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	04/15/2025

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 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** 38271 Based on observation, interview and record review, the facility failed to ensure Nursing standards of practice were utilized including transcribing/implmenting Phyiscan orders and notifying administration of new skin injuries for one resident (R902) of two resident's reviewed for non-pressure wound care. Findings include: On 4/15/25 at approximately 11:21 a.m., R902 was observed in their room, laying in their bed with CNA A (Certified Nursing Assistant A). R902's left upper thigh area was observed to have a pink/healing burn on it without any blistering. CNA A reported that it was looking better and healing. On 4/14/25 the medical record for R902 was reviewed and revealed the following: R902 was initially admitted to the facility on [DATE] and had diagnoses including Presence of Urogenital Implants and Neuromuscular Dysfunction of Bladder. A review of R902's MDS (minimum data set) with an ARD (assessment reference date) of 4/2/25 revealed R902 needed assistance from staff with most of their activities of daily living. R902's BIMS score (brief interview for mental status) was 15 indicating intact cognition. A progress note dated 3/8/25 revealed the following: Skilled Charting Note Text: Resident complained of red abrasion sited on his left upper thigh. Wound assessment completed in . (Electronic medical record). A eINTERACT SBAR (Situation, Background, Assessment, Recommendation)Summary for Providers dated 3/8/25 revealed the following : .Situation: The Change In Condition/s reported on this CIC (change in condition) Evaluation are/were: Skin wound or ulcer . A Skin and Wound Evaluation dated 3/8/25 revealed the following: Describe: Burn .Degree: second degree . Location: Front Left Trochanter (Hip) .Acquired: In-house acquired .How long has the wound been present?: New .Wound Measurements: Area-4.9 CM2 (centimeters squared) .Length-3.6 CM .Width-1.8 CM .Depth-0.1 CM .Wound bed: Epithelial .% Epithelial: 40% of wound covered .Granulation: 40% of wound filled .Slough: 20% of wound filled .Eschar: 0% of wound filled .Exudate: Sanguineous/Bloody .Treatment: Generic wound clenanser .Primary Dressing-Other .Specify Other: Silver sulfadiazine Further review of the medical record did not reveal any physician orders transcribed into the EMR for the Silver Sulfadiazine order on 3/8/25. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R902's March 2025 TAR (treatment administration record) did not reveal any treatments applied to R902's identified burn on 3/8/25. An admission summary note dated 3/15/25 revealed the following: Note Text: .The patient reports pain in right thigh due to thermal burn Abdomen is soft, non-tender with bowel sounds present in all four quadrants. Skin is warm, dry, and intact with thermal burn noted on left thigh; burn is stable with no s/s (signs and symptoms) of infection at this time . On 4/15/25 at approximately 1:14 p.m., the Director of Nursing (DON) was queried regarding R902's burn and they reported that they go to the bistro to get coffee and lattes all the time. The DON reported that R902 went out to an eye appointment on and did not tell anyone about spilling coffee on themselves and then the next day they started complaining about it. The DON reported they did not know about the burn until R902 was readmitted from the facility from the hospital on 3/15/25. The DON reported they had a soft file on R902's burn investigation and would provide the report on it. On 4/15/25 a review of the investigation conducted by the facility pertaining to R902's burn revealed the following: 3/17-Upon completing manager skin assessment and admission, red abrasion was noted to guest thigh. Dressing was clean dry and intact upon assessing guest. During assessment dressing was removed and wound was assessed. Wound was red but did not have any other signs of infection. Writer asked guest what had happened as it was listed as a thermal burn in his chart. Guest stated that when he went to his eye appointment he had got coffee from the bistro and that he had spilled it on himself. Guest was asked if he notified anybody about this and he said no because he didn't want to bother anyone .Eye appointment was on 3/6. On 3/8 guest reported to Nurse that he had a red abrasion on left upper thigh at 0704 (military time). At 1530 on 3/8 guest was sent to the hospital after calling 911 with complaints of urethral pain. Guest was readmitted to facility on 3/15. Wound care orders were placed on 3/15 upon re-admission. On 4/15/25 a review of the investigation summary conducted by the facility and provided by the DON pertaining to R902's burn revealed the following: .DON educated [Nurse B] on the importance of notifying the DON and the Administrator of injuries of unknown origin and when there is a wound or open area that a treatment needs to be in place Administrator spoke with the guest regarding the situation and the guest told him he burned it with coffee from the bistro Spoke with guest on how it happened and guest stated he took the lid off of the coffee and it spilled and asked why he takes the lid off and he stated that he drinks it fast and the top doesn't allow for him to drink it quickly Guest made an agreement that he would leave the lid on if he is getting hot drinks until he decides if he wants the tumbler or not and the guest agreed Further review of the investigation file revealed the following one to one Education provided to Nurse B by the DON on 3/17/25 regarding the deficiency. 1:1 Education-Injury of Unknown Origin is an injury that as not observed and could not be easily explained by resident and the injury is suspicious do <sic> the severity, location, or the number of injuries at once or over time. Ensure that Abuse coordinator is notified immediately A treatment order needs to be (in)place for all new wounds that are observed . (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/15/25 at approximately 2:37 p.m., the DON was queried regarding the investigation of R902's thermal burn on their left thigh and reported that they had to provide education to Nurse B due to them identifying the burn on 3/8/25 and not notifying them or the Administrator regarding it. The DON indicated that Nurse B should have implemented a Physician's order into the EMR and documented that it had been completed but they did not. The DON reported that when they interviewed Nurse B regarding the identification of the burn, Nurse B reported they place an abdominal pad on it but did not document that either or the completion of the identified treatment in the record. The DON reported that they have been reviewing Nurse B's documentation since they provided the education on 3/17/25 and have not had any further instances of them not documenting treatments or implementing Physician orders or notifying administration of new injuries of unknown origin. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included education to the identified Nurse (Nurse B) and ongoing monitoring of Nurse B's documentation of treatments. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.