STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235520	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Springs Skilled Nursing and Rehab	700 Stewart Rd 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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3018035. Based on interview and record review the facility failed to notify the physician of missing medications for one (R506) of four residents reviewed for medication administration resulting in the physician being unaware that R506 missed two consecutive medication doses for a respiratory inhaler and an antibiotic. Findings include: The State Agency received a complaint that R506 missed several doses of medications.According to the Electronic Health Record (EHR) R506 admitted to the facility on [DATE]. The admission orders dated 4/8/26 for medication included the following: 1) Advair Diskus Aerosol Powder Breath Activated 250-50 MCG/DOSE (respiratory inhaler)one (1) inhalation orally every 12 hours for copd (chromic obstructive pulmonary disease). 2) Cefadroxil Oral Capsule 500 MG (antibiotic) Give 1 capsule by mouth two times a day.A progress note on 4/8/26 at 6:40 PM indicated R506's Advair Diskus was not available.Review of R506's April 2026 Medication Administration Record (MAR) revealed R506's Advair Diskus and Cefadroxil were not administered on 4/8/26 at the 9:00 PM dose or on 4/9/26 at the 9:00 AM dose. There is no additional documentation to support the physician was notified.R506 did not reside in the facility during the time of the survey.During interview on 6/24/26 at 12:31 PM, Licensed Practical Nurse (LPN) C was asked about R505's missing medications and stated, I think there was a delay in the pharmacy delivering their medications. I can't really recall. But we are supposed to notify the doctor if two consecutive doses are missed.On 6/24/26 at 2:00 PM during an interview with the Director of Nursing (DON), R506's EHR was reviewed. The DON acknowledged that two consecutive doses of the Advair and Cefadroxil were not administered to R506 and there is no documentation to support the physician was notified. A request for the facility's Medication Administration policy was made.According to the facility's policy for Medication Administration updated on 12/19/2019 read in part: It is the policy of this facility that medications shall be administered as prescribed by the attending physician.2. Medications must be administered in accordance with the written orders of the ordering/prescribing physician.12. Should a drug be withheld, refused or given other than the scheduled time, the nurse must enter an explanatory note. NOTE: The Director of Nursing and the attending Physician must be notified when two (2) doses of a medication are refused or withheld.

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
	235520	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Springs Skilled Nursing and Rehab	700 Stewart Rd 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. This citation pertains to intake 3037808. Based on interview and record review the facility failed to report an injury of unknown origin for one (R507) of four residents reviewed for abuse. Findings include:According to R507's the Electronic Health Record (EHR) R507 admitted to the facility in 2019 with multiple diagnoses that included Multiple Sclerosis, severe malnutrition, and dementia. The Minimum Data Set (MDS) indicated R507 had moderately impaired cognition and was totally dependent on staff for bed mobility and transfers from surface-to-surface. A progress note dated 6/18/26 at 8:39 AM indicated R507 complained of left knee pain. The physician was notified, pain medication was administered, and an X-ray ordered. The X-ray radiology report dated 6/18/26 indicated R507 had a slight comminuted fracture of the proximal left femur (comminuted fracture is when a bone splits or shatters into more than 3 pieces, usually caused by high impact trauma). R507 was transported to the emergency room for further evaluation and treatment. R507 was not present in the facility during the time of the on-site survey.On 6/24/26 at 12:05 PM the Nursing Home Administrator (NHA) was interviewed regarding R507's left leg fracture and stated, The resident had a fall from a mechanical lift on 5/29/26. The resident had never complained of leg pain until 6/18/26 which was about 3 weeks after the fall. We did not think that the fracture was caused by the fall. Since we didn't know what happened we started an investigation. I talked with the resident about how this could have happened. The resident denied that staff had hurt them or was abusive towards them. The NHA went on to say a full investigation was conducted and it could not be determined exactly when or how the resident sustained the left femur fracture. When asked if the injury of unknown origin was reported to the State Agency the NHA said, No, I didn't think it was abuse nor was there any allegation of abuse, so I didn't report it. I guess I should have. A request for the facility's abuse policy was requested.According to the facility's policy on Abuse and Neglect last updated on 6/28/2025 in part read;V. Investigation: Investigate all allegation of abuse, neglect, misappropriation of property and incident such as injuries of unknown source.VII. Reporting: All allegations and/or suspicions of abuse/neglect must be immediately reported to the facility Administration or designees in the absence of the administrator.Preliminary Investigation Report: The abuse coordinator must submit a preliminary investigation report to the appropriate State Agencies immediately once assurances for the resident's safety have been established. However, if the event that caused the allegation involved abuse or resulted in serious bodily injury, the allegation of abuse must be reported to appropriate state agencies immediately and not later than 2 hours after receiving the allegation of abuse or not later than 24 hours if the event that caused the allegation did not involve abuse and did not result in serious bodily injury.Final Investigation Report: The abuse coordinator must submit a final investigation report to the appropriate State Agency within five (5) working days of the allegation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235520	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Springs Skilled Nursing and Rehab	700 Stewart Rd 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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3018035.Based on observation, interview, and record review, the facility failed to make an ophthalmology appointment as ordered by the physician for one (R505) of three residents reviewed for the coordination of outside physician appointments resulting in the delay of ophthalmology services for R505.Findings include:On 6/23/26 at 3:40 PM, R505 was observed lying in bed with the TV on. During interview R505 reported that the facility had not scheduled an appointment for their cataract extraction. R505 said, The doctor said I would be able to see better if I got my cataracts removed. I was all set up to go and then something happened. I never went to the eye doctor again. I keep asking about it and no one can tell me anything. I want to know why I haven't got my cataracts out yet.Review of R505's Electronic Health Record (EHR) revealed R505 re-admitted to the facility on [DATE] with multiple diagnosis that included peripheral vascular disease and legal blindness. An Optometry Order Form dated 12/9/25 read as follows: patient has been scheduled at [Named Eye Center] for bilateral cataract extraction. Please reschedule it when possible. There is no further documentation to support the appointment was made for R505 to have their cataracts extracted.On 6/23/26 at 3:55 PM during an interview with Social Worker (SW) N they said, We tried to set up an appointment, but we couldn't contact the family to assist with transport. I don't know what happened after that. We should have attempted to reschedule this appointment. I can't see we did that.On 6/24/26 at 1:00 PM the Director of Nursing (DON) reviewed R505's EHR and confirmed that R505 was ordered to have cataract extraction on 12/9/2025 and the appointment had not been made as of this time. The DON said, I'm not sure why we did not proceed with scheduling that. We will be scheduling that appointment as soon as possible.On 6/24/26 at 1:00 PM the Nursing Home Administrator (NHA) said R505 should have had the ophthalmology appointment made for cataract extraction and could not explain why it was not done. A request for the facility's policy for scheduling and transporting residents to an outside physician appointment was requested.According to the facility's policy for ?Resident Transport and Escort Services' last updated on 6/27/2024 read in part: It is the policy of this facility to establish a process to ensure that all employees are capable and able to participate in the care of residents during transport. To promote the safety of our residents/employees during escort to appointments in a facility or a contracted vehicle.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235520	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Springs Skilled Nursing and Rehab	700 Stewart Rd 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 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** This citation pertains to intake 3037808.Based on interview and record review the facility failed to provide adequate supervision from two staff members during a transfer with a mechanical lift for one (R507) of five residents reviewed for accident hazards/safety resulting in R507 falling off the lift during transfer, hitting their head, and requiring five staples for wound closure.Findings include:The State Agency (SA) received a complaint that R507 fell from a mechanical lift and sustained injuries.According to the Electronic Health Record (EHR) R507 admitted to the facility in 2019 with multiple diagnoses that included Multiple Sclerosis, severe malnutrition, and dementia. The Minimum Data Set (MDS) indicated R507 had intact cognition and was totally dependent on staff for bed mobility and transfers from surface-to-surface. A care plan for Activities of Daily Living (ADL) initiated on 3/29/26 and the Kardex (a reference guide that summarizes the resident's care plan and daily needs), indicated that R507 required the use of a mechanical lift and two staff persons for transfers. A progress note dated 5/29/26 at 3:30 PM indicated R507 fell out of the mechanical lift onto the floor and hit their head. The resident was transferred to the hospital for evaluation and returned at 8:00 PM with five staples to close the head wound.A review of the post fall assessment dated [DATE] completed by Licensed Practical Nurse (LPN) M documented that resident fell from the lift during transfer from only one staff member.R507 was not present in the facility during the time of the survey and therefore could not be interviewed.During an interview on 6/24/26 at 1:13 PM LPN M said that CNA E had transferred the resident using a mechanical lift by their self. The mechanical lift's sling slipped off one of the hooks and the resident (R507) slid off the sling onto the floor headfirst. LPN M said the resident had a small laceration on the top of their head and no other visible injuries. The resident's only pain was their head. The area was assessed and first aid was provided to the laceration on the top of the head. The resident returned to the facility a couple hours later with five staples to the area and no additional treatments were ordered. During an interview on 6/24/26 at 2:20 PM with Certified Nurse Assistant (CNA) E they said they performed the transfer for R507 with the mechanical lift by themselves without asking for assistance. CNA E acknowledged that they were aware R507 required two persons for transferring with a mechanical lift. CNA E reported that they were re-educated on the facility's policy and then observed afterwards. CNA E stated, They made sure I was doing it correctly. I?ll never do that again. I'll definitely go and get someone else to help with transfers when using the lift.On 6/25/26 at 12:05 PM during an interview with the Nursing Home Administrator (NHA) they acknowledged R507 had been transferred with only one staff member and the facility's policy is to always use two staff members during transfers with a mechanical lift. The NHA said that re-education on proper mechanical lift transfers had been given to all nursing staff as of 6/5/26. Weekly audits had been conducted and will continue for one month to ensure compliance. At this time sign-in sheets for the re-educations were provided and reviewed. The sign-in sheets revealed all nursing staff had received the re-educations by 6/5/26. The NHA said safety with transfers was were included in the facility's Quality Assurance meetings. A review of the facility's investigation, subsequent actions, and Quality Assurance meetings on 5/29/26 and 6/5/26 were conducted. During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:-Mechanical lifts inspected 5/29/26 via maintenance and no issues noted.-Education was completed with all nursing staff regarding the policy and procedure for mechanical lifts. Completed on 6/5/26.-Resident reassessed to ensure appropriate sling size via nursing and rehab.-Random Audits/validation will be conducted on all shifts to ensure residents requiring the use of the mechanical lift are being transferred correctly. Audits will be conducted weekly for 4 weeks and extended for 1 month.-Audits of slings to ensure appropriate size as well as checking integrity of sling is on-going and will be extended for 1 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235520	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Springs Skilled Nursing and Rehab	700 Stewart Rd 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 0689 Level of Harm - Actual harm Residents Affected - Few	month.-Nurse assistants will complete Clinical Competency training on mechanical lifts. -Nursing assistant involved with incident was provided immediate education, completed clinical competency validation (mechanical lift) and was suspended during investigation.-Nurse assistant involved with incident returned on 6/3/26.-Findings will be reported and tracked in QAPI for review, recommendations, and ensure continued compliance.The facility was able to demonstrate monitoring of the corrective action and maintained compliance.