Printed: 06/05/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235726	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellbridge of Clarkston	5655 Clarkston Road Clarkston, MI 48348

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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2790121.Based on observation, interview and record review, the facility failed to ensure care was provided in a safe manner to prevent accidents for one (R802) of two residents reviewed for accidents, resulting in unnecessary pain and a fall with subsequent fractured manubrium and multiple rib fractures and transfer to the emergency department for further evaluation. Findings include:Review of a complaint filed with the State Agency included allegations that care was not provided in a safe manner to prevent a fall with injury.Review of the documentation provided by the facility identified R802 as a resident that had a fall with major injury.On 3/10/26 at 9:58 AM, R802 was observed lying in bed. When asked about with television on. When asked about their general health and what they could recall from a recent fall during care, R802 began crying and stated they were upset they didn't think they were continuing therapy and they felt they really needed it. The resident was too upset to continue talking and requested someone come see them about their therapy. At 10:10 AM, the Administrator was notified and reported they would follow up.Review of the clinical record revealed R802 was initially admitted into the facility on 9/17/25, and recently readmitted on [DATE] with diagnoses that included: fracture of manubrium (2/7/26), multiple fractures of ribs, right side (2/7/26), displaced intertrochanteric fracture of right femur (1/16/26), trigeminal neuralgia, Meniere's disease, and unspecified psychosis not due to a substance or known physiological condition.According to the significant change Minimum Data Set (MDS) assessment dated [DATE], R802 had no communication concerns, had intact cognition (scored 15/15 on the brief mental status exam), was independent with self-care, used a walker and wheelchair for mobility, had no upper extremity functional limitation in range of motion, had impairment on one side of lower extremity functional limitation in range of motion, was dependent for toileting hygiene, required supervision or touching assistance for lower body dressing, required substantial/maximal assistance to roll left and right and for lying to sitting on side of bed; has an indwelling urinary catheter, was occasionally incontinent of urinary and bowel, and had not had a fall since admission or prior assessment.Review of the care plans included: Risk for falls r/t (related to) Sternal Fx (fracture), Multi Rib Fx, R Femur Fx, Fall, urinary tract infection, other asthma, type 2 diabetes mellitus without complications, headache, unspecified, essential (primary) hypertension, chronic kidney disease, stage 3 unspecified, hypothyroidism, atherosclerotic heart disease of native coronary artery without angina pectoris, encephalopathy, acute kidney failure, anemia, trigeminal neuralgia, meniere's disease, unspecified ear, gastrointestinal hemorrhage, hypo-osmolality and hyponatremia, hyperkalemia, dysphagia, unspecified presence of automatic (implantable) cardiac defibrillator, personal history of transient ischemic attack (tia), and cerebral infarction without residual deficits, heart failure. Date initiated 9/18/25, revision on 2/10/26.Interventions included: Encourage and assist guest to be positioned in the middle of the bed prior to rolling. Date initiated 2/2/26. Transfer: 1 PA w/ 2WW, non ambulatory. Init. 9/18/25, revision on 2/10/26On 3/10/26 at 10:10 AM, the Administrator and Corporate Clinical Nurse were informed of R802's request and reported they would follow-up - the Administrator further reported the resident was currently under Medicare A skilled care and their (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 0689 Level of Harm - Actual harm Residents Affected - Few	baseline was they were easily upset and tearful and was not a new onset.R802's diagnoses included:Fracture of manubrium (upper sternum) (2/7/26), multiple fractures of ribs right side (2/7/26), displaced intertrochanteric fracture of right femur (1/16/26), trigeminal neuralgia, Meniere's disease, and unspecified psychosis not due to a substance or known physiological condition.Review of the interdisciplinary progress notes included:An entry on 2/2/26 at 1:26 AM by Nurse ?C' read: .NA (Nurse Aide) notified me that resident rolled out of bed in the middle of her ADL (Activities of Daily Living) care, resident was observed on the floor on her left side. writer assessed resident and took vitals, upon assessment writer observed blood on residents left pinky, resident pinky nails is broken and half way detected. resident was assisted back into bed by staff.An entry on 2/2/26 at 4:13 AM by Nurse ?C' read: resident is experiencing left shoulder pain, pain medication administered as prescribed , physician confirmed order for x-ray to left shoulder due to fall. continue to monitor remainder of shift.An entry on 2/2/26 at 11:01 PM read: .[02/02/2026 09:04 AM].resident fell last night ordered stat xray for left shoulder guest complained of pain, right arm and shoulder, arm to shoulder is swollen, verbalized pain during ROM (Range of Motion), bilateral ribs and hip ordered, guest complained of hip pain and rib pain on both sides.resident results were clear. no fractures np (Nurse Practitioner) notified no additional orders.An entry on 2/3/26 at 3:30 PM by Nurse Practitioner (NP ?A') read: .Pt (patient) seen and examined, pt observed in bed, in mild distress.S/p (status post) fall out of bed. XRs (x-rays) reiewed, negative for acute process. Continues to c/o (complain of) right rib pain with deep breathing. Reports that right arm pain persists. RUE (Right Upper Extremity) with +1 non pitting edema.RUE weakness noted. Right hand grip weak and only able to lift arm approximately 20 degrees off of bed which is not baseline. Patient reports that she hit her head during fall event and has not felt the same since. Purple bruising noted to right temple - unclear if bruise is from fall event as patient states she hit the left side of her head. Patient has headaches at baseline r/t (related to) trigeminal neuralgia, stating that she has a headache differing from her baseline. States that she feels dizzy and she is having new onset visual changes she describes as dark shadows in her peripheral vision.continues on Heparin (blood thinnger) subq (subqutaneously) for DVT (Deep Vein Thrombosis) prophylaxis. D/W (discussed with) nursing - send to hospital for CT (Cat Scan) head due to complaints s/p fall with head injury.surgical incisions right rear, right lateral thigh, and right rear above knee - well approximated, staples in place (from a previous fall with injury on 1/11/26 which resulted in a displaced intertrochanteric fracture of right femur).An entry on 2/7/26 at 4:47 PM by Nurse ?B' read: resident has returned from hospital, a/ox2 (alert and oriented to person and place) - new signs of confusion only knew her name and that she fell and broke her ribs.c/o pain - gave prn (as needed) oxycodone.Review of the hospital documentation available in R802's clinical record included:CT (computed tomography) Imaging results dated 2/3/26 read, .Impression.Minimally displaced fracture in the right anterior superior manubrium.Mildly displaced fracture in the anterior right 2nd rib. Nondisplaced fracture in the anterior right 1st rib.Patient is a 78 y.o. female prsents to the hospital after a fall from bed at her rehab facility resulting in new minimally displaced right anterior superior manubrium and right 1-2 rib fractures. Given her injuries and RIG score (a clinical triage tool used in trauma centers to assess the severity of traumatic rib fractures and determine the appropriate level of care for a patient), patient was sent to the ICU (Intensive Care Unit). She was also found to have the flu and was given tamiflu.Review of the hospital History & Physical (H&P) documented, .H&P TRAUMA.recently admitted to the trauma service last month for R (Right) hip fracture presenting after falling from the bed at her rehab facility resulting in new minimally displaced R anterior superior manubrium and R 1-2 rib fractures. Patient states she rolled out of bed as she was being turned by staff at her facility.On 3/10/26 at 9:55 AM, the facility was requested to provide any concerns/grievances, incident/accident reports and facility investigations since 2/1/26.Review of the documentation provided by the facility included an undated, unsigned soft file that documented, in part: Soft File Investigation - (R802) Fall with Subsequent Fracture.At the time of the event the resident's BIMS score was 14, indicating she was cognitively intact with mild impairment. Her (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	functional status included independent transfers and ambulation with assistance of one person and a two-wheeled walker.On 02/02/2026 at approximately 0050, the nurse was notified by the CNA (Certified Nursing Assistant) that the resident had rolled out of bed during ADL care. The CNA reported that while providing care, the resident rolled over and went too far toward the edge of the bed, resulting in her sliding onto the floor. The CNA remained present in the room at the time of the event. Upon entering the room, the nurse observed the resident lying on the floor on her left side. The resident was noted to be continent and wearing non-skid socks at the time. The nurse immediately asked the resident what had occurred. The resident stated that she did not know what happened but reported pain in her left shoulder. The CNA reported she did not observe whether the resident struck her head during the event.The resident expressed pain with movement of the left shoulder, but no other injuries were identified at that time. Neurological checks were initiated immediately following the fall and remained within the resident's baseline. Vital signs.were stable.The on-call physician was notified, and new orders were received for an x-ray of the left shoulder and continued monitoring with neurological checks.The x-ray of the left shoulder returned negative for fracture.The resident was subsequently sent to the emergency department the following day for further revaluation and treatment per nurse practitioner assessment.The investigation determined that the resident rolled too far while repositioning during ADL care, resulting in her sliding from the bed onto the floor. A the time of the incident, staff were present in the room providing care (it should be noted that there was only one staff member who was providing care - this makes is seem as if there were multiple).The root cause analysis concluded that the fall occurred due to the resident rolling beyond the edge of the bed during repositioning.Additional intervention was implemented to encourage and assist the resident to remain positioned in the middle of the bed prior to rolling during care to reduce the risk of rolling beyond the bed edge.Review of the included QA (Quality Assurance) Tool: Fall with fracture included a check list of report details, which included, .Environment & Equipment.Bed height appropriate (check mark) Yes.Root Cause & Preventability.Was the fall preventable? .(check mark) No.Explanation: isolated event - 1:1 given to CNA.New interventions implemented: encourage and assist to be in middle of bed with care.Staff education provided: (left blank). The bottom of this document identified a date of when this incident was reviewed with QA committee, DON, Administrator and Medical Director signatures however all of these sections were left blank (incomplete).Review of the Witness statement from CNA ?D' dated 2/1/26 documented: I entered the resident's room to provide care bed was already elevated to an appropriate working height and did not require adjustment. I explained what I was there for to the resident and asked which side she preferred to turn to the resident indicated her preference and I unsnapped the brief prior to turning when the resident turned she started exhibiting unusual movements including sudden jerking and jolting I asked the resident what was wrong and during the next movement the resident fell onto the floor.Included with this was a One on One Education with CNA ?D? which read, .Employee will position residents in the center of the bed and roll the residents towards her body to provide personal care.Employee provided personal care with resident and resident was not rolled towards the employee during care.Method of Education: Discussion.At the conclusion of this One on One Education session the participant will be able to verbalize/demonstrate the objective of the education.via phone education 2/2/26. This form was signed by the DON and another Nurse on 2/2/26.On 3/10/26 at 1:07 PM, a phone interview was conducted with CNA ?D'. When asked to recall the events from 2/1/26 during ADL care, CNA ?D' reported they were coming in to provide care and had gathered their supplies and was rolling R802 over and she began jerking or something and she wasn't herself and by the time I knew it she had went on the floor. CNA ?D' further reported R802 was having weird behavior.When asked if they could recall the position/placement of the bed in the room, CNA ?D' reported they were changing the resident who was incontinent and the bed was pulled up higher. CNA ?D' further reported they had told R802 to roll to the side a little bit so they could do the rest but she began jerking herself.When asked if they could recall if they rolled R802 away or towards them during the repositioning, CNA ?D' (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	reported I rolled her away from me. When asked if they typically rolled residents away during incontinence care and they reported they would normally roll from side to side (both away and towards) to pull the brief around and tuck in.When asked how long they had worked as a CNA, they reported about five years. When asked if they had received any education or write-up after the incident with R802, CNA ?D' reported they wrote up a statement. When asked again if they received anything such as a one to one education following this incident, CNA ?D' reported, Um, yes let me see what I can remember. No can't recall it's been too long.When asked to why they didn't stop providing care and ask for help when R802 began jerking around, CNA ?D' reported I think people were doing someone at the time. I let the nurse know her behavior after.When asked to recall where they were in the room, CNA ?D' reported they were on the side by the window and reported R802's bad hip was on that side (right) so that's why it was easier to roll her onto the other side (left). When asked if they considered moving themselves to the other side, CNA ?D' reported that's what they normally do but that side was better to put the brief under the resident.It should be noted that R802's soft file documentation revealed several discrepancies within the documentation available in the clinical record and documentation provided of the facility's investigation documents.The soft file documented staff were present which suggested multiple, but there was one CNA providing ADL care; the facility's QA tool also identified the bed height as appropriate but failed to identify it was in an elevated position during ADL care as included in CNA ?D?s statement; and the investigation identified R802 as being continent at the time of the incident, but they had just received incontinence care in which they rolled out of the bed.Additionally, this investigation did not identify or address the CNA's statement of R802's sudden jerking and jolting movement, nor was this included in any of the progress notes, communications with the provider per the text statements reviewed, QA tool, or the facility's investigation. The facility identified the cause of the fall was due to the resident rolling beyond the edge of the bed during repositioning with ADL care and did not identify concerns with the positioning of the resident by CNA ?D', or whether R802 had limitations to repositioning due to their recent fall on 1/11/16 with subsequent intertrochanteric fracture of right femur which required surgical intervention.On 3/10/26 at 2:00 PM, an interview was conducted with the DON and Administrator. When asked what the process should be when a resident has a sudden change of condition during care if care is provided, the DON reported the expectation would be the CNA stops what they are doing and notifies the Nurse. They were informed that when CNA ?D' was asked if they stopped care to get help, or notify the nurse and they reported they didn't because they knew there wasn't anyone else to help, the DON reported even if there is one person, they should've stopped to get help.When asked about the general process for positioning and whether staff would position a resident away from them, or towards them, the DON reported the expectation is to roll towards you, or get help.When informed of the discussion with CNA ?D' about not being able to recall what they were educated on, the DON expressed their frustration and reaffirmed the expectation is to roll towars you or get help.On 3/10/26 at approximately 2:30 PM, the Administrator, and DON were asked about the policies requested. At that time the corporate clinical staff (Nurse ?F') reported they didn't have a policy specific to positioning. Nurse ?F? reported that was a part of basis skills that staff should know to ensure proper positioning in the bed.On 3/10/26 at 2:40 PM, during the exit conference with the Administrator, DON, and Corporate Nurse ?E' and Corporate Nurse ?F'. All present were informed of the concerns and when asked if there were any additional questions, all present reported they did not.On 3/10/26 at 3:19 PM and 3:21 PM, Corporate Nurse 'F' attempted to contact this surveyor by phone and a message was left that stated they had a few more questions and requested a return call.On 3/10/26 at 3:35 PM, Corporate Nurse ?F' was contacted by phone and they acknowledged they reported they didn't have any questions at the exit but they did have further questions now. Corporate Nurse ?F' proceeded to say they were not able to find anything that specifies how a residents should be positioned and then multiple other people began talking. They were informed that the concerns were discussed with the Administrator and DON during the survey and as a courtesy, the phone call was returned but this was not open for further discussion.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure proper medication storage in one of six controlled medication wall storage units. Findings include:On 3/10/26 at 10:03 AM, observation of the 800 hall narcotic storage wall unit revealed the outer door was not properly secured. Upon further observation, the outer door was able to be opened completely and there was a second inner door that also had a locking mechanism and this was also unlocked. The inner door was observed to have several rubber bands around the locking mechanism and a rubber band secured around the lock and top of the inner door. There were multiple resident narcotic medications observed stored inside. There was no staff present in the hallway.On 3/10/26 at 10:04 AM, the Administrator came onto the hallway and was asked about the unlocked controlled substance wall unit. The Administrator sent a text message via their cell phone and reported they were going to look for the Nurse.On 3/10/26 at 10:06 AM, Nurse ?B' exited a room from further down the hallway and approached the wall unit. At this time, both the Administrator and Director of Nursing (DON) were present. Nurse ?B' was asked about the unlocked controlled substance wall unit and they reported they thought it was locked and proceeded to attempt to engage the lock on the outer door which was already in the locked position and unable to close. Nurse ?B' proceeded to insert the key and locked the outer door. When asked about the inner door, Nurse ?B' attempted to use the key but reported it didn't work and further reported they thought the lock had recently been changed or fixed. The DON then opened the outer door and attempted to secure the inner door with the same keys Nurse ?B' used and confirmed there was no working key for that door. When asked when the last time they had accessed the narcotic wall unit, Nurse ?B' reported they thought probably around 9:00 AM.On 3/10/26 at 2:40 PM, during the exit conference with the Administrator, DON, and two Corporate Nurses (Nurse ?E' and Nurse ?F'), the DON confirmed the facility had six controlled medication wall units and further reported nurses had been educated and they didn't find an issue with any other wall units. Corporate Nurse ?E' reported they had been aware of the need for repair to that controlled medication wall unit prior to today and were working on having the lock fixed and reported the nurse might not have put the key in correctly. They were informed of the observation in the presence of the Administrator and DON. Corporate Nurse ?E' was further asked if the facility had known the wall unit was not locking properly, why weren't the controlled medications removed from that storage area prior to today and they offered no further explanation. All were asked if there were any additional questions and all reported they did not.According to the facility's policy titled, Medication Storage Controlled Medication Storage dated 11/2017: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the nursing care center n accordance with federal, state and other applicable laws and regulations.Only authorized licensed nursing and pharmacy personnel have access to controlled medications. The medication nurse on duty maintains possession of the key to controlled medication storage areas.