in the resident's room during the observation on 7/9/25 at 8:50 AM. Further, there was no indication in R701's care plan that noted

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #1201662.Based on interview and record review, the facility failed to ensure appropriate documentation of administration and accountability of controlled substances for one (R702) of one resident reviewed for medication administration. Findings include:Review of a complaint reported to the State Agency included an allegation the facility failed to prescribe controlled substances according to standards of practice. Clinical record review revealed R702 was admitted to the facility on [DATE] for physical therapy and back pain management related to a compression fracture to the lumbar spine (lower back). Record review did not reveal a calculated Brief Interview of Mental Status (BIMS) score, however Provider Progress notes documented R702 was alert, orientated, and able to make their needs known.Review of the Medication Administration Record (MAR) and the corresponding Control Substance Proof of Use Records (CS) revealed multiple discrepancies in which Oxycodone (an opioid pain medication) was documented as administered on the MAR but not reflected on the CS record.On 7/9/25 at 2:30 PM, an interview and record review with the Director of Nursing (DON) and Regional Clinical (RC) C confirmed documentation of controlled substances must be on the CS form and documented on the electronic MAR. The DON and RC C reviewed CS Record #12273520 and R702's April 2025 electronic MAR and acknowledged Nursing did not document the administration correctly based on the following discrepancies:On 4/26/25, R702 was ordered Oxycodone (an opioid pain medication) 15 milligram (mg) give 0.5 tablet (7.5 mg) by mouth every six hours as needed for pain.The CS Record for Prescription number #12273520 documented administration of the medication on:4/27/25 8:00 4/27/25 20:46 4/28/25 18:454/29/25 2:20 4/29/25 20:00 The April 2025 Electronic MAR only documented administration on Wednesday 4/30/2025 at 4:19 and 19:39. None of the documented administrations listed above were reflected on the MAR.Record review of R702's Oxycodone orders revealed the following:On 4/28/25 at 18:38 Oxycodone 15 mg give 0.5 tablet by mouth every six hours as needed for pain. Quantity 60On 5/1/25 11:17 Oxycodone 15 mg give 0.5 tablet four times a day. Quantity 56On 5/2/25 at 8:48 Oxycodone 15 mg give 1 tablet by mouth four times a day. Quantity 52The DON confirmed when the orders indicate give 0.5 tablet, the Pharmacy scores the tablets in half, so when documentation shows amount given as 1 that is a half tablet and, in this order, would be 7.5 mg of Oxycodone.Record Review of the CS record for prescription number #12273922 documented administration as:5/2/25 20:17- One Tablet5/3/25 02:20-One Tablet5/3/25 07:50-One Tablet5/3/25 13:12-One Tablet5/7/25 08:30-One Tablet5/7/25 02:40-One Tablet5/7/25 20:10-One Tablet5/8/25 02:10-One Tablet5/8/25 08:23-One Tablet5/8/25 13:03-One TabletOn 7/9/25 at 2:30 PM, The DON and RC C reviewed the above orders and confirmed that on 5/2/25 at 11:17AM, R702's pain medication was increased from 7.5mg to 15 mg of Oxycodone and administration of the dose increase would be reflected as giving 2 tablets. The DON and RC C acknowledged Nursing did not administer the medication as ordered.Further record review of the CS record for prescription number #12273922 documented on Line One on 4/30/25 Delivery 60 Tablets. The last entry line of the page was dated 5/9/25 at 8:33AM amount remaining 15 Tablets. The DON and RC C were asked if there was another CS form that continued this medication count, at which time a CS form was reviewed only documenting on 5/9/25 amount remaining was 13 and on 5/12/25 zero remained. The DON and RC C said this must be the continuation sheet, however, there was no pharmacy label on the sheet indicating the resident and the medication. The DON acknowledged there was no patient identifier and could not confirm what was the medication and or who the CS form belonged to.The complainant was concerned regarding multiple prescriptions for Oxycodone were filled within a very short time frame from the same Provider, Nurse Practitioner (NP) B and same Resident, R702 and provided the State Agency with a NarxCare Report (a report that reviews a patients-controlled substance data from government-managed and regulated prescription drug monitoring programs). The report was generated on 5/19/25 for R702 and revealed the following prescriptions were all ordered by NP B, filled and delivered to the facility:4/29/25 Oxycodone 15 mg Quantity 305/01/25 Oxycodone 15 mg Quantity 305/02/25 Oxycodone 15 mg Quantity 52On 7/9/25 around 2:45 PM, RC C further reviewed the Oxycodone orders written by NP B and confirmed they were discontinued correctly by NP B, but the Pharmacy still refilled each order and sent to the facility. RC C remarked the Pharmacy should have caught this and not have delivered.Further record review of the CS record for prescription number #12274320 documented on 5/11/25 that 59 tablets of Oxycodone remained. Administration documented on 5/12/25 at 2:00 AM one tablet was given and a heavily scratched