STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235447	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Cove Health and Rehabilitation	243 Wiley Road Douglas, MI 49406

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235447	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Cove Health and Rehabilitation	243 Wiley Road Douglas, MI 49406

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2593174 and #2604697.Based on observation, interview and record review the facility failed to ensure residents received the necessary care and services (assessment, monitoring, and treatments) for PICC line (a long, thin tube inserted through a vein in the arm for long-term IV (intravenous) access to administer antibiotic medication) and non-pressure wounds for 2 of 6 residents (Resident #101 & #104) reviewed for quality of care, resulting in infection and the potential for worsening of medical conditions. Findings include:Resident #101Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: infective endocarditis (infection of the inside of the heart). Resident #101 transferred to a different skilled nursing facility on 8/28/25.In an interview on 9/2/25 at 11:00 AM, Nursing Home Administrator (NHA) A explained that they had recently discovered that Resident #101 had not received adequate care and services at the facility following his admission from the hospital on 8/5/25, specifically lack of wound care for his surgical wound on the right foot and management of his PICC line. In an interview on 9/3/25 at 2:07 PM, Registered Nurse (RN) N reported that she was part of a program that provided supplemental care to residents at a community day center. RN N reported that she had noticed concerns related to the care Resident #101 was receiving at the nursing home; his wound bandage was not being changed and his PICC line cap (cover) was not in place. RN N reported that when she saw the resident on 8/8/25 he still had the wound dressing that the hospital applied to his right foot on 8/5/25 and his PICC line was not capped. RN N communicated her concerns to the nursing home and was told that they would implement the care. RN N reported that the PICC line was a direct line to the resident's heart, and a cap was a standard order in place to prevent infection. On 8/11/25 Resident #101 was observed with the same wound dressing that RN N had applied on 8/8/25, his PICC line dressing had not been changed, and there was no cap on the PICC line. At that time RN N communicated with the nursing staff again to ensure that the resident received the proper treatments going forward. On 8/18/25 when the community day center arrived to transfer Resident #101 to the center, they noticed that his PICC line was no longer in place, so they transferred the resident to the hospital to have the PICC line reinserted. RN N reported that they had not been notified of the issue prior to arriving to pick the resident up that day. On 8/20/25 RN N observed that Resident #101 had the wound dressing on his right foot that she had applied on 8/11/25. RN N reported that management got involved at that time to ensure Resident #101's care improved and ultimately decided to transfer the resident to a different facility for skilled nursing care. Review of Resident #101's Hospital Discharge Orders dated 8/5/25 revealed, .Acute bacterial endocarditis.Cellulitis of right lower extremity.Right leg: non-weight bearing.Change Dressing daily as instructed: .Daily, apply 1/4 inch iodoform packing, gently packed to open area proximal incision leaving long tail laid flat over periwound at incision, then cover in stepwise nature with 4 x 4 inch gauze covering the wound, 4 inch kerlix (stretchy gauze) loosely wrap with figure 8 around ankle, 4 inch ACE (wrap) from toes to ankle, 1-3 inch paper tape to secure.you need IV antibiotics for weeks. The antibiotic will be given through the IV access line that was place in the hospital.Cefazolin (antibiotic).into a venous catheter every 8 hours for 20 days.Review of Resident #101's admission Assessment dated 8/6/25 indicated the resident had excoriation (missing the outer layer of skin) on left and right buttocks, swelling to groin, wound on right outer ankle, redness to right lower leg, and scattered scabbing to his left lower leg. The assessment also indicated that the resident was receiving IV medications, but it did not specify the location of the IV and/or PICC line. Review of Resident #101's Care Plan revealed, The resident has potential/actual impairment to skin integrity of the (specify location) r/t (related to). Date initiated 8/6/25. The care plan was not resident centered and did not include locations and/or relevant interventions. Review of Resident #101's Weekly Skin Review dated 8/11/25, 8/18/25 and 8/25/25 each revealed, Skin observation: Any new skin issues identified? No, Indicate sites below: (none listed), Progress note r/t (related to) current skin condition noted on assessment: no new concerns. Review of Resident #101's Care Plan revealed, .requires PICC line therapy r/t acute endocarditis. Date initiated: 8/6/25. Interventions: Dressing changed to PICC line as per MD orders. Dated initiated 8/6/25. The care plan was not resident centered and did not include the PICC line location and/or monitoring. Review of Resident #101's Treatment Administration Record (TAR) revealed, PICC line dressing change dressing weekly and PRN (as needed). Every day shift every Saturday for monitoring. Start date: 8/16/25. The resident admitted on [DATE] (10 days before) therefore missed one weekly PICC line dressing change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235447	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Cove Health and Rehabilitation	243 Wiley Road Douglas, MI 49406

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. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235447	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Cove Health and Rehabilitation	243 Wiley Road Douglas, MI 49406

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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide quality care and treatment for pressure ulcers, consistent with professional standards of practice for 1 resident (Resident #103) of 3 residents reviewed for pressure ulcer prevention and treatment, resulting in the potential for worsening of pressure wounds, and overall deterioration in health status. Findings include: Review of an admission Record revealed Resident #103 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: acquired absence (amputation) of left and right leg below the knee and fractures of the spine. In an observation and interview on 9/3/25 at 10:37 AM in Resident #103's room with CNA (Certified Nursing Assistant) I preparing to provided incontinence care. Observed a large dressing bordered with adhesive on the sacrum (tailbone) dated 9/2/25; the dressing was not fully intact on the bottom edge. Observed a bright red wound on the right buttock with a dark red center and active bleeding, with no dressing over it. There was a dressing covering Resident #103's right knee. After incontinence care was finished CNA I notified the nurse that Resident #103 would need new wound dressings. Review of Resident #103's Treatment Administration Record (TAR) for 9/3/25 revealed, Wound care to rt (right) posterior amputation site (knee): cleanse wound with wound cleanser, pat dry. Apply calcium alginate with silver to wound bed, cut to fit. Cover with bordered dressing. Change daily and PRN (as needed) every day shift for wound care.Review of Resident #103's TAR for 9/3/25 revealed, Coccyx (sacrum): cleanse wound with wound cleanser, pat dry. Apply calcium alginate with silver to wound bed, cut to fit. Cover with silicone super absorbent dressing. Change daily and PRN (as needed) every day shift for wound care.Review of Resident #103's TAR for 9/3/25 revealed, RT (right) buttock shearing: cleanse with wound cleanser, pat dry. May cover with hydroccoloid (moisture-retentive) dressing. Every day shift every Tuesday, Friday for wound care.In an observation on 9/3/25 at 11:34 AM in Resident #103's room with Licensed Practical Nurse (LPN) E to provide wound care to right knee, sacrum and right buttock. LPN E removed the dressing from the right knee, cleansed the wound, and applied a silicone foam dressing over the area. There was no calcium alginate topical applied to the wound and the dressing was not bordered. Next the resident was rolled onto her side, and there was bright red blood noted on the incontinence brief from the open wound on her right buttock. LPN E removed the dressing that was partially detached from the sacrum. Observed an open wound with a small area of slough on sacrum. LPN E cleansed the area and applied a silicone foam dressing over the wound. There was no calcium alginate topical applied to the wound. Lastly the open wound on the right buttock was cleansed and also covered with a silicone foam dressing. The dressing was not a hydrocolloid dressing as the physician order indicated. LPN E was not aware that the wound treatment orders indicated calcium alginate and reported that a hydrocolloid dressing was similar to the foam dressing. Review of Resident #103's Weekly Pressure Wound Observation tool dated 8/28/25 revealed, .sacrum.stage 2, .Date acquired: 8/22/25.40% necrosis (dead tissue) and/or slough (dead tissue) in the wound bed.unchanged. Review of Resident #103's Weekly Pressure Wound Observation tool dated 8/28/25 revealed, .right knee (rear). stage 2, Date acquired: 8/22/25.100% eschar/scab.unchanged.Review of Resident #103's Weekly Pressure Wound Observation tool dated 8/28/25 revealed, .right buttock. stage 2, Date acquired: 8/1/25. peri-wound red.unchanged.Review of Resident #103's Care Plan revealed, .has a stage 2 to right buttock with the potential for discomfort and infection. Date initiated: 8/15/25. Interventions: Administer treatments. Assess/record/monitor wound healing weekly.Follow facility policies/protocols for the prevention/treatment of skin breakdown.Monitor dressing every shift.Monitor/document/report PRN (as needed) any changes in skin status.Weekly treatment documentation.Date initiated: 8/15/25. There was no record of the resident's stage 2 pressure ulcer on her coccyx and/or her stage 2 pressure ulcer on her right knee. Review of Resident #103's Weekly Skin Observations with the most recent skin observation was documented on 8/12/25 revealed, Skin observation: Any new skin issues identified? No, Indicate sites below: (none listed), Progress note r/t (related to) current skin condition noted on assessment: no new concerns.In an interview on 9/5/25 at 11:11 AM, Director of Nursing (DON) B reported that LPN E had forgotten to apply Resident #103's calcium alginate and would be disciplined for not following physician orders. DON B reported that Resident #103's care plan did not include all of her wounds and the CNA's use that as their direct care reference. DON B also reported that Resident #103 did not have weekly skin observations documented for the past 3 weeks.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235447	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Cove Health and Rehabilitation	243 Wiley Road Douglas, MI 49406

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235447	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Cove Health and Rehabilitation	243 Wiley Road Douglas, MI 49406

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2593174 & 2604697. Based on observation, interview, and record review, the facility failed to provide necessary oxygen and CPAP (a device that delivers continuous positive airway pressure to ensure airway stays open during sleep) per physician orders and maintain oxygen tubing according to the standards of practice for 2 residents (Resident #101 & #104) of 4 residents reviewed for respiratory care, resulting in the potential for respiratory distress, the development and spread of respiratory infection and disease, and the exacerbation of respiratory conditions. Findings include: Resident #101Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: chronic obstructive pulmonary disease (blocks airflow and makes it hard to breathe).Review of Resident #101's admission Assessment dated 8/6/25 indicated that he used oxygen and a CPAP. The settings for these were not noted. Review of Resident #101's Physician Orders revealed, Resident may use CPAP from home. Settings should remain on APAP (automatic positive airway pressure) at 8-15 cm of water. At bedtime for OSA (obstructive sleep apnea). Start date 8/11/25 at 6:00 PM and CPAP; clean mask with soap and water daily. Allow to air dry. Every day shift for CPAP. Start date 8/12/25. This order was 6 days after the resident admitted . Review of Resident #101's Physician Orders revealed, Continuous O2 (oxygen) therapy via NC (nasal cannula) at 2-3L (liters) to maintain SPO2 (percentage of oxygen in your blood) of >90%. Please provide portable tank during activities and when visiting the day center. Every shift for respiratory monitoring. Start date: 8/11/25. This was 5 days after the resident admitted . Review of Resident #101's Care Plan revealed, The resident has oxygen therapy r/t (related to). Date initiated: 8/6/25. The care plan was not resident centered and did not include the resident's type and/or amount of oxygen. There was no care plan for CPAP. In an interview on 9/2/25 at 1:52 PM, Director of Nursing (DON) B reported that Resident #101 should have had orders in place upon admission to ensure his Oxygen and CPAP were being administered consistently. The orders were entered into the computer and TAR after the community day center expressed concerns. In an interview on 9/2/25 at 1:39 PM, Licensed Practical Nurse (LPN) E reported that Resident #101 required constant supplemental oxygen to ensure his blood oxygen level stayed in the mid 90's; if the oxygen was not positioned correctly on his nose, his blood oxygen level would drop quickly. In an interview on 9/3/25 at 2:07 PM, Registered nurse (RN) N reported that she was part of a community day center that provided supportive care for Resident #101. RN N reported that Resident #101 arrived at the day center on 8/13/25 short of breath, and it was discovered that his portable oxygen tank was not turned on and the tubing for his oxygen was kinked; he was without his supplemental oxygen for at least 25 minutes while he was driven to the day center. Resident #101's blood oxygen level was 80% and should be above 90%. Resident #104Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: heart failure.During an observation and interview on 9/3/25 at 9:21 AM in Resident #104's room, he was lying in bed wearing oxygen via nasal cannula (NC) running via concentrator at 2 liters. Resident #104 reported that he wears his oxygen all the time. The oxygen tubing was observed with tape labeled with the date of 8/24/25. Review of Resident #104's Physician Orders revealed, .Oxygen at 1L (liter) as needed, wean off to keep O2 (oxygen) saturation >92%. Active date: 7/10/25. This order was not transcribed to the TAR to ensure nursing would administer and monitor. Review of Resident #104's TAR revealed, Change and date O2 tubing every Sunday NOC (night) every night shift every Sunday. Start date: 7/20/25. The administration record indicated that the tubing was changed on Sunday 8/31/25 but based on the observation made in Resident #104's room on 9/3/25 it was last changed on 8/24/25. Review of Resident #104's Oxygen Saturation Level record indicated, 96% on room air 9/1/25, 8/25/25, & 8/18/25. In an interview on 9/3/25 at 9:40 AM, LPN E reported that oxygen tubing should be replaced once a week on Sundays. LPN E was not sure what Resident #104's oxygen setting was supposed to be and it wasn't listed on the TAR.