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	12/20/2024

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

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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 0574 Level of Harm - Potential for minimal harm Residents Affected - Many	The resident has the right to receive notices in a format and a language he or she understands. 27446 Based on observation, interview, and record review the facility failed to ensure 11 of 12 residents in group knew what their resident rights were, where the posting of resident rights, the Ombudsman and State Agency contact information was located. Findings Included: During group meeting on 12/19/2024 at 11:03 AM, 11 of the 12 residents in attendance did not know who the Ombudsman was, or where the posting was located with the Ombudsman contact information. The 11 residents also did not know where the State agency contact information was located nor were the 11 residents aware that they had the right to put in a complaint with the State agency. 11 of the residents also stated they did not know what resident's right were, and were not ever told of them. On 12/20/2024 at 9:47 AM, the State agency, Ombudsman contact information, was observed to be located in a common area that led to the dining/activity room in a glass case on the wall. The poster for resident to file a complaint to the State agency was observed to have the incorrect department listed. In an interview on 12/20/2024 09:50 AM, Activities Director (AD) M stated she had been working as the (AD) for the past year. AD M stated she did attend resident council meetings monthly. AD M said she not inform or educate residents of their rights at council meetings. In an interview on 12/20/2024 at 10:20 AM, Administrator A observed the posters on the wall in the common area going into the dining/activity room, and was made aware residents did not know where to locate the poster on resident rights, did know who the Ombudsman was, and the contact information for the State agency. Administrator A was also made aware that residents were not being education during the resident council meets or otherwise of their resident.

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on observation, interview and record review, the facility failed to revise the Care Plan for one (Resident #33) of 18 reviewed. Findings include: Review of the medical record reflected Resident #33 (R33) admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included unspecified dementia, Alzheimer's Disease with early onset, major depressive disorder and anxiety disorder. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/8/24, reflected R33 scored three out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/19/24 at 11:22 AM, R33 was observed seated at a dining table, drinking a beverage. On 12/19/24 at 2:52 PM, R33 was observed lying in bed, with their eyes closed. Snacks and a beverage were observed on the over-bed table. A Psychiatric visit note for 10/16/24 reflected R33 had dementia with violent behaviors, which was not related to their terminal hospice diagnosis. According to the note, R33 had ongoing moderate dementia with psychotic and violent behaviors, including hitting staff. During an interview on 12/19/24 at 2:47 PM, Certified Nurse Aide (CNA) I reported R33 could be aggressive some days and displayed their aggression with facial expressions or pulling their hand back at staff. Interventions they attempted included talking with R33, sitting with R33 in their room for a short period of time and attempting snacks. CNAI reported sometimes providing one-on-one attention to R33 was effective. They reported sometimes it was best to walk away and leave R33 alone. During an interview on 12/19/24 at 3:24 PM, Social Worker (SW) J reported they had never personally observed R33 having behaviors, so they had to go by what staff was documenting. SW J reported they encouraged the use of non-pharmacological interventions before administering R33's PRN Xanax, which included sitting R33 down for an activity or sitting and interacting with R33. During an interview on 12/20/24 at 12:38 PM, CNA K reported R33's mood and behaviors depended on the day. Most times R33 was happy and laughed, but they did not like other residents getting in their face. R33's behaviors started with swearing or becoming quiet. CNA K reported interventions they attempted for R33 included music and lying R33 down. CNA K reported R33 had a harmonica that they enjoyed playing. CNA K reported the life story, contained in the shadow boxes near resident rooms, was a tool that could be used to identify interventions. CNA K stated the Care Plan could also be used. In an interview on 12/20/24 at 1:02 PM, Social Worker (SW) J reported determining which mood or behavioral interventions to Care Plan included asking staff what made R33 agitated, resident likes and dislikes and identifying triggers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's Care Plan was not reflective of behavioral triggers or interventions, including the use of music or their enjoyment of playing the harmonica, as mentioned by staff.

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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** 46954 Based on observation, interview, and record review the facility failed to ensure nephrostomy tube care was ordered and completed for one (Resident #47) of one residents reviewed for nephrostomy care. Findings include: Resident #47 (R47) Review of the medical record revealed Resident #47 (R47) was admitted to the facility on [DATE] with diagnoses that included tubulointerstitial nephritis (inflammation of the tubules of the kidneys), hydronephrosis with renal and ureteral calculus obstruction (kidney and ureter obstruction due to stones), and obstructive and reflux uropathy (urine unable to flow due to obstruction). R47 was unable to participate in an interview due to an intellectual disability. On 12/17/24 at 12:09 PM, R47 was observed in bed, peering around the room. R47 was not conversant. A nephrostomy bag was observed on the left side of R47, laying flat on the mattress at the left elbow level of R47. Urine was observed in the bag and in the entire length of the nephrostomy bag tubing. Review of the electronic medical record revealed R47 admitted to the facility with bilateral nephrostomy tubes (tubes inserted into the kidney to drain urine). On 12/18/24 at 11:36 AM, R47 was observed in bed. The left nephrostomy bag was visible and was observed laying on the mattress at the waist level of R47. On 12/18/24 at 1:52 PM, R47 was observed in bed. The left nephrostomy bag was observed laying on the bed resting at the elbow length of R47. Review of a Progress Note dated 12/19/24 revealed R47 had been experiencing some redness at the nephrostomy tube site. On 12/20/24 at 10:10 AM, R47 was observed in bed. The left nephrostomy dressing was not secured to R47 and was observed laying on the bedsheet of R47's bed. The dressing was undated and appeared to be soiled with a greenish discharge. In an interview on 12/20/24 at 10:13 AM, Licensed Practical Nurse (LPN) F removed the gauze dressing from R47. The insertion site appeared red and was observed to have a light green discharge at the site. LPN F stated that the insertion site looked worse since the last time she worked (the day before) and stated that she was going to call the physician and notify him of the change. Review of the Physician Orders revealed an order which stated cleanse resident's nephrostomy tube incision sites with normal saline, pat dry. Apply drain sponge and secure with tape. The order was not initiated until 12/17/24, well past the initial admitted [DATE]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Treatment Administration Record (TAR) confirmed that the Physician order for cleaning the nephrostomy tube site was not initiated until 12/17/24. The same TAR revealed that the order for cleaning the nephrostomy tube site had not been signed out as completed on 12/17/24. In an interview on 12/20/24 at 10:35 AM, Director of Nursing B reported that the expectation for residents with nephrostomy tubes would be to ensure orders were in place at admission for the cleaning of the nephrostomy tube sites. After review of R47's electronic medical record, DON B agreed that the order had not been implemented until 12/17/24. Additionally, per the Cleveland Clinic, the nephrostomy bags must always be lower than the kidneys to ensure that the urine can drain correctly.

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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. 49103 Based on observation, interview and record review the facility failed to initiate intervention for the prevention of repeated falls at bedside for 1 resident (R38) of 3 residents reviewed for falls resulting in the potential for repeated falls at bedside. On 12/17/24 at 3:53 PM during observation and interview R38 pointed at her eye which appeared bruised extending around the entire eye. R38 responded, uh huh when asked if she had fallen. R38 was quite busy in her room, moving place to place independently in the wheelchair. A nurse on the unit said that R38 had recently fallen twice in one day. Review of the electronic medical record (EMR) revealed that R38's original admitted was 3/27/23 and recent admitted was 4/15/23. R38 had the following pertinent diagnoses: Dementia (a neurological condition affecting the brain which can cause loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), Aphasia (a language disorder affecting the ability to communicate), Transient Ischemic Attack and Cerebral Infarction (stroke symptoms causing lack of blood flow to the brain), Weakness and Lack of Coordination. Further review of the EMR revealed documentation entered by the Director of Nursing (DON) B dated 12/15/24 stating that R38 had a seizure on 12/14/24 and was sent to emergency room (ER) and received Ativan (a medication which produces sedation and hypnosis, relieves anxiety and muscle spasms, and reduce seizures.) The note further stated that R38 had 2 falls after return from ER, both appear to be from drowsiness from Ativan. New interventions implemented to keep wheelchair in room next to bed for self-transferring d/t (due to) refusal with assistance. Monitor frequently while Ativan wears off. On 12/19/24 at 9:30 AM R38 was observed sitting in wheelchair in front of the toilet in her room. The toilet was yellow with urine and several pieces of tissue. R38 turned her head slightly and smiled when spoken to and nodded yes when asked if she was doing well. The bathroom floor was noted to have a type of non-slip coating and non-skid tape strips were observed in front of R38's closet. There were no non-skid tape strips on the floor near the bed. On 12/19/24 at 9:45 AM during interview with Licensed Practical Nurse (LPN) Q R38's toileting schedule was asked about and LPN Q said staff checks R38 every two hours. She sometimes takes herself LPN Q said. When asked to clarify if R38 transfers independently LPN Q explained staff offers help frequently, but R38 does tend to transfer independently at times. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/19/24 at 1:18 PM during interview with the Minimum Data Set (MDS) Coordinator P who also is part of the Risk Management team the past history of R38's falls were reviewed. R38 had several past falls. MDS Coordinator P explained, We review risk management every morning; we look at care plans and incident reports and see what interventions were in place and we adjust as needed. We add new interventions. We evaluate the care and look at changes requiring updates. MDS Coordinator P also said that the nurse notifies responsible parties (family or guardian) of changes. The last care conference was 12/12/24 and a family member did attend by phone. MDS Coordinator P talked about R38's reluctance at times to accept help. We try to help her as much as she will allow. We also try and keep her door open also for visual checks as much as she will allow. The MDS Coordinator P also explained R38 prefers certain caregivers trusting them more and that that staff tries to assign her care accordingly. On 12/20/24 at 10:47 AM during interview with the DON B and MDS Coordinator P the flooring in front of the bed was discussed this being the site of R38's last two falls. I think skid strips is something we could use going forward, the MDS Coordinator P said, and DON B agreed it would be a good plan.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49103 Based on observation, interview and record review the facility failed to ensure water was available for 1 resident (R24) of 1 resident reviewed for hydration resulting in the potential for inadequate fluid intake. Findings Include: On 12/17/24 at 1:33 PM during observation and interview R24 was upright in bed and established strong eye contact and was able to participate in an interview. It was noted during observation that R24's water cup was on a bedside table positioned to the left side of the bed and up against the wall. This positioned the table and water to the left and behind her head and out of sight and reach. There was also a rolling type of bedside table near the bed, and within resident's reach, but no water cup on it. When asked if R24 enjoyed drinking water her response was, I love it. On 12/17/24 at 4:42 PM during observation and interview R24 smiled and said a few words. Her words were muffled as she spoke through a dry mouth. It was noted during observation that the water was in the same place as at 1:33 PM - still out of sight and reach. Review of the Electronic Medical Record (EMR) revealed that R24 was admitted [DATE] with pertinent diagnoses of Alzheimer's Disease and Dementia (Alzheimer's disease is the most common cause of dementia. Alzheimer's disease is the biological process that begins with the appearance of a buildup of proteins in the form of amyloid plaques and neurofibrillary tangles in the brain. This causes brain cells to die over time and the brain to shrink.) . The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 5/2/24 revealed R24 scored 3 out of 15 indicating cognitive impairment on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/18/24 at 2:00 PM R24 was observed in the dining area working on a painting exercise. R24 was smiling and said (when asked) said that lunch had been good. A nearby staff member said R24 had eaten well. On 12/19/24 at 10:05 AM during observation of R24's room it was noted that there was a water cup was on the bedside stand with a bottle of water next to it. Next to the bed was the rolling type of bedside table, but no water cup on it. On 12/19/24 at 10:15 AM during interview with Certified Nurse Assistant (CNA) N the tables and position of water was observed, CNA N explained that when residents are not in their rooms water cups are kept out of sight of other residents coming down the hallway due to the tendency confused residents have of entering a room and helping themselves to water. CNA N said when a resident is in the room the water is placed directly next to the bed within easy reach and acknowledged that is where the water should be when a resident is in the room. When asked if a resident could reach the water if it was positioned on the stand as it was when we entered the room CNA N said it would not be within reach in that case. On 12/19/24 at 10:29 AM Certified Nurse Assistant (CNA) O and CNA N were interviewed and said R24 eats about 50 to 75 percent at meals and she drinks everything. She drank a full cup of water at breakfast today and juice. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/20/24 at 10:47 AM interview was held with the Director of Nursing (DON) B and Minimum Data Set (MDS) Coordinator P. In response to questions about the availability of fluids the DON B stated, Water should be within reach for the resident. I can't argue that. An article published by the National Library of Medicine titled Hydration Status in Older Adults: Current Knowledge and Future Challenges states in part, Adequate hydration is essential for the maintenance of health and physiological functions in humans. However, many older adults do not maintain adequate hydration, which is under-recognized and poorly managed. Older adults are more vulnerable to dehydration, especially those living with multiple chronic diseases.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38383 Based on observation, interview and record review, the facility failed to ensure communication with the dialysis center, pertaining to a fluid restriction, for one (Resident #42) of one reviewed. Findings include: Review of the medical record reflected Resident #42 (R42) admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included dependence on renal dialysis. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/4/24, reflected R42 scored 12 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/18/24 at 2:51 PM, R42 was observed in bed and reported having had a dialysis treatment that day. R42 was observed to be drinking from a bottle of Coca Cola. On 12/20/24 at 11:55 AM, R42 was observed asleep, in bed. A 20 ounce bottle of Sprite and a 16 ounce styrofoam beverage cup, with a straw, were observed on R42's over-bed table. Review of R42's medical record reflected a fluid restriction of 1500 milliliters (mL) per day was in place from 11/1/24 to 11/10/24. According to the medical record, R42 was hospitalized from 11/8/24 to 11/13/24. A fluid restriction was not ordered upon readmission from the hospital on 11/13/24. During an interview on 12/18/24 at 2:40 PM, Licensed Practical Nurse (LPN) F reported R42 was on a renal diet and had been on a fluid restriction previously, but it may have been discontinued. According to LPN F, R42 was supposed to receive dialysis on Tuesday's, Thursday's and Saturday's, but the days sometimes changed due to R42's refusals to go to dialysis. A Nurse Practitioner Progress Note for 11/14/24 reflected R42 was sent from dialysis to the emergency room (ER), the week prior, for prolonged bleeding from their dialysis access site. According to the note, R42 was also diagnosed with dyspnea (shortness of breath) secondary to fluid overload (too much fluid volume in the body)/pulmonary edema (buildup of fluid in the lungs). In an interview on 12/19/24 at 3:44 PM, LPN G reported R42 had a fluid restriction prior to their hospitalization but did not return from the hospital on a fluid restriction. LPN G reported they checked R42 referral form from the hospital, the admission notes, provider notes and dialysis communication forms and did not see mention of a fluid restriction. LPN G reported they were going to check with the dialysis center. On 12/20/24 at 10:17 AM, LPN G reported they had not learned anything more about R42's fluid restriction. R42 refused their dialysis appointment that day, according to LPN G. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/20/24 at 11:07 AM, Director of Nursing (DON) B reported it was discussed that R42 no longer needed a fluid restriction, but they could not recall why. DON B reported R42 was non-compliant with dialysis. During a phone interview on 12/20/24 at 11:23 AM, dialysis Registered Dietitian (RD) L reported R42 was still on a fluid restriction of 1500 mL per day. On 12/20/24 at 11:37 AM, DON B reported R42's dialysis communication forms were not reflective of them being on a fluid restriction, and the dialysis RD had not communicated that R42 needed to be on a fluid restriction.

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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 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview and record review, the facility 1) failed to ensure justification for an increase in psychotropic medications and 2) failed to attempt nonpharmacological interventions for two (Resident #9, Resident #33) of five reviewed for unnecessary medications. Findings include: Resident #9 (R9) Review of the medical record revealed Resident #9 (R9) was admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses that included vascular dementia, bipolar disorder, and depression. The annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 9/29/24, reflected R9 scored four out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/17/24 at 2:21 PM, R9 was observed in his room watching television. Review of a Psychiatric Visit note dated 5/13/24 recommended a gradual dose reduction (GDR) of R9's Trazodone. The GDR recommendation was to reduce R9's Trazodone 150 milligrams (mg) to Trazodone 100 mg. The GDR was successful. Review of a General Progress Note dated 5/29/2024 Spoke with (Nurse Practitioner) regarding (Psych) recommendation to GDR Trazodone to 100 mg . Provider and Guardian in agreement . Review of R9's Physician orders reflected an order initiated on 5/29/24 for Trazodone HCl Tablet 100 mg. The order was discontinued on 10/26/24 after R9 was transferred out to the hospital. Review of the Physician orders revealed an active order for Trazodone HCl Oral Tablet 150 mg initiated on 10/16/24, after R9's return from the hospital. Review of a General Progress note dated 10/16/2024 reflected Res. [resident] returned from Hosp. [hospital] all meds continued . Review of the hospital discharge summary revealed an order for Trazodone 150 mg but did not contain any justification for the dose increase. Review of the medical record revealed no justification for the dose increase of Trazodone. In an interview on 12/20/24 at 10:27 AM, Director of Nursing (DON) B stated that when R9 came back from the hospital his new order went back to Trazodone 150 mg. DON B stated that she isn't sure what his behaviors were like when he was out to the hospital and confirmed that R9 was only at the hospital for one day, however, no justification for the dose increase could be located. 38383 (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #33 (R33): Review of the medical record reflected R33 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included unspecified dementia, Alzheimer's Disease with early onset, major depressive disorder and anxiety disorder. The quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/8/24, reflected R33 scored three out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 12/19/24 at 11:22 AM, R33 was observed seated at a dining table, drinking a beverage. On 12/19/24 at 2:52 PM, R33 was observed lying in bed, with their eyes closed. Snacks and a beverage were observed on the over-bed table. R33's October 2024 Medication Administration Record (MAR) reflected one milligram (mg) of as needed (PRN) Xanax (medication used for anxiety) for anxiety and/or agitation was administered on 10/2/24 at 5:53 PM, 10/3/24 at 3:08 PM, 10/4/24 at 9:04 AM, 10/5/24 at 5:08 PM, 10/10/24 at 6:41 PM, 10/12/24 at 2:06 AM, 10/15/24 at 4:36 PM, 10/17/24 at 6:50 PM, 10/18/24 at 7:28 PM, 10/20/24 at 7:35 PM, 10/21/24 at 7:30 PM, 10/24/24 at 4:53 PM, 10/28/24 at 8:37 AM and 9:04 PM and 10/29/24 at 9:00 AM. Correlating Progress Notes reflected PRN Xanax was administered due to agitation, exit seeking, being confrontational with other residents, anger, anxiety and aggression towards staff. Progress Notes did not reflect that non-pharmacological interventions were attempted prior to PRN Xanax administration on 10/2/24, 10/3/24, 10/4/24, 10/5/24, 10/10/24, 10/12/24, 10/15/24, 10/17/24, 10/21/24, 10/24/24, 10/28/24 and 10/29/24. R33's November 2024 MAR reflected one mg of Xanax by mouth, every eight hours as needed for anxiety, for 14 days, was ordered on 11/28/24. A dose was administered on 11/28/24 at 9:02 AM. A correlating Progress Note reflected the dose was administered due to R33 being very anxious and agitated that morning. There was no documentation of non-pharmacological interventions being attempted prior to administration. R33's December 2024 MAR reflected a PRN dose of one mg Xanax was administered on 12/6/24 at 5:43 PM. There was no documentation reflective of the rationale for administration or any non-pharmacological interventions attempted prior to administration. A PRN dose of one mg Xanax was documented as being administered on 12/7/24 at 4:41 PM. A correlating Progress Note reflected the dose was administered for anxiety and agitation. There was no documentation of non-pharmacological interventions being attempted prior to administration of the dose. On 12/19/24, R33's behavior task documentation was not reflective of any documentation of behaviors, interventions or response to interventions for the prior 30 days. During an interview on 12/19/24 at 3:24 PM, Social Worker (SW) J reported they had never personally observed R33 having behaviors, so they had to go by what staff was documenting. SW J reported they encouraged the use of non-pharmacological interventions before administering R33's PRN Xanax, which included sitting R33 down for an activity or sitting and interacting with R33.

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	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springcreek Rehabilitation and Nursing Center	130 Sand Creek Hwy 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 46954 Based on observation, interview and record review, the facility failed to, 1) ensure appropriate storage of medications, including narcotics; and 2) ensure one medication cart was free of expired medications. Findings include: On 12/18/24 at 1:36 PM, several medications were observed at the nurse's station unattended and readily accessible to staff, ambulatory resident's, and visitors. The medications included fentanyl Transdermal Patch (opioid medication), Bumetanide (water pill) Oral Tablet 2 milligrams (MG), Sinemet (Parkinson medication) Oral Tablet 25-100 MG, Carvedilol (used to treat high blood pressure) Oral Tablet 25 MG, Gabapentin (treatment for nerve pain and/or seizures) Oral Capsule 100 MG, Potassium Chloride Oral Tablet Extended Release, Spironolactone (treatment of high blood pressure/water pill) Oral Tablet 25 MG, Levothyroxine (thyroid hormone) Sodium Oral Tablet, and Omeprazole (treatment of acid reflux) Oral Tablet Delayed Release 20 MG. On 12/18/24 at 1:45 PM, Nursing Home Administrator A identified the unattended medication and removed the medication from the nurses station. NHA A stated that the medication should be locked up. 38383 During an observation of the A hall odd medication cart, with Licensed Practical Nurse (LPN) F, on 12/20/24 at 10:25 AM, a 100 unit per milliliter (u/mL) bottle of Lantus (long-acting insulin), belonging to Resident #25, was observed to have an open date of 10/12/24. LPN F reported Lantus was good for 28 days after being opened. During the same observation, a bottle of Latanoprost 0.005 percent eye drops, belonging to Resident #1, was observed to have an open date of 10/18/24. LPN F was unsure how long the drops were good for once opened. In an interview on 12/20/24 at 11:07 AM, Director of Nursing (DON) B reported medication carts were reviewed at least monthly and as needed for outdated medications. DON B reported Lantus was good for 28 days after being removed from the refrigerator. DON B reported they believed Latanoprost was good for 30 days after being removed from the refrigerator. According to pharmacy lists of medications with shortened expiration dates, provided by the facility, Latanoprost was good for six weeks (42) days after being opened or moving to room temperature. Lantus was good for 28 days.

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	12/20/2024

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

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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 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46954 Based on observation, interview, and record review the facility failed to coordinate hospice services for one resident (#56) out of one resident reviewed for coordination of hospice services. Findings Included: Resident #56 (R56) Review of the medical record revealed Resident #56 (R56) was admitted to the facility on [DATE] with diagnoses that included senile degeneration of brain. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/1/24, reflected R56 scored three out of 15 (severe cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). The same MDS revealed that R56 was utilizing hospice services. On 12/18/24 at 12:23 PM, R56's Hospice Communication binder was reviewed. R56's Hospice Care Plan was not located in the binder. On 12/18/24 at 1:14 PM, the electronic medical record was reviewed which revealed a hospice care plan dated October 2023. No current care plan could be located. On 12/20/24 10:17 AM, Director of Nursing (DON) B was asked to locate the Hospice Care plan in R56's hospice binder and electronic medical record but was unable to locate a current care plan. DON B stated that the care plan is used to coordinate care and services and should be located in the hospice binder and/or uploaded in the electronic medical record.