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	07/25/2024

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

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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 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. 39059 Based on observation, interview and record review, the facility failed to 1) Ensure dignity during a physician's visit for Resident #10, 2) Respond to call lights timely per a Confidential Resident Group Meeting, and 3) Respond to a grievance from Resident #8, resulting in embarrassment and loss of dignity. Findings include: Resident #10: On 7/24/24, at 3:05 PM, Physician O was observed in the main dining room leaning towards Resident #10. Physician O was overhead discussing with Resident #10 regarding their pain and if it was controlled. Resident #10 was asked if they needed any medication and Resident #10 replied, no I don't need anything. Resident #10 was seated closely next to other residents. On 7/24/24, at 3:15 PM, visitor K who was seated in the main dining room was asked if they overhead Physician O talking with the resident and Visitor K stated, yes and offered it seemed quite personal and wouldn't have liked that if it was them. On 7/25/24, at 12:05 PM, the Director of Nursing (DON) was asked if Physician O had an actual visit with Resident #10 and the DON responded that yes, and would document the note by 3:00 PM that day.

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 Based on interview and record review, the facility failed to provide a complete Notice of Medicare Non-Coverage (NOMNEC) and the Advanced Beneficiary Notice of Non-Coverage (SNF ABN) for one (Resident #300) of three residents reviewed for Beneficiary Notice, resulting in resident and/or a representative not being informed of the right to appeal and the potential for undue emotional and financial hardships. Findings include: On 07/24/24 at 11:25 AM, three residents were selected, and names were given to Staff S, who was the accounts payable and was in charge of informing the resident and the resident's representative. Upon review of the electronic medical record (EMR) on 7/25/24 at 12:39 PM, R300's SNF-ABN was not included in her notification file. R300 was admitted with Med A Part B that started on 1/12/24, with the last covered day on February 12, 2024. R300 was alert and oriented at the age of [AGE] years old with a Brief Mental Status Score of 15/15 assessed on 2/13/2024. She remained her own responsible person during her entire stay at the facility. Although the NOMNEC was provided and issued to R300 on February 8, 2024, it was issued on 2/8/24, too early, for the last covered day was February 12, 2024. R300 was admitted on [DATE]. R300's last covered day was February 12, 2024. However, R300's Face Sheet revealed that she did not go home after the assigned last covered day. R300 opted to stay in, pay out-of-pocket, and was discharged [DATE] under private pay insurance status. On 7/25/24 at 9:30 AM, an interview with the accounts payables Staff S. She stated that she was responsible for issuing the NOMNEC letters to the residents; however, the ABN's are issued by the social workers. According to Staff S, since R300 decided to be discharged home, we did not think we should issue the ABN. We did not give her the ABN Notification. The Social Services Manager Staff T on 7/25/24 at 11:30 AM revealed that since the resident opted to go home, they did not need to issue the R300 and ABN Notification. A Late Entry for the progress note dated 2/12/2024 entered by Staff T was reviewed. It noted: NOMNEC is not needed at this time, due to resident stating she did not want to continue therapy, at this time and designating her own discharge date home. E-signed by Staff T. On 7/25/24, at around 12:45 PM, The Administrator followed up on the ABN request from Staff S. The administrator admitted they missed it. The ABN was not issued to R300. A review of the electronic medical record dated 2/14/24 revealed that R300 remained at the facility after the last covered day (2/13/24) and was discharged home on 2/15/25. R300's payment status after 2/13/24 was private pay. The facility policy for Beneficiary Notice of Medicare Non-Coverage (NOMNEC) and the Advanced Beneficiary Notice of Non-Coverage (SNF ABN) was requested on 7/25/24 at 12:45 PM. Still, it was not received before or upon the survey exit date. (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy entitled Resident's Rights and Facility Responsibilities was reviewed. On page 30 of the policy under Notice of Rights, it stated: The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. Receipt of such information, and any amendments to it, must be acknowledged in writing .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22348 Based on observation, interview, and record review, the facility failed to review and revise care plans with resident changes to ensure that interventions necessary for care services for pain were provided for one resident (Resident #11) of 3 residents reviewed for care plans, resulting in the potential for unmet needs, pain, and suffering. Findings include: Resident #11 (R11): A review of R11's electronic medical record (EMR) revealed that R11 was alert and oriented. Her Brief Interview of Mental Status (BIMS) score was 11/15, assessed on 5/11/24. R11 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease, Dementia, Type 2 Diabetes, and Generalized Anxiety Disorders, in addition to other diagnoses. On July 23, 2024, at 1:30 PM, R11 was observed lying in bed in her room. When asked how she was doing today, R11 replied that she was in pain. When asked where it hurt, she lifted her right leg to show the pink lower extremity cast. R11 said, I broke my ankle when I rolled out of bed. A review of records on 7/23/24 at 4:00 PM showed, on 6/27/24, R11 persisted to complain of extreme pain to the right ankle. After an x-ray of her right ankle, the x-ray result found: 1) Displaced Segmental fracture of shaft of Right Tibia, initial encounter for closed fracture, and 2) other fracture of upper and lower end of right fibula, initial encounter for closed fracture. Radiologist findings dated 6/27/24 at 10:27 AM, sent electronically, revealed: Findings: Images of the right ankle are submitted. There is a recent spiral fracture involving the distal tibial meta-diaphysis with very mild displacement. There are old fixated and healed bimalleolar fractures. Joint alignment is maintained . Conclusion: Recent spiral fracture of the distal tibia . Another x-ray was performed, this time at the Urgent Care at the nearby hospital on the same day (dated 6/27/24 at 7:30 PM). Results concluded: Impression: 1. Acute, mildly displaced proximal fibular diaphyseal fracture. There is an acute, mildly displaced distal tibial diaphyseal fracture with approximately 4 mm posterior displacement of the main distal fragment. 2. Acute minimally displaced proximal fibular diaphyseal fracture. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the record review on 7/24/24 at 08:00 AM, no Incident Report (I/A) was found in R11's EMR for the event on 6/27/24. The Incident Report dated 6/10/24 revealed that R11 fell on [DATE]. R11 complained of pain after the fall on her right ankle. An X-ray was performed on 6/10/24, and no acute or recent fracture was found after the fall. R11 complained of pain daily regularly. Because of the fall on 6/10/24, R11 was evaluated by Physical Therapy (PT) on 6/12/24, and PT treatment started on 6/14/24. According to the Rehab Manager (Staff Q) on 7/24/24 at 4:54 PM, during an interview conducted, R11 was showing signs of progress during therapy sessions from 6/12/24 to 6/25/24. However, on 6/27/24, it was noted in the physical therapy notes that during the early morning session, the swelling, discoloration, and guarding pain that was reported was apparent and was different from the previous days of treatment. A repeat x-ray was performed and revealed an acute fracture of the right ankle. R11 was sent to the hospital for further evaluation and treatment. R11 returned with a right lower extremity cast. Medication Administration Record (MARS) recorded R11's pain level from 6/8/24 to 6/30/24: Pain Scale level from zero (no pain) up to 10 (worst pain imaginable) Pain Levels from June 8 to June 30 were recorded as follows: On 6/8/24=0, 6/9/24= 0, 6/10/24=0, 6/11/24=2, 6/12/24=9, 6/13/24=8, 6/14/24=0, 6/15/24=10, 6/16/24=10, 6/17/24=0, 6/18/24=0, 6/19/24=10, 6/20/24=10, 6/21/24=0, 6/22/24=2, 6/23/24=0, 6/24/24=10, 6/25/24=8, 6/26/24=10, 6/27/24=2, 6/28/24=8, 6/29/24=0, 6/30/24=8. No follow-up after pain medication/intervention/Administration for relief or effectivity was found documented in the MARS. During a review of R11's medication orders on 67/25/24 at 11:30 AM, it revealed the following orders for pain management: Started Revised date Pain management orders: 7/6/2024 7/5/2024 Tramadol HCL oral tablet 50 mg 7/1/2024 7/1/2024 Monitor Right Leg cast, monitor toes for color . 7/1/2024 7/1/2024 Monitor Right forearm bump 4/1/2024 3/31/2024 Celebrex Oral Capsule 200 mg 1 capsule by mouth . 5/11/2024 4/15/2024 Quarterly Assessments due to Fall, Pain, Braden . 3/19/24 3/19/24 Lidoderm External Patch 5%(Lidocaine) apply to Rt Hip 7/25/23 7/25/23 Ibuprofen Tab 200 mg. 2 tabs . 6/28/23 6/28/2023 Non-Pharmacological Pain Interventions . 11/16/2022 11/16/2022 Assess Pain twice daily for pain (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24 at 10:30 PM, R11's Care Plan for Pain was reviewed with the Director of Nursing (DON). It was noted that: Date initiated: 02/27/2018, with the revision was made: 5/17/2024. Focus: I have chronic back, hip, shoulder, and leg pain, neuropathy and trigeminal neuralgia, and trigger finger-left ring finger. My pain assessments are the same prior to medication administration and non-pharmacological interventions and after. Goal: 1. I will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date (5/17/2024) Interventions: 1. Administer pain medication as per physician orders. (Date initiated: 2/27/2018) 2. Evaluate for pain every shift and as needed. (Date initiated: 2/27/2018) 3. Evaluate the effectiveness of pain interventions as needed. According to the Director of Nursing (DON), on 7/25/24 at 10:30 AM, she revealed that she did the investigation for 6/27/24 for an injury of an unknown origin and submitted the final investigation summary to the state. According to the DON, it was concluded that R11's fracture was caused by the original fall on 6/10/24. The Care Plan for pain was discussed. The DON had indicated that the fracture was discovered when R11 complained of severe pain that took place on June 27, 2024. A second and third X-ray concluded a spiral fracture of the right fibula and tibia. R11 was sent to the hospital for further evaluation and treatment. The DON stated that the fracture was attributed to the fall that occurred on June 10, 2024. The DON admitted that they failed to make revisions of the pain care plan despite R11 experiencing severe pain due to fractures and injuries from an unknown origin. No revisions were made from June 11, 2024, a record until July 24, 2024, when the state was present for the recertification survey. There were no pain care plan revisions within the time of the fall on 6/10-24 until 7/24/24. The facility's Comprehensive Care Plan Policy (Revision Date: April 2023) was reviewed on 7/25/24 at 1045 AM. Policy: It is the policy of the facility (facility name mentioned) to initiate care plans for all residents in accordance with federal regulations and the identified needs of the resident. Procedure: .7. Initiate a person-centered care plans according to identified needs including measurable goals and individualized approaches. 8. Review Care plans and revise as needs change and in coordination with the MDS schedule. 9. Communicate to staff all care plan needs . (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident's Rights Policy/ Admission Booklet submitted by the facility was reviewed on 7/25/24 at 1047 am. It is noted in the section: Right to Adequate and Appropriate Pain and Symptom Management It was noted: A resident is entitled to adequate and appropriate pain and symptom management as a basic and essential element of his or her medical treatment.

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F 0689 Level of Harm - Minimal harm or potential for 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** 22348 This Citation pertains to Intake Number MI00145715 Based on observation, interview and record review, the facility failed to do complete investigations for injuries of unknown origin (2 skin tears for Resident #27, fracture for Resident #11) and follow, update, and implement care plan interventions for two residents (Resident #11, Resident #27), resulting in incomplete investigations with the likelihood of the injuries to reoccur. Findings include: Resident #27: On 7/23/24, at 10:52 AM, a record review of Resident #27's electronic medical record revealed an admission on 06/16/2021 with diagnoses that included History of falling, Diabetes and Dementia. Resident #27 required assistance with Activities of Daily Living and had severely impaired cognition. A review of the incident report Skin Issue Date: 6/21/2024 09:15 Incident Location: Dining Room . Nursing Description: CNA reported blood coming from resident, This writer observed 2 skin tears 3.5x3cm (centimeters), 3x3cm to left outer leg this am, dried blood black in color draining down le, no skin protectors on . Resident Unable to give Description . Immediate Action Taken . Cleansed with NS (normal saline) applied foam dressings, applied skin protectors to upper and lower ext, (extremity) education for staff to have skin protectors AAT (at all times) and bunny boots on as tolerated . Injuries Observed at Time of Incident . No Injuries observe at time of incident . Predisposing Physiological Factors . Confused and Impaired Memory was check marked . Predisposing Situation Factors . Using Wheelchair was check marked . Statements No Witnesses found . A review of the Progress Notes revealed Effective Date: 6/21/2024 09:37 Health Status Note . CNA reported seeing blood coming from resident, this writer observed 2 skin tears to left outer leg 3.5x3cm, 3x3cm, no skin protectors observed, cleansed with NS applied foam dressings, applied skin protectors to upper and lower ext, education for staff to have skin protectors AAT and bunny boots on as tolerated. Notified PCP, DON, POA . A review of the Interdisciplinary Team (IDT) documentation revealed an IDT progress note Effective Date: 06/24/2024 14:17 Data: IDT reviewed report of new skin issue observed on 6/21/24 @ 9:15. The CNA notified the nurse of blood coming from resident's leg. Resident observed to have 2 skin tears to her left outer leg, 1 measuring 3.5CMx3CM and the other 3CMx3CM. Dried, black blood observed draining down leg. Resident unable to state what happened, no s/s of pain. Area was cleansed with normal saline, foam dressing applied, skin protectors applied. The nurse educated staff on skin protectors due to resident not have skin protectors on when skin issues was observed. PCP and POA notified. Action: Per IDT review, maintenance inspected resident's w/c for any sharp/jagged edges. Response: Care Plan updated accordingly. Author (ADON). On 7/24/24, at 4:25 PM, the facility was asked to provide any further documentation as to how Resident #1 got their 2 skin tears. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24, at 10:58 AM, a record review of the Incident Report for Resident #27's 2 skin tear injuries along with The Director of Nursing (DON) was conducted. The DON offered that the ADON did the incident follow up. The DON was asked how Resident #27 injured themselves and the DON stated, the resident was unable to state what happened. The DON was asked what intervention was placed for the resident and the DON stated, they applied the skin protectors and educated the staff as the resident did not have the foam skin protectors on at the time of the injuries. The DON was asked when the foam skin protectors were added to the plan of care and the DON stated, a while back. The DON was asked if they investigated as to how the resident was injured and the DON stated, we figured it happened when she transferred out of bed. The DON was asked what staff member assisted the resident out of bed that morning and the DON stated, I don't know but could look at the charting to see who cared for the resident that day. The DON was asked to review the incident report as to what the resident was doing when the staff recognized the bleeding skin tears and the DON stated, she was using her wheelchair. The DON was asked if the skin tears occurred from the assisted transfer out of the bed or were they from the wheelchair itself and the DON offered they were not sure. The DON was asked if the CNA's were interviewed or if the staff had statements regarding the injuries and the DON stated, No. The DON was asked if they felt the investigation was thorough and the DON stated, No, we probably should have interviewed the CNA. The DON was asked again to provide any additional documentation for Resident #27's injuries/skin tears. A review of the Maintenance Work Order . Assigned on Jun 24, 2024 revealed Wheelchair During morning meeting I was asked to check wheelchair for sharp edges because resident got two skin tears, checked wheelchair over and found no sharp edges . Resident #11 (R11): On July 23, 2024, at 1:30 PM, R11 was observed lying in bed in her room. When asked how she was doing today, R11 replied that she was in pain. When asked where it hurt, she lifted her right leg to show the pink lower extremity cast. R11 said, I broke my ankle when I rolled out of bed. A review of R11's electronic medical record (EMR) revealed that R11 was alert and oriented. Her Brief Interview of Mental Status (BIMS) score was 11/15, assessed on 5/11/24. R11 was admitted to the facility on [DATE] with a diagnosis of Alzheimer's Disease, Dementia, Type 2 Diabetes, and Generalized Anxiety Disorders, in addition to other diagnoses. On 6/27/24, she continued to complain of extreme pain. After an x-ray of her right ankle, the x-ray result found: 1) Displaced Segmental fracture of shaft of Right Tibia, initial encounter for closed fracture, and 2) other fracture of upper and lower end of right fibula, initial encounter for closed fracture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the record review on 7/24/24 at 08:00 AM, no Incident Report (I/A) was created in the EMR for the event on 6/27/24. The Incident Report dated 6/10/24, revealed that R11 fell on [DATE]. R11 complained of pain after the fall on her right ankle. X-ray was performed on 6/10/24 and revealed no acute or recent fracture was found after the fall. R11 complained of pain daily regularly. Because of the fall on 6/10/24, R11 was evaluated by Physical Therapy (PT) on 6/12/24, and PT treatment started on 6/14/24. According to the Rehab Manager (Staff Q) on 7/24/24 at 4:54 PM, during an interview conducted, R11 was showing signs of progress during therapy sessions from 6/12/24 to 6/25/24. However, on 6/27/24, it was noted in the physical therapy notes that during the early morning session, the swelling, discoloration, and guarding pain that was noted was apparent and was different from the previous days of treatment. A repeat x-ray was performed and revealed an acute fracture of the right ankle. R11 was sent to the hospital for further evaluation and treatment. R11 returned with a right lower extremity cast. An Incident/ Accident (I/A) Report was not created in the EMR when the fracture was confirmed on 6/27/24. Upon request for the I/A from the Administrator on 7/25/24 at 9:37 AM, she stated there was no I/A created in the EMR. According to the Administrator, the facility started an investigation and reported it to the state. They concluded that the fracture happened during the fall on June 10, 2024. When asked about the results taken during the 6/10/24 x-ray that was negative compared to the results taken on 6/27/24, which was positive for fracture, the administrator said, Yes, but according to our investigation, we have concluded that the ankle fracture was considered an injury from an unknown source caused by the fall that occurred on June 10, 2024. Nurse N was interviewed on 7/23/24 at 1:32 PM. Nurse N stated she was the nurse when R11 fell out of bed on June 10, 2024. The Certified Nurse Aide (CNA) and Nurse N found R11 sitting on the floor mat. Nurse N did an assessment and got R11 up and back in bed. There were no abnormalities, skin discoloration, or swelling, although she complained of pain on the right side when we got her up. An x-ray was performed, but no recent fracture was found. A few days later, R11 continued to complain of the usual pain. But on 6/27/24, there was more pain, this time with swelling and bruising to the right ankle. R11, described by Nurse N, was observed cuddling her right ankle. When Nurse N asked her what had happened, R11 could not tell her story but continued to complain of pain. A second x-ray was ordered on 6/27/24 and showed a fracture. R11 was sent to the hospital immediately due to increased swelling, increased pain, and apparent bruising. Nurse N did not recall any incident, although she is care planned for self-transferring. There were no reports of falls or incidents after 6/10/24 until 6/27/24, when the pain increased, and other symptoms of fracture appeared. The facility, on 6/27/24, performed an X-ray, and the results and findings were the following: Date of service: 6/27/24 at 15:28 (3:28 PM) Procedure: Tibia and Fibula 2V (2 views) Reason for Study: Acute Pain due to trauma Findings: Tibia and Fibula 2 V Right Comparison to June 11, 2024. Fracture distal tibia appears recent. Cephalad to the patient's fixation hardware . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conclusion: Fracture tibia shaft appears separate from the patient's prior trauma. Correlation with the clinical findings suggested follow-up . Radiologist findings dated 6/27/24 at 10:27 AM, sent electronically, revealed: Findings: Images of the right ankle are submitted. There is a recent spiral fracture involving the distal tibial metadiaphysis with very mild displacement. There are old fixated and healed bimalleolar fractures. Joint alignment is maintained . Conclusion: Recent spiral fracture of the distal tibia . Another x-ray was performed, this time at the Urgent Care at the nearby hospital on the same day (dated 6/27/24 at 7:30 PM). Results concluded: Impression: 1. Acute, mildly displaced proximal fibular diaphyseal fracture. There is an acute, mildly displaced distal tibial diaphyseal fracture with approximately 4 mm posterior displacement of the main distal fragment. 2. Acute minimally displaced proximal fibular diaphyseal fracture. According to the Director of Nursing (DON), on 7/25/24 at 10:30 AM, she revealed that she did the investigation for 6/27/24 for an injury of an unknown origin and submitted the final investigation summary to the state. It was concluded that R11's fracture was caused by the original fall on 6/10/24. The DON had indicated that she had requested a comparative study with R11's x-rays taken on June 10, 2024, comparing it to June 27, 2024, to see if they had missed the fracture but did not get a reply from the x-ray company, not the radiologist. The DON was asked if she disagreed with the x-ray results on 6/27/24, both the facility x-ray and hospital x-ray. The DON did not answer. According to the record review, the facility investigations did not have interviews, clinical input, and record review with the rehab department after the fracture was discovered on 6/27/24. R11 was under Physical Therapy from 6/12/24 through 6/28/24. The facility investigations did not have interviews, clinical input, and record review with the rehab department after the fracture was discovered on 6/27/24. R11 was under Physical Therapy from 6/12/24 through 6/28/24. The surveyor interviewed Rehab staff who had actively participated in R11 care and PT treatment from June 12 to June 28 were not included in the facility investigation: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA P was interviewed on 7/25/24 at 10:54 AM. CNA P stated she was not working when R11 fell on [DATE]. CNA P heard about her fall when she came back. After the June 10 incident, CNA P recalled that R11 returned to her usual, continued to be her caregiver three days a week, and stated, because I am always assigned to her. CNA P described that at that time, between 6/10/24 and 6/27/24, R11 was doing most of her daily tasks, such as even putting her shoes on by herself. CNA P added with set up, of course. She was doing her transfer with one person assistance. There were no reported falls or incidents. On June 27, CNA P observed increased swelling and pain in R11's right ankle. The reason why she thought it was different is because R11 couldn't put on her slip-on sneakers. It did not fit her shoes. CNAP reported to PT R that she was guarding or babying her right ankle, and PT ordered a full max assist and no weight bearing on the right foot that day. They did an x-ray that day on 6/27th, and there was a fracture. Pain compared to her usual was more on the right foot on 6/27/24. R11 was sent to the emergency roiagnom on [DATE]. R11 returned with a cast on her right ankle and foot with an order of no weight bearing on her right leg. The Rehab Manager (Staff Q) was interviewed on 7/26/24 at 4:54 PM. Staff Q stated they were aware of R11's case because she was under our care from 6/12-6/28 when the fracture was found. PT evaluation was done on 6/12, PT Evaluation only*, and started therapy treatment on the following dates: 6/14/24 for 55 mins 6/17/24 for 55 mins 6/18/24 for 60 mins 6/19/24 for 40 mins 6/20/24 for 60 mins, Bilateral Strengthening Exercises 6/25/24 for 60 mins, Bilateral Strengthening Exercises 6/27/24 for 60 mins, Therapeutic Exercise (Left side only) 6/28/24 for 30 mins, did the left side only with no notes on the right lower extremities. Physical Therapy Service was discontinued due to a newly diagnosed fracture and the order for no weight bearing. Staff Q continued to explain that the goal was to strengthen R11's ability to transfer from lying in bed to sitting on the side of the bed, with no back support with supervision and no back assistance to help R11 get in and out of bed. R11 received therapeutic exercises and treatment. R11 was showing improvement with PT until an increase in pain and fracture was discovered on 6/27/24. When Staff Q was asked what a bilateral strengthening exercise consists of, Staff Q explained that bilateral strengthening exercises focus on active exercises in a seated position with 12 repetitions and three sets without resistance response. R11 significantly improved her usual pain because she could easily tolerate the therapeutic exercises. R11 was discharged from physical therapy on 6/28/24 because there were notes from nursing, and we received the morning report that R11 had a broken right tibia and fibula, and an order for No Weight Bearing (NWB) was put in place. A PT R was working with R11 on 6/27 and scheduled an interview for 7/27/24 in AM (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physical Therapist (PT R) was interviewed by telephone on 7/25/24 at 8:01 AM. PT R recalled R11 as having memory issues. Some days she can do exercises well and some days don't. She described R11's visit on 6/27th vividly because R11 complained of a lot of pain. After reviewing the notes from June 14 through June 27, R11's treatment and exercises consistently showed progress. One of the treatments was effleurage, which was tolerated well by R11. During the treatment sessions, her pain was at baseline, and she was a one-person assist during transfers, but because of R11's cognition, she may continue to self-transfer. PT R explained what therapy treatments were performed on R11, including effleurage. PT R stated, It is a type of massage performed to increase circulation to the area of the body intended to promote circulation and healing. R11 tolerated the massage, and PT R did not recall anything unusual during the sessions. PT R that another PT staff saw R11 on 6/27/24. On 6/27, 2024, R11 received PT only on the left side. It was noted that a 60-minute exercise was given to R11 focusing on the left leg because of complaints of increasing pain in the right ankle. R11 was unable to tolerate standing up with right-sided pain on 6/27/24. The PT Assistant wrote on the Rehab progress notes dated 6/27/24, that there was swelling and much more pain that day, different from previous therapy sessions in the past. The PT R notes indicated that R11 was improving with the treatments and exercises, but not sure what happened and how the fractures came about on 6/27/24. On 7/25/24 at 8:20 AM, Staff Q explained what Effleurage was about and that it: is a type of massage where, in this case, the Physical Therapist (PT) applies light pressure on a focused body part using fingers and flat hands. The purpose is to increase blood circulation, and the strokes are necessary to help increase the temperature of the soft tissues . Upon review of the facility's submitted R11 Facility Report Investigation on 7/23/24 at 3:30 PM, The interviews conducted with staff did not show evidence that the facility did a thorough investigation by obtaining an actual interview and written statements from staff members with pertinent details such as the date and time when the statements were collected. A review of the Summary of Investigation conducted on 7/25/24 at 10:00 AM revealed (with no name and date indicated the investigation was completed to its conclusion. It did not have a date of the inquiry to demonstrate the timeliness of the investigation. The staff interviews were written on a 2-page paper with first names listed and the word no next to the name. The 2-page list did not have a date and time and did not have any title/topic or purpose of the list of names and what actually no means next to the staff names. The Assistant Director of Nursing ADON was interviewed on 7/25/24 at 10:06 AM. The ADON agreed that he did all the interviews and described that he went to every staff member and asked them if they had witnessed anything unusual to R11 during care. He wrote no next to the staff name if they didn't. The ADON was asked if he had collected actual statements and had the staff sign them with the date and time of the interview. ADON stated he only went around and asked staff. I did not go further after the staff said no. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Administrator was interviewed on 7/25/24 at 9:37 AM. She stated that they ended up reporting the injury of unknown origin. The administrator admitted that she was unfamiliar with the current facility's investigation process. The administrator was unaware that an I/A report was not created in R11's EMR dated 6/27/24. However, she indicated that an investigation was thorough and concluded that the new fracture found on 6/27/24 was from the fall that occurred on June 10, 2024. After reviewing the Investigation Summary, the Administrator was questioned on who did the investigation and the completion date and time. She stated, The investigation summary was incomplete because there should have been the author who did the investigation's writing, collection, and conclusion, and was missing the date the summary was completed. The Administrator admitted there was no name, signature, or investigation date. The Administrator agreed that the timeliness of the investigation from start to conclusion was undetermined. The interviews collected did not have the complete names, dates, and the staff job/position. When the Administrator was shown the interview portion, she commented that it was unacceptable and that staff interviews should contain the statements, which must be followed by a signature and the date the staff made the statements. The DON on 7/25/24 at 10:30 AM stated she did the investigation and the investigation summary. She did not sign and date as the author upon completion of the investigation. She agreed that no date was specified in the completion/conclusion summary. She stated that the interviews were delegated to the ADON, which is not the recommended practice for doing interviews. The DON stated that the interview process was not acceptable for the investigation. That is not how it should be done. The facility policies for investigating and reporting abuse, including injuries from unknown origin and the I/A Report, were reviewed on 7/25/24 at 1:00 PM. 39059

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 39059 Based on observation, interview and record review, the facility failed to 1) Follow care planned interventions; 2) Notify the physician of a significant weight loss; 3) Notify the family of a significant weight loss; and 4) Provide meals as ordered for one resident (Resident #1), resulting in unassessed weight loss, meals not provided as ordered with the likelihood of hunger and continued weight loss. Findings include: Resident #1: On 7/23/24, at 9:55 AM, Resident #1 was lying in bed resting. Their breakfast tray remained at bedside and was untouched. On 7/23/24, at 1:03 PM, an observation of Resident #1's lunch offered. The tray was set up on the overbed table and consisted of 2 milks, a chocolate ice cream, peaches and cottage cheese. There was no main lunch meal and no grilled cheese offered. On 7/23/24, at 02:02 PM, a record review of Resident #1's electronic medical record revealed a readmission on 07/10/2023 with diagnoses that included Stroke, Dementia and Multiple Sclerosis. Resident #1 required assistance with all Activities of Daily Living and had severely impaired cognition. A review of the I prefer to stay in bed for meals . At times I refuse meals . Goal I am able to tolerate diet consistency . Interventions . Provide and serve diet as ordered: Regular diet, regular texture, thin liquids . Grilled cheese for lunch daily per request Cottage cheese daily with lunch . Report my weight monthly. Report changes to physician as needed . A review of Resident #1's weights revealed: On 12/05/2023, the resident weighed 132.8 lbs (pounds) and on 07/23/2024, the resident weighed 119.2 pounds which is a -10.24 % Loss. There were no weights for January and February. A review of the progress notes revealed the most recent Type: Dietary/Nutrition Note Effective Date: 06/18/2024 revealed Reweight obtained, current weight 119.2 pounds is reflective of 11.18 % loss x 90 days, 10.25 % loss x 180 days, Nursing stated resident has decreased appetite and meal intake, frequently refusing food and meals when offered. Average meal intake 16 % x 32 meals recorded with 8 refusal x past 14 days . Resident also stated that she enjoys cottage cheese and would like to receive daily; meal ticket updated to reflect preferences. Will continue to monitor PO intake and weight trends, goal is for weight stability, prevention of further weight loss as able. There was no documentation the physician was made aware of the 11.18 % weight loss. On 7/24/24, at 12:58 PM, Resident #1 was lying in bed awake. Resident #1 was asked if they ate and enjoyed their lunch meal. Resident #1 stated, I don't know. Their lunch meal appeared untouched on the overbed table and consisted of 1 bowl of cottage cheese approximately 1 cup, small bowl of jello, 1 piece of cake and 2 milks (1 was opened). There was no lunch plated meal and no grilled cheese. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24, at 1:38 PM, an observation along with the Director of Nursing (DON) of Resident #1 and their lunch meal was conducted. Resident #1 was lying flat in bed. The bowl of cottage cheese was empty. The jello, cake and milk was untouched. The DON asked the resident if they wanted a drink of water and Resident #1 stated, I don't know. The DON asked the resident if they were still hungry. Resident #1 answered yes and no to the question. The DON asked the resident if they wanted more cottage cheese and the resident stated, oh yes. On 7/24/24, at 1:44 PM, Server L was interviewed regarding Resident #1's meal service and why they weren't served a lunch meal and a grilled cheese. Server L offered, that they spoke with the CNA's and were told the resident wasn't eating well. Server L offered that they provided a magic cup and cottage cheese to the lunch meal. Server L was asked why they didn't provide the grilled cheese and a full lunch tray and Server L offered, I gave her a little piece of chicken, a little rice and that they had downsized her portions. Server L was alerted that the lunch meal that was given to Resident #1 did not have a plate of food; no chicken, rice or roll and Server L stated, she's not a big bread eater. Server L was asked if they follow the meal ticket and Server L stated, yes. Server L was asked if grilled cheese was written on the meal ticket for day prior why they were not offered a grilled cheese and Server L stated, she wanted a grilled cheese. Server L was asked why Resident #1 didn't receive a grilled cheese for the lunch meal this day and Server L offered, they didn't have that meal ticket. On 7/24/24, at 1:52 PM, Resident #1 was lying in bed. Their lunch tray now had a second bowl of cottage cheese which was empty. On 7/24/24, at 1:55 PM, Nurse J was asked if they received in report that Resident #1 was not eating well and Nurse J stated, the night nurse fills out the 24 hour report sheet. A record review of the nurse report sheet along with Nurse J revealed refused care next to Resident #1's name. On 7/24/24, at 2:30 PM, a further record review of Resident #1's most recent physician visit . Date 7/18/2024 Created Date 07/23/2024 . revealed no mention of the significant weight loss. On 7/25/24, at 7:55 AM, Registered Dietician (RD) M was interviewed regarding Resident #1's weight loss. RD M offered that they did add Ensure twice a day and that Resident #1 is one that refuses a lot including their January and February weight checks. RD M offered that Resident #1's appetite is down and had been liking the Ensure. A review of the nutritional care plan along with RD M was conducted and RD M was asked if grilled cheese was on their care plan why wasn't it being offered and RD M stated, it is on the care plan. RD M explained that they did just add the cottage cheese to the meal ticket on June 18th but was unsure why the grilled cheese was not on the meal ticket if it was on their care plan. RD M was alerted that the resident did not receive a full lunch meal the two days prior and was asked if the grilled cheese and cottage cheese was considered an alternate meal and RD M stated, she should be getting the full tray plus the cottage cheese and grilled cheese. RD M was asked to provide documentation that the physician was alerted of the weight loss and the meal service policy. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/24, at 12:42 PM, RD M entered the conference room and offered that they discussed with the staff and apparently Resident #1 gets overwhelmed when provided a full lunch meal although they need to provide the full meal and it's up to the resident if she wants it or not. RD M explained the grilled cheese was added to the meal ticket and that the staff was told to offer the entire meal plus the extra's. RD M was asked if the physician was notified of Resident #1's weight loss and RD M stated, no. A review of the facility provided WEIGHT MEASURMENTS Revision Date: July, 2023 revealed . Documentation . Record date and times of physician and family/responsible party notification .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 Based on observation, interview and record review, the facility failed to ensure that a continuous positive airway pressure machine/CPAP mask was cleaned and bagged after use for 1 resident of 1 resident reviewed (Resident #103) for CPAP's, and ensure that oxygen was on the resident as ordered and update the oxygen care plan for 1 of 2 residents reviewed (Resident #12) for oxygen, resulting in the likelihood of low oxygen, compromised respiratory status, increased lung infection, and increased antibiotic usage for respiratory infection with hospitalization . Findings Include: Resident #103: Review of the Face Sheet, diagnosis list, care plans and physician orders revealed, Resident #103 was [AGE] years old, alert and his own person, admitted to the facility on [DATE] from the hospital for rehab services after hip surgery. The residents diagnosis included, right hip replacement, diabetes, high blood pressure, chronic heart failure, heart disease, obstructive sleep apnea (required a CPAP at night), history of thrombosis (blood clot), a history of asthma, and required assistance with daily activities of daily living/personal care. The resident was a full code. Review of the facility Nursing Admission Screener dated 7/20/24, revealed under respiratory, apnea was not addressed, nor checked however, CPAP was checked (generating a care plan) and order for cleaning and maintenance. Review of the electronic medical record, revealed the resident used a CPAP at home and in the hospital at night. Upon admission to the facility physician orders for CPAP daily cleaning was required by this facility. Per observation and interview done on 7/23/24 at 11:07 a.m., the residents CPAP was noted to be sitting out on bedside table, not in a bag. The CPAP was observed to be dirty in the mask and the tube, Resident #103 stated, I usually clean it, no one offered to clean it, last Thursday (prior to surgery) I cleaned it (7/18/24, a total of 6 days without being cleaned, a total of 4 of the days while at the facility). Review of the residents physician orders, revealed on 7/23/24 (the day the surveyor noted the dirty CPAP mask and tube and it was not bagged), an order to clean the CPAP was obtained. Review of the CPAP care plan revealed it was also dated 7/23/24, no CPAP care plan was put in place until the first day of the recertification survey. Review oaf the order dated 7/23/24, stated CPAP daily cleaning every day shift, daily wipe the CPAP mask and wipe down tubing with a clean, damp paper towel. Rinse out the humidifier and refill it with distilled water. 39059 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #12: On 7/23/24, at 10:06 AM, Resident #12 was resting in their bed with a visitor at bedside. Resident #12 did not have their oxygen nasal annular on. The oxygen tubing and nasal cannula was inside a clear plastic bag hooked to their wheelchair. On 7/24/24, at 8:00 AM, a record review of Resident 12's electronic medical record revealed an readmission on 11/30/2023 with diagnoses that included Chronic ischemic heart disease, Chronic Obstructive Pulmonary Disease (COPD) and Alzheimer's disease. Resident #12 required assistance with Activities of Daily Living and their cognition fluctuates at times. A review of the physician orders revealed . Oxygen at 3LPM (liters per minute) continuously every shift . Start Date 1/18/2024 . A review of the I use Continuous Oxygen Therapy PRN r/t (related to) COPD and chronic respiratory failure with hypoxia . Goal I will have no s/s (signs and symptoms) of poor oxygen absorption through the review date . Interventions . OXYGEN SETTINGS: I have O2 via nasal prongs @ 3 L (liters) PRN (as needed) Revision on: 07/06/2021 . On 7/24/24, at 8:41 AM, Resident #12 was sitting at a dining table in the main dining room. Their lips and skin surrounding their lips had a dusky grey appearance. Resident #12's portable oxygen tank was hooked to the back of their wheelchair and was off. Resident #12 was asked how they felt and at the same time had reached behind them and dialed their oxygen tank to 1 liter. Resident #12 then stood up and pulled their oxygen tubing out from under their bottom. Resident #12 was sitting on their tubing. Resident #12 had placed their oxygen on and had placed the nasal cannula on correctly. On 7/24/24, at 8:43 AM, Nurse J was asked if they could obtain a pulse oximetry reading of Resident #12's oxygen level. Nurse J placed the pulse oximeter on Resident #12 and revealed the oxygen level to be 90%. Nurse J reassured the resident their tank was full and should last them through lunch and walked away. The oxygen tank remained dialed to only 1 liter. On 7/24/24, at 8:45 AM, Nurse K was alerted that Resident #12 had been sitting on their oxygen tubing and the tank remained dialed to only 1 liter. Nurse J reminded the resident of the need for assistance and dialed the oxygen tank to 3 liters. Resident #12 offered, I though I turned it 3. On 7/24/24, at 12:47 PM, Resident #12 was lying in their bed knitting. Their oxygen was not on. The oxygen concentrator was dialed to 3 liters and the tubing was coiled on the floor. The oxygen tank on their wheelchair was dialed to 3 liters and the oxygen tubing was coiled in a plastic bag. Nurse J was down the hallway at their medication cart and was asked if they had observed Resident #12 since lunch and Nurse J stated, no. Nurse J was alerted that Resident #12 was in their bed both oxygen sources were running and that the resident did not have either oxygen tubing on. Nurse J offered they would go put it on the resident. According to the facility provided OXYGEN ADMINISTRATION Release Date: March 2013 policy Purpose A resident will receive oxygen per physician orders .

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 39059 Based on observation, interview and record review, the facility failed to ensure that insulin pen administration was completed per professional standards of practice for one resident (Resident #11) of one resident reviewed for insulin administration, resulting in the likelihood of decreased insulin absorption and continued misadministation. Findings include: Resident #11: On 7/25/24, at 9:20 AM, During medication administration task, Nurse N was observed gathering Resident #11's morning insulin. Nurse N removed the insulin pen, placed a needle on the pen, dialed to 2 units and wasted the 2 units. Nurse N then dialed the insulin to the 4 units ordered. Nurse N entered Resident #11's room and prepared their abdomen for administration. Nurse N inserted the needle, pushed the plunger down and removed the needle. The entire process took only 3 seconds. Nurse N did not wait the required 5 to 10 seconds after the plunger was fully pushed in. On 7/25/24, at 10:00 AM, the Director of Nursing (DON) was alerted of Resident #11's insulin administration and that Nurse N failed to leave the needle inserted the required time. The DON was asked to provide the competency and the facility insulin pen administration instructions. On 7/25/24, at 10:30 AM, a record review of Resident #11's Physician orders revealed an order for NovoLOG FlexPen subcutaneous solution Pen-injector 100 UNIT/ML (Insulin Aspart) Inject 4 unit subcutaneously . Start Date 7/2/2024 On 7/25/24, at 12:30 PM, a record review of the facility provided Insulin and Non-Insulin Pen Quick Reference Guide . After pushing the dose button to inject the medication, hold pen in skin for an additional time period per manufacturer specific instructions (5 - 10 seconds) before withdrawing the needle from skin to allow sufficient time for entire dose to dispense from pen into subcutaneous tissue .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 Based on observation, interview and record review, the facility failed to 1). ensure the treatment cart on Garden View unit was locked and secured, 2). ensure 1 tube of medication was labeled, dated and the top was on it, and 3). maintain refrigerator temperature on Morning [NAME] unit, back-up refrigerator, resulting in the likelihood for increased infection rate, increased antibiotic usage, wasted topical medication, and refrigerated medications not usable due to decreased temperature maintenance. Findings Include: Observation of Treatment Cart: During observation done on 7/23/24 at 10:20 a.m., on Garden View unit, the treatment cart was found unlocked and no nurse was in sight. Nurse LPN D was in a resident's room at the time. When this surveyor opened the drawers, a small tube of Hydrocortisone cream that was un-labeled and un-dated was found half used and the top was off sitting next to it. Also, several nail clippers and a pair of seizers were found in the top drawer. During an interview done on 7/23/24 at 10:45 a.m., Nurse D stated it should have a top on it and be labeled, I don't know how it got un-locked. During an interview done on 7/24/24 at approximately 3:30 p.m., the Director of Nursing/DON said it was the second shift nursing staff who was responsible to clean the treatment and medication carts (and date un-dated medications). The DON stated, The treatment cart should have been locked. No policy for cleaning medication carts was available. 39059 On 7/25/24, at 9:07 AM, an observation of the Morning [NAME] medication room along with the Director of Nursing (DON) revealed the medication refrigerator temperature log revealed no temperature documented for the day of the 25th. The last temperature logged was on the 24 8:00 AM. On 7/25/24, at 9:12 AM, an observation along with the DON of the medication room [ROOM NUMBER] refrigerator temperature log revealed the last documented temperature check was 23 7:00 PM. A further record review of the REFRIGERATOR LOG revealed Record exact temperatures twice daily, including min/max once daily. Ensure min/max is cleared/reset daily. Keep temp logs for at least 3 years. Take IMMEDIATE action, follow your emergency response plan if any temperature is out-of-range. Notify Health Dept and manufacturers for out-of-range temperatures.

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	235269	A. Building B. Wing	07/25/2024

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22347 Based on observation, interview and record review, the facility failed to maintain a clean and sanitary kitchen and kitchen ice machine, resulting in the likelihood to affect up to 53 residents who currently consumed meals prepared in the facility kitchen, from a census of 53 residents. Findings Include: According to the Michigan Modified Food Code 2012, stated Clean equipment and utensils shall be stored: In a self-draining that allows air drying. All kitchen food prep areas and equipment are to be clean and sanitary. Initial Tour of the Facility Kitchen: On 07/23/24 at 9:46 a.m., a kitchen tour done with Dietary Manager F was done; the following concerns were found: -At 9:47 a.m., the kitchen hand sink closet to the ice machine and dish area was found to not have any soap nor paper towels. During an interview done on 7/23/24 at 9:48 a.m., Dietary Manager F stated Housekeeping is out on rounds right now. Dietary Manager F waited for housekeeping and did not replenish the soap or paper towels herself. -At 9:47 a.m., the large metal can opener was found to have stuck on wet and dry food on the blade and the paint was also chipping off the blade. -At 9:48 a.m., the Robot Coupe (food processor) was clean, ready for use and was found to have water still inside on the bottom, and the blades had food particles still on them. -At 9:50 a.m., the heavy duty blender that was clean and ready for use was found to have dust on top. -At 9:51 a.m., a large silver metal pan filled to the top with individual wrapped stake's was sitting out without any dates or times on it. When this surveyor touched to wrapped meat, it was found to be room temperature. During an interview done on 7/23/24 at 9:52 a.m., Dietary Manager F stated it should not be out like that. During an interview done on 7/23/24 at 9:53 a.m., [NAME] I stated It's (the pan pf raw meat) has been out for about an hour. -At 9:54 a.m., a clean and ready for use half-pan was found to be wet inside; it was stacked on another pan on the pan rack. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-At 9:55 a.m., the large white plastic bin that had thickener in it was not labeled with no dates on it. During an interview done on 7/23/24 at 9:55 a.m., Dietary Manager F stated It's thickener; we put it in this morning and forgot to date it. -At 9:56 a.m., a small trash bin with trash up to the top was observed sitting on top of the silver metal food prep table, next to open bacon and gravy (without lids). -At 9:57 a.m., x 11 spice containers were found to be sticky and dirty on the sides and tops of them. -At 10:00 a.m., 3 clean and ready for use white plates and a plastic pitcher were found to have dried food on them and were also wet. The plates were stacked on top of one another on the plate rack. -At 10:04 a.m., the kitchen ice machine was found to have a black substance (mold-like) all over the seal tape inside the cover and in the inside back of the machine was observed a dried yellow substance near the ice. During an interview done on 7/23/24 at 10:10 a.m., maintenance assistance F stated It looks like mold to me (the black substance on the seal tape of the inside cover of ice machine). Review of the kitchen Ice Machine Bin Cleaning documentation dated 12/29/22 through 6/13/24, revealed the ice machine was to be cleaned every month. The last time it showed it was cleaned was over a month ago (6/13/24); it was late to be cleaned. Review of the facility kitchen cleaning checklists revealed the last one filled out had several blank area's were no staff had documented the duties had been done, and there was no date on the sheet. During an interview done on 7/23/24 at 10:14 a.m., Dietary Manager F stated they are supposed to fill out the job duties (kitchen daily job documentation sheets) every day. We don't have one for today. A policy for kitchen ice machine and cleaning policy was requested, and not received during the survey.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** 22347 Based on observation, interview and record review, the facility failed to 1) Ensure a safe, clean and sanitary environment (Stachybotrys/black-mold and Chaetomium mold), and 2). Maintain and clean the facility kitchen ice machine for resident's, family members, visitors and staff, resulting in the likelihood for respiratory infections, increased bacterial infections, with exposure to molds: damage to nose, throat esophagus, lungs and blood stream, increased antibiotic usage, and unsafe environments. Findings Include: During the initial facility environmental tour done on [DATE] at 10:00 a.m., the following concerns were observed: -At 10:04 a.m., the kitchen ice machine was found to have a black substance (mold-like) all over the seal tape inside the cover and in the inside back of the machine was observed a dried yellow substance approximately 6 inches near the ice. During an interview done on [DATE] at 10:10 a.m., maintenance assistance F stated It looks like mold to me (the black substance on the seal tape of the inside cover of ice machine). Review of the kitchen Ice Machine Bin Cleaning documentation dated [DATE] through [DATE], revealed the ice machine was to be cleaned every month. The last time it showed it was cleaned was over a month ago ([DATE]); it was late to be cleaned. -At 10:20 a.m., in the public bathroom [ROOM NUMBER] (across from the main dining room on the first floor), there was no paper towels at all, management was informed. -At 4:00 p.m., still no paper towels in public bathroom [ROOM NUMBER], Infection Control Nurse C informed. -At 10:28 a.m., on the Garden View unit, a running white fan was found to have black dirt on the blades, it was observed to be blowing toward the nursing station next. -At 10:30 a.m., on the Garden View unit in the soiled utility room was observed 2 large blue bins filled with soiled linens, and both tops were off sitting on the floor. -At 10:31 a.m., on the Garden View unit, a running dehumidifiers filter was found to have heavy dust on it. Infection Control Nurse C went to check it out, and rubbed his hand over the dirty filter and dust fell out onto the floor. -At 10:37 a.m., on the Garden View unit, in the small shower room (it was not used as a shower room, crash cart in room) was noted to have a heavy sewer-like smell. The shower was no longer in use and the drain was open. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview done on [DATE] at 10:37 a.m., Nurse, LPN D stated it (the small shower room) smells like sewer. -At 10:50 a.m., on the Garden View unit a running fan was blowing air between 201 and 204; it was found to have black dirt on the blades. -On [DATE] at approximately 12:30 p.m., during catheter care observation, room [ROOM NUMBER] had right and left floor mats for safety; the left floor mat was noted to have a total of 12 small rips/tears in it. The resident was in bed at the time. During the basement (used for nursing meetings, staff orientation and staff education) environmental tour done on [DATE] at 2:40 p.m., accompanied by Maintenance Director A and Corporate maintenance G and H, the following concerns were observed: -At 2:43 p.m., in the medical records room above stored boxes records was noted 2 buckets, one with approximately 6 inches of water in it and the other had old pealed of pipe wrappings in it. There was three areas were the pipes from the ceiling were visibly wet and dripping; these ceiling area's had a black colored mold-like on them. One thin active data cord was stretched across the ceiling and touching one of the wet areas. During an interview done on [DATE] at 2:45 p.m., Maintenance Director A stated I have been here for [AGE] years, that's always been that way, it's (the pipe dripping and black mold-like) the building. -At 2:46 p.m., in the hallway outside of therapy storage room and down the hall toward staff education room, was observed approximately 6 large areas of back mold-like on the ceiling tiles. During an interview done on [DATE] at 2:48 p.m., Maintenance Director A stated I replace the tiles every month, the Administrator knows it. We are out of tiles or I would have replaced them; we don't have a policy for changing the tiles if I am not here. -At 2:50 p.m., in the staff education room, was observed a large area on the ceiling of black mold-like by the back window, on the right side. A computer and paper work was sitting directly under this area (staff were working in this area, sitting directly below the mold-like large area). -At 2:55 p.m., in the basement therapy equipment room, a large area of black mold-like circular area on the ceiling tiles directly over a uncovered resident wheeled walker was found. Review of the environmental independent lab report dated [DATE], stated (the company) conducted a limited visual inspection for mod growth. The pipe wrap is asbestos containing. mold growth on some of the ceiling tiles. The results indicated mold levels in the all three areas were above acceptable levels at the time of the sampling event. Chaetomium (exposure can cause respiratory symptoms, and skin irritation) and Stachybotrys (also known as black mold; can exposure can cause damage to the nose, throat, esophagus, lungs and blood stream) were detected in the medical records room air sample. There are no acceptable levels for Chaetomium or Stachybotrys. There are 20 documented species of Stachybotrys and at least two are reported to be toxigenic; if not speculated, the [NAME] Stachybotrys should be assumed to be toxigenic. Specifically, it can produce the mycotoxin Trichothecene, which can have adverse health effects. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At approximately 3:05 p.m., in the boiler room was observed the State Boiler license's, all of them were expired (expiration dates of 2019 through 2022). During an interview done on [DATE] at 3:05 p.m., Maintenance Director A stated I have been calling them (the State of Michigan boiler inspectors), I just gave-up. The facility boilers are each over a million BTU's (licenses are required). Review of the facility Environmental Service Manager job description dated [DATE], stated Essential Duties: Insure the building, rounds and equipment are maintained in a manner that protects the safety and health of all residents, employees and visitors.