STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235726	A. BUILDING _____ B. WING _____	08/13/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Numbers: MI 001, MI 361. Based on interview and record review, the facility failed to consistently provide routine showers as scheduled for four (R#s: 904, 905, 906 and 907) of five residents reviewed for activities of daily living (ADLs), resulting in showers not being provided for dependent residents. Findings Include: R#904 Review of the closed record revealed R904 was originally admitted into the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS) assessment dated [DATE], R904 scored 15/15 on the Brief Interview for Mental Status (BIMS) exam indicating intact cognition. The MDS assessment also indicated R904 required assistance of staff for all ADL's. Review of R904's ADL care plan revealed an intervention revised 2/4/20 that read, Wednesday/Saturday preferred shower days. Review of the clinical record revealed documentation that in February 2020, R904 received one shower on 2/28/20 (Tuesday). On 8/12/20 at 2:05 PM, an interview was conducted, and the Administrator was asked about R904 receiving only one shower in February. The Administrator explained R904 was independent with showers and could take them on their own. It is noted the MDS assessment dated [DATE] indicated R904 required a one-person physical assist for bathing/showers. On 8/12/20 at 3:47 PM, an interview was conducted, and Certified Nursing Assistant (CNA) 'F' was asked about documentation of showers for a resident that only required partial assistance. CNA 'F' explained it is documented when a resident takes or is given a shower, it would be noted what and how much assistance was needed for the shower. R#905 Review of the closed record revealed R905 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the MDS assessment dated [DATE], R905 scored 15/15 on the BIMS exam, indicating intact cognition. The MDS assessment also indicated R905 required the assistance of staff for all ADL's. Review of R905's care plan revealed an intervention revised 4/27/20 that read, Wednesday/Saturday preferred shower days, Afternoons. Review of the clinical record revealed that in March 2020, R905 received three showers: 3/3/20, (Tuesday) 3/6/20, (Friday) 3/30/20, (Monday) On 8/12/20 at 12:00 PM, an interview was conducted, and the Director of Nursing (DON) was queried about R905's showers. The DON explained March was at the beginning of the COVID-19 pandemic, but she was sure residents had received their showers. The DON was asked about the lack of documentation of showers for R905. The DON could not explain, but said they were doing better now. R#906 On 8/11/20 at 11:51 a.m., R#906 was observed in bed with bilateral protective boots and contracture of the left hand. When asked how often they received routine showers at the facility, R#906 stated, Not very often. I got a shower two weeks ago. I get a bed bath once in a while. Review of the clinical record revealed R#906 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the quarterly MDS assessment dated [DATE] revealed R#906 had a BIMS score of 14/15 which indicated intact cognition and required extensive assistance with two-person physical assist for ADL care. The MDS also indicated R#906 required total assist with one-person physical assist for bathing. The facility provided a Shower Schedule for the 300 Hall that was updated on 6/26/2020 that revealed R#906 shower days were Wednesday and Saturday (AM). On 8/11/20, a review of the CNA 30 Day POC (Plan of Care) Response History dated 7/14/20 - 8/12/20 documented R#906 received four showers: 7/25/20, 7/29/20, 8/8/20, and 8/12/20. On 8/11/20 at 12:02 p.m., CNA 'I' and CNA 'J' were observed repositioning R#906 in bed. When asked about the AM showers, CNAs 'I' and CNA 'J' explained they move from hall to hall/day to day, and they did not care for any resident on a regular basis . Both CNAs 'I' and 'J' stated, Passing dietary trays are a priority. On 8/12/20 at 11:40 a.m., during an interview, when queried about the facility's policy regarding missed showers or refused showers, Licensed Practical Nurse (LPN) 'K' stated, CNAs are supposed to let us know. We chart it if the resident refuses their shower. We try at least three times to talk them into it, and remind them of their next shower day . We let the doctor know, then clean them up in bed . I would put it in a progress note. On 8/12/20 at 11:53 a.m., the DON was queried about R#906's scheduled showers that were not documented as completed and provided a list as follows: 7/18/20 - CNA 'L' - Don't Remember 8/01/20 - CNA 'M' - Don't Remember 8/07/20 - CNA 'I' - Not Given At that time, the DON was queried about CNA documentation pertaining to resident showers, and explained CNAs chart by exception, they should offer times three, and nurses should enter a progress note. When asked what the process should be if there was not a progress note that the resident refused, the DON stated, They (Nurse) should go back and ask why the resident didn't get one (shower). They (residents) need their showers . The CNAs need to document . R#907 On 8/11/20 at 10:37 AM, R907 was observed sitting in a wheelchair in the doorway to their room. It was observed R907's bed had been stripped and the sheets, blanket and [MEDICATION NAME] were in a wad laying on the bottom corner of the bed. R907 was asked who had stripped the bed of linen. R907 was unsure if they or someone else had stripped the bed, or how long ago it had happened. Review of the clinical record revealed R907 was originally admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the MDS assessment dated [DATE], R907 scored 3/15 on the BIMS exam, indicating severely impaired cognition. The MDS assessment also indicated R907 required the extensive assistance of staff for all ADL's. Review of the facility's shower schedule revealed R907's shower days were Tuesday and Friday in the AM. Review of the clinical record revealed from 7/22/20 to 8/11/20, R907 received two showers: 7/30/20 (Wednesday) 8/5/20 (Wednesday) On 8/12/20 at 11:28 PM, an interview was conducted, and Physical Therapy Assistant (PTA) 'E' was asked if the Therapy Department had noticed an issue at the facility with residents not receiving showers. PTA 'E' explained the Therapy Department was performing a tremendous number of showers for residents at the facility. PTA 'E' was asked if Therapy documented the showers they gave. PTA 'E' explained they gave a paper to the CNAs with the names of the residents they had given showers to. Review of a facility policy titled, BATHING-TUB/SHOWER dated 7/1/08 read in part, PURPOSE: 1. To cleanse the skin; 2. To provide comfort for the resident; 3. To observe the condition of the skin . Honor resident preference for time and type of bathing .
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number MI 452 Based on observation, interview, and record review, the facility failed to ensure urinary catheter care was documented as completed, and failed to perform proper straight catherization for two residents (R#902 and 906) of three residents reviewed for urinary catheters, resulting in a formal complaint to the State Agency (SA), and the potential for the development of infections and complications from urinary catheters. Findings Include: Resident #902 A complaint was filed with the State Agency (SA) on 1/21/20 that alleged the facility staff were

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) incompetent in the catherization procedure, and the facility's bladder scanner was not properly functioning. The intake further read . I observed very poor nursing skills resulting in a two day hospital admission for a very simple and basic procedure - straight catheterization (cath). There were (sic) often time up to 4 nurses making multiple attempts to catharize (sic) (R3902), resulting in extreme discomfort and bleeding. On 12/17/19 the nurses were unsuccessful multiple times at performing straight catheterization resulting in [MEDICAL CONDITION] for greater than 24 hours. I requested that my (R#902) be transferred to a hospital due to concern for bladder injury to her urethra after numerous failed attempts, as well as infection . The ER nurse was able to perform catheterization without difficulty on the first attempt . A urologist . felt that the staff needed proper training on catheterization and positioning of the patient . A total of 5 nurses were able to successfully perform catheterization without difficulty . The staff at (Name of Facility Redacted) also seemed to lack proper training with using a bladder scan . One traveling nurse stating in front of my family that no one had trained her how to use a bladder scan at this facility. The bladder scanner (the only one in the entire facility) also malfunctioned one evening and the nurse stated that she believed the machine had never been calibrated. She did follow up with her supervisor and was told to contact the company . On 8/11/20 at 10:25 a.m., during a telephone conversation, the complainant stated, R#902 had to go to ER (emergency room) . They could not do a straight cath. Every single time, no one could do it. The ER nurse had no issue and stated, 'urine had been retained for so long' until they admitted (R#902) for 2-3 days. A review of the clinical record revealed R#902 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed R#902 had a Brief Interview for Mental Status (BIMS) exam and scored 15 out of 15 which indicated intact cognition. The MDS revealed R#902 was incontinent of bladder and required extensive assistance with two-person physical assist for toilet use. There was no care plan that related to catheter care. Continued review of R#902's clinical record indicated a section on the Medication Administration Record [REDACTED]. Straight cath over 300cc (cubic centimeters)- notify MD with any abnormal findings four times a day . On 12/17/20 at 1200 (12:00 noon) and 1800, the entries were blank which indicated the order had not been completed. Review of the facility Progress Notes revealed the following: 12/17/2019 02:26 (2:26am) Skilled Charting .: during repositioning pt noticed that her abd (abdomen) was distended. bladder scan read 575 ml (milliliter), two nurses attempted to strat (straight) cath x 3. both nurses felt resistance upon entry. Swelling and blood noted from urethra. Family is at bedside. Family is okay with patient being transferred to the hospital. spoke with NP (Nurse Practitioner) received orders to insert foley cath due to patient not tolerating and needing such frequent straight cath. family in building and made aware of orders . 12/17/2019 04:15 (4:15am) Skilled Charting .: attempted to insert 14fr (french) foley, unable to insert foley. had second nurse try and wasn't able to insert. spoke with NP about situation and orders to scan bladder in an hour, and limit fluid intake and call her back . 12/17/2019 07:42 (7:42am) Skilled Charting .: scanned bladder with 617 results. notified NP and requested that staff try once more. if unable to place foley to notify (Name Redacted) Dr 'H'. endorsed to oncoming shift. dr (doctor) notified awaiting return call . 12/17/2019 09:57 (9:57am) Skilled Charting .: Writer received report that previous shift was unable to straight cath guest due to meeting resistance. Writer and unit manger tried to straight cath guest and was also unable to due to meeting resistance. Guest contacted physician and received a verbal order to send guest to Local Hospital 'G' to be evaluated and treated. Guest was stable and vitals were stable . 12/17/2019 11:54 (11:54am) Activity Note .: Notify MD/NP/PA (Physician Assistant): Non-immediate Physician was notified concerning bladder scan and inability to void . 12/19/2019 19:35 (7:35pm) Admission Summary .: (Named Redacted) . admitted for physical and occupational. Hx (History): UTI, craniotomy, helmet on when transferring, when out of bed and when repositioning in bed. guest was transferred via ambulance from (Named Redacted) Local Hospital 'G'. guest is alertx3 able to verbalize needs, incont (incontinent) of bowel and bladder. guest has an order to PVR (Post Volume Residual) Q (Every) 6H (Hour) and perform ISC (Intermittent Straight Cath) if greater than 300ml. writer performed PVR which revealed 161 . On 8/12/20 at 12:07 p.m., during an interview, when queried about the missing documentation on the MAR/TAR (Treatment Administration Record), the Director of Nursing (DON) explained that the goal was for everybody to chart every day, and if it comes up on your board, you (staff) need to chart everyday . When asked if they could provide documentation that the residents received catheter care, the DON stated, I will check . At 1:33 p.m., the DON returned and stated, What is lacking is the documentation. No actual refusal . When asked about the functioning of the facility's bladder scanner, the DON explained that she was not aware. Resident #906 On 8/11/20 at 11:51 a.m., R#906 was observed in bed with a wound vac, and stated they had a sore on their bottom and a big sore on their right hip. Further observation revealed a catheter in a privacy bag. When asked about catheter care, R#906 stated, They have to change it, if they didn't, it would over flow . Review of the clinical record revealed R#906 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the quarterly MDS assessment dated [DATE] revealed R#906 had a BIMS score of 14 out of 15 which indicated intact cognition. The MDS also revealed R#906 had an indwelling catheter and required extensive assistance with two-person physical assist for toilet use. The physician's orders [REDACTED]. Assess catheter placement, tubing, and anchor. Record output. 20 Fr 10 cc. DX (Diagnosis): [MEDICAL CONDITIONS] bladder two times a day for [MEDICAL CONDITION] bladder related to [MEDICAL CONDITION] . D/C (Discontinue) Date 07/20/2020 0821 (8:21am). A new physician's orders [REDACTED]. Assess catheter placement, tubing, and anchor. Record output. 20 Fr 10 cc. two times a day related to NEUROMUSCULAR DYSFUNCTION OF BLADDER . PRESSURE ULCER OF SACRAL REGION . For the months of July and August 2020, there were missing entries on the TAR indicating that catheter care had not been completed as follows: 7/3/20 - (0600 & 1800), 7/6/20 - (0600 & 1800), 7/7/20 - (1800), 7/14/20 - (0600 & 1800), 7/17/20 (1800), 7/18/20 - (0600); 7/20/20 - (1800), 7/21/20 - (0600), 7/22/20 - (1800), 7/27/20 - (1800), 7/30/20 - (1800), 7/31/20 - (1800), 8/3/20 (0600), 8/5/20 - (1800), 8/6/20 - (1800), 8/7/20 - (1800), and 8/8/20 - (0600 & 1800). On 8/12/20 at 1:36 p.m., an interview was conducted with the DON along with a review of the MAR/TAR. The DON explained the reason why entries were missing was the order changed on 7/20/20, because there was a new diagnosis. The DON further stated, We don't have a lot of meds with the 1800, and I think they (nurses were not catching the 1800's .) A review of the facility's policy titled Catheter Care, Urinary revised October 2010, read as follows: The purpose of this procedure is to prevent catheter-associated urinary tract infections . Infection Control: 1. Use standard precautions when handling or manipulating the drainage system . 2.d. Empty the collection bag at least every eight (8) hours . Complications: 1. Observe the resident for complications associated with urinary catheters . c. Notify the physician or supervisor in the event of bleeding, or if the catheter is accidently removed. d. Report any complaints the resident may have of burning, tenderness, or pain in the urethral area. e. Observe for other signs and symptoms of urinary tract infection or [MEDICAL CONDITION]. Report findings to the physician or supervisor immediately . Documentation: The following information should be recorded in the resident's medical record: .6. Any problems or complaints made by the resident related to the procedure. 7. How the resident tolerated the procedure .
F 0691 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake #MI 001 Based on interview and record review, the facility failed to consistently provide [MEDICAL CONDITION] care and ensure physician's orders were written for one (R904) of three residents reviewed for a [MEDICAL CONDITION], resulting in the potential for excoriation of the skin and infection. Findings include: A complaint was submitted to the State Agency that alleged, .the facility failed to give the resident proper [MEDICAL CONDITION] care . Review of the closed record revealed R904 was originally admitted into the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. According to the Minimum Data Set (MDS) assessment dated [DATE], R904 scored 15/15 on the Brief Interview for Mental Status (BIMS) exam indicating intact cognition. The MDS assessment also indicated R904 required the assistance of staff for all Activities of Daily Living (ADL's). Review of the census record revealed R904 had been discharged into the hospital and readmitted multiple times while a resident at the facility: discharged from the facility on 11/27/19 and readmitted [DATE]; discharged from the facility on 1/1/20 and readmitted [DATE]; discharged from the facility on 1/23/20 and readmitted [DATE]; and discharged from the facility on 3/30/20 and readmitted on [DATE]. Review of Treatment Administration Records (TAR's) for R904 revealed: December 2019 TAR - a physician's order for Remove ostomy appliance, cleanse with soap and water. Pat dry. Apply skin prep (preparation) and reapply appliance as needed, every 24 hours as needed dated 8/18/19 and discontinued 12/6/19. The TAR was left blank, indicating [MEDICAL CONDITION] care was not done. It is noted R904 was readmitted into the facility on [DATE], no physician's order was noted after R904 was readmitted . January 2020 TAR - No physician order for [REDACTED]. Pat dry. Apply skin prep and

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F 0691 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) reapply appliance as needed, every 24 hours as needed dated 2/11/20 and discontinued 3/31/20. The TAR was left blank, indicating [MEDICAL CONDITION] care was not done. It is noted R904 was readmitted into the facility on [DATE], eight days before the order was written on 2/11/20. March 2020 TAR - a physician's order for Remove ostomy appliance, cleanse with soap and water. Pat dry. Apply skin prep ad reapply appliance as needed, every 24 hours as needed dated 2/11/20 and discontinued 3/31/20. The TAR was marked as completed on 3/3/20, all other days were left blank. April 2020 TAR - a physician's order for Remove ostomy appliance, cleanse with soap and water. Pat dry. Apply skin prep ad reapply appliance as needed, every 24 hours as needed dated 4/20/20 and discontinued 6/14/20. The TAR was marked as completed on 4/20/20, all other days were left blank. It is noted R904 was readmitted into the facility on [DATE], nine days before the order was written on 4/20/20. May 2020 TAR - the physician's order continued through May. The TAR was marked as completed on 5/20/20, all other days were left blank. June 2020 TAR - the physician's order continued through 6/14/20. The TAR was left blank, except a H on 6/13/20, indicating the order was On Hold By Physician. On 8/12/20 at 8:24 AM, a phone interview was conducted, and Licensed Practical Nurse (LPN) 'A' was asked how often a [MEDICAL CONDITION] appliance should be changed. LPN 'A' explained she would change the appliance if it looked like the seal was broken, was coming off, or was leaking. LPN 'A' further explained she was not sure if the facility's policy had a specific time to change the appliance or not, but explained if it was looking good, it didn't need to be changed. On 8/12/20 at 12:00 PM, an interview was conducted, and the Director of Nursing (DON) was queried about [MEDICAL CONDITION] care. The DON explained a [MEDICAL CONDITION] appliance should be changed PRN (as needed). The DON was asked how long an appliance should be left on before changing. The DON explained there was no specific time or date it needed to be changed, just PRN. On 8/12/20 at 12:44 PM, a phone interview was conducted, and Doctor 'C' was asked how often a [MEDICAL CONDITION] appliance should be changed. Doctor 'C' explained that because it differed for every person, based on their diet and comorbidities, he always wrote the orders as PRN. Doctor 'C' was asked how long an appliance could be left on before it needed to be changed. Doctor 'C' reiterated it was different for every person. On 8/12/20 at 1:03 PM, an interview was conducted, and Medical Secretary 'B', who also ordered medical supplies for the facility, was asked what [MEDICAL CONDITION] supplies were ordered for R904's [MEDICAL CONDITION]. Medical Secretary 'B' explained R904 used [MEDICAL CONDITION] supplies from (Name Redacted) Company 'O' that included a skin barrier ring and a skin barrier/pouch appliance. Review of the manufacture recommendations from (Name Redacted) Company 'O' titled Routine Care of Your Ostomy dated 2017 read in part, .Change your skin barrier on a routine basis . Wear time is based on personal preferences and stoma characteristics, but three or four days is considered normal . Review of a facility policy titled, [MEDICAL CONDITION]/[MEDICAL CONDITION] Care revised October 2010 did not address the frequency of providing [MEDICAL CONDITION] care.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Numbers: MI 001, MI 361 and MI 410 Based on interview and record review, the facility failed to provide sufficient staffing to meet resident needs for five residents (R#'s 902, 904, 905, 906 and 907) of six residents reviewed for staffing, resulting in complaints of short staffing and staff not being able to provide all aspects of care including showers and catheter care. Findings Include: R#902 A complaint was filed with the State Agency (SA) on 1/21/20 that alleged the facility is short staffed. The intake further read . I also have concerns regarding staffing and whether its (sic) safe for two nurses to carry 26 patients each as I believe was the case on night shift 7 p.m. - 7 a.m. 1/26 - 1/27 . I was also asked by a (sic) nurse's aides to be patient tonight (1/26 - 1/27) as only two aides were covering the entire facility. The nurse's aides are not available during breakfast, lunch or dinner, as their primary responsibility at that time is passing of food trays. I have pressed the call button on numerous occasions for assistance with my (R#902) and was told by the nurse's aides that they are busy passing trays, but will get back to me as soon as possible . This is very bizarre as I would think that dietary staff would be responsible for passing food trays and that nursing and nursing aides would be required to provide patient care .' The complainant further stated, The nurse's aides are severely understaffed and carry far too many patients along with job duties that seem to fall outside of their scope of care . A review of the closed clinical record revealed R#902 was admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed R#902 had a Brief Interview for Mental Status (BIMS) exam and scored 15 out of 15 which indicated intact cognition. The MDS also revealed R#902 was incontinent of bladder and required extensive assistance with two-person physical assist for activities of daily living (ADL) care. R#904 Review of the closed record revealed R904 was originally admitted into the facility on [DATE] and readmitted [DATE] with [DIAGNOSES REDACTED]. According to the MDS assessment dated [DATE], R904 scored 15/15 on the BIMS exam indicating intact cognition. The MDS assessment also indicated R904 required assistance of staff for all ADL's. Review of R904's care plan revealed an intervention initiated 7/16/19 that read, Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance. On 8/12/20 at 2:05 PM, an interview was conducted, and the Administrator was asked about R904 receiving only one shower in February. The Administrator explained R904 was independent with showers and could take them on their own. It is noted the MDS assessment dated [DATE] indicated R904 required a one-person physical assist for bathing/showers. On 8/12/20 at 3:47 PM, an interview was conducted, and Certified Nursing Assistant (CNA) 'F' was asked about documentation of showers for a resident that only required partial assistance. CNA 'F' explained it is documented when a resident takes or is given a shower, it would be noted what and how much assistance was needed for the shower. R#905 Review of the closed record revealed R905 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. According to the MDS assessment dated [DATE], R905 scored 15/15 on the BIMS exam, indicating intact cognition. The MDS assessment also indicated R905 required the assistance of staff for all ADL's. Review of R905's care plan revealed an intervention initiated 1/28/20 that read, Assist with dressing, hygiene and toilet needs. Another intervention initiated 2/27/20 read, Educated guest to have someone with her when using the bathroom at all times. R#906 On 8/11/20 at 11:51 a.m., R#906 was observed in bed with bilateral protective boots and contracture of the left hand. When asked how often they received routine showers at the facility, R#906 stated, Not very often. I got a shower two weeks ago. I get a bed bath once in a while. Review of the clinical record revealed R#906 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Further review of the quarterly MDS assessment dated [DATE] revealed R#906 had a BIMS score of 14/15 which indicated intact cognition and required extensive assistance with two-person physical assist for ADL care. The MDS also indicated R#906 required total assist with one-person physical assist for bathing. The facility provided a Shower Schedule for the 300 Hall that was updated on 6/26/2020 that revealed R#906 shower days were Wednesday and Saturday (AM). On 8/11/20, a review of the CNA 30 Day POC (Plan of Care) Response History dated 7/14/20 - 8/12/20 documented R#906 received four showers: 7/25/20, 7/29/20, 8/8/20, and 8/12/20. On 8/11/20 at 12:02 p.m., during and interview, CNA 'I' and CNA 'J' were asked about staffing at the facility. Both explained they move from hall to hall/day to day, and they did not care for any resident on a regular basis . CNA 'I' and CNA 'J' further explained that passing dietary trays were a priority and they had to pass the trays then go back and assist residents that required assistance with eating. CNA 'I' and CNA 'J' also explained that at times, they could not properly care for residents, and call lights were always going off . On 8/11/20 at approximately 12:30 p.m., during an interview, when asked about staffing for acuity of care, Staff 'N' stated, It was really bad about two weeks ago. Me and the DON worked the floor about 2-3 weeks ago. Afternoon shift is the worst . On 8/12/20 at 11:53 a.m., the DON was queried about scheduled showers that were not documented as completed and staffing for the acuity of residents. The DON explained that the facility had some staffing challenges in past. R#907 On 8/11/20 at 10:37 AM, R907 was observed sitting in a wheelchair in the doorway to their room. It was observed R907's bed had been stripped and the sheets, blanket and [MEDICATION NAME] were in a wad laying on the bottom corner of the bed. R907 was asked who had stripped the bed of linen. R907 was unsure if they or someone else had stripped the bed, or how long ago it had happened. Review of the clinical record revealed R907 was originally admitted into the facility on [DATE] and readmitted on [DATE] with [DIAGNOSES REDACTED]. According to the MDS assessment dated [DATE], R907 scored 3/15 on the BIMS exam, indicating severely impaired cognition. The MDS assessment also indicated R907 required the extensive assistance of staff for all ADL's. Review of R907's care plan revealed an intervention initiated 7/22/20 that read, Assist with dressing, hygiene and toilet needs. On 8/11/20 at approximately 10:45 AM, the DON was observed exiting a resident's room in the 300 Hall with a tied bag of used linen. The DON was observed placing the bag in a soiled utility room in the hallway. On 8/12/20 at 10:15 AM, an interview was conducted, and CNA 'D' was asked if there was

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) enough staff for her to do her job. CNA 'D' explained sometimes she had 17-18 residents, and when she had that many, there were a lot of ADL's that were not done because she could not get to them. On 8/12/20 at 11:28 PM, an interview was conducted, and Physical Therapy Assistant (PTA) 'E' was asked if the Therapy Department had noticed an issue at the facility with staffing and/or residents not receiving showers. PTA 'E' explained the Therapy Department was performing a tremendous number of showers for residents at the facility. On 8/12/20 at 3:47 PM, an interview was conducted, and CNA 'F' was asked how many CNA's were usually assigned to work. CNA 'F' explained there were usually three CNA's, unless there was a call-in. CNA 'F' was asked did the facility replaced the person who called-in with another CNA. CNA 'F' explained sometimes they would get a replacement, and sometimes other CNA's would agree to work extra hours to cover, but they were all getting burned out and that was why there were so many call-ins. Review of a facility policy titled, Staffing revised April 2007 read in part, .Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met .