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	05/26/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 3017844.Based on observation, interviews and record reviews the facility failed to complete a thorough investigation for an injury of unknown origin for one (R204) of three residents reviewed for an injury of unknown origin. R204 was diagnosed with a right leg . comminuted impacted proximal tibial shaft fractures, mild posterior displacement of the distal fracture fragment, minimal angulation. Comminuted proximal fibular shaft fractures (both lower right leg bones broken, the tibia and fibula fractured in multiple pieces and the broken bone pieces pushed into each other from the force of the injury) .Findings include:A review of a complaint submitted to the State Agency (SA) noted concerns regarding their loved one with dementia, who is immobile and required extensive assistance with care, to have sustained a broken right leg without a clear explanation as to how the injury occurred.A review of the medical record revealed R204 was initially admitted to the facility in 2024, with a readmission date of 5/19/26 and had diagnoses that included- dementia, parkinson's disease and absence of the left leg above the knee. A Minimum Data Set (MDS assessment) dated 3/15/26, noted Severely impaired cognitive skills for daily decision making and was dependent on staff assistance for all Activities of Daily Living (ADLs).On 5/26/26 at 12:23 PM, R204 was observed sitting up in an oversized portable reclining chair with their right leg elevated. The complainant was observed attempting to feed R204 lunch. The complainant helped to translate questions asked to R204 (whose primary language was noted to be Arabic). When asked, R204 could not remember how they obtained the injury to their right leg. The complainant then verbalized their frustration regarding the facility's explanation of R204 to have extensive medical comorbidities that made the resident prone to the multiple right leg fractures.A review of the progress notes revealed the following:A Nursing note dated 5/11/26 at 5:56 PM documented in part, . readmitted to (facility initials) from (hospital name) with a diagnosis of renal disease and hypoglycemia.A Skin issues note dated 5/11/26 at 4:05 PM, revealed a skin assessment that revealed no significant findings to the right leg or left amputated leg stump. An admission summary dated [DATE] at 7:30 AM, documented in part . resident is a/o x1 (alert and oriented times one- awake and alert but oriented to person); resident is incontinent of B/B (bowel/bladder). some language barrier; needing assistance 2PA (two person assistance); using a (mechanical lift) w (with)/transfer.A Change In Condition note dated 5/15/26 at 8:27 AM, documented in part . increased lethargy, decreased appetite, overall decline noted. recommendations: stat (immediate) cbc (complete blood count) and bmp (basic metabolic panel).On 5/16/26 at 11:02 AM, the Director of Nursing (DON) created a note and back dated it to 5/15/26 at 10:40 AM, that identified . No new skin issues identified.On 5/17/26 at 12:44 PM, a Change In Condition note documented in part . Observed a large bruise on guest right lower leg, MD (Medical Doctor) notified. CBC/BMP and 2view x-ray.On 5/17/26 at 1:54 PM, a Nursing note documented . Called 911 at 1817 (6:17 PM) to send EMS (Emergency Medical Services) at 1854 (6:54 PM). MD notified.On 5/17/26 at 1:55 PM, a Nursing note documented . his <sic> writer was informed by the Nurse assistant that resident had a large bruise on right lower leg and left stump, on assessment resident had a large bruise on her right lower leg and [NAME] <sic> bruises on left stump. Leg feel warm to touch and non pitting edema noted. report pain with movement. MD notified. CBC/BMP and 2 view X-ray order in per MD (Medical Doctor) orders. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Right leg elevated in bed. Care ongoing.On 5/17/26 at 6:11 PM, a Nursing note documented . X-ray result came back and result shows guest has fractures, MD notified and order to send guest to hospital.A hospital Consultation-Internal Medicine consult dated 5/18/26 at 8:11 AM, documented in part . REASON FOR CONSULT - Fall. presents to the emergency department from (facility name) for concern of a fracture of her right leg. Patient was recently discharged from the hospital here on May 11. She was complaining of pain of her right lower leg and also noted some bruising so they did an x-ray and noted that there was a break, patient does not ambulate at baseline secondary to her history of a left above-the-knee amputation, there was no no <sic> reported falls. CT (computed tomography scan) Lower Extem (extremity) W/O (without) Contrast-Rt (right) (Reason for exam: fx (fracture) follow up from xray) Finalized: 05/18/2026 01:04. IMPRESSION: Comminuted impacted proximal tibial shaft fractures, mild posterior displacement of the distal fracture fragment, minimal angulation. Comminuted proximal fibular shaft fractures. DX (DEXA scan- dual-energy X-ray absorptiometry) Knee Complete Right (Reason for exam: pain, swelling) Finalized: 05/17/2026 20:59 (8:59 PM). IMPRESSION. There appear to be acute fractures of the proximal fibula/fibular neck and proximal tibial diaphysis as above. CT may be of benefit for better evaluation. DX Tibia/Fibula AP (anteroposterior)/Lateral Right (Reason for exam: pain, swelling) Finalized: 05/17/2026 20:59. IMPRESSION. There appear to be acute fractures of the proximal fibula/fibular neck and proximal tibial diaphysis as above. CT may be of benefit for better evaluation. DX Ankle Complete Right (Reason for exam: pain, swelling) Finalized: 05/17/2026 20:59. IMPRESSION. There appear to be acute fractures of the proximal fibula/fibular neck and proximal tibial diaphysis as above. CT may be of benefit for better evaluation. IMPRESSION AND PLAN- Unwitnessed injury, R (right) proximal tibial and fibular fractures. does not ambulate at baseline, no reports of fall/trauma per daughter/(facility name). RLE (Right Lower Extremity) splinted in ED (Emergency Dept), pain control, RICE (Rest, Ice, Compression, and Elevation). ortho following, surgery vs. conservative management TBD (To Be Determined). earliest possible surgery 5/19 for IM (Intramedullary) nail.A review of a hospital Consultation-Orthopedic dated 5/18/26 at 7:18 AM, documented in part . REASON FOR CONSULT-right tibia fracture. presents with unwitnessed injury to right tibia right tibial shaft fracture. Plan: pain control. will discuss with granddaughter possible surgery vs (verses) conservative treatment. surgical risks due to her multiple medical conditions. medical optimization for surgery would be soonest tomorrow for possible IM nail. Otherwise may continue nonoperative care.Per the complainant on 5/26/26 at approximately 12:30 PM, they decided to hold off on surgery for now and will have to follow up with the Orthopedic physician to see if there is any improvement, if not, surgery may be required.A review of the medical record revealed no incidents or falls documented that involved the right leg from January 2026 to the date of the survey.On 5/26/26 at 10:55 AM, the Administrator was asked to provide all incident/accident and grievance reports from January 2026 to current.The Administrator provided an incident report dated 5/17/26 at 11:40 AM, of the incident of the identified large bruise on right lower left and left stump.No other incident, accident or grievance reports were provided.A review of a picture taken by the facility dated 5/17/25, revealed a dark purple/bluish bruise that covered the lateral aspect of the leg, from a little above the knee to the ankle of the right leg. Significant swelling was identified.A review of the facility's investigation submitted to the SA, documented in part . The guest was discovered to have bruising today on 5/17/2026 approximately around 12pm that was not present this morning at 6am. Guest was assessed for pain and presenting with pain. Further skin assessment were completed on rest of body with nothing else being noted. Investigation Summary/Actions Taken. Physician ordered a STAT X-Ray. Upon completion and results from the X-Ray at approximately 5:31PM, it showed a fx (fracture) in the left lower extremity of the tibia and fibula. The physician ordered immediate transfer to the emergency department. There were no falls, injuries, or incidents reported to the facility within the prior 24-48 hours. Chart review and staff interviews confirmed no observed trauma. Contributing Factors: Active malignancy as indicated by bilateral invasive breast cancer (diagnosed 3/13/2026), increasing risk of pathological fractures. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Bone fragility of the resident as documented with osteoporosis and diffused bone demineralization. Behavioral patterns witness by staff as repetitive striking of right lower extremity against left stump or objects (e.g. remote, bed controls) and guardian made aware. Lastly, diagnostic findings from hospital imaging confirmed diffuse osteopenia, osteoporosis, and muscle atrophy. No deficient practice by the facility was identified.A review of the medical record revealed no documentation of the resident to have previously strike their lower extremity or stump.A review of the care plans revealed no identified behavior for the resident regarding striking their lower extremity or stump.Further review of the medical record revealed that R204 was given a shower on 5/15/26, the day of their documented change in condition, however the staff on 5/15/26 was not interviewed.At 1:29 PM, the complainant who was still present in the facility observed the aides changing R204's brief and took pictures of R204's left stump. The complainant provided a picture of R204's left stump that revealed two circular purple bruises still present on the stump as of 5/26/26.On 5/26/26 at 2:01 PM, the Administrator (who also serves as the facility's abuse coordinator), DON and Regional Director Consultant (RDC) A were interviewed. All three confirmed they completed the investigation together. When asked their thoughts after their investigation on how R204 sustained a broken right leg, neither responded. When asked how a resident who requires extensive assistance from staff for all care obtained an injury forceful enough to have fractured their right tibia and fibula, RDC A resported that R204 is known to hit their leg with the remote. When asked about the care plans and medical record, having no documentation of the resident to have incidents of hitting their leg with the remote or any other objects, neither responded. When asked why they did not interview the staff on 5/15/26- the day of the noted change in condition and the day R204 received a shower, the DON responded when they interviewed the staff on the 16th , all denied seeing anything on the resident they did not go further back. The Administrator, DON and RDC A was asked to provide any additional information or documentation for review regarding the incident, and nothing was provided before the end of the survey.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3015838. Based on interview and record review, the facility failed to assess and implement interventions/diagnostics in a timely manner for one resident (R202) of three residents reviewed for changes in condition. Findings include:On 5/26/27 a concern submitted to the State Agency was reviewed which alleged R202 experienced a delay in assessment and interventions when they sustained a dislocated hip. On 5/26/27 at approximately 9:29 a.m., during a discussion with family member F (FM F), FM F indicated they had a concern regarding a delay in identifying a change in condition for R202 which resulted in a dislocation of their right hip. FM F reported that the change in condition started on 3/18/26 when they noticed R202 was experiencing increased pain in afternoon during a visit. On 3/20/26 another visit, a member from the therapy department reported that R202's right foot and hip looked turned out and R202 was experiencing more increased pain and on 3/21/26. A different family member informed a Nurse that something was wrong with R202's hip and an X-ray should have been done earlier. FM F indicated they had reported their concerns regarding the delay identifying the change to facility staff. On 5/26/27 the medical record for R202 was reviewed and revealed the following: R202 was initially admitted on [DATE] and was discharged on 3/23/26 with diagnoses including Aftercare following joint replacement surgery and Fracture of unspecified part of neck of right femur, subsequent encounter for closed fracture with routine healing. A review of R202's MDS (minimum data set) with an ARD (assessment reference date) of 3/16/26 revealed R202 required assistance from facility staff with most of their activities of daily living. R202's BIMS score (brief interview of mental status) was six indicating severely impaired cognition. 3/16/2026-Physican progress note- Note Text: HPI (history of presenting illness) Reason for Visit: Medical management, Pt (patient) is a [R202 demographics] presenting to facility for SAR (sub-acute rehab) s/p (status/post) hospitalization for fall, right femur fx (fracture). Here for PT/OT (physical therapy/occupational therapy) needs: Patient seen and examined .Tolerating PT/OT. Per nursing cloudy, foul odor urine noted. Also, restlessness at bedtime per nursing. Denies dysuria, flank pain. Collect UA (urine analysis) and CS (culture/sensitivity) to r/o (rule out) UTI (urinary tract infection). Assessment/Plan 5. Abnormal urine odor +UA and CS . 3/16/2026-Physican's order-Urinalysis to R/O suspected UTI. one time only for suspected UTI for 1 Day 3/17/2026-Therpay daily skilled services-Precautions: WBAT (weight bearing as tolerated) Rt (right) LE (lower extremity), cognition Contraindications Contraindications = No contraindications present. Pre-Tx (treatment) Is skilled therapy needed to address pain? = Nursing to address .: pt (patient) completed BUE (bilateral upper extremity) strengthening exercises with use of 1# weight in order to improve overhead grooming, assistance with sit to stands, and reaching. pt completed chest press, overhead press, bicpes curls, triceps ext (estensions), :progress report completed, goals reviewed with pt. pt alert and participated without encouragement this date. pt completed standing balance activity while crossing midline and forwards reach in order to improve standing tolerance during ADLs (activities of daily living) .functional mobility completed with use of 2ww (two-wheeled walked), mod pa (partial assist), and . for safety to improve I with functional transfers. toilet transfer completed min (minimal) pa from wc (wheelchair) to 3:1 commode and use of GB (grab bar) Response to Tx Response to Session Interventions: tolerated well this session . 3/18/2026-Skilled Charting-Writer unable to collect urine sample this shift. Gave report to oncoming Nurse. 3/19/2026-Therapy daily skilled services-Precautions: WBAT Rt LE, cognition .Contraindications = No contraindications present. Pre-Tx Is skilled therapy needed to address pain? = Nursing to address : family present for therapy, recommend wtd (weighted) gloves or universal cuff to help reduce tremors in BL hands during feeding. static standing pt reports pain in r hip when wt (weight) shifting Pt completes functional mob (mobility) taking a few steps with max pa and close wc follow pt unable to complete task 2* (secondary) to pain. UB (upper body) strengthening graded with 1# wt all available joints and planes (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to increase strength for all functional task . 3/20/2026-Therpay daily skilled services-Precautions Precautions: WBAT Rt LE, cognition . Contraindications = No contraindications present. Pre-Tx Is skilled therapy needed to address pain? = Nursing to address .: static standing at .pt complains of pain wt asked to wt shift, pt unable to task steps 2* to pain. nursing notified. family concerned pt was ambulating a few days ago. Pt completes UB (upper body) strengthening with 1 # wt all planes and joints to increase strength for t/fs (transfers). Pt completes reaching activity and core strengthening . 3/21/2026-Therapy daily skilled services-Precautions Precautions: WBAT Rt LE, cognition . Contraindications = No contraindications present. Patient Goals Patient Remarks/Goals: [daughter in-law] present, states pt c/o (complaints of) more pain today and she wants pt to remain in bed at this for now. Pre-Tx Is skilled therapy needed to address pain? = Nursing to address : gentle positioning for comfort and pain management via elevation changes HOB (head of bed), FOB (foot of bed), float heels, cold pack to R (right) hip . maintain hip precautions due to concern for increased pain Response to Tx Response to Session Interventions: nursing aware of pt increased pain c/o . 3/21/2026 at 10:00 a.m.,-Interact summary for providers-Situation: The change in condition/s reported on this (CIC-change in condition) evaluation are/were: Other change in condition .-Pain status evaluation: Does the resident/patient have pain? Yes .Nursing observation, evaluation, and recommendations are RT hip FX s/p survey. Guest family is at bedside and is requesting a x-ray of rt hip as guest is complaining of more pain and per family she will not let them touch her RLE due to pain. Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: STAT (emergent) x-ray rt hip two views . 3/21/2026 at 10:30-Physican's order-STAT xray rt hip 2 views one time only for rt hip pain for 1 Day 3/22/2026-Skilled charting-Guest did not receive shower per family request due to resident having pain in right hip . 3/22/2026-Skilled Charting-Writer call UA C/S this shift. Orders in [name of electronic medical record]. Sampe in 400 hall fridge. 3/22/2026 at 10:57-A physician's order dated 3/22/26 at 10:57 revealed the following STAT xray rt hip 2 views one time only for rt hip pain for 1 Day 3/22/2026-X-Ray Diagnostic-Examination Date: 3/22/2026 at 20:22. Reported Date: 3/22/2026 20:39 .Findings: There is hip arthroplasty with superior lateral dislocation. The prosthetic right femoral head is still properly situated relative to the femoral [NAME]. Pubic rami are normal There is not acute fracture seen. Conclusion: Dislocation of right hip arthroplasty 3/22/2026-Physician's order-UA C/S r/o UTI may straight cath (catheter) to obtain urine one time only for r/o UTI for 2 Days 3/23/2026-at 16:01-Skilled Charting- .Guest had STAT x-ray done, results reviewed by on call order to send gust to ER (emergency room) for further evaluation. Daughter was notified of situation . 3/24/2026-Urine Analysis and Culture Sensitivity Results-Received Date-3/24/2026. Reported Date 3/28/26 .Clarity-Turbid (abnormal) .Nitrite-Positive (abnormal) .Bacteria-Many (abnormal). Epithelial Cells-few (abnormal). Amorphous material-present (abnormal) .Organism > (greater than) 100,000 CFU/ML Hafnia Alvei . Further review of R202's medical record did not reveal any assessments or progress notes from the Nurse on 3/20/26 indicating they had assessed R202's increase in pain as reported by the therapy department or contacted the Physician regarding the change. Further review of R202's laboratory diagnostic results revealed no follow up from Nursing from the urinalysis ordered on 3/16/26 until the second analysis that ordered on 3/22/26 that had a noted reported date of 3/28/26 (approximately five days after the resident was transferred to the hospital).On 5/26/26 at approximately 11:29 a.m., Physical therapy assistant G (PTA G) was queried regarding the presentation of R202 during the therapy session on 3/20/26. PTA G reported that R202 could not walk in therapy that day and was grimacing on their right side that they were in a lot of pain. PTA G indicated that R202 stood up out of the wheelchair but was in too much pian to ambulate. PTA G reported that was a significant change for R202 as they were previously doing well with ambulation on previous days in the week. PTG G indicated they were working with COTA (certified occupational therapy assistant) H (COTA H) that day and that COTA H had informed the day shift Nurse about R202's change in status and increased pain. On 5/26/26 at approximately 11:40 a.m., COTA H was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	queried regarding the presentation of R202 during therapy on 3/20/26. CTOA H stated that the resident was in too much pain to do therapy in the gym that day and they reported they had spoken to the day shift Nurse reading R202's change in status including increase in pain and unable to do therapy. COTA H indicated they did not follow up at all as they had handed the concern of to Nursing after that to assess R202 to see why they could not ambulate and were having increased pain. On 5/26/26 at approximately 12:22 p.m., Nurse I was queried reading R202's status on 3/20/26. Nurse I indicated that they were informed by the CNA (Certified Nursing Assistant) earlier in the day that R202 was having increased pain and the CNA's were having difficulty transferring her and her not wanting to get out of bed. Nurse I was queried if they had called the Physician regarding R202's increase in pain and they indicated they did not and that they gave R202 their scheduled pain medication. Nurse I reported that they thought they had done a skin assessment to look at the painful area. At that time, a review of R202's medical record was done with Nurse I and they indicated that it wasn't there. Nurse I was queired what they did after COTA H informed them that they couldn't ambulate due pain, and they indicated they did not remember, but that they would have typically called the Physician and done an assessment. No documentation from 3/20/26 was present in the record regarding R202's increase in pain.On 5/26/26, a facility provided folder titled [R202] PNC (past-noncompliance) was reviewed which revealed the following: Statement from (CNA J)-'When I took care of her on 3/20 she had complaints about pain in her right leg. She told me she was in pain when she was lying down right after breakfast, so I left her in the bed. Then her family came around lunchtime and asked for her to be up in the chair so the nurse and I got her up. The only other time she mentioned pain was when I was taking her to the bathroom and the nurse assisted me in taking her each time. She did not have any falls during my shift.' .Background Events: On 3/11/2026, guest fell in in her room rolling from bed to the floor, was found laying on her left side next to her bed. Pain was assessed and none noted. Fall interventions were put in place. Guest continued therapy well for more than a week without complaining of any pain. It was not until 3/19/2026 and 3/20/2026 that guest refused therapy citing pain. Pain medication given around the clock (ATC) was effective in controlling her pain. Nursing pain assessment resulted negative for any pain nor guarding until 3/21/2026 when guest started guarding right hip from family's touch. Per family, they were attempting to assist guest to the bathroom as they do .Nurse immediately assessed after notification by family, pain med administered and ice pack applied-provider was contacted and x-ray ordered that was completed on 3/22/2026-Family agreed with provider that they will take guest to ortho appointment on 3/23/2026-In the morning hours of 3/23/2026, further nursing assessment noted increased pain and guarding of right hip, provider contacted immediately and order given to transfer guest to ER. Family notified immediately. Report from the hospital revealed dislocation of right hip arthroplasty, no fracture was noted .[Name of Facility], PNC March 27 th, 2026 Diagnostic tests: 1.Resident [R202] chart was audited by the DON to ensure diagnostic tests ordered were placed and completed timely. All residents have the potential to be affected. 2. A one-time audit of all diagnostic tests for the last 2 weeks was reviewed by nurse managers and all outstanding tests ordered for completion. 3. All licensed nurses were re-educated on lab diagnostic policy: System change: if diagnostics tests are ordered, nurse must place order immediately into the diagnostic site for completion and notify physician of result immediately it is received. Any non-compliance will result in a 1:1 education. Nurse managers are reviewing diagnostic test orders & progress notes Mon-Friday to ensure all tests are being completed timely.4.The DON/designee will audit 5 charts weekly x12 weeks to ensure all diagnostic tests ordered are completed. 5. All audits will be taken to QAPI, the DON is responsible for sustained compliance On 5/26/26 at approximately 12:43 p.m., during a conversation with Regional Clinical Director A (RCD A) and the Director of Nursing (DON). RCD A regarding the Past noncompliance folder for R202, RCD A indicated the facility had identified deficiencies regarding delays in the diagnostic testing during R202's change in condition. RCD A indicated the Nurse on 3/20/26 should have done a complete assessment and contacted the Physician for orders when R202 (continued on next page)

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