

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235668	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2025
NAME OF PROVIDER OR SUPPLIER Wellbridge of Brighton		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 Dorr Road Howell, MI 48843	

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 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. (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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This citation pertains to intake 1220695Based on interview and record review, the facility failed to report an alleged violation to the state agency (SA) related to injuries of Unknown Origin for one resident (R701) of one reviewed for abuse. Findings include:Clinical record review revealed R701 was a long-term resident and admitted under care of Hospice related to advanced Alzheimer dementia, psychotic and mood disturbances and anxiety. R701 was primarily nonverbal, bed/chair bound, required two-person assistance with transfers and had a BIMS (Brief Interview of Mental Status) score of 2/15 indicating severe cognitive impairment.On 7/8/25 the State Agency received a concern that R701 was observed with yellow colored bruising to their middle (sternal) chest wall, and dark red purple bruising to their right rib cage. Neither of these injuries were consistent with the care R701 received and neither was the injury reported to the Hospice Provider or Guardian.On 9/11/25 at 2:30 PM, an interview was conducted with Hospice Register Nurse (RN) D who confirmed on 7/9/25 when they arrived to care for R701, they were greeted by Certified Nurse Assistant (CNA) C who asked if they (RN D) had heard about the bruising to R701. Per RN D they replied they had not and immediately assessed. RN D observed old healing yellow bruising on R701's sternum and breast and dark purple bruising (newer bruise) on their right rib cage. RN D then contacted R701's daughter who confirmed they too were not aware nor informed of the bruising.On 9/11/25 RN B and CNA C were interviewed. Per RN B they first identified sternal yellow bruising on R701while they were at the dining room table and their shirt was lying low on their chest and was visible. RN B went to CNA C and asked what the large yellow bruise was from. During the interview, CNA C confirmed they told two other Nurses about the sternal bruising (cannot remember the names of the two Nurses) and RN B commented that because CNA C said she reported the bruising, they did not follow up further.Review of the facility policy titled Abuse, Neglect and/or Misappropriation of Resident Funds or Property dated 3/2013 documented: .Staff shall report all incidents immediately to their direct supervisors and Administrator (NHA).A licensed nurse should perform an initial assessment of the resident.When questioned who at the facility was the Abuse Coordinator, A replied the Nursing Home Administrator (NHA) and herself. Further record review documented a Change in Condition authored by Abuse Coordinator A on 7/3/25 11:37 AM that R701 had obtained bruising to their side from a two-person transfer. However, there was no further documentation of how the bright yellow sternal bruising had occurred or why a transfer would cause bruising to a resident.When Abuse Coordinator A was asked how they reached the conclusion that the rib bruising was from a two person assist transfer, they were unable to confirm who reported the incident, and they would have to see who was working that day. Abuse Coordinator A further remarked that R701 had a history of aggression with two person transfers and assumed this is how the injury to their side had occurred.Abuse Coordinator A was questioned if the family was notified of this assumption and Abuse Coordinator A was unable to recall. Record review did not reveal any documentation to the family being contacted on 7/3/25.Review of the facility policy titled Abuse, Neglect and/or Misappropriation of Resident Funds or Property dated 3/2013 documented: .The licensed nurse shall immediately contact the residents attending physician and legal representative when an incident involving suspected abuse or neglect of a resident has occurred.Record review documented not until 7/9/25 at 11:24 .spoke with daughter providing updates regarding care, skin conditions.On 9/11/25 at 1:21 PM, The NHA confirmed they were the facility's Abuse Coordinator and part of that role includes investigating injury of unknown origin. The NHA showed the documented pictures of R701's bruises and confirmed this would have been formally investigated and reported to the State Agency if they were aware of the injuries. The NHA confirmed this was just brought to their attention during this survey.</p>		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This citation pertains to intake 1220695Based on interview and record review, the facility failed to conduct a thorough investigation for one resident (R701) of one reviewed for Injuries of Unknown Origin. Findings include:Clinical record review revealed R701 was a long-term resident and admitted under care of Hospice related to advanced Alzheimer dementia, psychotic and mood disturbances and anxiety. R701 was primarily nonverbal, bed/chair bound, required two-person assistance with transfers and had a BIMS (Brief Interview of Mental Status) score of 2/15 indicating severe cognitive impairment.On 7/8/25 the State Agency received a concern that R701 was observed with yellow colored bruising to their middle (sternal) chest wall, and dark red purple bruising to their ride rib cage. Neither of these injuries were consistent with the care R701 received and neither was the injury reported to the Hospice Provider or Guardian.On 9/11/25 at 09:30 AM, a clinical record document of a wound evaluation revealed a colored photograph evaluated on 7/4/25 Labeled #8-Bruise Body location: Location not set, Age Unknown, documented length 10.42 centimeter (cm) In-house acquired.The photograph revealed a dark purple and red colored elongated oval bruise and verification of its location was unknown, or hard to determine based on the photograph angle.A clinical record document of a wound evaluation revealed a colored photograph evaluated on 7/4/25 Labeled #9-Other Body location: Location not set Age Unknown, documented length 0.0 centimeter (cm) In-house acquired.The photograph revealed a large body surface area around folded skin bruising was noted as bright yellow colored with a smaller purple bruise and verification of its location was unknown.On 9/11/25 at 10:50 AM, an interview with the Director of Nursing (DON) and Regional Clinical Director A was requested related to unidentifiable pictures of bruising on R701. Abuse Coordinator A reviewed the pictures and too could not identify the anatomy of the injuries and mentioned we would need to call Licensed Practical Nurse (LPN) E who was identified as the Nurse who took the pictures.On 9/11/25 around 11:15 AM, a telephone interview conducted with LPN E in the presence of the DON and Abuse Coordinator A informed that they were given report by Register Nurse (RN) B that R701's had new bruising and that photographs still needed to be taken.LPN E required prompting of the pictures and recalled #9-Wound- very yellow bruising was on R701's chest/sternal area and #8- Wound- dark purple bruising, was unable to recall anatomical location.On 9/11/25 RN B and CNA C were interviewed. Per RN B they first identified the sternal yellow bruising on R701while they were at the dining room table. Their shirt was lying low on their chest and questioned to CNA C what this large yellow bruise was from. During the interview, CNA C confirmed they told two other Nurses about the sternal bruising (cannot remember the names of the two Nurses) and RN B commented that because CNA C said she reported the bruising, they did not follow up further.Review of the facility policy titled Abuse, Neglect and/or Misappropriation of Resident Funds or Property dated 3/2013 documented: .Staff shall report all incidents immediately to their direct supervisors and Administrator.A licensed nurse should perform an initial assessment of the resident.When questioned who at the facility was the Abuse Coordinator, Abuse Coordinator A replied the Nursing Home Administrator (NHA) and herself. Further record review documented a Change in Condition authored by Abuse Coordinator A on 7/3/25 11:37 AM that R701 had obtained bruising to their side from a two-person transfer. However, there was no further documentation of how the bright yellow sternal bruising had occurred.When Abuse Coordinator A was asked how they reached the conclusion that the rib bruising was from a two person assist transfer, they were unable to confirm who reported the incident, and they would have to see who was working that day. Abuse Coordinator A further remarked that R701 had a history of aggression with two person transfers and assumed this is how the injury to their side had occurred.Abuse Coordinator A was questioned if the family was notified of this assumption and Abuse Coordinator A was unable to recall. Record review did not reveal any documentation to the family being contacted on 7/3/25.Abuse Coordinator A was asked if there was a soft file of this investigation, including staff interviews, and education and Abuse Coordinator A confirmed there was not.Review of the facility policy titled Abuse, Neglect and/or Misappropriation of Resident Funds or Property dated 3/2013 documented: .As part of the investigation, the Administrator, or his/her designee, shall take the following action: Interview all witnesses.Witnesses shall include anyone who (1) witnessed or heard the incident; (2) came in close contact with either the resident the day of the incident (including other residents, family members, etc.) (3) employees who worked closely with the.victim the day of the incident. To the extent possible, all interviews should be summarized into a written statement, which is signed and dated.On 9/11/25 at 1:21 PM the NHA confirmed they were the facility's Abuse Coordinator and part of that role included</p>		