STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235252	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lourdes Rehabilitation and Healthcare Center	2300 Watkins Lake Rd Waterford, MI 48328

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 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** Based on observation, interview and record review the facility failed to ensure wound treatments/interventions were completed for one resident (R21) of one resident reviewed for pressure ulcers. Findings include:On 8/26/2025 at approximately 8:38 a.m., R21 was observed in their room, laying in their bed. R21 was observed laying in the supine position in the middle of the bed without any wedges or pillows offloading pressure of their sacral area. On 8/27/25 at approximately 10:11 a.m., R21 was observed in their room, laying in their bed. R21 was observed laying in the supine position in the middle of the bed without any positing wedges or pillows offloading pressure of their sacral area. On 8/27/25 the medical record for R21 was reviewed and revealed the following: R21 was initially admitted to the facility on [DATE] and had diagnoses including Pressure Ulcer Sacral Region Stage 4 and Venous insufficiency. A review of R21's careplan revealed the following: A review of R21's careplan revealed the following: [R21] is at risk for pressure ulcer development d/t (due to) Venous insufficiency, declines repositioning at times, weakness, decreased mobility, incont (incontinent) B&B (bowel/bladder), prone to MASD (moisture associated skin damage), dementia, diuretic med use, inadequate PO (by mouth) intake at times, prefers to stay in bed Goals-[R21] will have no complications r/t (related to) pressure ulcer skin impairment to sacrum through the review date. Date Initiated: 07/10/2024 .Target Date: 11/07/2025 .Interventions-Follow physician order for treatment of skin impairment . A review of R21's physician orders revealed the following: Wound Cleanse sacral wound with Saline or soap and water, pat dry. Apply Skin prep to peri-woundmaceration and to the area where dressing will be. Apply FibraCol Plus (cut to fit) INTO wound bed. Cover with a foam dressing. Change daily and PRN (as needed). every day shift related to PRESSURE ULCER OF SACRAL REGION, STAGE 4 (L89.154) after lunch; administer Tylenol 1 hr to treatment A wound evaluation completed by Nurse Practitioner A (NP A) on 7/31/25 revealed the following: Wound #1 Stage 4 Pressure Injury of Sacrum Location(s): SacrumWound Length x Width x Depth: 1cm (centimeters) x 1cm x 0.6cm. Undermining/Tunneling-Yes Undermining 12-2 o'clock - 0.4cm depth Wound Thickness [ ] Partial [x] Full .Wound Type: [x] pressure injury A review of R21's TAR (treatment administration record) for July and August 2025 were reviewed and revealed R21's treatments for their sacral wound were not documented as being completed on 8/3, 8/4 and 8/5. A review of R21's progress notes revealed the following notes pertaining to the days of no treatments: 8/3/25-No notes noted, 8/4/25-unable to complete. night nurse will do tx (treatment), 8/5/25-completed by midnight nurse this am Further review of the August 2025 TAR had no documentation that the night nurse on 8/4/25 or the mid night nurse on 8/5/25 completed the treatment. Further review of R21's progress notes did not reveal any documentation by the indicated night nurse on 8/4/25 or the mid night nurse on 8/5/25 that R21's sacral wound treatments were administered. A skin/wound note dated 8/7/25 completed by the facility Wound Care Nurse revealed the following: RN (Registered Nurse) did wound assessment and treatment to resident's sacral wound with wound NP (Nurse Practitioner) A (NP A). The resident's sacral wound measurements are larger. The wound bed is red. There is minimal serosanguinous drainage. The peri-wound skin is slightly macerated. There is a foul odor that is new. Wound NP changed treatment to NS (normal saline) and pack wound with (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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dakin's moistened gauze, skin prep on peri-wound and Foam dressing. The resident remains bed bound. She requires maximum assistance for turning in bed. She is incontinent of bowel and bladder On 8/28/2025 at approximately 9:32 a.m., Wound Care Nurse B (WCN B) who coordinates the wound care and does the weekly skin assessments was queried regarding R21's sacral wound. WCN B indicated that when they saw the wound on 8/7 it had increased in size and had developed a new foul order and as a result, NP A changed the order to Daykins. WCB B was queried where the Nursing staff document completion of the treatment and the indicated it was in the TAR. WCN B was informed of the missing treatments on 8/3, 8/4, and 8/5 and they indicated that since R21 was incontinent, the dressing should have been changed and documented by the Nursing staff. On 8/28/2025 at approximately 9:39 a.m., NP A was queried regarding R21's sacral wound and they indicated that they felt it would not heal and that the goal was to prevent worsening/infection. NP A indicated that the wound presentation on 8/7 had foul order and slightly increased in size since they previous time they had seen them.NP A was informed of the missing treatments leading up to their exam on 8/7/25 and they indicated that since R21 had a history of urinating a lot the dressing would need to be changed. On 8/28/2025 at approximately 09:46 a.m., an observation of R21's sacral wound was done with a Nurse from the State Agency, WCN B and NP A which revealed the following: R21 was observed lying in supine position on their back with no offloading device such as pillows or wedges applied. R21's wound measurements were 3 cm (L) x 0.6 cm (W) x 0.5 cm (D) with undermining at 12-2 0.5 cm, deep red base, no peri-wound maceration noted. It was cleaned with NS (normal saline), packed with fiber col, barrier cream to peri-wound and foam dressing applied. After wound care was provided, NP A voiced wanting to turn R21, no offloading wedges were observed in their room. WCN B was observed opening the closet and removed a wedge, NP A applied the wedge to right side of resident offloading pressure to the wound. On 8/28/2025 at approximately 10:51 a.m., The DON was Interviewed pertaining to R21's missing treatments for their sacral wound on 8/3, 8/4 and 8/5 and reported that felt the Nurses did the treatments, but there was no documentation of them completing them in the record. The DON was queried if Nurses could document in progress note or the PRN administration on the TAR that they completed the administration of the treatment and they reported they could have but that was not done. The DON was queried if R21's should have been provided positioning wedges or pillows to offload pressure on the sacral wound and they indicated they should. No documentation that R21's sacral wound treatments were completed as ordered on 8/3, 8/4 and 8/5 by the Nurses that did the treatments, were provided by the end of the survey.