STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235716	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WELLBRIDGE OF ROCHESTER HILLS	252 MEADOWFIELD DRIVE ROCHESTER HILLS, MI 48307

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

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F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: MI 146. Based on observation, interview and record review, the facility failed to utilize and maintain completed grievance documentation to ensure that grievances had been thoroughly investigated for one (R#702) of four residents reviewed for grievances, resulting in expressions of frustration and helplessness regarding unresolved grievances, and grievances not being thoroughly documented, tracked, and the results of the conclusions and/or resolutions not being recorded. Findings include: On 6/22/20, review of a complaint submitted to the State Agency on 5/5/20 included an allegation that the facility failed to properly address grievances reported to facility staff, including the Administrator. On 6/22/20 at 11:20 AM, R#702 was observed seated in a wheelchair in the room with an overbed table placed in front of the resident. During a brief interview, R#702 was able to respond to simple questions, but due to significant cognitive limitations the questions asked were limited. R#702's clinical record was reviewed and revealed the following: R#702 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented R#702 had severely impaired cognition (scored 3/15 on Brief Interview for Mental Status Exam). On 6/22/20 at 10:15 AM, the Administrator was asked for any grievances/concerns reported to the facility for R#702. On 6/22/20 at 10:50 AM, the Administrator reported I only have one grievance from 2018. I've had discussions with the Ombudsman. (Ombudsman - an advocate for residents of nursing home to assist with complaints and advocate for improvements.) When asked if there were any discussions of concerns reported verbally from residents/families to facility staff, what was the facility's process, the Administrator reported, If nursing concern, they would handle. When asked who the facility person was responsible for grievances/concerns, the Administrator reported, I am. At that time, the Administrator was requested to provide any documentation of grievances or concerns that were reported for R#702, including any concerns/outcomes that had been discussed or reviewed with the Ombudsman. On 6/22/20 at 11:40 AM, an interview was conducted with Nurse Manager K. When asked about whether she had been aware of any grievances/concerns regarding R#702, Nurse Manager K reported being aware of concerns regarding the resident's dentures and further reported, Was present for one meeting with Ombudsman late February, early March, before COVID. It was with the daughter, Ombudsman, me and (name of Administrator). When asked if there was any documentation regarding the concerns discussed, Nurse Manager K reported, I'm not sure of documentation. It was his (Administrator's) meeting and I got called in. Nurse Manager K was unable to offer any further explanation as to the concerns discussed, or the outcome of that meeting. On 6/22/20 at 12:45 PM, the Administrator was asked if there was any documentation for any grievances/concerns for R#702, as no documentation had been provided. On 6/23/20 at 8:14 AM, the Administrator and Director of Nursing (DON) were requested to follow up on whether there were any grievances/concerns for R#702, as well as the facility's grievance policy. On 6/23/20 at 9:42 AM, the DON responded via email, We do not have any grievances for (name of R#702). On 6/23/20 at 11:50 AM, a phone interview was conducted with the Administrator. When asked about the lack of documentation for any grievances/concerns, the Administrator offered no further explanation. There was no additional documentation of any grievances/concerns for R#702 provided by the end of the survey. Review of the facility's RESIDENT COMPLAINT/ GRIEVANCE POLICY AND PROCEDURE dated 11/09/16 documented, in part: .Tell your grievance(s) to one of the individuals listed below: Director of Nursing, Administrator (Grievance Official), Social Services Director .Our time frames for investigating your grievances are .As soon as possible but within 15 days - for any other grievance .We will give you a written response as soon as possible but not later than 30 days after we receive your request .We will follow-up to ensure your grievance has been addressed satisfactorily and us <sic> findings of our investigation as part of our Quality Improvement Program . This policy did not address the facility's process for documenting grievances/concerns by facility staff if received by residents/families verbally, and/or in person.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: MI 146. Based on observation, interview and record review, the facility failed to report an allegation of abuse/mistreatment to the State Agency within the required timeframe for one (R#702) of four residents reviewed for abuse, resulting in the potential for unidentified or continued abuse. Findings include: A complaint was received by the State Agency that included allegations that a resident was pushed by a staff member resulting in a fall, and that the facility failed to conduct an investigation related to the allegation of abuse. On 6/22/20 at 11:20 AM, R#702 was observed seated in a wheelchair in the room with an overbed table placed in front of the resident. During a brief interview, R#702 was able to respond to simple questions, but due to significant cognitive limitations the questions asked were limited. R#702's clinical record was reviewed and revealed the following: R#702 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented R#702 had severely impaired cognition (scored 3/15 on Brief Interview for Mental Status Exam). A review of R#702's social service documentation included: An entry on 1/31/20 at 12:00 PM which read, Trauma assessment was completed with Guest's daughter. Guest has experienced trauma in her lifetime. Her daughter stated that at the previous ILF (Independent Living Facility) she stayed at .Guest was physically assaulted by a male resident .whom she thought was a male aid. The resident trapped Guest and an aid in the bathroom and threatened to kill the aid. Guest's daughter stated that this is why her mom does not want a male aid or nurse . On 6/22/20 at 10:15 AM, the Administrator was asked to provide any incident/accident reports including the investigations, and any grievances/concerns reported for R#702. A review of the incident/accident reports provided for R#702 did not include any abuse allegations. There were no abuse allegation/investigation documentation provided. On 6/22/20 at 12:45 PM, the Administrator was interviewed and confirmed he was the facility's Abuse Coordinator. When asked about whether he was aware of any abuse allegations reported regarding R#702, the Administrator reported, I got a call from (State's Certified Nursing Assistant Licensing Division) on June 4th. I got a call regarding whether anyone rough handled (name of R#702). When asked if that allegation had been reported to the State Agency and if an investigation was completed, the Administrator reported, I didn't report because I didn't know anything. When asked if there was any other documentation into this, the Administrator reported he would follow up. When asked if anyone else such as an employee had reported an abuse allegation to him, the Administrator denied. On 6/22/20 at 1:07 PM, the Administrator provided three documents which included: The first sheet was dated 6/4/20 and included the following typed statement, Staff interviewed and asked if (first name of R#702) reported to them an allegation of some woman pushing her around April 30th 2020. Staff all stated that (first name of R#702) never reported any type of allegation of being pushed or injured by any staff or woman on or

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

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F 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) near that date. Staff also stated that (first name of R#702) had not displayed any unusual behavior or mood during that time. There were five staff names typed which included: Nurse C, Certified Nursing Assistant (CNA B), Nurse P, CNA R, and Nurse Q. Next to these employee names was a handwritten via phone with the DON and Nurse Manager Ls initials. The bottom of this form included the DON and Nurse Manager Ls signature. This form had only a date, there was no times of the interviews, or actual statements obtained from the identified staff. The second sheet was dated 6/4/20 and was a body assessment which read, no injury observed and had been signed by the DON and Nurse Manager L. There was no time indicated of when this skin assessment had been completed. The third sheet was dated 6/4/20 and included the following typed statement, Guest interviewed by (name of DON) with (name of Nurse Manager L) present. Guest was asked if she had been pushed or hurt by any staff or any female that she could recall. Guest stated no. Guest was asked if anything unusual occurred or any interaction that made her uncomfortable or afraid occurred in the last few months. Guest stated no, guest verbalized she feels safe in the facility and is not fearful of any staff (male or female). This statement was signed by the DON and Nurse Manager L. There was no time indicated of when this interview had been completed, or that the resident's responsible party had been offered to participate in the interview with R#702, who had been assessed as having severe cognitive impairment according to the MDS assessment on 5/29/20. On 6/22/20 at approximately 1:10 PM, the Administrator provided an undated typed document signed by Nurse Practitioner S which read, I saw (first name of R#702) on multiple occasions between the period of April 30, 2020 and June 8, 2020. At no time did the guest state that she was abused by any staff member or feel that she was not safe in facility. When queried about this document, and when it had been completed, the Administrator reported, Just now. On 6/22/20 at 1:12 PM, upon review of the documentation provided, the Administrator was queried if there was any other documentation of what had been done to investigate, and whether he had been involved in the investigation as the facility's identified Abuse Coordinator. The Administrator reported, (R#702) doesn't like males. At that time, the Administrator was informed it was understandable if he was not part of the interview, and was asked as the Abuse Coordinator, would there be any additional documentation for the completion of an investigation and the Administrator offered no further response. On 6/22/20 at 1:15 PM, an interview was conducted with the DON, Nurse Manager L and the Regional Clinical Consultant. When asked to provide any further clarification of the alleged abuse incident, the DON reported the facility had been notified by a message left on the Administrator's voicemail. The DON was unsure of the specific details of the time the message was left but reported It came as phone call from (Name of State Agency). Thought it was prank at first and then saw it was a (name of city) phone number. Never gave a staff name. We looked at staff that worked on 4/29 and 4/30 and if anyone said anything (about being pushed). When asked why this allegation had not been reported to the State Agency upon facility notification on 6/4/20, the DON offered no further explanation. When asked if anyone had any knowledge of staff reporting an allegation of abuse regarding R#702, the DON and Nurse Manager L reported no. On 6/23/20 at 10:45 AM, a phone interview was completed with Nurse C. When queried about the allegation of abuse, Nurse C confirmed the allegation and reported, I came in at seven (on 4/30/20). (Daughter's name of R#702) said did my mom tell you she had been pushed in the bathroom .I know by law I have to report it to management. Nurse C further reported that Nurse Manager L had been notified by text about the allegation and had been directed by Nurse Manager L to notify the Administrator. Nurse C stated that she had notified the Administrator as well. Nurse C also reported that this allegation had also been mentioned to Nurse Manager K. When asked if anyone from the facility had conducted an investigation, or asked for any documentation such as a statement as to the specific events, Nurse C reported, A couple weeks ago and the DON had asked if I was aware and when I told her I had spoke with (name of Administrator) she said oh cause he said he didn't recall anything. A couple of hours later that same day, the Administrator actually apologized and said he remembered. (R#702) alleged it was a large white female, but I checked the staff and there was no one like that working. I recall reviewing that with (name of Administrator) in person. When asked about the documentation of a phone interview conducted with the DON and Nurse Manager L on 6/4/20, Nurse C reported she had declined signing anything that said it didn't occur, given that it was alleged and reported to the Administrator as required. On 6/23/20 at 11:47 AM, Nurse Manager L was interviewed by phone. When asked what to do if staff reported an abuse allegation, Nurse Manager L reported, Anytime, I'm going to direct them to the abuse coordinator. When asked to verify if she had been notified by any staff regarding an abuse allegation, Nurse Manager L reported she could review previous texts and get back with that information. There was no further follow up provided by Nurse Manager L by the end of the survey. Review of the facility's ABUSE, NEGLECT AND/OR MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY policy dated 12/10/18 documented, in part: .The Administrator and/or Director of Nursing (DON) must be notified of all alleged violations involving abuse .mistreatment .If the events that cause the allegation involve abuse .the facility administrator or DON will report to appropriate licensing agencies and local officials immediately but not later than 2 hours .Staff shall report all incidents immediately to their direct supervisors and Administrator .For the alleged violation involving abuse .mistreatment .the Center will report immediately but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse .in accordance to the state law, and within 5 working days of the incident with the conclusion .
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #: MI 146. Based on observation, interview and record review, the facility failed to thoroughly investigate an allegation of abuse for one (R#702) of four residents reviewed for abuse, resulting in an allegation of abuse not being thoroughly investigated and the potential for further allegations of abuse to not be thoroughly investigated. Findings include: A complaint was received by the State Agency that included allegations that a resident was pushed by a staff member resulting in a fall, and that the facility failed to conduct an investigation related to the allegation of abuse. An unannounced, onsite investigation which included the above allegation was completed on 6/22/20 to 6/23/20. On 6/22/20 at 11:20 AM, R#702 was observed seated in a wheelchair in the room with an overbed table placed in front of the resident. During a brief interview, R#702 was able to respond to simple questions, but due to significant cognitive limitations the questions asked were limited. R#702's clinical record was reviewed and revealed the following: R#702 was admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. A Minimum Data Set (MDS) assessment dated [DATE] documented R#702 had severely impaired cognition (scored 3/15 on Brief Interview for Mental Status Exam). A review of R#702's social service documentation included: An entry on 1/31/20 at 12:00 PM read, Trauma assessment was completed with Guest's daughter. Guest has experienced trauma in her lifetime. Her daughter stated that at the previous ILF (Independent Living Facility) she stayed at .Guest was physically assaulted by a male resident .whom she thought was a male aid. The resident trapped Guest and an aid in the bathroom and threatened to kill the aid. Guest's daughter stated that this is why her mom does not want a male aid or nurse . An entry on 5/28/20 at 11:38 AM read, .She received a score of 3/15, on the BIMS which indicates severe cognitive impairment. Guest's daughter (name redacted) is her DPOA (Durable Power of Attorney), and makes all of her decisions although the DPOA is not activated . On 6/22/20 at 10:15 AM, the Administrator was asked to provide any incident/accident reports including the investigations, and any grievances/concerns reported for R#702. A review of the incident/accident reports provided for R#702 did not include any abuse allegations, only fall incidents which included falls on 4/27/20 at 5:50 AM and 4/30/20 at 6:46 AM. There were no abuse allegation/investigation documentation provided. On 6/22/20 at 12:45 PM, the Administrator was interviewed and confirmed he was the facility's Abuse Coordinator. When asked about whether he was aware of any abuse allegations reported regarding R#702, the Administrator reported, Got a call from LARA (Licensing and Regulatory Affairs) CNA (Certified Nursing Assistant) on June 4th. I got a call regarding whether anyone rough handling (name of R#702). When asked if there was any other documentation of the facility's investigation into this allegation, the Administrator reported he would follow up. On 6/22/20 at 1:07 PM, review of the documentation provided by the Administrator revealed three documents which were identified by the Administrator as the facility's investigation of R#702's abuse allegation. Review of these documents revealed there were only five staff documented as being interviewed; these interviews contained no dates and times of when the interviews had been conducted. The facility failed to conduct interviews with any residents other than R#702 (who had been assessed as having severe cognitive impairment according to the MDS assessment on 5/29/20) to determine if there were any similar concerns. On 6/22/20 at approximately 1:10 PM, the Administrator provided an undated typed document signed by Nurse Practitioner S which read, I saw (first name of R#702) on multiple occasions between the period of April 30, 2020 and June 8, 2020. At no time did the guest state that she was abused by any staff member or feel that she was not safe in facility. When queried about this document, and when it had been completed, the Administrator reported, Just now. When asked why this had not been completed at the time of the investigation, the Administrator offered no response. On 6/22/20 at 1:12 PM, upon review of the documentation provided, the Administrator was queried if there was any other documentation of what had been done to

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) investigate, and whether he had been involved in the investigation as the facility's identified Abuse Coordinator. The Administrator reported, (R#702) doesn't like males. At that time, the Administrator was informed it was understandable if he was not part of the interview with R#702, and was asked as the Abuse Coordinator, would there be any additional documentation for the completion of an investigation and the Administrator offered no further response. On 6/22/20 at 1:15 PM, an interview was conducted with the DON, Nurse Manager L and the Regional Clinical Consultant. When asked to provide any further clarification of the alleged abuse incident, the DON reported the facility had been notified by a message left on the Administrator's voicemail. The DON was unsure of the specific details of the time the message was left but reported It came as phone call from LARA. Thought it was prank at first and then saw it was a Lansing phone number. Never gave a staff name . At that time, the DON was informed of the concern regarding the lack of thorough investigation given the lack of interviews with other residents to determine if there were any similar concerns, and lack of interview details regarding specific time/dates of interviews (also identified as required per facility policy). The DON was unable to offer any further clarification as to the facility's investigation and indicated the documentation provided was what the facility had completed. On 6/23/20 at 7:46 AM and 8:45 AM, Nurse C did not have a working phone number. The DON and Administrator were requested to provide an updated phone number on 6/23/20 at 8:29 AM. The DON reported at 9:04 AM that she was unable to get through the number provided and would follow up with Nurse C via text message. On 6/23/20 at 7:50 AM, Nurse Q was interviewed by phone and was unable to recall any specific details for R#702. On 6/23/20 at 8:07 AM and 10:12 AM, Nurse P was attempted to be contacted by phone, a message was left to return the call, but there was no return call by the end of the survey. On 6/23/20 at 7:48 AM, Certified Nurse Aide (CNA) R was attempted to be contacted by phone, a message was left to return the call, but there was no return call by the end of the survey. On 6/23/20 at 10:45 AM, a phone interview was completed with Nurse C. When queried about the abuse allegation with R#702, Nurse C confirmed the allegation and reported the allegation had been reported to Nurse Manager L, Nurse Manager K and the Administrator. When asked if the facility had interviewed or requested a statement of the allegation, Nurse C reported declining signing anything that said it (abuse allegation) didn't occur, given it was reported as required. Nurse C was unable to explain why their name had been included on the list of five staff interviewed as not being aware of an allegation, when in fact it had been reported as such. On 6/23/20 at 11:47 AM, Nurse Manager L was interviewed by phone and reported she was currently on vacation. When asked if staff had reached out to inform of an abuse allegation, what was the facility's process, Nurse Manager L reported, Anytime, I'm going to direct them to the abuse coordinator. When asked to verify if she had been notified by any staff regarding an abuse allegation, Nurse Manager L reported she could review previous texts and get back with that information. There was no further follow up provided by Nurse Manager L by the end of the survey. On 6/23/20 at 11:50 AM, a phone interview was conducted with the Administrator who reported he was currently on vacation. When asked who was covering as the survey was ongoing, the Administrator reported the DON was covering and he was available by phone. When asked to clarify whether there was any additional documentation into the abuse allegation for R#702, the Administrator reported, That is my complete investigation. Review of the facility's ABUSE, NEGLECT AND/OR MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY policy dated 12/10/18 documented, in part: .The investigation shall be initiated immediately, after the Administrator has knowledge of the incident, but in no event shall the investigation take longer than five (5) working days .As part of the investigation, the Administrator, or his/her designee, shall .Interview the resident, the accused .and all witnesses .To the extent possible, all interviews should be summarized into a written statement, which is signed and dated .