STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235359	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faith Haven Senior Care Centre	6531 W Michigan Avenue Jackson, MI 49201

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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: 3011032Based on observation, interview, and record review the facility failed to prevent the development of pressure ulcers for one resident (R1) out of two residents with pressure ulcers reviewed, resulting in the development of R1 facility acquired stage 4 pressure ulcer that required hospital transfer for sepsis related to wound infection and surgical debridement.Review of the Face Sheet and Minimum Data Set (MDS) with Assessment Reference Date(ARD) of 5/20/26 reflected R1 was a [AGE] year old female admitted to the facility on [DATE] with recent readmission post hospital transfer 5/14/26 related to stage 4 (full thickness tissue loss with exposed muscle, tendon and or bone) pressure ulcer infection, with additional diagnoses that included hemiplegia and hemiparesis aphasia following cerebral infarction effecting non-dominant side, hypertension, protein-calorie malnutrition, vascular dementia, bipolar disorder, postural kyphosis cervicothoracic region, and anxiety . The MDS reflected R1 had a BIM (assessment tool) score of 13 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for repositioning in bed, transfers, dressing, hygiene, and eating. Continued review of R1 MDS reflected R1 was at risk for pressure ulcer (PU) and had one unstageable-deep tissue injury that was not present on admission, and R1 was not on turning/repositioning program.Review of R1 MDS with ARD of 3/11/26 revealed BIMS of 8 (moderate impaired) and was at risk for pressure ulcer (PU) with no unhealed PU. Continued review reflected R1 was not on turning/repositioning program.During an observation on 5/28/26 at 11:11 a.m., R1 was in bed, eyes closed, air mattress functioning, mat on floor, music playing, clean linens, bilateral blue boots on, and wedge pillow under right hip with wound vac on and in place. During an interview on 5/28/26 at 11:18 a.m., Wound Nurse (WN) D reported had been in position for about two years. WN D reported completes resident wound care every Monday, Wednesday, and Friday and floor staff complete on the other days. WN D reported weekly wound rounds with Nure Practitioner (NP) E every Wednesday. WN D reported if staff identify new skin issue they are expected to document on shower sheet, inform head nurse who then would sign shower sheet, give to unit manager and inform wound nurse. WN D reported she would then assess resident that same day or next scheduled day. During an interview on 5/28/26 at 11:50 a.m., Nursing Home Administrator (NHA) A reported had, soft file for R1 and reported staff had informed management that surveyor was asking about R1 last week (6 days prior) and wanted to know if this surveyor would like to review it. NHA A provided word document, titled, Unavoidable Pressure Injury Summary for R1. The file included a blank document titled, Unavoidable PI [pressure injury] Statement that was printed from Electronic Medical Record and completed with handwritten responses. Not completed documented electronically in EMR. Handwritten notes with no electronic date stamping. During an observation on 5/28/26 at 12:25 p.m. R1 was in bed in same position with eyes closed with slight movement of arm.During an observation on 5/28/26 at 12:28 p.m., Certified Nurse Aid (CNA) Q entered R1 room with lunch tray, placed on bedside table and exited room. During an observation on 5/28/26 at 12:35 p.m., R1 was heard repeatedly yelling out, I want something to eat with tray at bedside.During an observation on 5/28/26 @ 12:36 p.m., CNA Q returned to R1 room and overheard staff remind resident he had told her he was passing trays and would return to assist. R1 bed was heard making (continued on next page)

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 Note: The nursing home is disputing this citation.	beeping noise.During an observation on 5/28/26 at 1:05 p.m., CNA Q exited R1 room with tray with about 50% of meal eaten and full, unopened might shake. Observed R1 in same position with wedge under right hip and continued to hear bed making beeping noise.During an observation on 5/28/26 at 1:30 p.m., R1 was observed in same position in bed with wedge under right side. (Two hours twenty minutes in same position).Review of R1 Bradon Scale for predicting risk for pressure ulcers, dated 1/2/26, reflected score of 13, which indicated high risk. Review of R1 Electronic Medical Record reflected no additional Bradon Scale assessments completed until 3/30/26 with score of 12 that indicated high risk.Review of R1 Nurse Progress Notes, dated 3/30/2026 at 11:54 a.m., reflected, New skin Location: Lower back. Issue type: Pressure ulcer / injury. Progress: New: new wound. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury. Wound acquired in-house. Exact date: 03/30/2026 Signs and symptoms of infection: Erythema/edema. Painful: No. Staged by: In-house nursing. Length (cm): 2.66 Width (cm): 2.58 Depth (cm): 0 Area (cm2): 5.12 Undermining: No. Tunneling: No. Slough: 60%. Eschar: 40%. Exudate amount: Light. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Edema: Non-pitting edema extends > 4 cm around wound. Additional care: Turning / repositioning program. Additional care: Mattress with pump.Review of R1 wound provider notes, dated 4/1/26, reflected, Ordered keflex 500mg BID[two times daily] x 10 days for signs of wound infection.Review of R1 Skin Progress Note, dated 4/13/26, reflected, Skin issue has been evaluated. Location: Lower back. 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: 03/30/2026 Signs and symptoms of infection: None. Painful: No. Staged by: In-house nursing. Length (cm): 6.45 Width (cm): 3.86 Depth (cm): 0 Area (cm2): 14 Undermining: No. Tunneling: No. Epithelial: 0%. Granulation: 0%. Slough: 0%. Eschar: 100%. Exudate amount: Moderate. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown.Review of R1 Wound Provider Note, dated 4/15/26 and 4/29/26, reflected wound debridement completed by provider. Continued review of 4/29/26 provider note, reflected, removed significant slough from wound bed. Base of wound appears in close proximity to spine. Requiring pt/wound to be monitored closely for s/sx [signs and symptoms] of infection.Revie of R1 Skin Progress Note, dated 4/30/26, reflected, New skin Issue. Location: Front right trochanter. Laterality / Orientation: Middle. Issue type: Other skin issue. Other skin issue description: Golf ball size lump with blanchable red mark on top Progress: New: new wound. Wound acquired in-house. It is unknown how long the wound has been present. Painful: No. Length (cm): 4 Width (cm): 4 Depth (cm): 0 Area (cm2): 16.Review of R1 Skin Note, dated 5/4/26, reflected, Location: Lower back. Issue type: Pressure ulcer / injury. Progress: Deteriorating: wound characteristics deteriorated. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury. Wound acquired in-house. Exact date: 03/30/2026 Painful: Yes. Wound pain (Frequency): Intermittent. Pain description: Sharp. Pain description: Burning. Wound pain interventions: Medicate prior dressing change. Wound pain interventions: Change in position. Relief from interventions: Yes. Staged by: In-house nursing. Length (cm): 3.74 Width (cm): 3.7 Depth (cm): 2 Area (cm2): 11.24 Undermining: Yes. Undermining = 1 instance of undermining. Undermining length (cm): 2.5 Undermining location 1 from: 1 o'clock. Undermining location 1 to: 8 o'clock. Tunneling: No. Epithelial: 0%. Granulation: 20%. Slough: 50%. Eschar: 30%. Exudate amount: Moderate. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Other wound bed: bone. Periwound: Non-attached. Periwound: Rolled edge (Epibole). Surrounding tissue: Excoriated. Surrounding tissue: Fragile. Surrounding tissue: Scarring. Surrounding tissue: Blanching. Surrounding tissue: Erythema. Induration: None present. Edema: Non-pitting edema extends > 4 cm around wound.Review of R1 Provider Progress Note, dated 5/5/26, reflected, Pressure ulcer of left lower back, unstageable X ray of her spine reviewed. Discussed with wound NP Wound recently debrided. She has no leukocytosis and is afebrile X ray showed possible osteomyelitis/discitis.Discussed possible MRI vs hospital for evaluation of osteomyelitis, will have (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Undermining length (cm): 3 Undermining location 1 from: 7 o'clock. Undermining location 1 to: 5 o'clock. Tunneling: No. Granulation: 50%. Slough: 50%. Eschar: 0%. Exudate amount: Moderate. Exudate type: Serous: clear watery fluid, which is separated from solid elements.Dressing saturation: Moderate 26-75%. Cleansing solution: Normal saline. Primary dressing: Negative pressure wound therapy. Secondary dressing: No secondary dressing applied. Modalities: None. frequency of treatment: 3 times a week.Review of R1 Skin Care Plan, dated 1/13/26, reflected, SKIN MANAGEMENT at risk rt [related to] Hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side, HTN [hypertension], Occlusion and stenosis of right carotid artery, dementia, anxiety, venous insufficiency, CAD [coronary artery disease], HLD [elevated lipids], Bipolar, depression, insomnia. R inner heel- ruptured blister. L outer heel/ankle area- ruptured blister. Resident is often anxious and is often crossing her legs and feet back and forth continuously from one side to the other causing friction and rubbing Date Initiated: 11/28/2025.Revision on: 01/13/2026. Continued review of the Skin Care Plan reflected interventions that included, Please help me get turned and repositioned while in bed or in my wheelchair. Date Initiated: 11/28/2025.Revision on: 01/13/2026. Please help me get turned and repositioned while in bed or in my Broda chair. Date Initiated: 11/28/2025.Revision on: 05/29/2026 [During Surveyor Investigation].Place pillow behind back while in chair. Date Initiated: 03/31/2026 . I have pressure reducing device on chair/wheelchair. Date Initiated: 11/28/2025.Revision on: 01/13/2026 [same intervention updated 3/30/26] I have pressure reducing device on Broda ChairRevision on: 03/30/2026 [same day as R1 pressure injury identified].encourage me and reposition me if I allow from side to side. Date Initiated: 03/30/2026.CNA's will check my skin daily with care and report anything unusual they notice to the nurse. Date Initiated: 11/28/2025. APM. Date Initiated: 12/29/2025. Call light accessible. Date Initiated: 11/28/2025.Review of R1 MDS with ARD date of 5/20/26 reflected R1 had unstageable deep tissue injury that was not present on admission. Hospital records reflected R1 had stage 4 pressure injury on admission 5/6/26.During an observation on 5/29/26 at 8:15 R1 was in high back geri chair in Dining Room with staff assisting with meal. During an observation on 5/29/26 at 8:40 a.m. CNA E and CNA F transferred R1 from high back chair into bed with use of mechanical lift. Observed R1 air mattress pump was not functioning indicated by no lights on pump at foot of bed and mattress appeared to be deflated with R1 sunk in bed. During an observation on 5/29/26 at 8:45 a.m., CNA E reported was very familiar with R1 and routinely cared for R1 prior to room move on 5/22/26. CNA E reported R1 able to make needs known and does not refuse position changes. CNA E reported received education after wound was found on R1 on 3/30/26 under foam dressing that was not labeled or removed during bath days. CNA E reported staff were educated to report all skin changes and dressing on shower sheets and report to nurse. CNA E reported was not responsible for bathing R1 because on another shift. CNA E reported air mattress was in place prior to identifying facility acquired pressure wound. CNA E reported R1 also had documentation sheet for turning and repositioning every 2 hours now and verified was unable to locate R1s documentation at nurse station but was able to locate other residents who required repositioning documentation.During an observation and interview on 5/29/26 at 9:00 a.m. to 9:54 a.m., Wound Nurse D entered R1 room to complete dressing change. Wound vac disconnected and dressing removed over lower spine area that had been bridged on right side (foam dressing redirected to anterior body to avoid pressure from track pad and hose of suction over bony prominence). Observed soft ball size open area over R1's spine on lower back with bright red angry peri wound noted that appeared to be stage 4 pressure wound with exposed bone ligaments. WN D reported R1 prior dressing was last changed by her and provider 5/27/26. WN D cleaned wound with normal saline, pryzm applied to undermining, black foam to wound bed, skin prep peri wound and duoderm framed wound, clear drape applied, bridge to right side (appears over right iliac crest). Track pad with no foam under entire pad area only about 3/4 inch bridge with track pad suctioned down over only clear drape with potential to create pressure from track pad on health skin. Track pad and hose also appeared to be place to right side again and directly (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	over boney prominence instead of anterior body. Observed R1 air mattress off as indicated by no lights on pump at foot of bed. R1 was transferred from bed to high back chair with back cutout foam by two staff and reported plan to go to therapy.During an interview on 5/29/26 at 10:00 a.m. WN D verified R1 wound was currently a stage 4 facility acquired pressure ulcer. During an interview and record review on 5/29/26 at about 10:20 a.m. Unit Manager (UM) G reported R1 was on a every two-hour turning and repositioning schedule and was responsible for collecting documentation. UM G provided documentation included 5/21/26 through current with several missing days with no documentation and UM G verified missing documentation days. During an interview on 5/29/26 at 10:30 a.m., Assistant Director of Nursing (ADON) H reported R1 had an Alternating Pressure Mattress (APM) since December 2025. During an interview and record review on 5/29/26 at 11:45 a.m., CNA F reported R1 every two hour turn document was located at the nurse station on a clip board and reported copy had to be made earlier so it may not have been observed at nurse station for that reason. During an interview and record review on 5/29/26 at 12:34 p.m., ADON H reported had been in position for about six months. ADON H verified the following Care Planned Interventions were in place.APM mattress initiated 12/29/25Broda chair 1/27/26.Turn and reposition initiated 3/31/26ADON H reported R1 facility acquired pressure ulcer to lower spine area was first identified on 3/30/26 and WN D assessed. ADON H reported cushion was added to back of Broda chair to offload pressure on wound related to Kyphosis. ADON H verified when R1 initially admitted was had regular wheelchair and because of Kyphosis was changed to Broda chair for safety. ADON H reported R1 was assessed by facility wound provider on 4/1/26. ADON H reported staff identified facility acquired unstageable deep tissue injury 3/30/26 after removing an unlabeled, unordered foam dressing from R1's lower spine area and investigation was started because was new open pressure wound with no physician ordered treatments. ADON H reported was unable to determine how long foam dressing had been in place and reported R1 had received showers on 3/23/26 and 3/26/26 with no changes in skin reported. Requested investigation for review.Review of the Education provided after R1 pressure ulcer identified on 3/31/26 to all nursing staff by ADON H included, If you put a treatment on a new area of concern you have to have a treatment and document what the skin issue is and notify your unit manager and DON. You cannot just put a dressing on anyone and not have treatment. Dressings need initials and dates on them, nothing else. Assure daily during rounds that treatments and other preventative measures are in place including turning and repositioning, pressure relieving devices (in good condition), dressing in place, etc. Incontinence care, offloading heels, checking skin during ADL [activity of daily living] care and showers, notification of areas of concern, documentation of decline and implementing skin prevention. Accurate completion and documentation of skin assessments, notification and documentation of new areas of concern. The facility provided above education along with facility, Wound Management Program Policy, dated 8/17/2017, and list of nursing staff with signatures with no dates.During an observation and interview on 5/29/26 at 1:05 p.m., CNA F was observed in R1 room and reported had just transferred R1 back to bed. R1 was currently on phone and CNA F reported with sister and CNA F exited room. Observed R1 positioned in bed with wedge under left side and air mattress continued to non-functioning as evidenced by no lights on pump. R1's call light was out of reach located 3 to 4 feet away from bed on nightstand. During an interview on 5/29/26 at 1:20 p.m. ADON H reported would provide R1 bath sheets and reported provided staff education 3/31/26 because non ordered foam dressing was removed from R1 lower spine that revealed open facility acquired pressure wound and facility was unsure when area was last assessed. ADON H verified R1's facility acquired pressure wound was open, had drainage, slough, and escar when first identified on 3/30/26. ADON H verified provided list of nursing staff with signatures was who was provided education and verified no dates were included on when education was completed. ADON H reported started to educate staff 3/31/26 until all staff educated.During an interview on 5/29/26 at 1:30 p.m., Director of Nursing (DON) B reported had investigation for R1 facility acquired pressure ulcer and would provide. Management team, including NHA A, DON B, Senior (continued on next page)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235359	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Faith Haven Senior Care Centre	6531 W Michigan Avenue Jackson, MI 49201

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 Note: The nursing home is disputing this citation.	interviewer and NHA A was witness to statement.During an interview on 5/29/26 at 4:35 p.m., DON B verified R1 had care planned intervention to turn and reposition added 11/25. DON B reported would expect staff to offer to reposition every two hours. DON B reported completed facility sweep of all resident air mattresses and reported all other mattresses were functioning and had maintenance staff assesses R1 room. DON B reported that R1 air mattresses was now functioning.During an interview on 5/29/26 at 6:00 p.m., NHA A, RNC K and SED J verified had no additional documentation to provide prior to survey exit.