STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235715	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Fenton	901 Pine Creek Drive Fenton, MI 48430

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area, resulting in the potential to spread food borne illness to all residents who consume food from the kitchen. Findings include:On 01/13/2026 at 8:25am-8:50am, during the kitchen tour with Certified Dietary Manager/Culinary Specialist A and Chef B, observed overhead spray nozzle hanging inside the sink basin near the dishwashing area. When interviewed at this time, CDM A stated there is a work order to fix the overhead spray nozzle. According to the 2022 Food Code, 5-202.13 Backflow Prevention, Air Gap, An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch).On 01/13/2026 at 8:25am-8:50am, observed yellow residue on the interior wall of the ice machine, located in the kitchen. When interviewed at this time on how often the ice machine is cleaned, CDM A stated it's cleaned every month. According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 01/13/2026 at approximately 12:30pm, during lunch observation, observed [NAME] C remove gloves and don gloves without washing hands during food preparation in the kitchen. During interview at this time, when asked about handwashing, CDM A stated staff are supposed to wash hands after removing and putting on new gloves.According to the 2022 Food Code, 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms.immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and.Before donning gloves to initiate a task that involves working with food.

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Based on observation, interview and record review, the facility failed to ensure that call lights were within reach, responded to in a timely manner, and that staff were respectful upon entering the residents' rooms and providing care for five confidential residents (#6, #35, #60, #75, #86) and a confidential group of residents.Findings include:Confidential Group of Residents On 1/13/26 at 2:00 PM, a group of Residents were assembled. The Residents were asked about any concerns they had regarding the care provided by staff at the facility. Three of the Residents answered questions and engaged in conversation. One Resident reported concerns of call lights not answered timely and reported wait times of 30 minutes at times. One Resident reported that staff would answer timely but leave to get supplies and then not come back or take a long time to return to address the Resident needs. When asked if there were concerns of staff with personal phone use while providing care, one of the Residents reported It has happened on occasion. They are talking and you don't know who it is they are talking to, and indicated during care provided, the staff was talking to someone else and indicated an earphone piece. Confidential Resident Z On 1/12/26, a Confidential Resident Z was observed in their room. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about concerns with their care and when asked if call lights were answered timely, the Resident reported concerns. When asked if they had to wait over 30 minutes, the Resident stated, Oh yeah. When asked if there were issues at a certain time of day, the Resident stated, varies shift to shift, depends on the shortage of workers and the workers themselves. The Resident reported that, at times, the call light would be answered, the staff does not help when they answer and stated, they don't always come back. I yell out or have to call again. Confidential Resident AA On 1/12/26 at 12:30 PM, observations were made in a dining area during the dining observation task of the survey. Resident AA was asked how their food was after introductions. The Resident had engaged in conversation and reported concerns with an issue with call light response times when the call light is used. The Resident reported long call light times and when asked if over 30 minutes, the Resident stated, Oh yeah, or they shut off the light and then don't come back, and we (indicated the Resident sitting next to them) have had to sit a long time, waiting for the call light to be answered. Resident #35 (R35) On 1/12/26 at 1:46 PM, an observation was made of Resident #35 sitting in his room. An interview was conducted with the Resident who answered questions and engaged in conversation. The Resident was asked about concerns with the care received at the facility. The Resident expressed, Call lights at night is a problem. Day time they answer quick, nighttime not so much. When asked if he had to wait more than 30 minutes and Resident stated, Yes, it can be, and reported 30 minutes or longer sometimes. The Resident reported that he would call for assistance, something to eat or drink and stated, It can take a while. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of R35's medical record revealed an admission into the facility on [DATE] and readmission on [DATE] with diagnoses that included end stage renal disease, emphysema, dementia, anxiety disorder, and stroke. A review of the Minimum Data Set assessment revealed R35 had a Brief Interview of Mental Status score of 15/15 that indicated intact cognition. On 1/13/26 at 4:59 PM, an interview was conducted with the Director of Nursing (DON) regarding call light response times. The DON was asked about call light response times and when should call lights be responded to by staff. The DON reported under ten minutes. The DON reported that they were working on a plan of correction for call light response times and reported they review call lights and anything over an hour, do a plan of correction, review at a weeks length, the Administrator reviews the call light response times, call the CNAs to see what happened and do education as needed. The DON reported that they were starting with getting two supervisors on the nightshift and reported hopefully that will remedy that if it is happening. When asked about concerns with turning off call lights before the needs are met, the DON reported that concern was not brought to my attention. Resident #75 (R75): According to R75's Electronic Medical Record (EMR), R75 was [AGE] years old admitted to the facility on [DATE] with the diagnosis of Hemiplegia and Hemiparesis following Cerebral Infarction affecting right dominant side, muscle wasting and atrophy, paralytic gait, anxiety disorders and major disorders in addition to other His Brief Interview for Mental Status (BIMS) score was 14/15 dated (11/25/25). A score of 14 means the person is cognitively intact. Minimum Data Set (MDS) assessment dated [DATE], revealed that R75 is dependent on toileting. Dependent means that the helper does all of the effort. The resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the residents to complete the activity. R75 Care Plan for Urinary Incontinence related to immobility (revised in 2/20/2024).R75's Goals were: Will have no complications due to incontinence. Will be free from skin breakdown. Will attain/maintain as clean and dignified state as possible. On 01/12/2026 at 12:28 PM, R75 was in his room watching a show on his iPad. R75 was asked how he was. Then he responded, I wet my pants a while ago, but they won't come. I think I am being ignored. When the surveyor asked what he meant and if he had activated his sensor touch alarm next to him. R75 said yes. R75 grabbed his call light (flat, rounded shape) and pressed to activate the sensor touch call light again. The surveyor observed and timed the call light after R75 activated the call button again at 12:30 PM on 01/12/26. The surveyor had noticed the nursing staff CNA Y came in at 12:48 pm (18 minutes elapsed since R75 activated his call lights). Certified Nursing Assistant (CNA) Y was interviewed on 1/12/26 at 12:58 PM, regarding R75's delayed call light response and why it took her a long time to answer his light. CNA Y explained that she was assigned to R75 and some residents in the 100 halls. She carried the pager and showed me that she knew that R75 had pressed off his call light, but he was at the dining hall feeding a resident, and that she could not leave the area. The CNA Y was asked how other staff can get notified to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	respond to the light when you can't? CNA Y replied, Yes, and showed where the monitor screen is located. This notifies and alerts staff in the hall when a call light is activated. The screen shows staff which call lights were activated, by room number, and the length of wait time since activation. It shows how long the call lights have been on, and it tells staff how long residents have been waiting. CNA Y confirmed that the monitor displayed the wrong time, date, and year. CNA Y recognized and confirmed that the time on the screen read 1:41 AM, while the actual time was 12:58 PM, and that the date and year were inaccurate. On 1/14/26 at 10:48 AM, R75 was observed receiving incontinence care with the nursing staff and the wound nurse. Irritation and skin impairment were observed. The wound nurse confirmed an open area that had recently developed at the coccyx area. During the assessment, the wound nurse measured the wound in the coccygeal area: L (length) 1.27 cm, W (width) 1.09 cm, Area 1.14 cm, and depth 0.1 cm. These measurements were recorded in R75's EMR on 1/14/26. Resident #3 (R3) On 01/12/2026 at 12:48 AM, R3 was interviewed and revealed issues with delayed call light response and staff failing to show respect and maintain the resident's dignity. R3's Power of Attorney (POA) F was at her bedside in R3's room. During the interview, the resident's POA F mentioned the following complaint: experiencing a longer wait after activating the call light. R3's POA stated a wait of about 45-50 minutes. POA F recalled walking down the hall to find staff. He revealed R3 had to wait a long time before staff laid wet on the bed, sometimes for a pain medication or assistance. R3's POA emphasizes that she needs pain medication and is on a Fentanyl Patch. POA F stated, The staff are never abusive nor rude, but they are neglectful with call light response. I walk to find them on their phones or computers in the hall. POA F recalled another incident and said, One time she was choking on her food, so I had to walk to the common area and found a nurse in her computer. According to the review of the Electronic Medical Record (EMR), R3 was [AGE] years old and admitted to the facility on [DATE] with the diagnosis of acute right heart failure, Dementia, Urinary Tract Infection, Chronic Kidney Disease, and polyneuropathy in addition to other diagnoses. R3's care plan (revised on 1/12/26) indicated a cognitive impairment with a Brief Interview for Mental Status (BIMS) Score of 8. A BIMS Score of 8 indicates a moderate cognitive impairment. R3's care plan revealed that R3 is on a diuretic (water pill) prescription, and the goal is for R3 to be free of any discomfort or adverse side effects of diuretic therapy. Two 2 Confidential group of residents reported: A confidential group of residents on 1/12/16 at 1:00 PM expressed: Nursing assistants are on their phones a lot while providing care. They are looking at their phones and don't care about us. Another confidential group of residents on 1/14/26 at 1:50 PM reported that staff continue to have a delayed response to call lights. This confidential resident stated, It's not quick enough, and sometimes I have to go bad. It's not as quick as I needed them to be, especially right after meals. When asked about any other concerns, he replied that one staff member is on her cell phone when helping me to the toilet. Resident 60: According to a review of R60's medical record, the resident was admitted to the facility on [DATE] (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for skilled nursing care related to medical diagnoses of: fracture of right great toe, cellulitis (Infection) of right toe, atherosclerosis (hardening of arteries) of right left with gangrene (infection), Proteus Mirabilis Morganii (multi-resistant drug organism – MDRO) Additional diagnoses included: diabetes mellitus, right dorsum 1st digit (Hallux) - amputation in 09/2025 including treatment of hyperbaric chamber therapy. R60's Minimum Data Set (MDS) record revealed Brief Interview of Mental Status (BIMS) score of 13/15 and indicated the resident was cognitively intact. On 01/12/2026 at 10:22AM, During a walkthrough of unit outside of R60's door was observed a sign that indicated enhanced barrier precautions (EBP) were in place for the resident, a cart of personal protective equipment was present. The infection control prevention (ICP) Nurse N was in the hall and was queried why the precautions were in place and she responded, for wounds. On 01/12/2026 at 10:22AM, An observation of R60 was made in his room, resident was sitting in his chair and was dressed wearing black and gray gloves on bilateral hands. When R60 was asked about the gloves, he said that he has neuropathy and wears those to help. R60 reports he has been at the facility for 11 months or so and that he had a wound on his right great toe and that he had part of it amputated, he reports being in hyperbaric oxygen therapy for it several times a week and that he had to put skilled services on hold until he healed. On 01/13/2026 at 08:20AM, During medication administration rounds R60's room was entered with Nurse J. Upon entrance to the room R60 stated Oh am I glad to see you this morning, I have a story to tell you. R60 proceeded to explain his concerns to Nurse J and SA. R60 expressed great concern over the many visits to his room earlier that morning and said it started at around 5:30AM. R60 reported that at least 7 staff members have been in and out of his room since that time. R60 stated I treated my inmates better and it's a level of respect; you don't just barge in someone's room/space. When R60 was asked to explain what he meant, R60 reported they barely knock and then enter my room, it is alarming and disrespectful; At least give me the dignity to answer before entering my room, and he said he did not understand why they were doing that last night or what games they are playing; I call when I need help. R60 said he doesn't sleep well and had to go to therapy offsite which was hard on him, and he needed his rest. R60 said he was upset over one of the early morning visits where he said the staff had made an attempt to clip (and clean) his toenails and he reported it was odd to him that they only completed the task on his right foot. R60 said he was concerned about his feet and said he wanted to see what the staff had done. R60 further expressed concern over the dressing and that it had been applied too tightly, he said he was worried about a setback on the progress he had made with healing. R 60 said they did not listen to him when he mentioned it this morning. R60 said they brought his breakfast too early at 7:30AM, he does not like to eat that early. R60 further complained that the breakfast was ice-cold. They (staff) don't care. R60's call light was observed wrapped around his nightstand drawer handle and knotted 3 times, R60 was unable to reach the call light when asked. Nurse J was present and responded, Oh my, that is really tied on there and she untied the call light and placed it where the resident could reach before she left the room. A record review of R60's care plan revealed: Focus: Risk for falls r/t (related to) bradycardia, OA (osteoarthritis), hx DVT (deep vein thrombosis), (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	OSA (obstructive sleep Apnea), PVD, prediabetes, vertigo, bilateral foot drop, neuropathy, cardiac dx(diagnoses), potential medication side effects Interventions: Reinforce need to call for assistance and Transfers: 2 PA (person assist) with 2ww (2 wheeled walker); non-ambulatory Focus: The resident has potential for and actual impairment to skin integrity r/t fragile skin, obesity, CHF (congestive heart failure), gout, hx DVT, PVD, prediabetes, BLE neuropathy, bilateral foot drop, hx pressure wound, R. Great toe amputation. Interventions: Encourage good nutrition and hydration in order to promote healthier skin. Focus: Alteration in nutritional status related to Recent hospitalization s/p (status post) fracture of (R) toe. PMH (primary medical history): GERD, obesity, CHF, prediabetes, gout. Interventions: Honor food preference. Focus: ADL/Mobility deficit related to right great toe fracture, right great toe cellulitis with dry gangrene, right groin abscess s/p debridement, wound positive for proteus mirabilis, obesity, CHF, gout, HTN, HLD, bradycardia s/p pacemaker, OA, hx DVT, OSA, PVD, prediabetes, vertigo, bilateral foot drop, GERD Interventions: Assist with dressing, hygiene and toilet needs. Focus: At risk for changes in mood r/t medical condition, adjustment disorder, reaction to severe stress concern of injuring his r foot/toe and losing his leg- fears he will not be able to go home, sadness, tearfulness. Interventions: -Provide opportunities to express self; Reassure him it is normal to be afraid of not being able to go home; Offer encouragement by highlighting the progress they have already made. And Offer choices and encourage participation in healthcare decisions to enhance sense of control. Resident 86: According to a review of R86's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to medical diagnoses of respiratory syncytial virus (RSV) pneumonia (PNA), fall, cellulitis of right lower limb (infection), bilateral lower extremity lymphedema (excessive fluid collection in lymphatic system), peripheral vascular disease (PVD) with venous insufficiency, and chronic kidney disease (CKD), stage 2 (mild kidney damage). On 01/12/2026 at 11:55AM, R86 was observed in her room, she was seated in a bariatric wheelchair with the bedside table placed in front of her. R86's call light was observed at the head of the bed hanging off the left side and, on the floor, out of reach. When R86 was asked if she was able to reach the call light, she confirmed that she was unable to reach it. Observed on R86's dresser was a tray of partially consumed food, R86 said that it was her tray from breakfast that staff had left. R86 said they should be bringing her lunch soon. Physical therapy manager H entered the resident's room with a lunch tray. Physical therapy manager H was asked to locate R86's call light, she looked and pointed at the head of the bed on the floor, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	when she was asked if that is where it should be she said, no it should be where the resident can reach it. Physical therapy manager H was asked about the tray on R86's dresser, and she stated Oh, that is from breakfast and should not be there. Physical therapy manager H said she was unsure why it was still there and that she was going to take it with her when she left R86's room. On 01/12/2026 at 12:34AM, An observation of Physical therapy manager H was made in the hall as she exited R86's room, there was nothing in her hands. At ~12:35PM During a follow up observation of R86's room, a dirty food tray was observed on the dresser with a meal ticket that read: 1 [NAME] sugar, 1 8-ounce spoodle Oatmeal, 1 Scrambled eggs #16 scoop, 1 Home fried potatoes with pepers#8 scoop, Cinnamon Struddle CC 2x2 square, 1 large OJ, 1 large water. R86 was eating lunch, when asked about the tray on the dresser, she said they (staff) say they are going to do things, but they don't and explained further, just like my bed is still unmade and they were supposed to clean up my room when I when to therapy this morning and as you can see they did not. She said they are too busy to stop and help. On 01/13/2026 at 1:58PM, R86 is observed resting in bed, watching television. During a follow up interview, R86 said she was upset that last night she did not eat her pie, and she asked them (staff) to leave the pie for her, and she would eat it later. R86 said when they took her tray, they took her pie and when she asked later for a piece there was no more. R86 said she does not think that staff listen to her. A record review of R86's Kardex bedside care plan revealed: Behavior/mood: Allow me time to express my feelings. A record review of R86's care plan revealed: Focus: Risk for falls r/t RLE (right lower extremity) cellulitis, BLE (bilateral lower extremity) lymphedema, falls, HTN (high blood pressure), GERD, PVD, hypothyroidism, edema, HLD (high cholesterol), neuropathy, venous insufficiency, CKD. Intervention: Educate guest wo (to) wait for assistance and use call light for toileting needs. and Transfers: 1 PA (person assist) w/ 2WW (with 2 wheeled walker); non-ambulatory. Focus: ADL/Mobility deficit related to GI bleed and anemia RLE cellulitis, BLE lymphedema, falls, HTN, GERD, PVD, hypothyroidism, edema, HLD, neuropathy, venous insufficiency, CKD. Intervention: Assist the pt with showers/bed baths and Assist with dressing, hygiene and toilet needs. Focus: Behavior r/t new environment with recent hospitalization Intervention: Allow me time to express my feelings. A record review of facilities Policy titled Quality of life- Dignity revealed: Statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Policy interpretation and implementation: 1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. 6. Residents' private space and property shall be respected at all times. a. Staff will knock and request permission before entering residents' rooms. 7. Staff shall speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide an appropriate and timely Beneficiary Notification (NOMNC and ABN) to two (2) residents (Resident #95 and Resident #67) of 3 residents reviewed for Medicaid/Medicare Coverage/Liability Notice.Findings include:FacilityResident #95 (R95)On 1/13/26 at 12:00 PM, the surveyor requested a NOMNC and ABN Notification for 3 residents. It was noted upon review of the submitted documents that the facility did not issue Resident #95 (R95) a Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) on the resident's last covered date of 8/30/2025.A review of the Electronic Record revealed that, according to the Census Report in PCC, R95 billing status immediately switched from Medicare Part A to private pay on 8/30/25.The facility Social Worker SW was interviewed on 1/13/26 at 2:50 PM. The SW explained why no NOMNC and ABN Form were submitted for R95. She apologetically explained that they had missed issuing R95's NOMNC and ABN. The facility believed his Last Covered Day (LCD) was on September 5, 2025, but corporate billing corrected them, stating it was actually 8/30/25. By the time they were informed, the LCD had already passed, and it was too late to issue the NOMNC. When asked what policy is, SW knew that NOMNC letters are notices informing the resident or the financially responsible party of the end date of insurance coverage. The residents have the right to appeal for an extension before the last covered day. The SW admitted , It was my job to issue the NOMNC Letter to the residents. The ABN forms are issued by the [NAME] Department. I am responsible for the NOMNEC letters. I remembered, we missed giving both NOMNC and ABN notices to R95. When the SW was asked what happened as a consequence, the SW revealed that they spoke to R95 and R95 decided he wanted stay and opted to pay as a private payor for the remaining days.R95 pay status was explained by the Business Office Manager (BOM) on 1/13/26 at 4:41 PM. The BOM admitted that she missed issuing the ABN to R95 because it was too late. By the time they realized the actual LCD, R95 had already passed the cut date. R95 had exhausted his 100 days. The BOM explained that R95's payor source changed from Medicare Part A status to a full private pay right after the CD on 8/30/25. R95 opted for private pay status from September 1, 2025, until the resident was qualified and eligible for Medicaid benefits. The BOM admitted she was responsible for issuing the ABN Notices to residents, and that in case R95, they missed it. The facility's LCD was incorrect; the correct date was 8/30/25, but they thought it was 9/5/25. It was too late to issue a cut letter. The BOM further stated that because R95 opted to remain in the facility, he had to pay the full amount of his stay daily until he became Medicaid eligible. The BDM revealed that R95 was not able to appeal because the NOMNC and ABN notifications did not happen.A review of R95's Electronic Medical Record conducted on 1/13/26 at 12:00 PM revealed that R95 was admitted on [DATE] under Medicare Part A through 8/30/25. Because he opted to remain in the facility, R95 immediately switched to Private Pay status effective September 1, 2025. He currently remains on Medicaid at the facility.Resident #67 (R67)R67 was [AGE] years old and admitted to the facility on [DATE]. According to the NOMNEC, the effective date coverage of the current Skilled Nursing Services ends on 12/27/25. R67's wife was the designated Power of Attorney for both Medical and Financial Agreements/Transactions.The SW was interviewed on 1/13/26 at 2:55 PM and indicated that she issued a NOMNC to R67's wife on 12/23/25. His LCD was 12/27/25. When asked why the ABN was missing, the SW stated that the Business Office Manager (BOM) had issued it. Wife did not appeal to the NOMNEC letter.On 1/13/26 at 4:45 PM, the Business Office Manager (BOM) revealed that the ABN was issued to R67 and signed by the wife on 1/24/25. The BOM was asked to explain why the date the document entered was covered with whiteout. The BOM admitted that the wife signed the ABN 12/26/26 and stated that she had changed the date to 12/24/25. The BOM admitted that she used whiteout to change the date to an earlier one. The BOM revealed that she was unsure when or what the ABN Notification date should be, so she changed the date to 12/24/25 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Fenton	901 Pine Creek Drive Fenton, MI 48430

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the wife had signed. R6's wife was at the facility after Christmas and had signed the ABN on 12/27/25. The BOM indicated that the date was changed to 12/24/25. BOM was asked whether the wife knew and consented to the BOM changing the date to 12/24/25; the BOM did not reply.A phone call was made to R67's wife on 01/15/26 at 10:42 AM. R67 stated she was not at the facility on 12/24/25 but remembered signing papers during her visit at the facility the weekend (12/27/25) after Christmas Day.During a Quality Assurance and Performance Improvement (QAPI) Meeting with the Administrator and the Corporate Staff held on 1/14/26 at 4:00 PM, concerns were raised about the surveyor's findings regarding the Beneficiary Notices. Neither the Administrator nor Corporate had any comment.The Beneficiary Notice policy was requested and reviewed. The Form Instruction CMS 10095-NOMNC OMB Approval 0938-0910 (undated) was submitted by the facility for the NOMNC. The second Form was titled: ABN Decision Tree (undated) Beneficiary Notice Initiative Summary (Medicare FFS Beneficiaries only). Both forms submitted to the surveyor for review were not the facility policies.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that nail care was provided, and handwashing was offered prior to dining for one resident (Resident #6), of one resident reviewed for Activities of Daily Living (ADL) care.Findings include:Resident #6 (R6):On 1/12/26 at 1:08 PM, an observation was made of R6 sitting up in bed eating lunchtime meal. The Resident expressed that he liked the food. An observation was made of the Resident eating some of his food. The Resident had chocolate on his overbed table, bed sheet, blanket, and on the bed frame. The Resident asked to have his pillow put back underneath his head that was laying on the floor underneath his bed. Staff were summoned and assisted with the pillow underneath the Resident. The Staff member did not assist with cleaning the chocolate from the items or offered to wash the Resident's hands. An observation was made of R6's hand with long fingernails on right hand with debris under the nails. Around the nails in the cuticle area, there were dried red tainted debris. The Resident did not have anything on the meal tray that had red sauce. The lunch time meal had a red sauce/soup and rice that had been observed during dining in the dining room, but the Resident did not have that item available at this time. When asked about showering or bathing, the Resident reported getting a bed bath about once a week or more. When asked if staff have offered to do nail care the Resident indicated they have not always asked and stated, It's something that can be easily overlooked. The Resident showed his left hand that he picked up with his right hand and reported he does not use that side after a stroke. An observation was made of the nails longer on his left hand but were cleaner underneath the nailbeds. The Resident reported he liked to have short nails. Closer observation of the right hand revealed a broken jagged nail. The Resident was unshaven and reported he liked it that way. On 1/13/26 at 12:32 PM, an observation was made of R6 sitting up in bed. An observation was made of R6's fingernails that remained long on both hands and debris under the nails on the right hand with red debris around the cuticle area of the nails on the right hand. After leaving the Resident's room, an observation was made outside at the Resident's doorway, two staff came in to set the lunch meal tray for the Resident. The staff did not offer to have the resident wash his hands prior to eating his lunch. A review of R6's medical record revealed an admission into the facility on 9/13/24 and readmission on [DATE] with diagnoses that included stroke affecting left non-dominant side, depression, bipolar disorder, anxiety disorder, and metabolic encephalopathy. A review of R6's Minimum Data Set assessment revealed a Brief Interview of Mental Status of 12/15 that indicated intact cognition and the Resident needed substantial/maximal assistance with bathing and personal hygiene. On 1/13/26 at 4:30 PM, an interview was conducted with the Director of Nursing (DON) regarding ADL care for Resident #6. An observation was made with the DON of R6 lying in bed. An observation was made of R6's nails that were long with debris on the right-hand nailbeds. The DON stated, Yeah, he needs some attention. The Resident reported they were too long when asked how he liked his nails and reported he wanted his nails done.A review of the medical record for R6 revealed a lack of documentation of the refusal of nail care. The DON reported they don't always document the refusals if its care planned. The Resident's care plan reflected that the Resident was known to refuse nail care. When asked how they know when nail care was provided, the DON reported that under the task when the shower or bathing is documented, then it was all encompassing to reflect that the nail care was performed at the same time. When asked if staff was then documenting nail care completed when shower was marked, the DON replied yes. The concern was brought up that the residents did not have nail care completed with the recent showers documented. The DON was asked about handwashing before meals. The DON was asked when should hand washing be accomplished prior to meals, the DON reported that if they were visibly soiled, she would help them get up and wash their hands. The DON was asked if R6's hands were visibly soiled; the DON reported yes and indicated his hands would need to be washed. A policy regarding nail care was requested but not received prior to the exit of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that medications were securely stored for safe administration, for one resident (Resident #78 (R78)) of 12 residents, 1 medication storage room, and 4 wall-mounted medication storage units reviewed for medication storage, resulting in the potential for medication error or misappropriation.Resident #78 (R78):According to a review of R78's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to medical diagnoses of Chondrocostal junction syndrome (inflammatory condition affecting the cartilage where the ribs in sternum meet), subsequent fall, acute with chronic respiratory failure, Myocardial infarct (heart attack), chronic obstructive pulmonary disease (COPD) and Dementia. R78's Minimum Data Set (MDS) record revealed Brief Interview of Mental Status (BIMS) assessment score of 6/15 indicating severe cognitive impairment. On 01/12/2026 at 9:45AM, R78 was observed resting in bed. R78 said she has not been at the facility long but was unable to give details.On 01/12/2026 at 10:26AM, R78's family member M approached SA in the hall and asked for assistance. Family member M was holding a small white pill in her hand and said R78 was asleep when she arrived and found this just sitting on her (R78's) over the bed tray, family member M said she was concerned about what the medication was and if R78 was supposed to take it now that she was awake or what it was and if she needed it or was supposed to have already had it. SA walked down the hall with family member M to find the nurse. Encountered on the hall was ICP Nurse N and family member M asked her the same questions. ICP Nurse N said I don't know I am not (R78's) nurse. ICP Nurse N said she would find R78's nurse to ask her and ICP Nurse N took the medication from family member M and walked away with the medication.As Family member M walked back toward R78's room she stated, I just need to know what it is and if she needs to take it and said that R78 was unable to tell her and she did not want her to take the medication without finding out what was going on first. On 01/12/2026 at 10:54AM, During a follow up interview with family member M she said R78's nurse (Nurse I) told her that she witnessed the resident take her morning medication and nothing dropped and she was not sure where the pill found had come from. Family member M said she was concerned that R78 had missed other medications, but they (family) were not able to be at the facility to observe R78 at medication times. R78 was observed resting in bed visiting with family. On 01/12/2026 at 10:56AM, During an interview with Nurse I she was asked about R78's medication, Nurse I said she had spoken with ICP Nurse N and had identified the pill as prednisone. When asked if R78 was prescribed prednisone she said yes. Nurse I further explained that she had witnessed R78 when she took her morning medication, and she had no idea where the unsecured pill came from. A record review of R78's medical orders revealed:?Prednisone oral tablet 5mg: give 1 tablet by mouth in the morning' On 01/12/2026 at 11:05AM, During a follow up interview with ICP Nurse N she was queried about the medication family member M found in R78's room, she reported that she had checked with the nurse on R78's hall Nurse I. ICP Nurse N said that Nurse I' told her, ?She (Nurse I) witnessed (R78) take her medication that morning and that she (R78) swallowed all her medication'. ICP Nurse N speculated that the pill was potentially left from yesterday but could not verify when it was left at the bedside. ICP Nurse N said the medication was identified as Prednisone. ICP Nurse N stated I am doing an on-the-spot education through the building to assure that we are confirming medications are witness and never left at the bedside. A record review of the facilities policy titled medication administration general guidelines revealed: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility patient distribution system (procurement, storage, handling and administration). The facility has sufficient (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff and medication distribution system to ensure safe administration of medications without unnecessary interruptions. Medications are prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to prepare and administer medications. A record review of the facilities policy titled Medication storage in the facility revealed:Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.Procedure: B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are permitted to access medications. Medication rooms, carts, and medication supplies are locked when not attended by persons with authorized access.C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label.E. Except for those requiring refrigeration or freezing, medications intended for internal use are stored in a medication cart or other designated area

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow enhanced barrier precautions (EBP) for residents identified with qualifying wounds and percutaneous endoscopic gastrostomy tubes (PEG - delivers nutrition and medications directly into the stomach), for two residents Resident #9 and Resident #60 (R9 and R60)) of eight residents reviewed for infection prevention. Findings include:Resident #60 (R60):According to a review of R60's medical record, the resident was admitted to the facility on [DATE] for skilled nursing care related to medical diagnoses of: fracture of right great toe, cellulitis (Infection) of right toe, atherosclerosis (hardening of arteries) of right left with gangrene (infection), Proteus Mirabilis Morganii (multi-resistant drug organism - MDRO) Additional diagnosis included: diabetes mellitus, right dorsum 1st digit (Hallux) - amputation in 09/2025 including treatment of hyperbaric chamber therapy. R60's Minimum Data Set (MDS) record revealed Brief Interview of Mental Status (BIMS) score of 13/15 and indicated the resident was cognitively intact.On 01/12/2026 at 10:22AM, During a wall through of unit outside of R60's door was observed a sign that indicated enhanced barrier precautions (EBP) were in place for the resident, a cart of personal protective equipment was present. The infection control prevention (ICP) Nurse N was in the hall and was queried why the precautions were in place and she responded, for wounds.On 01/12/2026 at 10:22AM, An observation of R60 was made in his room, resident was sitting in his chair and was dressed wearing black and gray gloves on bilateral hands. When R60 was asked about the gloves, he said that he has neuropathy and wears those to help. R60 reports he has been at the facility for 11 months or so and that he had a wound on his right great toe that he had part of it amputated, he reports being in hyperbaric oxygen therapy for it several times a week and that he had to put skilled services on hold until he heals.On 01/13/2026 at 08:20AM, During medication administration rounds R60's room was entered with Nurse J. Upon entrance to the room R60 stated Oh am I glad to see you this morning, I have a story to tell you R60 proceeded to explain his concerns to Nurse J and SA. During this time R60 expressed great concern over the many visits to his room that early morning starting at 5:30AM and reported that at least 7 staff have been in and out. R60 was concerned over the attempt staff had made that morning to clip his toenails (and reported it was only completed on his right foot). R60 was concerned and wanted to see what the staff had done as he expressed concern over that the dressing had been applied too tightly and the potential for a setback on the progress he had made with healing. R60 requested Nurse J to unwrap his feet and evaluate them and said that he also wanted to visualize them for his self.During wound care observation Nurse J was observed. During preparation of wound care supplies she placed unwrapped rolls gauze wrap directly onto R 60's bed prior to applying it to resident with no barrier used to cover the dirty linen. On 01/14/2026 at 12:02PM, During an interview with ICP Nurse N she was advised on concerns over use of proper PPE and barriers used in both wound care and medication administration via PEG tub with residents in EBP. ICP Nurse N revealed that Nurse K had come to her after the medication administration and was very upset with herself, reported that Nurse K said she was nervous and had told ICP Nurse N that she had not donned a gown until she was asked about the proper PPE needed to perform the tube feeding site and medication administration care. ICP Nurse N said We just recently had training and that it is known to staff to use barriers and PPE.A record review of R60's medical orders revealed: Dated 01/08/2026: Enhanced Barrier Precautions as directed. This includes gowns and gloves for high-contact resident care activities. Specify why: wound.Dated: 01/06/2026: WOUND CARE: Right foot wound. Cleanse with mild soap and water, pat dry completely. Cover wound bed with hydrogel and gauze. Place dry gauze between incision and between amputation site and second toe. Wrap with kerlix and do not apply tape to skin to secure in place. Monitor for increased s/sx (signs and symptoms) of infection, report spreading redness, increased drainage, streaking, fever, malaise to provider.Dated 01/02/2026 Wound Care: Left foot, great toe, second, third and fourth digit: Cleanse (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with betadine swab, allow to dry completely, gauze between toes. Can wrap with kerlix for comfort. Monitor for s/sx of infection, notify provider of any abnormalities.Resident #9 (R9):According to a review of R9's medical record, the resident was admitted to the facility on [DATE] for long term nursing care related to medical diagnoses of cerebral infarction (stroke), dysphasia and aphasia (difficulty or inability to speak, swallow and comprehend language), palliative care, PEG tube and obstructive uropathy. R9's Minimum Data Set (MDS) record revealed Brief Interview of Mental Status (BIMS) score of 00/15 indicating severe cognitive impairment.On 01/12/2026 at 11:00AM, During a wall through of unit outside of R60's door was observed a sign that indicated enhanced barrier precautions (EBP) were in place for the resident, a cart of personal protective equipment was present.On 01/12/2026 at 11:05AM, ICP Nurse N was in the hall and was queried why the precautions were in place and she responded, for PEG tube and wounds.On 01/12/2026 at 1:37PM, R9 is observed in her room resting in bed with eyes closed. Resident was nonverbal and had minimal physical response when spoken to, she was unable to interview. On 01/12/2026 at ~(approximately) 1:56PM, During an interview with CNA P she reported R9 is on hospice, and she was nonverbal but will nod or track with her eyes. CNA P said R9 had EBP's for wounds. Nurse T was present and when asked about wound care and PEG tube observations, she said she had already changed the wound and tube feed dressing for the day. On 01/13/2026 at 9:18AM, During an observation of R9 being repositioned by Nurse K and CNA P R9 was yelling out in pain. Nurse K stopped and said she was going to get the residents pain medication before proceeding. When Nurse K was asked what she was going to administer she replied that (R9) had an order for morphine (a narcotic pain medication) every hour as needed (PRN). Nurse K was asked to be observed during administration and the dressing care of the T-sponge to observe the ostomy site. Nurse K retrieved the narcotic medication from the Narcotic wall box on the unit and brought it to the room in an oral medication syringe the tip was placed inside a medication cup.Once back at the resident's room, Nurse K prepared the water flush and stopped the Tube feed and flushed the line. Nurse K had donned gloves and no other PPE. Nurse K pulled back R9's blanket back and lifted R9's gown and moved the residents hand out of the way of the peg tube. Nurse K was queried if the resident had any precautions and she said, yes that R9 had EBP. Nurse K was further queried if she had all the PPE she needed and she stated, oh I thought this was ok. Nurse K was asked if she had read the sign on R9's door about EBP's. Nurse K went out and looked at the door and then donned a gown got new gloves and said she said I am sorry I wasn't thinking I needed a gown. Nurse K proceeded with ostomy site care and changed the T-sponge, R9's site was unremarkable.Nurse K the prepared to administer the medication via R9's Peg tube, no barrier was used to cover the bedside table where Nurse K placed the supplies. Nurse K removed the uncapped morphine syringe from the medication cup and place it directly onto the bedside table. Nurse K connected the 60 ml syringe to the residents uncapped tube and free flushed the line, Nurse K picked up the morphine syringe and administered it to R9 via the 60 ml flush syringe. Nurse K flushed the line with water again and recapped the tube. A record review of R9's Kardex bedside care plan revealed: Resident care: enhanced barrier precautions as directed. This includes gowns and gloves for high-contact resident care activities. Eating and nutrition: Provide diet per physician order; NPO -Provide Supplement as ordered. A record review of R9's orders revealed: Enhanced Barrier Precautions as directed. This includes gowns and gloves for high-contact resident care activities. Specify why: foley, peg tube, wound. NPO (nothing by mouth) diet, NPO texture, NPO consistency. Cleanse PEG tube site once daily with NS. Pat dry and apply clean T drain sponge. Monitor for signs and symptoms of infection. Morphine Sulfate (Concentrate) Oral Solution 20MG/ML (Morphine Sulfate) Give 0.25 ml via PEG. A record review of the facilities policy titled Enhanced Barrier Precautions policy and procedure revealed: Definition: Enhanced Barrier Precautions: Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. High-Contact Resident Care Activities include: Dressing Bathing/showering Transferring Providing hygiene Changing linens (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Changing briefs or assisting with toileting Device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator Wound care: any skin opening requiring a dressing. The policy listed Key points as: Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs.Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities.EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following:Wounds or indwelling medical devices, regardless of MDRO colonization status.Infection or colonization with a CDC targeted MDRO.Effective implementation of EBP requires staff training on the proper use of personalprotective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care. A review of the procedure reveals the facility will.: 3 a. Identify residents who may require EBPi. Residents with an indwelling medical device or wound (regardless of MDRO colonization or infection status).ii. Residents currently infected or colonized with a CDC targeted MDRO.b. Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE (e.g., gown and gloves)c. For Enhanced Barrier Precautions, signage should also clearly indicate high contact resident care activities that require the use of gown and glovesd. Make PPE, including gowns and gloves, readily available. and g. Incorporate periodic monitoring and assessment of adherence to recommended infection prevention practices, such as hand hygiene and PPE use, to determine the need for additional training and education. A record review of the facilities policy titled medication administration general guidelines reveals: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility patient distribution system (procurement, storage, handling and administration). The facility has sufficient staff and medication distribution system to ensure safe administration of medications without unnecessary interruptions.