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	01/14/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary treatment and care consistent with professional standards of practice to promote healing of a compromised skin integrity to the coccyx area (area above the buttock region) and prevent new and or worsening pressure ulcer development for one resident (R5) of one reviewed for pressure ulcers resulting in R5 developing an unstageable pressure ulcer(a severe wound characterized by full-thickness tissue loss, where the base of the wound is obscured by slough or eschar, making it difficult to assess the true extent of tissue damage) to their coccyx area.Findings include:Clinical record review revealed R5 was admitted to the facility on [DATE] for physical therapy following hospitalization for surgical repair on 12/8/25 of their right femoral (large bone in leg) fracture related to a fall at home. R5 had developed urinary retention post operative and arrived at the facility with a Foley (indwelling urinary catheter). On 1/12/26 a review of the facility matrix identified R5 had a facility acquired pressure sore.On 1/12/26 at 10:39 AM, R5 was observed asleep, and unable to be interviewed. The brother who was visiting indicated that R5 fell at their home and required surgery to fix their leg. The brother further stated the facility informed them of a very bad sore on their backside and the pain medication Norco (narcotic medication) did not work and R5 was now on morphine. The brother remarked the wound was brought to his attention by the facility and has gotten so bad R5 has just since declined.Review of an admission skin check dated 12/11/25 at 8:00 PM by Licensed Practical Nurse (LPN) C documented .skin assessment of new admit day 1. Head to toe assessment completed w/3 <sic> (with three) people.lower backside their <sic> is a cluster of raised scab markings, guest did have on a foam dressing to the coccyx area. No open areas present. Scant amount of poop observed under dressing. admission skin check documented .No skin issues identified. Braden Score (tool used to assess a person's risk for developing pressure ulcers) totaled 13 which indicated R5 was at moderate risk for developing a pressure sore.Record Review authored by Registered Nurse (RN) D Documented as a Late Entry Effective Date: 12/12/2025 13:18:00, Created 12/30/2025 17:26:18 documented .2nd skin check completed.Foam dressing in place on coccyx, dressing removed redness noted to coccyx with small open area and non-blanchable.New Skin Issue documented on 12/19/25 at 18:22 by LPN I identified: New skin Issue. Location: Coccyx. Issue type: Moisture associated skin damage (MASD). Progress: New wound. Wound acquired in-house. Length centimeters (cm) 4.74 Width (cm), 2 Depth (cm):0 Area (cm2):8.09 undermining.Nursing Progress note dated 12/26/25 at 15:37 documented skin issue .coccyx area.Deteriorating, wound acquired in-house. It is unknown how long the wound has been present. Braden Score recorded on 12/26/25 was 7 indicating very high risk for worsening of pressure ulcer development.Nursing Progress note dated 12/27/25 (Saturday) at 9:00 AM, authored by LPN K documented .guest coccyx wound decline message sent to manager to assess on Monday and change wound care order. There was no new treatment obtained or implemented for two days after identifying the worsening of the coccyx wound.Clinical Record review of a Physician Progress note dated 12/29/25 (Monday) at 13:15 Physician Progress Note documented .Patient was seen for wound evaluation. Sacral wounds were evaluated. Wound is unstageable areas of eschar noted with yellow slough. Surrounding skin with erythema and MASD. On exam, patient is guarded.wound care (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

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	01/14/2026

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 0686 Level of Harm - Actual harm Residents Affected - Few	orders updated.pressure relieving interventions.On 1/13/26 at approximately 2:00 PM, a record review of R5's care plan was reviewed with the Director of Nursing (DON). The DON was asked why the care plan documented .The resident has.Unstageable pressure coccyx.Date Initiated: 12/11/2025. when this was not diagnosed by the Physician until 12/29/25, The DON opened a different care plan screen from their laptop which verified the author and change was done on 12/29/25 by Corporate Clinical (CC) AOn 1/13/26 at 2:30 PM, an interview with the DON and CC A regarding LPN C documentation of no open areas on 12/11/25. They both acknowledged a thorough skin assessment had not been completed. CC A was questioned who was RN D as their name was not on the facility employee roster, CC A replied RN D was Corporate and used as a Floating DON. CC A said RN D was in the facility helping on 12/12/25 and must had gotten busy. CC A figured RN D would be returning to the facility on [DATE] to document the skin assessment but must had been assigned to another facility, hence the Late Entry on 12/30/25.On 1/13/26 at 2:44 PM LPN C was attempted to be contacted by phone for an interview, but their phone indicated the caller was unable to leave a message. The facility also tried to contact LPN C and there was no response by the end of this investigation.On 1/14/26 at 8:38 AM, a telephone interview with RN D acknowledged recall of R5 and immediately reported they forgot to document their findings. RN D recalled R5 was in so much pain, that they rolled them to their side by themself, quickly assessed and redressed the coccyx area with a foam dressing. RN D admitted they are not good at measuring wounds by just looking at them, they had no measuring device, but confirmed the area was not blanchable, red, and had open skin. When questioned why they did not document Skin Assessment #2 from 12/12/25 until 12/30/25, the day after the Physician diagnosed the wound as unstageable, RN D stated they forgot to document and had left for vacation.Review of the Policy titled Pressure Ulcers/Skin Breakdown-Clinical Protocol dated 10/2010 documented: .The physician and staff will examine the skin of a new admission for ulcerations or indications of a Stage I pressure area.In addition, the nurse shall assess and document/report the following: Full assessment of pressure sores including location, stage, length, width, and depth.The physician will help the staff define the type.of an ulceration.

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	01/14/2026

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 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** Based on interview and record review, the facility failed to support continuity of a previous resolved grievance for one resident (R37) of one reviewed for grievances.Findngs include:Clinical record review revealed R37 was admitted to the facility on [DATE] with impaired mobility deficits related to recent hospitalization for respiratory and congestive heart failure. R37 required wound care for a diabetic right foot ulcer and required supplemental oxygen. Brief Interview of Mental Status (BIMS) assessed on 11/14/25 scored 15/15 indicating R37 was cognitively intact.On 1/12/26 at 9:49 AM, during initial interview and introductions, R37 voiced concern they previously complained to the facility that Certified Nurse Assistant (CNA) B hurts them when they are repositioned or placed into a Hoyer lift (mechanical lift). R37 stated they can't prove there is intent, they just handle them roughly. R37 said their concern was shared with the staff and was informed that CNA B would no longer be assigned to take care of them. R37 stated that CNA B sees them in their room, and R37 must remind the staff CNA B are not to care for them.On 1/14/26 at 8:26 AM, a Resident grievance/complaint form dated 12/29/25 by the Nursing Home Administrator (NHA) for R37 documented Complain regarding transfer, not comfortable w/one <sic> (with one) aide in particular. The NHA was interviewed and confirmed the aide was CNA B. The NHA documented on the investigation summary follow up dated 12/31/25, .Removed aide from all care. The NHA assured they informed the staff CNA B was not to be assigned to that room.Clinical record review revealed CNA B had documented on the Eating Treatment Administration Record (TAR) for R37 on 12/31/25, 1/2/26, 1/5/26, 1/8/26, 1/13/26. The NHA was informed of this information and replied they had informed the scheduler, and nursing staff that CNA B was not to be scheduled to care for R37's room.On 1/14/26 at 10:18 AM, CNA B accompanied with the NHA were interviewed. CNA B acknowledged they were not to take care of R37. However, they had been scheduled to the 700 hall and care for that room because there is suitemate and must ask other CNAs to oversee the care of R37 because of the grievance. CNA B validated they charted on the R37's Eating TAR because they were assigned to the room and put down the information which another CNA reported to them.On 1/14/26 at 11:45 AM, an interview with the Facility's Scheduler/CNA/Central Supply Scheduler F was questioned why CNA B was scheduled to care for the room of R37, and responded with surprise and said, That's the room?. The Facility Scheduler F who often works as a CNA, said the CNAs should collaborate and swap out rooms in such situations and there is no documentation on the schedule what room was picked up or what room was swapped. The CNA is assigned that hall and has that room; it is their responsibility to swap it out. CNA B had confirmed this in the interview but indicated sometimes they must care for the roommate and must be in room of R37.Scheduler F provided the following documentation confirming CNA B's assignment:Friday 1/2/26- CNA B assigned set #5-entire 700 hall.Monday 1/5/26- CNA B assigned set #5-entire 700 hall and documented room for R37 as highlighted in blue.Tuesday 1/13/26- CNA B assigned set #5-entire 700 hall.Scheduler F was asked if the NHA had made arrangement for R37's room not to be assigned to CNA B, why are they scheduled to the 700 unit, Scheduler F replied the CNA's have their units (indicating preference) and provided continuity of care.