STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235720	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Pinckney	664 South Howell Street Pinckney, MI 48169

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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

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

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2691527Based on interview and record review the facility failed to prevent an avoidable fall as well as conduct a thorough root-cause analysis investigation into a fall for one resident (R801), of three residents reviewed for falls resulting in fractures of their clavicle and thoracic vertebra number four. Findings include:A complaint received by the State Agency alleged R801's bed was not in the lowest position when they sustained a fall resulting in injury.On [DATE] at 10:22 AM, a review of R801's closed clinical record revealed they admitted to the facility on [DATE], elected Hospice Services on [DATE] and expired in the facility on [DATE]. R801's diagnoses included: repeated falls, stroke, heart disease, vascular dementia with behaviors, and adjustment disorder.Continued review of R801's record revealed an Incident Note entered into the record on [DATE] at 12:04 PM by Nurse ‘A' that read, Writer was notified that resident had fallen on the floor. When writer went to assess resident, resident was on the side if [sic] the bed lying on her side. Resident was unable to explain who [sic] she fell onto the floor or what happened at all. When writer was assessing resident, writer found a skin tear to her right knee, a large known [sic] (knot) on the left side of her forehead and a large knot on the right side of her neck.Writer contacted hospice and daughter who wanted her to be sent to (Hospital Name) .A review of a late entry eINTERACT SBAR (Situation, Background, Assessment, Recommendation)Summary for Providers entered into R801's record on [DATE] for the fall that occurred on [DATE] was conducted and read, Late Entry: Situation: The Change In Condition/s reported.are/were: Falls.-Mental Status Evaluation: No Changes observed.Behavioral Status Evaluation: (Blank). - Pain Status Evaluation: Does the resident/patient have pain? Yes.- Neurological Status Evaluation: No changes observed. A. Recommendations: Hospice and family notified. Due to pain and visible knot on guest. Send to Ed (Emergency Department) for further evaluation per hospice.Further review of R801's progress notes revealed an Incident Note entered into the record by Nurse ‘A' on [DATE] at 5:05 PM that read, .Resident returned from the hospital from being sent there earlier due to fall. Resident had imaging done in ER (emergency room) and it came back that she has a T4 (thoracic vertebra) compression fracture and a right clavicle fracture. Due to resident being on hospice and also not being a good candidate for surgery, the ER did not treat the fracture.Upon arrival, resident stated that she was in pain. Writer administered PRN (as needed) Morphine.On [DATE] at 11:45 AM, an interview was conducted with Nurse ‘A' regarding R801's fall on [DATE]. They were asked to describe what they remembered about the incident and said they were charting when they heard CNA (Certified Nurse Aide) ‘C' call for their help in R801's room. They said R801 was observed on the floor next to their bed with a knot on their head and a knot on their right clavicle. Nurse ‘A' said R801 cried out in pain when they tried to move her. Nurse ‘A' went on to say when they entered the room they noticed, The bed was higher than it was supposed to be. They were asked to demonstrate an approximation of the bed height and Nurse ‘A' (who reported their height at 5'10) gestured to their waist level. Nurse ‘A' said, It was not normal for R801's bed to be at that height. They were asked if they knew how R801's bed could have been raised from its previously observed low level and said, I think I know what happened. When queried further, Nurse ‘A' did not provide any additional details. Nurse ‘A' continued to say after they assessed R801 they were sent to the hospital to return later in their shift with a broken clavicle and T4 vertebra. Nurse ‘A' was then asked about the last time they observed R801 prior to the fall and said they gave R801 a breathing treatment and when they left the room the bed was in the lowest position. They were then asked if they observed anyone else entering R801's room after they gave the breathing treatment and said they knew CNA ‘C' had gone in there after them for a check and change. They were further queried if they observed anyone else entering the room after CNA ‘C' and before the fall and they offered no response.On [DATE] at 12:02 PM, an interview was conducted with CNA ‘C', R801's assigned CNA on [DATE]. They were asked to describe what they remembered from the incident and said they were working with a resident one room away when they heard R801 yelling for help. CNA ‘C' said they went to the room and observed R801 on the floor next to their bed. They said they called for Nurse ‘A' and another CNA and they put R801 back in bed. They were asked if they observed anything unusual about the bed and said, When I walked in the bed was high. CNA ‘C' then said, We all know (R801), and her bed is supposed to be low. CNA ‘C' said they performed a check and change before R801 fell and reported the bed was in the lowest position when they left the room. CNA ‘C' was then asked if they knew how the bed got raised after they provided care and before the fall. They said they heard a housekeeper was in the room, raised the bed