

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  06/05/2024
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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>34208</p> <p>This citation pertains to intake #MI00141722</p> <p>Based on observation, interview, and record review, the facility failed to ensure treatment in a dignified manner for three residents (R#'s 54, 72, and 235) of four residents reviewed for dignity, resulting in the potential for feelings of embarrassment. Findings include:</p> <p>A complaint was received by the State Agency that alleged residents were not being treated in a dignified manner.</p> <p>A review of a facility provided policy titled, Quality of Life-Accommodation of Needs was reviewed and read, Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving independent functioning, dignity, and well-being .</p> <p>R54</p> <p>On 6/3/24 at 9:56 AM, R54 was observed in their bed. At that time, they were asked about various aspects of their stay in the facility and said some staff, Are not respectful. R54 said staff argue and are rude to one another. R54 continued to say the facility was their home but, staff make them feel like, you are in their facility, not home.</p> <p>R72</p> <p>On 6/3/24 at 1:24 PM, a review of R72's progress notes was conducted and revealed the following note entered into the record by Nurse 'B' on 4/23/24 that read, .resident was yelling and calling out at the beginning of shift. writer went to check on resident and found resident laying in bed c/o (complaints of) not being able to see still and that sh*t &lt;sic&gt; needed to used the restroom. writer attempted to remind resident that she uses a brief, resident became upset and stated how much she hated being incontinent, then starts crying about how she's ready to 'just pass' .</p> <p>On 6/4/24 at 2:55 PM R72 was observed in their bed. At that time, an interview was conducted with R72 and they were asked if staff ever directed them to urinate or have a bowel movement in their incontinence brief. R72 said I have been told that, I am not buying into it. R72 was asked if they can feel the sensation of when they need to use the bathroom and said, Occasionally.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R235</p> <p>On 6/3/24 at 10:23 AM, R235 was observed being transferred via wheelchair to their room by Certified Nursing Assistant (CNA) 'A'. When they arrived to their room, CNA 'A' did not close the room door and could very loudly be heard from the hallway giving R235 instructions saying, I need you to sit down on the toilet so I can change that brief.</p> <p>On 6/5/24 at 9:20 AM, an interview was conducted with the facility's Director of Nursing (DON) regarding resident dignity. They said it was inappropriate for staff to be overheard from the hallway giving instructions about bathroom use and staff should never tell a resident to use their incontinence brief.</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30675</p> <p>This citation pertains to intake #s: MI00140148, MI00141564, MI00141722, and MI00143733.</p> <p>Based on observation, interview, and record review, the facility failed to ensure call lights were within reach and answered promptly for three residents (R14, R60, and R72) reviewed for accommodation of needs, and two of five residents that attended the confidential resident council meeting.</p> <p>Findings include:</p> <p>Review of multiple complaints reported to the State Agency included allegations that call lights were not placed within reach, and call lights were not answered timely (beyond half an hour and longer).</p> <p>On 6/3/24 at 10:25 AM, observation of the facility's call light monitor screen included a split screen in which the top portion showed the rooms that were activated and not yet responded to, and a lower portion that showed call lights that had been activated but were answered (turned off). The room occupied by R14 on the top portion of the screen identified it had been activated at 9:42 AM and was still active (not responded to).</p> <p>Review of the previous six months of resident council minutes identified a concern with call lights during the 2/7/24 meeting which read, .Nursing - call lights need improvement .</p> <p>Review of the Resident Council Departmental Response Form dated 2/7/24 further documented, .Nursing . Issue(s) Identified by Resident Council Per Resident Council call light times needs some improvement . Explanation and/or Response/Actions Taken by Department to Resolve Issue(s) Identified New staff coming in creating 2 hr schedule to monitor call lights. This form was signed by the Director of Nursing (DON) and Former Administrator (Staff 'J') on 2/7/24.</p> <p>On 6/4/24 at 8:20 AM, while reviewing the call light monitor screen between the 300 and 400 hallways, the [NAME] President of Clinical Services (Staff 'L') inquired if there were any questions about the observation of the call light monitor. Staff 'L' reported the facility's call light responses have been better and had reviewed the past resident council minutes and had not been aware of any concerns with call light responses. They reported their average response times were between 10-12 minutes and they were working on encouraging staff to make sure they have pagers on them and the nurses have their portable phones. Staff 'L' further reported the Director of Nursing and Administrator also has portable phones and they get notified if call lights are prolonged. When asked if they could print call light reports for a specific room and they reported they thought they could but would have to figure out how to access.</p> <p>On 6/4/24 at 10:00 AM, a confidential resident council meeting was conducted with five residents, most of whom attend meetings regularly. When asked about whether there were any current concerns with staff's response to call lights, two of the five residents expressed concern. Their responses included:</p> <p>Sometimes we've waited an hour or hour and half while they help with someone else.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Sometimes it's a long time, but only when short on staff. Weekends they were short.</p> <p>On 6/4/23 at 12:36 PM and 6/5/24 at 10:23 AM, the Administrator was requested to provide the call light for several rooms on several dates, including the room occupied by R14 from 6/3/24. Review of the documentation provided revealed there was no documentation of R14's room of any call light activations on 6/3/24.</p> <p>On 6/5/23 at approximately 12:45 PM, the Administrator reported they were unable to print the call light report but would take a picture of the screen from their monitor and provide that for review.</p> <p>On 6/5/23 at 12:55 PM, Staff 'L' was asked about the call light report for R14's room and why the documentation provided revealed no call light activations despite actual observation of that on 6/3/24, they reported they were able to find that and put into the electronic system for review.</p> <p>Review of the documentation now revealed R14's the call light was activated on 6/3/24 at 9:42 AM, and was cleared at 10:26 AM. There were no other call-light activations documented or provided for the remainder of 6/3/24.</p> <p>34208</p> <p>R72</p> <p>On 6/3/24 at 9:31 AM, R72 was observed lying in their bed. They verbalized they were uncomfortable and activated their call light for assistance.</p> <p>On 6/3/24 at 9:41 AM, an observation from the hallway was made. At that time Staff Member 'T' peeked into R72's room from the hallway but did not enter the room. Staff Member 'T' was then observed to proceed up the hallway and enter another room. Staff Member 'T' was not observed to address R72, the reason the call light was on, or deactivate the call light. Immediately after Staff Member 'T' entered the second room, an observation of the call light box in R72's room was made and displayed a red light indicating it was still activated.</p> <p>On 6/3/24 at 9:48 AM, Staff Member 'T' exited the room they were assisting in and an interview was conducted about them previously peeking their head in R72's room. They were asked if they were aware the call light was on when they looked in the room and said they did not know. They were asked how staff were aware of an activated call light and said they carried pagers. They were asked if they attended to R72's request and said they did not previously, but would go and check on them.</p> <p>38271</p> <p>R60</p> <p>On 6/4/24 at approximately 8:37 a.m., and again at 12:57 p.m., R60 was observed in their room, laying in their bed. R60's call light button was observed on the floor, out of reach of the resident The call light button was observed in the same spot and position during both observations.</p> <p>(continued on next page)</p>		

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/5/24 at approximately 8:54 a.m., 10:08 a.m., 11:16 a.m., and at 11:30 a.m., R60 was observed in their room, laying in their bed. R60's call light was observed on the floor out of reach of the resident. R60's call light button was in the same spot and position during all the observations. The DON (Director of Nursing) was shown R60's call light button that was out of reach during the 11:30 a.m., observation and reported that it should have been within her reach and that R60 needed a clip for their call button to hold it in place. The DON reported they would look to find a clip and that staff should be looking for the call light to ensure it is within the residents reach.</p> <p>On 6/3/24 the medical record for R60 was reviewed and revealed the following: R60 was initially admitted to the facility on [DATE] and had diagnoses including Anxiety disorder and Chronic obstructive pulmonary disease. A review of R60's MDS (minimum data set) with an ARD (assessment reference date) of 5/5/24 revealed R60 needed assistance from facility staff with most of their activities of daily living.</p> <p>On 6/5/24 a facility document pertaining to answering the residents call light was reviewed and revealed the following: Purpose-The purpose of this procedure is to respond to the resident's requests and needs. 1. Explain the call light to the new resident. 2. Demonstrate the use of the call light. 3. Ask the resident to return the demonstration so that you will be sure that the resident can operate the system) (Note: Explain to the resident that a call system is also located in his/her bathroom. Demonstrate how it works. ) 4. Be sure that the call light is plugged in at all times. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. 6. Some residents may not be able to use their call light. Be sure you check these residents frequently. 7. Report all defective call lights to the nurse supervisor promptly. 8. Answer the resident's call as soon as possible. 9. Be courteous in answering the resident's call .</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39592</p> <p>Based on observation, interview and record review, the facility failed to ensure a Resident's personal preferences for care was honored for one (R53) of one resident reviewed for self-determination/choices. Findings include:</p> <p>On 6/3/24 at 9:31 AM, R53 was observed lying in bed. R53 was asked about care at the facility. R53 explained they were scheduled to get showers on Tuesday and Friday afternoons. They had asked to have them in the mornings, but had been told they could not be moved to mornings because the day shift nurse aids were too busy.</p> <p>Review of the clinical record revealed R53 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: chronic obstructive pulmonary disease, heart failure and paraplegia. According to the Minimum Data Set (MDS) assessment dated [DATE], R53 was cognitively intact and required the assistance of staff for activities of daily living (ADL's).</p> <p>On 6/4/24 at 11:01 AM, R53 was observed lying in bed. R53 was asked about their indwelling urinary catheter. R53 explained the indwelling catheter was changed once a month on the midnight shift, but did not want it done at night, they would prefer to have it done during the day.</p> <p>On 6/5/24 at 9:00 AM, the Director of Nursing (DON) was interviewed and asked about R53's shower and indwelling catheter preferences. The DON explained R53 wanted to be switched to have their showers on the day shift, but the day shift is full and the Certified Nursing Assistants (CNA's) can not take on another shower, so R53 has to stay on the afternoon shift.</p> <p>Review of a facility Resident Rights Handbook, undated, read in part, .Self-Determination and Participation: The resident has the right to- (1) choose activities, schedules, and health care consistent with his or her interests .</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47283</p> <p>This citation pertains to intake #MI00141722, and MI00142873.</p> <p>Based on interview and record review facility failed to follow-up and resolve a grievance promptly for one (385) of two Residents reviewed for grievances resulting in feelings of frustration.</p> <p>Findings include:</p> <p>R385</p> <p>A record review revealed R385 was a former resident of the facility and they were originally admitted on [DATE]. R385's admitting diagnoses included Parkinson's, neuropathy, depressive disorder, anxiety disorder and muscle weakness. R385 was discharged home with their family with 24-hour care. Based on the most recent Minimum Data Set (MDS) assessment, R385 had a Brief Interview for Mental Status of 15/15, indicative of intact cognition.</p> <p>A complaint received by the State Agency revealed that R385 did not receive their showers/baths for several days despite the requests from the Resident and the family members. The compliant read in part, (R385 - Pronoun omitted) had gone couple of weeks without being showered the concerns have already been reported .after several complaints .</p> <p>Review of R385's Electronic Medical Record (EMR) reveled that R385 was at risk for falls related to their diagnosis and they needed staff assistance with their activities of daily living such as dressing, baths/showers, toileting, and personal hygiene. R385 had back surgery prior to admission to the facility and surgery for hearing impairment during their stay at the facility.</p> <p>A request was sent via e-mail to the facility Administrator on 6/4/24 at 1:50 PM to provide all grievances and follow-up for R385 between 1/1/24 to 4/23/24. The facility Administrator had reported that they did not have any documentation of the grievances for R385.</p> <p>An interview with the Complainant was completed on 6/4/24 at approximately 4:25 PM. During the interview, the Complainant had confirmed that resident and their family had addressed their concerns with showers and other care issues to facility leadership (who were no longer at the facility) on multiple occasions.</p> <p>An interview was completed with the Director of Care Transitions T on 6/5/24, at approximately 10:05 AM. During the interview they were queried about the facility's grievance process. They reported that if a resident/family brought any grievances to their attention they would follow the document and follow the facility's grievance process. The grievance follow up was completed by the department head and the Administrator.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was completed with the Director of Nursing (DON) on 6/5/24, at approximately 9:15 AM. The DON was queried about the facility's grievance process. The DON reported that if any concerns were brought to their attention they would document and follow the facility's grievance process. The DON was queried if they could recall any grievances that were brought to their attention. The DON reported they were not aware of any grievances that were brought to their attention and added that (former) Assistant Director of Nursing (ADON) was handling the grievances from the residents/resident representatives and following up. When reported the concern, the ADON reported that they understood the concern.</p> <p>An interview was completed with the facility Administrator on 6/5/24, at approximately 10:20 AM. The Administrator was queried about the facility's grievance process. They reported that if a grievance was brought by a resident/family member to any staff member's attention they would initiate a grievance form and follow-up within 24 hours typically. The Administrator was queried further on any grievances that had come up on after hours and weekends. They reported that they had weekend managers onsite who would follow up on any grievances that were brought to their attention.</p> <p>A review of the facility's provided document titled, Resident Concerns Policy with a revision date of 11/14/23, read in part, Instructions for requesting Assistance from Staff. We are committed to providing the highest quality of care to residents in our center. In order for us to assist you, please follow the procedure identified below if you have any complaint/ grievance about your care, treatment by staff or anything else related to your stay in our center.</p> <p>FORM: RESIDENTS ASSISTANCE FORM PROCEDURES:</p> <p>Step 1. Tell your grievance(s) to one of the individuals listed below:</p> <p>Director of Nursing</p> <p>Administrator (Grievance Official)</p> <p>Social Service Director</p> <p>Charge Nurse (if after hours)</p> <p>Step 2. If you are not satisfied with the staff person's response please complete our Resident's Assistance Form/Grievance Form.</p> <p>Let us know if you need help in completing the form.</p> <p>Step 3. Submit the form to our Administrator or Director of Nursing.</p> <p>Step 4. If you are not satisfied with the center's written response, complete a request for the administrator to review the investigation findings.</p> <p>(continued on next page)</p>		

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F 0585  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Step 5. If you are not satisfied with the Administrator's resolution; you may contact the State Ombudsman or the Michigan Department Licensing and Regulatory Affairs to file a formal complaint .		

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<p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide doctor's orders for the resident's immediate care at the time the resident was admitted.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38271</p> <p>This citation pertains to intake(s): MI00140148</p> <p>Based on interview and record review the facility failed to timely and accurately transcribe Physician orders for admission medications for one resident (R387) of one residents reviewed for admissions. Findings include:</p> <p>On 6/3/24 a concern submitted to the State Agency was reviewed which indicated R387 was not provided their medications in a timely manner including their anticoagulant and antirejection medications used for their lung transplant.</p> <p>On 06/04/24 the medical record for R387 was reviewed and revealed the following: R387 was initially admitted to the facility on [DATE] and had diagnoses including Lung transplant status, and idiopathic pulmonary fibrosis. A review of R387's MDS (minimum data set) with an ARD (assessment reference date) of 9/25/24 indicated that R387 required assistance from facility staff with most of their activities of daily living.</p> <p>A Nursing progress note dated 9/21/23 revealed the following: Resident arrived from [local hospital] via personal vehicle with wife at 1900 (7:00 PM.). Resident vitals within normal limits ., no s/s (signs/symptoms) of respiratory distress and no complaints of pain at this time. Pt (patient) orientated of room and call light. MD (medical doctor) aware of arrival .</p> <p>A review of R387's discharge summary from the hospital revealed the following Discharge Medication List: New medications-Start taking as prescribed: Acetaminophen 500 mg (milligrams) tablet-1000 mg, Oral, every 8 hours .bupropion 300 mg, oral, once daily .Oxycodone 5 mg tablet-5 mg, oral every 4 hours PRN (as needed) .Modified Medications: tacrolimus 1 mg capsule-2 mg QAM (every morning), 2 mg QPM (every evening) .Home Medications: Continue taking as previously prescribed: acetylcysteine 200mg/ml-3ml, nebulization 2 times daily . albuterol 2.5mg/3ml neb solution-2.5 mg, Nebulization, every 6 hours PRN . azathioprine 50 mg tablet-50mg oral, at bedtime . calcium carbonate 1250 mg-1250 mg, oral 2 times daily . docusate sodium 100 mg capsule-100 mg oral, once daily .metformin 1000 mg tablet-1000 mg, oral, 2 times daily .omeprazole 20 mg delayed release capsule-20 mg oral, daily .prednisone 5mg tablet-5 mg, oral every morning sulfamethoxazole-trimethoprim 400-80 mg-1 tablet, oral, three times weekly (M,W,F) .tadalafil 5 mg tablet .warfarin 2.5 mg tablet-Take 3 tablets by mouth daily or as directed by Michigan medicine anticoagulation service .</p> <p>A review of R387's September 2023 MAR (medication administration record) revealed R387 did not receive any medication on 9/22/23 with the exception of their calcium carbonate (2100 dose), metformin (2100 dose), and their acetaminophen (2100 dose).</p> <p>A review of R387's medication order summary revealed the only medications that had a Start date (date of first administration) on 9/22/23 were their oxycodone, metformin, albuterol sulfate inhalation solution, azathioprine 50mg and acetaminohen. The following medications had a start date of 9/23/23: Omeprazole, bupropion HCl ER, Docusil Oral Capsule, Prednisone, tadalafil and Warfarin.</p> <p>(continued on next page)</p>		

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<p>F 0635</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/4/24 at approximately 2:04 p.m., during a conversation with the Director of Nursing (DON), the DON was queried why R387 did not receive the majority of their medications until 9/23/23 (2 days after admission) and they indicated that the Nurse who admitted R387 did not put in any orders for medication and they were not transcribed appropriately. The DON indicated they had a second Nurse put in the medication orders on 9/22/23 after they caught the problem but the second Nurse still did not transcribe R387's tacrolimus 1 mg capsule (anti-rejection medication) so the DON reported the facility started a PNC (past non-compliance action plan) for the issue and that they had disciplined both of the Nurses for failing to transcribe R387's medications correctly. The DON indicated they began auditing all new admissions for transcription accuracy and that their compliance date for their plan was 10/2/23.</p> <p>On 6/5/24 a facility document titled Reconciliation of Medications on Admission was reviewed and revealed the following: Purpose: The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosage upon admission or readmission to the facility . General Guidelines-2. Medication reconciliation reduces medications errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process .</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47283</b></p> <p>This citation pertains to intake #MI00141722, MI00142873, MI00140148, MI00140897</p> <p>Based on observation, interview, and record review, the facility failed to ensure activity of daily living care including personal hygiene, bathing/showers, facial hair care, and dressing for eight residents, (R#'s 385, 391, 2, 39, 54, 238, 49, and 71) of 12 residents reviewed for activity of daily living (ADL) care, resulting in verbalized complaints, frustration, and embarrassment from poor personal hygiene. Findings include:</p> <p>A complaint was made with the State Agency that alleged residents were not receiving ADL care.</p> <p>R385</p> <p>A review of the medical record and face sheet revealed that R385 was a former resident of the facility and they were originally admitted on [DATE]. R385's admitting diagnoses included Parkinson's, neuropathy, depressive disorder, anxiety disorder and muscle weakness. R385 was discharged home with their family with 24-hour care on 4/23/24. Based on the most recent Minimum Data Set (MDS) assessment, R385 had a Brief Interview for Mental Status score of 15/15, indicative of intact cognition.</p> <p>Review of a complaint received by the State Agency revealed that R385 did not receive their showers/baths for several days despite multiple requests from the Resident and the family members. The compliant read in part, (R385 - Pronoun omitted) had gone couple of weeks without being showered the concerns have already been reported .after several complaints, someone washed (R385's name omitted) .</p> <p>Review of R385's Electronic Medical Record (EMR) reveled that R385 was at risk for falls related to their diagnosis and they needed staff assistance with their activities of daily living such as dressing, baths/showers, toileting, and personal hygiene. Review of R385's care record revealed that R385 did not receive any showers or baths from 1/1/24 to 1/16/24 (for 16 days). Further review revealed that R385 received baths/showers on 4 days for the entire month.</p> <p>An interview with the Complainant was completed on 6/4/24 at approximately 4:25 PM. During the interview, the Complainant had confirmed that they had addressed their concerns with showers and other care issues to facility leadership.</p> <p>An interview with CNA Q was completed on 6/4/24 at approximately 11:45 AM. During this interview, CNA Q was queried on how they had documented showers/baths and other ADL care provided for their residents. CNA Q reported that they documented on their EMR system and they had showed the tablet they were documenting on. CNA Q was queried on their process if a resident refused their showers/baths. CNA Q reported that if a resident had refused any showers/baths they were documenting on the EMR and had notified their nurse.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview with the Unit Manager P was completed on 6/4/24 at approximately 9:25 AM. During the interview Unit Manger P was queried how the showers/ADL care documentation was completed by the Certified Nursing Assistants (CNA) and they reported that the CNA's were documenting on their EMRs using the tablets that were mounted on a cart/stand. Unit Manager P had confirmed that they did not use any other forms of documentation.</p> <p>An interview with Director of Nursing (DON) was completed on 6/5/24 at approximately 9:10 AM. The DON was queried about the shower and bathing process. The DON reported that residents typically were scheduled to receive two showers/week and staff were able to provide additional showers as needed. They also reported that bed baths were provided on the days that residents were not scheduled for showers. Staff were documenting on their EMR using their tablets. Unit Managers were monitoring their residents to ensure that staff were meeting their needs. When notified of the concerns, they reported that they understood the concerns.</p> <p>R391</p> <p>A review of the medical record and face sheet revealed R391 was admitted to the facility on [DATE] for a short-term stay to receive skilled nursing and rehabilitation after hospitalization due to a fall at home. R391 had injuries on both of their lower extremities from the fall. R391's admitting diagnoses included fracture of right ankle and left ankle sprain, pneumonia, and chronic pain syndrome. Based on the Minimum Data Set (MDS) assessment dated [DATE], R391 had a Brief Interview for Mental Status (BIMS) score 15/15, indicative of intact cognition.</p> <p>An initial observation was completed on 6/3/24, at approximately 1:05 PM. R391 was sitting in their wheelchair. R391 had a hard cast on their right leg that extended from below the knee to their foot and a Controlled Ankle Motion (CAM) boot on their left leg. An interview was completed during this observation. R391 reported that they had been in the facility for a little over two weeks. R391 reported that they were upset as they did not receive any staff assistance with their showers for several days. When queried further they reported that they had spoken with several staff members and the Unit Manager P. Unit Manager P reported that they were initially notified of one shower schedule when they had asked the staff on their scheduled day, the Resident was given a different schedule. R391 stated I kept getting different days when I asked for one and no one bothered to give me one. R391 added that they received assistance form their occupational therapist for their first shower and they had received a shower that AM (on 6/4/24). R391 was queried about the bed baths and R391 reported that they did not receive the help they needed from the staff timely when they had asked for one. When queried further they reported that they were not allowed to bear weight on their right leg and they needed help with the setup and assistance with baths. R391 reported that their plan was to return home with their daughter.</p> <p>A follow-up observation was completed on 6/4/24 at approximately 9:30 AM. R391 was observed in their bed. When the surveyor asked how they were doing, R391 stated You don't want to know. When queried further R391 reported that they had to wait for assistance to go to the bathroom for long time and they had transferred from bed to wheelchair and the toilet twice that night without any staff assistance. R391 reported that their legs are sore and they had their pain medications in the morning. When queried further they reported that it was later at night, after dinner between 11 PM and 4 AM.</p> <p>Review of R391's EMR revealed a shower/bathing report revealed that R391 received a shower/bath on 5/17/24 and one on 6/3/24. There were no showers/baths for approximately 16 days.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of R391's Kardex (care plan for CNAs) revealed that R391 needed staff assistance with their transfers due to their weight bearing restrictions on their leg and they needed assistance with their baths/showers. Review of R391's most recent physical and occupational therapy progress notes revealed that R391 needed staff assistance with their transfers from bed to wheelchair and from wheelchair to toilet. The progress notes also revealed that R391 needed staff assistance with bathing and toileting.</p> <p>34208</p> <p>R2</p> <p>On 6/3/24 at 11:45 AM, R2 was observed in their bed and appeared to have several days of unshaven facial hair. At that time, an interview was conducted with R2 regarding their preferences for facial hair. They indicated they normally had a clean shaven face. They were asked if anyone in the facility offered assistance to remove their facial hair and said, No. They went on to say their daughter usually took care of it, but hadn't in quite some time.</p> <p>On 6/4/24 at 8:47 AM, R2 was observed in their bed asleep. R2 remained with several days of unshaven neck and facial hair.</p> <p>On 6/5/24 at 8:51 AM, R2 was observed in their bed eating breakfast. R2 remained with several days of unshaven face and neck hair.</p> <p>A review of R2's clinical record revealed their most recent re-admission to the facility was on 4/3/24 with diagnoses that included: acute respiratory failure, pneumonia, falls, atrial fibrillation and dementia. R2's most recent completed Minimum Data Set assessment dated [DATE] indicated moderately impaired cognition and partial/moderate assist with personal hygiene. R2's care plans were reviewed and an intervention for Activities of Daily Living (ADL's) dated 3/27/24 read, .Assist with dressing, hygiene and toilet needs .</p> <p>R39</p> <p>On 6/3/24 at 9:23 AM, R39 was observed in their bed dressed in a green dress, it appeared eggs had been spilled down the front of the garment. R39 was also observed to have several long hairs on their face/chin. At that time, R39 was asked about various aspects about their stay in the facility and said staff had not assisted them with changing their clothing in two days. They were asked how often they were not assisted to change their clothing and said it happened at least twice a week. R39 was asked if they had extra clothing and offered the observation of their closet and drawers that revealed numerous articles of clothing. R39 was also asked about the hair on their chin and said the were unaware of the hair and would want it removed.</p> <p>On 6/5/24 at 8:45 AM, R39 was observed in bed watching television, long facial hairs remained on R39's chin.</p> <p>A review of R39's clinical record revealed they admitted to he facility on 8/14/23 with diagnoses that included: heart attack, protein calorie malnutrition, and high blood pressure. R39's MDS assessment dated [DATE] indicated they had intact cognition, required substantial/maximal assist for shower/bathing, and set-up assist with hygiene.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of R39' CNA task documentation for showers/bathing was conducted and revealed the following:</p> <p>March 2024-No documented shower/bathing given from 3/1/24 thru 3/26/24.</p> <p>April 2024-No documented shower/bathing given from 4/4/24 thru 4/30/24. There were no documented refusals and nursing progress notes did not indicate R39 refused any shower/bathing for the month of April.</p> <p>May 2024-One documented incidence of shower/bathing from 5/1/24 thru 5/18/24. There were no documented refusals and nursing progress notes did not indicate R39 refused any shower/bathing for the month of May.</p> <p>A review of R39's care plans was conducted and an interventions for ADL's dated 8/14/23 that read, .Assist pt (patient) with showers/bed baths .Assist with dressing, hygiene, and toilet needs .</p> <p>R54</p> <p>On 6/3/24 at 9:56 AM, R54 was observed in their room. R54 appeared with several days/weeks of facial/neck hair growth. At that time an interview was conducted with R54. They were asked about various aspects of their life in the facility including whether they were provided regular showers. They said they were not.</p> <p>6/3/24 at 3:58 PM, a follow-up interview was conducted with R54 regarding their facial hair. They were asked if they preferred a moustache/beard and said they would like to have their facial hair groomed soon. They were asked the last time they were assisted with shaving and said it was the last time they got their hair cut. They further said they didn't need a hair cut at this time, but would still like their facial hair groomed.</p> <p>On 6/4/24 at 8:44 AM, R54 was in bed, watching television. At that time, R54 remained with long, unshaven facial hair.</p> <p>A review of R54's clinical record revealed they admitted to the facility on [DATE] with diagnoses that included: stroke, hemiplegia, dysphagia, cellulitis falls, adjustment disorder and psychotic disorder with delusions. R52's most recently completed MDS assessment dated [DATE] indicated they had moderately impaired cognition, and required substantial/maximal assistance with showering, bathing, and hygiene.</p> <p>A review of R52's Certified Nursing Aide (CNA) task documentation for showers/bathing was conducted and revealed the following:</p> <p>March 2024-No documented showers/bathing provided from 3/2/24 thru 3/18/24, and no documented shower/bathing after 3/19/24. There were no documented refusals and nursing progress notes did not indicate R54 refused any shower/bathing in the month of March.</p> <p>April 2024-No documented shower/bathing given from 4/16/24 thru 4/30/24. There were no documented refusals and nursing progress notes did not indicate R54 refused and shower/bathing for the month of April.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>May 2024 thru June 2024-No documented shower/bathing given 5/4/24 thru 5/17/24, and no documented shower/bathing from 5/25/24 thru 6/3/24. There were no documented refusals and nursing progress notes did not indicate R54 refused any shower/bathing for the months of May or June.</p> <p>A review of R54's care plans was conducted and an interventions for ADL's dated 2/22/24 read, .Assist pt (patient) with showers/bed baths .Assist with dressing, hygiene, and toilet needs .</p> <p>R238</p> <p>On 6/3/24 at 4:00 PM, R238 was observed in their room, seated in a chair visiting with their family. R238 was observed to be wearing red and blue, tiger stripe print, cotton lounge pants. At that time, an interview was conducted with R238's family about their family member's stay in the facility. They reported their only complaint was R238's was not having their clothing changed regularly. They said every time they visited R238 was wearing the same pants (the red/blue tiger striped lounge pants) and they had assisted their family to change their shirt three times. They said they were aware R238 had refused showers, but believed they would not refuse to have their clothing changed with some assistance.</p> <p>On 6/4/24 at 8:49 AM, R238 was observed receiving therapy in the gym. At that time, R238 was observed to be wearing the same red/blue tiger stripe printed lounge pants.</p> <p>38271</p> <p>R49</p> <p>On 6/03/24 at approximately 9:58 am., R49 was observed in their room, laying in their bed. R49 was queried if they had any concerns regarding their care and they reported the facility is short staffed. R49 was queried why they believed the facility was short of staff and they reported that the CNA's (Certified Nursing Assistants) come in and tell them they cannot give them any bed baths because there was not enough help. R49 reported they only get one bed bath a week due to short staffing.</p> <p>On 6/4/24 at approximately 11:06 a.m., R49 was observed in their room, laying in their bed. R49 was queried if anyone had offered to bathe them the previous night and they reported nobody had. R49 reported again estimated they have only been proved three bed baths in last month. R49 reported that nobody was around to help and they were supposed to get bathed twice a week.</p> <p>On 6/5/24 at approximately 9:00 a.m., R49 was observed in their room, laying in their bed. R49 was queried if anyone had offered to bath them on the previous day (6/4) and they reported nobody had. R49 was informed that documentation was in the medical record that they had a shower the previous day and they indicated that was not true and nobody had offered to bath them.</p> <p>The medical record for R49 was reviewed and revealed the following: R49 was initially admitted to the facility on [DATE] and had diagnoses including Morbid obesity and Muscle weakness. A review of R49's MDS (minimum data set) with an ARD (assessment reference date) of 4/14/24 revealed R49 needed assistance from facility staff with most of their activities of daily living. R49's BIMS score (brief interview for mental status) was 14 indicating intact cognition.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of R49's comprehensive careplan revealed the following: Focus-Potential/Actual ADL/Mobility deficit R/T (related to) Wound infection, Chronic lymphedema, HX (history) PE (Pulmonary embolism) , restless Leg Syndrome, HTN (Hypertension), HLD (Hyperlipidemia), Osteoarthritis, Glaucoma, DM (Diabetes Mellitus) and Morbid Obesity, Rt (right) ankle fracture Date Initiated: 01/02/2024 .Interventions-Assist the pt (patient) with showers/bed baths Date Initiated: 01/02/2024 .</p> <p>A review of R49's CNA bathing documentation for the previous 30 days was reviewed and revealed R49 was documented as being bathed only on 5/21, 5/24 and 6/4. Further review of the record revealed no documented episodes of refusals.</p> <p>On 6/5/24 at approximately 11:23 a.m., during a conversation with the Director of Nursing (DON), the DON was queried regarding the lack of bathing documentation in the record for R49. The DON was then observed reviewing the record and indicated they agreed that R49 had only three instances of bathing in the previous 30 days. At that time, the DON was queried if they had identified problems getting residents bathed and they indicated that they had and that they had recently hired a new Nurse Manager who was going to assist in making sure bathing was being provided.</p> <p>39592</p> <p>R71</p> <p>On 6/3/24 at 12:10 PM, R71 was observed sitting in a wheelchair in their room. R71's Legal Guardian was also sitting in R71's room. Both R71 and R71's Guardian were asked about the care in the facility. R71's Guardian explained that there were six hours a day, in two hour blocks of time, at breakfast, lunch and dinner, where there was no staff available for ADL care due to the CNA's having to carry trays one by one from the kitchen to the rooms, then having to pick up all the trays when the meal was over to take back to the kitchen. R71's Guardian also explained they had to make sure R71's brief was changed before mealtimes, or R71 would have to sit in soiled briefs until after all the trays were picked up after the meal service.</p> <p>On 6/3/24 at approximately 12:25 PM, observation of the kitchen/dining room revealed staff standing in a line. As a tray was assembled for a resident's lunch, a staff member would take the tray and walk with it to a resident's room, then walk back to stand in line until they received another tray. The only staff in the hallways were delivering trays.</p> <p>On 6/5/24 at 11:50 AM, R71's Guardian explained when they came to see R71 in the morning on 6/1/24, both R71 and the bed were completely wet, they were informed that several other residents on the same hall were in a similar condition.</p> <p>Review of a facility policy titled, Assisting the Nurse in Examining and Assessing the Resident revised 10/2010 read in part, .Activities of daily living (ADL) include the resident's physical, psychological, social and spiritual activities . As you provide the resident with personal care needs, you should note: a. The type of bath the resident likes (i.e., tub, shower, etc.); b. Assistance needed with bathing, hair and nail care, dressing and undressing, mouth care . As you provide the resident with personal toileting needs, you should note: a. Assistance needed with going to the bathroom; and b. Any changes in the resident's toileting habits .</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38271</p> <p>Based on observation, interview and record review the facility failed to ensure a splint was applied per Physicians order for one resident (R26) of two residents reviewed for range of motion. Findings include:</p> <p>On 6/03/24 at approximately 9:20 a.m., R26 was observed in their room, up in their bed. R26 was observed to not have use of their right arm. No splinting device was observed applied to it. A resting hand splint was observed on their dresser. R26 was queried if any staff help offer to apply the splint and they shook their head no and indicated that staff do not offer to put it on.</p> <p>On 6/4/24 at approximately 8:42 a.m., R26 was observed on their room, laying in their bed. R26 was queried if anyone had offered to apply their resting hand splint on their right arm/hand and they indicated that nobody had the previous night. R26's splint was still observed in the same spot and position as the observation on 6/3/24.</p> <p>On 6/4/24 the medical record for R26 was reviewed and revealed the following: R26 was initially admitted to the facility on [DATE] and had diagnoses including Hemiplegia and Hemiparisis following cerebral infarction affecting right dominant side. A review of R26's MDS (minimum data set) with an ARD (assessment reference date) of 4/30/24 revealed R26 had upper extremity impairment on one side. R26's BIMS score (brief interview for mental status) was 13 indicating intact cognition.</p> <p>A Physicians order dated 12/22/23 revealed the following: Right resting hand splint donned (applied) during nighttime hours for contracture prevention. Further review of the order did not reveal any schedule/frequency or duration was observed attached with the order.</p> <p>A review of R26's comprehensive careplan revealed the following: Focus-Alteration/at risk for musculoskeletal problems r/t (related to) Arthritis, contracture RUE (right upper extremity) and R (right) foot drop, Joint replacement b/l (bilateral) hips Date Initiated: 05/04/2023 .Interventions-Assist the resident with the use of supportive devices (Specify: splints, braces, canes, crutches etc.) as recommended. Date Initiated: 05/04/2023 .</p> <p>A review of R26's May and June 2024 TAR (treatment/medication administration records) did not reveal any documentation that R26's resting hand splint had been applied per the Physician's order.</p> <p>On 6/5/24 at approximately 11:23 a.m., during a conversation with the Director of Nursing (DON), R26's record was reviewed for documentation that R26's resting hand splint had been applied and the DON reported that there was not documentation because the Nurse who entered the order for the splint entered it into the record wrong and they did not enter a schedule for the splint so it would not pop up on the screen to be applied. The DON indicated that Nurse is the one responsible for the application of the splint and they would have to correct the the splint order so the Nursing staff would know to apply it.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39592</p> <p>Based on observation, interview and record review, the facility failed to follow physician orders and ensure accurate documentation of an indwelling urinary catheter for one (R53) of two residents reviewed for urinary catheters. Findings include:</p> <p>On 6/4/24 at 11:01 AM, R53 was observed lying in bed, a urinary catheter bag was observed hanging from the bed. R53 was asked if she had any problems with the urinary catheter. R53 explained the indwelling catheter was supposed to be changed monthly, but it had been one month and four days since it had been changed. R53 then clarified, that it was not just four days overdue, but a month and four days since it had been changed.</p> <p>Review of the clinical record revealed R53 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: chronic obstructive pulmonary disease, heart failure and paraplegia. According to the Minimum Data Set (MDS) assessment dated [DATE], R53 was cognitively intact and required the assistance of staff for activities of daily living (ADL's).</p> <p>Review of R53's May 2024 Medication Administration Record (MAR) revealed a physician order with a start date of 11/30/24 for, Replace Indwelling Foley Catheter at bedtime starting on the last day of month and ending on the last day of month every month. The MAR had been marked off as completed by Licensed Practical Nurse (LPN) I on 5/31/24.</p> <p>On 6/5/24 at 8:09 AM, LPN I was interviewed by phone and asked if she had changed R53's indwelling catheter on 5/31/24. LPN I explained she had tried to change the catheter, but R53 had not wanted their catheter changed on the midnight shift, they wanted it done on the day shift, so she did not change it and had told them (the facility) to change the time to the day shift. When asked why the MAR had been marked as completed, LPN I had no explanation.</p> <p>On 6/5/24 at 9:00 AM, the Director of Nursing (DON) was interviewed and asked if the MAR should be marked as completed before the task was done, or if the resident refused. The DON explained nothing should be documented until after it is done, and if the resident refused something, the refusal should be documented. The DON was informed that R53's indwelling catheter had not been changed, but it was marked as completed on 5/31/24. The DON explained that since the MAR had been marked as done, she had not known it had not actually been done.</p> <p>Review of a facility Job Description for a License Practical Nurse (LPN) revised 8/12/15 read in part, . Providing car to resident by performing a variety of treatments, including . performing Foley Catheterizations . Accurately record resident observations in clinical records .</p>		

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  06/05/2024
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.			
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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>39592</p> <p>Based on observation, interview and record review, the facility failed to ensure a medication error rate less than five percent when six medication errors out of 27 opportunities for error were observed for three (R44, R43 and R68) out of five residents reviewed during the medication administration observation, resulting in a 22.22% error rate. Findings include:</p> <p>Review of a facility policy titled, Medication Administration dated 1/2021 read in part, .Medications are administered as prescribed in accordance with manufacturers' specifications . Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record (MAR). Compare the medication and dosage schedule on the resident's MAR with the medication label. If the label and MAR are different, . the prescriber's orders are checked for the correct dosage schedule .</p> <p>On 6/4/24 at 8:01 AM, Licensed Practical Nurse (LPN) C was observed as part of the medication pass task. LPN C was observed to place a needle on a NovoLog FlexPen, turn the dial to 14 and inject the Insulin into R44's arm. LPN C was then observed to prepared seven oral medications, including Docusate Sodium 250 mg (milligrams). LPN C administered all seven medications to R44. After exiting R44's room, LPN C was asked about the lack of priming of the NovoLog FlexPen. LPN C explained she had been taught that priming was not needed for Insulin pens.</p> <p>On 6/4/24 at 8:52 AM, LPN E was observed to prepare seven medications, including one Super Omega-3 1200 mg, one Vitamin B Complex with B-12 and one Senna Plus 50mg/8.6mg. LPN E took a Vitamin D3 5000 IU (international units) or 125 mcg (micrograms) bottle out of R43's medication cabinet, and attempted to place a tablet into the medication cup however, the bottle was empty. LPN E then took a bottle of Magnesium out of the cabinet and explained it was not the correct dosage so she did not give the Magnesium into the medication cup. LPN E explained R43's family member brought the supplements for R43 as they did not want R43 to get the facility's stock medications. LPN E was then observed to administer the medications to R43.</p> <p>On 6/4/24 at 9:08 AM, LPN F was observed to prepare five medications, including a Multivitamin tablet. LPN F was then observed to administer all the medications to R68.</p> <p>On 6/4/24 at 9:46, R44's physician orders were compared to the medications observed to have been given. The reconciliation revealed R44 had an order for Docusate Sodium 100 mg. It should be noted R44 received Docusate Sodium 250 mg.</p> <p>On 6/4/24 at 9:51 AM, R43's physician orders were compared to the medications observed to have been given. The reconciliation revealed R43 had an order for Omega-3 1200 mg, two capsules, Vitamin B Complex two capsules and Senna 8.6 mg. R43 received only one capsule each of the Omega-3 1200 mg and Vitamin B Complex, and had received Senna Plus (also containing Docusate Sodium) 50mg/8.6mg. The physician order for Vitamin D3 was for 1000 IU or 25 mcg, the bottle in the cabinet was 5000 IU or 125 mcg. It was also noted that the order for Magnesium 400 mg two capsules was marked off as given on R43's Medication Administration Record (MAR) when it was observed LPN E did not administer any Magnesium.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/4/24 at 10:00 AM, R68's physician orders were compared to the medications observed to have been given. The reconciliation revealed R68 had an order for Multivitamins with minerals ordered. It should be noted R68 received a Multivitamin with no added minerals.</p> <p>On 6/5/24 at 9:00 AM, the Director of Nursing (DON) was interviewed and asked if Insulin pens should be primed before every use. The DON explained an airshot (priming) should be done before every use. When informed of the dosage errors observed, the DON had no explanation. The DON was asked if a medication should be marked off as given if it was not given. The DON explained nothing should be marked off as given or done until after it was given or done.</p> <p>Review of the Manufacture's Instruction For Use for the NovoLog FlexPen revised 4/2015 read in part, . Before each injection small amounts of air may collect in the cartridge during normal use. to avoid injecting air and to ensure proper dosing: E. Turn the dose selector to select 2 units. F. Hold your NovoLog FlexPen with the needle pointing up Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip .</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38271</p> <p>This citation pertains to intake(s): MI00140148</p> <p>Based on interview and record review the facility failed to timely and accurately transcribe and Administer Physician ordered medications including anticoagulant (warfarin) and antirejection medicine (tacrolimus) for one resident (R387) of one residents reviewed for significant medication administration. Findings include:</p> <p>On 6/3/24 a concern submitted to the State Agency was reviewed which indicated R387 was not provided their medications in a timely manner including their anticoagulant and antirejection medications used for their lung transplant.</p> <p>On 06/04/24 the medical record for R387 was reviewed and revealed the following: R387 was initially admitted to the facility on [DATE] and had diagnoses including Lung transplant status, and idiopathic pulmonary fibrosis. A review of R387's MDS (minimum data set) with an ARD (assessment reference date) of 9/25/24 indicated that R387 required assistance from facility staff with most of their activities of daily living.</p> <p>A Nursing progress note dated 9/21/23 revealed the following: Resident arrived from [local hospital] via personal vehicle with wife at 1900 (7:00 PM.). Resident vitals within normal limits ., no s/s (signs/symptoms) of respiratory distress and no complaints of pain at this time. Pt (patient) orientated of room and call light. MD (medical doctor) aware of arrival .</p> <p>A review of R387's discharge summary from the hospital revealed the following Discharge Medication List: Modified Medications: tacrolimus 1 mg capsule-2 mg QAM (every morning), 2 mg QPM (every evening) . Home Medications: Continue taking as previously prescribed: acetylcysteine 200mg/ml-3ml, nebulization 2 times daily . albuterol 2.5mg/3ml neb solution-2.5 mg, Nebulization, every 6 hours PRN .azathioprine 50 mg tablet-50mg oral, at bedtime . calcium carbonate 1250 mg-1250 mg, oral 2 times daily . docusate sodium 100 mg capsule-100 mg oral, once daily .metformin 1000 mg tablet-1000 mg, oral, 2 times daily .omeprazole 20 mg delayed release capsule-20 mg oral, daily .prednisone 5mg tablet-5 mg, oral every morning sulfamethoxazole-trimethoprim 400-80 mg-1 tablet, oral, three times weekly (M,W,F) .tadalafil 5 mg tablet . warfarin 2.5 mg tablet-Take 3 tablets by mouth daily or as directed by Michigan medicine anticoagulation service .</p> <p>A review of R387's September 2023 MAR (medication administration record) revealed R387 did not receive any medication on 9/22/23 with the exception of their calcium carbonate (2100 dose), metformin (2100 dose), and their acetaminophen (2100 dose). No documentation that R387 had received their antirejection medication (tacrolimus) during their stay was observed in the record.</p> <p>A review of R387's medication order summary revealed the only medications that had a Start date (date of first administration) on 9/22/23 were their oxycodone, metformin, albuterol sulfate inhalation solution, azathioprine 50mg and acetaminohen. The following medications had a start date of 9/23/23: Omeprazole, bupropion HCl ER, Docusil Oral Capsule, Prednisone, tadalafil and Warfarin. Further review of the medication order summary revealed R387's Tacrolimus was not present in the medication profile.</p> <p>(continued on next page)</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/4/24 at approximately 2:04 p.m., during a conversation with the Director of Nursing (DON), the DON was queried why R387 did not receive the majority of their medications until 9/23/23 (2 days after admission) and they indicated that the Nurse who admitted R387 did not put in any orders for medication and they were not transcribed appropriately. The DON indicated they had a second Nurse put in the medication orders on 9/22/23 after they caught the problem but the second Nurse still did not transcribe R387's tacrolimus 1 mg capsule (anti-rejection medication) medication so the DON reported the facility started a PNC (past non-compliance action plan) for the issue and that they had disciplined both of the Nurses for failing to transcribe R387's medications correctly. The DON indicated they began auditing all new admissions for transcription accuracy and that their compliance date for their plan was 10/2/23.</p> <p>On 6/5/24 a facility document titled Reconciliation of Medications on Admission was reviewed and revealed the following: Purpose: The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosage upon admission or readmission to the facility . General Guidelines-2. Medication reconciliation reduces medications errors and enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption, in the correct dosages and routes, during the admission/transfer process .</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 39592</p> <p>Based on observation, interview and record review, the facility failed to ensure medications were appropriately inventoried and stored in one (R53) resident's room. Findings include:</p> <p>On 6/3/24 at 9:31 AM, R53 was observed lying in bed. Four clear storage cubes were observed on R53's over-bed tray table. One of the clear storage cubes was observed to contain several medications including a bottle of Roloids, eye drops, two inhalers and two bottles of medications that were turned on their sides so the labels could not be read. R53 was asked about the medications. R53 explained the inhalers were their medications, but the other medications were their family members medications. When asked why their family member's medications were kept in their room, R53 explained their family member would come by after work and would take the medications then.</p> <p>Review of the clinical record revealed R53 was admitted into the facility on [DATE] and readmitted [DATE] with diagnoses that included: chronic obstructive pulmonary disease, heart failure and paraplegia. According to the Minimum Data Set (MDS) assessment dated [DATE], R53 was cognitively intact and required the assistance of staff for activities of daily living (ADL's).</p> <p>On 6/4/24 at 11:01 AM, the same medications were observed in the same clear storage cube on R53's over-bed tray table.</p> <p>Review of a facility policy titled, Medication Storage dated 1/2021 read in part, .Medication storage conditions are monitored on a regular basis as a random quality assurance (QA) check. As problems are identified, recommendations are made for corrective action to be taken .</p> <p>On 6/4/24 at 2:27 PM, the Director of Nursing (DON) was interviewed and asked about R53's family member's medications in R53's room. The DON explained R53 refused to let them take the medications out of their room. The DON was asked if they had ever talked to the family member about not keeping their medications at the facility. The DON explained they had never talked to R53's family member about the medications. When asked if they knew what medications were being kept in R53's room, the DON explained they did not know.</p> <p>On 6/5/24 at 8:45 AM, R53's clear storage cube on the over-bed table was observed to contain all the same medication bottles.</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Employ staff that are licensed, certified, or registered in accordance with state laws.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 30675</p> <p>This citation pertains to intake # MI00143489.</p> <p>Based on interview and record review, the facility failed to verify an employee (Staff 'M') who was employed at the facility as a Registered Nurse (RN) had the required education, experience and valid nursing license to provide nursing services. This deficient practice had the ability to affect multiple residents that resided in the facility.</p> <p>Findings include:</p> <p>A complaint was filed with the State Agency (SA) that alleged the facility allowed a staff member to work 12 shifts before it was found they did not have a valid RN license.</p> <p>Review of documentation provided by the facility which was identical to the documentation provided from Attorney General (AG) office included an initial complaint filed by the [NAME] President of Clinical Services (Staff 'L') which documented Staff 'L' had been checking licenses of staff and identified some discrepancies with Staff 'M's license and registry information.</p> <p>The interview statement provided to the Office of the Oakland County Sheriff by Staff 'L' conducted with Staff 'M' on 3/9/25 at 5:00 PM documented, in part:</p> <p>.Q: (Question) Please state your first middle and last name?</p> <p>A: (Answer) [Name of Registered Nurse/RN 'O'].</p> <p>Q: Help me understand why the RN license is under the name: [Name of RN 'O'] and your ID MI (Michigan) Driver's license is: [Name of Staff 'M'].</p> <p>A: States I feel like an alien there is no account of me. It's like I vanished &lt;sic&gt; the earth. Maybe someone stole my identity. Maybe it's because I got a divorce in 2007.</p> <p>Q: Help me understand why your employment application state no for a degree/certificate but you stated you graduated from Davenport?</p> <p>A: I wasn't thinking that was a degree since it was a RN license. I let my LPN (Licensed Practical Nurse) expire 1990.</p> <p>Q: Can you confirm your date of birth? X/XX/72 [full date redacted] How is it your RN licence &lt;sic&gt; was issued on X/X/1982 [full date redacted] and you were [AGE] years old? I am really struggling to follow your story. Is there something else you would like to tell me because none of this makes sense?</p> <p>A: I need to confess. I faked all of this.</p> <p>Q: What do you mean? Your not a nurse?</p> <p>(continued on next page)</p>

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A: No, I am not a nurse.</p> <p>Q: Were you ever a nurse?</p> <p>A: No, I have experience in phlebotomy.</p> <p>Q: Please confirm you were never a nurse?</p> <p>A: No, I was never a nurse .</p> <p>Q: .I will also report you to the professional licensing bureau for impersonating a RN.</p> <p>A: I understand and I am ready to pay for this.</p> <p>Q: This writer asked if there was anything else she wanted to disclose.</p> <p>A: She states No.</p> <p>Q: Asked how were you able to fake it without getting caught?</p> <p>A: I knew enough from phlebotomy conversation ended.</p> <p>On 6/3/24 at 12:30 PM, an interview was conducted with Staff 'L'. They recalled the same events as included in the above interview with Staff 'M' and further reported their former HR (Human Resource) Manager (Staff 'K') had not identified the discrepancies with Staff 'M's identification and license and had since resigned. When asked what had been done to ensure this would not occur again, Staff 'L' reported they had reviewed all employee files to verify their information was correct, and there were no further concerns identified. They further reported the new HR Manager verified all new employees closely upon hire.</p> <p>Review of the documentation provided of the facility's investigation included Staff 'M's time-punch reports which identified in addition to three days of orientation, they were assigned 25 shifts as an RN which included:</p> <p>1/23/24 in 9:00 AM - out 4:30 PM - ORIENTATION</p> <p>1/24/24 in 9:00 AM - out 6:00 PM - ORIENTATION</p> <p>1/25/24 in 9:20 AM - out 1:00 PM - ORIENTATION</p> <p>1/25/24 in 6:53 PM - out 7:45 AM</p> <p>1/26/24 in 6:54 PM - out 3:04 AM</p> <p>1/27/24 in 3:36 AM - out 7:30 AM</p> <p>1/29/24 in 6:56 PM - out 2:44 AM</p> <p>(continued on next page)</p>

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1/30/24 in 3:24 AM - out 7:14 AM</p> <p>2/1/24 in 6:56 PM - out 3:03 AM</p> <p>2/2/24 in 3:32 AM - out 7:40 AM</p> <p>2/5/24 in 6:50 PM - out 7:30 AM</p> <p>2/6/24 in 6:54 AM - out 8:17 AM</p> <p>2/10/24 in 6:52 PM - out 3:31 AM</p> <p>2/11/24 in 4:03 AM - out 8:39 AM</p> <p>2/11/24 in 6:51 PM - out 8:39 AM</p> <p>2/12/24 in 6:54 AM - out 7:21 AM</p> <p>2/15/24 in 6:55 PM - out 8:21 AM</p> <p>2/19/24 in 6:51 PM - out 7:20 AM</p> <p>2/20/24 in 6:53 PM - out 8:23 AM</p> <p>2/24/24 in 6:49 PM - out 7:08 AM</p> <p>2/25/24 in 6:53 PM - out 7:30 AM</p> <p>2/26/24 in 6:54 PM - out 7:07 AM</p> <p>2/29/24 in 6:57 PM - out 7:16 AM</p> <p>3/1/24 in 6:58 PM - out 7:16 AM</p> <p>3/4/24 in 6:58 PM - out 4:38 PM</p> <p>3/5/24 in 5:02 AM - out 7:42 AM</p> <p>3/5/24 in 7:05 PM - out 4:21 AM</p> <p>3/6/24 in 5:02 AM - out 7:41 AM</p> <p>On 6/4/24 at 8:58 AM and 6/5/24 at 2:00 PM, multiple attempts were made to contact the former HR Manager (Staff 'K') for an interview, however the phone number was no longer in service and there was no other contact information available.</p> <p>(continued on next page)</p>		

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<p>F 0839</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the facility's investigation summarized, .The facility believes based on the interview &amp; record review that [Staff 'M'] had utilized [RN 'O'] Registered Nursing License and she was never a RN herself. She did have a background in phlebotomy. She worked at the facility for approximately 1 month. No negative outcome was seen with any patients who were under her care during this time. This investigation was also submitted to the professional licensing bureau .</p> <p>Further review of the documentation provided of the facility's investigation and audits, revealed no further concerns. Discussion with the survey team acknowledged this deficient practice as an accepted Past Non-Compliance.</p> <p>Review of the facility's documentation provided for their process for hiring included a New Hire/Rehire Checklist that included, .Pre-Employment .License/Certification Verified .I-9 Document/Verify completed .</p> <p>Review of the Registered Staff Nurse Job Description dated 7/31/2015 documented, .Must be a graduate from an accredited school of nursing with an Associate's or Bachelor's Degree, or higher .Current license to practice as an RN in Michigan .</p>		