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	12/03/2025

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to properly date-label stored food and remove expired food in resident refrigerators affecting all the residents who consumed food from the unit refrigerators resulting in unidentifiable resident food items, expired food items, and the potential for food-borne illness.Findings include:On 12/02/2025 at 10:30 AM unit refrigerators were observed with the Dietary Supervisor (DS) A. The following were noted:2nd floor unit fridge-Expired fruit, unlabeled.-A chocolate cake unlabeled.-A half loaf of expired bread.3rd Floor unit fridge-A container of unlabeled, undated spinach dip.-An expired cake unlabeled.-A container of a leftover meal undated, unlabeled.On 12/2/2025 at 10:40 AM DS A was interviewed and said dietary staff were responsible to maintain the unit refrigerators. DS A further said all staff were aware that resident food items need to be labelled and dated to decrease the risk for food borne illness.On 12/03/2025 at 11:14 AM the Director of Nursing (DON) was interviewed regarding the kitchenette refrigerators and said the expectation is for resident food to be labelled and dated and expired food to be thrown out to limit risk of foodborne illness.Review of the facility policy titled Food Brought by Family/Visitors reviewed 7/31/2023 revealed in part .Perishable foods must be stored in a re-sealable container with tightly fitting lids in the refrigerator. Containers will be labeled with the resident's name, the item and the use by date. The nursing staff is responsible for discarding perishable foods on or before the use by date. The nursing and/or food service staff must discard any food prepared for the residents that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates).

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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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent the misappropriation of one resident's (R22) property from four residents reviewed for abuse resulting in 26 tablets of R22's narcotic pain medication (oxycodone 10-325 milligram (mg)) missing and unaccounted for.Findings include:On 3/11/2025 the State Agency (SA) received a Facility Reported Incident (FRI)indicating R22 had missing narcotic pain medications.According to the facility's investigation report, 26 tablets of R22's Oxycodone 10-325 mg could not be accounted for during the 3/11/25 A.M. shift change narcotic count. It was determined that the discrepancy began on 3/10/25 with Registered Nurse (RN) E. The facility terminated RN E and reported their license to the State Licensing Board and local police. R22 was interviewed and reported receiving pain medications as requested. The facility replaced R22's missing medications.On 12/1/25 at 3:03 PM, R22 was interviewed regarding the FRI and said, I knew my meds were missing after they told me. I was still getting my pain meds so I really don't know what happened. R22 had no concerns at this time.According to R22's Electronic Health Record, the resident admitted to the facility on [DATE] with multiple diagnoses that included history of cellulitis and left leg above the knee amputation. R22 had intact cognition and was their own responsible party. A review of the resident's Mediation Administration Record revealed R22 was receiving her medications as prescribed by the physician.During the medication administration and storage tasks on 12/2/25 all narcotics were correctly reconciled and accounted for. No deficient practices were identified with regard to medications. On 12/3/25 at 2:15 PM during interview the Director of Nursing (DON) said, This was an isolated incident. We had no other medication discrepancy. We reviewed the policy and process for reconciling narcotics and did in-services for all licensed staff that passed meds. Audits for two months concluded we had no further issues.During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included narcotic count with determination of no further discrepancy of narcotic medications, re-education of all licensed staff on narcotic reconciliation, and audits of the narcotic reconciliations for two months to ensure continued compliance. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review the facility failed to provide appropriate PEG tube care (a tube placed directly into the stomach through an abdominal wall incision for the administration of food, fluids, and medication) for one (R47) resident reviewed for tube feeding resulting in a compromised PEG tube with no cap, difficulty administering medications, and the potential for infection.Findings include: On 12/02/2025 at 9:33 AM, during observation of medication administration for R47, the resident's PEG tube was compromised and missing the attached cap. The PEG tube was clamped with a plastic clamp but not completely or securely capped off. The opening of the tube was covered with white tape. The white tape was soaked with beige colored liquid that was the same color and consistency of the resident's tube feeding formula. The tape easily slid off the port when LPN B touched it. The PEG tube was visibly worn with crushed medications observed inside the tube. Closer inspection revealed that the PEG tube port could not be securely connected to the feeding tube. The tube feeding connector port also had white tape on it that was covered with beige liquid.At this time Licensed Practical Nurse (LPN) B said, Oh, that's not supposed to be like that. The cap is broken off. That needs to be replaced. It's ill-fitting and not secure. We have new connectors in central supply. I will change it out. LPN B retrieved a ?Y' port connector and attempted to connect it to R47's PEG tube. The connector did not fit securely into the PEG tube. LPN B said, It's still not secure. I will notify the nurse practitioner. LPN B administered R47's medication through the PEG. The medication and water flush was very slow and took several minutes for administration. Some of the water flush leaked back out of the PEG tube, not through it. LPN B said, This whole tube needs to be replaced. You can see the medications stuck inside the PEG tube and it's difficult to give the meds through it. R47's Electronic Health Record (EHR) indicated the resident admitted to the facility with a PEG tube and diagnoses of Stroke and dysphagia (difficulty swallowing). A physician's order dated 5/29/25 reads as follows: cleanse peg tube site with Normal Saline pat dry and apply drain sponge. if there are any concerns with placement, notify medical provider immediately.A care plan for tube feeding initiated on 5/29/25 included the following intervention: provide care to feeding tube site as ordered and monitor for signs/symptoms of infection.A review of R47's progress notes from 11/1/2025 through 12/1/205 did not reveal any documentation regarding the resident's PEG tube. On 12/2/25 at 10:00 AM a progress note written by LPN B reads as follows: Writer in to administer medications this am and noted integrity of peg tube impaired and cap broken off and no longer present. (Named Guardian) contacted regarding this issue, family notified. Order obtained to send to [hospital] for peg tube replacement.On 12/3/25 at 11:30 AM the Director of Nursing (DON) said they were aware of R47's compromised PEG tube on 12/1/25. The DON said, There was a note written in the Nurse Practitioner (NP)/Doctor's log on 12/1/25 that the resident's (R47) PEG tube was compromised but there was no progress notes or documentation in the resident's chart. I don't know why there wasn't a follow-up. The resident was sent out to the hospital for the PEG tube replacement.