

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 5/30/2025
--	---	--	--

NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	<p>INITIAL COMMENTS</p> <p>Wellbridge of Novi was surveyed for an Abbreviated survey on 05/30/2025.</p> <p>Intake(s): I00153035, MI00153101, MI00153132, MI00153179</p> <p>Census = 99</p>	F0000		
F0635 SS= D	<p>Admission Physician Orders for Immediate Care §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to Intake Number(s): MI00153132.</p> <p>Based on interview and record review, the facility failed to accurately reconcile and implement physician's orders from the hospital upon admission into the facility for one (R803) of two residents reviewed for admission orders, resulting in increased psychiatric symptoms including agitation, throwing objects, and combativeness. Findings include:</p> <p>A review of a complaint submitted to the State Agency revealed an allegation of R803 not receiving appropriate care by the facility.</p> <p>On 5/27/25 at 11:18 AM, an interview was conducted with the complainant. The complainant reported concerns about how R803 presented when she visited her in the facility prior to being discharged. The</p>	F0635		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>complainant reported R803 had a diagnosis of bipolar disorder and had a recent psychiatric hospitalization where she was started on a new medication (Abilify) in addition to the medications she took previously, including Lithium (a mood stabilizer that treats or prevents manic episodes of bipolar disorder). The complainant explained she was concerned when she saw R803 in the facility because she had developed slurred speech and other symptoms such as difficulty swallowing.</p> <p>On 5/29/25 and 5/30/25, an unannounced, onsite investigation was conducted.</p> <p>A review of R803's clinical record revealed R803 was admitted into the facility on 5/9/25 and discharged home on 5/18/25 with diagnoses that included: bipolar disorder. A review of a Minimum Data Set (MDS) assessment dated 5/15/25 revealed R803 had moderately impaired cognition and no behaviors during the assessment period.</p> <p>A review of R803's "Discharge Summary" from the hospital provided to the facility upon admission into the facility on 5/9/25 revealed the following orders with instructions to continue the medications and when the next dose was due:</p> <p>Lithium 300 milligrams (mg) once a day with the next dose due 5/10/25 in the morning.</p> <p>Lithium 600 mg once a day (in the evening) due 5/9/25 in the evening.</p> <p>A review of R803's Physician's Orders and Medication Administration Record (MAR) revealed the following:</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>An order dated 5/9/25 for Lithium Carbonate ER (extended release) 300 mg give 2 tablet by mouth at bedtime for Bipolar. (It should be noted the hospital discharge instructions did not note the order to be an ER tablet.</p> <p>There was no order for the 300 mg dose of Lithium that R803 was supposed to get in the morning daily.</p> <p>A review of R803's MAR revealed she received the 300 mg ER dose of Lithium at bed time on all days she resided in the facility, 5/10/25 through 5/17/25. R803 did not receive the dose on the evening of 5/9/25 as the medication was not on hand or in backup.</p> <p>A review of R803's progress notes revealed the following:</p> <p>On 5/10/25 at 5:04 PM it was documented R803 was throwing things at 7:00 AM, was yelling that she wanted to go home. R803 yelled and threw things throughout the day, and banged on a cabinet at 5:10 PM.</p> <p>On 5/11/25 at 6:09 AM it was documented R803 was awake during the whole shift, was very combative and uncooperative with care, continuously banged on cabinets, and screamed during the night.</p> <p>On 5/11/25 at 6:20 PM, it was documented R803 was very combative, threw everything in her room in the trash after visitors left because she wanted to go home, kept getting in and out of bed on her own without a wheelchair, and threw all her meals.</p> <p>On 5/12/25 at 6:48 AM it was documented</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>R803 was very confused and uncooperative with care, continuously banged on cabinet doors while screaming about wanting to go home, spit up food into trash, threw personal items at staff, was aggressive with staff, and remained awake and agitated all night.</p> <p>On 5/12/25 at 11:45 AM, R803 was seen by Physician 'C' who documented R803 was confused, but did not note any behaviors. It was documented R803's medications were reviewed at that time. However, there was nothing noted that R803's Lithium dose should be changed from what it was in the hospital discharge instructions.</p> <p>On 5/12/25 at 4:49 PM it was documented R803 was very confused and uncooperative with care, continuously spit up food into hands and floor, threw personal items at staff, and was aggressive when redirected.</p> <p>On 5/13/25 at 6:25 AM it was documented R803 spit medication out at bedside, slammed the closet door repeatedly throughout the night and continued to do so until 7:00 AM.</p> <p>On 5/13/25, the following was documented in a "Pharmacy Recommendation", "RE: Lithium Extended-Release - Resident currently receiving 600 mg PO (by mouth) QPM (at night). Hospital discharge order indicate that resident was receiving 300 mg PO QAM (every morning) AND 600 mg PO QPM. Please clarify appropriate dosing.</p> <p>Further review of R803's progress notes and Physician's Orders revealed no changes to R803's Lithium orders after the pharmacy recommendation was made. R803 was seen by Physician 'C' on 5/14/25 after a fall and it</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>was documented R803's bipolar disorder was stable.</p> <p>On 5/15/25 at 7:11 AM it was documented R803 was very uncooperative and combative, banged on cabinets, continuously spit and threw objects at staff, constantly got out of bed and wheelchair without assistance, did not sleep all night, and was disruptive.</p> <p>On 5/16/25 at 6:21 AM it was documented R803 was up and awake all night, very restless, and hyperverbal.</p> <p>On 5/16/25 at 9:40 AM, the following was documented in a "discharge management" note written by the Nurse Practitioner (NP): R803 appeared at her baseline mental status, was confused, had agitation at times secondary to bipolar disorder which was stable.</p> <p>On 5/16/25 at 10:10 AM it was documented R803 screamed, asked for applesauce and then threw it at the wall, screamed, and pulled her hair.</p> <p>R803 was discharged on 5/18/25 without any changes to her Lithium per hospital discharge instructions.</p> <p>On 5/29/25 at 10:04 AM, an interview was conducted with the Director of Nursing (DON). When queried about who was responsible for entering the physician's orders when a resident was admitted into the facility, the DON reported it was a collaboration between the floor nurses and the unit managers. When queried about who ensured the admission orders were accurate,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>the DON reported the unit managers did a second check for accuracy. When asked why R803's Lithium order did not get implemented upon admission according to the hospital discharge instructions, the DON reported she would look into it.</p> <p>On 5/29/25 at 10:45 AM, an interview was conducted with Physician 'C' via the telephone. When queried about what could happen if a resident with bipolar disorder treated with Lithium was given too small of a dose too quickly, Physician 'C' said it would not be dangerous, but the resident could certainly become "very hyper" (manic). When queried about whether he reviewed R803's medication when he saw her on 5/12/25 and if he was aware of the behaviors she was having, Physician 'C' reported he recalled the resident being calm when he evaluated her, knew she had falls throughout her stay, but could not recall any behaviors. Physician 'C' reported the staff call him whenever there is an issue but did not recall being notified of anything being wrong behaviorally. When queried about how it was ensured that the orders on the hospital discharge summary were accurately reconciled and ordered for the resident at the facility, Physician 'C' reported there were multiple layers of people who reviewed the order, including nurses and pharmacy. Physician 'C' said R803 should have received her full dose of Lithium during her stay and stated, "We missed it".</p> <p>On 5/29/25 at 10:55 AM, Physician 'C' called back and reported he spoke with the DON who told him nursing did not contact him because R803's behaviors were because she wanted to go home. When asked if it could be a result of not receiving her full dose of Lithium, Physician 'C' reported he</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F0684	<p>understood the concern, but wanted to give all the information he could.</p> <p>On 5/29/25 at approximately 1:45 PM, a follow up interview was conducted with the DON. When queried about whether she found any additional information to justify why R803's Lithium order was not entered according to the hospital discharge instructions, the DON stated, "We are all human" and said they go through second and third checks to ensure accuracy and said the orders should have been entered accurately on admission. The DON then said pharmacy did not catch the error. When queried about the Pharmacy Recommendation documented on 5/13/25, the DON did not offer a response.</p> <p>A review of a facility policy titled, "Reconciliation of Medications on Admission" (undated) revealed, in part, the following, "...The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility...Gather the information needed to reconcile the medication list...list all medications from the medication history, discharge summary, the previous MAR (if applicable), and the admission orders ("sources")...Review the list carefully to determine if there are discrepancies/conflicts...If there is a discrepancy or conflict in medications, dose, route or frequency, determine the most appropriate action to resolve the discrepancy...Document findings and actions..."</p>	F0684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
SS= J	<p>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by:</p> <p>This citation pertains to intake: MI00153179.</p> <p>Based on interview and record reviews the facility failed to adequately assess/monitor a resident with an identified change of condition, notify the Physician of continued decline and transfer the resident to a higher level of care in a timely manner, for one of six residents reviewed for a change in condition, resulting in an approximately 12 hour delay in identifying and treating the resident for an "acute stroke" contributing to the resident's death. The deficient practice resulted in the increased likelihood of serious harm, serious injury and/or death to occur. Findings include:</p> <p>The Immediate Jeopardy (IJ) began on 5/12/25 when the facility staff failed to adequately assess/monitor R802 who had an identified change of condition and notify the Physician of the continued decline.</p> <p>The IJ was identified on 5/29/25 and the Administrator was notified of the Immediate Jeopardy on 5/29/25 at 4:08 PM. A plan of removal was requested at that time to remove the immediacy.</p> <p>The surveyor team confirmed by Observation,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>Interview and Record review that the Immediate Jeopardy was removed on 5/29/25 based on the facility's implementation of an acceptable plan of removal. The noncompliance remains at an isolated event with the potential for more than minimal harm that is not immediate jeopardy due to sustained compliance that has not been verified by the State Agency (SA).</p> <p>A review of a complaint submitted to the SA documented allegations of the facility's failure to timely address a change in condition and the delayed transfer to the hospital for R802 that resulted in death .</p> <p>An "Emergency Documentation" ED Triage report dated 5/13/25 at 7:40 AM, documented in part " ... pt (patient) to ed (emergency department) via EMS (emergency medical services) pt was found unresponsive low O2 (oxygen level) upon arrival pt AOx0 (alert and oriented times zero) ... Transferred From: Skilled nursing facility ... Glasgow coma Scale (measures the extent of impaired consciousness and severity of brain injury)- Eye Opening Response Glasgow: To pain ... Best Verbal Response Glasgow: None ... Best Motor Response Glasgow: Flaccid ... Glasgow Coma Score: 4 (indicates a severe level of impaired consciousness and suggests serious neurological impairment) ... Temperature Rectal ... 100.0 ... Pulse Rate: 114 ... Respiratory Rate: 24 ... Systolic Blood Pressure 170 ... Diastolic Blood Pressure 93 ... Oxygen Saturation: 84%... Oxygen Therapy: Non rebreather ... Tracking Acuity: 1 - Immediate ... Diagnosis ... unresponsive ... Level of Consciousness ... unresponsive ... intubated ..."</p> <p>A review of the medical record revealed R802 was admitted to the facility on 4/30/25, with the primary diagnosis of aftercare following joint replacement surgery. A Minimum Data Set</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>(MDS) assessment dated 5/6/25 documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R802 was mostly Independent with some "limited assistance" needed for Activities of Daily Living (ADLs). The resident was their own responsible party and signed to be a "Full Code" status.</p> <p>An "Admission" nursing assessment dated 4/30/25, documented R802 to be oriented to person, place, time, situation and noted to be verbally appropriate. Further review of the assessment documented breath sounds to be clear and heart sounds to be regular. The assessment documented the admission vitals as follows: Temperature 97.6. Pulse 94, Respirations 18 and Blood Pressure 125/75.</p> <p>A review of the complaint submitted to the SA documented on 5/10/25, " ... the resident was throwing up non-stop. The complainant states the resident had to use a garbage can to throw up in because staff weren't around to give him an appropriate container ..."</p> <p>A review of the medical record and progress notes, revealed no documentation of R802's emesis episodes, however a Zofran 4 MG (milligram) tablet was ordered on 5/10/25. The order noted " ... Give 1 tablet by mouth one time only for Nausea and Vomiting for 1 Day Nausea and Vomiting ..."</p> <p>A review of the May 2025 Medication Administration Record (MAR) documented the Zofran medication to have been administered on 5/10/25 at 1:36 PM.</p> <p>A review of the blood pressure summary documented on 5/11/25 at 8:30 AM, R802's blood pressure was 167/101 mmHg (millimeters of mercury).</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>A review of the medical record revealed no progress notes on 5/11/25, however a Physician order for hydralazine HCl 25 mg tablet was ordered on 5/11/25, that noted "... one time only for elevated bp (blood pressure) for 1 Day ..."</p> <p>This medication was documented as administered on 5/11/25 at 6:26 PM.</p> <p>A review of the "Blood Pressure Summary" documented the following on 5/12/25:</p> <p>At 9:55 AM- 177/109 mmHg</p> <p>At 10:04 AM- 172/106 mmHg</p> <p>At 10:30 AM- 167/101 mmHg</p> <p>A review of the May 2025 MAR documented Metoprolol Tartrate 50 mg by mouth one time only for HTN (hypertension- high blood pressure) for 1 Day. This medication was documented as administered on 5/12/25 at 10:16 AM.</p> <p>A review of the progress notes revealed the following:</p> <p>On 5/12/25 at 11:42 AM, a Physician Assistant (PA)- later identified as PA "D" note documented in part "... Reason for visit ... Request by patient/family/nurse regarding cough, Urianry <sic> sx (symptoms) ... Patient seen and examined. Resting comfably <sic> in bed. Awake, alert, in no acute distress. No <sic> as respisnvei <sic> to answering questions as usual. Afebrile, non-toxic. C/o (complaints of) cough. Not eating or drinking much per nurse. Pt (patient) had N/V (nausea/vomiting) over the weekend- resoled <sic>. BP elevated over the weekend and this AM (morning). Received hydralazine over the weekend. Per nurse, pt requesting melatonin to be discontinue due to nausea from it. Also, C/o dysuria (painful</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>urination), urgency, urianru <sic> frequency. +generalized weakness. C/O pain, worse with movement and better with rest and meds (medications). Denies fevers, chills. Denies CP, SOB (shortness of breath) , N/V, abd (abdominal) pain. Tolerating PT (physical therapy)/OT (occupational therapy) ... Physical Exam BP 169/99 P (pulse) 99 R (respirations) 22 T (temperature) 98.6 02 (oxygen saturation) 90%... chronically ill appearing, appears weak ... PERRLA (pupils equal, round, reactive to light and accommodation), EOMI (extraocular movements intact), MMM (moist mucous membranes), + HOH (hard of hearing), CV (cardiovascular): RRR (regular rate and rhythm), S1 S2 (first and second heart sounds), Resp (respiratory): CTAB (clear to auscultation bilaterally), no wheezes, no rales ... Alert, awake, some confusion, appropriate mood and affect. Assessment N/V- resolved, Urianry <sic> sx, Dehydration, HTN (hypertension) Insomnia, S/P (status post) fall Left femoral neck fracture s/p anterior THA (total hip arthroplasty) ... DVT (deep vein thrombosis) ppx (prophylactically) per ortho (orthopedics) ... Plan ... Dehydration: check CBC (complete blood count) BMP (basic metabolic disorder) stat (immediately). Begin IV (intravenous) fluids as patient not eating/drinking much today per nurse. Cough: Check labs, check CXR (chest x-ray) and covid. Urianry <sic> sx: check labs, check UA (urinalysis) C&S (culture & sensitivity). HTN: Metoprolol 50mg x1 this AM with improvement. Pt (patient) not on meds. Monitor for persistent elevations ... d/w (discussed with) patient at length and pt verbalized an understanding of all risks and instructions. All questions answered. Pt verbalized an understanding of all instructions. D/W staff at length ..."</p> <p>A Nursing note dated 5/12/25 at 1:25 PM, documented in part " ... The Change in Condition/s reported ... Altered mental status ..."</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>Guest is less responsive than baseline. Not eating or drinking. Irregular movement of arms. High BP (blood pressure)/ P (pulse) ... Primary Care Provider responded with the following feedback ... stat labs, stat CXR, IV (intravenous) fluids ... Blood Tests Urinalysis or culture X-ray ... New Intervention Orders: IV or subcutaneous fluids ..."</p> <p>This note was documented by Licensed Practical Nurse (LPN) "A".</p> <p>A Physician note dated 5/12/25 at 10:49 PM, documented in part " ... labs reviewed-leukocytosis (elevated white blood cell count) noted. Pt with Urianry <sic> sx and dark, cloudy urine per nurse. Will begin IV Rocephin (antibiotic) 1 gm (gram) QD (every day) x7 days-1sr <sic> dose today ..."</p> <p>Further review of the complaint submitted to the SA and interviews conducted with the complainant noted that on 5/12/25 the family visited the resident and found them " ... laying in bed with his tongue hanging out of his mouth and his breathing was shallow ... female nurse on the afternoon shift told (the family) the resident was getting a Covid test and could possibly have pneumonia because he hadn't been responsive and was unable to be woken from his sleep ..."</p> <p>A review of the May 2025 MAR revealed the following medications were not administered on 5/12/25 for the "HS" (hour of sleep) doses: Apixaban 2.5 mg for DVT (deep vein thrombosis/blood clot) prophylaxis, Aspirin 81 mg for DVT prophylaxis, Calcium Carbonate 500 mg, Metformin 500 mg, Senna-Docusate Sodium 8.6-50mg, and Sodium Chloride solution 0.9% intravenously for dehydration. There was no documentation in the medical record of the Physician to have been notified of the omitted medications.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>A Nursing note dated 5/13/25 at 6:54 AM, documented " ... Chest x-ray reviewed, unremarkable. Resident has remain in the same condition throughout the shift. Resident is stable, yet unarousable ..." This note was documented by LPN "B" who worked the midnight shift on 5/12/25 from 7:00 PM on 5/12/25 to 7:00 Am on 5/13/25.</p> <p>Review of the medical record revealed no documentation of any additional assessment of the resident on the midnight shift despite LPN "B" to have documented that the resident remained unarousable all shift.</p> <p>A review of a facility policy titled "Acute Condition Changes" revised December 2012, documented in part " ... Before contacting a physician about someone with an acute change of condition, the nursing staff will make detailed observations and collect pertinent information to report to the Physician ... Phone calls to attending or on-call physicians should be made by an adequately prepared nurse who has collected and organized pertinent information, including the resident's current symptoms and status ... The nursing staff will contact the Physician based on the urgency of the situation. For emergencies, they will call or page the Physician and request a prompt response ..."</p> <p>A review of the medical record revealed on 5/12/25 at 9:24 PM, R802's vital signs were documented as: BP 169/99 mmHg, Temperature 98.6, Pulse 99, Respirations 22, and O2 Sats 90% on room air. (Note this is the same vitals documented in the Physician Assistant - PA "D" note from 11:42 AM on 5/12/25.</p> <p>The medical record revealed no adequate monitoring of the resident from 5/12/25 at 9:24 PM to 5/13/25 at 7:14 AM.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>On 5/13/25 at 7:14 AM a pulse was noted at 115 beats per minute. At 7:15 AM R802's temperature was noted as 100.5 F (Fahrenheit) and O2 Sat was noted at 79% on room air (normal readings would be 90% or above). There was no documentation of a blood pressure obtained at this time.</p> <p>A review of a Nursing note dated 5/13/25 at 7:22 AM, documented " ... Per provider, resident is being sent out to hospital 911 ..." This note was documented by LPN "B".</p> <p>A review of the hospital records revealed the following:</p> <p>A "History & Physical" dated 5/13/25, documented in part " ... comes to the emergency room with acute hypoxic respiratory failure, sepsis secondary to UTI (urinary tract infection), acute toxic encephalopathy. He has been also intubated. Right now, he is in ICU (intensive care unit). Management per ICU team ..."</p> <p>An "Admit/Progress Note" dated 5/14/25, documented in part " ... ICU team at bedside to round at 0900. Patient is off sedation, does not follow commands. Pending CT (computerized tomography scan) Head ... seen and examined ... breathing over vent, withdrawing to pain but no response to commands pupils equal but non reactive ... The patient does have cerebral edema (swelling of the brain) (Addendum 5/15/25) ..."</p> <p>A "Neurosurgery Consultation" note dated 5/14/25, documented in part " ... Patient ... with recent history of left hip fracture s/p (status post) THA (total hip arthroplasty) on 4/27/2025, reportedly on Eliquis for DVT prophylaxis who presented to hospital from rehab facility on 5/13/2025 ... Patient was discharged to rehab facility in good condition was awake alert and oriented and answering questions appropriately.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>At some point on ... 5/12/2025, patient became unresponsive not answering questions. For unknown reasons, patient was not brought to the ER (emergency room) for evaluation until the morning of 5/13/2025. This morning (5/14/2025) CT head was obtained which demonstrated bilateral cerebellar infarcts (stroke) with mass effect on the fourth ventricle and obstructive hydrocephalus (the flow of cerebrospinal fluid is blocked along one or more passages connecting the ventricles). Neurosurgery was consulted in this regard. At the time of evaluation, patient intubated off sedation. Does not open eyes pupils 4 mm (millimeters) nonreactive, absent cough/gag/oculocephalic (neurological test used to assess the brainstem function) reflexes ...</p> <p>Recommendations: Long discussion was had with patient's brother and sister at bedside. CT findings and patient's clinical status and neuroexam were described in depth to family. We explained that given his poor neurological exam, his prognosis is extremely guarded and his likelihood of functional recovery is quite low. He has likely suffered some irreversible damage to his brain/brainstem based on neuroexam ...</p> <p>Ultimately given the patient's poor prognosis, his brother and sister agreed that patient would not want to undergo surgery and elected for comfort measures ..."</p> <p>Review of a "Discharge Documentation" dated 5/16/2025, noted the resident was pronounced deceased at 2:01 AM.</p> <p>A review of the "Certificate of Death" documented the only cause of death noted as " ... Acute Stroke ... Approximate Interval Between Onset and Death four to five Days ..."</p> <p>On 5/29/25 at 12:16 PM, LPN "B" was interviewed via telephone and was asked where they document the residents vitals that are</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>obtained. LPN "B" replied they document it in the (Electronic Medical Record) chart. LPN "B" was asked about the vitals not being obtained for R802 on the nightshift of 5/12/25 into 5/13/25. LPN "B" stated they were unsure why there was no vitals documented. LPN "B" could not recall the values obtained. LPN "B" then stated in part " ... It was alarming to me (R802's presentation/status). I had been off two or three days. Dayshift said he (R802) was already like that (unresponsive) and the Physician had been notified. Based on what I was told we were not able to send him (R802) to the hospital ..." When asked why they were not allowed to send R802 to the hospital, LPN "B" replied that the dayshift nurse (LPN "A") had informed them of that in their verbal shift report at the change of shift. LPN "B" then stated in part " ... The same thing the unit manager (Unit Manager- UM, later identified as UM "G") told me as well and I blew up on him. I tried advocating for him (R802) throughout the night ..." When asked who they contacted in attempts to advocate for R802, LPN "B" stated the provider that was on call, they were unsure of who it was. LPN "B" stated in part " ... I told him (UM "G") No, you need to come and look at him and he needs to go to the hospital. I was pissed off the entire night and I begged them to send him and they told me I cannot ..." LPN "B" was asked why R802's medications had not been administered for the evening of 5/12/25 and stated in part " ... No, he couldn't take nothing. He (previously) was A&O x4 (alert and oriented times four) which is why I was so upset. He would get up on his own and do his own personal care. He would talk to me (in the past), but he couldn't do any of that when I came on shift. He was not responding to me at all. When I went in there (R802's room) I was shocked that they would not let me send him to the hospital. It was upsetting they would not allow me to send him to the hospital. The IV and antibiotics was not enough for me, but they would not allow us to</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>send him out. I had to wait until the morning to talk to (UM "G" name). I blew up on him. I went off and told (UM "G") it was unsafe and this is my license and he (R802) needed to go to the hospital ... It was very disheartening because I wanted to send him out when I got to work (at the beginning of their shift) but they told me that I could not ... LPN "B" then stated " ... Please talk to (LPN "A" name) first because they (Administration team) have a habit of trying to cover their stuff up. (LPN "A") was upset too because they wouldn't let her send him out before on dayshift ..." When asked who is "they" that they keep referring to, LPN "B" kept referencing the report given to them by LPN "A" of not being able to send the resident to the hospital.</p> <p>On 5/29/25 at 12:31 PM, a message was left on LPN "A" voicemail to return the call.</p> <p>On 5/29/25 at 1:05 PM, an interview was conducted with UM "G". When asked how often a resident with an identified change of condition should be assessed and monitored, UM "G" replied in part " ... it depends on the change of condition, very frequently the nurse should be spending a lot of time with that patient if they were responsive and now unresponsive. At least hourly ..." UM "G" was then asked about R802 and UM "G" stated they remembered the resident had a change from their baseline and the Nurse and PA was in there (R802's room). UM "G" stated they didn't have a chance to see the resident that day. UM "G" stated they were approached by the Nurse the next day who said (R802) was not doing well and they did not like the way that (R802) was presenting. UM "G" stated " ... I told the PA he didn't look good and ensured I had a fresh set of vitals ..." UM "G" stated they were instructed to send R802 to the hospital.</p> <p>On 5/29/25 at 1:18 PM, a message was left on PA</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>"D"'s voicemail to return the call.</p> <p>At 1:24 PM, a text message was sent to the Medical Doctor (MD) "C" who was the Physician assigned to R802. A reply was not received that day.</p> <p>At 1:37 PM, LPN "A" returned the surveyor's call. When asked about R802 on the day of 5/12/25, LPN "A" replied when they came on duty R802's blood pressure was "way up". LPN "A" stated they called to get an order for something and kept checking on R802 because " ... he was not responding normally ..." LPN "A" stated R802 was very hard of hearing and had speaker "things" that they would utilize. LPN "A" stated R802 was not eating and " ... he wasn't very responsive ..." LPN "A" stated R802 would respond by groaning but " ... he was getting worse responsive wise ..." LPN "A" stated they notified (PA "D") and the PA ordered a few things. LPN "A" stated they then talked to UM "G" (their supervisor) who was sitting with (Unit Nurse Manager- UNM "J") and " ... they would not get off their butts and I was pissed ..." LPN "A" stated they talked to R802's brother and stated they really thought R802 needed to go to the hospital. LPN "A" stated " ... (UM "G" name) told me no, you already have orders for him (R802) ..." LPN "A" stated I told (UM "G" name) to go down there and look at (R802) and LPN "A" stated UM "G" told them they were busy. LPN "A" stated " ... I was so scared ... I was like please come and look at him and set eyes on him.. all the CNAs (Certified Nursing Assistants) said this is not him (R802's presentation) ... The Nurse (LPN "B") sent him out because she had enough ..." LPN "A" then stated in part " ... I am an LPN but I have been doing this for a million years and I asked (UM "G" name) to come and see him and he wouldn't. It was not a good situation and the managers put a stop to it and wouldn't allow us to send him out. I was pissed about it. This has</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>happened before, there have been other incidents. There is a lot of things that they do there, they don't let us chart the truth ... It was disturbing and the fact that we got no support and I couldn't do what I wanted to do and send him to the hospital because I had no manager support ..."</p> <p>Despite to have verbalized that R802 needed to go to the hospital, neither LPN "A" or LPN "B" called emergency services timely.</p> <p>At 1:58 PM, PA "D" returned the surveyor's call. When asked if they were notified of the change in condition of the resident becoming unresponsive, PA "D" stated in part " ... I was notified in the morning and prior to leaving the shift he (R802) was stable. He was able to talk to me when I assessed him and I ordered labs and he was awake and alert. No, I wasn't aware until they reported to me the next morning ..."</p> <p>On 5/29/25 at 3:35 PM, the Administrator and Director of Nursing (DON) was interviewed and asked if they were familiar with R802. The DON stated they believed he came to the facility after he had a fall. The DON remembered the resident was hard of hearing and had a headset that looked like a Walkman (assisted him with hearing). The DON stated they remember the resident would always come down to the community room to eat. The DON stated they remember the resident told them their story (on what happened that caused them to be at the facility) but they couldn't remember it. At this time the Administrator and DON were both interviewed on the concerns of the facility staff inadequately assessing/monitoring a resident with an identified change of condition, the failure to notify the Physician of continued decline and the delay in transferring the resident to a higher level of care, both acknowledged the concerns and offered no additional explanation at that time.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>At 5:57 PM, a second phone call was received from LPN "A" who stated the facility Administration team were repeatedly calling them. LPN "A" stated " ... They told me that I couldn't tell the nurse (LPN "B") not to call the doctor for the resident with a change in condition. I told them I didn't tell the nurse (LPN "B") not to ... They kept trying to blame me and I hung up on them ..."</p> <p>On 5/30/25 at 9:07 AM, the Vice President of Operations (VPO) "H", Medical Doctor (MD) "C" and Regional Nurse Consultant (RNC) "I" requested to provide additional information. MD "C" reported they had information that they felt would be useful for the investigation. MD "C" went on to verbalize that they talked to their PA (PA "D") who had examined R802 on 5/12/25 and the resident didn't have any signs/symptoms of a stroke. MD "C" stated the stroke was identified the day after the resident went into the hospital and the resident was moving his limbs in the ER. MD "C" stated the resident was on a blood thinner and aspirin and they don't believe that they could have change the direction of how the incident played out. The findings of inadequate assessment/monitoring, lack of notification to the Physician of the continued decline and the delay in transferring the resident to the hospital was discussed. MD "C" was asked if they were notified by the nursing staff of the continued decline of R802 and MD "C" stated they were not notified. RNC "I" stated the medical team was not aware of a continued decline and believed there was a glitch in the facility's EMR as to the reason a blood pressure was not documented on the morning of 5/13/25. It was discussed with VPO "H", MD "C" and RNC "I" that if they had any additional information they could provide it for further review.</p> <p>On 5/30/25 at approximately 10:00 AM, UM "G"</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>and the DON was recalled together for a second interview. UM "G" was asked about being informed multiple times by the nursing staff of the concern of R802's condition declining, the request for them to "set eyes" on R802 and to send R802 to the hospital. UM "G" replied they recalled being asked about the patient and informing the nurse that if it was any change of condition with the resident to notify the provider. When asked if they told the nursing staff that R802 was not going to the hospital, UM "G" stated they did not say that (R802) was not going to the hospital and remembered telling the staff to contact the provider for changes. UM "G" was asked to recall 5/13/25 the morning R802 was transferred to the hospital. UM "G" stated the nurse said (R802) wasn't presenting well. UM "G" stated they remember going into the room with the nurse and they could not recall who obtained the vitals that morning, but they remembered they called PA "D" who instructed the resident to be sent out. UM "G" stated they remember the resident only responded to painful stimuli. When asked what was different about R802 from the evaluation completed the day before by PA "D" and (R802) not presenting well on the morning of 5/13/25, if there was no alleged changes for R802 throughout the night and UM "G" stated in part " ... with the new vitals that we just obtained which is the new change of condition and we sent him out ..." The DON was asked if they felt it was acceptable practice for a resident to have an identified change of condition and not be closely monitored or have vitals obtained from 5/12/25 at 9:24 PM until 5/13/25 at 7:14 AM, especially considering the one time doses of blood pressure medications that were given in attempts to control R802's blood pressure. The DON replied " ... I expect them to follow the physician orders..." The DON was asked if there needed to be an order for the nurse to monitor and obtain the vitals of a resident with an identified change of condition and the DON</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>repeated that they expected the nurses to follow the Physician orders.</p> <p>On 5/30/25 at 11:30 AM, RNC "I" entered into the conference room and stated that Unit Nurse Manager (UNM) "J" seen R802 on 5/12/25. Shortly after UNM "J" entered the conference room and stated LPN "A" was believed to be irritated with their assignment on 5/12/25 because they were normally assigned to another part of the facility. UNM "J" stated they remember (R802)'s vitals to be "fine and beautiful". UNM "J" stated they remembered that R802 was responsive when they saw them just slow to respond. UNM "J" stated they were in the room with LPN "A". When asked where their documentation was of their assessment from R802, UNM "J" stated they did not document the assessment. UNM "J" was asked what time they went off duty on 5/12/25 and stated they leave the facility by 4 or 4:30 PM.</p> <p>On 5/30/25 at 10:14 AM, a voicemail was left on the surveyors phone from LPN "A" which noted in part, " ... He (R802) would move you know moan and and <sic> and kind of push away ... he (R802) wasn't unresponsive on my shift. He responded to movement to. He would mumble and try and talk ... he was the same ... he didn't get worse on my shift ..."</p> <p>No additional information was provided to the survey team before the end of the survey.</p> <p>The Immediate Jeopardy that began on 05/12/2025 was removed on 05/29/2025 wen the facility took the following actions to remove the immediacy, including the following:</p> <p>Resident 802 no longer resides at the facility.</p> <p>Root cause: The physician was not notified by LPN A and LPN B of the resident's continued</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 634601	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 5/30/2025
NAME OF PROVIDER OR SUPPLIER WELLBRIDGE OF NOVI, LLC			STREET ADDRESS, CITY, STATE, ZIP CODE 48300 11 MILE ROAD NOVI, MI 48374		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>decline (unresponsive, not alert, not responding, and unable to take medications), leading to the resident being transferred to the hospital.</p> <p>A one-time audit was completed for the last 14 days of nurses notes and change of conditions to ensure appropriate MD notification and follow-up was completed. There are no concerns noted.</p> <p>Licensed Nurses were re-educated on 5/29/2025 on the change of condition policy, including appropriate assessment, and timely notification of the physician to prevent serious injury, harm, and or death.</p> <p>SYSTEM CHANGE: The facility nurse leadership team did a one-time visual assessment of all current residents to ensure no change in condition is noted and required physician notification is completed timely. No concerns were noted. The policy on change in condition was reviewed and deemed appropriate.</p> <p>DON/designee will review 5 charts weekly x 12 weeks to ensure appropriate MD notification and change of conditions have been completed timely. Non-compliance will be addressed immediately. Audits will be forwarded to QAPI (Quality Assurance Process Improvement) committee for review and recommendations.</p> <p>COMPLIANCE DATE: 5/29/25</p>				