STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235171	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Grand Blanc	3139 East Baldwin Road Grand Blanc, MI 48439

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 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** This citation pertains to Intake Number 2698891.Based on observation, interview, and record review, the facility failed to ensure adequate staff supervision in the common area and that appropriate assistance to the bathroom was provided to prevent falls or accidents for one resident (Resident #303) of 3 residents reviewed for falls, resulting in a fall requiring a transfer to the emergency room for evaluation and treatment of bleeding coming from a laceration of the scalp requiring six (6) staples (stitches) and a hematoma to the left side of the head Findings include:Resident #303 (R303): On 1/6/26 at 3:30 PM, R303 was observed in the hallway heading towards her room. R303 appeared confused as she approached the surveyor and asked where she should go. Another staff member was two doors away, yelling to R303 to go to her room (yelling out the room number). R303 was very confused, teary-eyed, while self-ambulating in her own wheelchair. The surveyor asked her for her name and her room number, but R303 was unable to answer. R303 was observed to have an obvious bruise on both sides of the temple and head (left and right) and a healing scalp laceration. The Director of Nursing (DON) came to her, led her into her room, and shut the door. R303's Fall Incident Report was requested on 1/7/26 at 10:30 PM, it revealed that on 12/20/25 at 13:05 PM, R303 fell in the common area bathroom by herself and without any staff witnessing the fall. The report had indicated:Nursing Description: Resident was found down on the bathroom floor in the common area. She was alert and talkative. The resident was noted to have a laceration on the top of the head (right-sided) with blood oozing out of the wound. Pressure was immediately applied to the site. The resident also noted a hematoma on the left side of the forehead. No other injuries noted.Resident Description: Resident said she was using the bathroom and attempted to get back into her wheelchair and fell on the floor.Was the incident witnessed? NoInjury Type:1. Hematoma. Location: Face2. Laceration. Location: Top of Scalp This Fall Incident Report, dated 12/20/25, indicated that R303 was sent to the nearby Emergency Center for further evaluation and treatment of a laceration to the head. An interview with Registered Nurse A (RN A) was conducted on 1/7/26 at 12:32 PM. RN A stated that she was the nurse assigned and responded to R303 during the fall on 12/20/25. She indicated that she found R303 alone in the common area bathroom (by the common dining room). R303 was sitting with other residents after lunch.RN A' was asked how she was alerted about R303's Fall?RN A replied: I just got done with her 12 o'clock med pass and was going into the nurses' working area when a CNA (CNA B) hurriedly approached me and said that a resident was on the floor inside the common area bathroom.RN A was asked if the CNA who found R303 witnessed the fall?RN A replied: No. No one witnessed the fall. CNA B happened to pass by the common area and heard R303 screaming for help, and was alone in the bathroom. The bathroom door was wide open, but I did not find any other staff with the resident nor in the common area. Just a group of residents. So CNA B went to the nurses' working area to find a nurse and found me. I immediately responded. RN A further described that she found R303 lying with her face down next to her wheelchair. Blood was (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	all over the floor. There was a [NAME] of blood on top of her head, but we could not tell how or where she hit her head. R303 sustained a cut requiring six (6) staples on her scalp. RN A recalled that she immediately assessed her and called the Nurse Practitioner, Nurse Manager, and the guardian.RN A was asked to describe the R303's cognition status and her transfer status on 12/20/25.RN A replied: R303 was alert to herself and often forgot that she needed assistance in going to the bathroom. She has Dementia as her diagnosis.RN A was asked whether any staff were assigned or present who put her in the common-area bathroom?RN A replied: No. RN A was asked: Are you sure the fall was unwitnessed by staff?RN A replied: Yes.RN A was asked: Was R303 supposed to be going to the bathroom and left by herself unattended?RN A replied: Staff generally sit out there with residents during activities, but we did not find any staff at that time. R303 was noted to be impulsive and forgets that she needed assistance to go to the bathroom. Her Care plan was to make sure she needed to be watched and therefore should not have been left there without staff in the common area. An attempt to interview the nurse aide (CNA B) who found R303 on the floor covered with blood in the common area bathroom, either in person or by phone. But CNA B was unavailable on 1/7/26 at 1:12 PM. A call was made, and the surveyor left a voicemail to call back with a callback number, but no call was returned. The Facility Social Worker (SW C) was interviewed by phone on 1/7/26 at 3:14 pm. SW C had access to R303's EMR at the time of the interview. SW C indicated that she was no longer assigned to the facility; however, she revealed that she performed the Brief Interview for Mental Status (BIMS) assessment for R303 on 11/24/25. SW C described R303's BIMS Score as a 5/15. SW C had indicated that R303 was observed to be more confused in the afternoon. SW C reported that the assessment also revealed that R303 required one-person assistance during transfers and 2-person assistance with a rolling walker. She commented that R303 should not have gone to the bathroom on her own without assistance. The BIMS assessment dated [DATE] was reviewed, and it was confirmed that there was no acute mental status change at the time of the assessment. However, R303 had behaviors present that come and go and change in severity. SW C further explained, R303 can be very impulsive to get up and out of bed and most often forgets that she needs assistance during transfers and walking. She needed assistance to go to the bathroom. R303 according to the review of the Electronic Medical Record (EMR) conducted on 1/7/25 at 10:35 PM, revealed that R303 was [AGE] years old, admitted to the facility on [DATE], with the diagnosis of Senile degeneration of the brain, Intracapsular Fracture of the Right Femur (status/post fall in October 23, 2025 at the facility), Aftercare Following Joint Replacement, repeated falls, Alzheimer's Disease, Cognitive and Communication Deficit, General Anxiety Disorders, Mood Disorder, Psychophysical Visual Disturbances, Psychotic Disorder with Delusions due to known physiological condition, in addition to other diagnoses. R303's Brief Interview for Mental Status Score was 5/15, assessed on 11/24/25. A score of 5/15 indicates severe cognitive impairment. Minimum Data Set (MDS) Assessment Section GG dated December 2, 2025, revealed: one-sided impairment on the upper extremity(shoulder, elbow, wrist, and hand), and no impairment on the lower extremities (hip, knee, ankle, foot). R303 uses mobility devices, including a walker and a manual wheelchair. Although R303 was assessed as independent with eating and oral hygiene, she requires substantial maximal assistance with toileting, hygiene, shower/bathing, and lower-body dressing. R303's transfer ability was assessed and required partial/moderate assistance with the following activities:(D.) Sit to stand (the ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed),(E.) Chair/bed-to-chair transfer (The ability to transfer to and from a bed to a chair or wheelchair), (F.) Toilet transfer (the ability to get on and off a toilet and commode) and(FF). Tub/Shower transfer (the ability to get in and out of the tub/shower).(I.) Walk 10 feet: (once standing, the ability to walk at (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	least 10 feet in a room, corridor, or similar space), and lastly(J.) Walk 50 feet with 2 turns: (once standing, the ability to walk at least 50 feet and make two turns).The above ADLs were assessed, and these specific activities of daily living (ADL) required partial to moderate assistance for R303. R303's MD Orders included: Transfer 1PA/Ambulation status, 2PA with walker, order date 10/29/2025, and Plavix Oral Tablet 75 mg (Clopidogrel Bisulfate once daily by mouth ordered on 11/8/2025. Plavix is a type of blood thinner that may cause bleeding , black or tar-like stools, red dark urine and vomiting blood. R303's Fall Incidents Report 2025 was reviewed:10/23/25. R303 had a Fall and sustained a right Femoral neck fracture and underwent surgical repair. Unwitnessed Fall12/20/25. R303 had a Fall and sustained a hematoma and laceration and was transferred to the ER for 6 staples to her scalp laceration. Unwitnessed Fall.12/25/25 R303 was found on her knees next to the bed. No injuries or transfer to the ER noted. Unwitnessed Fall. A review of the R303 Care Plan was conducted on 1/7/26 at 10:35 AM.It revealed:R303 was a care plan for incontinence: Provide assistive devices as needed was part of the incontinence intervention care plan dated 7/24/2024, which was not updated or revised. There was nothing written about assisting the R303 to and from the bathroom, as required for the one-person assist transfer in the GG assessment dated [DATE].R303 will experience no decline in the Range of Motion (ROM) or Ambulation. (Date initiated: 07/24/2024. Revision on 10/28/2025. Interventions: (A.) Encourage active ROM to the bilateral shoulders, elbows, and wrists. Date initiated: 7/23/25, Revision on 9/23/25. (B.) Encourage and assist with ambulation using a walker as tolerated. (Date initiated: 07/23/24, Revision on 07/03/2025.R303's care plan interventions were updated related to R303's fall at the facility on 1023/25, resulting in a hip fracture, and R303 underwent a hip replacement after a fall. R303 returned to the facility on [DATE]. The care plan is specified as follows:Reinforce the need to call for assistance.Transfer assistance status: 1 PA (Person Assist) Ambulation was 2PA (2-person assistance) with a walker (Date 7/13/2024, Revised on 10/29/2025).Weight Bearing status: WBAT (Weight Bearing as Tolerated) (Date initiated: 7/13/24, Revised on 10/29/25)R303's fall, dated 12/20/25, description indicated that the fall was unwitnessed, and there was no staff who assisted R303 in going to the common area bathroom. There were no staff members monitoring the residents in the common area at that time. The activity occurred simultaneously after lunch at 1:05 PM, after lunch time, and most residents' urge to use the bathroom may have been anticipated, although there was no call light access and no staff were present in the common area when R303 went to the common area bathroom by herself. Although the Hospital record dated 10/23/25 noted that R303 was in Hospice status due to a Dementia diagnosis, no hospice category was found in R303's Care Plan Report during the review of records held on 1/7/2026 at 4:00 PM. There was no Care Plan found reflecting that she was receiving Hospice Care ServicesAccording to the review of the facility's Interact SBAR Communication Form dated 12/20/2025 at 1315 (1:15 PM) for R303, the nurse noted, Appearance: (Summarize your observations and evaluation): Guest fell and requires sutures/staples for cranial laceration closure. The Facility's SNF/NF to Hospital Transfer Form described the following:Usual Functional Status before the acute change in Condition:Mobility: R303 Ambulates only with human assistance.ADLs: Needs Assistance with Bathing, dressing, toileting, and transfers. Independent with eating.Sensory Impairment: VisionBladder and Bowel Function: INCONTINENTUsual Mental Status/ Cognitive Function before the Acute Change in Condition:Alert, disoriented, but can follow simple instructionsA review of the Emergency Department ED Patient Discharge summary dated [DATE] revealed, admit date and Time: 12/20/25 Time 1400 and discharge date and Time: 12/20/25 at 14:44. Discharge Instruction: Head Injury, Adult and Laceration Care, Adult. Follow-up Instructions: Follow up with the Primary Care Provider or Specialist within 5 days. Staples will need to come out in approximately 1 week. Return to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Emergency Department for persistent, worsening or new symptoms. During the discussion with the Director of Nursing (DON) and the Administrator regarding R303's Fall on 12/20/25, the Director of Nursing (DON) immediately responded on 1/7/26 at 4:15 PM, stating that every resident has the right to use the bathroom on their own at any time. The DON further stated that, it is R303's right to go when she needs to go. She was not under one-on-one supervision. When the surveyor asked who was with the residents in the common area on 12/20/25 at 1:05 PM? The DON did not answer. The surveyor also asked whether they were supposed to be left with no staff during a group activity. The DON did not answer. Who was supposed to assist residents at the common area when they needed to go? Since R303 fell in the common area bathroom, who took her to the toilet? The DON answered, Residents can go to the bathroom on their own. We cannot stop them. R303 was not a one-on-one supervision. Then the DON said, That's fine! We are going to IDR (Independent Dispute Resolution) the citation anyway. Administrator on 1/7/25 at 4:20 PM, agreed on R303's right to go independently to the bathroom when she wants to. The Administrator stated, We can't stop residents if they want to go to the bathroom on their own when they choose to, while in their own room, and should not be restricted. She reiterated that it is the resident's right and they honor that. When the Administrator was asked whether she was aware of the 12/20/25 incident in the common-area bathroom, she insisted that it occurred in R303's own bathroom. The fall on 12/20/25, sustaining 6 staples and a head laceration and left-sided hematoma, occurred at the common area bathroom, not in the resident's room.The incident occurred in the common-area bathroom, not in the resident's room. She was unaware of this particular incident and stated, I thought she fell in her bathroom. The Facility's Fall Reduction Program (revised date of 9/25/2016), was reviewed on (1/7/25 at 4:00 PM).Purpose: To provide a safe environment for residents, modify risk factors, and reduce risk