

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 03/04/2025
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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083</p> <p>This citation pertains to MI00150120.</p> <p>Based on interview and record review, the facility failed to notify the Physician of a change in condition post fall for one (R901) of three residents reviewed for accidents. Findings include:</p> <p>An allegation was sent to the State Agency on 2/10/25 alleging the facility failed to assess, monitor, and delayed sending R901 to higher level of care for injuries that resulted from a fall.</p> <p>Clinical record review revealed R901 was admitted to the facility on [DATE] with significant cardiac disease which included hypertensive emergencies (severe elevated blood pressure systolic pressure >180) with convulsions (involuntary muscle contractions that occur during a seizure). The medical history included lung cancer and chronic obstructive pulmonary disease (COPD) and diabetes. R901 had a Brief Interview for Mental Status (BIMS) assessed on 2/11/25 and scored 9/15 indicating moderate cognitive impairment.</p> <p>Record review authored by Registered Nurse (RN) D documented at 6:47 that R901 was found on the floor in their bedroom and had an injury to their head (described as a skin tear to forehead) and right shoulder. RN D contacted the on-call physician of the findings .who gave orders (Xray to right shoulder. Writer notified the guest family (SON) awaiting call back .</p> <p>On 2/8/25 at 8:30 AM, A Nursing progress note authored by RN A (dated 02/08/2025) .Spoke with night shift Nurse .stated had a fall and sustained an abrasion to right forehead and right shoulder. Upon assessment, patient in fact had a gash to the right side of (their) forehead and an abrasion on the shoulder. I followed up the DON (Director of Nursing) and on-call and informed them of what I visualized myself and notified them of the discrepancy between the writer and night shift nurse assessment and categorization of the injuries .Vitals read as follows Blood Pressure (BP) 180/116 .and was A&Ox1 (A scale used to assess alertness and orientation. There are four levels of awareness Person, Place, Time, Situation. The higher the number indicates better orientation).</p> <p>Asked Night shift nurse if this was baseline and she stated, from what I've been told.Was told to cleanse, dress patients wound with gauze and continue neuro checks. Informed the on-call that I felt patient needed to be sent out and was informed to continue to monitor .</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/4/25 at 11:36 AM, RN A was contacted and acknowledged they were not familiar with R901 as they work at the facility as a PRN Nurse (contingent status) and recalled when they started their shift on 2/8/25, there was a vague report of the fall. RN A was expecting to see R901 with an abrasion to their forehead and during their assessment revealed an open bloody gash above the right eyebrow, actively bleeding, swollen and bruised and was concerned about the extent of injury, RN A then sent a picture to the on-call Provider and recommended they be sent out (the resident). RN A remarked, I should have used my Nursing Judgement and just sent them out (to the hospital).</p> <p>Record review of the Post Fall checklist/Neuro Checklist (dated 02/08/2025) and vital sign documentation revealed two manual blood pressures from 10:38 AM sitting Left arm was 180/116. BP at 10:38 sitting Right arm was 180/116. Ordered blood Pressure medication was administered. Vital signs documented on the post fall neuro check at 12:30 PM revealed R901 had a blood pressure of 201/96.</p> <p>On 3/4/25 at 12:47 PM, an interview with Nurse Practitioner (NP) D. NP D acknowledged they were contacted by Nursing regarding R901's laceration to their forehead, reviewed the picture and instructed to cleanse the wound, cover with gauze, and continue with neuro checks. NP D confirmed they too were not familiar with the resident's medical history or mental status baselines, and commented they oversee 30 different facilities and provide Telemedicine only. All decisions are dependent on what Nursing communicates. When asked if they were later notified of mental status changes or increased blood pressure readings, and increased bleeding, NP D confirmed they were not notified.</p> <p>On 3/4/25 at 1:15 PM, the Director of Nursing (DON) indicated that Certified Nurse Assistant (CNA) B was very familiar with R901 and available for an interview. CNA B confirmed on 2/8/25 at the start of their shift they overheard R901 had fallen. When CNA B went into the room they remarked to Nursing if R901 was being sent out to get stitches. CNA B said the gash on their forehead was open and bleeding and their right eye was swollen shut and bruised badly.</p> <p>When questioned how R901 presented for the duration of the morning and afternoon CNA B remarked that they seemed more tired and informed RN A who then escorted R901 to their bed. When asked how the dressing (on R901's head) appeared, CNA B remarked that it kept bleeding through the dressing and had to be changed three to four times that they observed.</p> <p>CNA B said R901's son had arrived at the unit around dinner time (3:30-4:30PM) and commented to CNA B that they were left a message that morning that R901 had a fall. They contacted the facility by phone four times, but there never was an answer. The son was unable to receive information on the condition of their parent and decided to drive up to facility. CNA B said the son was very concerned about the forehead, saw blood on the floor, started taking pictures of R901, and the room.</p> <p>Nursing Progress note dated 2/8/25 at 5:00 AM documented R901's son arrived at the facility, and explained the extent of the fall, at which time the son requested R901 be transferred to the hospital.</p> <p>Record review of Emergency Department (ED) medical documentation (dated 02/08/2025) revealed R901 presented to the ED, was admitted under trauma surgery service given fall with confusion. Later in the day, R901 was noted to be more confused and had more bruising to their eye and is on aspirin. Primary consideration includes possible head injury given their confusion they are A&Ox1 (alert and oriented), typically more A&Ox2-3 and trauma had to repair the laceration.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/4/25 at 4:30 PM, during an interview with the Nursing Home Administer (NHA) and the DON, both remarked that the sutures placed by trauma at the hospital were necessary seeing how thin the skin as they would have just used steri strips. When asked if they physically assessed the laceration, both denied, but remarked based on the photograph, the facility could have treated the laceration accordingly. The high blood pressure readings and R901's history of Hypertensive Crisis were reviewed and both agreed Nursing should have notified the on-call provider. When asked if the facility had a charge nurse or nurse manager as resource for Nursing on weekends, both said they do not but the DON is on call and they should have been notified if Nursing was not satisfied with a Providers response.</p>		