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	04/14/2026

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake(s): 2706041 & 2711391.Based on observation, interview, and record reviews the facility failed to protect the resident's right to be free from misappropriation by a facility staff member, for one (R203) of three residents reviewed for misappropriation and abuse. Findings include:A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) documented in part, . Resident (R203) presented story to both daughter and officer regarding the ring being taken by someone who had covered their face and took the ring off her finger. review of the time frame it was made possible that the perpetrator mentioned above was the first person into room (number) after the daughter had left for the night. Immediately after speaking with officer (name), the facility suspended the employee listed at <sic> the perpetrator above. Around 10:03PM officer (name) called writer back to state ring was in fact taken off guest and pawned the morning of 12/12/2025. The suspect was not fully identified at this time, but was mentioned it was the person this writer described to the officer.The staff member suspended for stealing R203's ring was identified to be Certified Nursing Assistant- CNA A.A review of the medical record revealed R203 was readmitted to the facility on [DATE], with diagnoses that included: senile degeneration of brain and chronic atrial fibrillation. R203 was dependent on staff for all Activities of Daily Living (ADLs) and identified to be on hospice care. The residents daughter (Family Member- FM B) was identified to be the Durable Power Of Attorney (DPOA) for R203's care.Review of the progress notes revealed the following:11/4/25 at 2:33 PM, a Care Transition Note documented in part . she does have some forgetfulness and is hard of hearing. speech is clear and easily understood. She did complete the BIMS (Brief Interview for Mental Status) with a score of 5 (severely impaired cognition).12/15/25 at 9:26 AM, a Physician note documented in part . Chief complaint: Bruising left ring finger. is seen for bruising left ring finger. Patient noted to have small bruise to left ring finger on dorsal side, on exam no local tenderness noted. No swelling of the finger or hand. Will do x-ray of the left finger but clinically do not suspect fracture.Further review revealed no documentation in the progress notes regarding the incident.A review of the hospice notes revealed the following:12/16/25 at 11:30 AM, . Prior to visit, Xray of L (left) hand requested to r/o (rule out) fx (fracture) after incident resulting in bruising/swelling. Xray arrived at end of visit for imaging. bruising to L 4th digit.12/18/25 at 11:00 AM, . L hand x-rays negative. Pt (patient) remains bedbound.On 4/13/26 at 10:41 AM, an interview was conducted with FM B. FM B was asked when they were first notified of the incident. FM B stated on 12/11/25 at 4:15 PM, a nurse called them and asked if they had their mother's ring and they informed the nurse that they did not. FM B stated they told the nurse that the ring was on their mother's finger the night before when they had visited. FM B stated after work they drove to the facility and arrived a little after 4:30 PM. FM B stated immediately after entering their mother's room, R203 told FM B that someone stole her ring and the person had turned off the room lights and covered their face before taking the ring from R203's finger. FM B stated the nurse was in the doorway of the residents room, heard what the resident reported. The nurse informed FM B that they were leaving to report what R203 stated to their Nurse Manager. FM B stated they waited awhile and no one came to the room to follow up. FM B stated initially they were convinced that R203 had lost their ring, because (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
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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they were never informed of the allegation of someone to have stole the ring off of her mom's finger until R203 informed them. FM B stated after waiting awhile with no further follow up from the facility they decided to call the police. FM B stated the Police came to the facility and started their investigation. FM B stated they were contacted by the Officer the next day about a quarter to 10 AM and informed that the ring was found at a pawn shop. The officer went on to inform FM B that the license provided to the pawn shop to pawn the ring matched that of a CNA who was confirmed to have worked in the facility on the date of the incident. When asked the current status of the case, FM B stated the case remains open and they continue to have communication with the Detective assigned to the case. FM B stated a warrant has been issued for the CNA and an arrest is still pending. FM B stated at this time the Police department had been unable to locate the CNA. FM B stated they had taken pictures of the their mother's bruised finger the next day (12/13/25). Those pictures were submitted to the SA for review.On 4/13/26 at 7:45 AM, an initial request to the Administrator was made to provide the full investigation for review.The investigation contained the following statements: Activities assistant (AA C) - On December 12th when I was in room (number) the resident told me that the day prior in the evening someone came into her room with their face covered up and took her ring from her finger. She reported that she yelled out but nobody heard her. I then let the nurse on duty know.A Nurse statement (later identified as Licensed Practical Nurse- LPN D) documented, I (nurse name) was told today 12/12/25 that the ring worn by the guest in (room number) was missing and not on her finger by activities staff. The statement to me was that somebody took it off, they had something dark over their face and she couldn't see who it was. The last time I recall seeing her ring on her finger was Wednesday 12/10/25 as I did not pay attention to it yesterday 12/11/25. After it was stated to me today that it was missing . I searched the room, bed and guest to look for it. I called her daughter (name) to see if she had taken it and she said no. She did state to me that the ring was starting to fit big but she didn't want to take it off. Guest had a bed bath yesterday and guest daughter thinks that it could have possible come off in her clothes, and went to Laundry.On 4/13/26 at 11:49 AM, AA C was interviewed and asked to read their statement provided for the investigation. AA C reviewed and confirmed everything to be correct as documented. When asked, AA C could not recall the exact time they were informed of the incident but knew it was after lunch and before 4 PM on 12/12/25. AA C said they immediately informed the Nurse (LPN D). AA C was asked if the Administration team followed up with them regarding their statement and AA C replied in part . besides (Director of Nursing - DON name) telling me. that the family got the ring back. no other follow up was conducted.On 4/13/26 at 12:02 PM, LPN D was interviewed and asked to read their statement to confirm accuracy. LPN D read the statement and confirmed the statement was accurate. LPN D was asked why they initially searched for the ring, instead of immediately reporting the allegation to the Abuse Coordinator. LPN D said they wanted to . go through all of my options. before reporting it. LPN D explained after not finding the ring they called R203's daughter (FM B) to see if they had it. LPN D was asked if they informed the daughter of the resident allegation of the ring to have been stolen, LPN D stated they did not. LPN D stated they contacted both the DON and the Administrator and informed them on what the resident reported. LPN D stated the Administration informed them they would look into it. LPN D stated FM B called the police and the police came to the facility. LPN D stated they were interviewed by the police that night. LPN D stated they wrote a statement and slid it under the door of the DON.On 4/13/26 at 1:22 PM, R203 was observed sitting up in bed. An interview was conducted utilizing a white board to ask the resident questions due to the resident hearing loss. When asked R203 stated they were resting in bed when she took the ring off of their finger. R203 said she felt terrible because it was her wedding ring. R203 stated she felt safe in the facility knowing the person is no longer at the facility. On 4/13/26 at 2:03 PM, the facility's Administrator who also serves as the facility's Abuse Coordinator was interviewed. When asked, the Administrator stated the DON was the first to inform them of a person to have covered their (R203's) face and stolen their ring. The Administrator said they had a conversation with the officer who (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed them that the ring was located at a pawn shop and the staff member described was the suspect. The Administrator stated the staff was immediately suspended.A review of a facility policy titled ABUSE, NEGLECT AND/OR MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY revised 3/15/23, documented in part . will not tolerate.physical. abuse. misappropriation of resident's funds or property by anyone. Freedom from Abuse: Each resident has the right to be free from all types of abuse. Misappropriation means the deliberate. wrongful temporary or permanent user of a resident's belongings. without the resident(s) consent. Mistreatment as defined. means inappropriate treatment. of a resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake(s): 2706041 & 2711391.Based on observation, interview and record reviews the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act and failed to accurately and timely report findings to the State Agency (SA) for one (R203) of three residents reviewed for Misappropriation and Abuse. Findings include:A review of an initial investigation report submitted to the SA on 12/12/25 at 10:41 PM, documented in part . Guest in (room number and name) mentioned to a staff member that her ring was missing and had been taken off her hand. Guest has a BIMS of 5/15. Staff member notified nurse on unit who notified DON (Director of Nursing). DON then notified abuse coordinator. Nurse called daughter who is POA (power of attorney) to notify her of the situation. Skin and pain assessment completed. Responsible party notified, Authorities notified. Ring has not been located in the facility at this time.A review of the investigation summary submitted to the SA on 12/22/25, documented in part, . Resident involved in incident has severe impairment with her mental capacity as noted by her 5/15 BIMS. On Friday 12/12/2025 around 3:00PM she was taking part in 1 on 1 activities with activity assistant (name). During this time she had made mention that the previous night someone had come in and taken her ring. Upon the activity aide learning of this matter, she had let the nurse assigned to the (number) hallway know immediately. The nurse then searched the room and spoke with the resident regarding the missing ring. The ring was not found in the room and upon negative findings the nurse let the DON (Director of Nursing) know of the situation and then the DON notified this writer/Abuse coordinator know of the situation. Between the time the daughter was contacted and some time around 6:30PM the daughter had decided to notify the authorities. The guest recalled the same story to this writer that she told the officer and her daughter. Skin and pain assessment were completed. MD (Medical Doctor) was notified. Social work was consulted as well and a psychosocial assessment completed.The Activity Assistant was identified as AA C and the Nurse was identified as Licensed Practical Nurse - LPN D.A review of the medical record revealed R203 was readmitted to the facility on [DATE], with diagnoses that included: senile degeneration of brain and chronic atrial fibrillation. R203 was dependent on staff for all Activities of Daily Living (ADLs) and documented to be under hospice care. The residents daughter (Family Member- FM B) was identified to be the Durable Power Of Attorney (DPOA) for R203's care.On 4/13/26 at 1:22 PM, R203 was observed sitting up in bed. An interview was conducted utilizing a white board to ask the resident questions due to the resident hearing loss. When asked, R203 stated they were resting in bed when she took the ring off of their finger. R203 stated she felt terrible because it was her wedding ring. R203 stated she felt safe in the facility knowing the person is no longer at the facility. A review of the facility's investigation identified a skin assessment completed on 12/12/25 that revealed no abnormal findings identified and contained no pictures taken of the resident's hand.A review of the medical record and care transition notes and assessments revealed no psychosocial assessment completed with R203 after the incident as reported to the SA.Further review of the medical record revealed no social work assessments completed in December 2025 or January 2026.A review of a Care Transition Note noted by Social Worker SW E dated 12/15/26 at 12:01 PM, documented . Follow up with guest. She denied any concerns at this time. She had eaten her breakfast. She said that she feels safe in her room.On 4/13/26 at 10:41 AM, an interview was conducted with FM B . FM B was asked when they were first notified of the incident. FM B stated on 12/11/25 at 4:15 PM, a nurse called them and asked if they had their mother's ring and they informed the nurse that they did not. FM B stated they told the nurse that the ring was on their mother's finger the night before when they had visited. FM B stated after work they drove to the facility and arrived a little after 4:30 PM. FM B stated immediately after entering their mother's room, R203 told them someone stole her ring and the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	person had turned off the room lights and covered their face before taking the ring from R203's finger. FM B stated the nurse (LPN D) was in the doorway of the residents room, heard what the resident reported and LPN D stated they were leaving to report what R203 stated to their Nurse Manager. FM B stated they waited awhile and no one came to the room to follow up. FM B stated initially they were convinced that R203 had lost their ring, because they were never informed of the allegation of someone to have stolen the ring off of her mom's finger, until R203 informed them. FM B stated after waiting awhile with no further follow up from the facility they decided to call the police. FM B stated the Police came to the facility and started their investigation. FM B stated they went home and the Administrator called them approximately a quarter after 9 PM. FM B said they had expressed to the Administrator that it was devastating that their mom said they were screaming and yelling when the person took the ring off of their finger and no staff came to her aide. FM B stated the Administrator informed them that R203 had a bruise identified to their left hand ring finger and that they would take photos of it. FM B stated they were contacted by the Officer the next day about a quarter to 10 AM and informed that the ring was found at a pawn shop. The officer went on to inform FM B that the license provided to the pawn shop to pawn the ring matched that of a CNA who was confirmed to have worked in the facility on the date of the incident. When asked the current status of the case, FM B stated the case remains open and they continue to have communication with the Detective assigned to the case. FM B stated a warrant has been issued for the CNA and an arrest is still pending. FM B stated at this time the Police department have been unable to locate the CNA. FM B stated they had taken pictures of the their mother's bruised finger the next day (12/13/25). Those pictures were submitted to the SA for review. The pictures revealed a dark maroon/purple color bruise to the dorsal left hand 4th digit.A review of a Physician note dated 12/15/25 at 9:26 AM, documented in part . Chief complaint: Bruising left ring finger. is seen for bruising left ring finger. Patient noted to have small bruise to left ring finger on dorsal side, on exam no local tenderness noted. No swelling of the finger or hand. Will do x-ray of the left finger but clinically do not suspect fracture.On 4/13/26 at 11:49 AM, AA C was interviewed and asked to recall the incident. AA C stated they walked into the resident's room and introduced themselves and she (R203) immediately said that her ring was missing and that someone came in with their face covered. The resident reported the room was dark and the person took it off her hand. AA C stated the resident said they yelled for help but no one came. AA C stated they immediately informed the Nurse (LPN D). AA C was asked if they notified the Administrator (who also serves as the Abuse Coordinator) and AA C stated No, they immediately notified the nurse.A review of a facility policy titled Abuse, neglect and misappropriation of property policy (no date noted on the first page provided), documented in part . physical. or misappropriation of property will not be tolerated. Facility staff are required to report any incident or suspicion of abuse, neglect or misappropriation of property to the Executive Director immediately, on in his/her absence the DON.A statement documented by LPN D noted, I (nurse name) was told today 12/12/25 that the ring worn by the guest in (room number) was missing and not on her finger by activities staff. The statement to me was that somebody took it off, they had something dark over their face and she couldn't see who it was. The last time I recall seeing her ring on her finger was Wednesday 12/10/25 as I did not pay attention to it yesterday 12/11/25. After it was stated to me today that it was missing . I searched the room, bed and guest to look for it. I called her daughter (name) to see if she had taken it and she said no. She did state to me that the ring was starting to fit big but she didn't want to take it off. Guest had a bed bath yesterday and guest daughter thinks that it could have possibly come off in her clothes, and went to Laundry.On 4/13/26 at 12:02 PM, LPN D was interviewed and asked to read their statement to confirm accuracy. LPN D read the statement and confirmed the statement was accurate. LPN D was asked why they initially searched for the ring, instead of immediately reporting the allegation to the Abuse Coordinator. LPN D stated they wanted to . go through all of my options. before reporting it. LPN D explained after not finding the ring they called R203's daughter to see if they had it. LPN D was asked if they informed the daughter of the resident allegation of the ring to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have been stolen, LPN D said they did not. LPN D stated they contacted both the DON and the Administrator and informed them on what the resident reported. LPN D stated the Administration informed them they would look into it. LPN D said the resident's daughter called the police and the police came to the facility. LPN D said they were interviewed by the police that night. LPN D said they wrote a statement and slid it under the door of the DON.On 4/13/25 at 1:35 PM, the Care Transition Staff (also documented in the medical record as a Social Worker- SW E) was interviewed and asked their involvement with the investigation of the incident that involved R203. CTS E said they followed up with the resident to ask how they were doing and to ensure that she felt safe in the facility. CTS E was asked why a psychosocial assessment was not completed and they replied that the facility did not have an actual assessment, however some could do the PHQ9 (depression scale) questions but they did not do that with the resident.On 4/13/26 at 1:45 PM, the DON was interviewed and asked the date, time and by whom they were first notified of the incident with R203. The DON replied it was the date the facility had just finished their annual recertification survey and they could not recall the exact time. The DON identified LPN D to have called them and reported the missing ring. The DON was asked if LPN D reported the allegation verbalized by R203 of a person to have covered their face and stolen the ring off of their finger and the DON confirmed they did. The DON stated they directed the nurse to look around the room to search for it. The DON was asked why they directed the nurse to look around the room if the resident had already stated that someone covered their face and took the ring off of their finger. The DON replied because of the resident's cognitive state, they wanted to make sure that the resident was not hallucinating or dreaming. The DON stated once LPN D confirmed that they could not find the ring, the DON said they reported the incident to the Administrator. The DON said they obtained statements from the staff and reported it to the Administrator.On 4/13/26 at 2:03 PM, the Administrator was interviewed and asked who conducted the investigation for R203's ring and the Administrator replied they completed the investigation. The Administrator was asked on what date and time they were notified of the resident to have stated that someone covered their face and took the ring off of their hand. The Administrator replied that the DON notified them on 12/12/26 between 3 and 4 PM. The Administrator was asked why they failed to notify the SA timely and notify law enforcement and the Administrator replied in part . Initially it wasn't much concern. The daughter called authorities and I rushed up here as quickly as I could. The initial submission to the SA was reviewed with the Administrator and was asked why they omitted the details of a person coming into the dark room of the resident with their face covered and had taken the ring off the resident and the Administrator stated . again, initially, we thought it was lost. The Administrator was asked even with the resident reporting that someone took it off they hand, they still thought it was lost? The Administrator replied yes. The Administrator was asked about the detail of the omission to the SA of the left hand ring finger to have been bruised and the skin assessment to have noted no findings after the incident occurred. The Administrator stated they were unable to tell, but the finger . was a little swollen that night. The Administrator was reminded that the details was omitted from the investigation report submitted a few days later on 12/22/25, as well. The Administrator was asked why they reported to the SA that a psychosocial assessment was completed and it had not done and the Administrator said they would look into it and follow back up.No further explanation or documentation regarding the psychosocial assessment was provided before the end of the survey.A review of a facility policy titled ABUSE, NEGLECT AND/OR MISAPPROPRIATION OF RESIDENT FUNDS OR PROPERTY revised 3/15/23, documented in part . REPORTING/RESPONSE. For the alleged violation involving. mistreatment, including injuries of unknown source and misappropriation of resident property, the Center will report immediately but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2711407.Based on interview and record review the facility failed to ensure a Physician evaluation and/or assessment of wounds and failed to follow the facility's policy for Pressure Ulcers for one (R205) of three residents reviewed for wounds. Findings include:A review of a complaint submitted to the State Agency (SA) revealed poor care provided to R205 resulting in the worsening of wounds.A review of the medical record revealed R205 was readmitted to the facility on [DATE], with diagnoses that included: dementia and sarcopenia (age-related progressive loss of muscle mass, strength, and function). A Minimum Data Set (MDS) assessment completed 12/23/25, documented a Brief Interview for Mental Status score of 11 (which indicated moderately impaired cognition). R205 required staff assistance for all Activities of Daily Living (ADLs).A review of the progress notes revealed an identified Stage II pressure wound to the Coccyx and a right elbow abrasion.A review of the medical record revealed R205 was examined by Physician F (the resident attending Physician) on the following dates:12/18/25, 12/19/25 & 12/22/25- none of the examinations noted an evaluation or assessment of the resident wounds.A Nursing note dated 12/24/25 at 6:27 PM, documented in part . Guest verbalized some discomfort on R (right) heel. Site assessed for abnormalities and noted to have a pre-existing ruptured blister. Wound pictures and orders implemented per protocol. All involved party made aware.The medical record revealed R205 was again examined by Physician F on the following dates:12/31/25 & 1/2/26- there was no documentation of the wound to have been examined or assessed.Further review of the medical record revealed no examinations or assessments completed by a Physician, despite multiple wound treatments to have been ordered under the directive of Physician F.A progress note dated 1/2/26 at 4:25 PM, documented the resident to have been transferred to another facility.A review of a facility policy titled Pressure Ulcers/Skin Breakdown. revised October 2012, documented in part . The Physician and staff will examine the skin of a new admission for ulcerations. The physician will help the staff define the type. and characteristics. of an ulceration. The physician will help identify factors contributing or predisposing residents to skin breakdown. The physician will help identify medical interventions related to wound management. During resident visits, the physician will evaluate and document the progress of wound healing.On 4/14/26 at 1:14 PM, the Director of Nursing (DON) was interviewed and asked about the management of wounds in the facility. The DON explained that if a wound is found, pictures are taken and an assessment is completed by the nursing staff. The Physician is notified to initiate treatment. When asked if the Physicians come to assess and evaluate the treatment they ordered to be implemented, the DON stated the Nurses and interdisciplinary team- excluding the Physician- . will review it and if it's not effective we will contact the Physicians. When asked if the Physicians are supposed to assess and evaluate wounds and the treatment, they prescribed the DON stated they could not say if the Physicians did or did not examine or assess the residents. When asked if it is the expectation that the Physicians examine and assess the wounds and document it in the resident's medical record, the DON stated they had no control over what the Physicians document.On 4/14/26 at 1:45 PM, Physician F was interviewed via telephone and asked if they assessed and examined the resident wounds in the facility. Physician F stated Yes, the nursing staff will notify them and they would usually assess them. Physician F was asked to review the medical record of R205 and provide any documentation they found of the resident wounds to have been assessed by a Physician. The Physician stated they would review the record and inform the Administration team if they found the documentation.On 4/14/26 at 2:12 PM, the DON noted they spoke to Physician F who stated he was unable to find any assessment or evaluation of the resident wounds.No further information or documentation was provided by the end of the survey.