STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235726	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Clarkston	5655 Clarkston Road Clarkston, MI 48348

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0689

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47283

This citation pertains to intake MI00148800

Based on observation, interviews and record review, the facility failed to implement timely resident specific interventions and provide adequate supervision to prevent falls, for one (R702) of two residents reviewed for falls.

Findings include:

A complaint received by the State Agency revealed that R702 had two falls after they were admitted to the facility, within nine days. The first fall was on 10/25/24 and R702 was transferred to the emergency room (ER) and returned to the facility. The second fall was on 10/31/24 and R702 was transferred to the ER and required surgery for a right hip fracture. On 10/31/24, R702 was sitting up in the wheelchair alone in their room. The compliant stated that facility was well aware that R702 was a high risk for falls and did not have appropriate interventions in place.

R702

An observation of the unit where R702 was residing was completed on 12/17/24 at approximately 11:55 AM. R702 resided at the end of the hallway, second from the last room in the hallway. The common area was approximately 100 feet away from the room.

A review of R702's Electronic Medical Record (EMR) revealed R702 was admitted into the facility for a short-term stay after hospitalization due to a fall at home that resulted in a left hip fracture. R702 had surgery to the left hip and they were admitted to the facility on [DATE]. R702's other diagnoses included dementia, osteoarthritis and age-related osteoporosis (brittle bones) without any pathologic fracture. Based on a MDS assessment dated [DATE], R702 had severe cognitive impairment. Prior to admission into the facility, R702 lived with their daughter who was their primary care giver. R702's daughter was the Durable Power of Attorney (DPOA) for R702 and made decisions on their behalf.

(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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R702's EMR revealed the following nursing progress notes. An admission progress note dated 10/23/24 at 7:16 PM read in part, Patient arrived via the ambulance with the daughter. Patient was alert and oriented X1- 2 .right hip has staples. Review of the fall risk assessment dated [DATE] revealed a score of 17, indicative of high risk for falls. Intervention /comment section of the fall assessment read PT (Physical Therapy) will evaluate. Review of R702's care plan revealed a fall care plan. The care plan read, Risk for falls related to left femur fracture, falls, dementia, osteoporosis etc and interventions initiated on 10/23/24 (day of admission) included: Administer medication as ordered by physician; transfer 1 person assist with 2 wheeled walker - non ambulatory; and weight bearing as tolerated. Review of 702's Kardex - information/plan of care for Certified Nursing Assistants (CNA) revealed care information that included: Section that read safety staff to assist patient with toileting and settle patient in bed after dinner initiated on 10/29/24 and Resident care encourage guest to stay in high traffic areas while awake initiated on 10/25/24. Prior to the initiation of the interventions on 10/25/24 and 10/29/24, R702 (who had severe cognitive impairment and was a high risk for falls) did not have resident specific fall prevention interventions and or supervision in place. A care transition progress note dated 10/24/24 read in part, Guest is alert and oriented to person only with confusion to place and time. She does have a diagnosis of dementia .guest has been given a BIMS score of 3/15, cognitively intact . A practitioner progress note dated 10/24/24 read in part, Discussed plan of care with daughter at bedside .melatonin ordered per request. Per daughter with some agitation and delirium at bedtime. A change in condition progress note dated 10/25/24 revealed that R702 was transferred to hospital for x-ray per family request. The progress notes and incident report revealed that CNA observed R702 on the floor next to their bed. An investigative summary dated 10/29/24 (4 days after the fall) revealed, Resident had unwitnessed fall around shift change .was unable to explain what happened .stated that she was trying to go to her apartment. Resident did not activate call light.Staff will implement toileting schedule and assist patient to settle in bed. A care transition note dated 10/31/24 at 10:21 AM revealed that R702 planned to return home with their daughter and with hospice services. The plan was to return home on 11/1/24 at 11 AM. Nursing progress note dated 10/31/24 at 18:42 read in part, Guest was observed laying on the floor on her buttocks .guest was visiting with her son and once he left she was trying to stand up and the wheelchair was not locked wheelchair rolled back . Review of an incident report dated 10/31/24 at 18:54 read in part under immediate intervention, .I transferred guest into bed position reiterated to please call staff for assistance press call light red button for assistance don't stand on her own and guest verbally acknowledged understanding . It must be noted that that R702 had significantly impaired cognition with diagnosis of dementia. The mental status section of the report revealed that R702 was oriented to person, place and situation. The incident report also revealed an investigative summary dated 11/9/24 (7 days after R702 was transferred to the hospital) and root cause section read in part, .BIMS of 3, severe cognitive impairment. Guest was trying to self-transfer without assistance and fell . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R702's EMR revealed x-rays that two sets bilateral hip x-rays and pelvis were ordered and completed on 11/1/24 and 11/2/24. Results did not reveal any fracture or dislocation on both hips. The reports revealed old hardware on the right hip with no hardware complication. A progress note dated 11/3/24 revealed that R702 was transferred to hospital as daughter had concerns with ongoing hip pain after the fall and were not comfortable with x-ray findings. Review of pain assessment for 11/3/24 at 4:30 revealed a score of 8/10. An interview was completed with R702's representative on 12/16/24 at approximately 4 PM. R702's representative reported that they had been taking care of their mother for [AGE] years and they were admitted to the facility for healing and recovery. They added that when R702 was admitted to the facility they had communicated that they were a high fall risk, requested floor mats next to their bed, and asked them to check on R702 frequently due to their dementia. They added that confusion had gotten worse after the left hip surgery (prior to admission to the facility). R702's representative further added that they were notified by floor staff that facility did not use floor mats as they are a trip hazard. They stated that they did not understand why it was a trip hazard when their mom could not walk. They added that after the second fall on 10/31/24, they noticed their mother was in severe pain in the right groin area. The two sets of x-rays that were ordered did not show anything new. They went in to see her on 11/3/24 with their brother and their mother was in a lot of pain. They had requested R702 to be transferred to the hospital. When R702 arrived at the hospital they did x-rays and they were notified that the right hip was completely shattered. R702 had surgery on their right hip Monday morning. R702 was currently at home with their daughter and they were receiving hospice services. They added that they did not see appropriate fall precautions in place even after they had brought the concern to the attention of the facility staff. An interview was completed with CNA A on 12/17/24 at approximately 12:05 PM. They reported that thy usually were on a different hall and they covered the hall they were on due to a call off. They were queried how did they know what to do for their patients and they added they obtained the information from the Kardex (CNA car plan) from the EMR and that included their mobility level, fall precautions, diet, etc. An interview was completed with the unit manager (UM B) who covered the hallway that R702 resided on during their stay at the facility. They reported that they were new to their role. They were queried what was their expectation for their staff if a high fall risk resident with history of falls and recent fracture due to fall was newly admitted to the facility. They reported that based on their clinical assessment they would recommend frequent rounding, knowing their routines to meet their needs, floor mats, enabler bars, or positioning pillows. They were not able to provide why any resident specific interventions were not in place for R702 as they had just started working at the facility. An interview with Licensed Practical Nurse (LPN C) was completed on 12/17/24 at approximately 1:10 PM. They reported that they had been at the facility for a total of one year. They were queried on what they would do if a high fall risk resident with history of falls and recent fracture due to fall was admitted to the facility. LPN C reported that they would do frequent rounding, try to do every 15 minutes between the nurse and CNA, had the bed in the lowest position, floor mats on the sides of the bed, and to keep them in a room closer to a common area/station and tried to keep them in the front end of the hallway as soon as a bed became available. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with CNA D was completed on 12/17/24 at approximately 1:25 PM. CNA D reported that they had been at the facility for approximately 3 months. They were queried how did they get their information to care for their residents. They reported that they would get the care and safety related information from the Kardex. An interview with LPN E' was completed on 12/17.24 at approximately 1:35 PM. They reported that they had been at the facility for approximately 6 months. They were queried on what they would do if a high fall risk resident with history of falls and recent fracture due to fall gets admitted to the facility. LPN D' reported that they would add interventions based on their assessment and that might include low bed, floor mats, frequent t rounding, make sure personal items were within reach, change to a touch pad call light as they are more sensitive etc. and communicate with their CNA. An interview was completed with Director of Nursing (DON) on 12/17/24 at approximately 1:40 PM. DON reported that they were new to their role at this facility. They were asked about their expectations for their staff if a high fall risk resident with history of falls and recent fracture due to fall gets admitted to the facility. DON reported that they would expect them to put interventions in place and be proactive based on their assessment and that might include touch pad call light, positioning, frequent rounding, move them closer to the front end of the hallway. They were queried about R702 and what was in place when they were admitted . They reported after review of the EMR that R702 had standard of care every 2 hours rounding in place. The DON did not provide any further explanation. An interview with Regional Nurse Consultant (RNC) F was completed on 12/17/24 at approximately 2:05 PM. They were queried about their expectations for their staff if a high fall risk resident with history of falls and recent fracture due to fall was admitted to the facility and what was in place for R702 when they were admitted and after the falls. They reported that they would try and work with family to understand their needs and routines and tried to put interventions in place. They were queried further on interventions that were in place when R702 was admitted to facility and how educating a cognitively impaired resident with a BIMS of 3 would be an effective immediate intervention. RNC 'F' acknowledged the concern. An interview with the facility administrator was completed on 12/1724 at approximately 3:45 PM regarding the concerns with R702's fall interventions. The Administrator reported they understood the concern.