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	11/21/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure nursing services were provided in accordance with professional standards for one resident (R401) of three residents reviewed for medication administration. This failure had the potential to place R401 at risk for adverse medication effects.Findings include:Findings include:On 10/6/25 at 11:35 AM R401 was interviewed regarding the care the facility provided. R401 said the nurse (later identified as LPN A) had given her a double dose of a medication called Budesonide. R401 said she usually takes two pills but there were four pills in the cup. R401 said when she questioned the nurse, the nurse admitted there should only be two pills. R401 said the medication mix up concerned her because it will come a day when she does not remember what medications and how many she is supposed to be taking.On 10/6/2025 at 2:35 PM Licensed Practical Nurse (LPN) A was interviewed and queried about R401 Budesonide medication. LPN A said she had received report and the off going nurse had informed her there was a change in R401's medication. LPN A said she thought it was a new medication being added. LPN A said she did give four pills in the medication cup given to R401. LPN A said because she is a new nurse she was not familiar with the computer system and did not know the first order was discontinued. LPN A admitted she did not do a progress note about the incident.On 10/6/2025 at 3:40 PM, Nurse B was interviewed and said they were the Director of Nursing (DON) at the time of the incident. Nurse B said they were contacted by R401 resident representative and informed of the incident. Nurse B said they informed LPN A they needed to follow the five rights when passing medications. Nurse B said she also informed LPN A in the future they need to document such incidents as a near miss medication incident.On 10/6/2025 at 3:50 PM, the Nursing Home Administrator (NHA) and the DON were interviewed. The DON said LPN A had only been a nurse since May of 2025. The DON said they expect all nurses to verify orders and follow correct procedures when passing medication. The NHA had no additional information to add.Record review of document titled, Grievance and Complaint Report noted the facility was informed on 8/27/2025 by R401's resident representative that LPN A attempted to administer four capsules instead of the prescribed two capsules of Budesonide ER 3mg to R401.Record review of document titled, Medication Pass Guidelines with a date of September 2023. The section labeled Physician's Orders, documented medications should be given in accordance with the attending physician orders. In addition, it noted if the order seems excessive the physician should be contacted.Record review revealed R401 was admitted on [DATE] with the following diagnosis: Gastroenteritis and colitis, Major Depressive Disorder, Atrial Fibrillation and DementiaReview of R401 Electronic Medical Orders (EMR) revealed the provider ordered Budesonide ER 3 mg 2 capsules by mouth one time a day for COPD. The order had a start date of 8/2/2025 for COPD and the order was discontinued on 8/26/2025 at 2:11 PM. The EMR documented there was an order Budesonide ER 3mg 2 capsules to start on 8/27/25 at 9:00 AM by mouth one time a day for bowels. Review of Minimum Data Set (MDS) with an effective date of 10/1/2025 for Brief Interview for Mental Status (BIMS) R401 was a 15 out of 15 which indicated intact cognition.The NHA had no additional information to provide at the end of the survey.

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