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	12/11/2025

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2677719Based on interview and record review, the facility failed to protect the residents' right to be free from neglect for 14 residents (R's 3, 5, 7, 25, 26, 39, 66, 70, 72, 88, 97, 103, 104 and 108) of 19 residents reviewed for neglect. Findings include,A complaint was filed with the State Agency (SA) that alleged on 11/23/25 There were no nurses on the 200 and 400 hallway. My family member did not receive their night meds [medications] and other residents did not either. Staff said they called the 'DON' [Director of Nursing] and their managers to get help but no one answered. A review of the November 2025 Medication admission Records [MAR] for residents currently on the 200 and 400 Halls revealed multiple missed medications and treatments for residents on the 200 Hall on the midnight shift 11/23/25-11/24/25. Continued review revealed missed medications and treatments were also missed on the100 Hall on 11/23/25. On 12/10/25 at 1:02 PM, Licensed Practical Nurse [LPN] 'H' was interviewed by phone and asked if she had worked on 11/23/25. LPN 'H' explained she had worked the day shift from 7:00 AM to 7:00 PM on the 200 hallway and Unit Manager [UM] 'B' asked her to stay over and help pass the evening medications, because a nurse had called in for the midnight shift, so she stayed until sometime between 9:00 PM and 10:00 PM. LPN 'H' was asked who took over the 200 Hall when shed had left. LPN 'H' explained there were two midnight nurses and neither one would count her cart [ensure all narcotic medication were accounted for] or take the keys, so she had to reach out to management then LPN 'I' counted the cart with her and she gave LPN 'I' the keys. LPN 'H' was asked who the other midnight nurse was. LPN 'H' explained the other nurse was LPN 'J'. On 12/10/25 at 1:18 PM, LPN 'I' was interviewed by phone and asked about 11/23/25. LPN 'I' explained she worked from 7:00 PM to 7:00 AM that day, and there were call ins, they had been told two managers were going to split the night, but then after the shift started, we found out they had asked a day shift nurse to stay to pass medications on the 200 Hall. LPN 'I' was asked how the Halls were divided between the nurses. LPN 'I' explained LPN 'H' had the 200 Hall until she left, LPN 'J' had the 300 Hall, she had the 400 Hall and they all split the 100 Hall, then when LPN 'H' left she was banned from the 200 Hall, so she could not take that so she took the 100 Hall and LPN 'J' kept the 300 Hall but refused to take the 200 Hall. LPN 'I' was asked who counted LPN 'H's' cart when she left. LPN 'I' explained she had counted the cart because LPN 'J' refused to count it, but she took the keys and left them in the hall. LPN 'I' was asked if she knew about any medications or treatments that had not been done that night. LPN 'I' explained she was sure there were, because LPN 'H' only passed the medications that were due at 9:00 PM. When asked if she had received any education and/or disciplinary action, LPN 'I' explained she had been terminated, but LPN 'J' still worked at the facility. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/25 at 1:48 PM, LPN 'J' was interviewed by phone and asked about the midnight shift on 11/23/25. LPN 'J' explained LPN 'H' had stayed to help because of a call off and there were only two nurses scheduled, usually the on-call nurse is supposed to come in and take over the slack and stay until 11:00 PM to pass medications, LPN 'H' stayed until 9:00 PM. LPN 'J' was asked how the Halls were split. LPN 'J' explained she was responsible for the 300 Hall and three rooms on the 100 Hall, LPN 'I' had the 400 Hall and six rooms on the 100 Hall, and LPN 'H' had the 200 Hall and three rooms on the 100 Hall; but usually when there are only two nurses, the Halls are split into 100 and 200 for one nurse and 300 and 400 for the other, it was unfair I had 200 and 300, they are the biggest and heaviest Halls. LPN 'J was asked if she knew if medications or treatments that had not been done that night. LPN 'J' explained she knew there were, because when she looked at the computer, all the residents' medications were red [indicating the medication had not been given and was overdue]. LPN 'J' continued to explain she passed the medications due at 6:00 AM [on 11/24/25] for the residents on the 200 Hall. Review of LPN 'I's' employee file revealed a letter of termination dated 11/25/25 that gave the reason for termination as Failure to perform job duties satisfactorily, and according to established job description. Review of LPN 'J's' employee file revealed an Employee Corrective Action form dated 11/24/25 that read in part, .Written Warning. refused to work assigned hall on 11/23 shift directed by DON. refusal by words/actions to comply with a direct order or job assignment. On 12/10/25 at 5:00 PM, the DON was interviewed and asked if she was aware medications and treatments had been missed on 11/23/25. The DON explained she did not know until she came into work on 11/24/25 that medications had been missed. The DON was asked why medications and treatments were missed. The DON explained there was a call in and a day shift nurse stayed to help, then the two midnight nurses refused to take the assignment. The DON was asked why one nurse was terminated and one continued to be employed by the facility. The DON explained they both received written warnings, but it was the final written warning for LPN 'I', so she was terminated. The DON was asked if any medications or treatments should be missed due to only having two nurses working. The DON explained no medication or treatments should have been missed, these were experienced nurses, they should have worked together to get everything completed. On 12/10/25 at 5:14 PM, Certified Nursing Assistant [CNA] 'L', who served as the Scheduler for the facility, was interviewed and asked if she had created a schedule for 11/23/25. CNA 'L' explained as 11/23/25 was on a Sunday, she did not work that day but had made the schedule for three nurses on the midnight shift. when one nurse called in and a day shift nurse stayed to help no one contacted her, if they had, she would have advised them how to proceed with the assignments. CNA 'L' was asked if LPN 'I' had been banned from the 200 Hall. CNA 'L' explained LPN 'I' was not allowed to be assigned to one specific room on the 200 Hall, but when that happened, they would say they could not have the entire Hall. CNA 'L' was asked if LPN 'I' could have given medication to other residents on the 200 Hall excluding that one specific room. CNA 'L' explained she could have. On 12/11/25 at 8:25 AM, UM 'B' was interviewed and asked about the midnight shift on 11/23/25. UM 'B' explained she was the on-call supervisor that day and there had been a call in for days, so she had worked the floor, then there was a call off for midnight. she asked LPN 'H' if she would stay to pass evening medications, she agreed to stay until the 9:00 PM medications were passed. LPN 'H' texted her to say the midnight nurses would not count the cart or take the keys, she advised her one of them had to count with her and take the keys and if they did not, she needed to call the DON. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/25 at 9:30 AM, the DON was asked if LPN 'H' had contacted her on 11/23/25. The DON explained LPN 'H' had contacted her because the other two did not want to count the cart with her, she spoke with LPN 'I' and told her to count the cart with LPN 'H' and that LPN 'J' was to take over the 200 Hall, it was not until she came in the next morning that she found out that did not happen. Review of time records revealed LPN 'H' punched out at 9:02 PM on 11/23/25. Review of facility provided Past Non-Compliance documents were examined by the survey team; however, due to current neglect concerns the Past Non-Compliance was not accepted. R3 Review of the November 2025 MAR against a Medication Admin Audit Report revealed the following medications were not given per physician orders: Morphine Sulfate ER 30 MG [milligrams] [a narcotic pain medication] was due at 9:00 PM Novolog Insulin sliding scale due at 9:00 PM [it should be noted the blood glucose was not completed to determine the sliding scale amount] R7 Review of the November 2025 MAR against a Medication Admin Audit Report revealed the following medications were not given per physician orders: Budesonide Suspension 0.5 MG/2 ML [milliliters] 2 ml inhale orally [a corticosteroid inhaler for asthma] was due at 9:00 PM Eliquis 5 MG [an anticoagulant] was due at 9:00 PM Enteral Feed Order, administer 960 ml Osmolite 1.5 via pump was due at 8:00 PM Enteral Feed Order, administer free water via pump was due at 8:00 PM The following treatments were not completed per physician orders: Monitor trach [tracheostomy] site due at Night Groin and buttocks, cleanse with soap and water due at Night Monitor PEG [percutaneous endoscopic gastrostomy – a tube passed through the abdomen to the stomach] tube site due at bedtime Vital signs [including pain score] was due at Night R26 A review of the November 2024 MAR/TAR revealed the following omitted medications and/or services on 11/23/25: (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Blood sugar check 9PM Norco 5-335 mg 9 PM dose. All were omitted and not signed for on the MAR/TAR. The review of the medication audit confirmed the omission. R88 A review of the November 2024 MAR/TAR revealed the following omitted medications and/or services on 11/23/25: Norco 5-325 8PM dose. Gabapentin 100mg 8 PM dose Tramadol 50 mg 8 PM dose Losartan potassium 50 mg 9PM dose All were omitted and not signed for on the MAR/TAR. The review of the medication audit confirmed the omission. R72 A review of the November 2024 MAR/TAR revealed the following omitted medications and/or services on 11/24/25: Cleanse L (left) shin w/ NS (with Normal Saline), apply petroleum gauze and cover w/ foam dressing. every shift. For the day time shift. All were omitted and not signed for on the MAR/TAR. The review of the medication audit confirmed the omission. R5 A review of the November 2024 MAR/TAR revealed the following omitted medications and/or services on 11/23/25: Xanax 0.5 mg 8 PM dose. All were omitted and not signed for on the MAR/TAR. The review of the medication audit confirmed the omission. R104 On 12/9/25 at 11:54 AM, R104 was interviewed about their current stay at the facility. R104, reported that the other day they had to use the restroom themselves (without assistance from staff) because the girls did not have time to take them to the restroom because they were passing breakfast trays. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R104 reported that they are able to go to the toilet but they need assistance getting there. R104 reported that, they did not want to use the restroom themselves, but the aids had to pass trays first. Review of medical record revealed that R104 was admitted to the facility on [DATE] with the admitting diagnosis of Bilateral osteoarthritis of the knee and lower back pain and had a brief interview for mental status score(BIMs) of 15. On 12/11/25 at 10:15 AM an interview was conducted with the director of nursing (DON). The DON was asked what the expectation for patient care was during mealtimes, the DON reported that it is expected that the Certified nurse aids (CNA) come in at 7 AM get report, change (residents that are soiled) and get everyone up for the day; by 7:45AM the CNA can be a part of the dining line to help pass trays. The DON was then asked, would she expect someone to be taken to the bathroom or personal care needs be met during mealtimes. The DON reported that patient care should still happen during mealtimes. The DON was then informed of the accident that R104 experienced in the dining room and reported that they would look into it but that incident should have not happened because R104 is alert and oriented able to make their needs known. The DON was also informed that R104 was not the only resident who mentioned not being able to receive assistance during the breakfast meal when the trays are being passed. The DON reported the facility would have to work on their procedures during the breakfast mealtime. R97 Review of R97's November (2025) MAR/TAR revealed the following omitted medications: 11/23/25: Oxycodone – Acetaminophen 5-325 mg (controlled pain medication). 1 tablet every 4 hours for moderate to severe pain (scheduled): 2000 (8:00 PM). Fiber One - 2 tablets by mouth 3x day for constipation (scheduled): 2000 (8:00 PM). 11/24/25: Oxycodone – Acetaminophen, 5-325 mg. 1 tablet every 4 hours for moderate to severe pain. (scheduled): 0000 (12:00 AM) and 0400 (4:00 AM)). Vitals signs every shift (scheduled). R97's medications/treatments reflected were omitted (blank with no explanation) and unsigned, with no explanation regarding the omissions on the MAR/TAR. Review of R97's November medication audit (provided by facility management) confirmed the omissions. Review of R97's pain log entry, dated 11/24/25 at 6:28 (AM), showed increased pain shortly after missing their pain medication of 8/10 (with 10 the worst pain level). R70 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R70's November (2025). MAR/TAR revealed the following omitted medications (blank entries): 11/23/25: Gabapentin (nerve medication) 100 mg. 2 tablets 3 x day for wedge compression fracture (nerves/pain). 2000 (8:00 PM). Hydroxyzine (anxiety medication), 25 mg. 1 tablet 4x day for anxiety. 2100 (9:00 PM). Hydrocodone – Acetaminophen Tablet 10 – 325 mg. 1 tablet 4 x day for pain. (scheduled): 2000 (8:00 PM). 11/24/25: Hydrocodone – Acetaminophen Tablet 10 – 325 mg. 1 tablet 4 x day for pain. (scheduled): 0000 (12:00 AM). 0400 (4:00 AM). R70's medications/treatments reflected were omitted (blank with no explanation) and not signed for, with no explanation on the MAR/TAR. Review of R70's November (2025) Medication Audits confirmed the omissions (blank with no explanations). Review of R70's pain log entry, dated 11/24/25 at 11:40 (AM), showed increased pain shortly after missing their pain medication of 9/10. R66 11/23/25: Acetaminophen (OTC – Over the counter) pain medication. 2 tablets 3x day for pain (scheduled). 2000 (8:00 PM). Muscle Rub External Cream 10-15% (Menthol) Apply to knees 3x day. 2000 (8:00 PM). Monitor skin integrity and circulation to LLE (left lower extremity) every shift. R66's medications/treatments reflected were omitted (blank with no explanation) and not signed for, with no explanation on the MAR/TAR. Review of R66's November (2025) Medication Audits confirmed the omissions. Review of R66's pain log entry, dated 11/24/25 at 7:51 (AM), showed increased pain shortly after missing their pain medication of 5/10. R25 A review of the November 2025 MAR/TAR revealed the following omitted medications and/or services (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 11/23/25: Minoxidll 2.5 mg (milligram) tablet for hypertension, 9 PM dose. Clonidine HCl 0.3 mg tablet for hypertension, 8 PM dose. Hydralazine HCL 100 mg tablet for hypertension, 8 PM dose. Blood sugar level for Humalog (insulin coverage), 9 PM dose. All were documented as administered and/or obtained, however when compared to the facility's medication administration audit it revealed the above medications were not administered. R39 A review of the November 2025 MAR/TAR revealed the following omitted medications and/or services on 11/23/25: Fluticasone-Salmeterol inhalation aerosol 250-50 MCG (microgram)/ACT (actual puff from inhaler) one puff every 12 hours for acute and chronic respiratory failure with hypoxia (low levels of oxygen), 9 PM dose. Ipratropium-Albuterol 0.5-2.5 MG/3ML (milliters) via nebulize for COPD, 9 PM dose. All were omitted and not signed for on the MAR/TAR. The review of the medication audit confirmed the omission. R103 A review of the November 2025 MAR/TAR revealed the following omitted medications and/or services on 11/23/25: Blood sugar level for Humalog (insulin coverage) for the 6 PM & 8 PM doses. Both were omitted and not signed for on the MAR/TAR. The review of the medication audit confirmed the omissions. R104 A review of the November 2025 MAR/TAR revealed the following omitted medications and/or services on 11/23/25: Gabapentin 100 mg capsule for idiopathic progressive neuropathy, 8 PM dose. The medication was omitted and not signed for on the MAR. The review of the medication audit confirmed the omission. R108 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the November 2025 MAR/TAR revealed the following omitted medications and/or services on 11/23/25: Tylenol Extra Strength 500 mg tablet for pain, 9 PM dose. The review of the medication audit confirmed the omission.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide information regarding an advance directive & failed to offer the resident and/or resident representative the opportunity to formulate an advance directive for one (R56) of one resident reviewed for advance directives. Findings include: A review of the medical record revealed R56 was initially admitted to the facility on [DATE], with a readmission date of 11/7/25. Diagnoses included: chronic kidney disease, colostomy status and sepsis. On 12/9/25 at 10:47 AM, R56 was observed in their room sitting in their wheelchair. An interview was conducted with the resident at that time. Review of the EMR (electronic medical record) revealed R56's brother was documented to be the POA (Power of Attorney) for Care and Financial for R56.A review of the medical record revealed no documentation of the facility staff to have provided information to R56 or R56's brother regarding information on advance directives and no documentation that the resident or their POA was provided the opportunity to formulate an advance directive. On 12/10/25 at 11:17 AM, the Care Transitions (CT) personnel O was interviewed and asked about the facility's policy and their department involvement in providing the residents and/or resident representatives information on advance directives and the option to formulate an advance directive. CT O replied their department only ensured the advance directives are in the medical record and stated it was the nursing department responsibility to provide the information to the residents and/or representatives.On 12/10/25 at 11:21 AM, the Director of Nursing (DON) was interviewed and asked the nursing departments involvement in the education and providing residents and/or representatives the opportunity to formulate an advance directive. The DON stated they would look into it and follow back up with the surveyor. At 12:04 PM, the DON followed back up and stated it is not the Nursing department responsibility to provide information and the option to formulate an advance directive to the residents and/or representatives. The DON stated the social work department (care transitions) is responsible for that. A review of a facility policy titled Advance Directives revised April 2008 documented in part , . Advance directives will be respected in accordance with state law and facility policy. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to. formulate advance directives.On 12/10/25 at 12:19 PM, a follow up interview was conducted with CT O. CT O stated they called R56's brother and provided them information on the advance directive today (12/10/25). No further information or documentation was provided by 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** Based on observation, interview, and record review, the facility failed to provide adequate positioning to prevent the potential for wound development and progression for one Resident (R108) of two residents reviewed for positioning. Findings include: On 12/09/25 at 11:38 a.m., R108 was observed at approximately 11:38 a.m. seated upright in their recline high back wheelchair, dressed, pushing their wheelchair down the hallway. R108 was sacral sitting (sliding forward in their wheelchair seat, onto their sacrum - bone at base of spine). R108 was observed with a full body mechanical lift sling underneath them, with no wheelchair cushion observed. On 12/09/25 at approximately 11:45 a.m., R108's Certified Nurse Aide, (CNA) P, was asked if R108 had a wheelchair cushion underneath them. CNA P confirmed R108 did not have a wheelchair cushion underneath them. R108's room was observed, and there was no wheelchair cushion. Two blue foam heel protectors were observed and an air bed mattress. Review of R108's nursing progress note, dated 12/05/25 at 12:48 p.m., revealed, SW - Skin Issues: #001: New skin Issue. Location: Coccyx. Issue type: Pressure ulcer/injury. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis (middle layer of skin). Wound acquired: In - house (during stay). Wound is new. Signs and symptoms of infection: None. Length (cm - centimeters): 0.59 width (cm): 0.72. Depth (cm): 0. Area: 0.33 (cm2).Surrounding tissue: fragile.Additional care: Mattress with pump.Additional care: Heel suspension / Protection device.Skin Issues Note: Stage 2 to left buttock. Review of R108's physician orders, accessed 12/09/25 at 3:58 p.m., revealed R108 continued to receive wound treatment to their bottom. Wound care orders read as follows: .R (right) buttock wound: Cleanse w/ (with) NS (Normal Saline solution). Pat dry. Skin prep (protective wound covering) to surrounding area (peri-wound). Aquacel ag (antimicrobial treatment used in wound care) to wound bed and cover w/ (with) foam dressing.Active. Start date: 12/05/25 13:45 (1:45 p.m.).End date: (Blank)., showing a current order. This order confirmed R108's pressure ulcer was not healed during the survey. Review of R108's Electronic Medical Record (EMR) revealed R108 was admitted to the facility on [DATE], with diagnoses including diabetes, dementia, falls, and stroke. The EMR revealed R108 was receiving hospice services. Review of R108's Care Plan, accessed 12/09/25 at 3:53 p.m., revealed R108 required assistance with activities of daily living (ADL cares) and had cognitive impairment. The Care Plan further revealed R108 used a high back wheelchair and a full body mechanical lift for transfers. There was no mention of a wheelchair cushion in R108's Care Plan, including in the ADL or skin management section, or throughout their current care plan. R108's Care Plan showed they wore heel protectors when they were in bed, stating, float heels while abed (sic), encourage PRAFO (positioning) boots as ordered. On 12/10/25 at approximately 10:40 a.m., R108 was observed in the dining room with a full body mechanical lift sling underneath them. There did not appear to be a wheelchair cushion underneath R108, as no cushion was observed on either edge of the wheelchair or above or underneath the sling. On 12/10/25 at approximately 10:42 a.m., R108 was asked how they were doing. R108 pointed to their left foot and said it hurt. R108's nursing staff were notified R108 was in pain after the interaction. No heel protector was observed on R108's left foot. On 12/10/25 at approximately 10:52 a.m., R108's CNA, CNA Q, reported they did not observe a wheelchair cushion underneath R108. CNA Q looked in R108's room and reported they did not observe a wheelchair cushion. On 12/10/25 at approximately 1:30 p.m., R108 was observed with Family Member, FM R, who acknowledged R108 had a black wheelchair cushion underneath them which was hard, as felt by FM R' and Surveyor. The cushion did not have adequate pressure relief. No gel or air was felt or observed on the cushion as an overlay. On 12/10/25 at 1:35 p.m., R108's left foot was observed with FM R, with the left foot sliding off the black metal wheelchair footrest foot plate, striking the footplate directly on the left side, on their left lateral heel. R108 was not wearing any heel protectors or PRAFO positioning/offloading boots during the observation. On 12/10/25 at 1:36 p.m., FM R asked (continued on next page)

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	235716	A. Building B. Wing	12/11/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R108 how they were doing, and R108 communicated to FM R their right foot was hurting. R108 told FM R it had been hurting for some time but was unable to specify further. On 12/10/25 at 1:38 p.m., FM R removed R108's blue gripper sock. R108's left heel had a half-dollar sized wound on their lateral heel observed where the foot plate was striking their left heel. The wound had a black outer ring, and an inner yellow circle, with a burgundy red center. The wound did not appear to be a new wound as it was covered with thickened skin. R108's entire left foot up to their calf was erythemic (abnormally reddened due to inflammation, injury, infection, or irritation caused by dilated blood vessels). FM R removed R108's right foot gripper sock (for comparison), and there was a demonstrable difference in color. R108's right foot had no erythema and was cream colored in appearance. R108's FM R noted the difference in R108's foot coloration and was concerned about the new wound. FM R reported they had not been made aware of this wound to R108's left foot. Surveyor notified nursing staff of R108's wound, who confirmed this was a new wound and sent for a wound nurse team to assess and treat the wound. Review of R108's EMR showed there was no documentation of R108's heel wound prior to the 12/10/25 observation with FM R and Surveyor. On 12/10/25 at approximately 1:55 p.m., R108 was observed with FM R with their foot positioned on their left footrest foot plate. On 12/10/25 at 2:00 p.m., R108 was observed sliding off their foot at the footrest towards their midline, so their left lateral heel directly struck the right side of the left footrest. R108 was assisted with positioning by FM R to relieve the direct pressure to this area, and the nursing wound staff were made aware of the pressure area and observed R108's positioning when they came to observe and measure the heel wound. Review of R108's Physician Provider Note, by Physician V, dated 12/10/25 at 16:18 (4:18 p.m.), revealed, .(Physician V) received a call from nursing staff regarding elevated blood sugars.Will increase (Brand name) insulin.and continue to monitor blood sugars closely with sliding scale insulin coverage as needed. Patient also has redness to left foot and left lower leg; pictures are reviewed. Patient previously had small callus (thickened skin) type area on the heel in September which has healed and now seems like worsened again. From picture (photo) looks like the patient has callouses which can be painful with the pressure, also discoloration of the left leg probably (due to) underlying peripheral vascular disease (PVD- blood circulatory disorder). Patient is diabetic and (at) high risk of PVD. Will try to keep pressure off, pain management and local care and monitor. Review of the provider note acknowledged R108's wound was related to pressure as well as a likelihood of vascular compromise and R108's unstable blood sugars from diabetes. Review of R108's physician order, dated 12/10/25 at 19:00 (7:00 p.m.), revealed, DM (diabetes mellitus) ulcer/callous at left lateral foot/side of heel: Swab with skin prep, let dry, leave OTA (open to air), monitor site and notify MD (physician) of acute changes. Review of R108's physician order, dated 12/10/25, revealed, Foot buddy (padded wheelchair footrest cradle / overlay) to wheelchair when footrests are engaged (in place) .Review of R108's physician order, dated 12/10/25 at 19:00 (7:00 p.m.) revealed, (Brand name air) cushion to wheelchair; check for inflation and refill (air) cushion as needed. Review of R108's wound note, dated 12/10/25, revealed, Diabetic foot ulcer. Location: Left lateral foot. Onset. New.Side of heel.In-house acquired.Intermittent pain.Sensitive to touch.Measurements: Length: 1.55 (centimeters - cm). Width: 1.12 (cm). Depth: 0. Area: 1.31 (cm) .Exudate (drainage): None.non-pitting edema (swelling) extends 4 cm around wound. This note confirmed R108's wound was new, after being discovered by FM R, with Surveyor present. On 12/11/25 at 12:55 p.m., Registered Nurse (RN) S, R108's hospice nurse, was asked during a phone interview about R108's wounds. RN S acknowledged they were R108's visiting nurse who completed wound care with R108. RN S confirmed during their visit earlier this week, R108 continued to have a Stage 2 pressure ulcer on their sacrum (triangular bone at the base of the spine), which was not infected and smaller than a pencil eraser in size. RN S was asked if R108 had any other wounds and reported they were not aware of R108 having any other wounds, including on their left heel. On 12/11/25 at approximately 2:30 p.m., the Rehabilitation Director, Physical Therapist (PT) U, was asked about R108's positioning in their wheelchair. PT U acknowledged the therapy department had placed the protective blue padded foot board over R108's wheelchair foot plates on (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/10/25. PT U confirmed a screening was requested by nursing management after nursing staff had learned R108 had a new heel wound from a potential pressure area from their left wheelchair footrest. PT U confirmed this was an appropriate intervention, given R108's heel wound. PT U acknowledged this intervention may have prevented the pressure area, when they learned R108's heel was sliding off their left wheelchair footrest. PT U reported they and their department staff had not been made aware of this concern by nursing staff until 12/10/25, after the left lateral heel wound was discovered. On 12/11/25 at 2:44 p.m., the Director of Nursing (DON) was interviewed regarding R108's sacral pressure ulcer and the lack of an appropriate wheelchair cushion. The DON acknowledged the concern and reported a new (Brand name) air cushion was in place underneath R108 currently.On 12/11/25 at approximately 2:50 p.m., the DON was asked about R108's foot slipping off their wheelchair and the blue padded foot board currently over R108's footrests. The DON concurred that this was an appropriate intervention to prevent pressure and slippage and noted R108's heel foot protectors were also in place. The DON reported R108's Physician V had seen R108 on 12/10/25 and documented the heel wound as a diabetic wound, which may have been PVD-related as well as a past wound there. Concerns were shared related to the location of R108's new left lateral heel would and pressure being observed. Surveyor described how R108's foot made direct contact with their wheelchair footrest footplate more than once prior to the preventative positioning intervention newly put in place during the survey. Surveyor also described concerns related to R108 not having a wheelchair cushion or the cushion not providing adequate pressure relief for a Stage 2 sacral pressure ulcer. The DON understood the positioning concerns and confirmed the new interventions would ensure adequate pressure relief for R108's sacral wound and R108's left heel wound, due to their high risk of breakdown, and help prevent wound progression. On 12/11/25 at approximately 2:55 p.m., the DON and Surveyor observed R108's positioning in their high back wheelchair in their room. R108 was seated in their wheelchair, with a (Brand name) air cushion underneath them in their wheelchair. R108 also had the blue padded foot board over their wheelchair footrests and the blue foam pads covering their heels. The footboard prevented R108's feet from sliding off separate footrests as the device covered both footrests to adequately support their feet and lower calves. On 12/11/25 at approximately 3:01 p.m., Regional Nurse Consultant, RN M, the DON, and RN S asked to speak to the survey team regarding R108's wounds and causative factors. RN M and RN S clarified they believed R108's left heel wound was a diabetic wound, and possibly from PVD, which was being evaluated further. This was described related to Physician V's wound assessment/description dated 12/10/25, review of podiatry notes, and their prior wound history of a diabetic heel wound from 3/2025. Surveyor described R108's heel wound was observed directly more than once located in a pressure contact area with their left footrest, however, regardless of the cause, R108 would have benefitted from the padded protective positioning device over their footrests, given R108's vulnerability and subjectivity to skin breakdown. Additionally, Surveyor described R108 would have benefitted from having a pressure relieving wheelchair cushion / air cushion in place, per standards of practice, to prevent the development and/or progression of an existing Stage 2 pressure ulcer on their sacrum. Per Surveyor understanding, the nursing management team understood the positioning concerns however denied any presence of a new pressure ulcer to R108's left heel. RN M clarified they understood both R108's heel and sacral pressure ulcer developed from former wounds which predisposed them to skin breakdown. Review of a policy for skin and wound, titled, Pressure Ulcers/Skin Breakdown - Clinical Protocol. Assessment and Recognition, revised October 2010, revealed the following: 1. The nursing staff and Attending Physician will assess and document an individual's significant risk factors for developing pressure sores; for example, immobility, recent weight loss, and a history of pressure ulcer(s). 2. In addition, the nurse shall assess and document/report the following: a. Vital signs. b. Full assessment of pressure sore including location, stage, length, width and depth, presence of exudates or necrotic tissue. c. Pain assessment. d. Resident's age and sex. e. Resident's mobility status. f. Current treatments, including support (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure a resident received assistance with their hearing aides to maintain their hearing ability for one (R89) of one resident reviewed for hearing. Findings include: On 12/9/25 at 10:17 AM, R89 was observed lying on their back in bed. An interview was attempted, however R89 stated they were unable to hear the surveyor. A signage on the resident wardrobe was observed to alert the staff that the resident had new hearing aids. The surveyor had to talk into the right ear of R89 to complete the interview. On 12/10/25 at 12:40 PM, R89 was observed lying on their back in bed. An interview was attempted, however R89 stated they were unable to hear the surveyor. The surveyor talked into the right ear of the resident and asked about their hearing aids. R89 stated their hearing aides were in the drawer of their nightstand but could not reach them. R89 stated staff would have to provide them with their hearing aids to put them in.A review of the medical record revealed R89 was initially admitted to the facility on [DATE], with a readmission dated of 6/9/25. R89 was admitted with a diagnosis that included dementia and required assistance from staff for all activities of daily living (ADLs). A review of the medical record revealed no active care plan regarding the R89's hearing deficit and/or the responsibility of which staff to assist with applying the resident's hearing aids. Further review of the medical record revealed no documentation of the resident's hearing aids. On 12/11/25 at 9:23 AM, an interview was conducted with the Director of Nursing (DON). The DON was asked whose responsibility it was to assist R89 with applying their hearing aids daily. The DON responded that the aids or nurses are both capable to assist the resident with their hearing aids. The two above observations were discussed with the DON and the concern of the facility staff failure to assist R89 with the application of their hearing aids. The DON stated they would look into it and follow back up. No further explanation or documentation was provided before the end of the survey.