

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235408	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/09/2025
NAME OF PROVIDER OR SUPPLIER St. Anthony Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 31830 Ryan Road Warren, MI 48092	

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)
<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>(continued on next page)</p>

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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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2609532Based on interview and record review, the facility failed to ensure timely identification and treatment of pressure ulcers for one (R701) of four residents reviewed for pressure ulcer care. Findings include:Review of Intake 2609532 revealed a concern regarding the presence and/or condition of multiple pressure ulcers on R701 upon their most recent admission to the hospital on [DATE]. At the time of this investigation on 09/09/25, R701 remained hospitalized. Review of R701's facility record revealed an original admission date of 10/08/21 and a most recent admission date of 08/13/25 with diagnoses including Protein-Calorie Malnutrition, Sepsis, and Profound Intellectual Disability. This admission followed a hospitalization from 08/08/25 to 08/13/25. Review of the hospital Discharge summary dated [DATE] revealed the Wound Detail section which included the following:A right anterior ankle wound staged as a Deep Tissue Pressure Injury (DTPI-Persistent non-blanchable deep red, purple, or maroon areas of intact or non-intact skin), measuring 1.5 cm (centimeters) length x 1.5 cm width and wound base color of purple/red.A left anterior ankle DTPI measuring 4 cm length x 3 cm width.Additional review of R701's facility record revealed the resident was readmitted to the facility on [DATE] following hospital discharge and a Nursing Comprehensive Evaluation was completed on 08/13/25 by Licensed Practical Nurse (LPN) A. The skin assessment portion of the evaluation (K. Skin) included the question Does the resident have any skin conditions? which was answered No. This assessment included no additional notation identifying any ankle/foot skin conditions. The facility records also included the Total Body Skin assessment dated [DATE] completed by LPN B which included the item Enter the number of new wounds which was answered 0. No notation to this assessment identified any ankle/foot wounds. Notation was made of buttocks pink/red to red with no excoriation. Review of R701's last Total Body Skin Assessment prior to the 08/08/25 hospitalization dated 08/02/25 as well the active physician orders revealed no presence or treatment of any ankle/foot wounds.On 09/09/25 at 1:55 PM, LPN B was interviewed in person and reported they were able to recall R701. They were asked about the skin assessment they authored/completed on 8/14/25 and whether they could recall if they had inspected the resident's feet/ankles. LPN B reported they could not specifically recall if they had or not. LPN B was asked if this assessment would normally include inspection of the entire body and they indicated that it would.On 09/09/25 at 2:21 PM, LPN A was interviewed via phone call and asked whether they could recall if R701 had any skin or wound issues during their 08/13/25 nursing admission assessment. LPN A indicated the resident did not have any that they were aware of and reported if there were any skin issues they would have noted it in the assessment.Further review of the facility record revealed a Change in condition note dated 08/24/25 requesting wound physician consult due to a skin/pressure ulcer issue. The record indicated the wound care consult was completed 08/28/25 and included the following findings:Left lateral foot, deep tissue injury, present on admission, 2.7 cm length x 2.6 cm width.Right dorsum foot, deep tissue injury, present on admission, 2.2 cm length x 1.1 cm width. On 09/09/25 at 2:30 PM, LPN C reported they were the Unit Manager covering R701's room at the time of the 08/13/25 admission. LPN C was informed of the concern that R701 was documented as having bilateral foot/ankle DTPI's upon their 08/13/25 hospital discharge and that the DTPI's were not identified in the facility until 08/28/25, indicating a 15-day delay in initiation of treatment. LPN C reported their expectation is the nursing admission skin assessments should be thorough, include the entire body, and any skin concerns whether previously present or new should be documented.On 09/09/25 at 3:00 PM, the facility Director of Nursing (DON) reported their expectation is the initial admission skin assessments should include the entire body, and any skin concerns should be identified and initial treatment orders put in place.Review of the facility policy Skin Management dated 09/19/24 revealed the Practice Guidelines items:1. Upon admission/re-admission all residents are evaluated for skin integrity by completing a baseline total body skin evaluation documented in the electronic medical record.4. Residents admitted with any skin impairment will have: .Appropriate interventions implemented to promote healing A physician's order for treatment, and Skin impairment location, measurements and characteristics documented.</p>		