STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235269	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellspring Lutheran Services	725 West Genesee Frankenmuth, MI 48734

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure choices on meals are honored and prompt response to call lights for Resident #6 (R6), maintain the resident's confidentiality of an emergency plan for Resident #49 (R49) and provide resident's privacy during medication administration for Resident #29 (R29) for three residents (R6, R49 and R29) of three reviewed for dignity. Findings include:Resident #49 (R49):A review of the Electronic Medical Record (EMR) conducted on August 12, 2025, at 3:00 PM revealed that R49 was admitted to the facility on [DATE]. She is currently under hospice care. Her Brief Interview of Mental Status (BIMS) Score dated July 2, 2025, was undetermined. The score box was left blank. However, staff indicated in the assessment that R49 had a memory problem (both short-term and long-term memory), a problem with recalling (names, faces, seasons, and locations), and her cognitive skills for daily decision making, according to the facility, were severely impaired. Her Minimum Data Set Assessment Section GG (dated July 2, 2025) revealed that R49 is dependent on staff for eating, oral hygiene, toileting, showering and bathing, dressing, and personal hygiene.According to the facility's RightsADLOn 08/12/2025 at 10:14 AM, R49's ADLs were being done in another resident's room. R49 was observed coming out of Rm112. R49 was greeted and was addressed by the name of the person residing in room [ROOM NUMBER]. The Certified Nurse Aide (CNA M), who was pushing R49 out of the room, corrected the surveyor and explained that the resident was not the person belonging to room [ROOM NUMBER]. CNA M explained that she used room [ROOM NUMBER] to cleaned and washed R49, who resides next door (Room # 114) CNA furthermore stated that she has been using room [ROOM NUMBER] to provide ADL Care for R49 because R49's roommate does not want R49's ADLs done in the room (#114), so she does it next door in room [ROOM NUMBER] since the resident in room [ROOM NUMBER] is out in the hall. When the surveyor asked, CNA M did not know if it was acceptable to use another resident's room to wash up another resident and complete their ADL task for another resident who belonged to a different room.On 8/12/2025 at 10:15 AM, an attempt to interview R49 revealed that although R49 was alert, she was not able to answer the surveyor's questions. An interview with Certified Nurse Aide (CNA) M was conducted on 8/12/25 at 10:15 AM. CNA M came out of the room, pushing R49, and stated that the resident who lived in room [ROOM NUMBER] was not in the room. They explained that R49's room is next door, but R49 had decided to use another resident's room. CNA was unsure whether she could use another resident's room to wash up another resident. She did not understand the reason why or why not. CNA# explained that she used another room for R49's ADL because R49's roommate does not want us to clean her up in her room. If you have met her roommate, you will know why.Advanced DirectivesUpon entering R49's room on 8/12/24 at 10:15 AM, R49's Emergency Plan was posted on the wall of her room right next to her bed for everyone to see. R49's name was handwritten with a black Sharpie pen, and the contents of the posted Emergency Plan specified:The Patient Name,The patient is currently receiving hospice care. Please call the Hospice Nurse for changes in patient status and comfort levels.In Bold Letters and All Caps- DO NOT CALL 911Following line written: Do NOT Resuscitate. R49's Nurse N was interviewed on 8/12/25 at 11:30 AM, Nurse N validated that the emergency plan was posted on the wall. Nure N stated she did not see anywhere else except for R49's room and did not know the reason behind whether it was her Advanced Directive status or because she was receiving hospice care.According to R49's roommate on 8/12/25 at 10:21 AM, she denied issues with the staff doing her roommate's (R49) ADLs in the room. Although she was bothered by the posted note taped on the wall that says Emergency Plan Do Not Call 911. Because it was R49's roommate's birthday recently, a lot of visitors came and were asking about the note on the wall. R49's roommate felt R49's privacy was violated and had stated that she does not want that paper posted on her wall. The roommate indicated that her own family was concerned and asked about the note when someone sees it.Upon review of the form on 8/12/25 at 10:30 AM, the form is from the facility hospice care agency notifying staff of her advanced directive status.The Social Worker (SW O) on 8/13/25 at 4:40 PM and the surveyor visited R49's room and noticed that the form was removed from the wall. Entering R49's room, the roommate stated that the form had come off this morning. R49's roommate was excited and said, Hallelujah! and was glad that it was no longer there. The SW O validated on 8/13/25 at 4:45 PM, that the form needed to come off the wall and did not need to be posted either.The Administrator, on August 13, 2025, at 4:45 PM, during an interview, revealed that the facility owns the hospice. However, the sheet was left there, and we instructed the hospice not to place it there for privacy

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F 0684 Level of Harm - 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 ensure a timely response to a change in condition for Resident #65; assess/respond to abnormal vital signs for Resident #52 and Resident #65; and ensure antibiotics were ordered and administered timely for Resident #63, for three residents (#52, #63 and #65) of four residents reviewed for a change in condition and antibiotic administration, resulting in a delay in treatment, increased abdominal pain and hospitalization for Resident #65, and a delay of antibiotics for Resident #63 with the potential for continued infection and delay in assessment/treatment of abnormal vital signs for Resident #52.Resident #52: A review of Resident #52’s medical record revealed an admission into the facility on [DATE] and date of discharge [DATE] with diagnoses that included fracture of right humerus and greater trochanter of right femur, chronic kidney disease, heart failure, atrial fibrillation, and hyperkalemia (a medical condition where the body has high levels of potassium in the blood). Further review of the medical record revealed the Resident had gone unresponsive, cardiopulmonary resuscitation was initiated and the Resident died at the facility. A review of Resident #52’s medical record of documented Pulses revealed the following abnormal vital signs of heart rate (Pulse): [DATE] at 11:57 PM, Pulse of 58 bpm (beats per minute). [DATE] at 11:57 PM, Pulse of 59 bpm. [DATE] at 6:46 PM, Pulse of 45 bpm. [DATE] at 10:03 PM, Pulse of 50 bpm. [DATE] at 12:54 AM, Pulse of 46 bpm. [DATE] at 7:48 PM, Pulse of 42 bpm. [DATE] at 10:15 PM, Pulse of 37 bpm. [DATE] at 1:22 PM, Pulse of 42 bpm. [DATE] at 2:10 AM, Pulse of 56 bpm. [DATE] at 12:38 AM, Pulse of 54 bpm. [DATE] at 12:38 AM, Pulse of 58 bpm. A review of the progress notes for Resident #52 revealed a lack of assessment, contacting the practitioner and follow-up interventions or monitoring by rechecking the heart rate of the abnormal heart rates obtained. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:07 AM, an interview was conducted with the Nurse Practitioner (NP) “O” regarding Resident #52’s care. The NP was asked about abnormal pulse rates and reported that parameters for below 60 on a regular basis and above 90 on a regular basis with abnormal and communicated to the practitioner. When queried regarding assessment of the Resident, the NP indicated that the vitals would be rechecked and if it remained high or low then call the practitioner. The pulses for Resident #52 were reviewed. The NP indicated that at 50 and asymptomatic, need to do assessment to see if asymptomatic or having symptoms, at 37 and 42, if rechecked and stayed low, “I would send her out. ” The NP indicated that with the abnormal pulse rate, the nurse would need to recheck, do an assessment and notify the practitioner. On [DATE] at 1:19 PM, an interview was conducted with the Director of Nursing (DON) regarding Resident #52’s abnormal pulse readings. Resident #52’s abnormal pulses were reviewed with the DON. When asked about facility policy, the DON reported that vital signs were to be obtained in the morning before medications are administered and in the evening before the medication pass. The DON reported that if the vital signs were out of range, the provider would be contacted. Resident #52’s medical record was reviewed with the DON, and it was determined that the vital signs were documented into the medical record when staff were charting and not necessarily when the vital signs were taken. Resident #52’s documentation lacked timely reassessment of the abnormal results, assessment of the Resident symptomatic or asymptomatic and the notification of the practitioner. Resident #63 (R63): A record review of Resident 63's (R63) medical chart included medical diagnoses: Cellulitis of the left lower limb (infection of the skin), non-pressure chronic ulcer of left lower leg, Urinary tract infection (UTI), Anxiety, Diabetes Mellites 2 (DM2), need for assistance with personal care. R63 was admitted to facility on [DATE] for rehabilitation. On [DATE] at 10: 40 AM, during an observation of R63 is sitting in a wheelchair in room, and reportedly had just returned from physical therapy, is alert and oriented. During an interview R63 said she was supposed to continue antibiotics when she came to the facility from the hospital for rehabilitation. There was a 3-day delay receiving them. When R63 asked the nurse on duty about the antibiotics, she was told it was because it was not on her medication list. On [DATE] at 10:48 AM, An interview with R63, clarified when she was admitted and she confirmed it was [DATE]; she stated, “I did see the facility doctor the day after I got here ([DATE]) and was told he confirmed my orders for the antibiotics, and they were being ordered that day”. R63 stated, “I did not get the antibiotic until Monday night ([DATE]). I was not happy that it took 3 additional days to get the antibiotics, it is important for healing my infection up”. On [DATE] at 11:59 AM, in an interview with director of nursing (DON) about the process for physician rounds and orders, she stated, “Usually myself or the floor nurse follows with the doctor. All new orders are verbal orders and are entered into at the time of the visit. They may or may not end up as a written order”. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:28 PM, in an interview with Nurse manager “A”, she was asked about the process for physician rounding and stated, “Doctor (Dr “E”) comes in 2-3 times a week usually in the early morning; Dr “F” and his Nurse practitioner (NP “G”) round 2-3 times weekly as well”. She stated, “They come in and check in with the nurse on the floor and tell them who they plan to see”. When asked about any orders that come from that visit she stated, “If there are new orders, they stop at the desk and tell the nurse before they leave”. The DON was asked when the orders are put in the computer and she stated, “That varies by the nurse but at a minimum by the end of their shift”. On [DATE] at 1:50 PM, an interview was conducted with the Medical Director and admitting doctor Dr “E”, who was asked about frequency and process for rounding. He stated, “I round 2 times a week, the time and day varies depending on the admissions and needs of facility, within 48 hours of admissions is the standard. All the admissions go through me personally” and “I prioritize the order of my visits by admissions, residents with issues noted in my book, and then my scheduled routine visits”. Dr “E” stated, “As far as the process goes, I come into the facility and talk to the nurse on duty. I ask for any updates on the residents I am seeing. I see the residents. If there are any new orders, I discuss them with the nurse on duty, and they enter them. If I am ordering a controlled substance medication, I sign those orders at that time as well”. His response to the expectation of when the ordered medications should be ordered and begin was, “If stock (medications on hand at the facility) then they should start right away and pull from there (the stock on hand), if oral antibiotics are ordered then they should be ordered expedited. the pharmacy delivers 2 times a day so they should get that next dose”. [DATE] at 2:20 PM, in an interview with Assistant Director of Nursing (ADON), she was asked about the process for physician rounding and stated, “the doctor comes in to do rounds and talks to the nurse on duty. If there are orders he tells the nurse. The nurse enters the orders, and a progress note into the system”. The ADON was asked to look at the R63 admission date and she stated, “8/7” and then she was asked the date of the progress note of the physician visit and stated, “8/8”. The ADON was asked to view the order date for the antibiotic, and she stated, “8/11”. She stated, “I put that order in because I had to call the doctor about it”. The ADON was asked, why did you have to call about the order? “Well, the resident asked about her missing antibiotic, so I called the doctor to ask for clarification. We did not realize the antibiotic wasn’t on the discharge med list (medication), so it was not ordered or given. I ordered it, and she got a dose that night”. The ADON was asked to confirm that it was the night of [DATE] and she replied, “Yes”. The ADON was asked if the nurses review the physician progress notes, or the discharge plan for admission to the facility and she stated, “No, we just look at the medication list”. A record review of R63’s discharge paperwork from the hospital, dated [DATE], on the progress note, dated [DATE], in plan section states, “Left lower extremity cellulitis Reports bumping her left leg about 3 days prior to presentation and suddenly noticing worsening erythema (redness) denies any fever or chills wound continues to weep, however surrounding erythema. patient initially on ceftriaxone and Zyvox (both are antibiotics), ceftriaxone discontinued and started on meropenem (antibiotic) continue routine wound care, CT lower extremity … Plan is to discharge on p.o. (per os/ by mouth) Zyvox the next 24 hours”. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of final discharge summary from the hospital on [DATE], plan states “Left lower extremity cellulitis . Patient has been started on ceftriaxone and Zyvox in the emergency room, and appears to be improving white blood count (WBC) count continues to trend downward… Cat Scan (CT) of lower extremity 8/3 demonstrated extensive subcutaneous edema with cellulitis, no evidence of abscess of the left leg, continued with zyvox (started on 7/31) and meropenem (started on 8/4)…”. The resident was discharged from the hospital on [DATE] with lower left extremity cellulitis and a Urinary tract infection (UTI) and was receiving Zyvox and Meropenem. A record review of R63’s admission progress notes from Physician Dr “E” from [DATE] with a late entry that was written on [DATE], “Antibiotic therapy was initiated for the cellulitis, with infectious disease involvement. The patient is currently continuing with Zyvox… Her left lower extremity still shows some redness…”. A record review of the physician's orders for R63 revealed, “Linezolid Oral Tablet 600 MG (Zyvox) Give 1 tablet by mouth two times a day for Cellulitis, UTI for 10 Days Pharmacy Active [DATE] at 20:00 -stop [DATE]”. According to the facility's medication administration policy, the purpose stated is, “To assure the most complete and accurate implementation of physicians’ medication orders and to optimize drug therapy for each resident by providing the administration of drugs in an accurate, safe, timely and sanitary manner…”. Change of Condition Resident #65: On [DATE] at 12:15 PM, Confidential Person “J” was interviewed about Resident #65. She said she visited the resident 2 days ([DATE]) after Resident #65 was admitted to the facility on [DATE]. The Confidential Person said the room was hot that day and there was no fan. She said in the hospital the resident was alert, walking with assistance, talking and sitting in a bedside chair. The Confidential Person “J” said she visited the resident again on [DATE] and the facility staff said Resident #65 had not been out of bed and the resident appeared to be declining. A record review of the electronic medical record indicated Resident #65 was admitted to the facility on [DATE] with diagnoses: recent hernia surgery, pain, diarrhea, and COPD/emphysema. A Brief Interview for Mental Status/BIMS score of 15, indicating full cognitive abilities was assessed on [DATE] after admission. A record review of the progress notes identified the following: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	[DATE] at 12:42 PM, a “Physician Extender” note “History of Present Illness: (Resident #65) a [AGE] year-old female with a history of COPD, was admitted to (the facility) for physical conditioning following hospitalization for an incarcerated right inguinal hernia. The patient initially presented to the hospital with complaints of abdominal pain and was diagnosed with an incarcerated inguinal hernia in the right lower quadrant. On [DATE]th, she underwent a right inguinal hernia repair with mesh and a small bowel resection. During her hospital stay, she developed an ileus, from which she has since recovered. Currently (the resident) is experiencing severe nausea and vomiting… She is alert and oriented with stable vital signs… Ordered stat abdominal x-ray to rule out ileus or obstruction…” A record review of the vital signs for Resident #65 revealed the following: Blood Pressure: Identified low on [DATE] at 11:48 PM- 93/57; high on [DATE] at 12:56 AM 140/100; very low on 7/26//2025 71/51. Pulse: high on [DATE] at 11:42 AM 111 beats/per minute (bpm); [DATE] at 7:53 PM 118 bpm, [DATE] 109 bpm. Temperature: high 99.6 [DATE] and 100.4 [DATE] at 11:42 AM. Respiratory Rate: high on [DATE] at 11:42 AM 24 breaths/min; high [DATE] 26 breaths/min. Oxygen saturation rate: Low [DATE] at 11:42 AM 92% room air; Low [DATE] at 5:10 PM 93% room air; [DATE] at 10:46 AM 91% room air. Pain: “8” high on [DATE] at 2:34 PM. Resident #65 had abnormal vital signs beginning [DATE]. Further review of the progress notes for Resident #65 identified the following: [DATE] at 2:25 PM, a “Health Status Note, “NP (Nurse Practitioner) notified of patient nausea and inability to take the Zofran pill due to it making the nausea worse…” [DATE] at 6:46 PM, a “Health Status Note revealed, “NP (Nurse practitioner) in doing rounds. New orders. STAT Flat plate 2 view of abdomen”. [DATE] at 3:54 AM, a “Health Status Note- X-ray completed at 9:07 PM awaiting results.” [DATE] at 11:27 AM, a “Health Status Note” provided, “Received X-ray results small bowel ileus vs obstruction…” A review of the STAT X-ray ordered for Resident #65 identified the order did not indicate it was to be completed STAT. The “Radiology Results Report” indicated the examination date was [DATE] at 4:20 PM and the results were reported to the facility on [DATE] at 6:40 PM. This was approximately 24 hours after the orders for the STAT X-ray were mentioned. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The STAT (immediately) X-ray was ordered on [DATE] at 6:46 PM, per the progress notes. The results were documented in the medical record on [DATE] at 11:27 AM. This was greater than 1 ½ days later and Resident #65 continued to complain of abdominal pain, nausea and vomiting. An additional progress note for Resident #65 dated [DATE] at 1:25 PM provided, “Health Status Note, patient c/o (complains of) abdominal pain and nausea, stated has vomited bile. Requesting to go to the hospital… order received to send to hospital…” On [DATE] at 3:47 PM, the Director of Nursing/DON was interviewed about Resident #65. Reviewed with the DON, that the resident had repeatedly complained of increasing abdominal pain. Reviewed the resident’s vital signs with very low blood pressure, high pulse, increased respiratory rate, decreased oxygen saturation. The nurses did not document they were aware of the abnormal vital signs or what interventions were enacted. Reviewed the order documenting that a STAT abdominal X-ray was to be completed ([DATE]). The X-ray was completed on [DATE] at 4:20 PM and reported to the facility on [DATE] at 6:40 PM and reviewed in a progress note on [DATE] at 11:27 AM. The X-ray was not completed STAT (immediately) and the resident’s abnormal vital signs were not reviewed in the assessments or notes. Resident #65’s condition continued to decline, and she was transferred to the hospital emergency room on [DATE] at approximately 1:25 PM. The DON reviewed the resident’s medical record and identified the date [DATE] at 4:20 PM that the X-ray was completed for Resident #65. She also reviewed the time the results were provided to the facility ([DATE] at 6:40 PM). She said the results were sent to the facility on a fax and she was not sure when the nurses would have received them. Reviewed the resident’s condition was declining and the X-ray results were not mentioned in the progress notes until the next day [DATE] and then the resident was transferred to the hospital. A review of the facility policy titled, “Change of Condition,” review date [DATE] provided, “Policy: It is the policy of (the facility) to enable staff to evaluate and manage residents at the facility and avoid transfer to a hospital or emergency room by recognizing an Acute Change of Condition and identifying its nature, severity, and causes… An acute change of condition is defined as a sudden, clinically important deviation from a patient’s baseline in physical, cognitive, behavioral, or functional domains… The licensed nurse completes an assessment of the resident and based on the findings notifies the physician of any change of condition… Continued monitoring and assessment of the resident is documented in the resident’s clinical record.”

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the appropriate backflow prevention was installed on cross connections. This deficient practice increases the likelihood of contamination of the water supply due to a backflow event, potentially affecting all residents, staff, and visitors who consume water at the facility. Findings include: On 08/12/2025 at approximately 9:30AM observed a hose with an attached spray nozzle connected to the water line downstream of an atmospheric vacuum breaker (AVB) located in the kitchen near the dishwasher. On 08/12/2025 at approximately 1:30PM during the environmental tour of the facility, an interview was conducted with the Director of Maintenance I on the cross connection related to the attached spray nozzle in the kitchen. The Director of Maintenance I was knowledgeable about the cross connection and removed the hose with the attached spray nozzle. On 08/12/2025 at approximately 1:45 PM observed chemical feed dispenser supplied by the utility sink with an atmospheric vacuum breaker without an attached wasting tee, located in the janitor's closet in the basement, [NAME] hallway, and Morning [NAME] hallway. When interviewed about the cross connection, the Director of Maintenance I was unfamiliar with wasting [NAME] (or bleeder device). According to the 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve). According to the 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure.