STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235726	A. Building B. Wing	01/30/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00149594. Based on interview and record reviews the facility failed to follow the facility policy on oxygen administration, ensuring orders were timely implemented for one (R404) of four residents reviewed for a change in condition. Findings include: A review of a complaint submitted to the State Agency (SA) documented concerns regarding R404's oxygen administration while inpatient at the facility. Review of the medical record revealed R404 was admitted to the facility on [DATE]. R404's admitting diagnoses included: acute on chronic systolic congestive heart failure, atrial fibrillation, chronic kidney disease, cardiac murmur, cardiac pacemaker and dyspnea (difficulty breathing). Review of an admission nursing assessment dated [DATE] at 2:53 PM, documented in part, . Respiratory . Equipment - Oxygen . Rate 1 L (liter) . A review of the physician orders revealed no implementation of an initial physician order for the administration of oxygen. Review of a facility policy titled Oxygen Administration revised October 2010, documented in part . The purpose of this procedure is to provide guidelines for safe oxygen administration . Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration . Review of the progress notes revealed the following: On 3/30/24 at 7:10 PM, a Nursing note documented in part . patient on oxygen 2 liters nasal cannula . On 3/31/24 at 5:46 PM, a Nursing note documented in part . On Oxygen concentrator 3 liters nasal cannula . Further review of the physician orders revealed the implementation of the following oxygen order on 4/1/24: (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

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 01/30/2025
NAME OF PROVIDER OR SUPPLIER Wellbridge of Clarkston		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer 1.5 L/NC (nasal cannula) if oxygen saturation is 90% or below . every 24 hours as needed and every shift. Review of the medical record revealed no documentation or clarification on why R404's oxygen orders were implemented three days after admission. On 1/30/25 at 1:12 PM, the Director of Nursing (DON) was asked the facility's protocol of a resident who admitted to the facility with oxygen administering via nasal cannula, who may or may not have oxygen orders documented on their hospital discharge documents. The DON replied that all orders are clarified with the doctor upon admission and if they arrived with oxygen and no orders for oxygen, the physician should have been notified for further directive. The DON was asked why orders were not implemented upon admission/timely for R404. The DON stated they were not employed with the facility at the time of R404's inpatient stay but would look into it and follow back up. At 1:55 PM, the DON returned with the facility's Nurse Consultant (NC) A, both acknowledged the concern. No further explanation or documentation was provided by the end of the survey.