STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235400	A. Building B. Wing	05/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellspring Lutheran Services	1390 Maple Drive Fairview, MI 48621

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 45123 Based on interview, and record review the facility failed to provide adequate supervision to prevent one Resident (R1) of four Residents reviewed for resident-to-resident incidents from initiating an altercation. Findings include: This citation pertains to intake #MI00139599. Review of intake #MI00139599's Incident Summary, dated 8/17/23, read in part, .At time of incident, it was reported to Administrator that Resident 1 [R1] was swinging a coffee mug at Resident 2 [R2] with potential contact .Cameras were reviewed at that time, and it was determined that a resident-to-resident altercation did occur . Review of intake #MI00139599's Investigation Summary, dated 8/23/23, read in part, On 8/16/23 at 16:52 [4:52 PM] [staff name], RN D [registered nurse] notified Administrator of incident involving R1 and R2 at 16:38 [4:38 PM] . CNA E [certified nurse aide] observed R1 swinging coffee cup at R2 with possible contact. R2 was observed to have coffee on his face and shirt . R1 was interviewed by licensed bachelor social worker LBSW B on 8/17/23 at 07:45 [7:45 AM]. R1 stated that he was trying to get through Hall 3 when he noted a resident blocking the way. He voiced that he assisted the resident to move the wheelchair, so he could get by and then moved past R2, when R2 grabbed his left arm and would not let go. He denied calling out for staff and voiced 'I told him to let go or I would hit him. He did not let go, instead he was getting worse.' . 'I swung at him with my coffee mug.' . Administrator . and Social Worker . reviewed camera footage at time of incident . R1 was observed approaching the nurses' station and was unable to continue locomotion due to position of wheelchairs. R1 is seen attempting to move back R2 wheelchair. R1 then proceeds to attempt to get through opening and makes contact with R2 chair three times. He is then able to advance in front of R2 . then reaches forward for R1 left arm. R1 then proceeds to swing his coffee cup at R2 eleven times. R2 is attempting to block strikes using his left arm before CNA E intervenes and separates residents . Review of R1's census, revealed an original admission on 11/30/2022 into the facility and discharged on [DATE] from the facility. Review of R1's progress note, dated 8/16/23 at 4:38 PM, read in part, CNA alerted the nurse of a possible altercation between two residents . (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's care plan, dated 12/05/2022, read in part, . Focus: I have an ADL [activities of daily living] Self Care Performance Deficit r/t [related to] Hemiplegia (paralysis of one side of the body) . Interventions . Mobility - I use a w/c [wheelchair] as my main source of locomotion and am able to propel myself short distances. Staff assist me as needed with reaching my desired location . Review of camera footage with the Nursing Home Administrator (NHA), dated 8/16/23, revealed seven residents sitting in chairs and wheelchairs all around the nurses' station and three staff in the area just prior to the altercation between R1 and R2 and then staff exiting the area where all residents were left unattended. R2 is seen sitting to the left of Hall 3 next to the nurses' station and an unidentified resident sitting on the right of Hall 3 blocking the entrance to Hall 3. R1 is seen attempting to move the unidentified resident to the right of Hall 3 without success and then moves toward R2 and attempts to move him out of the way. After R1 bumps into R2 three times he could proceed forward and turns in front of R2 when R2 reaches out and grabs R1's left arm. R1 is observed swinging his coffee mug at R2 and hits him in the left arm and the left side of his face and continues to swing eleven times. Staff then enters the nurses' station area and then separates both residents. Review of witness statement by CNA E, dated 8/17/23, read in part, . Before dinner I was in the equipment room when I heard a resident yell out, Don't do that! I ran out of the room to see R1 raising his coffee cup up towards R2 who was facing in my direction. I was not able to get in between them in time when R1 cup looked as if it contacted R2 left cheek . Review of witness statement by RN C, dated 8/17/23, read in part, I was in the equipment with CNA E. CNA E was in the doorway and opened it because we heard a louder voice, she then said, 'R2 and R1 are fighting .' Review of witness statement by RN D, dated 8/17/23, read in part, I was in room [ROOM NUMBER] when I heard, [CNA E] yell out my name. I came out of room [ROOM NUMBER] . I noticed R2 had coffee on his shirt and hair. CNA E told me that she seen R1 with his coffee cup up in the air towards R2 . On 5/30/24 at 10:50 AM, an interview was conducted with the NHA, and she was asked if the area around the nurses' station had not been congested if the resident-to-resident altercation would have taken place and replied, No. I have not had any concerns between the two residents until the altercation. The NHA was asked if she felt any of the three staff members that were present at the nurses' station prior to the resident-to-resident altercation should have been supervising the residents and replied, Yes. The NHA was asked if any of the three staff members should have been aware of the congestion at Hall 3 and replied, I guess not. We recognized that activities had just gotten out and they added more residents to the area. Other staff were parking wheelchaired residents in that same area getting them ready to go to the dining room for dinner. Since the incident we have made some changes. On 5/30/24 at 11:12 AM, an interview was conducted with RN D, and she was asked to confirm her witness statement. RN D confirmed her witness statement. RN D stated, I felt like R1 was excessive with his reaction and he could have waited for staff to assist moving other residents out of his way. R1 was aware of what he was doing, and his actions were wrong. After he tried to leave as soon as he could, and I felt he knew he did something wrong and was trying to get away from the situation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy titled, Safety Interventions, dated April, 2021, read in part, Policy .Safety interventions can also be used to help prevent serious injury .Supervision/Adequate Supervision refers to an intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents .