STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235668	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Brighton	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 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. This citation pertains to Intake 2990713.Based on interview and record review, the facility failed to follow up following an outside consultation, and receive an After Visit Summer (AVS) for one resident (R700) of two reviewed for outside appointments, resulting in missed antibiotic treatments. Findings include: Family Member O was interviewed on 5/11/26 at 10:20 AM and confirmed an allegation the facility failed to deliver appropriate medical care based on R700's specific needs and follow through with R700's (AVS) from ID (Infectious Disease) on 2/25/26 that indicated R700 was to receive antibiotics through August 2026. Family ?O' said they were contacted by the facility on 4/20/26 and the facility reported that R700 had increased drainage and required an urgent visit to the wound care clinic. Family ?O' further reported R700 had not been receiving their ordered long-term antibiotic (Keflex) as recommended by ID 3/11/26. The complainant stated they contacted the Director of Nursing (DON) and after multiple conversations, the DON confirmed the facility did not have the AVS from the 2/25/26 ID visit noting the long-term use of Keflex. A review of R700's clinical record revealed they were admitted to the facility 1/30/26 after a recent hospitalization for a prosthetic joint infection with an open wound over their left patella (knee bone). Upon admission, hospital discharge records recommended conservative management and collaboration with Infectious Disease (ID) for long term antibiotic therapy. A Nursing progress note dated 2/25/26 by Licensed Practical Nurse (LPN) A documented R700 returned from their ID appointment, with no paperwork. Continued review of the note documented LPN A spoke with Staff ?P' from the ID office regarding R700's guest visit on 2/24/26 and per Staff ?P', R700 had no new orders. It was noted the progress note from LPN ?A' did not indicate Staff ?P's position at the clinic (i.e. physician, nurse, etc.) On 5/11/26 at 12:00 PM, LPN A was contacted by phone for an interview, and no return call was made by the end of the survey. On 5/11/26, A clinical record review of the March 2026 Medication Administration Record (MAR) documented Keflex 1000 milligram (mg) was last administered at 6 AM on Wednesday 3/11/26. Record review revealed on 4/21/26 at 5:17 PM the facility received a fax from ID dated 2/25/26 titled, Infectious Disease Outpatient Return Visit Clinic Note (AVS) which documented to continue Cephalexin (Keflex) started during last admission from the hospital. The recommendations were to continue oral Keflex to complete the planned 6 weeks (until 3/2/26) then decrease to 500 mg (milligrams) twice daily. The Clinic notes further read, .Since there is an opening in the patella to the outside and the infection cannot be resolved surgically that is a method to minimize infection where the risk is significant. On page six of the clinic note (AVS) it was documented medication changes, Cephalexin (KEFLEX) 500 mg capsule take 1 by mouth every 12 hours-Previously 1000mg three times a day Start Date 3/2/26 End Date 8/17/26 . On 5/11/26 at 12:20 PM, the DON was interviewed and questioned about the note authored by LPN A from 2/25/26 which documented LPN A was told there were no new orders. When asked who Staff ?P' at the ID office reported to LPN ?A' there were no changes, the DON indicated they did not know. The DON was then asked if taking a verbal confirmation from an unknown person not knowing who they were, and not having valid written documentation from the consultant was appropriate, the DON replied it was not appropriate. The DON was questioned why the ID AVS from 2/25/26 was entered into the record on 4/21/26 and they confirmed after speaking with Family O it was discovered LPN ?A' did not receive the AVS for the (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/25/26 visit to ID and it was requested by the DON and provided from ID on 4/21/26. During the interview, the DON acknowledged the facility failed to ensure outside appointment consultations were followed identifying R700's missed AVS from 2/25/26. A Past Noncompliance (PNC) from 4/20/26 was presented and the DON/Designee would review five medical records weekly for 12 weeks to ensure outside appointment consultations are followed. Compliance date April 28, 2026. Audit Week One revealed R700 had an appointment with Nephrology on 5/4/26 at 11:30 AM and had no follow up communication from the appointment in the chart. The audit was documented on 5/5/26 to have receptionist contact physician to retrieve and fax to facility. On 5/11/26 The DON was informed the Electronic Medical Record (EMR) revealed no follow up documentation from their visit. The DON stated they remembered telling Receptionist C to contact the office and have it faxed. On 5/11/26 the Nursing Home Administrator confirmed both Receptionists C and D worked Tuesday 5/5/26. On 5/11/26 at 2:08 PM, an interview with Receptionist C stated they had no recollection of being asked by the DON to contact and retrieve the AVS and have it faxed for R700. On 5/11/26 at 2:22 PM, an interview with Receptionist D said they had no knowledge of R700 needing to retrieve the AVS and have it faxed for R700. Receptionist D further stated they thought that appointment was cancelled but could not confirm. On 5/11/26 at 3:02 PM, the DON acknowledged there was nothing to be found or documented whether R700 went to the appointment on 5/4/26. The DON acknowledged they performed the audit and did not follow up ensure outside appointment consultations were followed for R700. The DON then questioned if the PNC and audit was no good.