STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	**5/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	**5655 CLARKSTON ROAD CLARKSTON, MI 48348**

(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=	INITIAL COMMENTS Wellbrige of Clarkston was surveyed for a Recertification survey on 5/15/25. Census: 88.	F0000		
F0658 SS= D	Services Provided Meet Professional Standards §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one Resident (R64) of one resident reviewed for standards of practice, had complete and accurate vital monitoring per physician orders and professional standards of practice. Findings include: Review of R64's Minimum Data Set (MDS) assessment, dated 4/23/25, revealed R64 was admitted to the facility on 1/15/25, with diagnoses including Alzheimer's disease, diabetes, and high blood pressure. The assessment revealed R64 required supervision for transfers, walking, and toileting and showed R64 had two falls, and was on an anti-coagulant medication (blood thinner), an anti-platelet medication (second different type of blood thinner), and insulin. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 9/15, which showed R64 had moderate cognitive impairment.	F0658	1.) Resident #64 was assessed and no acute issues were noted. All residents have the potential to be affected. 2.) A one-time review of all guests on hypertensive medications from the last 30 days was completed to ensure hypertensive parameters are being followed. A one- time review of falls within the last 14 days were reviewed to ensure neuro checks were being completed as ordered. 3.) Licensed nurses were re-educated on following parameters on hypertensive medications and on completing neuro checks with unwitnessed falls. System change: The nurse managers will review all new hypertensive medications for parameters if needed and will review all falls to ensure neuro checks were completed for unwitnessed falls. 4.) DON/Designee will review 5 medical records weekly x 12 weeks to ensure that hypertensive medications with parameters are being followed. Any non-adherence will result in 1:1 education. All audits will be taken to the QA committee for review. DON/Designee will review 5 medical records weekly x12 weeks to ensure that neuro checks were being completed for unwitnessed falls. Any non-adherance will result in 1:1 education. All audits will be taken to the QA committee for review.	6/5/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/05/2025

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	**5/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	**5655 CLARKSTON ROAD CLARKSTON, MI 48348**

(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
	On 5/13/25 at 1:11 p.m., R64 was observed dressed in their room, seated in a chair, with a front wheeled walker next to her. R64 was wearing white slippers with an open-back, which appeared worn. On 5/13/25 at 1:13 p.m., R64 reported they had a fall last week, and said, "I went to the bathroom fine, and fell flat on the floor and hit my head ... I move too fast ..." R64 pointed to the right side of the back of their head, and told this surveyor there was a bump which was gone now. R64 could not describe the bump further. Their right arm was observed with a bandage, with steri-strips closing a wound with some dried blood. Review of R64's progress note, dated 5/07/25 at 23:08 (11:08 p.m.), showed, "On 5/07/25 at approximately 0810 (8:10 a.m.), the nurse was notified the guest (R64) was on the floor in (their) bathroom .... The nurse observed (R64) on the bathroom floor sitting upright. (R64) was continent and (their) slippers were next to (R64) ... (R64) stated that after (they) used the toilet (they) tried to wear their slippers and lost (their) balance and slipped to the floor. (R64) stated that (they) hit (their) head and pointed to the right side of (their) head ...The nurse noted a bump to the right side of the head, with no open areas. The nurse also noted a skin tear to the right arm ..." The note further revealed neuro checks (assessment of an individual's neurological functions, motor and sensory response, and level of consciousness) were initiated. The nurse contacted the on-call provider, who did not send R64 out emergently, and noted they were taking Plavix (anti-platelet blood thinner) and Eliquis (anti-coagulant blood thinner) medications. There was no further description of R64's		5.) The Executive Director is responsible for maintaining compliance with the regulation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	**5/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	**5655 CLARKSTON ROAD CLARKSTON, MI 48348**

(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
	head wound (measurements or size), and no skin assessment or documents in the Electronic Medical Record (EMR) describing R64's head bump further. Review of the electronic medical record (EMR) on 5/15/25 at 9:45 a.m. by the survey team revealed no neuro checks were found in the EMR. On 5/15/25 at approximately 10:00 a.m., the Survey team verbally requested R64's neuro checks from their fall on 5/07/25 from the Director of Nursing (DON) and nursing management, with none received or able to be located at that time. On 5/15/25 at approximately 10:20 a.m., the survey team requested R64's neuro checks via email from the Nursing Home Administrator (NHA) and the Director of Nursing (DON). On 5/15/25 at 11:18 a.m., during a phone interview, Registered Nurse (RN) "P" confirmed they were working as R64's nurse when R64 was found on the floor in their bathroom, sitting up. RN "P" described a protruding bump on R64's head as about 5 cm in length and 3 cm wide and was closed. When asked why this description was not in the medical record, RN "P" explained they did not believe this was necessary since it was a smaller closed bump. RN "P" reported they monitored R64 with completing vitals and neuro checks, and saw no change in R64's mental status. R64 conveyed there was no medical or functional decline since the fall, as they were their nurse regularly. RN "P" reported they called R64's Nurse Practitioner, (NP) "H", who recommended they continue to monitor R64, and keep them			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	in house for monitoring. RN "P" reported there was no change in R64's pupils during the neuro checks. RN "P" explained when asked a patient on blood thinner medication who hits their head was typically sent out emergently, but they did not see a concern, given there was no status change, and NP "H" was made aware. RN "P" was asked why R64's neuro checks were not found in the medical record, or their vitals at the time of their fall at 8:10 a.m., and had no explanation. Further review of R64's May (2025) Medication Administration Record (MAR), accessed 5/15/25, confirmed R64 was on Plavix and Eliquis medications. The MAR also showed R64 was on Metoprolol Tartrate (blood pressure mediation which lowers blood pressure and heart rate), 50 mg. The dose showed, "Give 1 tablet by mouth two times a day for htn (hypertension - high blood pressure). Hold if SBP (systolic blood pressure) (below) 110 or HR (heart rate below) 60. Start Date - 01/15/2025 1800 (5:00 p.m.) ..." The medication was documented as administered twice a day, 5/01/25 through 5/14/25, with one dose given on 5/15/25. The MAR was absent of any blood pressure readings. Further review of R64's MAR and TAR (Treatment Administration Record) revealed no documentation of R64's blood pressure readings being monitored prior to the administration of their Metoprolol Tartrate medication doses, per physician orders. Review of R64's blood pressure readings, in the vitals section of the EMR, revealed R64's blood pressure was monitored five times during the month of May (2025), only once a			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	**5/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	**5655 CLARKSTON ROAD CLARKSTON, MI 48348**

(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
	day, as follows: 5/14/25 07:26 (7:26 a.m): 136/76. 5/10/25 21:29 (9:29 p.m.): 187/88. 5/04/25 09:04 (9:04 a.m.): 156/76. 5/02/25 15:24 (3:24 p.m.): 120/73. 5/01/25 21:15 (8:15 p.m.): 144/61. The vitals blood pressure logs for May (2025) showed there were five blood pressure readings of 29 opportunities (given Metoprolol was initialed as given twice a day from 5/01/25 through 5/14/25, with one dose administered on 5/15/24). This showed no record of consistent blood pressure monitoring in the EMR. Without consistent blood pressure readings per physician orders, it was unable to be determined if low blood pressure may have contributed to R64's fall with injury on 5/07/25. On 5/15/25 at 11:38 a.m., R64's one page neuro checks were received at 11:38 a.m.. Review of R64's neuro check document revealed this one-page document had no neuro checks when R64's injury occurred at 8:10 a.m.. The documentation of R64's neuro checks began at 8:25 a.m., 15 minutes after R64's fall. This document was not found in the EMR earlier in the survey. Review of R64's change of condition nursing assessment, dated 5/07/25, showed R64's vitals were dated 5/04/25, showing inaccurate vitals reflected in the EMR, with none available at 8:10 a.m. on 5/07/25, when			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	**5/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	**5655 CLARKSTON ROAD CLARKSTON, MI 48348**

(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
	their fall occurred. On 5/15/25 at 12:02 p.m., NP "H" reported they oversaw R64's care, and saw R64 on 5/07/25, after their fall. NP "H" described R64 was alert and oriented times three (identity, location, and time) after their fall, and had appropriate conversation. NP "H" confirmed they knew R64 was taking Plavix and Eliquis at the time of their fall, when they hit their head. NP "H" described the bump on R64's head as about the size of a quarter, with a bruise and no bleeding, as well as a skin tear on their right arm. NP "H" was asked why R64 was not sent out of the facility emergently, given a bump on their head while on blood thinning medications, per typical standards of practice. NP "H" reported they were in the building monitoring R64, and ensured R64 had no change in status, cognition or vital signs. NP "H" was asked about R64's vitals not being consistently taken for their blood pressure medication, Metoprolol, as there was no way to ascertain if low blood pressure may have contributed to R64's fall. NP "H" reported they understood this concern. NP "H" reported they saw no reason to send R64 out emergently, as they monitored them closely in house with nursing monitoring input, and there was no change in R64's functional or neurological status. NP "H" conveyed they had not seen a neuro check record but understood R64 was being monitored. On 5/15/25 at 12:44 p.m., the DON (Director of Nursing) was interviewed with the NHA (Nursing Home Administrator) present. The DON shared their standard of practice was to do vital monitoring for falls, not skin assessments, and this was why there was no assessment describing the wound to R64's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	**5/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	**5655 CLARKSTON ROAD CLARKSTON, MI 48348**

(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
	head. The DON reported they pushed a wrong button when inputting data on the change of condition form, which was locked on 5/08/25, which showed the set of older vitals. The DON conveyed they understood the concern related to R64's blood pressures not being taken consistently when their blood pressure medication was administered. The DON reported they concurred with NP "H" R64 did not need to be sent out emergently with a bump on their head on blood thinner medications, given no change in neuro or functional status. The DON produced the original neuro check monitoring one page document, which was not found in the EMR, which showed R64's vitals and neurological status was monitored beginning 15 minutes after their fall, beginning at 8:25 a.m. on 5/07/25. The DON reported they understood the concern with R64's vitals not being monitored at 8:10 a.m., when the fall occurred, with no vital signs found taken at 8:10 a.m. The DON asked if they could call RN "H" and see if they had vitals documented elsewhere. The Survey team related the expectation would be vital signs would be found in the medical record. The DON reported they understood the concern related to vital monitoring, accurate documentation, and potential outcome for R64, given R64's vitals were not monitored with each dose of their blood pressure medication, and the incorrect vitals in the SBAR (situation,background, assessment, recommendation) document. The DON stated no outcome was found related to the missing vitals when R64's blood pressure medications were administered. On 5/15/25 at 2:46 p.m., the DON brought a paper to the conference room to the survey team, with hand printed vitals on the back of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	the neuro check paper, showing vital monitoring at 8:10 a.m., the time of R64's fall. The DON reported that the NHA had forgotten to scan the backside of the neuro check sheet, which showed vitals dated 5/07/25 at 8:10 am., which were within normal range. This was not earlier provided when the one-page neuro check page was reviewed with the survey team. A policy was requested related to professional standards of practice, and none received by survey exit on 5/15/25. Review of the policy, Medication Administration, dated 1/21, revealed on Page 3, "Medications are administered in accordance with written orders of the prescriber ...2. Obtain and record any vital signs as necessary prior to medication administration ..." Review of the policy, "Falls Reduction Program", revised 4/14/25, revealed, "To provide a safe environment for residents, modify risk factors, and reduce risk of fall-related injury. All residents who are admitted are at risk for falls ...3. If fall occurs, Charge Nurse to complete the following: ...Neurological Assessment, as applicable with any known or suspected head trauma ..."			
F0684 SS= D	Quality of Care § 483.25 Quality of care 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	F0684	1.) Residents #66 & #57 were reassessed, and no acute changes were noted. All residents have the potential to be affected. 2.) A one-time skin sweep was completed to ensure that all impaired skin integrity had treatments or were identified in other parts of the medical record as needed.	6/5/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess, monitor and document on skin wounds or growths for two (R57 and R66) of two residents reviewed for non-pressure skin conditions. Findings include: R57 On 5/13/25 at 10:32 AM, R57 was observed lying in bed. R57 was observed to have male pattern baldness and on the top of his head there was what appeared to be a cutaneous horn (conical-shaped skin protrusions) that was observed protruding approximately 3/4-1 inch in height from the top of R57's head. R57 was asked what was on the top of his head. R57 explained he knew about the "stand up thing" on his head, at which time R57 grabbed it and wiggled it from side to side, and said he had not pulled it out because he knew it would bleed a lot, and that he had other similar things on his hand. Observation of R57's left hand and forearm revealed two other smaller protrusions of similar color. Review of the clinical record revealed R57 was admitted into the facility on 8/16/24 and readmitted 4/4/25 with diagnoses that included: heart failure, emphysema and		3.) Licensed nursing staff were re-educated on skin assessment, documentation, and treatment orders with impaired skin integrity. System change: The nurse managers will review skin assessments and 24-hour summary on the next business day to ensure the MD/provider was notified of impaired skin integrity. 4.) DON/Designee will review 5 medical records weekly x 12 to ensure that residents with impaired skin integrity had documentation and an order for treatment. Any non-adherence will result in 1:1 education. All audits will be reviewed by the QA committee. 5.) DON is responsible for ongoing compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	dementia. According to the Minimum Data Set (MDS) assessment dated 2/22/25, R57 had severely impaired cognition. Review of R57's admission "Total Body Skin Assessment" dated 8/16/25 documented R57 had "Dry" skin and "0 New Wounds". No mention of any skin protrusions were documented. Review of R57's progress notes revealed an Admission Summary dated 8/16/25 at 4:03 PM by Licensed Practical Nurse (LPN) "F" that contained no mention of any skin protrusions. Further review of R57's progress notes revealed no documentation of a skin protrusion by nursing, physician or nurse practitioner. On 5/14/25 at 10:44 AM, LPN "E", R57's assigned nurse, was interviewed and asked about R57's skin protrusion. LPN "E" explained she usually did not have that unit, but she knew R57 had one on the top of his head. LPN "E" was asked if it was there when R57 had admitted into the facility, or had occurred after admission. LPN "E" explained she thought it had been there since he admitted. On 5/14/25 at 12:02 PM, LPN "F" was interviewed by phone and asked about R57's admission. LPN "F" explained she had been working contingent at the facility at the time			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	and only slightly remembered R57, but did not remember any skin protrusion on the top of his head. On 5/14/25 at 1:07 PM, the Director of Nursing (DON) was interviewed and asked if R57 had admitted into the facility with the skin protrusion on the top of his head, or did it develop after admission. The DON explained she thought it was present on admission. When informed there was no documentation of any skin protrusion in R57's clinical record, the DON explained she would look into it. On 5/14/25 at 2:39 PM, Dr. "G", R57's Attending Physician, was interviewed by phone and asked about R57's skin protrusion that resembled a cutaneous horn. Dr. "G" agreed it was a cutaneous horn, but that was not something he would normally document anything about. On 5/14/25 at 2:42 PM, the DON provided hospital discharge paperwork dated 4/23/24 that read in part, "...Exophytic lesion (cutaneous horn) on scalp, superior at midline..." The DON was asked if it was present on admission, should it have been documented. The DON agreed there it should have been documented on admission. On 5/15/25 at 11:56 AM, Nurse Practitioner (NP) "H" was interviewed and asked about there being no documentation on R57's cutaneous horn. NP "H" explained there was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	not much that could be done about it. NP "H" was asked if it should be monitored due to the fact it could be premalignant. NP "H" explained cutaneous horns were always benign. NP "H" was asked if there was no baseline assessment done, how would it be known if there was a change. NP "H" agreed there should be a baseline assessment done. According to an article from the National Library of Medicine titled, "Cutaneous Horn" updated 2/29/24, link at https://www.ncbi.nlm.nih.gov/books/NBK563820/ read in part, "...cutaneous horns signify underlying conditions more significantly than the horns themselves... The etiology of cutaneous horns varies as it is a secondary manifestation of a benign, premalignant, or malignant primary disease... They are also more likely to be premalignant or malignant in geriatric populations..." R66 On 5/13/25 at 11:21 AM, R66 was observed sitting in a wheelchair in a common area of the facility. R66 had an undated adhesive foam bandage on their right forearm. There was shadowing of drainage visible on the bandage approximately 1 inch in diameter. When asked questions, R66 did not answer. Review of the clinical record revealed R66 was admitted into the facility on 4/19/23 and readmitted 11/23/24 with diagnoses that included: Parkinson's disease, dementia and			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	major depressive disorder. According to the MDS assessment dated 4/28/25, R66 had a staff assessment of moderately impaired cognition and required the assistance of staff for all activities of daily living (ADL's). Review of R66's progress notes revealed a Skilled Charting note dated 5/10/25 at 4:12 AM that read in part, "At approx (approximately) 2140 (9:40 PM), guest was observed on the floor... assessed for immediate injury and a skin tear with blood was noted on R (right) forearm..." Review of R66's physician orders revealed no order for a dressing to R66's right forearm. On 5/14/25 at 1:15 PM, R66 was observed sitting in a wheelchair in a common area. The adhesive foam dressing on R66's right forearm appeared to have been changed as the drainage shadowing was different that the previous day. The dressing was also undated. On 5/14/25 at 3:40 PM, R66 was observed sitting in a wheelchair in a common area. The bandage to R66's right forearm was dated with"5/14/25", however the drainage shadowing appeared to be approximately the same as the undated bandage seen at 1:15 PM. On 5/14/25 at 3:43 PM, Registered Nurse (RN) "C", R66's assigned nurse, was asked if he had changed R66's right forearm bandage			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	that day. RN "C" explained he had not changed R66 bandage. When asked who did dressing changes at the facility, RN |"C" explained the assigned nurse changed dressings. On 5/14/25 at 3:51 PM, the DON was interviewed and asked about R66's right forearm dressing. At that time, Unit Manager (UM) "D" walked up and explained she had changed R66's bandage that day. UM "D" was asked about the bandage being undated when seen earlier and was now dated. UM "D" explained she had not had a sharpie marker when she changed the dressing. UM "D" was asked why there was a dressing on R66's right forearm. UM "D" explained they had "figured out" that it was from R66's fall on 5/9/24. UM "D" was asked if she knew how old the bandage she had removed from R66's right forearm was. UM "D" had no answer. UM "D" and the DON were informed there was no order for dressing changes. The DON was asked if a nurse thought a wound required a bandage, should the nurse call the doctor and get an order for treatment. The DON agreed there should be an order for wound treatments. When asked if all dressing should be dated, the DON agreed. On 5/14/25 at 4:24 PM, the facility was asked for a policy on wound/skin including assessment and treatment. The policy provided, "Pressure Ulcer/Skin Breakdown" revised 10/2010 did not address non-pressure skin conditions.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
F0689 SS= D	Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review facility failed to complete a thorough investigation and root cause analysis of a skin tear and timely follow-up with implementation of plan for one (R61) of one Resident (with fragile skin and multiple comorbidities) reviewed for accident hazards. This deficient practice has the potential for further accidents. Findings include: R61 Record review revealed R61 was recently admitted to the facility on 4/28/25 after hospitalization for skilled nursing and rehabilitation services. R61's admitting diagnoses included compression of lumbar vertebra, sick sinus syndrome (a problem with the heart's natural pacemaker, the sinus node, which controls the heartbeat), postural dizziness, cirrhosis of the liver and kidney failure. Based on Minimum Data Set (MDS)	F0689	1.) Resident #61 is no longer in the facility. All residents have the potential to be affected. 2.) A one-time review of residents in-house was completed to ensure that a root cause analysis was completed for any accident/incident that resulted in an injury. A one-time audit of all wheelchairs was completed to ensure no safety issues were identified. If any were found they were corrected by IDT. 3.) Licensed nursing staff were re-educated on assessing potential cause of injury due to an accident/incident. System change: Nurse Managers will complete documentation on root cause analysis resulting in injury from accident/incident. 4.) Don/Designee will review 5 E-interact change of condition assessments weekly x 12 weeks to ensure that all injuries from an accident/incident are reviewed for root cause analysis. Any non-adherence will result in 1:1 education. All audits will be taken to QA for review. 5.) The Executive Director is responsible for maintaining compliance with the regulation.	6/5/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	assessment dated 5/4/25, R61 had a Brief Interview of Mental Status (BIMS) score of 12/15, indicative of moderate cognitive impairment. However, a recent practitioner evaluation (dated 5/13/25) read that R61 had no cognitive deficits; had good insight and judgment. R61's had signed their admission agreement with the facility. An initial observation was completed on 5/13/25 at approximately 11:55 AM. R61 was observed in their room sitting in a wheelchair. R61 had a dressing on their right forearm. When queried what happened, R61 reported that they had a skin tear from their wheelchair two days ago. They added that they were in the bathroom when it happened and stated that something scrapped their arm when their forearm hit on the armrest of their wheelchair, and pointed to the right arm rest. When the surveyor observed under the right armrest pad, the plastic cap for the metal frame for the armrest was missing and the sharp area from the metal pipe (which was part of the armrest frame) was exposed. The plastic cap was intact on the left side of the wheelchair. This sharp area is not visible for the resident while sitting in the wheelchair, as the missing cap was under the padding; it was visible from the front of the wheelchair for an observer at a chair/barstool height. When queried if anyone had come into inspect the wheelchair, R61 reported that no one had checked their wheelchair. A follow-up observation was completed on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	5/14/25 at approximately 9:30 AM. R61 was observed in their bed and had dressing on their right forearm. When queried how they were doing, R61 stated "I feel ok". When asked if they remembered the surveyor, they reported "yes, I remember you from yesterday". R61's walker was at bedside and the wheelchair was parked in the bathroom. When the surveyor checked under the right armrest padding the cap was still missing, exposing the sharp edges. Later that day at approximately 10:30 AM, R61 was observed in their room in their bed. R61 reported that the staff had just moved them and they were resting. When queried if they had therapy, R61 reported "no" and that they were going in the afternoon. During this observation the wheelchair was parked in the bathroom. When the surveyor checked the wheelchair's right arm rest frame, the cap was still missing. On 5/14/25, at approximately 1:20 PM, when the surveyor was in the hallway speaking to the nurse, a staff member from therapy was taking R61 in the same wheelchair (with missing armrest cap). At approximately 2:20 PM, R61 was walking in the hallway (between salon and training room) with a therapy staff member and staff member was pulling the wheelchair behind. At approximately 3:45 PM, R61 was sitting up in wheelchair in their room, with their feet up on their bed and arms on the wheelchair arm rests. R61 was sitting in the same wheelchair and the right arm rest frame cap was missing.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	A final observation was completed on 5/15/25 at approximately 10:05 AM. R61 was observed standing in front of the sink and the wheelchair was behind. R61 had a different wheelchair, when queried R61 reported the staff had brought a different wheelchair for yesterday evening. Review of R61's order summary revealed a treatment dated 5/11/25 that read, "Cleanse Right outer forearm with NS, Pat dry, apply foam lite patch two times a day every 3 day (s) for skin tear". A request for incident/accident reports and investigation for R61 (from date of admission to current date) was sent via e-mail to the facility administrator and Director of Nursing (DON) on 5/14/25 at 9:41 AM. The Administrator replied on 5/14/25 at 11:50 AM that they did not have any incident/accident reports for R61. Review of R61's Electronic Medical Record (EMR) revealed a nursing progress note dated 5/11/25 at 19:27, that read, "guest reports hitting their arm on wheelchair. Skin tear noted on right outer forearm, minimal bleeding noted controlled by pressure, no signs of infection present treatment applied". Another nursing note dated 5/11/25 at 19:30 read, "guest states that he wants kerlix wrapped around the patch for additional security".			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	Review of R61's care plan revealed that R61 has potential/actual impairment to skin due to fragile skin and interventions included "use caution during transfers and bed mobility; educate resident/family/caregivers of causative factors and measures to prevent skin injury", dated 4/29/25. There were no other care plan updates after 5/11/25 event. Review of R61's EMR revealed progress note dated 5/14/25 at 20:07 that was completed by the Director of Nursing (DON), after concern was brought to the attention of the facility. The note read in part, "Guest reported to the nurse he hit his arm on the wheelchair and obtained a skin tear to right outer forearm ...DON also assessed the wheelchair and did not find any potential signs that could have caused the injury and guest has a fragile skin ...PT did not observe any abnormalities with wheelchair. It was identified on 5/13/25 that that that the wheelchair arm rest had a missing cap that caused the skin tear. Wheelchair was replaced and cap placed on old chair". It must be noted that R61 had been using the wheelchair with the missing cap since the incident until 5/14/25 at approximately after 4 PM when the surveyor brought the concern to the facility's attention. An interview with the Licensed Practical Nurse (LPN) "K" was completed on 5/14/25 at approximately 3:45 PM. LPN "K" was assigned to care for R61 on 5/13/25 and 5/14/25 during the 7 AM - 7 PM shift. LPN "K" was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	also the nurse assigned to care for R61 on 5/11/25 (date of event). During the interview they were questioned about the skin tear incident. LPN "K" reported that they remembered the incident and reported that R61 hit their right arm on their wheelchair while attempting to self-transfer. R61 was not sure how it happened and added that they checked the wheelchair and did not see anything wrong with it. When queried further about the follow-up process on checking the equipment they added they had usually had maintenance or therapy check and follow up. At approximately 3:50 PM, this surveyor walked in with LPN "K" to R61's room. R61 was sitting up in their wheelchair. This surveyor asked LPN "K" if they see anything wrong with the wheelchair, LPN "K" reported that they did not see anything wrong the wheelchair. This surveyor showed them the missing cap on the right arm frame with exposed sharp edges, LPN "K" stated "I see it now" and agreed that it needed to be fixed and they would follow up. R61 witnessed the missing cap and reported they did know there was a missing cap exposing a sharp area. At approximately 4 PM, LPN "K" approached the surveyor and reported that they did not see anything wrong with the chair when they had checked after the incident. This surveyor asked why they did find anything wrong with the chair a few minutes ago, until it was brought to their attention by the surveyor,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	LPN "K" did not provide any further explanation. They were queried if any of their unit managers were involved, they reported that they had few unit managers and they were unsure. An initial interview with the DON was completed on 5/14/25 at approximately 4:15 PM. During the interview they were queried about the investigation process for skin tears. They reported that they completed investigations for skin tears and completed their root cause analysis. They added that the investigation involved their interdisciplinary team and they were documented in EMR. They were notified of the missing cap and exposed sharp edges in the right arm rest of R61's wheelchair. DON agreed on the concern and reported that they would follow up. Approximately 15 minutes later, at 4:30 PM, Regional Nurse Consultant "RNC" RNC1 and RNC2, with the DON approached the surveyor and asked for clarification on the concern. The surveyor explained the multiple observations, and the missing wheelchair part on the right-side where R61 had acquired a skin tear, and the incident was on 5/11/25 why there were no further investigation and why the risk was not addressed timely by the interdisciplinary team (IDT). They reported that they understood the concern. During the conversation the DON and RNC1 had left and RNC2 stayed back and they agreed on the concern.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	At approximately 4:45 PM, the DON, accompanied by another leader from a different facility (RNX) approached the surveyor. The DON reported that they were still investigating the incident and they were in the 72-hr. window. No rationale on why R61 was still sitting in the wheelchair with an exposed sharp area till 5/14/25 until the concern was brought to the attention of the facility by the surveyor. The DON confirmed that R61 was provided with a different wheelchair. On 5/15/25 at approximately 11:25 AM, the DON brought a folder and reported that it was the investigation folder for R61's skin tear. It had statements from LPN "K", maintenance staff, and occupational therapist (OT) "O". The statement from OT "O" was dated for 5/14/25. An interview with OT "O" was completed on 5/15/25 at approximately 11:40 AM. They were queried if they had worked with R61 on 5/14/25 and what time. They reported that they worked with R61 after lunch and they had signed their note at 2:54 PM. They were queried about the statement written for the investigation and how did they check R61's wheelchair. OT "O" reported they just checked "overall". They were queried further if they had performed a thorough inspection of the wheelchair related to R61's skin tear on their right forearm, they reported that they did not do an inspection. They added if they			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	saw anything obvious they would address it. Review of the facility provided document titled "Accidents and Incidents - Investigating and Reporting" with a revision date of 2011 read in part, "All accidents or incidents involving residents, employees, visitors, vendors, etc., occurring in our premises shall be investigated and reported to the administrator. Policy Interpretation and Implementation: 1. The nurse supervisor/charge nurse/ or the department director or supervisor shall promptly initiate and document investigation of the incident or accident. 2. The following data, as applicable, shall be included on the report of accident form: a. the date and time of accident or incident took place b. the nature of injury/illness example bruise, fall, nausea etcetera next bullet the circumstances surrounding the accident or incident next bullet where the accident or incident took place next bullet the names of witnesses and their accounts of the incident are accident next bullet the injured person's account of the incident or accident next bullet the time the injured persons attending physician was notified, as well as the time the physician responded and his or her instructions...			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	5/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	5655 CLARKSTON ROAD CLARKSTON, MI 48348

(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
	c. the date slash time the injured person's family was notified and by whom ..." 6. The director of Nursing shall ensure that administrator receives a copy of the Report of Incident/Accident for each occurrence ...".			
F0921 SS= E	Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant potentially affecting all 88 residents residing in he facility, resulting in the increased likelihood for cross-contamination and bacterial harborage and accidents. Findings include: On 5/13/25 at approximately 8:47 a.m., an environmental tour of the kitchen was conduced with Regional Kitchen Manager "Q" (RKM "Q"). At approximately 8:51 a.m., a review of the facility ice machine was conducted which revealed an expired filter with a "change by date" of 8/12/24. RKM "Q" was queried why the filter had not been changed in August 2024 as indicated and	F0921	1.) The Laundry room including all machines and the floor behind the machines was cleaned and dusted, and the ice machine filter was changed. 2.) A one-time audit was completed to ensure that dusting was completed throughout the facility and all ice filters were clean and changed. The housekeeping and maintenance department were re-educated. 3.) System Change: All water filters will be changed according to manufacturer guidelines. The administrator/designee will complete rounds weekly to ensure the facility, including appliances/machinery, is kept clean. 4.) Administrator/Designee will complete weekly rounds x 12 weeks to ensure the facility, including appliances/machinery, is dust free and will also conduct routine rounds to ensure there are no expired water filters. Any non-adherence will result in 1:1 education. All audits will be taken to QA for review. 5.) The administrator is responsible for ongoing compliance.	6/5/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	634604	A. BUILDING _____ B. WING _____	**5/15/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLBRIDGE OF CLARKSTON	**5655 CLARKSTON ROAD CLARKSTON, MI 48348**

(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
	they reported they did not know, but that they they would get it changed out that day. On 5/13/25 during at approximately 11:13 a.m., a tour of the facility environment was conducted with the facility Administrator. At that time, the laundry room was observed for sanitary conditions and cleanliness. The area behind the multiple dryers was observed to have a floor surface covered with dried liquid spillage from the cleaning chemicals. The top of the dryer was observed to have a thick layer of lint encompassing the entirety of the top of the dryers. The Administrator was queried regarding the layer of dryer lint and the dried chemicals on the floor and acknowledged they would have to get some help to have the area cleaned.			