STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235716	A. Building B. Wing	09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Rochester Hills	252 Meadowfield Drive Rochester Hills, MI 48307

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 Based on observation, interview and record review the facility failed to ensure nursing staff correctly provided residents with their physician ordered medications for three (R25, R30 and R45) out of three residents reviewed for professional standards. Findings include: On 9/9/25 at approximately 10:33 AM, R30 was observed sitting in their wheelchair in their room. When asked about care provided in the facility, R30 reported that at times they do not receive their medication timely. On 9/9/24 at approximately 10:50 AM, R25 was observed lying in bed. The resident was alert and able to answer most questions asked. When asked about care provided in the facility, R25 reported that they had been dropped and hit by a Hoyer lift and indicated that they felt staffing needed additional training in certain areas. On 9/10/24 at approximately 10:58 AM, Incident and Accident (IAs) reports were requested for R25 and R30. The facility was asked to include all documentation that accompanied the investigation, including interviews with staff and residents. No IA's were provided for R30. IAs were provided for R25 that included a report dated 7/4/24. Review of the IA revealed, in part, the following: Medication Error .Date: 7/4/24 .Resident: R25 .Person Preparing Report: Nurse F .Incident Description: Writer administered wrong medication to guest, physician, DON (Director of Nursing) and guest notified. Immediate Action Taken: Nursing 1:1 education between writer and DON .Notes: Reviewed report that the nurse administered incorrect medication in error .Root cause determined to be that nurse was preparing medication for two guests at one time. Nurse was educated/coached on proper med pass processes . *It should be noted that the IA did not contain any documentation as to the other Guest/Resident, nor did it provide the name of the medication given in error. A record of R25's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: type II diabetes, morbid obesity and unspecified dementia. A review of the resident's Minimum Data Set (MDS) indicated the resident had a Brief Interview for Mental Status (BIMS) score of 8/15 (moderately impaired cognition). R25 did not have an order for Xanax. Continued review of R25's clinical record showed no notes that indicated the resident was given the wrong medication or that the resident was notified. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/11/24 at approximately 2:12 PM, an interview was conducted with Nurse F. Nurse F was asked about the incident that occurred on 7/4/24. Nurse F reported that they had worked a long shift and when it came time to pass medication, they mistakenly gave R25 medication that should have been given to another resident. Nurse F was not able to provide the name of the resident but noted their room number. Confirmation regarding rooms indicated the resident at issue was R30. When asked what type of medication was given, Nurse F reported that did not recall the exact name but believed it was an antianxiety medication. Review of Nurse Personnel record revealed a document titled, Employee Corrective Action. The document noted the following: Date: 7/6/24 Employee Name: Nurse F .Job Title: RN (registered nurse) .Describe situation and/or concerns: On 7/4 and 7/5 employee had med errors involving two different guests. Employee had prepared two guest medications at the same time and administered wrong meds to 1 guest. On 7/5 employee administered incorrect med and dose to 1 guest .Supervisor's signature: DON (Director of Nursing) . On 9/11/24 at approximately 2:35 PM, an interview was conducted with the DON. When asked about the medication errors involving Nurse F, the DON indicated they were aware of the incidents. The DON reported that on 7/4/24, Nurse 'F gave R25, R30's Xanax. The DON noted that when Nurse F knew that she had made the error, they went and gave R30 their ordered dose as well. As for the incident that occurred on or about 7/5/24, the DON indicated that they believed it involved R45 but was not able to provide an IA. The DON stated that they believed Nurse 'F gave R45 an extra dose of their ordered Ativan and failed to give them their ordered Trazadone. A review of R30's clinical record noted the resident was initially admitted to the facility on [DATE] with diagnoses that included: type 2 diabetes, major depressive disorder, adjustment disorder with mixed anxiety. A review of R30's MDS, noted a BIMS score of 15. R30 had an order for Xanax Tablet .25 MG (milligrams), give 1 tablet by mouth two times a day related to adjustment disorder with anxiety. A review of R45's clinical record noted the resident was initially admitted to the facility on [DATE] with diagnoses that included: acute respirator failure, type II diabetes and peripheral vascular disease. A review of R45's MDS, noted a BIMS score of 15/15 (cognitively intact cognition). R45 had an order for Lorazepam/Ativan give 1 MG (milligram) tablet by mouth two times per day related to anxiety disorder. A review of the facility policy titled, Adverse Consequences and Medication-Related Problems revealed, in part .Policy Statement: The facility evaluates medication usage to prevent and detect adverse consequences and medication-related problems such as adverse drug reactions .the staff .shall strive to minimize adverse consequences by .Following relevant clinical guidelines and manufacturers specifications for use, dose, administration, duration, and monitoring of the medications .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to identify and treat new venous ulcers, ensure physician oversight, and accurately assess a change in skin condition for two (R21 and R12) of three residents reviewed for non-pressure skin conditions. Findings include: Resident #21 (R21) On 9/9/24 at 9:14 AM, R21 was observed seated in a wheelchair with her feet flat on the ground. R21's legs were very swollen. The right leg was observed unwrapped with no dressing and the skin was bright red and peeling. The sock on R21's right foot was stained with tan colored drainage and the top of the foot appeared swollen. R21's left leg was covered by her pant leg. There appeared to be a tight bandage near the ankle and the skin below it was bright red. R21's sock on the left foot was falling off and revealed her foot which was very swollen and red. On 9/9/24 at 11:18 AM, R21 was observed seated in a wheelchair with her feet flat on the ground. R21's left leg was observed wrapped with an elastic bandage that was visibly saturated with drainage and appeared tight at the bottom of the leg due to swelling. R21's sock on the right foot remained saturated with what appeared to be dried drainage and the sock on the left foot remained falling off of R21's foot. At 1:11 PM, R21 remained seated in a wheelchair with her feet on the ground with the bandage and socks in the same condition as documented above. On 9/9/24 at 1:30 PM, a review of R21's active physician's orders revealed R21 had an order to clean the bilateral lower extremities with soap and water, apply an antimicrobial dressing, where indicated, cover with a multi-layer compression bandage system used to venous leg ulcers, secure with a woven gauze dressing, and cover with an elastic skin protection sleeve. There were no physician's orders for any treatment to R21's feet. On 9/9/24 at 1:30 PM, a review of R21's Wound Evaluation assessments revealed R21 was evaluated on 9/5/24 and had a blister to the left lateral calf. In the picture of the left lateral calf, R21's right foot is visible which shows an open area to the top of the right foot. A review of a Total Body Skin assessment dated [DATE] revealed R21 did not have any new wounds identified. A review of a Physician Progress Note dated 9/9/24 at 8:36 AM revealed no documentation of wounds to R21's legs or feet. It was documented in the progress note that R21 had, .significant swelling both legs. Patient very noncompliant with elevating legs .+2-3 edema both legs .Patient is very noncompliant with elevating legs, and is also aware. Patient always refuses to elevate her legs . Further review of Physician Progress Notes revealed no documentation of any venous wounds to her legs or feet. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/9/24 at 3:36 PM, an observation of R21's legs and feet was conducted with Unit Manager, Licensed Practical Nurse (LPN) 'A'. LPN 'A' asked R21 if she could observe her legs and feet. R21 agreed, but asked that she not unwrap the bandage on the left leg. When LPN 'A' removed the sock from R21's left foot, five shallow, open areas, weeping with clear drainage were observed on the top of the foot. R21's left foot was very swollen on the top from the ankle to the toes. When LPN 'A' removed the sock from R21's right foot, she verbalized it was, wet. An open area, resembling a ruptured blister was observed to the top of the right foot and the foot was swollen, shiny, and red from the ankle to the toes. LPN 'A' reported R21 often refused care when queried about the lack of dressings on R21's right leg and bilateral feet. When asked to describe the areas identified on the tops of R21's feet, LPN 'A' did not offer a response and said she was going to have LPN 'D' (R21's assigned nurse) dress the wounds. On 9/9/24 at approximately 3:50 PM, LPN 'D' reported R21 refused to allow her to do wound care. When queried about the open areas to the tops of R21's bilateral feet, LPN 'D' reported R21 refused wound care that morning (9/9/24) and did not assess her feet that day. LPN 'D' explained that if new skin alterations were identified, they notified the physician and the Director of Nursing (DON). When queried about what was on the tops of R21's feet, LPN 'D' reported she was not qualified to assess the wounds and it would be deferred to the DON. On 9/9/24 at 4:20 PM, an interview with the DON was conducted. When queried about the facility's process when new wounds were identified on a resident, the DON reported nurses should document the wounds, notify the physician and family, and take a picture of the wound. The DON reported the facility did not employ a Wound Nurse and did not contract with an outside wound provider. The DON reported she was responsible to review the photos taken and sign off on the assessment of the wound and the attending physician provided oversight of wounds. At that time, an observation of R21's feet was conducted with the DON. When asked to describe the open areas to R21's bilateral feet, the DON said they must be new and did not give a description. When queried about where new skin impairments would be documented, the DON reported she would have to look into it but usually in the progress notes or the Wound Evaluation. Further review of R21's clinical record revealed R21 was admitted into the facility on [DATE] with diagnoses that included: congestive heart failure and peripheral vascular disease. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R21 had moderately impaired cognition, no behaviors including rejection of care, and had one venous ulcer. A review of a Wound Note dated 9/5/24 and written by LPN 'D revealed, Heels intact pink and blanchable with edema noted .Wound orders in and pics updated . There was no documentation in the progress note or the Wound Evaluation of the open area to the top of R21's right foot that was visible in the photo from the 9/5/24 Wound Evaluation of the left leg. A review of a progress note written by LPN 'D' on 9/9/24 at 8:33 AM revealed R21 refused to have her dressings changed. There was no documentation that R21 refused to have her pants and socks that were saturated with drainage changed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/10/24 at approximately 10:00 AM, the DON and Regional Clinician, Registered Nurse (RN) 'E' followed up and reported R21 was seen by the physician on the morning on 9/9/24 and he did not document any new skin impairments. In addition, no skin impairments were documented on the skin assessment dated [DATE]. When queried about whether the physician physically assessed R21's skin, the DON reported sometimes R21 did not let him look at her skin. When queried about whether it should be documented if she refused a skin assessment, the DON reported the physician documented R21 was noncompliant about elevating her legs. The DON reported the open areas identified on the tops of R21's bilateral feet must have developed between the time she was seen by the physician at 8:33 AM and 3:36 PM when LPN 'A' removed the socks. There was no explanation given regarding the photo of R21's right foot in the 9/5/24 Wound Evaluation of the left leg. Further review of R21's clinical record at that time, revealed no documentation of R21 refusing to allow her saturated pants and socks to be changed or the physician evaluation of her skin. A review of facility policy titled, Pressure Ulcers/Skin Breakdown-Clinical Protocol (focused on the physician's involvement in skin management) revealed, in part, the following, .During resident visits, the physician will evaluate and document the progress of wound healing-especially for those with complicated, extensive, or non-healing wounds . No other skin management policies were received. 49083 Resident #12 Clinical record review revealed R12 was admitted to the facility on [DATE] with medical diagnosis that included: hyperlipidemia, gastro-esophageal reflux disease (GERD), hypothyroidism, asthma, heart disease, and diabetes. R12 has anxiety, depression, bipolar, and dementia without behavioral disturbance. The Brief Interview for Mental Status assessed in July 2024 scored 12/15 indicating R12 has moderate cognitive impairment. On 9/9/24 at 1:47 PM, R12 was observed, neat, clean, well-groomed sitting in the Bistro area watching television. Upon initial interview, R12 was very pleasant and capable of holding conversation appropriately. After introductions, R12 was questioned if they had any concerns. R12 replied (in a frustrated tone) that for the past three weeks, they have been complaining of abdominal itching and groin irritation and needed an antifungal powder. R12 specifically mentioned the medication Nystatin (a medication used to treat fungal infections). R12 commented that the skin issue has happened before and that was the medication that was used. According to R12, they have told many nursing staff about the irritation, they did not do anything or look at it. R12 remarked there was conversation with a Doctor and the Doctor instructed R12 to tell the nurse and have the nurse call. During the end of the interview, R12 asked to be provided with Nystatin. On 9/11/24 at 10:08 AM, With permission from R12, a skin assessment observation was made with Registered Nurse (RN) F of R12's abdominal folds, and peri-area. Upon observation, the abdominal fold was raised and identified within the left mid medial area, multiple raised red, and white colored scaly patches. R12 admitted that the area is itchy, and that Nystatin Powder was needed. Upon further observation of the peri area, RN F wiped the area upon inspection and R12 stated Ouch! That hurts. The entire groin and peri-area was observed to be red indicating it was not a recent/new developed irritation. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked a second time if the nursing staff was aware, R12 replied the exact answer as she disclosed on Monday 9/9/24. That the nurses were told, nothing has been done, and nobody has looked at it. R12 further commented again about how the Doctor was informed and the Doctor instructed to tell the nurses which R12 stated they told the nurse. RN F reviewed R12's medications after the skin observation and confirmed no orders were implemented for the skin and commented the Doctor will be contacted the findings from the observation. On 9/11/24 at 11:26 AM, an Interview with the Director of Nursing (DON) was completed, the DON was made aware of the skin observation with RN F and replied, This is the first I am hearing of any of this. On 9/11/24 at 12:54 PM, The DON commented that R12 was assessed by the Facility Nurse Practitioner and informed the DON all skin impairments were new. The DON further commented that R12 had episodes of impaired cognition and must not remember things .The DON further commented that R12 has a history of using Nystatin that's why R12 knew the name of the medication.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32568 Based on observation, interview, and record review, the facility failed to safely assist with a transfer to the toilet, wheelchair, and bed, complete a thorough and timely investigation to determine the root cause of injuries and accidents, and implement effective interventions to prevent multiple falls for four (R9, R8, R25, and R35) of seven residents reviewed for accidents, resulting in R9 falling during a transfer to the toilet and sustaining a tibia fracture that required surgery, R25 sustaining a hematoma that required treatment in the hospital after being injured during a mechanical lift transfer and two additional hospitalization s regarding hoyer lift injuries, and R35 sustaining abrasions to the legs and face after falling. Findings include: Resident #9 (R9) On 9/9/24 at approximately 1:00 PM, R9 was observed sitting up in bed. An immobilizer brace was observed on R9's right leg which extended from the ankle to above the knee. When queried about what happened, R9 reported she fractured her tibia (shinbone) when being assisted onto the toilet. R9 reported Licensed Practical Nurse (LPN) 'B' assisted her in the bathroom. R9 reported she stood up by pushing up on the arm rests of the wheelchair, then grabbed the assist bars, and began to pivot to move onto the toilet, but started slipping. R9 further explained LPN 'B' then grabbed her under the arms but could not prevent her from falling. R9 stated, I felt so bad. I took her (LPN 'B') out. R9 reported she was transferred to the hospital expecting to get a cast and instead I ended up with three and a half hours of surgery. R9 reported she experienced a lot of pain since the fracture and had to keep her leg straight. When queried about whether LPN 'B' used a gait belt to assist with the transfer, R9 stated, I don't' think so. A review of R9's clinical record revealed R9 was admitted into the facility on [DATE] and readmitted on [DATE] with diagnoses that included: Right tibia fracture (7/16/24). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R9 had intact cognition, was not assessed for toilet transfers, and was dependent on staff for transfers to chair from the bed/bed to chair with no history of falls. Review of a significant change MDS dated [DATE] had one sided impairment to the lower extremity, was dependent for transfers, toilet transfers were not attempted, and had recent orthopedic surgery to repair fractures. It was documented R9 did not have any falls since the last MDS assessment. A review of a progress note written by LPN 'B' on 7/10/24 at 10:58 AM revealed, During transfer to toilet guest right knee buckled. Guess assisted to floor by writer .ROM (range of motion) intact .Guest assisted back to bed . A review of a SBAR (Situation Background Appearance Review and Notify) Communication Form dated 7/10/24 revealed the physician ordered a STAT (right away) X-ray. On 9/10/24 at 7:48 AM, incident reports and any associated investigations for R9 were requested from the Administrator. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a Fall incident report for R9 dated 7/10/24 at 10:48 AM revealed, Writer assisted resident to toilet. During transfer guest right knee buckled. Writer assisted resident to floor. It was documented R9 reported her knee buckled and it was the first time that happened. It was documented ROM (range of motion) was intact with decrease in the RLE (right lower extremity). R9 was assisted back to bed by writer and orders for stat X-ray were obtained. R9's documented pain level was seven out of 10. There were no documented statements. In the notes section (which was explained to be the facility's investigation), the following was documented, Reviewed report that guest was being assisted to the toilet by nurse. Guest was at the time a 1pa (one personal physical assist) with transfers and non ambulatory. During the transfer the guest felt her knee buckle and she was lowered to the floor. She was assessed for pain and injury, pain noted in her leg, ROM within her normal limits .Physician ordered stat x-ray which came back positive for leg fracture. Guest was then sent to the hospital for further evaluation. Root cause determine to be that guest being transfer as ordered with 1pa and at this time her knees buckled from under her and she was lowered to the floor. Plan of care updated to have guest become a 2pa for transfers for safety. There was no additional information provided. On 9/11/24 at 11:02 AM, an interview was conducted with LPN 'B' regarding R9's fall on 7/10/24. LPN 'B' reported she was helping out and took R9 to the bathroom after putting her in the wheelchair. LPN 'B' reported R9 required assistance from one staff member for transfers. Once in the bathroom, LPN 'B' locked the wheelchair, R9 stood up and held on to the assist bars and LPN 'B' grabbed the back of her (R9's) pants to help her pivot to the toilet. LPN 'B' explained that while pivoting to the toilet, R9's leg gave out and she had to help lower the resident to the floor by grabbing her underneath the arm pits. LPN 'B reported she did not use a gait belt to assist with the toilet transfer. LPN 'B' reported she received education regarding properly transferring residents. When queried about how R9 got up from the floor, LPN 'B' reported a Certified Nursing Assistant (CNA) assisted her by lifting R9 from under her arms and putting her into the wheelchair. LPN 'B' said R9 was then transferred from the wheelchair to the bed by her arm pits and her pants. Further review of R9's progress notes revealed R9 was readmitted into the facility on [DATE] with a Closed fracture of right tibia. On 7/19/24, R9 was seen by a medical provider for uncontrolled pain and additional pain medication was added for breakthrough pain. A review of an OT (Occupational Therapy) Discharge Summary for dates of service 4/30/24 through 7/10/24 revealed on 6/29/24 R9 was evaluated as needing max pa (maximum physical assist) at parallel bar, max pa with increased difficulty to pivot feet for Pt (patient) will demo toilet transfer and hygiene with set up assist in bathroom. It was documented R9 was discharged from OT due to being transferred to the hospital on 7/10/24. On 9/11/24 at 12:26 PM, an interview was conducted with the Director of Nursing (DON) and Nurse Manager, Registered Nurse (RN) 'C'. When queried about the proper technique for transferring a resident who required maximum assistance from one person, no response was given. When queried about the facility's policy on the use of gait belts, the DON reported gait belts were not typically used unless therapy recommended it. When queried about what was done to look into R9's fall that occurred in the bathroom on 7/10/24, the DON reported that R9's leg buckled during a transfer and that the appropriate assistance was provided. When queried about whether residents should be transferred by holding on to the back of their pant and/or under their arm pits, no response was given. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 9/11/24 at 12:50 PM, an interview was conducted with the Director of Therapy who confirmed R9 was max assist for toilet transfers at the time of the fall on 7/10/24 based on the last documented assessment. When queried about the use of gait belts, the Director of Therapy reported that would have to be discussed with the facility staff, but from a therapy perspective a gait belt should always be used for safety for residents who require assistance with transfers. 34275 R25 A complaint was filed with the State Agency (SA) that alleged R25 was dropped during a Hoyer lift transfer and/or injured by the Hoyer lift on more than one occasion. Following each accident R25 had to go to the hospital due to pain and injury. On 9/9/24 at approximately 10:50 AM, R25 was observed lying in bed. The resident was alert and able to answer most questions asked. When asked about care provided in the facility and if they had had any falls and/or accidents, R25 reported that they had. R25 stated that a few weeks ago they fell from the Hoyer lift during a transfer and hit their head and had to go to the hospital. They also noted they had another incident just a few days prior to that incident involving the Hoyer lift. Also, they had another incident a few months ago. R25 noted that the girls were not using the chair and lift correctly. A review of R25's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: type II diabetes, morbid obesity and unspecified dementia. A review of the resident's Minimum Data Set (MDS) indicated the resident had a Brief Interview for Mental Status (BIMS) score of 8/15 (moderately cognitively impaired). Further review of the resident's record indicated the resident required a Hoyer lift for transfers. Continued review of R25's clinical/hospital records, revealed, in part, the following: 5/17/24 (12:05 AM)-Total Body Skin Assessment: .Skin Color .Normal .Temperature: Warm(normal) . Condition (normal) . 5/17/24(2:06 PM)-Skilled Charting: Noted an elevated bruised skin on the right lower leg of unknown origin, is tender and painful, informed NP (nurse practitioner) and got order for an x-ray . Authored by Nurse I. *It should be noted that there was no further assessment noted in the resident's clinical record pertaining to the unknown injury noted above. Further it was reported that Nurse I no longer works at the facility. 5/20/24-Skilled Charting : new order for Doxycycline 100 mg BID (twice per day) for cellulitis . 5/20/24-Skilled Charting: Writer spoke with guest regarding bruise on her right lower extremity(RLE). She stated her leg bumped into the mechanical lift during transfer to her chair last week. She reported this was accidental . 5/24/24-Skilled Charting: RLE (right lower extremity) swollen, warm to touch and redness with moderate pain 5/10 transfer guest to ER (emergency room) for evaluation .transferred to (name redacted) Hospital . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	5/24/24 (Hospital Records): ED (emergency department) .R25 presents with leg pain. It started a few days ago after an injury at her facility. Swelling continues to worsen which prompted her visit .swelling and hematoma noted to lower leg patient states several days ago, staff was attempting to use the Hoyer lift to move her out of bed when it swung around and hit her R (right) leg to the arm of the lift. She states then she had severe pain in her leg extending from her R ankle to her R thigh. She describes the pain in her leg as a burning sensation .Discharge Summary (6/3/24) .Injury of right lower leg .Hematoma of right lower leg . *It should be noted that the Hospital records included a photograph of R25's right lower leg that displayed a large black/purple bruise that appeared to be caused by trauma. 7/29/24 (Skilled Charting): During rounds it was brought to this writers attention that earlier today when staff was attempting to transfer the guest (R25) to the chair, during the transfer .while pulling her back the Hoyer titled, they had to bring down quickly to avoid a fall and, in the process, she bumped the top of her head, forehead, numbness to lower face and lips, pain in b/l (bilateral) ribs left more than right .Guest was sent out to (name redacted hospital) for further evaluation . 7/29/24 (Hospital Records): .ED (emergency department) .Chief Complaint: Head Injury .patient presents to the Emergency Center today .with reports of head injury .it is reported that the patient was being transferred from chair back to bed when a part of a Hoyer lift fell out and hit the left/top side of patient's head. The patient reports this occurred around 2 PM .and specifies that the bar that holds the bands from the lift struck the side of her face on the left .patient also mention that when she was being lifted, she was hit on the left arm . 8/8/24 (Skilled Charting): Guest being transferred from bed to wheelchair by the Hoyer with two aides assisting. During the transfer the Hoyer began to lean over causing guest to fall Doctors order to send guest out to ER for a cat scan of her head. Guest was complaining of head pain 8/10. 8/8/24 (Hospital Records): .Chief Complaint: FALL from Hoyer lift at (name redacted) Facility when being attempted to be lowered into a chair .hit head twice on large beam that lowers Hoyer, rates head pain 8/10 . left-sided headache and bilateral shoulder pain s/p (status post) being hit by a Hoyer lift around 11:00 AM today .she was being lowered into a chair by care staff .when became destabilized and impacted her head and shoulders bilaterally on the beam of the Hoyer lift .nose feels numb . On 9/10/24 at approximately 10:58 AM, a request was made for all Incident and Accident (IA) reports pertaining to R25 including but not limited to all documentation that accompanied the investigation. No IA was provided for the incident noted on 5/17/24 (injury of unknown origin). As for the IA for the incidents that occurred on 7/28/24 and 8/24/24 the following information was provided and reviewed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	7/29/24-IA: .Date: 7/29/24(2:00 PM) .Resident (R25) .Person Preparing Report (Nurse K) Nursing Description: While transferring guest into Hoyer with the assistance of other aides, the Hoyer hit guest in the head as they were bringing her down. CNA let writer know. Writer observed and assessed guest .Immediate Action Taken: Guest let writer know she had a headache and would like a pain pill .Notes (7/31/24): Reviewed report that guest was being transferred by three CNAs by Hoyer lift from her bed to chair. During the transfer, the Hoyer lift titled .In the process the Hoyer lift made contact with her head .Hoyer lift was checked and found to be in working condition .Hoyer lift can accommodate up to 600 lbs.(pounds) to be used for her transfer and coaching given to all parties involved . *It should be noted that no accompanying documents were provided for this IA. There was no indication in the IA document as to the staff involved in the transfer of R25 or interviews involving R25. On 9/11/24 at approximately 12:08 PM, an interview was conducted with Nurse K. When asked about the incident that occurred on 7/29/24 and the staff that were involved, Nurse K stated that they were not in the room when the accident occurred but recalled being told by a CNA that R25 hit her head on the Hoyer lift. Nurse K was not able to provide the name of any of the staff that were involved in the incident, including the name of the CNA who reported the incident to her. 8/8/24-IA: .Date: 8/8/24 (12:00 PM) .Resident (R25) .Incident Description: Guest was being transferred to the Hoyer from bed to chair when lift tipped over causing guest to fall on her broad chair. Guest also landed on top of one of the aides that was assisting with the transfer .Immediate Action Taken: .after reports of hitting head, she was sent to the hospital .450 lb. Hoyer removed from room, replaced with 600 lb. Hoyer .Level of Pain: 8 Notes: .Root cause determined to be that during transfer using the 450 lb. lift the lift malfunctioned and tipped causing the guest to fall into the back of the broad chair which then tipped over. The 450 lb. Hoyer lift is no longer safe for guest 450 lb. Hoyer lift was removed from use for guest and replaced with 600 lb. Hoyer . On 9/10/24 at approximately 2:34 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked about the incident that occurred on 5/17/24 and lack of any IAs. The DON reported that an IA was not completed and was not aware of the staff involved in the incident. The DON was then asked if there were any accompanying documents that would indicate who was involved in the incident that occurred on 7/29/24. The DON reported that they were not certain and did not believe there was any further investigation documentation. When asked about the incident that occurred on 8/8/24 the DON noted that they believed they had additional documentation to provide. The DON returned after the interview noted above with additional information. Again, the DON reported that an IA was not done for the incident on 5/17/24 and noted that the wording injury of unknown origin was written incorrectly by Nurse I . The DON did provide a half one-page document (dated 5/20/24) that they had authored that read: .On 5/17/24, nurse noted an elevated bruise on RLE (right lower extremity) that was tender and painful. Guest said she bumped it during a transfer to from bed to W/C by mistake on the transfer equipment. Guest could not remember exact date or time .she said it was sometime last week .Nurse assessed RLE .guest was diagnosed with RLE cellulitis which was treated with ABX (antibiotics) . It is inconclusive if the bruise is a result of a bump or from RLE cellulitis. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The second document provided by the DON included a handwritten and signed statement by Nurse J. The statement read, in part, the following: On 8/8/24 I was taking care of R25 .I asked another co-worker to help me .we got the wheelchair positioned .We pushed the Hoyer under the bed and hooked up the Hoyer sling . we pushed the Hoyer under the bed and hooked up the Hoyer sling that was under her. We then proceed to move R25 toward the chair. We had to turn the Hoyer one time after we lifted her from the bed .Head was facing the window .my co-worker then continued to help position her over the wheelchair. My co-worker was at the top of the wheelchair. I was at the side operating the Hoyer and guiding it into the chair. R25 was halfway into the wheel and the wheelchair and Hoyer began to tip backward. The weight of guest and Hoyer tipping caused the wheelchair to tip as well . On 9/11/24 at approximately 11:35 AM, a phone interview was conducted with Nurse J. Nurse J reported that they had been employed by the facility for three years. When asked about the incident that occurred on 8/8/24, Nurse J reported that they were acting as a CNA on that day due to staffing and worked along with CNA G. They confirmed that when transferring the resident, the Hoyer started to tip over and then the wheelchair tipped over causing the resident to fall. When asked about the Hoyer that was used, Nurse J reported they just grabbed the first Hoyer that they saw. Nurse J noted that they must have used a lift applicable for 450 lbs. and indicated the resident's weight was under 450lbs. Nurse J was asked if there was any documentation in R25's chart that indicated a Hoyer lift that would accommodate resident up to 600 lbs. needed to be used during transfers. Nurse J responded that they were not aware at the time as to what Hoyer to use. On 9/11/24 at approximately 12:00 PM, an interview was conducted with CNA G. CNA G reported that at the facility for about six months. When asked as to the incident involving R25, they reported that they had worked with R25 just a few times and was assigned to the resident on 8/8/24 and was asked to assist Nurse J. CNA G stated that during the transfer something happened to the lift, and it tilted and so did the resident's chair. They indicated that the resident fell partially on them, and they were also injured. CNA G was asked about the Hoyer lift that was used. CNA G noted that they were not aware that they should have used a Hoyer lift that would accommodate residents up to 600lbs. Review of the facility policy titled, Safe Lifting and Movement of Residents (): Policy Statement: In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniquest and devices to lift and move residents .Staff will document resident transferring and lifting needs in the care plan. Such assessments shall include .Residents size .Staff responsible for direct resident care will be trained in the use of .mechanical lifting devices .Mechanical lifts shall be made readily available and accessible to staff 24 hours a day .Maintenance shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order .all equipments design and use will meet or exceed guidelines and regulations concerning resident safety and use of restraints .Safe lifting and movement of residents is part of an overall facility employee health and safety program .provides training on safety, ergonomics and proper use of equipment . 49083 Resident #8 This citation pertains to Intake: MI00145995 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of a complaint filed with the State Agency included an allegation that R8 was sliding down in their chair and staff pushed the resident without adjusting resident and caused leg pain. Clinical record review revealed R8 was admitted to the facility on [DATE] as a transfer from another Skilled Nursing Facility for Long Term Care. R8 has a medical history which includes, Parkinson's (disease that affects the nervous system), dementia, depression, absence of left leg above the knee, heart failure, diabetes with neuropathy (nerve damage), chronic kidney disease, and requires hemodialysis (a procedure to externally remove waste from the body). R8 is verbal in native language, speaks limited English. The Brief Interview Mental Status (BIMS) dated 7/19/24 scored 4/15 indicating R8 has severe cognitive impairment. On 9/5/24 at 9:59 AM, a telephone interview was conducted with the complainant and stated that on 7/28/24 while on the phone (Facetime) with R8, they observed the staff were transferring R8 by pulling the reclining wheeled chair, her bottom was falling off and was screaming of leg pain. The complainant called the police, a report was made, and called 911 for R8 to be transported to the Emergency Department for evaluation. Progress Note dated 7/28/24 documented while the family was speaking to R8 in native language, R8 complained of 10/10 leg pain while being transferred via Hoyer lift to stretcher and required pain medication. 9/11/24 at 09:00 AM, an interview with the Nursing Home Administrator confirmed that two of the facility's Certified Nursing Assistants (CNA) were transporting R8 in the wheeled chair improperly. The NHA remarked there was video of the incident, but it has since been wiped out and unable to retrieve for review. The NHA confirmed the transfer was not dignified, the resident was being pulled, not pushed. The NHA, confirmed the family was on Facetime, translated for R8, which then lead to calling the Police. Family was concerned of leg trauma and was sent to the ED per family request for evaluation. An inquiry for medical documentation from ED Visit was requested, and the NHA was unable to provide the ED after visit summary. On 9/11/24 at 12:09 PM, an interview was conducted with CNA G. Per CNA G, R8 was in a reclining wheeled chair, and recalled R8 was slipping down into the chair and was then pulled up. CNA G indicated the chair is difficult to maneuver and while transporting, R8 started yelling of leg pain, was taken back to their room and informed the assigned nurse. Resident #35 A clinical record review revealed R35 was admitted to the facility on [DATE] with medical history of hypertension, respiratory failure, repeated falls, muscle weakness, malnutrition, sacral pressure ulcer, atrial fibrillation (abnormal heartbeat) and colon resection with colostomy placement (bag appliance attached to the outer abdomen to collect waste). A Brief Interview of Mental Status (BIMS) score revealed 1/15 indicating severe cognitive impairment. Record review revealed on 7/12/24 at 5:34 AM, R35 was found on the floor. A skin assessment discovered an abrasion on the left scalp. R35 indicated to nursing staff that they rolled out of the bed and hit their head hard on the floor. Root cause determined that R35 had poor cognition and safety awareness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Record review revealed on 7/24/24 at 2:20 AM, R35 was found lying on their right side on the floor, and the bed was elevated to its highest position. R35 sustained abrasion injuries to the right buttock, right knee, face, and left outer ankle. Root cause determined R35 raised the bed to highest position, has poor cognition and safety awareness, and rolled out of the bed. On 7/24/24, Plan of care was updated to include bolsters to the side of the mattress to prevent from rolling out of bed. Record review revealed on 8/25/24 at 1:00PM, R35 was observed laying on their left side on the floor. R35 had sustained trauma, redness and swelling to their left eye. Root cause determined poor cognition and safety awareness, restless when in room. Plan of care updated to include encouraging guest to be in common areas while awake and in chair. Record review revealed on 9/7/24 at 6:44 PM, R35 was observed on the floor and reported rolled out of bed. Root cause was determined R35 becomes restless if in bed to eat, has poor cognition, impulsive, and would benefit to eat in the dining room. Plan of care updated to include and encourage guest to go to dining room. On 9/9/24, Prior to morning care, R35 was observed lying in bed in the high position. R35 was observed asleep in the fetal position facing the wall, brief on, legs very thin, floor matt noted next to bed, tray table middle of room, oxygen delivered via nasal canula not on correctly and laying on top of forehead. On 9/10/24 at 10:14 AM, R35 was observed asleep, with television on. The tray table with three full beverages and television remote were observed in the middle of room out of reach for resident. On 9/10/24 at 11:28 AM, R35 was observed in wheelchair propelling out of room independently, repeating I am going to fall oxygen tubing was off and on the floor in room. Assigned Licensed Practical Nurse (LPN) M was observed assisting R35 and redirecting for lunch and encouraged R35 to go to dining room for lunch. R35 agreed and was wheeled to dining room. On 9/10/24 at 11:57 AM, R35 was observed in the dining room with one other resident at table both waiting for lunch to be served. R35 was observed calmly moving backward from the table and propelled self towards the middle of dining room. Moments later, Registered Nurse (RN) L was observed speaking with R35, then observed RN L wheeling R35 out of the dining area prior to meal delivery and opportunity to eat. On 9/10/24 at 12:08 PM, R35 was observed alone in the middle of the 300 hallway. After minutes of observation, RN L was observed walking toward R35 and overheard asking if they want to go watch the birds. On 9/10/24 at 12:40 PM, R35 was observed lying in bed assisted by CNA O eating a peanut butter sandwich and bacon. When inquired why R35 was not eating in the dining room, CNA O replied I don't know. LPN M was also inquired why R35 did not remain in the dining room for lunch. LPN M replied in a frustrated tone that R35 should not be eating in bed, should have remained in dining area but RN L Took Over and that is why R35 is eating in bed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	09/10/24 at 2:45 PM, an interview was conducted with the Director of Nursing (DON) who was aware R35 has had four episodes of being found on the floor since admission on 7/11/24. The DON acknowledged they have implemented interventions to prevent falls, but R35 continues to be found on the floor. When inquired what measures were being implemented, the DON stated more frequent brief changes and commented Activities was involved but if R35 wants to go back to bed, that is their choice. The DON referenced other possible interventions could involve Hospice & Palliative services, and further stated that gets complicated when a Guardian is involved.