STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235274	A. Building B. Wing	01/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellspring Lutheran Nursing and Rehab Services	1236 S Monroe St Monroe, MI 48161

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 This citation pertains to intake MI00149175. Based on interview and record review the facility failed to ensure residents privacy was maintained for two residents (R16 and R22) out of 20 residents reviewed for residents' rights. Findings include: Review of a facility reported incident sent to the state agency dated 12/20/24, reported a staff member sent videos to a coworker using Instagram (social media) using private messaging. R16 Review of electronic medical records (EMR) documented R16 was initially admitted into the facility on [DATE] with a pertinent diagnosis of Alzheimer's disease (common cause of Dementia and memory loss). Review of Brief interview for Mental Status (BIMS) dated 10/7/24, R16 scored 3 out of 15 (severe cognitive impairment). Review of Minimum Data Set (MDS) dated [DATE], documented R16 required substantial/maximal assist with most Activities of Daily Living (ADLS). An interview was conducted on 1/12/25 at 11:25 AM with R16, resident had no recollection of the event. Review of Video 2.mov (no date) revealed Resident Assistant (RA) A standing in front of R16 eating a cookie. A caption at the bottom of the screen noted, Eating a cookie and dripping all the crumbs on the devil's floor because she beats me on a regular. R22 Review of EMR documented R22 was initially admitted into the facility on [DATE] with a pertinent diagnosis of dementia (a group of symptoms affecting memor). (continued on next page)

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Brief interview for Mental Status (BIMS) dated 11/14/24, R22 scored 1out of 15 (severe cognitive impairment). Review of Minimum Data Set (MDS) dated [DATE], documented R22 required substantial/maximal assist with most Activities of Daily Living (ADLS). An interview was conducted on 1/12/25 at 12:15 PM, R22 was not able to respond appropriately related to impaired cognition. Review of Video 2.mov (no date) RA A's video revealed an empty plastic drinking cup on the floor, RA A then holding a cat, followed by another empty plastic drinking cup on the floor. Finally, R22 sitting in a wheelchair. A caption at the bottom of the screen noted, Came back and (R22) took my Dr. Pepper (soda) drank all of it and then put it on the floor. An interview was conducted with Social Worker (SW) B on 1/14/25 at 10:03 AM, it was reported the video recordings of the residents were inappropriate and was an invasion of the resident's privacy. An interview with Nursing Home Administrator (NHA) on 1/14/25 at 11:30 AM, reported that RA A had made videos using Snapchat (social media) with private messaging and had sent the videos of the two residents (R16 and R22) without any consent. It was further reported that the videos of the residents were an invasion of their privacy. Finally, it was reported by the NHA that RA A was terminated related to the videos of the residents. Review of the facility's policy Personal Communication Devices (Cell Phones) (no date), documented .6. Photographing residents with any and all devices is prohibited.7.Employees who use an electronic device as mentioned above which constitutes an interference with resident care or uses a device in a manner that is profane, indecent, or obscene or constitutes an invasion of privacy will be subject to disciplinary action including termination. Review of Admission Booklet (no date), documented Privacy-A resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity and individuality.