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	02/06/2025

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 - 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** 49310 Based on interview and record review, the facility failed to develop and implement interventions or revise the fall care plan for one Resident (#1) of three residents reviewed for falls. This deficient practice resulted in R1 falling who sustained a skull fracture with subdural hemorrhage. Findings include: Resident #1 (R1) R1 was admitted to the facility on [DATE]. R1 fell on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], and [DATE]. A nurse's progress note dated [DATE] at 11:34 p.m. documented R1 was found by staff on the floor of his room. The progress note indicated R1 was bleeding from a head injury. Emergency Medical Services (EMS) was contacted and R1 was sent to the hospital Emergency Department (ED). An ED record dated [DATE] documented R1 was diagnosed with a skull fracture with subdural hemorrhage (bleeding under the membrane covering the brain). The ED physician documented, in part: .there does appear to be new acute on chronic bleeding .CT imaging also did reveal a significant skull fracture. I spoke with trauma surgery at [hospital name redacted]. They recommend I talk to neurosurgery. I did have a lengthy discussion with the neurosurgeon stating he believes the patient has a poor outcome which we do agree with. He [the neurosurgeon] deems he [R1] is not a surgical candidate . R1 was discharged back to the facility on [DATE] to resume hospice services. A review of progress notes [DATE] and [DATE] revealed R1 experienced an overall decline in health condition including hypotension as reflected by blood pressure of ,d+[DATE] (documented [DATE]), oxygen saturation levels of 57% (documented [DATE]), and scant intake of food or fluids (documented [DATE]). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235400	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2025
NAME OF PROVIDER OR SUPPLIER Wellspring Lutheran Services		STREET ADDRESS, CITY, STATE, ZIP CODE 1390 Maple Drive Fairview, MI 48621	

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A hospice progress note dated [DATE] read, in part: [R1] is seen today for a routine nursing visit today. He suffered a fall with head injury the night of [DATE]. Went to ER [emergency room], required stitches, CT showed new brain bleed and a skull fracture. [R1] was noted to be minimally responsive since . [R1] is placed on daily hospice nursing visits at this time. Progress notes dated [DATE] and [DATE] documented R1 became unable to safely swallow and experienced intermittent terminal (end of life) restlessness. The physician note dated [DATE] at 12:58 p.m. read, in part: .His intake is less than adequate to support life. Apneic breathing [temporary and involuntary cessation of respirations] 12 sec [seconds] apart . A hospice progress note dated [DATE] at 5:05 p.m. documented R1 was minimally responsive, pale and his bilateral lower extremities were mottled (discoloration due to slowed circulation and oxygen flow, typically indicative of approaching death). R1's heart rate was thready and irregular. The hospice note recorded R1 was experiencing terminal restlessness and was provided with Morphine (an opioid pain-relieving medication) and Ativan (an antianxiety medication) every four hours. On [DATE] at 2:08 p.m., the hospice nurse documented R1 was comatose and nonresponsive with , d+[DATE] second periods of apnea. R1 was pronounced deceased on [DATE]. Review of R1's care plans revealed no new or revised interventions to minimize the risk of injury from a fall or to minimize the risk of fall recurrence after R1's falls on [DATE], [DATE], and [DATE]. The Director of Nursing (DON) was interviewed on [DATE] at 12:31 p.m. The DON was asked what care plan modifications or interventions had the facility put in place for R1 after the falls on [DATE] and [DATE] to prevent or minimize the risk of extensive injury following the fall on [DATE]. The DON said a medication regimen review (MRR) was completed after the fall on [DATE] to determine if medications were contributing to R1's falls. The DON said staff education on R1's fall interventions was completed in response to the fall on [DATE]. When asked what interventions were implemented after the fall on [DATE], the DON said 30-minute checks were implemented when R1 returned from the hospital on [DATE]. A copy of the MRR, staff education, and documentation of 30-minute checks was requested. On [DATE] at 1:15 p.m., the DON provided a MRR dated [DATE]. When asked why the Interdisciplinary Team (IDT) determined a MRR was indicated for the fall on [DATE] if a MRR was completed by the pharmacist the day prior to the fall, the DON responded she would have to review the IDT note. On [DATE] at 1:15 p.m., the DON provided a copy of a form Meeting Attendance Sign-In Sheet Nurses Meeting dated [DATE]. The attendance form contained Certified Nurse Aide (CNA) names and signatures. A second form was provided dated [DATE] that read, in part: This is to inform everyone that room [ROOM NUMBER] (R1's name) is now 30-minute checks . The form was unsigned with no other documentation on the form. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The DON was questioned regarding the date on the education form and was again asked when 30-minute visual checks were implemented for R1. The DON reiterated R1 was not placed on visual checks every 30 minutes until after the fall on [DATE] despite the education of staff on [DATE] to provide 30-minute visual checks. The DON said there was a discussion in the daily IDT meeting on [DATE] to provide education to remind staff to visually check R1 for safety. The DON explained R1 fell on the night of [DATE] which was a Friday, so the facility did not review the fall to develop an intervention until [DATE], a Monday. The DON said, On Monday [[DATE]] we talked in the morning meeting and decided he needed official 30-minute checks. The DON provided a CNA task report for the month of [DATE]. The report documented 30-minute visual checks of R1 commencing [DATE]. When asked for documentation prior to [DATE], the DON admitted 30-minute visual check documentation for R1 did not start until [DATE], six days after R1 fell and sustained the skull fracture. R1's care plan was reviewed with the DON. The DON confirmed none of the interventions she had conveyed for the falls on [DATE], [DATE], and [DATE] were on R1's care plan. There was no evidence the fall care plan was reviewed or modified after the falls on [DATE], [DATE], or [DATE]. There were no interventions on the fall care plan for MRR, staff education, or visual checks every 30 minutes. When asked again what interventions were implemented or changes made to the plan of care after the falls on [DATE] and [DATE], the DON said, nothing. When asked if documentation of 30-minute checks commencing [DATE], at which time R1 was documented as being minimally responsive, was a timely and appropriate intervention, the DON said, No. The DON said, I can't disagree with you. I am disappointed. We have a problem with our falls [program]. The DON said fall prevention and management was scheduled as the facility's next QAPI (Quality Assurance Performance Improvement) project. The policy Resident Fall Occurrences dated as revised ,d+[DATE] (no day provided on policy) read, in part: . The facility must implement process improvement systems to reduce the prevalence of falls and significant injury . Objectives: to minimize injurious resident incidents, to minimize repeat resident incidents .The licensed nurse documents . review of care plan and any new preventative measures initiated .The IDT then modifies and implements care plans and the treatment approach to minimize repeat incidents . The policy Fall Management Guidelines dated as revised ,d+[DATE] read, in part: .The IDT will review/modify the plan of care to minimize repeat falls . The facility's undated Fall Management Algorithm directed staff to Update Fall Care Plan after a resident fall.