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	04/03/2025

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48680 Based on observation, interview, and record review, the facility failed to ensure a physician's order, assessment and specify the times to be used while in wheelchair for a seatbelt device per plan of care for one (R7) resident reviewed for physical restraints. Findings include: On 4/1/25 at 10:00 AM, R7 was observed in their room sitting in wheelchair positioned in a slouched manner over a bedside table. R7 was also observed with a seatbelt device on and clasped together. R7 was asked how they were doing but the conversation was intangible. A review of the Electronic Medical Record (EMR) revealed R7 was admitted to the facility on [DATE] with the diagnoses of falls, difficulty in walking and cerebral palsy. The Minimum Data Set (MDS) assessment completed on 12/27/24 indicated R7 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) Score of 7/15. On 4/2/25 at 11:00 AM, the assigned Nurse was asked if R7 could release the seatbelt device by themselves. The nurse attempted asking several times for R7 to release the seat belt independently without success. The Nurse then went on to get the Certified Nursing Assistant (CNA) for the unit. The CNA asked R7 if they could release their seat belt device. The CNA went on to cue R7 and placed the seatbelt device in the hand of R7 who then demonstrated ability to unsnap the safety belt device. A review of the record revealed R7 had not been assessed for the seat belt device since 10/12/21. There was no physician order for the safety belt, no consent, and the 'fall' care plan stated it was for safety. There were no indicators for restraint use noted on any of the MDS assessments. On 4/2/25 at 12:20 PM, the Director of Nursing (DON) was asked, how often assessments were supposed to be done for restraints. The DON reported the facility was a restraint free facility, so they did not have assessments. The DON was then informed R7 had a seatbelt on that took several cues and direct placement of the seatbelt device clasp into R7's hands before R7 could remove seatbelt. The DON stated, the seat belt used for R7 was not a restraint because they were able to remove the device by themselves. The DON was then asked how often the use of this device should be reassessed, and the DON reported at least quarterly. (continued on next page)

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

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 12:23 PM, the Occupational Therapist was observed completing an assessment for the seat belt in the dining room while R7 was eating lunch. On 4/3/25 12:28 PM, an interview with the Family Member of R7 stated, the seat belt was for pleasure since R7 worked a General Motors for so long making their seat belts so it was a comfort thing. Family Member reported, that R7 should be able to take it off but they rarely paid it any attention when they visited. On 4/3/25 at 3:30 PM, in an interview with the DON and the Regional Nurse, they were asked why the seat belt was care planned under falls if it was for pleasure or activities, and why the progress note stated that it was for trunk support and positioning. The DON and Regional Nurse reported the seat belt was not a restraint. No additional information was provided by the exit of survey.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interview and record review, the facility failed to timely report an allegation of an elopement to the State Agency (SA), for one Resident (R89) of one resident reviewed for elopements. Findings include: On 4/1/25 at 11:30 AM, R89 was observed sitting in their wheelchair in the dining area with their daughter. A brief interview was conducted with the resident and the resident's daughter at that time. R89's daughter stated they had no concerns with the care provided at the facility. R89's daughter stated the facility staff has kept them and their siblings informed of everything, . like the other day he (R89) was found in the parking lot thinking he was going home . R89's daughter stated the staff called them and stated because of the incident an ankle bracelet was placed on the resident. A review of the medical record revealed R89 was admitted to the facility on [DATE] with diagnoses that included dementia. The medical record revealed R89 was deemed unable to make medical treatment decisions and had an activated power of attorney. A review of R89's medical record revealed no documentation of the resident being found outside of the facility. Review of the SA Facility Reported Incident (FRI) system database revealed no submission from the facility regarding the alleged elopement. A review of a Nursing note dated 3/30/25 at 11:18 AM, documented in part . Resident is exit seeking multiple times today. He states, I'm going home today A wander guard to his Right ankle has been applied (wander guard number) EXP (expiration): 7/27 . This note was documented by the facility's Director of Nursing (DON). On 4/2/25 at 11:08 AM, R89 was observed in their wheelchair propelling themselves through the dining room towards the hallway their room was located on. A wander guard was observed on the resident's right ankle. On 4/2/25 at 11:59 AM, the DON was interviewed and was asked about the elopement incident with R89. The DON replied they had . just found out about that on Sunday . (Sunday 3/30/25). The DON stated the incident occurred early in the morning. The DON indicated one of the night shift aides was leaving and observed R89 outside under the facility's awning and brought the R89 back into the facility. The DON stated the aides came and told them about it on Sunday when they came to the facility. The DON identified two of the day shift aides that informed them of the incident. The DON was asked the name of the CNA that found the resident outside and the DON provided the name of Certified Nursing Assistant (CNA) H. The DON stated they would have expected staff to notify them of the incident so that they could notify the Administrator. The DON was asked if they notified the Administrator when they were informed of the incident and the DON stated they did. This confirmed the DON and Administrator was aware of the incident on 3/30/25. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 12:05 PM, the Administrator was asked to provide CNA H time punches for the last two weeks. On 4/2/25 at 12:06 PM, a telephone interview was conducted with CNA H, who was asked about the elopement incident with R89. CNA H stated they were driving leaving work to go home and saw (R89) outside by themselves under the awning in front of the facility. R89 stated they pulled over their car and brought the resident back into the facility and told CNA I and CNA J that the resident was found outside by themselves. When asked, CNA H stated they could not recall the exact times of last seeing R89, or finding R89 outside of the facility. A review of CNA H's time punch documented CNA H last day worked was noted as 3/28/2025 on the 7 PM to 7 AM shift. Review of the facility assignment sheets revealed CNA H on duty for the midnight shift and confirmed CNA I and CNA J as the day shift CNA's. On 4/2/25 at 12:16 PM, the Administrator was interviewed and asked about the elopement incident with R89. The Administrator was asked the date and time that the facility identified for the elopement incident for R89. The Administrator stated they would have to review their investigation report. The Administrator was asked what they had identified regarding the incident and the Administrator stated it was their understanding (R89) was found outside in front of the facility. The Administrator was asked the name of the staff member the facility identified to have found R89 outside the facility and the Administrator stated they would have to refer to their investigation report. The Administrator was asked when they were informed of the incident and by whom, the Administrator stated the DON had informed them but they did not recall the date and time that they were informed. The Administrator was asked why they failed to report the incident to the SA and the Administrator stated they were still investigating the incident. The Administrator was asked to provide their investigation thus far and to provide the facility's incident and accident report of the elopement incident for review. On 4/2/25 at 1:32 PM, a second request was made to the Administrator to provide the facility's investigation and Incident and Accident report regarding R89's elopement incident. On 4/2/25 at approximately 2:03 PM, the Administrator accompanied by Nurse Consultant (NC) A, explained the DON was just informed of the elopement incident this Sunday (3/30/25). The Administrator was asked why they failed to report the allegation of R89 eloping from the facility and the Administrator stated they were still investigating the allegation. The Administrator stated they informed NC A about the incident yesterday (4/1/25) to help them complete the investigation. The Administrator and NC A was asked third time to provide the investigation and the Incident and Accident report for R89's elopement. On 4/2/25 at approximately 3:20 PM, NC A provided the facility's investigation. An Incident and Accident report was not provided. On 4/3/25 at 8:54 AM, the investigation file was reviewed. Review of the investigation file contained the following: (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Employee Corrective Action documented for CNA H which noted the resident was found by CNA H outside and failed to report the incident per the facility's protocol. This Corrective Action was back dated to 3/31/25. (As of 4/2/25 when interviewed, CNA H denied having been contacted by anyone regarding follow up from finding R89 outside of the facility and having to bring them back in to safety.) A statement from CNA I and CNA J who denied being informed by CNA H about R89 being found outside. A telephone statement from CNA H which documented they found (R89) outside in their wheelchair on the last day they worked (3/28/25). CNA H was driving home and stopped their car to bring R89 back into the facility. CNA H informed the interviewer that they gave R89 to CNA I and CNA J who both stated they would inform the nurse. This statement was dated 3/31/25. Review of a report submitted to the SA on 4/3/25 documented in part . year the incident occurred-3/28/2025 . During the annual survey the surveyors are alleging the guest was at the front doors and brought in by a staff member. Investigation has been put in place, POA, and physician contacted. I acknowledge that the information provided is true to the best of my knowledge- Yes . On 4/3/25 at 1:23 PM, the Administrator and NC A were interviewed and asked about the submission to the SA on 4/3/25 regarding the incident with R89. The Administrator and NC A were asked why they documented on the report that the surveyors are alleging the guest was at the front doors and brought in by a staff member . when they were fully aware of CNA H verbalizing the allegation, and the facility obtained a statement from CNA H that documented the incident as described. The Administrator stated that was documented in error and apologized for the mistake. The Administrator stated the report was not supposed to say that. The facility also completed an Employee Corrective Action documenting CNA H's failure to report the incident. The Administrator and NC A were then asked about the Employee Corrective Action for CNA H and how it was dated 3/31/25 when CNA H had already verbalized no follow up was conducted with them by anyone regarding the incident. The Administrator and NC A acknowledged the concern and left the conference room. A short time later, the Administrator and NC A returned and stated the Employee Corrective Action for CNA H was not accurate and was not obtained on the date of 3/31/25. No further explanation was provided. The facility failed to timely submit and provide an accurate report to the SA. A review of a facility policy titled Elopements revised December 2008, documented in part . Staff shall investigate and report all cases of missing residents . Staff shall promptly report any resident who tries to leave the premises . to the Charge Nurse or Director of Nursing . The Director of Nursing or Charge Nurse shall . complete and file Report of Incident/Accident; and . Document the event in the resident's medical record . The facility staff failed to follow the facility policy. No further explanation or documentation was provided by the end of the survey.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interviews and record reviews the facility failed to thoroughly investigate an elopement incident for one Resident of one resident reviewed for elopements. Findings include: On 4/1/25 at 11:30 AM, R89 was observed sitting in their wheelchair in the dining area with their daughter. A brief interview was conducted with the resident and the resident's daughter at that time. R89's daughter stated they had no concerns with the care provided at the facility. R89's daughter stated the facility staff keep them and their siblings informed of everything, . like the other day he (R89) was found in the parking lot thinking he was going home . R89's daughter stated the staff called them and because of the incident an ankle bracelet was placed on the resident. A review of the medical record revealed R89 was admitted to the facility on [DATE] with diagnoses including dementia. The medical record revealed the resident was deemed unable to make medical treatment decisions and had an activated power of attorney. A review of medical record revealed no documentation of the R89 being found outside of the facility. A review of a Nursing note dated 3/30/25 at 11:18 AM, documented in part . Resident is exit seeking multiple times today. He states, I'm going home today A wander guard to his Right ankle has been applied (wander guard number) EXP (expiration): 7/27 . This note was documented by the facility's Director of Nursing (DON). A review of the Medication Administration Record (MAR) revealed Licensed Practical Nurse (LPN) G was the assigned nurse for R89 on day shift for 3/30/25. On 4/2/25 at 11:08 AM, R89 was observed in their wheelchair propelling themselves through the dining room towards the hallway where their room was located on. A wander guard was observed on the resident's right ankle. On 4/2/25 at 11:47 AM, LPN G was interviewed and asked about the incident of R89 being found outside of the facility. LPN G stated the incident did not happen on their shift. LPN G stated they were informed of the incident by the off going nurse on 3/30/25. LPN G stated they were informed the resident was found outside in the early morning hours. LPN G stated usually there is a person sitting at the front desk to monitor the elopement risk residents, however at the time of the incident there was no personnel at the front desk. LPN G stated usually R89 was not . exit seeking, but he actually got out. LPN G stated they placed a wander guard on R89 during their shift the day of 3/30/25. LPN G opened their cell phone pictures and stated, see I took a picture of the wander guard before I put it on him. The picture was reviewed and confirmed. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at 11:59 AM, the DON was interviewed and asked about the elopement incident with R89. The DON replied they had . just found out about that on Sunday . (3/30/25). The DON stated the incident occurred in the early morning and one of the night shift aides was leaving who observed R89 outside under the facility's awning. The DON stated the aide brought the resident back into the facility. The DON stated the aides came and told them about it on Sunday when they came to the facility. The DON identified two of the day shift aides that informed them of the incident. The DON was asked the name of the CNA that found the resident outside and provided the name of Certified Nursing Assistant (CNA) H. The DON stated they would have expected staff to notify them of the incident so that they could notify the Administrator. The DON was asked if they notified the Administrator when they were informed of the incident and the DON stated they did. This confirmed the DON and Administrator was informed of the incident on 3/30/25. On 4/2/25 at 12:05 PM, the Administrator was asked to provide CNA H time punches for the last two weeks. On 4/2/25 at 12:06 PM, a telephone interview was conducted with CNA H, who was asked about the elopement incident with R89. CNA H stated they were driving, leaving work to go home and saw R89 outside by themselves under the awning in front of the facility. R89 stated they pulled over their car and brought the resident back into the facility and told CNA I and CNA J the resident was found outside by themselves. When asked, CNA H stated they could not recall the exact times of last seeing R89 or the exact time R89 was found outside of the facility. CNA H was asked if any of the Administration, Corporate or any other staff have followed up with them regarding this incident and CNA H stated no one had contacted them to question them about the incident. CNA H stated since the incident they had not been back to work and had been off for a few days and will return to work tomorrow (4/3/25 night shift). A review of the time punch detail for CNA H revealed the last day worked was noted as 3/28/2025 the 7 PM to 7 AM shift. Review of the facility assignment sheets for 3/28/25 revealed CNA H was on duty for the midnight shift and confirmed CNA I and CNA J were the oncoming day shift CNA's. On 4/2/25 at 12:16 PM, the Administrator was interviewed and asked about the elopement incident with R89. The Administrator was asked the date and time that the facility identified for the elopement incident for R89. The Administrator stated they would have to review their investigation report. The Administrator was asked what they had identified regarding the incident and stated it was their understanding (R89) was found outside in front of the facility. The Administrator was asked who they identified as the staff who found R89 outside and stated they would have to refer to their investigation report. The Administrator was asked what interventions were implemented to ensure the safety of R89 after the incident and replied, LPN G put a wander guard on the resident. The Administrator was asked when they were informed of the incident and by whom, the Administrator stated the DON had informed them but they did not recall the date and time that they were informed. The Administrator was asked to provide their investigation thus far and to provide the facility's incident and accident report of the elopement incident for review. On 4/2/25 at 1:32 PM, a second request was made to the Administrator to provide the facility's investigation and Incident and Accident report regarding R89's elopement incident. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/2/25 at approximately 2:03 PM, the Administrator accompanied by Nurse Consultant (NC) A explained, the DON was just informed of the elopement incident this Sunday (4/30/25). The Administrator was asked why they failed to report the allegation of R89 to have eloped from the facility, without staffs knowledge and stated they were still investigating the allegation. The Administrator stated they informed NC A about the incident yesterday (4/1/25) to help them complete the investigation. NC A stated they started in-servicing the staff today and explained they were interviewing staff now regarding the incident. The Administrator was asked why the investigation did not start before when they were first made aware of the incident by the DON on 3/30/25 and NC A explained the staff stories were all over the place and they were still interviewing the staff. The Administrator and NC A were asked a third time to provide the investigation and the Incident and Accident report for R89's elopement. On 4/2/25 at approximately 3:20 PM, NC A provided the facility's investigation. An Incident and Accident report was not provided. Shortly after the Administrator and corporate staff were asked for the facility's camera footage of the front foyer area at the time of the incident. NC A informed the survey team that the facility footage was only kept for 24 hours and no longer had the camera footage for review. On 4/3/25 at 8:54 AM, the investigation file was reviewed. Review of the investigation file contained the following: A Employee Corrective Action documented for CNA H which noted R89 was found by CNA H outside and failed to report the incident per the facility's protocol. This 'Corrective Action' was back dated to 3/31/25. A statement from CNA I and CNA J who denied being informed of R89 being found outside by CNA H. A telephone statement from CNA H which documented they found R89 outside in their wheelchair on the last day that they worked (3/28/25). CNA H was driving home and stopped their car to bring R89 back into the facility. CNA H informed the interviewer that they gave R89 to CNA I and CNA J who both stated they would inform the nurse. This statement had the date of 3/31/25. The file did not contain a narrative of the incident, investigation findings, identification of the root cause, and failed to identify if there was lack of accountability and/or lack of supervision from any of the facility staff assigned to R89. A review of R89's medical record revealed no information documented regarding the incident. Further review of the medical record revealed a Wandering assessment dated [DATE] and 3/31/25, which documented the resident as Low Risk for Wandering. The facility failed to complete the 3/31/25 assessment accurately after the identified elopement. A review of a facility policy titled Elopements revised December 2008, documented in part . Staff shall investigate and report all cases of missing residents . Staff shall promptly report any resident who tries to leave the premises . to the Charge Nurse or Director of Nursing . The Director of Nursing or Charge Nurse shall . complete and file Report of Incident/Accident; and . Document the event in the resident's medical record . (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility staff failed to follow the facility policy. As of 4/3/25, the last day of the facility's survey, the Administrator and Corporate staff had not provided a thorough and full investigation to the surveyors for review, despite CNA H having to stop their car to bring R89 back into the facility on [DATE], six days prior. No further explanation or documentation was provided by the end of the survey.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review the facility failed to administer medication according to professional standards of practice for one Resident (R12) of one resident reviewed for medications. Findings include: On 4/1/25 at approximately 10:03 AM, R12 was observed sitting in their wheelchair watching television. The resident had a full breakfast tray in front of them. On the tray was a small cup filled with approximately 10 pills. The resident was asked about the pills sitting on the breakfast tray. While alert, R12 was not able to provide an answer as to what pills were in the cup and why they were left on their tray. On 4/1/25 at approximately 10:11 AM, Nurse E who was assigned to R12, was asked about the pills left on R12's breakfast tray. Nurse 'E entered the room and viewed the pills and noted they thought the resident took the medication and then noted they should not have left the pills on the tray. Nurse E lifted the cup and asked R12 to take the medication. Nurse E did not provide the names of the medication to the resident. R12 swallowed the all the pills at approximately 10:12 AM. A review of R12's clinical record revealed the resident was initially admitted [DATE] with diagnoses including: delusional disorders, type II diabetes, vascular dementia and chronic kidney disease. The resident had a court appointed guardian assigned, effective 3/12/25. A review of the resident's Minimum Data Set (MDS) assessment R12 had a recent Brief Interview for Mental Status (BIMS) score of 14/15 (intact cognition). There was no order in the clinical record indicating R12 could self-administer medication. Continued review of R12's clinical record revealed Nurse E recorded in the Medication Administration Record (MAR) dated 4/1/15 that at 8:36 AM the following medications were administered to R12: 1. Jardiance (used for diabetic neuropathy) 10 MG (milligrams), 2. Duloxetine (used for depression/anxiety) 60 MG, 3. Metoprolol (used for high blood pressure), 4. Zyrtec (used for seasonal allergies) 10 MG, 5. Atorvastatin (used for high cholesterol), 6. Glipizide (used to treat diabetes) 10 MG, 7. Ferrous Sulfate (used to treat anemia), 8. Depakote (used to treat bipolar patients and for seizures)125 MG. On 4/2/25 at approximately 10:46 AM, an interview was conducted with the Director of Nursing (DON) who noted, Nurse E reported they were aware of the pills that were left on R12's breakfast tray. Nurse E stated to the DON, they believed the pills may have been spit out by the resident. It should be noted, the pills viewed on 4/1/24 at approximately 10:03 AM appeared untouched, dry and remained in the cup. The DON was informed, Nurse E documented in the MAR, all medications were administered at 8:36 AM. The DON acknowledged Nurse E should not have left the medications with the resident and should not record they were administered if Nurse E did not view they were taken.

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	235720	A. Building B. Wing	04/03/2025

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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** 41415 Based on observations, interviews and record reviews, the facility failed to ensure the implementation of accurate assessments, appropriate and effective care plans/interventions and adequate supervision for the safety of R89 (elopement) and R's 69, 3 and 16 (falls), five of seven residents reviewed for accidents. Findings include: R89 On 4/1/25 at 11:30 AM, R89 was observed sitting in their wheelchair in the dining area with their daughter. A brief interview was conducted with the resident and the resident's daughter at that time. R89's daughter stated they had no concerns with the care provided at the facility. R89's daughter stated the facility staff has kept them and their siblings informed of everything, . like the other day he (R89) was found in the parking lot thinking he was going home . R89's daughter stated the staff called them and because of the incident an ankle bracelet was placed on the resident. A review of the medical record revealed R89 was admitted to the facility on [DATE] with diagnoses that included dementia. The medical record revealed the resident was deemed incompetent and R89's children shared Power of Attorney. A review of a Nursing note dated 3/30/25 at 11:18 AM, documented in part . Resident is exit seeking multiple times today. He states, I'm going home today A wander guard to his Right ankle has been applied (wander guard number) EXP (expiration): 7/27 . This note was documented by the facility's Director of Nursing (DON). A review of R89's medical record revealed no documentation of the resident to have been found outside of the facility. On 4/2/25 at 11:59 AM, the DON was interviewed and asked about the elopement incident with R89. The DON replied they had . just found out about that on Sunday . (Sunday 3/30/25). The DON stated the incident occurred one early morning and one of the night shift aides was leaving and observed R89 outside under the facility's awning. The DON stated the aide brought the resident back into the facility. The DON stated the aides came and told them about it on Sunday when they came to the facility. The DON identified two of the dayshift aides that informed them of the incident. The DON was asked the name of the CNA that found the resident outside and the DON provided the name of Certified Nursing Assistant (CNA) H. (continued on next page)

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	235720	A. Building B. Wing	04/03/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/2/25 at 12:06 PM, a telephone interview was conducted with CNA H. CNA H was asked about the elopement incident with R89. CNA H stated they were driving leaving work to go home and saw (R89) outside by themselves under the awning in front of the facility. R89 stated they pulled over their car and brought the resident back into the facility and told CNA I and CNA J that the resident was found outside by themselves. When asked, CNA H stated they could not recall the exact times of last seeing R89 nor the exact time of finding R89 outside of the facility. CNA H was asked if any of the Administration, Corporate or any other staff have followed up with them regarding this incident and CNA H stated no one had contacted them to question them about the incident. CNA H stated since the incident they had not been back to work and had been off for a few days and will return to work tomorrow (4/3/25 night shift). On 4/2/25 at 12:16 PM, the Administrator was interviewed and asked about the elopement incident with R89. The Administrator was asked the date and time that the facility identified for the elopement incident for R89. The Administrator stated they would have to review their investigation report. The Administrator was asked what they had identified regarding the incident and the Administrator stated it was their understanding (R89) was found outside in front of the facility. The Administrator was asked what interventions were implemented to ensure the safety of R89 after the alleged incident and the Administrator replied that LPN G put a wander guard on the resident. The Administrator was asked when they were informed of the incident and by whom, the Administrator stated the DON had informed them but they did not recall the date and time that they were informed. On 4/2/25 at approximately 3:20 PM, the Nurse Consultant (NC) A provided the facility's investigation. An Incident and Accident report was not provided. On 4/3/25 at 8:54 AM, the investigation file was reviewed. Review of the investigation file included the following: An Employee Corrective Action documented for CNA H that noted the resident (R89) to have been found by CNA H outside and the failure to report the incident per the facility's protocol. This Corrective Action was back dated to 3/31/25. A telephone statement from CNA H that documented on the last day that they worked (3/28/25) they found (R89) outside in their wheelchair. CNA H was driving home and stopped their car to bring R89 back into the facility. CNA H informed the interviewer that they gave R89 to CNA I and CNA J who both stated they would inform the nurse. This statement had the date of 3/31/25. The investigation file failed to identify the lack of supervision for R89. A review of the medical record revealed a Wandering assessment dated [DATE] and 3/31/25, documented the resident to be Low Risk for Wandering. The facility failed to complete the 3/31/25 assessment accurately after the identified elopement. Review of the 3/31/25 wandering assessment failed to note any checks or documentation for the following sections- B. Behavior/Mood, C. Recent Experiences, D. Mobility and G. History of wandering. All sections were left blank. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R89's care plans including a care plan titled Resident at risk for wandering or elopement r/t (related to) altered mental state and expressing need to leave building Initiated on 3/30/25, revealed no documentation of the resident elopement incident. On 4/3/25 at 12:00 PM, the DON was interviewed and asked about R89 to have been exit seeking, the implemented wandering/elopement care plan/interventions and the inaccurate 3/31/25 wandering assessment. The DON stated they would look into the concerns and follow back up. No further explanation or documentation was provided by the end of the survey. Review of a facility policy titled Wandering, Unsafe Resident revised December 2008, documented in part . The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement . The staff will identify residents who are at risk for harm because of unsafe wandering (including elopement) . The staff will assess at-risk individuals for potentially correctable risk factors related to unsafe wandering . The resident's care plan will indicate the resident is at risk for elopement or other safety issues . Nursing staff will document circumstances related to unsafe actions . FALLS R16 On 4/1/25 at 10:06 AM, R16 was observed sitting in their wheelchair eating a cookie and drinking water. The resident was not able to appropriately respond to interview questions. A review of the medical record revealed R16 was admitted to the facility on [DATE], with diagnoses that included Parkinson's, Lupus, history of falls and repeated falls. R16 required staff assistance for all Activities of daily living. A review of the hospital documents provided to the facility upon R16's admission noted the following in part, . Reason for hospitalization . apparently attempted to stand on his own which led to him falling . hit his head . EMS (Emergency Medical Services) was called following the fall and patient brought . for further evaluation . Patient admitted . for recurrent falls and failure to thrive . Over this last month, the patient has fallen about 5 times . Recurrent falls, gait instability . Concern the patient requires higher level of care and assistance . Review of an Admission fall risk assessment dated [DATE], revealed to be inaccurate. The assessment categorized R16 as Moderate Risk for falls. Section 4. Medication Use was noted to be blank and failed to identify the medications the resident was currently taking that included gabapentin. A review of R16's medical record revealed a care plan titled Risk for falls r/t Hx (history) of falls, non-verbal, Impaired balance/poor coordination, unsteady gait, Parkinsonism . initiated 1/1/25, documented the following interventions: Administer medications as ordered by physician, evaluate lab tests & xray PRN (as needed), Neuro checks per protocol, Reinforce need to call for assistance and Transfers and Gait: 1 PA (person assistance) with U-step walker: WBAT (Weight Bearing as Tolerated) . The form also failed to identify the resident's unsteady gait in section 11. Gait Analysis. This care plan was not adequate or individualized to prevent further falls for R16, a resident with a known history of falls and current hospitalization due to a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the medical record revealed the following falls: January 2025 - 13th, 20th, 21st. February 2025- 10th & 12th. On 4/2/25 at 2:21 PM, the Administrator was asked to provide all of R16's Incident and Accident (I&A) reports for falls. The facility provided an I&A for every fall except for the 1/21/25 fall. Review of the medical record revealed no Interdisciplinary meeting or documentation to identify the root cause of the 1/21/25 fall. Review of R16's care plan revealed no additional interventions implemented for the 1/21/25 fall. On 4/3/25 at 11:47 AM, the Director of Nursing (DON) was interviewed and asked about the inaccurate admission fall assessment and the inadequate fall interventions to prevent further falls for a resident identified with a known history of falls and who should have been identified as a high fall risk. The DON stated they would look into the concern and follow back up. At 3:31 PM, the DON returned and stated they identified concerns of the staff to have inaccurately completed the assessments and apologized for not documenting the follow up of R16's 1/21/25 fall into their medical record. At this time, the DON provided and investigation summary. Review of the investigation report documented the following in part . Root cause was determined to be that Guest is a 1 PA using U-step walker for transfer . was self-transferring from bed without calling for assistance. His call light was closed to reach and not activated . Intervention: Physician to review medication, therapy to work on strengthening and transfer mechanism. IDT reviewed and cp (care plan) updated . The care plan was not updated as documented. Review of a facility policy titled Falls Reduction Program dated 9/25/16, documented in part . PURPOSE: To provide a safe environment for residents, modify risk factors, and reduce risk of fall-related injury . Identify/analyze resident risk for falls . Implement and indicate individualized interventions on Care Plan . If fall occurs Charge Nurse to complete . Immediate interventions as identified by physical assessment and environmental observation . Identify any additional interventions in the Care Plan . No further explanation or documentation was provided by the end of the survey. 47283 R3 (continued on next page)

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	235720	A. Building B. Wing	04/03/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review revealed R3 was a long-term care resident of the facility, originally admitted on [DATE]. R3 was recently sent to the emergency room (ER) on 3/23/25 due to complaints of pain in the left forearm. R3's admitting diagnoses included left wrist fracture due to a fall at the facility, respiratory failure, dementia, Chronic Obstructive Pulmonary Disease (COPD), urinary retention, neuromuscular dysfunction of bladder, dementia and heart failure. Based on Minimum Data Set assessment dated [DATE], R3 had a Brief Interview for Mental Status (BIMS) score of 14/15, indicative of intact cognition. An initial observation was completed on 4/1/25 at approximately 9:05 AM. R3 was observed in their bed. They were dressed and observed wearing a night top. R3 had a brace on their left forearm due to a recent fall at the facility and they were diagnosed with a left wrist fracture. R3 was queried about the cast, they reported that they fell in the bathroom a few days ago and they went to the hospital. When queried further on how they fell , R3 stated that they fell right here and pointed to the bathroom; added that somebody put something on the floor that shouldn't be there and I stumbled and fell . They added that they were not able to use their left hand. Review on R3's hospital discharge summary dated 3/23/25 read in part, Presents with wrist injury. Patient came via EMS (Emergency Medical Services) from nursing facility for left wrist injury with obvious deformity. Facility denies patient fell but is unsure how the injury occurred. Wrist has been injured x few days per EMS . Discharge summary from the hospital revealed closed fracture of the left distal radius. Review of R3's nursing progress note revealed that R3 had a fall on 4/1/25 at 2 PM, slipped from wheelchair. Review of R3's progress notes revealed no nursing progress notes between 3/16/25 to 3/23/25, the day R3 was transferred to the ER due to complaints of left arm pain and swelling. A Progress note dated 3/23/25 at 10:23, read, patient complaints of left arm pain to touch, swelling observed, on call MD (Medical Doctor) notified, stat (urgent) 2-view x-ray ordered'. R3 returned from hospital on 3/24/25 and the progress note dated 3/24/25 at 00:05 read, .patient stated she was tired and little confused of her surroundings. Patient left arm is in a cast and a sling. Writer put bed to lowest position .patient was re-educated on safety and importance of using call light and waiting for assistance. Received report from EMS, who stated she had received oxycodone and morphine at the hospital. Review of R3's fall risk assessment dated [DATE] deemed R3 as low risk for falls with a score of 5.0., when the nursing assessment upon re-admission revealed increased confusion. Review of fall risk assessment scores from 1/15/24 revealed the following scores that did not correlate with the rest of the nursing/interdisciplinary findings/assessments: 1/15/24 - 9.0 ->Moderate Risk 1/22/24 - 11.0 ->Moderate Risk (no fall risk assessments between 1/22/24 and 12/23/24 - approximately 11 months) and had a significant change Minimum Data Set (MDS) assessment dated [DATE]. 12/23/24 - 11.0 -> Moderate Risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/24/25 - 5.0 ->Low Risk (after they had a fall at the facility with wrist fracture and was transferred to ER) R3 was transferred to hospital on 3/23 and they were receiving diuretics and narcotics and a fall risk assessment dated [DATE] did not reflect R3 receiving the medications. 4/1/25 - 7.0 ' Moderate Risk A request was sent via e-mail to provide all Incident & Accident reports for R3 from 12/1/24 to 4/2/25 on 4/3/25 at 9:22 AM. Two incident reports were received for 3/23/25 and 4/1/25. Review of investigation report for the incident dated 3/22/25 revealed a summary of meeting note that read, reviewed environment - ability to get up unassisted, self-reported .therapy agrees - could get up unassisted, suspect fall related to clutter, not tubing. MDS assessment dated [DATE] and R3's care plan revealed that they needed moderate assistance with toileting needs (less than 50% help from staff) and needed substantial/maximal assistance (more than 50% help from the staff) with bed to wheelchair transfers and toilet transfers. There was no other objective clinical assessment on R3's Electronic Medical Record (EMR) that revealed that they were able to perform transfers (including floor transfers) unassisted other than the statement written on the investigation report. Review of a rehabilitation screen dated 3/24/25 revealed a Physical Therapy (PT) evaluation was recommended to address the recent fall on 3/22/25, PT evaluation was completed on 4/1/25 (7 days) after another fall. An interview with Unit Manager (UM) N was completed on 4/3/25 at approximately 9:30 AM. They reported that they had worked as the on call nurse manager on 3/22/25 and 3/23/25 and had also worked on the unit when R3 was sent out emergency room (ER) for further evaluation. They reported that R3 was not able to provide any information on fall. They were queried about the fall risk assessment from 3/24/25 after the fall with left wrist fracture and how R3's fall risk changed from moderate to low risk after their fall? They reviewed the assessment on EMR and reported they did not complete the assessment, when queried who did, they reported that it was completed by their corporate nurses. An interview with the Director to Rehab (DOR) O was completed on 4/3/25 at approximately 12 PM. They were asked about the rehab screen that was ordered and completed on 3/24/25 and why the PT evaluation was completed on 4/1/25 (approximately a week later) after R3 had another fall. DOR O reported that their team was unable to do the evaluation. They reported that R3 was scheduled for a Physical Therapy (PT) evaluation on 3/27/24 (reviewed the schedule on their computer) but the Physical Therapist was unable to complete the evaluation as they had too many admissions and they had to prioritize the new admission evaluations. An interview with the Director of Nursing (DON) was completed on 4/3/25 at approximately 10:25 AM. The DON was queried about R3's unwitnessed fall and transfer to the ER with a fracture to the left wrist. The DON reported that they spoke with the resident and R3 reported that they fell and got themselves up and did not tell anyone until the next morning when their wrist started hurting. When queried about their ability to transfer and the fall risk assessment dated [DATE] that deemed R3 was a low risk, the DON reported that they would check and report later. Later that day, the DON came back and reported that change in score was related to history of falls and an error in incontinence score. No additional documentation or explanation was provided prior to survey exit. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	48680 R69 On 4/1/25 at 11:13 AM, an observation was made of R69 in their room in the wheelchair with a neck brace on getting their hair combed by a staff member. R69 was convinced they were going to the hospital to get surgery; an interview attempt was made but R69 was not able to have an appropriate conversation. A review of the record revealed that R69 had a fall on 3/19/25 and was sent to the hospital in case they hit their head. R69 also had a fall on 3/21/25. A further review of the record revealed that R69's care plans were not updated from the fall that took place on the 19th and there were no neurological checks completed. On 4/3/25 4:34 PM, the Director of Nursing (DON) and the regional Nurse was interviewed and asked after a fall what was the facility's process. The DON reported, they assess the resident, call the doctor and family, imitate a neurological assessment and they will send the resident to a higher care setting if needed. The DON was asked to provide the neurological assessment for R69 for the unwitnessed fall on 3/19/25. The DON presented a handwritten neurological sheet that was filled out entirely, however, there were times recorded with vital signs and other data while the resident was in the emergency room and not at the facility. The DON was asked how was that possible to get information such as vitals for a resident that was not in the facility. The DON had no answer. On 4/4/25 at approximately 10 AM, this writer received a call from the Administrator stating that their team discussed the neurological assessment that was submitted was deemed false documentation and that it should not be used. No additional information was provided by exit of survey. 34275

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283 Based on observation, interview, and record review facility failed to ensure an indwelling foley catheter was secured appropriately for one Resident (R3) of two residents reviewed for catheter care resulting in the potential for catheter dislodgement, urethral trauma, and Urinary Tract Infection (UTI). Findings include: R3 A review of the medical record for R3 revealed admission to the facility on [DATE] with diagnoses including urinary retention, neuromuscular dysfunction of bladder, and dementia. The Minimum Data Set (MDS) assessment dated [DATE], revealed R3 had Brief Interview for Mental Status (BIMS) score of 14/15, indicative of intact cognition. On 4/1/25 at approximately 9:05 AM, R3 was observed in their bed and a foley catheter collection bag was connected to the wheelchair. A velcro catheter securement device was observed laying on the floor of the bathroom on the right side of the toilet. During this observation an interview was completed. When asked how long the catheter was place, R3 reported they had the catheter for a while. When queried about the catheter securement strap and if they had taken it off, R3 was unaware. When queried about how they were transferring in/out of bed and going to the bathroom, R3 reported staff had been helping them after their fall. At approximately 9:20 AM, Licensed Practical Nurse (LPN) L who was assigned to care for R3 came into R3's room. LPN L was queried about the catheter securement device observed on the bathroom floor and confirmed it was a foley securement device. They picked up the device from the floor and disposed it. They were queried on how the device ended up on the bathroom floor and what was securing the foley. LPN L checked for a foley securement device on R3, while this Surveyor waited outside the room. At approximately 9:22 AM, LPN L came to the door and replied, R3 did not have any securement device and they were unsure how it came off. LPN L stated they were going to get a new catheter securement device. When asked how long the catheter securement device was off, LPN L stated they were unsure. At approximately 9:23 AM, LPN L notified Certified Nursing Assistant (CNA) M to get a catheter securement device for R3. CNA M brought a catheter securement device and gave it to the nurse. At approximately 9:40 AM, LPN L was in R3's room when the Director of Nursing (DON) came by R3's room. LPN L reported to the DON, the surveyor observations and the new catheter securement device they had put on R3, while the surveyor was standing in the hallway, outside R3's room. Review of E3's progress note revealed a nursing note dated 4/1/25 at 10:52 AM (after the securement strap was observed on the floor and brought to the staff's attention), that read, Patient (R3) is noncompliant with foley strap (catheter securement device). Staff notified nurse manager. Care plan will be updated. There was no further documentation of the resident's noncompliance. (continued on next page)

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	235720	A. Building B. Wing	04/03/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's physician order revealed an order dated 1/26/25 that read in part, Foley cath. care Q (every) shift. Assess catheter placement, tubing, and anchor . Review of nursing Q-Shift follow-up for this order from 3/1/25 to 4/3/25 revealed 10 blank entries on Treatment Administration Record. Review of R3's foley catheter care plan revealed an updated intervention dated 4/1/25 (after the concern was brought to the attention of the facility) that read, ensure that foley is properly anchored to leg. Resident frequently removes Cath secure . An interview with CNA M was completed on 4/1/25 at approximately 9:25 AM in the hallway. CNA M reported being regularly assigned to the unit and they knew R3 well. They were queried about R3's functional status and their ability to transfer. CNA M reported R3 needed help with their transfers because of their cast and they were assisting them with getting in and out of bed with their toilet transfers. CNA M was queried if they assisted R3 with toileting during their shift and they reported that they assisted the resident in the morning. When queried about the catheter securement device found on the floor of the bathroom, CNA M was unsure and did not provide any further explanation. An interview with Unit Manager (UM) N was completed on 4/3/25, at approximately 9:30 AM. UM N' was queried about their staff expectations for foley catheter care. UM N explained, nurses and CNA's had specific orders to follow depending on the type of catheter. They were notified of the observations of R3 and the catheter securement device observed on the floor in an area of the bathroom which could not be reached from the area where R3's was (in her bed). UM N was also made aware of the interviews with staff and acknowledged the concern of staff not ensuring a catheter securement device was in place for R3 to prevent accidental dislodgement. On 4/2/25 at approximately 10:55 AM, during an interview, the DON was queried about the facility standards for foley care and expectations from their staff. The DON reported there was an order for nurses to do foley care every shift which included checking the anchor. The DON was notified of the observations for R3 and the location where the catheter securement device was observed while R3 was observed in their bed under their blankets. The DON reported R3 was non-complaint and had a care plan. The DOB was asked why the care plan and documentation was not entered into the medical record until after this Surveyor brought the concern to facility's attention. The DON was also asked why there was no prior evidence of R3's non-compliance with removing the catheter securement device in the medical record. The DON reported they had sent the resident out to replace foley after they had started. They added that they would look for additional documentation. No further documentation was provided prior to survey exit. Review of facility provided document titled CATHETER CARE (INDWELLING CATHETER AND SUPRAPUBIC) with a revision date of 8/17/17 read in part, PROCEDURE FOR INDWELLING CATHETER: . 7. Properly secure tubing to leg using a catheter strap to reduce risk of trauma .

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observations, interviews and record reviews the facility failed to consistently ensure the required Physician visits at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter and/or failed to ensure the first initial comprehensive visit was conducted by the Physician for six (R's 89, 62, 3, 67, 34 and 11) of six residents reviewed for Physician visits. Findings include: R89 On 4/1/25 at 11:30 AM, R89 was observed sitting in their wheelchair in the dining area with their daughter. A brief interview was conducted with the resident and the resident's daughter at that time. A review of the medical record revealed R89 was admitted to the facility on [DATE] with diagnoses that included: dementia, intracerebral hemorrhage intraventricular, chronic kidney disease, dysphagia, and diastolic congestive hear failure. A review of the medical record revealed Physician D consulted with the resident in July 2024 and failed to conduct a physician visit once every 30 days for the first 90 days. Review of the medical record revealed the next documented Physician D visit was dated 10/14/24. There was no other documented consultations by Physician D. Further review of the medical record revealed R89 was seen by the Nurse Practitioner (NP) on 11/12/24, 1/22/25 and 3/13/25. The facility failed to ensure the frequency and timeliness of the required Physician visits. R62 On 4/1/25 at 1:12 PM, R62 was observed in their room in bed. R62's husband was observed sitting by the bedside. An interview was conducted with R62 at that time. A review of the medical record revealed R62 was admitted to the facility on [DATE] with diagnoses that included: acute and chronic respiratory failure with hypoxia, Guillain-Barre syndrome and hypertension. Further review of the medical record revealed R62's first initial visit was conducted by a Nurse Practitioner (NP) C and not by the assigned Physician D. The facility failed to ensure the initial comprehensive visit was conducted by the Physician. R67 (continued on next page)

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	235720	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/1/25 at 11:07 AM, R67 was observed sleeping in their room. R67's wife was observed at the bedside, a brief interview was conducted with R67's wife at that time. A review of the medical record revealed R67 was admitted to the facility on [DATE] with a primary diagnosis of acute on chronic systolic congestive heart failure. Further review of the medical record revealed R67's first initial visit was conducted by NP C on 3/17/25. Physician D completed a consultation on 3/19/25. The facility failed to ensure the initial comprehensive visit was conducted by the Physician. On 4/2/25 at 11:58 AM, the Director of Nursing (DON) was interviewed and asked the protocol on Physician D and NP C consultations with the facility residents. The DON stated the Physician D does the initial visit for all of the residents. Physician D then informs NP C what to monitor and watch for thereafter. The DON was then asked why R89 had not been seen by Physician D at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. The DON was asked about R62 and R67's first initial comprehensive visit being conducted by NP C and not Physician D as required. The DON stated they would look into it and follow back up. On 4/3/25 at approximately 2:53 PM, the DON accompanied by Nurse Consultant (NC) A asked what the concern was with the Physician visits for R89. The concern of the frequency of Physician D visits to meet the requirements was discussed regarding R89, R62 and R67, both the DON and NC A acknowledged the concern. No further explanation or documentation was provided by the end of the survey. 34275 R#34 On 4/1/24 at approximately 9:51 AM, R34 was observed lying in bed. The resident was alert and able to answer all questions asked. R34 reported that they had been a resident at the facility for about two years. When asked about the care provided at the facility, R34 responded that while most of the staff are very nice and most care is provided, they were upset that they are never seen by their doctor. R34 noted that they reported their concern to some of the staff members but could not specifically recall their names. A review of R34's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: type II diabetes, COPD (chronic obstructive pulmonary disease) and rheumatoid arthritis. A review of the resident's MDS noted that R34 had a BIMS score of 14/15 (cognitively intact cognition). The last physician notes in R34's chart was dated 1/24/25 (late entry) and authored by Physician D. Prior to the visit on 1/24/25, R34 was seen by Physician D as seen on a progress note dated 10/23/24 (late entry). (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/3/25 at approximately 12:34 PM, R34 reported to the Surveyor that Physician D came to their room yesterday (4/2/25) walked in the door, looked around the room and left. R34 noted that the physician did not perform a full examination and/or talk with the resident. *It should be noted that on 4/3/25 at approximately 1:30 PM, a review of R34's clinical record showed no indication that Physician D had seen the resident. On 4/3/25 at approximately 3:02 PM, an interview was conducted with Unit Manager Nurse F. UM F was queried as to Physician D care visits. UM F reported that they believed the facility policy/protocol was that the Physician was to see residents every three months, unless it is made none to them that the resident needs to be seen or that they and/or a family member requests a visit. With respect to R34, UM F reported that they recalled that R34 wanted to be seen in February for reasons associated with their diabetes. UM F could not recall if they noted the concern in the resident's clinical record, but did explain how physician forms can be filled out by staff. 47283 R3 Record review revealed R3 was long-term care resident of the facility, originally admitted on [DATE]. R3's admitting diagnoses included left wrist fracture, respiratory failure, Chronic Obstructive Pulmonary Disease (COPD), urinary retention, neuromuscular dysfunction of bladder, dementia and heart failure. Based on Minimum Data Set assessment dated [DATE], R3 had Brief Interview for Mental Status (BIMS) score of 14/15, indicative of intact cognition. Review of R3's Electronic Medical Record (EMR) revealed a physician/NP (Nurse Practitioner) progress notes dated 6/21/24; 10/2/24; and (late entry note dated) 1/15/25. There were no other physician visits completed during this period. The physician or NP visits were not completed at least once every 60 days. The facility failed to ensure the frequency and timeliness of the required Physician visits. R11 Record review revealed R11 was a long-term resident of the facility. They were admitted to the facility on [DATE]. R11's admitting diagnoses Chronic Obstructive Pulmonary Disease (COPD), atrial fibrillation, cancer of the breast and respiratory failure. Review of R11's EMR revealed that they were receiving hospice services. Review of R11's progress notes revealed an initial physician note dated 4/3/24. Further review reveled Physician/NP notes dated 4/29/24; 7/24/24 (approximately 3 months); 8/9/24; 10/2/24 and 3/26/25 (approximately over 5 months after the previous visit). There were no other physician/NP visits in between during this period. The facility failed to ensure the frequency and timeliness of the required Physician visits. An interview with the Nurse Practitioner (NP) C was completed on 4/3/25 at approximately 3:05 PM. They were queried how often they were seeing the residents. They reported that they worked with Physician D and they were at the facility Monday through Friday. They were seeing long-term residents if they had any issues or needed any labs or other diagnostic tests etc. and did not have any schedule to see the long-term care residents. (continued on next page)

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Director of Nursing (DON) was completed on 4/3/25 at approximately 3:10 PM. They were notified of the concerns with frequency of physician visits for R3 and R11. DON reported that they understood the concern and their corporate vice president was aware of the concern and they were following up with Physician D. An attempt was made to contact Physician D via phone on 4/3/25 at approximately 4:01 PM. There was no answer and it went to their voicemail, and the mail box was full; unable to leave any message.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 Based on observation, interviews, and record reviews the facility failed to prevent a significant medication error for one (R67) of one resident reviewed for a significant medication error. Findings include: On 4/1/25 at 11:07 AM, R67 was observed sleeping in bed. R67's wife was at the bedside. When asked if they had any concerns with R67's care at the facility R67's wife stated there was a problem with the resident's Lasix medication when they were first admitted . R67's wife stated R67 had congestive heart failure in the hospital and was prescribed Lasix medication. R67's wife said the nurses was not giving the medication to R67 and they had questioned the nurses about it and they did not listen until they informed the facility's Director of Nursing (DON) of the issue. R67's wife stated the DON did fix their concern but R67's wife stated .What if I wasn't here? I am always by his side because I don't know what could happen . A review of the medical record revealed R67 was admitted to the facility on [DATE] with a primary diagnosis of acute on chronic systolic congestive heart failure. Review of the hospital discharge documents provided to the facility upon R67's admission documented the following in part, . Acute decompensated heart failure . furosemide 20 mg (milligram) tablet, commonly known as: LASIX. Take 1 tablet (20 mg) by mouth once daily. Please take 40mg (2 tablets) for weight gain over 2 lbs (pounds) in 24hrs and reach out to cardiologist. Last Given: March 14, 2025 6:04 AM . A review of the March 2025 Medication Administration Record revealed the following: Lasix Oral Tablet 20 MG, Give 1 tablet by mouth in the morning. Start Date: 3/16/25. The first administration for this order was given on 3/17/25, two days after admission to the facility and three days after their last dose of Lasix. A review of the medical record revealed no documentation on why the Lasix administrations were omitted and no documentation of the Physician to have been notified for further directive. A Physician note dated 3/17/25 at 9:45 AM, revealed no documentation of the Lasix medication. Review of the Physician notes revealed the following: On 3/19/25 at 10:40 AM, . Daily weights ordered . On 3/21/25 at 12:52 PM, . c/w (continue with) daily weights . On 3/27/25 at 9:02 AM, . c/w daily weights . A review of the documented weights for R67 revealed the facility failed to obtain a daily weight on the following days: (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/18/25, 3/19/25, 3/20/25 and 3/23/25. Despite the continuous documentation from the Physician to conduct weekly weights, an order was placed on 3/14/25 for Weekly weights. A review of the medical record revealed no clarification of the discrepancy regarding how often the staff were to obtain R67's weight. There was no admission weight noted for 3/15/25, however the weight documented on 3/16/25 was recorded at 188.8 lbs (pounds). A review of a Nursing note dated 3/20/25 at 2:50 PM, documented in part . Resident presents with some SOB (shortness of breath), 2-3+ pitting edema to bilateral feet/ankles. Lungs assessed and there is some crackles in the lower bases. (Nurse Practitioner Name) notified and we will give extra Lasix doses NOW and then increase to 40mg BID (twice per day) and (NP) will reevaluate . Review of a Nursing note dated 3/20/25 at 9:22 PM, documented in part . Took all meds including increased 40mg . Extra fluids given per request. Some crackles still noted as earlier this day. 02 (supplemental oxygen) on with no further respiratory distress noted . Review of a Physician note dated 3/21/25 at 12:02 PM, documented in part . Patient was admitted for fluid overload. Patient was diuresed <sic> . Patient was seen today as a follow up to diuretic management. Wife at bedside and had concerns regarding an increase in Lasix. States his BP (blood pressure) was low in the hospital and felt his Lasix dose was too high. Patient's BP at the facility ranges from stable to elevated. Wife is adamant that Lasix dose be reduced despite discussion of risks and benefits. Patient's weight was noted to be uptrending <sic>. Education provided . CHF (congestive heart failure)- Lasix decreased per wife. Provider recommends maintaining BID (twice a day) Patient and family decline. c/w daily weights . On 3/25/25 R67's weight was recorded at 191.0 lbs. On 3/26/25 the resident's weight gain was recorded at 191.8 lbs. A Physician note dated 3/27/25 at 9:02 AM, documented in part . Patient was admitted for fluid overload. Patient was diuresed <sic> . Patient was seen today as a follow up to diuretic management. Weight reviewed and are down trending . CHF- Lasix decreased to maintenance- c/w daily weights . This Physician note is not accurate, R67's weight was not down trending. As noted above R67's weight was noted to have a weight gain. The Physician and/or NP failed to identify the weight gain. On 4/1/25 and 4/2/25 the resident's weight gain was recorded at 192.2 lbs. This is a 3.4 lb weight gain from the admission weight. Review of the record revealed no documentation of the additional weight gain to have been identified and no documentation of the Cardiologist to have been notified as instructed by the transferring hospital. Further review of the record revealed no notification to the Physician of the weight gain. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/3/25 at 11:54 AM, the DON was interviewed and asked why R67's Lasix was not implemented and administered timely, considering their primary diagnosis to have been congestive heart failure. The DON was asked why daily weights were not obtained as noted by the Physician and asked about the weekly weights order implemented instead of the daily weights noted in the Physicians plan of care. The DON was asked about the missing weights and the weight gain with no identification by the facility staff and no notification to the Cardiologist. The DON stated they would look into it and follow back up. At 2:48 PM, the DON was accompanied by Nurse Consultant (NC) A and stated they reviewed the concern and acknowledged the missed doses of the Lasix and the lack of follow-up with the Physician regarding the missed Lasix dose on the 15th. NC A stated it could have possibly been missed due to the late admission to the facility. NC A was asked would they have expected the admitting nurse to clarify with the Physician when they are reconciling the medications and NC A acknowledged that would have been the expectation. NC A and the DON both acknowledged the discrepancies with the weekly weight order, physician plan of care to obtain daily weights and the weights that were not obtained and the DON stated they would complete education with the nursing staff to prevent further incidents. On 4/3/25 at 4:01 PM, an attempt was made to contact Physician D, however Physician D did not answer their phone and a voice message could not be left due to the mailbox being full. No further explanation or documentation was provided by the end of the survey.