STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235184	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Nursing and Rehabilitation	3011 North Center Road Flint, MI 48506

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number 2709347. Based on interview and record review, the facility failed to implement and operationalize policies and procedures for advance care planning for three residents (#701, #704, and #706) of three residents reviewed, resulting in the lack of timely determination of decision-making capacity and arranging appropriate and legal representation for Resident #701 and Resident #706 and the lack of current guardianship documentation for Resident #704.Findings include:Review of intake documentation revealed a concern that Resident #701 is a vulnerable adult who requires total care. Per the intake, Resident #701 was transferred and admitted to the hospital due to an infection from a pressure ulcer (wound caused by pressure) and was in serious condition. The intake specified the Resident had been at the facility for several months and indicated they had been and were currently unable to make their own medical decisions and did not have guardian or POA (Power of Attorney). Resident #701:Record review revealed Resident #701 was admitted to the facility on [DATE] with diagnoses which included dementia, psychosis, and anxiety. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was rarely/never understood and was dependent upon staff for all Activities of Daily Living (ADLs) with the exception of supervision for eating. Resident #701's Electronic Medical Record (EMR) revealed the Resident was discharged to the hospital on [DATE] and did not return to the facility. A review of Resident #701's face sheet revealed the Resident was their own responsible party. Their granddaughter (Witness G) was listed as their first emergency contact followed by their two daughters. Review of Hospital documentation dated 8/16/25 to 8/22/25 revealed Resident #701 presented to the emergency room due to altered mental status and was found to have had a heart attack. The hospital documentation detailed Resident #701 was a poor historian, confused, and alert to self only throughout their hospitalization. Review of Resident #701's EMR revealed the Resident was confused and primarily alert to themself throughout their stay at the facility. Documentation from August and September 2025 revealed the Resident also displayed verbal and physical behaviors towards staff. On 12/5/25, a new stage three (full thickness tissue loss) pressure ulcer (wound caused by pressure) was identified on the Resident's coccyx. A detailed review of Resident #701's EMR documentation revealed the following: - 8/25/25 at 10:31 AM: Social Services. spoke to resident concerning advanced directives and reported no wishes to issue any further advanced directives at this time. Resident remains own person. - 8/25/25 at 10:36 PM: Nursing/Clinical. Resident has been agitated first half of this shift. was grabbing staff's arms and would squeezed tight and would not let go and tried to hit staff. - 8/26/25 at 8:47 AM: Care Conference Note. Resident lives with daughter and granddaughter and both were present. (Witness G) reported she is (Resident's) care giver. The patient is their own decision maker. Patient is not exhibiting behavioral symptoms. - 8/26/25 at 1:05 PM: Nursing/Clinical. Resident attempts to climb out of bed and chair numerous. has become aggressive with staff (continued on next page)

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: 235184	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/15/2026
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	while trying to redirect. - 8/26/25 at 11:27 PM: Physician/Practitioner Progress Note. Review of Systems (ROS): Unable to complete fully due to underlying dementia. - 8/27/25 at 2:44 AM: Nursing/Clinical. Resident is confused during conversation. Resident is laying in reclining chair in hallway. - 8/27/25 at 10:40 AM: Skilled Note. alert and oriented to person (only). - 8/27/25: Psychiatric Evaluation & Consultation. interview was complicated by advanced dementia, leaving them mostly noninteractive and unable to meaningfully participate in the evaluation. An independent history was obtained from the unit nurse, who reported that (Resident#701) is very demented and minimally engaged in their environment. - 8/29/25 at 8:45 AM: Activities Note. Resident is alert and oriented to self with and cognitive impairment. - 8/28/25 at 1:45 PM: Social Services. Resident has been displaying the following behaviors-physical aggression such as hitting, grabbing and throwing food at staff. becomes very agitated and anxious in the evenings and expresses anger without reason towards staff. - 9/2/25 at 9:02 AM: Nursing/Clinical. alert and oriented x 0. unable to verbalize needs. does not follow directions. cannot retain education. - 9/3/25: Psychiatric Evaluation & Consultation. minimally interactive, only able to answer some questions with limited responses. The interview was complicated by advanced dementia, requiring reliance on collateral history from staff and social work. - 9/5/25 at 11:32 AM: Social Services. Resident has been displaying the following behaviors-physical aggression such as hitting, kicking, pushing and attempting to scratch staff. becomes very agitated and anxious in the evenings and expresses anger without reason towards staff. - 9/5/25 at 4:17 PM: Physician/Practitioner Progress Note. Review of Systems (ROS): Unable to complete fully due to underlying dementia. Neuro: Alert, at baseline dementia. - 9/24/25 at 5:48 PM: Social Services. Writer called resident's daughter and presented NOMNC (Notification of Medicare Non-Coverage) . to be mailed to resident's daughter. - 9/26/25 at 9:41 AM: Nursing/Clinical. (Resident #701) is mostly non- verbal with advanced dementia. does not retain education, does not verbalize needs. - 10/1/25: Psychiatric Evaluation & Consultation. The interview was complicated by advanced dementia and limited verbal communication. An independent history was obtained from the unit social worker and nursing staff. spends more time seated in chair and appears calm. They note that (Resident #701) is being prepared for transfer to a memory care facility, and the transition process is underway. - 10/17/25 at 11:13 AM: Skilled Note. alert and oriented to person. - 11/5/25: Psychiatric Evaluation & Consultation. interview was limited due to dementia-related cognitive decline. - 12/3/25: Psychiatric Evaluation & Consultation. interview was significantly limited by severe dementia. Independence with history was impaired, and independent history was obtained from nursing staff and the social worker. alert and oriented to self only. Eye contact was intermittent. Speech was sparse, soft, and concrete. Thought processes were concrete and significantly restricted by dementia. cognition were severely impaired and consistent with baseline dementia. presentation is consistent with advanced dementia, with profound cognitive impairment and limited capacity for engagement. - 12/5/25 at 2:56 PM: Nursing/Clinical. highly cognitively impaired and is unable to make needs known. - 12/5/25 at 8:56 PM: Physician/Practitioner Progress Note. pt (patient) cognitively impaired. Pt unable to make decisions. will need guardianship. sacral wound examined. - 12/7/25 at 1:11 PM: Nursing/Clinical.Resident was alert. does not make needs known. - 12/15/25 at 4:03 PM: Nursing/Clinical. this nurse spoke with (Witness G) regarding, patient's decline and advised her it would be in (Resident #701's) best interest to pursue guardianship, in order to make sound medical decisions . (Witness G) sounded non-committal to do so. - 12/18/25 at 10:38 AM: Nursing/Clinical. Doctor notified of degrading wound and overall health decline. order received to send patient to hospital for evaluation and treatment. (Witness G) regarding, patient's decline and patient being sent to (Hospital) for evaluation and concerns for end-of-life care. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	make decisions, Director I verbalized they were not. Director I was then asked why a competency assessment had not been completed and stated, the Resident and family had set up in place. When asked what that meant, Director I revealed the Resident was living with their granddaughter (Witness G) and had in home services for care prior to going to the hospital and being admitted to the facility. When queried who was making decisions for the Resident, Director I replied Resident #701 was their own person and made their own decisions and indicated the family was involved. Director I was then asked why they provided Resident #701's NOMNC to the Resident's daughter and not the Resident when they were their own person but did not provide a response. When queried regarding consent for psychotropic medications, Director I indicated the Resident had provided consent. When asked how they were able to provide consent when they were unable to make informed medical decisions, an explanation was not provided. On 1/15/26 at 11:50 AM, an interview was completed with LPN J. When queried if they remembered Resident #701 and if they had provided care to them, LPN J responded they did. LPN J was asked about the Resident's cognitive status and stated, (Resident #701) was very demented and confused right from the beginning. When queried, LPN J indicated the Resident remained very confused throughout their stay at the facility. When queried regarding the Resident not having a DPOA and/or guardian, LPN J stated, We thought the family was going to be very involved and then they weren't. They just never come in. LPN J was then queried regarding facility policy/procedure related to obtaining consent for care/medical decisions when a resident is very confused and does not have a legal representative and revealed they were unsure. Resident #706:A list of facility residents with a BIMS (Brief Interview for Mental Status) score of less than 6, indicating the Resident was severely cognitively impaired was requested and received from the facility Administrator on 1/14/26 at 2:57 PM. Review of the list revealed Resident #706 was listed as having a BIMS score of zero. Record review revealed Resident #706 was originally admitted to the facility on [DATE] with diagnoses which included cerebral infarction (stroke) with resulting right sided hemiplegia and hemiparesis (one sided paralysis), dysphagia (difficulty swallowing), and dysarthria (impaired and unclear speech). Review of the MDS assessment dated [DATE] revealed the Resident was rarely/never understood and required moderate to substantial assistance to complete ADLs.A review of Resident #706's face sheet revealed Resident #706's mother was listed as their Responsible Party and Emergency Contact #1. Review of documentation in Resident #706's EMR revealed no documentation of competency assessment, guardianship and/or POA. The following progress note documentation was present in the EMR:- 11/7/25 at 9:05 PM: Nursing/Clinical. Resident arrived to facility via EMS. Resident is Aphasic (acquired language disorder which impairs ability to communicate) can answer question as a yes or no. Resident is alert and hard to understand. - 11/10/25 at 12:05 PM: Social Services. Social worker spoke to resident concerning advanced directives and reported no wishes to issue any further advanced directives at this time. Resident remains own person and expressed wishes to remain a full code status. - 11/11/25 at 11:23 AM: Social Service Assessment &History. Resident is nonverbal but able to indicate needs and answer yes and no questions. SW (Social Work) to contact family for additional information for verification. - 11/11/25 at 1:02 PM: Social Services. Writer contacted resident's mother for information pertaining to resident. Mother let me know that the resident resides with (their aunt) and will return there upon discharge. (Aunt contacted) confirmed that the resident does not have. DME (Durable Medical Equipment) at this time. Note: Resident Aunt was not listed on face sheet as a contact. - 11/12/25 at 8:21 AM: Social Services. Resident's mother refused psych services on resident's behalf. - 12/19/25 at 10:33 AM: Social Services. Resident remains own person. Additional review of documentation in Resident #706's EMR revealed no documentation of competency assessment, guardianship and/or DPOA/legal decision (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number 2709347. Based on observation, interview and record review, the facility failed to implement and operationalize policies and procedures for the care of pressure ulcers for two residents (#'702 and #703) of three residents reviewed, resulting in a lack of accurate documentation of care and implementation of planned interventions. Findings include:Resident #702: On 1/14/26 at 3:30 PM, Resident #702 was observed laying in bed in their room. The Resident was positioned on their back with their heels directly against the mattress. Heel boots (cushioned, pressure-relieving positioning boots) were observed sitting on a table in the Resident's room. The Resident had one pillow on their bed, under their head. There were no pillows present in the room, including on the floor for positioning use. An interview was completed at this time. When queried if they had any pressure ulcers, Resident #702 replied, Just on my heels. When asked if they had pressure ulcers on both of their heels, Resident #702 revealed they have dressings in place on both feet but only have a pressure ulcer on their right heel. When asked if staff assist them to position their heels off of the mattress for pressure relief, Resident #702 indicated they did not. Record review revealed Resident #702 was admitted to the facility on [DATE] with diagnoses which included diabetes mellitus, anxiety, and kidney disease. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, required moderate to total assistance to complete Activities of Daily Living (ADLs) with the exception of eating, and had a pressure ulcer. Review of Resident #702's Electronic Medical Record (EMR) reviewed a care plan entitled, I have impaired skin integrity related to admission with pressure ulcers present (Initiated and Revised: 11/26/25). The care plan included the interventions:- Daily skin assessments (Initiated: 11/26/25)- Float my heels while in bed (Initiated: 11/26/25)- Turn and reposition q (every) 2h (hours) (Initiated: 11/26/25)- Low air loss mattress to bed (Initiated: 11/26/25) The Resident did not have a care plan in place pertaining to refusal of care nor did they have an active or discontinued intervention for heel boot use. Review of documentation in Resident #702's Electronic Medical Record (EMR) revealed the Resident was admitted with a pressure ulcer on their right heel. The documentation of the stage of the pressure ulcer was inconsistent. Documentation detailed: - 11/26/25 at 6:43 PM (Signed and Locked on 11/28/25 at 8:37 AM: Nursing Assessment Admission/Readmission. Skin. wound to right heel. - 11/27/25 at 11:58 PM: Physician/Practitioner Progress Note. Late Entry. History and physical. Stage I (intact skin with localized area of non-blanchable redness) R (right) heel pressure injury. - 12/1/25 at 8:24 AM: Nursing/Clinical. admitted . from (hospital). Skin Assessment. Left heel is soft, no open areas. Right heel is soft, red and macerated (skin that is soft and mushy often due to prolonged exposure to moisture) . Treatment Plan: Cleanse bilateral heels with NS (Normal Saline), pat dry, apply skin prep, cover with ABD pad (wound dressing) and wrap with Kerlix dressing QD (every day) and PRN (as needed) . - 12/1/25 at 9:44 AM: SW - Skin Issues. New skin Issue. Location: Right heel. Issue type: Blister (area of underlying tissue damage with unknown depth - often a Suspected Deep Tissue Injury (SDTI) pressure ulcer) . new wound. Wound was present on admission. It is unknown how long the wound has been present. Length (cm- centimeters): 1.9, Width (cm): 1.53. Exudate amount: None. Surrounding tissue: Fragile. - 12/9/25 at 10:46 AM: SW - Skin Issues. Right heel. Blister. Deteriorating. Length (cm): 1.59 Width (cm): 1.59. Slough: 100% . Surrounding tissue: Erythema (redness often from injury, infection, or inflammation) . Fragile. - 12/18/25 at 5:00 AM: External Wound Care Provider Wound Consult. An open wound of the right posterior heel, likely related to pressure. Unstageable Pressure Injury (pressure ulcer with unknown depth) - Right heel Wound . 2cm (length) x 1.8cm (width) x 0.1cm (depth) . Wound Thickness. Unable to Determine (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235184	A. Building B. Wing	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Briarwood Nursing and Rehabilitation	3011 North Center Road Flint, MI 48506

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	based on wound presentation. Wound Bed Tissue. Slough - 100 % . Drainage. Serous. Pressure Redistribution Recommendations. Turn/Repositions Q2H. Offloading heel boots or may alternate w/ floating heels. Note: A weekly SW- Skin Issues note was not present in the EMR for 12/23/25. - 12/29/25 at 1:15 PM: SW - Skin Issues. Location: Right heel. Issue type: Blister. Length (cm): 0.88 Width (cm): 0.45. Surrounding tissue: Erythema. Fragile. - 1/8/26 at 11:02 AM: SW - Skin Issues. Location: Right heel. Issue type: Blister. Progress: Stable: previously deteriorating wound characteristics plateaued. Length (cm): 0.78 Width (cm): 0.56. On 1/15/26 at 8:30 AM, Resident #702 was observed laying in bed on their bed with their eyes closed. The Resident's knees were bent, and their feet were positioned directly against the mattress. The heel boots were in the same place on the table as they were on 1/14/26. An interview was completed with Registered Nurse (RN) A on 1/15/26 at 8:36 AM. When queried regarding Resident #702's skin, RN A verbalized the Resident has a pressure ulcer on their right heel. When queried regarding interventions related to the pressure ulcer, RN A stated, (Resident #702) does like the (heel) boots because they make their feet hot. When queried regarding other interventions to reduce pressure on the Resident's heels, RN A responded that staff float the Resident's heels on a pillow. RN A was asked if they had seen the pressure ulcer and replied, The one is small and scabbed. At 11:15 AM on 1/15/25, Resident #702 was observed in their bed. The Resident was positioned on their back with their heels positioned directly against the mattress. A wound care observation of Resident #702's heel was completed on 1/15/25 at 11:19 AM. Resident #702 was observed in bed with their heels positioned directly against the mattress upon entering the room. RN A removed the dressing in place on the Resident's right heel. A small amount of gray/red colored drainage was observed on the removed dressing. The pressure ulcer was directly over a bony prominence on the heel. The wound bed comprised an oblong area of black colored, necrotic tissue. The edges of the necrotic area were unattached, and the surrounding tissue was red/purple in color. The total wound bed, comprising the necrotic and surrounding red/purple tissue was irregularly circular in shape and approximately the size of a half dollar. Upon request, RN A measured the wound. RN A measured the necrotic, black colored area and stated it was approximately 1 by 0.5 (cm) and the size of the entire wound bed was approximately 2 by 3 (cm). After completing the dressing change, Resident #702 resumed the same position, with their heels positioned directly against the mattress. No pillows for positioning were present in the room. Review of the past 30 days of task documentation in Resident #702's EMR revealed the task, Float heels (as tolerated) while in bed. Review of the documentation revealed No was documented four times and Yes was documented 77 times including three times on 1/14/26 and twice on 1/15/26. On 1/15/26 at 2:30 PM, Resident #702 was observed in their room in bed. They were positioned directly on their back with their heels positioned directly against the mattress. When queried regarding the Resident's heel positioning and pressure reduction, RN A looked around the room and verbalized the Resident did not have an extra pillow to float their heels. RN A exited the room. An interview and review of Resident#702's EMR was conducted with RN A on 1/15/26 at 2:45 PM. When asked, RN A confirmed they also worked and were Resident #702's assigned nurse on 1/14/26. Resident #702's Float heels. task documentation was reviewed with RN A at this time. When queried if they observed Resident #702's heels floated off the mattress yesterday or today, RN A replied, Have not been. RN A was then asked how staff attempted to float the Resident's heels if a pillow/positioning device was not present in the Resident's room and replied, Not attempted. When queried regarding documentation indicating staff had floated the Resident's heels, RN A stated, Will have to talk to them (Certified Nursing Assistants [CNAs]) about that. Resident #702 did not have a task for heel boots. When queried, RN A responded that nurses document if the boots were applied on the Treatment Administration Record (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(TAR). RN A proceeded to obtain a pillow and enter Resident #702's room to float their heels off the mattress.An interview was conducted with the DON on 1/15/26 at 3:00 PM. When queried regarding lack of implementation of the intervention of floating Resident #702's heels including staff documentation of task completion, interview and observations of task not being completed, the DON reviewed the EMR documentation. The DON then verbalized CNA staff complete the task documentation, and they would receive additional education and training. Resident #703: On 1/14/26 at 3:35 PM, Resident #703 was observed laying in their bed, positioned on their back. Family Member Witness B was present in the room. An interview was completed at this time. When queried if they had any wounds, Resident #703 responded they did on their butt. When asked if they had any pain, Resident #703 responded, Yeah, in my backside. Resident #703 was then asked to rate their pain, on a scale of zero to 10 with 10 being the worst possible pain, and stated, Four. When queried if they are able to turn and reposition themselves in bed, Resident #703 indicated they could not. Resident #703 was then asked how often staff turn and reposition them in bed and replied, Whenever I need to be changed. When queried how often staff provided incontinence care and changed them, Resident #703 replied, Couple times a day. Witness B was asked when they arrived at the facility and replied, Noon to 1:00 PM. Witness B then stated Resident #703 had not moved since I've been here. Record review revealed Resident #703 was admitted to the facility on [DATE] with diagnoses which included Left Below the Knee Amputation (LBKA), diabetes mellitus, and kidney disease with dialysis dependance. Review of the Resident's admission assessment dated [DATE] revealed the Resident was alert and orientated to person, place, time and orientation, non-ambulatory, required assistance with ADL care, and had an open area on their coccyx. Review of Resident #703's EMR revealed they had an unstageable pressure ulcer on their left gluteal area which was being treated with Santyl (debriding wound ointment used to remove dead tissue from wounds) to remove eschar (black colored, necrotic tissue). Review of Resident #703's EMR revealed a care plan entitled, I am at risk for altered skin integrity related to decreased mobility, weakness, debility. (Initiated: 1/9/26; Revised: 1/11/26). The care plan included the interventions:- Encourage me to turn and reposition q2h. (Initiated: 1/9/26)- Float my heels as I tolerate (Initiated: 1/9/26)A second care plan entitled, I have an ADL self-care performance. (Initiated: 1/9/26; Revised: 1/11/26) included the following interventions:- Bed Mobility: I require assistance by (2) staff to turn and reposition in bed (Initiated: 1/9/26)- Dressing: I require assistance by (2) staff to dress (Initiated: 1/13/26)- Transfer: I require mechanical lift with (2) staff assistance for transfers (Initiated: 1/13/26) An interview was completed with Licensed Practical Nurse (LPN) C on 1/15/26 at 8:40 AM. When queried regarding Resident #703's skin, LPN C confirmed the Resident had a pressure ulcer. When queried regarding the appearance of the wound, LPN C stated, A lot (of the wound bed) looks like shearing. There is one area that looks black.On 1/15/26 at 8:45 AM, Resident #703 was observed in their room. The Resident was laying in bed, positioned slightly on their right side. When queried how long they had been laying in that position, Resident #703 revealed they did not remember. Resident #703 was asked if they were having any pain and replied, Little bit in my butt. When asked if staff had assisted them to get cleaned up for the day, Resident #703 stated, No.At 10:42 AM on 1/15/25, a wound care observation for Resident #703 was completed with LPN C and CNA D. Upon entering the room, Resident #703 was observed in bed, positioned on their back, wearing the same shirt as prior observation. CNA D was asked when they last repositioned Resident #703 and responded they were In here 10 minutes ago to change them. LPN C removed the dressing in place on the Resident's left buttocks and cleaned the wound. An area of black, necrotic tissue approximately the size of a nickel with bright red tissue surrounding the necrotic tissue was present. A separate area, approximately the size of a (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dime with a white colored wound bed was noted proximal to the necrotic area. Directly following the wound care treatment/dressing change, Resident #703 was transferred with a mechanical lift from their bed to sit in a wheelchair. At 2:35 PM, Resident #703 was observed sitting in the wheelchair in their room. When asked how they were, Resident #703 responded sore and tired. When queried if have gone back to bed since they were put in the wheelchair after their dressing change, Resident #703 replied, No. When asked if staff assisted them to move and reposition in the wheelchair while sitting up, Resident #703 replied, No. When queried if any incontinence care had been provided, Resident #703 revealed their brief had not been checked and/or changed since they were put in the wheelchair. An interview was completed with LPN C on 1/15/26 at 2:40 PM. When queried if Resident #7003 has been sitting up in the wheelchair since their wound care observation/dressing change was completed or if they had went back to bed, LPN C stated, Been up. An interview was conducted with the DON on 1/15/26 at 3:00 PM. When queried how often dependent residents should be turned and repositioned, the DON indicated every two hours. The DON was informed of observations of Resident #703 not being repositioned as well as interviews completed, the DON responded, Okay, that is education for staff. Review of facility policy/procedure entitled, Skin Management Guidelines Prevention of Pressure Ulcers/Injuries (Reviewed: 11/2025) revealed, The purpose of this procedure is. to identify specific interventions to assist with prevention and management of skin alterations. 1. Skin is assessed on admission to the facility and at least weekly to identify alterations in skin, and any wound assessments should be documented in the medical record. Pressure Ulcer/Injury Care Plan Considerations. Potential Interventions to Consider: Turning and repositioning, off-loading, Scheduled time out of bed. Mobility Friction/Shearing: Head of bed ?30o, unless contraindicated. Heel off-loading - positioning, use of orthotics. Sensory perception: Turning and repositioning, off-loading, Support surfaces - bed, chair etc. Treatment & Monitoring. 3. Wound rounds are completed weekly on pressure ulcers and complex wounds to assess the wound and determine the optimal treatment plan. 4.Review the interventions and strategies for effectiveness on an ongoing basis.