STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235504	A. Building B. Wing	01/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springcreek Rehabilitation and Nursing Center	130 Sand Creek Highway Adrian, MI 49221

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement the Comprehensive Care Plan for one (R6) of three reviewed.Findings include:Review of the medical record reflected R6 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included fracture of unspecified part of neck of left femur (6/8/25), seizures, difficulty walking, diabetes, dementia and impulse disorder. The modification of the Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/11/25, reflected R6 scored six out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool) and had two or more falls since admission or the prior assessment. On 12/30/25 at 12:57 PM, R6 was observed up in their wheelchair, in a common area, with shoes on both feet. Anti-rollback brakes, rear anti-tip bars and a drop seat (seat tilted back) were observed on R6's wheelchair. R6's bed height was observed to be in a low position, with a standard mattress in place (sides of mattress were not elevated). The left side of the bed was against the wall. Non-skid strips were not observed on the floor at the bedside. R6's Care Plan reflected they were at risk for falls. Interventions included but were not limited to non-skid strips at the bedside (initiated 2/2/25) and an edge defined perimeter mattress (initiated 7/25/24).In an interview on 1/6/26 at 11:58 AM, Director of Nursing (DON) B reported Care Plans were reviewed by the MDS nurse quarterly. If a resident had a fall, the falls Care Plan was reviewed by the Interdisciplinary Team (IDT). DON B described an edge defined perimeter mattress as a mattress with slightly elevated sides. DON B reported R6 had a room change in October 2025, and their interventions were not moved to their new room. According to DON B, Unit Managers were to ensure all interventions were in place upon a room change.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2697023.Based on interview and record review, the facility failed to 1) ensure the accuracy of medication orders for one (R4); and 2) administer medication according to Physician Orders for one (R4) of three reviewed.Findings include:Review of the medical record reflected R4 admitted to the facility on [DATE], with diagnoses that included rheumatoid arthritis, pain, diabetes, atrial fibrillation and fibromyalgia. The Medicare 5-day Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/15/25, reflected R4 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). According to the medical record, R4 discharged from the facility on 12/15/25. R4's December 2025 Medication Administration Record (MAR) reflected Alendronate Sodium 70 milligrams (mg) by mouth, once daily, every Sunday, for Osteoporosis was due to be administered on 12/14/25 at 6:00 AM. The medication was not documented as administered. Progress Notes did not reflect rationale for the medication not being administered, nor that the Physician had been notified. R4's December 2025 MAR reflected Arava (Leflunomide) 20 mg by mouth, in the morning, for inflammation was due on 12/12/25 at 8:00 AM and was not documented as administered. A correlating Progress Note for 12/12/25 at 8:34 AM reflected, n/a for Arava. There was no documentation that the Physician had been notified of the medication not being administered. R4's December 2025 MAR reflected an order for Liraglutide 18 mg per 3 milliliters (mL), inject 1.2 mg subcutaneously (under the skin) daily for diabetes at 8:00 AM. The medication was not documented as administered on 12/12/25 or 12/14/25. A correlating Progress Note for 12/12/25 at 1:34 PM reflected, n/a for Liraglutide. A correlating Progress Note for Liraglutide for 12/14/25 at 1:13 PM reflected, Not given due to wrong order. The Progress Notes did not reflect that the Physician had been notified of the medication not being administered.R4's December 2025 MAR reflected Cyclobenzaprine HCl (hydrochloride) 10 mg by mouth was to be administered three times daily for muscle spasm relief, at 8:00 AM, 2:00 PM and 8:00 PM. The medication was not documented as administered on 12/11/25 at 8:00 PM. A correlating Progress Note for 12/11/25 at 10:26 PM reflected the medication was on order. There was no documentation that the Physician had been notified of the medication not being administered.In a phone interview on 12/30/25 at 3:50 PM, Physician M reported the intended dosing for R4's Liraglutide should have started with 0.6 mg subcutaneously, daily, for one week. Then the dose should have increased to 1.2 mg subcutaneously, daily, for one week. The dose may have then increased to a maximum of 1.8 mg daily for diabetes management. In an interview on 1/6/26 at 11:58 AM, Director of Nursing (DON) B reported medications would not arrive from the pharmacy until the following day, if a resident admitted to the facility later at night. If medications were not available in the facility's backup supply, the pharmacy could drop ship the medication, if they were notified. If a medication was unavailable for administration, DON B reported the Physician should have been notified to determine if an alternate medication could be given or if there were any further instructions from the Physician. DON B reported the notification should have been documented in a Progress Note. According to DON B, Liraglutide was a pharmacy interchange for Ozempic.