STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235716	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Rochester Hills	252 Meadowfield Drive Rochester Hills, MI 48307

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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
	235716	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Rochester Hills	252 Meadowfield Drive Rochester Hills, MI 48307

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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation relates to Intakes 2614504 and 2569835. This citation has two Deficient Practice Statements (DPS).DPS #1 Based on observation, interview, and record review, the facility failed to prevent an avoidable accident when one resident, R901, of two residents reviewed for supervision fell out of bed during care. Findings include: Review of a complaint intake, received on 9/10/25 at 3:43 p.m., revealed the complainant reported they received a call from the facility on August 17, 2025, at 11:30 a.m., when they learned R901 rolled off their bed with two people assisting them, which they did not believe was possible. Afterwards, they were told their family member was being changed and fell off the bed. The complainant alleged their family member subsequently developed bruising on their right arm and had head and back pain. They alleged they were not given an explanation of what occurred and were concerned about R901's safety in the facility. Review of R901's Fall Assessment report, dated 8/18/25 at 1:31 p.m., revealed, .Guest (R901) was being assisted via 2pa (two person assist) with brief change, when during the brief change guest rolled from bed and onto the floor guided by staff. Guest was assessed for pain and significant injury, pain reported in head and shoulder. Guest sent to hospital for further evaluation due to being on blood thinners. She returned a short time later with no injury and scans reported to be clear. All parties were notified. Guest is an [AGE] year-old long term-rehab guest. She has a primary diagnosis of ESRD (End Stage Renal Disease - on dialysis) .Root cause was determined to be that the CNA failed to maintain safe bed mobility during routine care. Plan of care updated, and bolsters were added to bed, fall mat at bedside, and nursing staff provided with education regarding appropriate bed mobility. On 9/23/25 at 4:54 p.m., R901 was observed in their hospital bed dressed, appearing clean and well-groomed, with clean hair. R901's nails were observed as freshly painted, with no dirt or residue under their nails. R901 was calm and smiled at surveyor and agreed to an interview. R901 was observed in a bariatric hospital bed with an air mattress, with contoured edges to prevent falls. There was also a geriatric pressure-relieving large lounge chair with cushion in their room, newer in appearance. No bruises were observed. R901's nurse and aide were observed on the unit hall. On 9/23/25 at 4:56 p.m., R901 was asked how they were doing and said, Good. R901 was aware of their name, surroundings, and situation. R901 was able to follow one-step directions to show Surveyor their nails and common room objects. R901 was asked how staff took care of her and said, Good. R901 reported they were treated well by staff. R901 was asked about getting showers and reported they received their showers. R901 was asked if they felt safe in the facility and responded Yes and denied any abuse or mistreatment. R901 was asked about their fall out of bed last month, and said they were not hurt or injured, and denied any bruising. Review of R901's Minimum Data Set (MDS) assessment, dated 7/17/25, revealed R901 was admitted to the facility on [DATE], and was dependent for bed mobility including rolling and transfers. The Brief Interview of Mental Status (BIMS) assessment revealed a score of 7/15, which showed cognitive impairment. Review of R901's Electronic Medical Record (EMR) revealed they had a guardian, and had diagnoses including kidney disease, dementia, depression, anxiety and an above knee left leg amputation. Review of R901's nursing progress note, dated 8/17/25 at 11:00 a.m., revealed R901 was observed on the floor by a Certified Nurse Aide (CNA) with right shoulder, arm, and head pain. Pain medication was administered. R901 was sent to the hospital emergently by their nurse and on-call physician. Review of R901's nursing progress note, dated 8/17/25 at 6:54 p.m., revealed R901 returned to the facility on a stretcher, was alert and oriented x 2-3 spheres, had normal range of motion, no signs of distress, and their CT scan (head) was negative. There was no mention of bruising or other injuries noted, and no new orders reported. Review of R901's shower skin assessment, dated 8/18/25, showed no bruising or other injuries. Review of R901's pain assessment vital log showed R901 had pain 9/10 (10 highest pain) at the time of the incident, however pain decreased to 0 to 3 range (no to low pain) on 8/18/25 and 8/19/25. On 9/23/25 at 5:30 p.m., Registered Nurse (RN) F was asked about R901's fall out of bed on 8/17/25. RN F reported the aides were in the middle of changing R901 when one of them reached for gloves and R901 rolled off the bed. RN F reported they did not know R901's position on the bed, or any other details about the incident. RN F confirmed there were two aides in R901's room when they were changing R901 in the bed, as they observed them enter R901's room together and neither exited the room. After the fall, R901 was observed by RN F sitting on their bottom next to the bed. RN F explained there was no bruising or injury was observed. RN F confirmed the incident was an accident. RN F said R901 denied they hit their head, and they assessed