STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235462	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corewell Health Rehab & Nursing Center-Commons Far	21450 Archwood Circle Farmington Hills, MI 48336

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

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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 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 Complaint #2575124.Based on observation, interview, and record review, the facility failed to effectively monitor residents' skin, identify new skin impairments in a timely manner, thoroughly assess and determine the root cause of new skin impairments, and implement treatment in a timely manner for two (R802 and R803) of three residents reviewed for wounds. Findings include:R802On 8/14/25 at 12:05 PM, R802 was observed lying in bed. R802 had a dressing dated 8/13/25 applied to the top part of her left lower leg. The skin surrounding the dressing was observed with dark, purple discoloration. When queried about what happened to her leg, R802 stated, Nothing exciting. R802 appeared confused with further questioning. On 8/14/25 at 2:06 PM, R802 was observed lying in bed on her back. When queried about when treatment is completed on her leg, R802 reported the wound nurse said she would do it at 2:30 PM. R803 said, Be ready for some screaming! and reported it was painful when the bandage was removed. On 8/14/25 at approximately 2:06 PM, an observation of wound care to R802's left leg was conducted with the Wound Care Coordinator, Registered Nurse (RN) ‘C'. RN ‘C' confirmed with R802 and their assigned nurse that R802 received pain medication one hour prior to wound care. RN ‘C' said R802 screamed out with all care and treatments but was cooperative with having the treatment rendered. RN ‘C' removed the wound dressing. A small open area was observed on the top of R802's left lower leg with dark, purple discoloration surrounding the open area. A review of R802's clinical record revealed R802 was admitted into the facility on 6/2/23 and readmitted on [DATE] with diagnoses that included: dementia and congestive heart failure. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R802 had severely impaired cognition, was dependent on staff for bed mobility and transfers and did not walk. During that assessment, R802 did not have any non-pressure related skin impairments. On 8/14/25 at 1:44 PM, any incident reports for the past three months for R802 were requested. The DON reported R802 did not have any incident reports for the past three months. A review of R802's progress notes revealed on 6/11/25, R802 had a small pinpoint abrasion on left lower leg. A review of Physician's orders revealed an order for treatment was put into place on 6/12/25 and discontinued on 6/26/25 when it was documented the skin impairment was resolved on 6/24/25. Further review of R802's clinical record revealed no assessment of the pinpoint abrasion to R802's left lower leg.A review of R802's Shower Skin Assessments dated 6/30/25, 7/3/25, 7/10/25, 7/14/25, 7/17/25, 7/21/25, 7/24/25, 7/28/25, 7/31/25, 8/4/25, 8/7/25, and 8/11/25 revealed R802 had skin discoloration to the front of her right and left lower leg and no new wounds. A review of a Skin/Wound Note dated 8/1/25 revealed, Upon inspection of skin during treatment for coccyx PI (pressure injury), left lower leg with bruising with 2 open wound areas were discovered. Distal (farthest from the center of the body) wound measuring 1.1 x 1.5 cm (centimeters) and proximal (closest to the center of the body) wound measuring 0.5 x 0.6 cm. Nurse. reported that this has been present for some time, but no wound care orders nor incident report were found. Treatment orders now in place. (It should be noted that it was documented the previous skin impairment to R802's left lower leg was resolved as of 6/24/25).Further review of R802's clinical record revealed no documentation of how R802 sustained open areas with surrounding discoloration to the left lower leg. A review of R802's active Physician's Orders revealed an order with a start date of 8/2/25 for Medihoney to the left lower leg every day shift. On 8/14/25 at 2:38 PM, an interview was conducted with the facility's Wound Care Coordinator, Registered Nurse (RN) ‘C'. When queried about the facility's protocols for monitoring residents' skin for new skin impairments, RN ‘C' reported on admission, the primary nurse conducted a skin assessment and RN ‘C' did a second assessment. Additionally, the nurses assessed resident's skin during showers two times a week. When queried about the protocol when a new skin impairment was identified, RN ‘C' referred to a document titled, Wound Identification and Follow-Up Checklist and explained it was recently implemented after identified concerns with wounds. A review of the document revealed the following, 1. When a wound is initially identified, it is the responsibility of the Nurse first observed the wound to assess the area, location, size, depth, exudate, etc.2. Document the findings in the Nurse's notes, and 24 Hour Report. 3. Notify the Physician of the assessment findings, obtain appropriate Treatment orders based on facility treatment protocols.4. Document the notification of the Physician, and any new orders in the Nurses Notes.6. Follow-up with the Physician's Orders.7. Initiate the Treatment order and document.8. Communicate the new area and treatment orders to the Wound Care Nurse.10. The Wound Care Nurse will update the plan of care with the Current stage and location of the wound. RN ‘C' explained that Physician ‘B' came to the facility

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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	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #2575124.Based on observation, interview, and record review, the facility failed to thoroughly assess and implement timely treatment for a shearing injury for two (R801 and R803) of three residents reviewed for pressure ulcers, resulting in R801 developing an avoidable Stage III (Full-thickness skin loss) pressure ulcer that worsened to an Unstageable (Obscured full-thickness skin and tissue loss) pressure ulcer. Findings include:A review of R801's clinical record revealed R801 was admitted into the facility on 6/13/25 and discharged on 7/18/25 with diagnoses that included: spinal stenosis. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R801 had intact cognition, required substantial/maximal assistance for bed mobility and transfers, was always incontinent of urine and stool, was at risk for developing pressure ulcers, and did not have any unhealed pressure ulcers at the time of the assessment.A review of an admission Assessment dated 6/14/25 (the day after R801 was admitted into the facility) revealed R801's skin was intact. A review of R801's Shower Skin Assessments conducted on 6/21/25, 6/25/25, and 6/28/25 revealed R801 did not have any new skin issues. The next Shower Skin Assessment was dated 7/9/25, 11 days after the previous assessment, and indicated R801 did not have any new skin issues. A review of R801's progress notes revealed the following:A Nurses Note dated 6/27/25 documented, .dry dressing in place.family notified of situation.wound consult in place. There was nothing documented that indicated where the dry dressing was located, what the situation was, or why a wound consult was needed.A Skin/Wound Note dated 6/30/25, three days later, documented, Resident seen for wound consult r/t (related to) wound to coccyx, wound measuring 4.0 x 2.0 cm (centimeters), pink bed, serosanguinous drainage. Area cleared with ns (normal saline), pat dry, Medihoney (wound dressing) and dry dressing applied. Treatment orders in place. A Skin/Wound Note dated 7/2/25 revealed Resident seen for wound consult (on 7/1/25) r/t wound to coccyx, wound measuring 4.0 x 1.0, pink bed, serosanguinous drainage.A review of R801's physician's orders revealed an order dated 6/27/25 for wound consult: opened area to coccyx area. There was no treatment order for the wound until 7/1/25 which was ordered by the contracted wound provider, Physician 'B'.A review of a Wound/Vascular Consult written by Physician 'B' on 7/1/25 revealed R801 was seen for an initial consult for a coccyx ulcer. It was documented in the consult that R801 had a Stage 3 coccyx ulcer that measured 4.0 x 1.0 cm, and the wound bed was pink with slough (non-viable yellow, tan, gray, green or brown tissue). The treatment recommendations were for Medihoney to the ulcer every day. Further review of R801's clinical record revealed the next time R801's coccyx ulcer was evaluated by Physician 'B' was on 7/15/24, 14 days after the last consult mentioned above. There were no other assessments of the wound documented in the clinical record between 7/2/25 and 7/15/25. A review of a Wound/Vascular Consult dated 7/15/25 revealed R801's coccyx ulcer was Unstageable and measured 4.0 x 2.5 cm and necrotic (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like, usually firmly adherent to the base of the wound). A review of an incident report dated 6/26/25, written by Licensed Practical Nurse (LPN) 'A' revealed, Aid <sic> made Nurse aware of a small skin tear on pts (patient's) butoxy <sic> while she was changing her brief.writer applied barrier cream to area.A review of an Injury of Unknown Origin - Investigation Report signed off by the Director of Nursing (DON) on 7/1/25 revealed a skin tear to the coccyx area was found on R801 on 6/26/25 (it should be noted that there was no documentation of any skin impairment in the clinical record on that date). It was documented that a dry dressing and barrier cream was applied, R801 was to have a wound consultation, offloading as possible, the area kept clean and dry, and barrier cream applied. It was documented R801 was seen for a wound consultation, five days later, on 7/1/25 and the wound was identified as a Stage 3 pressure ulcer. It was documented the pressure ulcer started as shearing (When layers of skin rub against each other or when the skin remains stationary and the underlying tissue moves and stretches and angulates or tears the underlying capillaries and blood vessels causing tissue damage). Further review of R801's clinical record revealed R801 did not have any ordered treatment in place between 6/26/25 when the skin tear was first identified and 7/1/25 when Physician 'B' assessed the wound to be a Stage 3 pressure ulcer. There was no further assessment of the skin impairment to R801's coccyx after it was identified as a skin tear on 6/26/25 until the Skin/Wound Note documented on 6/30/25 that did not mention any slough as assessed by Physician 'B' on 7/1/25. No impairment to R801's skin was identified on any Shower Skin Assessments.A review of R801's care plans revealed a care plan created on 6/13/25 that