STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235266	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Orchards at Southgate	15400 Trenton Road Southgate, MI 48195

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 - 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 implement interventions to prevent and promote healing of a facility acquired unstageable pressure ulcer (a severe skin injury that occurs at the heel and cannot be accurately staged because the wound base is covered by dead tissue) for one resident (R4) of three residents reviewed for pressure ulcers, resulting in the development of an unstageable heel pressure ulcer.Findings include:On 9/9/2025 at 12:13 PM, R4 was observed in bed, wearing a hospital gown, and watching TV. R4's head of bed was slightly raised, and their right heel was positioned off of the bottom of the mattress without support of heel protectors or a pillow for support. R4's right foot revealed a heel dressing with the date of 9/8/2025. R4 was asked what happened to their foot. R4 said the wound occurred on their foot from laying their foot on the footboard and bed frame. R4 stated their mattress was not long enough. R4 said, I'm kind of tall and my feet hangs over.On 09/09/2025 at 2:27 PM, R4 was observed in bed with their right leg uncovered. R4 was not wearing a heel protector. There were no interventions in place to promote wound healing.On 09/10/2025 at 08:55 AM, R4 was observed in bed and was not wearing heel protectors. There were no interventions in place to promote wound healing.09/10/2025 at 10:00 AM, Wound Care Nurse A was observed preparing to perform wound treatment for R4. The wound was located on the right heel. At that time was observed a wound that extended through all skin layers. There was a scant amount of wound drainage present and pink tissue. Wound Care Nurse A was asked how R4 developed the foot wound. Wound Care Nurse A said that R4 developed an unstageable right heel wound from resting their right foot against the bed frame and footboard. Wound Care Nurse A was asked if the wound was facility acquired and said, Yes it was. Wound Care Nurse A added that the facility extended the bed and applied a mattress spacer (foam cushion used to fill in the space between the mattress and the footboard). After Wound Care Nurse A performed wound care, she was queried if R4 required heel protectors. Wound Care Nurse A stated, Yes, but I couldn't find them in the room.On 09/10/2025 at 1:17PM, R4 was observed without heel protectors or any interventions to promote wound healing.A review of R4's Treatment Administration Record (TAR) was conducted. The facility documented that R4 refused to wear the heel protectors on day shift 9/9/25, and night shift documented that the heel protectors were applied on 9/10 and 9/11. The heel protectors were not available in the room on 9/9, 9/10, and 9/11.A review of R4's electronic medical record (EMR) revealed an admission to the facility on [DATE] with a diagnosis of Cerebral Infarction (stroke) left side dominant (left hemisphere controls the body's right side-damage there can lead to weakness or paralysis on the right side of the face, arm, and leg), Type II Diabetes Mellitus, Foot drop (the inability to lift the front part of the foot), and Chronic Kidney Disease. R404's Brief Interview for Mental Status (BIMS) score dated 08/06/2025, was 15/15, which indicated no cognitive impairment. A review of R4's Minimum Data Set (MDS) (assesses residents' ability to perform daily activities such as walking, eating, and personal hygiene) dated 8/07/2025 revealed resident's Lower extremity (hip, knee, ankle, foot) was impaired on both sides and was dependent with lower body activities.A review of R4's care plan revealed the following: I have an unstageable pressure injury to my right heel.Revision on 07/16/2025.follow your Skin Management Program.I require total assistance with transfers, toileting, (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 - Actual harm Residents Affected - Few	personal hygiene, lower body dressing.Revision on 05/13/2025.A review of the care plan did not reveal that R4 was noncompliant with wearing heel protector or wound care interventions. In addition, the care plan did not describe the Skin Management Program details or resident specific interventions.A review of R4's Braden Scale (an assessment tool used to predict a patient's risk for developing pressure ulcers or skin breakdown) dated 3/20/2025 (admission date) revealed a score of 14/23 (moderate risk for developing pressure sore). In addition, R4 was admitted to the facility with a coccyx pressure ulcer (damage to the skin and underlying tissues that occur over the bony prominence of the coccyx-tailbone).A review of R4's EMR revealed the following: Weekly Head-To-Toe Assessment-Licensed NursesDate: 3/20/2025.Coccyx pressure wound. Moles Keloid on upper left side of back. Raised skin mid back. Bilateral fungal nail infection. Bilateral foot drop.A review of R4's Weekly Head-To-Toe Assessment-Licensed Nurses dated 3/28/2025 revealed the following: Note: no new areas (wounds, skin concerns) of concern.A review of R4's Weekly Head-To-Toe Assessment-Licensed Nurses dated 4/4/2025 revealed the following: Note: no new areas (wounds, skin concerns) of concern.A review of R4's Weekly Head-To-Toe Assessment-Licensed Nurses dated 4/4/2025 revealed the following: PEG (Percutaneous Endoscopic Gastrostomy). It is a medical procedure that involves inserting a feeding tube directly into the stomach) tube removed from abdomen, dressing intact with dried serosanguinous drainage no new skin integrity issues observed at this time.A review of R4's Weekly Head-To-Toe Assessment-Licensed Nurses dated 4/25/2025 revealed the following: Resident has open area on right heel, treatment is in place. Writer observed no other skin issues at this time.A review of R4's progress notes created by Licensed Practical Nurse C revealed the following: 4/13/2025 11:38 Nurse into (sic) see resident for wound treatment. Redden area noted to right heel MD (physician) notified new to clean right heel with wound cleanser pat dry apply 4x4 ABD pad gauze (a highly absorbent, sterile pad designed to protect and manage heavily draining wounds) to heel wrap with kerlix roll secure with tape. Wound consult order.A review of R4's progress notes created by Wound Care Nurse A revealed the following: 4/14/2025 13:53 Note Text: writer observed resident skin this am noted dry skin and soft unopened nontender area to r (right) heel.A review of R4's progress notes created by Wound Care Nurse A revealed the following: Wound Care Nurse A 4/23/2025 08:05 Skin/Wound Note Text: resident (R4) received longer bed r/t (related to) resident resting BL (bilateral) heels on foot board causing unstageable to heel. resident was educated to not rest feet upon footboard, resident (R4) stated understanding, the rested his feet upon footboard.A review of R4's progress notes created by Wound Care Nurse A revealed the following: Wound Care Nurse A 4/23/2025 07:58 Skin/Wound Note Text: resident right heel is an acute unstageable pressure injury obscured full thickness skin and tissue loss pressure ulcer, initial wound encounter measurements 4cm x 6cm without depth.A review of R4's progress notes created by Wound Care Nurse A revealed the following: 4/25/2025 08:37Skin/Wound Note Text: for wound visit 4-24-2025 resident right heel is an acute unstageable pressure injury obscured full thickness skin and tissue loss pressure ulcer, initial wound encounter measurements 4cm x 6cm without depth.A review of R4's progress notes created by MDS Coordinator D revealed the following: 4/30/2025 12:24 Note MDS (Minimum Data Set) Coordinator D Note Text: Significant change for (R4) due to new unstageable wound to right heel.A review of R4's physician order dated 5/5/2025 revealed the following: Order Summary: apply heel protectors while in bed as resident will allow every shift for protection.A review of R4's progress notes created by Wound Care Nurse A revealed the following: 7/26/2025 09:18 Skin/Wound Note A skin/subcutaneous level excisional/surgical debridement (a procedure where a surgeon uses a scalpel (sharp surgical knife) or other metal instruments to remove dead, infected, or nonviable tissue from a foot ulcer to promote healing) was performed of the right heel.subcutaneous was removed along with devitalized tissue (dead or non-viable tissue that has lost its blood supply and ability to function normally): necrotic/eschar and slough, using a blade. There was a minimal amount of bleeding which was controlled using pressure.Post debridement stage noted as unstageable pressure injury obscured (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	(covered by) full thickness skin and tissue loss.A review of R4's progress notes created by Wound Care Nurse A revealed the following: 8/24/2025 09:27 Skin/Wound Note Text: for wound visit 8-14-2025 Resident right heel is an acute unstageable pressure injury obscured full thickness skin and tissue loss pressure ulcer, subsequent wound measurements 3.1cm x 4.8cm.There is a small amount of serosanguineous drainage without odor. On 09/11/2025 at 8:31 AM, Wound Physician E was interviewed and queried about R4's unstageable heel wound. The Wound Physician E said they were consulted to provide care to the wound. Wound Physician E said the wound was doing better especially after the debridement. Wound Physician E stated padding might have helped to relieve pressure. On 09/11/2025 at 10:22 AM, R4 was observed in bed, a dressing was observed on R4's right foot and was not wearing heel protectors. R4 was interviewed and asked if they remembered when the last time was wearing foot protectors and R4 said about a week ago.On 09/11/2025 at 10:25 AM, Nurse B was interviewed and queried about R4's wound and heel protectors. Nurse B said the wound was healing and the wound care nurse was going to retrieve R4 another pair.On 09/11/2025 at 11:51 AM, The Director of Nursing (DON) was interviewed and queried about R4's unstageable heel wound and interventions not being followed. The DON said nursing staff should follow the physician orders and policy to prevent wounds.A review of the facility's policy Skin Management Facility Guidelines (undated) revealed the following: Conduct a baseline head-to-toe skin check on each resident upon admission, readmission, and quarterly and with significant change.A care plan is developed upon admission and may address Preventative devices, education when appropriate.