STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235450	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Allendale Nursing and Rehabilitation Community	11007 Radcliff Drive Allendale, MI 49401

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** This citation pertains to intakes # 2801558 and 2807946Based on interview and record review, the facility failed to provide care following professional standards of practice and facility policy to prevent the development and/or worsening of pressure injuries for 3 of 5 residents (Resident #100, #42, and #41) reviewed for pressure injury prevention and management, resulting in a stage IV sacral decubitus ulcer with exposed bone and presumed osteomyelitis for R100.Findings:Resident #100 (R100)Review of an admission Record revealed R100 was a [AGE] year-old female, originally admitted to the facility on [DATE] and readmitted following a hospitalization from 6/12/25-6/26/25, with pertinent diagnoses which included: frontal brain mass resection, urinary incontinence, cognitive communication deficit, and need for assistance with personal care. Further review of the admission Record revealed R100's spouse was Emergency Contact #1.Review of R100's SLUMS Evaluation (St. Louis University Mental Status Exam to determine mental status) dated 6/5/25 completed by Speech Language Pathologist (SLP) N revealed, .Examination for detecting mild cognitive impairment and dementia is more sensitive than the Mini-Mental Status Examination. A score from 1-20 for a person with a high school education indicates dementia. R100 scored a 10.Review of a Minimum Data Set (MDS) assessment for R100, with a reference date of 7/2/25 revealed a Brief Interview for Mental Status (BIMS) score of 11, out of a total possible score of 15, which indicated R100 was moderately cognitively impaired. Review of R100's Care Plan dated 06/10/2025 revealed, Cognitive Loss / Dementia-Resident has impaired cognition that fluctuates.Review of R100's Electronic Medical Record (EMR) revealed R100 was hospitalized from [DATE]-[DATE] following a craniotomy with the surgical excision of a large meningioma (brain tumor). Upon return to the facility, R100 required the use of an enteral feeding tube for nutrition and hydration supplementation but was also able to consume food and liquids orally.During an interview on 03/25/2026 at 10:17 AM, Family Member (FM) I reported that she and R100's spouse had not been notified of R100's pressure injury at the time of the care conference on 7/9/25. FM I reported that the care conference was to discuss all areas of concern and treatment plans and goals with family involvement, and she would have expected to be notified of a pressure injury at that time. FM I reported that the family and R100's spouse were completely unaware of the pressure injury or the severity of her wound until 7/30/25 when R100's spouse was at the facility during the time wound care was being completed stating we didn't know through that whole timeframe! FM I reported that she requested a meeting with management based on R100's spouse's observation from 7/30/25 and on 8/4/25 she was notified of the severity of the wound but had been told the wound was getting better. FM I reported that the director had told her that upon R100's return from the hospital a stage 1 pressure injury was identified and blamed the hospital. She was then told that it was a stage 3 pressure injury by 7/11/25. FM I reported that throughout her readmission on [DATE] until the meeting on 8/4/25 nobody said anything about treating it (the pressure injury) and stated, I don't know when it went to a stage 4. FM I reported that they were unaware of the severity of the wound until R100 was sent to the emergency department on 8/6/25 where they were told the pressure injury and infection that went into the bone. FM I reported R100 was in extreme pain and reported she did not recover from the pressure injury and infection, and (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	her cause of death was from a stage 4 sacral ulcer.Review of R100's Care Plan with an approach start date 6/27/25 revealed, Category: ADLs Functional Status/Rehabilitation Potential Resident needs assistance with ADLs and care r/t: recent hospitalization, weakness, debility, overall functional decline. Bed mobility: 2PA (2 person assistance). R100 was independent for bed mobility prior to readmission.Review of R100's Care Plan dated 6/2/25 revealed, Category: Urinary Incontinence Resident is occasionally incontinent of bladder. Apply moisture barrier to skin PRN (as needed). R100's care plan did not reflect she was incontinent of bowels.Review of R100's Order Summary dated 6/26/25 revealed, Apply skin protectant after each incontinent episode / toileting assistance / brief change.Review of R100's Care Plan dated 06/02/2025 revealed, 06/05/2025 Category: Nutritional Status .*7/10/25: Significant weight loss at 30 days (prior to Corpak) .Approach Start Date: 06/05/2025 Observe labs.Review of R100's Laboratory Results dated 6/11/25 revealed R100's Albumin was 3.6 (Reference Range 3.5-5.7) and her protein was 6.4 (Reference Range 6-8.3). Review of R100's Critical admission Assessment dated 6/26/25 revealed Skin: Check all that apply-reddened.sutures to craniotomy site.Review of R100's Skin Body Assessment dated 6/26/25 written by Registered Nurse (RN) O revealed, left temporal hs bump and discoloration (sic). Head has 49 stitches and open to air. Left hand has bruising. Left wrist and left forearm have bruising. Left antecubital area has bruising. left outer and inner upper arm has bruising. Laft (sic) anterior shoulder have bruising. left thigh inside has bruising. Right hand and right antecubital area have bruising. Lower abdominal has multiple bruising. There was no documentation regarding a pressure injury to R100's buttocks.Review of R100's Progress Note written by Assistant Director of Nursing (ADON) B revealed, incontinent of bowel and bladder, A&O2-3 (A&O x4 refers to a person's level of orientation to four aspects: person, place, time and situation/circumstances. A&O x 2 can indicate confusion regarding time or situation).bilateral buttock red but blanchable. indicating no pressure injury. (Per the National Pressure Injury Advisory Panel, a Stage 1 Pressure Injury is non-blanchable erythema (redness) of intact skin.)Review of R100's Skin Body Assessment dated 6/26/25 written by RN O revealed the document was modified on 8/3/25 by ADON B to include .Stage one to buttock.Review of R100's EMR revealed no documentation that R100's spouse/emergency contact or provider were notified of the stage 1 pressure injury or that R100's care plan was updated to reflect the pressure injury with interventions to heal and/or prevent the worsening of the pressure injury or with R100's change of bowel control to incontinence.During an interview on 03/25/2026 at 3:22 PM with Regional Nurse Consultant (RNC) A present, Assistant Director of Nursing (ADON) B reported that due to the time that had lapsed she could not recall why she had modified Registered Nurse (RN) 0's Skin Body Assessment dated 6/26/25 but believed it was prompted from RN O's admission assessment upon her return from the hospital. RNC A and ADON B reported R100's husband was not notified of the pressure injury on 6/26/25 because R100 was her own person and did not have an activated power of attorney or responsible party.Review of the facility policy Notification of Change dated 7/2017 revealed, .9. The resident's legal representative or interested family member is notified of a significant change in the residents condition unless the resident has specified otherwise.Review of R100's physician Progress Note dated 6/27/25 revealed no documentation of a stage 1 pressure injury.Review of R100's dietary Progress Note dated 6/27/25 revealed, .Skin observation 6/26/25 indicates sutures to craniotomy. Score of 7 on mini nutrition screen indicating malnutrition, no interventions requested at this time. Continue to monitor weights/skin with po (oral) intake and adjust nutritional POC (plan of care) as needed. Confirming there was no pressure injury documented upon R100's readmission and therefore no supplements were initiated.During an interview on 3/26/26 at 10:06 AM, Registered Dietician (RD) K reported that had she been notified of R100's pressure injury identified on 6/26/25 she would have initiated the supplement pro heal to promote wound healing. RD K reported that she used the skin assessments completed upon a resident's return to determine their needs. RD K reported that she reviewed weekly wound and skin assessments to determine ongoing needs for the residents and their healing/nutritional requirements. Once a wound advances to a stage (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	physician's determination R100's pressure injury was unavoidable.)Review of R100's Order Summary dated 7/10/25 revealed, Cleanse area with soap and water, apply thin layer of triad cream to wound bed. Reapply twice daily.Review of R100's Treatment Administration Record revealed the wound treatment was completed on 7/10/25 between 7PM-11PM. (Approximately 24 hours after the identification of the wound).During an interview on 03/25/2026 at 3:22 PM RNC A and ADON B reported the reason there was a lapse from the initial identification of R100's pressure injury and the initiation of treatment was because previous Director of Nursing (PDON) L abruptly quit her position without notice while ADON B was on vacation. The concern was acted upon when ADON B returned.Review of R100's Wound Consultant Note dated 7/11/25 revealed, (R100) is seen today for a wound to her sacrum present for less than a week. Staff notes area did start to break down last week-treating with triad paste. She does verbalize some tenderness to the area.She does require staff assistance with mobility. The wound measured 4 (cm) x 3 (cm) x 0.2 (cm) and was determined be a Stage 3 pressure injury. A mechanical debridement (removal of dead tissue from wound bed). An order to start Medihoney gel to wound bed on sacrum.Cover with silicone bordered foam dressing every other day was initiated.Review of R100's EMR revealed no documentation that R100's spouse/emergency contact was notified of the worsening of the pressure injury, the debridement, or the treatment order change. R100's Care Plan was not updated to reflect the deterioration of the wound and no new interventions were implemented to promote the healing of and/or prevent the worsening of the pressure injury.Review of R100's Dietary Assessment dated 7/14/25 revealed, Skin observation 7/8/25 indicates open area to left buttock, request Pro Heal 30ml (100 kcal, 15 grams pro, ea) QD (everyday) be added. Review of R100's EMR revealed Pro Heal was ordered 7/14/25.Review of R100's Laboratory Results dated 7/16/25 revealed R100's Albumin was 2.4 and her protein was 5.1 (now below normal limits). R100's WBC (white blood cell-indicative of infection) was 10.6 (Reference Range 4-11). A handwritten date of 7/18/25 was reflected on the report indicating the provider reviewed the results.Review of R100's EMR revealed no documentation of any new treatments, medications, or interventions for R100's abnormal labs.Review of R100's Wound Consultant Note dated 7/18/25 revealed R100's sacrum wound was deteriorating and now measured 5.2 x 5 x 2.8 and required a sharp debridement. (use of scalpels, scissors, or forceps to remove dead tissue from wound bed). An order to start Dakin's solution 0.125% moistened gauze into wound bed.twice daily.Review of R100's Wound Management Note dated 7/18/25 revealed the wound was stable which contradicted the wound providers assessment.Review of R100's EMR revealed no documentation that R100's spouse/emergency contact was notified of the deteriorating pressure injury or the debridement. R100's Care Plan was not updated to reflect the deterioration of the wound and no new interventions were implemented to promote the healing of and/or prevent the worsening of the pressure injury.Review of R100's Progress Note dated 7/19/25 revealed, Resident returned from Hospital.resident was diagnosed with PNA (pneumonia) and hospital prescribed Ceftin 500mg x2 day for 5 days and Doxycycline 100mg x2 day for 5 days (antibiotics).DON notified of residents return and new diagnosis of PNA and ABX (antibiotics) order.Review of R100's Wound Consultant Note dated 7/25/25 revealed, She was sent out to the ED (emergency department) last week for pneumonia.Recent pneumonia may affect mobility. R100's sacrum wound was deteriorating and now measured 7.4 x 7 x 3.4, had a mild odor, and required a sharp debridement. Continue Dakin's solution 0.125% moistened gauze into wound bed .Twice daily. RD (registered dietician) to ensure nutritional intake is ideal for wound healing including increase protein intake.Review of R100's EMR revealed no documentation that R100's spouse/emergency contact was notified of the deteriorating pressure injury or the debridement. R100's Care Plan was not updated to reflect the deterioration of the wound and new diagnosis of pneumonia and no new interventions were implemented to promote the healing of and/or prevent the worsening of the pressure injury. There was no documentation that the dietician was notified of the worsening of R100's wound.Review of R100's Order Summary dated 7/25/25 revealed, Cleanse area with NS/wound cleanser. Apply Dakin's solution 0.125% moistened gauze into (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	wound bed. Cover with bordered dressing. Every shift.Review of R100's Medication/Treatment Administration Record revealed that from 7/25/25-8/2/25 the Dakins 0.125% treatment was completed 3 times a day and not 2 times a day as recommended.During an interview on 03/25/2026 at 3:22 PM, ADON B reported that the wound consultant ordered the Dakin's treatment himself. ADON B reported that the wound treatment may have been inputted into the system incorrectly but the error was on his end.Review of R100's EMR revealed no documentation of the treatment order discrepancy or communication to the wound provider for a clarification order.Review of R100's Order Summary revealed the enteral feeding was held/discontinued on 7/30/25.Review of R100's Dietary Assessment dated 8/1/25 revealed, .Wound report indicates stage III to coccyx, stable 7/18/25.Considering NG (nasogastric) tube feeding on hold and average po intake, request med pass 120ml.TID (three times a day) and mighty shake.QD (daily) be added also increase pro heal.from QD (daily) to BID (twice a day). The assessment did not include a review of her abnormal laboratory studies (worsening of protein and albumin) and did not accurately reflect the state of R100's deteriorating pressure injury.Review of R100's Wound Consultant Note dated 8/1/25 revealed, Her appetite has been poor. Currently working on increasing PO (oral) intake. They have placed her tube feeding on hold. R100's sacrum wound was deteriorating and was now a stage 4 pressure injury. The wound measured 6.5 x 8.3 x 4 and had undermining with exposed fascia (connective tissue). The periwound (surrounding) was noted to have excoriation (skin damage) and rubor (redness caused by inflammation). A sharp debridement was performed and it was recommended to continue Dakin's solution 0.125% moistened gauze into wound bed .Twice daily.Review of R100's Order Summary revealed Coccyx: Cleanse area with NS/wound cleanser. Apply Dakin's solution 0.125% moistened gauze into wound bed. Cover with bordered dressing. Every shift. Twice A Day which was implemented on 8/3/25. (Previous order of Sakin's solution 0.125% three times a day ongoing until 8/3/25.)Review of R100's EMR revealed no documentation that R100's spouse/emergency contact was notified of the deteriorating pressure injury or the debridement. R100's Care Plan was not updated to reflect the deterioration of the wound and no new interventions were implemented to promote the healing of and/or prevent the worsening of the pressure injury.Review of R100's Laboratory Results resulted on 8/1/25 at 8:28 PM revealed R100's Albumin was 2.0 and her protein was 4.9 (continuing to trend down). R100's WBC was 14.8 (indicating an infection). A handwritten date of 8/4/25 was reflected in the report indicating the provider reviewed the results.Review of R100's Care Conference dated 8/4/25 revealed it was a family requested care conference. Care Conferencce (sic) held with residents daughter in law to discuss residents progress with wounds, therapy and to determine if there is a time frame that resident is expected to go home. information on wound statues, interventions, intake status and corpak given to (FM I). all questions were answered to the best of our ability and (FM I) verbalized understanding.Review of R100's Order Summary dated 8/4/25 revealed the osmolyte enteral tube feeding was restarted. (Approximately 3 days following R100's low protein and albumin levels).Review of R100's Dietary Assessment dated 8/5/25 revealed, .Wound report is indicating stage IV to coccyx stable as of 7/18/25.Agree with restarting tube feeding as po intake of meals has not improved with significance/ not meeting her elevated nutritional needs, unknown current weight status and coccyx wound has changed from stage III to IV. Suggest continuing with current po supplements as ordered.Review of R100's Practitioner Progress Note dated 8/6/25 revealed, .This morning the patient is seen lying in bed. She states that she did not sleep well last night because of her sacral pain. There is an order for her to be turned every 2 hours but she claims they are not doing it.Review of R100's Progress Note dated 8/6/25 revealed, (R100) was working with therapy, she was unable to sit on the EOB (edge of bed) less than 5 minutes without feeling lightheadedness and dizziness. Resident stated that it started yesterday and today it's worse. Pulse elevated, WBCs 14. NP (Nurse Practitioner) notified, order received to send resident to the ED for evaluation and treatment.Review of R100's Hospital Record dated 8/6/25 revealed, .There is a significant 10 x 10 centimeter stage IV decubitus ulcer along her sacrum. Foul-smelling purulent (oozing pus) drainage (continued on next page)

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(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	3/18/26 through 3/24/26 the order for dressing changes to be completed on Monday, Wednesday, and Friday was completed on 3/18/26, 3/20/26, 3/23/26 and 3/25/26. The treatment was an ongoing order.From 3/19/26 until 3/23/26 the order that was to be completed daily was completed on: 3/19/26 on the afternoon and evening shift3/20/26 on the morning, afternoon, and evening shift3/21/26 on the morning and evening shift3/22/26 on the morning and evening shift3/23/26 the order was discontinued.Confirming the wound clinic's order for 3 times a week wound care/treatment was not followed as ordered.Review of R42's Electronic Medical Record revealed no documentation related to the treatment order implemented on 3/19/26 or a rationale for initiating an additional treatment.During an interview on 03/26/2026 at 12:06 PM, Assistant Director of Nursing (ADON) B reported that the additional order for wound care was due to the nurse working on 3/19/26 erroneously believing there was no order for R42's wound care thus obtaining an order from the facility provider.On 03/25/2026 at 1:08 PM, Nursing Home Administrator (NHA) provided documentation confirming the additional order from 3/19/26 was not discontinued until 3/23/26.Review of R42's Order Summary dated 2/19/26 revealed, Skin Assessment Weekly.Review of R42's weekly Skin Body Assessments for the month of March 2026 revealed the only assessment that was completed was on 3/23/26 (last skin assessment was completed on 2/27/26).Review of R42's Electronic Medical Record revealed no documentation for missed/late weekly skin assessments.Resident #41 (R41)Review of an admission Record revealed R41 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Parkinson's disease, protein-calorie malnutrition, and muscle weakness. Further review of the admission Record revealed R41 was hospitalized from [DATE]-[DATE].Review of R41's Order Summary dated 2/23/26 revealed, Skin Assessment Weekly.Review of R41's Care Plan dated 2/23/26 revealed, Skin Integrity-(R41) is at risk for impaired skin integrity related to: recent hospitalization with overall decline from baseline, decreased mobility, advanced age, presence of pressure ulcers currently, fragile skin, advanced age, incontinence. Complete skin inspection weekly and as needed.Review of R41's weekly Skin Body Assessments beginning on 2/23/26 revealed:A skin assessment was completed on 2/23/26. There was no skin assessment completed on 3/2/26. An assessment was not completed again until 3/5/26 (10 days).There was no weekly skin assessment completed on 3/12/26 or 3/19/26. R41's skin assessment was not completed until 3/23/26 (18 days).Review of R41's Electronic Medical Record revealed no documentation for missed/late weekly skin assessments.During an interview on 03/25/2026 at 1:16 PM, RNC A reported that ADON B was in charge of the wound management program and weekly wound meetings were to be held to monitor and track the progress of resident wounds. RNC A reported that weekly skin assessments were to be completed by the licensed nurses and the Certified Nursing Assistant (CNA) shower sheets were not to be utilized in place of the weekly skin assessments. RNC A reported that the licensed nurses would sign off on the CNA shower sheets but that was not a replacement for the licensed nurse assessment of resident skin. RNC A confirmed that weekly skin assessments had not been completed as directed by the facility policy.Review of the facility policy Pressure Injury Prevention and Care last revised 01/2025 revealed, This policy is intended to supplement the clinical staff's knowledge and provide a resource to guide on wound prevention and management procedures. The procedures and information contained herein are not intended to replace a licensed nurse's clinical judgment and experience and may not pertain to each individualized pressure injury occurrence.Purpose: To promote and facilitate pressure injury prevention and implement appropriate interventions and treatment of pressure injuries to promote and facilitate resolution of pressure injuries.Procedure:Nurses will complete the Skin Body Assessment Observation upon admission/readmission, then weekly and as needed.5. Interventions will be implemented, and care planned to prevent pressure injury development or to promote pressure injury resolution. Examples of interventions based on individualized resident needs may include the following. This list is not all-inclusive, nor does