| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235299 | A. Building<br>B. Wing | 06/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Laurels of Bedford | 270 N Bedford Road<br>Battle Creek, MI 49017 |

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<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake: 2960508Based on observation, interview, and record review the facility failed to prevent the development of pressure ulcers for one resident (R2) out of three residents with pressure ulcers reviewed, resulting in the development of three facility acquired stage 3 pressure ulcers (full thickness tissue loss) and worsening of one stage 3 pressure ulcer present on admission to stage 4 (full thickness tissue loss with exposed bones and or tendons) that required hospital transfer for osteomyelitis (wound and bone infection), pain, and debridement. Findings: Review of the Face Sheet and Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 4/2/26 reflected R2 was a [AGE] year old female admitted to the facility on [DATE] with diagnosis that included stage 4(full thickness tissue loss with exposed muscle, tendon and or bone) pressure ulcer along with two facility acquired stage 3 (full thickness tissue loss that extends into subcutaneous fat), quadriplegic, Crohn's disease, depression and anxiety . The MDS reflected R2 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for repositioning in bed, transfers, dressing, bathing, hygiene, and eating. Continued review of the MDS reflected R2 was at risk for pressure ulcer (PU) and had three stage 3 pressure wounds that was not present on admission, and one stage 4 pressure wound present on admission(worsening). The MDS reflected R2 was not on a turning/repositioning program.Review of the complaint received by the State Agency alleged the facility failed to provide care, consistent with professional standards of practice to prevent the development or worsening of avoidable pressure ulcers.During an observation and interview on 6/11/26 at 8:40 a.m. R2 was lying in bed and able to answer questions without difficulty. R2 had an air mattress with pump on foot of bed and wound vac in use. R2 reported wound vac had been used for long time for three open wounds on backside and the facility wound nurse changed the dressing every Tuesday and Friday. R2 reported admitted to facility in 2024 with one wound to bottom and reported wound had gotten worse and had developed new wounds since admission that developed at facility. R2 reported facility had wound doctor that rounded with wound nurse every Tuesday and new treatment orders were given to treat wound on left foot and staff had not yet completed them(two days later). Observed R2 had personal sock on left foot with no dressing in place and R2 verified did not use blue heel boots because caused too much heat. R2 reported does not go to wound clinic because facility talked her out of going. R2 reported requires staff assist with everything including repositioning and eating and reported staff do not always reposition her every two hours. Observed meal tray on foot of bed. R2 reported staff had delivered it about 8:20 a.m. and had not returned yet to assist resident with meal and verified weight loss. Facility staff entered room at 8:50 a.m.(30 minutes after tray delivered) and informed R2 plan to assist with breakfast.Review of the Electronic Medical Record (EMR), dated 11/13/24 through 6/11/26, reflected R2 admitted to the facility on [DATE] with the following wounds:-one stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister);-one unstageable with slough pressure wound (Known but not stageable due to coverage of wound bed by slough and/or eschar);-2 unstageable pressure injuries presenting as deep tissue injury. Continued review of R2 EMR reflected<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | R2 had current (6/2/26) wounds as follows:-Worsening stage 4 sacral wound (present on admission [DATE]);-New facility acquired rear left thigh stage 3 pressure ulcer with start date 1/9/26;-New facility acquired rear right thigh stage 3 pressure ulcer with start date 1/9/26;-New facility acquired left lateral foot, stage 3 pressure ulcer with start dated of 11/23/25; During an observation and interview on 6/12/26 at 8:40 a.m. R2 was laying in bed with no wound vac at this time. R2 reported Wound Nurse (WN) G had informed R2 of plan to complete wound treatments between 7:00 am and 8:00 am but had not completed yet. R2 granted surveyor permission to observe wound care. During an observation on 6/12/26 at 9:07 a.m. Wound Nurse G along with Registered Nurse Staff Educator (SE) H entered R2 room and informed R2 plan to complete wound treatments. WN G removed border foam dressings from R2 sacral and both right and left posterior thigh areas dated 6/12/26. WN G first cleansed R2 right thigh wound, then left thigh wound then sacral wound with gauze soaked with wound wash with no change of glove between wounds. Bilateral posterior thigh wounds appeared about golf ball size including depth and sacral wound appeared slightly larger. WN G again washed all three wounds and applied dry gauze in each wound and changed gloves. WN G applied skin prep around right posterior thigh wound, framed wound with thin duederm, removed dry gauze from wound and placed black wound vac foam inside wound, and covered with clear drape and changed gloves. WN G then applied skin prep around sacral wound, framed wound with thin duederm, removed dry gauze and placed black wound vac foam inside wound, and covered with clear drape and changed gloves. WN G then applied skin prep around left posterior thigh wound, framed wound with this duederm, removed dry gauze, placed black wound vac foam inside wound, and covered with clear drape and changed gloves. WN G place clear drape over intact skin with plan to bridge to wound vac tubing away from pressure areas. WN G cut three holes in clear drape over each wound and bridged (connected by black foam) right thigh wound to sacral wound then bridged left thigh wound to sacral wound followed by bridge from sacral wound to right hip area where WN G placed [NAME] pad, connected tubing and wound vac set at 150. R2 was repositioned with pillows and WN G exited room at 10:00 a.m. R2 appeared to tolerate treatment with some reported muscle spasms observed and reported pain with spasms. R2 reported wound vac came off yesterday before lunch, nurse placed dressings then night staff changed dressings last night. Observed dressing in place on left foot and R2 verified nurse completed left foot dressing change yesterday afternoon, first time since doctor ordered on Tuesday. Review of R2, Skin Issue assessment, dated 1/6/26, reflected, Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure ulcer staging: Stage 3 Pressure ulcer / injury - full thickness skin loss. Wound was present on admission. Exact date: 11/13/2024.Length (cm): 2.79 Width (cm): 3.1 Depth (cm): 1 Area (cm2): 6.5 Undermining: No. Tunneling: No. Epithelial: 0%. Granulation: 100%. Slough: 0%. Eschar: 0%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery.Surrounding tissue: Maceration.#002: Skin issue has been evaluated. Location: Left lateral foot.Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury. Wound acquired in-house. Exact date: 11/23/2025.Length (cm): 1.23 Width (cm): 0.82 Depth (cm): 0 Area (cm2): 0.81 Undermining: No. Tunneling: No. Epithelial: 0%. Granulation: 0%. Slough: 0%. Eschar: 100% .Review of R2 Resident At Risk Progress Note, dated 1/9/26, reflected, Reviewed Clinical Indicator: Skin Action Taken: New DTI [deep tissue injury] to the right and left gluteus. Response to Previous Actions Taken: Wound MD [medical doctor] and RD [registered dietician] to follow. Tx[treatment] initiated.Review of R2, Skin Issue assessment, dated 1/12/26, reflected, Skin Issue: #001: Skin issue has been evaluated. Location: Rear left thigh. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury. Wound acquired in-house. Exact date: 01/09/2026 Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 3.02 Width (cm): (continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 2.22 Depth (cm): 0 Area (cm2): 5.57 Undermining: No. Tunneling: No. Epithelial: 0%. Granulation: 0%. Slough: 0%. Eschar: 0%. Exudate amount: None. Exudate type: None. Odor after cleansing: None.#002: Skin issue has been evaluated. Location: Rear right thigh. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury. Wound acquired in-house. Exact date: 01/09/2026 Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 1.42 Width (cm): 1.15 Depth (cm): 0 Area (cm2): 1.62.#003: Skin issue has been evaluated. Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure ulcer staging: Stage 4 Pressure ulcer / injury - full thickness skin and tissue loss. Wound was present on admission. Exact date: 11/13/2024 Signs and symptoms of infection: None. Painful: No. Staged by: Health care provider. Length (cm): 2.95 Width (cm): 1.85 Depth (cm): 1 Area (cm2): 3.9 Undermining: No. Tunneling: No. Epithelial: 0%. Granulation: 100%. Slough: 0%. Eschar: 0%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery.Review of R2 Physician wound note, dated 1/13/26, reflected R2 complained of 7 out of 10 pain on pain scale and wound treatment was changed to Negative Pressure Wound Vac.Review of R2, Skin Issue assessment, dated 1/20/26, reflected, Skin Issue: #001: Skin issue has been evaluated. Location: Rear right thigh. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound acquired in-house. Exact date: 01/09/2026.Length (cm): 3.28 Width (cm): 1.44 Depth (cm): 0.1 Area (cm2): 3.25 Undermining: No. Tunneling: No. Epithelial: 0%. Granulation: 40%. Slough: 0%. Eschar: 60%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery. #002: Skin issue has been evaluated. Location: Rear left thigh. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure ulcer staging: Stage 2 Pressure ulcer / injury - partial thickness skin loss with exposed dermis. Wound acquired in-house. Exact date: 01/09/2026 Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 2.18 Width (cm): 1.14 Depth (cm): 0 Area (cm2): 2.12 Undermining: No. Tunneling: No. Epithelial: 0%. Granulation: 100%. Slough: 0%. Eschar: 0%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery.Review of R2 Physician wound note, dated 1/20/26, reflected R2 complained of 8 out of 10 pain on pain scale and wound treatment was Negative Pressure Wound Vac.Review of R2 Physician wound note, dated 2/3/26, reflected R2 wounds declined including Right thigh stage 3 pressure ulcer measured 1.99 cm x 1.45cm x. 0.1 cm Treatment changed to santyl. Left thigh stage 3 2.23 cm x 1.49 cm x 0.1 cm.Review of R2 Skin Issue assessment, dated 2/17/26, reflected, #001.Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Stage 4 Pressure ulcer / injury - full thickness skin and tissue loss. Wound was present on admission. Exact date: 11/13/2024 Painful: No. Staged by: Health care provider. Length (cm): 2.56 Width (cm): 2.4 Depth (cm): 4 Area (cm2): 4.8 Undermining: No. Tunneling: No. Granulation: 80%. Slough: 20%. Exudate amount: Heavy. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery. #002: Skin issue has been evaluated. Location: Rear left thigh. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure ulcer staging: Stage 3 Pressure ulcer / injury -full thickness skin loss. Wound acquired in-house. Exact date: 01/09/2026 Signs and symptoms of infection: Smell increased. Signs and symptoms of infection: Size has increased. Staged by: In-house nursing. Length (cm): 4.13 Width (cm): 3.23 Depth (cm): 0.5 Area (cm2): 10.04 Undermining: No. Tunneling: No. Slough: 30%. Eschar: 20%. Exudate amount: Moderate. Exudate type: Purulent: indication of pus, typically thick, yellow, green, tan or brown. Odor after cleansing: Faint. #004: Skin issue has been evaluated. Location: Rear right thigh. (continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure ulcer staging: Stage 3 Pressure ulcer / injury - full thickness skin loss. Wound acquired in-house. Exact date: 01/09/2026 Signs and symptoms of infection: Smell increased. Signs and symptoms of infection: Size has increased. Staged by: In-house nursing. Length (cm): 3.09 Width (cm): 3.27 Depth (cm): 0.8 Area (cm2): 7.79 Undermining: No. Tunneling: No. Granulation: 50%. Slough: 50%. Exudate amount: Moderate. Exudate type: Purulent: indication of pus, typically thick, yellow, green, tan or brown. Odor after cleansing: Faint.Review of R2 Physician wound note, dated 2/17/26, reflected R2 wounds declined, including R2 Right thigh was documented as Stage 4 and R2 complained of 8/10 pain and provider performed sharp debridement.Review of R2 Physician wound note, dated 2/24/26, reflected R2 wounds declined with signs of infection noted and culture and sensitivity (C&S) sample collected and sent related to infection.Review of Braden Scale for Predicting Pressure Ulcer Risk Evaluation, dated 2/24/2026, reflected, Sensory Perception: Slightly limited. Moisture: Occasionally moist. Activity: Chairfast. Resident is Completely Immobile: does not make even slight changes in body or extremity position without assistance. Nutrition: Adequate. Friction and shear: Problem. SW - BRADEN Score: 13.0.Review of R2 Nurse progress Note, dated 3/2/2026 wound C&S resulted and discussed with [named wound physician] Orders for clindamycin 300mg qid[4 times daily] x 14 days given and entered. Guest notified.Review of R2 Skin Issue assessment, dated 3/3/26, reflected, . #001: Skin issue has been evaluated. Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Stage 4 Pressure ulcer / injury - full thickness skin and tissue loss. Wound was present on admission. Exact date: 11/13/2024 Signs and symptoms of infection: Smell increased. Signs and symptoms of infection: Non-healing. Painful: No. Staged by: Health care provider. Length (cm): 3.38 Width (cm): 1.94 Depth (cm): 3 Area (cm2): 5.22 Undermining: No. Tunneling: Yes. Number of tunnels: 2. Tunnel length (cm): 4 Tunnel location 1: 5 o'clock. Tunnel length (cm): 4 Tunnel location 2: 7 o'clock. Granulation: 80%. Slough: 20%. Exudate amount: Heavy. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery. Odor after cleansing: Faint.Dressing appearance: Saturated.#002: Skin issue has been evaluated. Location: Left lateral foot. Laterality / Orientation: Lateral. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury. Wound acquired in-house. Exact date: 11/23/2025.Length (cm): 1.34 Width (cm): 1.12 Depth (cm): 0 Area (cm2): 1.16 . Eschar: 100% .#003: Skin issue has been evaluated. Location: Rear right thigh. Laterality / Orientation: Medial. Issue type: Pressure ulcer/ injury. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Stage 3 Pressure ulcer / injury - full thickness skin loss. Wound acquired in-house. Exact date: 01/09/2026 Signs and symptoms of infection: Non-healing. Signs and symptoms of infection: Smell increased. Signs and symptoms of infection: Increased exudate. Signs and symptoms of infection: Size has increased. Painful: No. Staged by: In-house nursing. Length (cm): 3.61 Width (cm): 4.3 Depth (cm): 2 Area (cm2): 11.53 Undermining: No. Tunneling: No. Slough: 80%. Eschar: 20%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery. Odor after cleansing: Faint.#004: Skin issue has been evaluated. Location: Rear left thigh. Laterality / Orientation: Medial. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Stage 3 Pressure ulcer / injury - full thickness skin loss. Wound acquired in-house. Exact date: 01/09/2026 Signs and symptoms of infection: Size has increased. Signs and symptoms of infection: Non-healing. Signs and symptoms of infection: Smell increased. Signs and symptoms of infection: Increased exudate. Painful: No. Staged by: In-house nursing. Length (cm): 4.55 Width (cm): 3.11 Depth (cm): 1.5 Area (cm2): 11.02 Undermining: No. Tunneling: No. Granulation: 20%. Slough: 10%. Eschar: 70%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery. Odor after cleansing: Faint.Review of R2 Physician wound note, dated 3/2/26, (continued on next page) |

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | reflected R2 wounds declined including Right thigh wound stage 4 pressure wound with signs of infection noted and R2 complaint of 9/10 pain.Review of R2 Physician wound note, dated 3/10/26, reflected R2 wound decline and R2 reported 9/10 pain.Review of R2 Nurse Progress Note, dated 3/17/2026, reflected, Wound MD in to see guest this shift. After assessment of sacral wound, an order to extend clindamycin x 14 days was given and entered. guest notified.Review of R2 Physician wound note, dated 3/24/26, reflected R2 wound decline and plan to start IV antibiotics for wound infection.Review of Physician orders, dated 3/25/26, reflected R2 was ordered Vancomycin Intravenous every 12 hours for osteomyelitis for six weeks.Review of Provider Progress Note, dated 3/25/26, reflected, [named R2] is a [AGE] year-old woman seen today for chronic disease management and evaluation of her ER[emergency room] visit. She was sent to ER because she is starting antibiotics for osteomyelitis. They were unable to have it placed in the facility due to difficult insertion. Therefore she was sent to ER for placement and returned with a left arm PICC[peripheral inserted central catheter] line. She will begin antibiotics today. Pain Level: 10.Other osteomyelitis, multiple sites:1. PICC line placed into left arm2. Start Vancomycin every 12 hours today through 5/6 - dosed per pharmacy3. Start Meropenem 1 gram every 8 hours through 5/64. Start Flagyl 500 mg every 6 hours through 5/6.Review of R2 History and Physical, dated 4/8/26, reflected, [AGE] year-old female is seen for an admission visit. She was previous at our facility for long-term care and continued wound treatments. She has a history of quadriplegia and has non-healing sacral decubitus ulcers. She underwent a colostomy to help with care of her wound and frequent infections.Pain level 8.Review of R2 Change of Condition assessment, dated 4/9/26, reflected, Nursing observations, evaluation, and recommendations are: Patient was c/o[complaint of] pain r/t[related to] sacral wound. Patient rated pain 10/10 and refused scheduled and PRN[as needed] pain medications stating she just wants to go to the ER for pain medication.Review of R2 Skin Issue assessments, dated 4/14/26 to 6/8/26 reflected facility acquired stage 3 bilateral thigh pressure wounds were present on admission 4/6/26 as well as left lateral foot stage 3 facility acquired pressure wound and sacrum stage 4 pressure wound.Review of R2 Nurse Progress Note, dated 4/30/26, reflected, Call placed to [wound provider] related to PICC malfunction. Due to antibiotics scheduled to end on 5/4 [named wound provider] gave orders to discontinue abx[antibiotics] now and begin negative pressure wound therapy. Abx orders d/c. wound vac ordered. order to remove PICC entered. Plan discussed with guest and they are in agreement.Review of R2 Skin Issue assessment, dated 6/2/26, reflected, #001: Skin issue has been evaluated. Location: Left lateral foot. Issue type: Pressure ulcer / injury. Progress: Stalled: previously improving wound characteristics plateaued. Pressure ulcer staging: Stage 3 Pressure ulcer / injury - full thickness skin loss. Length (cm): 1.75 Width (cm): 1.2 Depth (cm): 0.5 Area (cm2): 1.63 Undermining: No. Tunneling: No. Granulation: 50%. Slough: 50%. Exudate amount: Light.Debridement: Sharp. Other primary dressing: thera honey, collagen Secondary dressing: Foam.#002: Skin issue has been evaluated. Location: Rear right thigh. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Stage 3 Pressure ulcer / injury - full thickness skin Loss. Length (cm): 3.93 Width (cm): 2.38 Depth (cm): 2 Area (cm2): 7.48 Undermining: No. Tunneling: Yes. Number of tunnels: 1. Tunnel length (cm): 4.5 Tunnel location 1: 12 o'clock. Granulation: 100%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery.Debridement: Mechanical. Debridement: Sharp. Primary dressing: Negative pressure wound therapy.#003: Skin issue has been evaluated. Location: Sacrum. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Stage 4 Pressure ulcer / injury - full thickness skin and tissue loss.Length (cm): 4.11 Width (cm): 3.25 Depth (cm): 2 Area (cm2): 9.35 Undermining: No. Tunneling: Yes. Number of tunnels: 2. Tunnel length (cm): 4.5 Tunnel location 1: 2 o'clock. Tunnel length (cm): 4.5 Tunnel location 2: 9 o'clock. Granulation: 100%. Exudate amount: Moderate. Exudate type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red, and watery. Debridement: Sharp. Debridement: Autolytic. Debridement:<br>(continued on next page) |

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|---|---|
| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Mechanical. Primary dressing: Negative pressure wound therapy.#004: Skin issue has been evaluated. Location: Rear left thigh. Issue type: Pressure ulcer / injury. Progress: Stable: previously deteriorating wound characteristics plateaued. Pressure ulcer staging: Stage 3 Pressure ulcer / injury - full thickness skin Loss.Length (cm): 6.01 Width (cm): 4.1 Depth (cm): 1.5 Area (cm2): 16.8 Undermining: No. Tunneling: Yes. Number of tunnels: 1. Tunnel length (cm): 3 Tunnel location 1: 12 o'clock. Granulation: 90. Slough: 10%. Exudate amount: Moderate. Primary dressing: Negative pressure wound therapy.Review of R2 Skin Care Plans, dated 11/14/25 with last revision 6/10/26, reflected R2 included, [named R2] has an actual impaired skin integrity r/t: Stage 4 Sacrum, stage 3 left lateral foot, Left rear thigh stage 3, Right rear thigh stage 3, DTI right heel DTI left heel.[named R2] refuses to be repositioned while in bed. [named R2] refuses dressing changes [named R2] has a wound vac bridged from sacrum to bilateral thighs [named R2] prefers wound vac application be completed by wound nurse. Date Initiated: 11/14/2024.Revision on: 06/10/2026. Continued review of R2 care planned interventions included, Air mattress Date Initiated: 12/05/2025. Encourage [named R2] to allow repositioning to alleviate pressure areas Date Initiated: 01/07/2025 .(revised 6/6/25 to read as follows) Encourage [named R2] to allow repositioning in bed and wheelchair to alleviate pressure areas. Roho cushion Date Initiated: 08/11/2025. Supplement as ordered Date Initiated: 12/17/2024. Provide _1:1___ assistance with eating or drinking as needed. Date Initiated: 07/16/2025.Review of Treatment Administration Records(TAR), dated 1/1/26 through 6/12/26 reflected several holes(missing documentation indicating treatments not completed) on record.During a telephone interview on 6/12/26 at 11:26 a.m., Licensed Practical Nurse (LPN) I reported R2 had wound vac ordered prior to recent room change then changed to wet to dry then changed again and had not cared for R2 recently. LPN I reported R2 preferred to be up in chair all day and verified motor chair was able to position back for position changes and offloading. LPN I reported R2 would occasionally refuse to have dressings changed when up in chair and reported if residents refused staff expected to document on TAR and then complete progress note. During an interview on 6/12/26 at 11:50 a.m., LPN J reported completed R2 left later foot dress on 6/11/26 evening and verified no dressing was in place prior to completing physician ordered treatment including kling wrap.During an interview on 6/12/26 at 1:55 p.m. WN G reported had been facility wound nurse for five months and as not currently wound care certified. WN G reported R2 admitted with sacral wound on 11/13/24 and verified had declined and was currently a stage 4 pressure wound. WN G reported R2 also currently had both right and left posterior thigh stage 3 pressure wounds that were facility acquired that presented as deep tissue injuries on 1/9/26. WN G verified R2 also had a current stage 3 facility acquired left later foot pressure wound that was identified on 11/23/25. WN G was quired, What led to R2 facility acquired bilateral posterior thigh pressure ulcers on 1/9/26. WN G stated, the wheelchair she is in. WN G reported R2 does not allow staff to lay her down and report R2 up until 3:00am to 4am at times. WN G verified R2 had motor chair that was able to recline to offload and verified had observed R2 in that position. WN G reported had educated R2 of importance of offloading including when up in motor chair. Requested evidence of resident education be provided. WN G verified R2 had specialized cushion in motor chair. WN G reported R2 refused to have any other staff except WN G complete wound vac treatment and reported that is why R2 is only scheduled for every Tuesday and Friday wound vac dressing changes. WN G reported R2 recently had colostomy to aid in wound healing related to frequent wound infections and wound decline including osteomyelitis in sacral wound. WN G was last treated for osteomyelitis in May 2026 with intravenous (IV) antibiotic treatments. WN G' reported facility wound physician rounds weekly and provides treatment orders including R2 current wound vac orders. WN G reported R2 wound vac removed when signs of infection and then resumed after antibiotic treatment complete and reported wound physician and not ever had three wounds bridged prior to R2. WN G reported had prior experience with wound vac treatment prior to facility including bridging wounds. Requested supporting evidence that all three wounds could be bridged together, pulling wound drainage directly over other wounds including stage 4 pressure wound with<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235299 | A. Building<br>B. Wing | 06/12/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| The Laurels of Bedford | 270 N Bedford Road<br>Battle Creek, MI 49017 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0686<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | history of osteomyelitis. WN G verified R2 was high risk for skin breakdown on admission and continued to be high risk and verified would expect staff to follow care plans including assistance with turning and repositioning, and assistance with feeding. WN G verified forgets to document treatments completed on TAR during wound rounds and verified holes on TAR included more areas than just treatment days and reported staff should always document on TAR including if resident refuse and progress note should be linked. WN G verified R2 lateral foot dressing change was not completed as ordered on 6/9/26 or on 6/10/26 according to R2 EMR and verified hole on R2 TAR and reported was related to timing of order transcription. During an interview on 6/13/26 at 3:30 p.m., Director of Nursing (DON) B' reported would expect staff to follow physician orders and document on Treatment Administration Record (TAR) if treatments completed or refused and verified would not expect holes on TAR. DON B' reported would expect Certified Nurse Aids to follow Kardex and staff to educate residents if they refuse Care Planned interventions or physician orders and document. DON B reported facility Wound Physician notes not available after 5/26/26 related to physician under review and auditing purposes. DON B reported acceptable practice to bridge wounds with wound vac directly from one wound over another and wound. Requested supporting documentation along with facility wound Policy.Review of the facility provided, Negative Pressure Wound Therapy (NPWT) Procedure, revised 4/21/26, reviewed by Academy of Medical-Surgical Nurses, reflected, Special Considerations *If the patient has multiple wounds of a wound smaller than 1.6 (4 cm) that requires NPWT, specific techniques may be indicated. (See Strategies for multiple and smaller wounds.) STRATEGIES FOR MULTIPLE AND SMALLER WOUNDS Depending on the size of wound or the number of wounds, you may use the bridging or picture framing technique for negative pressure wound therapy (NPWT). Bridging. When a patient has [NAME] than one wound of similar origin and the wounds are positioned in close proximity, one NPWT unit can be used to treat them. Wounds that are infected shouldn't be bridged with noninfected wounds.After the foam dressing is placed inside the wounds, connect the wounds using another piece of foam (a bridge piece). Ensure that all the foam pieces directly touch. Place the vacuum pad in a central area in a manner that prevents one wounds drainage from being pulled across another. (observed each of R2 posterior thigh wounds bridged directly over R2 stage 4 sacrum pressure wound.)Prior to completion of survey and survey exit the facility failed to provide supporting evidence that all three of R2 pressure wounds could be directly bridged together. No supporting evidence regarding pulling wound drainage directly over other wounds including stage 4 pressure wounds. The facility failed to provide requested supporting documentation that R2 had been educated on refusal of care planned interventions to support wound healing. |

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| | 235299 | A. Building<br>B. Wing | 06/12/2026 |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation Pertains to Intake 2989698. Based on interview and record review the facility failed to follow a physician order to administer an anti-seizure medication for one resident (Resident #4) of one resident reviewed for seizure medication. Findings include: Review of the clinical record, including the Minimum Data Set (MDS) 3/25/26 reflected Resident 4 (R4) was a [AGE] year-old female admitted to the facility with diagnoses that included epilepsy and seizure disorder on 06/02/21 with a readmission date of 4/14/26. R4 was scored 14 out of 15 on the Brief Interview for Mental Status (BIMS). Further review of R4's electronic medical record (EMR) revealed R4 had a seizure on 4/11/2026 that lasted approximately 30 minutes and resulted in a hospitalization. Review of R4's April 2026, monthly Physician orders for revealed a Physician order for Midazolam solution 5 Milligram/0.1 Milliliter 1 spray in nostril every 24 hours as needed for active seizure. May give additional spray in opposite nostril after 10 minutes if no response from the first dose the patient does not have difficulty breathing or is not excessively sedated. Review of the medication administration audit revealed one dose of Midazolam was administered by Registered Nurse (RN) F on 4/11/26 at 11:46 pm. There was no documentation that R4 was given the second dose of Midazolam, nor was there any documentation that the medication was held due to R4 having difficulty breathing or being excessively sedated. On 6/10/2026 at 3:00 PM, during an interview with Director of Nursing (DON) B, she reported RN F was no longer employed at the facility, an attempt to interview RN F was made via telephone, voice mail requesting return call was made with no response on 6/10 and 6/11. DON B offered no explanation why RN B did not administer the second dose of Midazolam. It was discussed that Midazolam comes from pharmacy in a two pack of single use doses. Review of Physician progress note dated 4/11/2026 revealed they received a call from a nurse at the facility who reported R4 was having a seizure and the nurse requested Inter Muscular (IM) Ativan. A Verbal order for 2mg/ml give 1mg (0.5ml) IM one time dose was given. Nurse then reported all IM Ativan had been pulled from out of back up. Verbal order was then given to transfer R4 to hospital. Review of the controlled substance log for R4 reflected one dose of Midazolam was administered to R4 on 6/26/25, leaving one dose, thus after the 4/11/26 dose was administered that left the count at 0, thus the second dose of Midazolam that was to be administered on 4/11/2026 was not available, along with the IM Ativan that was not available. On 6/12/26 at 11:40 am during an interview with DON B she reported the Midazolam was not administered to R4 because the Midazolam was not available, DON B acknowledged according to the Physician Orders two doses of Midazolam should be available at all times and should have been reordered on 6/26/25 after the nurse administered the initial dose. |