

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2025
NAME OF PROVIDER OR SUPPLIER Evergreen Manor Senior Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 111 Evergreen Battle Creek, MI 49015	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>(continued on next page)</p>

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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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2648236. Based on observation, interview, and record review, the facility failed to provide adequate post-surgical wound care for one (R201) of one resident reviewed. Review of the clinical record revealed R201 was admitted into the facility on 9/25/25 with diagnoses that included: encounter for surgical aftercare following surgery on the nervous system, depression, anxiety, and difficulty walking. According to the Minimum Data Set (MDS) assessment dated [DATE], R201 required substantial/maximal assistance for shower/bathing and scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). A review of R201's After Visit Summary (instructions provided to resident at discharge from the hospital) dated 9/25/25 revealed resident underwent spinal surgery. The incision care instructions documented in part Shower every day, when showering, use a mild soap and let warm soapy water wash over the incision. If unable to shower daily, wash the incision gently with a mild soap and water twice a day. Pat dry with a clean towel. A review of physicians orders for R201 revealed the following: 9/26/25 Monitor Staples to Spine Q-Shift, every shift for surgical care related to encounter for surgical aftercare following surgery on the nervous system. Monitor for Dehiscence, Drainage, increased redness, intractable pain report to MD and (neurosurgeon name and phone number redacted). 10/3/25 Nrsng (nursing)>> keep incision clean and dry>> apply dry gauze drsg (dressing) BID (twice daily) and as needed, Wound nurse to follow, Enc (encourage) pt (patient) to lay on right or left side>> Avoid lying on back, two times a day for skin infection A review of the treatment Administration Record revealed the order dated 10/3/25, to keep the incision clean and dry, wound nurse to follow and to encourage resident to lay on her right or left side twice a day for skin infection was not documented as being completed until 10/14/25. No documentation was found that the wound was routinely being kept clean and dry from her admission on [DATE] through 10/14/25. A review of R201's progress notes revealed the following: 9/25/25 6pm Resident arrived from (hospital name redacted) via stretcher. Dx (diagnosis): L1-L5 surgery (surgery on lower back) r/t Foraminal stenosis of Lumber Region-with staples-intact. Skin remarkable with surgical incision to back. 10/2/25 10:56pm .She requires help toileting and performing hygienic care. Her incision has reddening and is painful to touch, shows no discharge and is odorless, she has a follow-up appointment with Neuro tomorrow 10/3. Symptoms reported to (Nurse practitioner name redacted). 10/3/25 3:58am (Nurse practitioner name redacted) in to see resident, new order received for Augmentin 500mg/125mg BID x10 days. Wound/surgical site dressing orders 10/3/25 2:34pm Returned from outpatient consultation today. Started on ABX (antibiotic), pt is aware. Called physician to clarify what abx they would like to start as two medication orders prescribed. Awaiting clarification. 10/3/25 11:05pm (R201) had a offsite appointment this morning to remove staples. Staples were left intact. Surgeon suspects a probable infection. Was started on ABX. This RN assessed the wound: all staples intact, redness around staples, no drainage Applied one Aquacel dressing to cover staples. 10/4/25 10:16pm .She requires help toileting and performing hygienic care. Her incision appears less red than last time this nurse assessed area and is still painful to touch but less sensitive, shows small amount of discharge and is malodorous. 10/9/25 3:10pm Wound had moderate amount of sanguineous drainage, concerns of dehiscence staples remain intact. Wound cleansed and dressing reapplied. 10/16/25 10:28am Labs reviewed with (physician's name redacted). Wants nurse to contact (Neurosurgery name redacted) for increased pain tenderness to surgical site on her back. Resident up in w/c (wheelchair) this AM to therapy. Incision site tender and painful to touch. Staples intact. 10/17/25 5:28pm Resident out to Neuroscience consult for purulent drainage to Laminectomy Site. Resident recently completed oral ATB therapy, but Purulent drainage persists with increased tenderness to site. Staples intact. 10/17/25 11:23pm In the hospital. Review of Outpatient consultation Record dated 10/3/25 revealed R201 was seen by an outside provider. Consultation report read as follows: Wound appears angry-possible infection Keflex 500mg QID (four times per day) Keep incision clean and dry-dress as needed Next appt one week A review of R201's shower task log revealed bed baths were provided on 10/6, 10/9, 10/13 and 10/16. Two paper shower sheets were provided, which revealed on 9/19 resident was provided a shower and on 10/2 resident refused a shower and was provided a bed bath. On 12/16/25 at 11:21 AM during an interview with Wound Nurse A, it was reported that post-surgical wound care instructions usually come from the hospital discharge orders. Wound Nurse A confirmed the records from the hospital indicated R201's incision site should have been cleaned daily. Wound Nurse A confirmed there was an order dated 10/3 for Wound nurse to follow R201's incision. It was</p>		