STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235502	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Corewell Health Rehabilitation & Nursing Center -	16391 Rotunda Dr Dearborn, MI 48120

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 intake 2961759.Based on interview and record review, the facility failed to implement interventions and skin treatments as prescribed to prevent the development or worsening of pressure ulcers for two (R703 and R708) of five residents reviewed for pressure ulcers resulting in R703 and R705 developing stage 3 pressure ulcers (total loss of skin, exposing fatty tissue) to the coccyx area while in the facility.Findings include:The State Agency received a complaint that R708 developed a pressure ulcer at the facility.R708:According to R708's closed Electronic Health Record (EHR), R708 re-admitted to the facility on [DATE] with multiple diagnoses that included surgical repair in the cervical region of C3-C6, diabetes, and metabolic encephalopathy. On 12/12/25, the Clinical admission Assessment Section 5 - Skin Condition indicated R708 had no ulcers, no skin problems, and no skin treatments. A skin assessment dated [DATE] identified R708 to have MASD (moisture associated skin disorder) on the groin and scrotum with cicatrix (scar tissue following a healing wound). The left heel was non-blanchable (does not fade or lighten in color when light pressure applied) and discolored. Protective heel boots were ordered and Triad paste (zinc-oxide based cream) to the coccyx area. There is no documentation to support the Triad paste was applied to R708's coccyx area or the protective heel boots were applied. The Minimum Data Set (MDS) dated [DATE] indicated R708 had severe cognitive impairment, required extensive assistance for mobility, and one unstageable DTI (deep tissue injury that is a full thickness wound where depth cannot be measured because it is covered with dead tissue). The location of the DTI is not specified. Section M1200 indicated there was no pressure reducing bed or chair and no turning and repositioning program. A care plan for at-risk for skin breakdown was initiated on 12/16/25 that included floating heels while in bed, use of pressure reducing mattress to bed and cushion while in wheelchair and encourage and assist resident to turn and reposition. There are no additional progress notes or skin assessments regarding R708's skin from 12/16/25 - 12/25/25.On 12/25/25 a progress note written by Licensed Practical Nurse (LPN) B documented the following: a foam dressing was observed on the coccyx, when removed noted an area with eschar (blackened dead tissue), edges are rough, no drainage. Noted additional open areas along the bilateral buttock region at tailbone. There are no measurements or additional descriptions of R708's wounds. An order for Manuka Honey 100% was prescribed for R708's coccyx area 3 times a week; Tue, Thu, Sat. The Medication Administration Record (MAR) indicated R708 received the treatment two times; 12/25/25 and 12/27/25.During interview with LPN B on 3/27/25 at 10:20 AM they said they observed the foam dressing on R708's coccyx during incontinence care. LPN B stated, I did not know he had any wound prior to that. It alarmed me to see the foam patch. When I removed it there was eschar over the wound. LPN B said they did not know when the foam patch was applied to R708 because there was no date on it. LPN B reviewed R708's EHR and confirmed there were no progress notes, skin assessments or treatments for the coccyx area prior to 12/25/25. LPN B did not recall if R708 had any skin concerns with the left heel. During an interview with the Director of Nursing (DON) on 3/27/25 at 11:00 AM, confirmed there were no skin assessments or treatment orders for the coccyx area until 12/25/25. The DON stated, I determined who put the foam patch on. They worked on 12/23/25. There is no documentation. There (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	are no skin treatment orders until 12/25/25. The DON confirmed this was not facility protocol. A request was made for the facility's skin care protocol/policy.On 3/27/25 at 11:47 AM LPN C said they put the patch on R708 on 12/23/25 sometime during the day shift. LPN C stated, I was doing care and saw the ulcer on the coccyx. I put a foam patch on it real quick, got too busy, and forgot to chart on it or tell the doctor. LPN C acknowledged that was not the facility protocol. They did not recall if R708 had a pressure ulcer on the left heel.On 12/30/25 the initial wound care note identified R708's coccyx wound to be an unstageable pressure ulcer that measured: length 7.0 cm (centimeter) x width 8.5 cm x 0.2 cm. 90% covered with eschar. A second pressure ulcer to R708's Left Heel was described as a DTI that measured: L 8.5 cm x W 8.5cm x D 0.0 cm. At this time an order for Low-Air-Loss Mattress was made and coccyx skin treatments were changed to Santyl (chemical debriding agent) every day.On 3/27/25 at 2:30 PM, Registered Nurse (RN) A was asked about R708's pressure ulcers and confirmed they were acquired while at the facility and there was a delay in prevention and treatment of the coccyx pressure ulcer and left heel.R703:A review of R703's closed Electronic Health Record (EHR) revealed R703 admitted to the facility on [DATE] with multiple diagnoses including osteoarthritis of the left knee with DVT (deep vein thrombosis). On 10/16/25, Registered Nurse (RN) F documented R703 had a dime sized open area on the coccyx. An order was prescribed for facility-stock barrier cream as needed after incontinence care. A care plan was initiated for at risk for skin breakdown. The approaches/interventions included the following: encourage and assist resident to turn and reposition frequently, staff may apply floor stock barrier cream as needed after incontinence care, and pressure-reducing mattress on wheelchair and bed. There was no documentation to support that barrier cream had been applied to the open area on R703's coccyx. On 10/22/25, the Minimum Data Set (MDS) indicated R703 had intact cognition, required extensive assistance with mobility, and one stage 2 pressure ulcer (partial loss of skin, presents as a shallow open crater). The care plan was not revised to indicate R703 had actual skin breakdown. There were no additional progress notes or assessments for R703's coccyx pressure ulcer until 10/24/25.On 10/24/25, (9 days after admission) the following skin treatment for R703's pressure ulcer was ordered: cleanse coccyx with wound cleanser, pat dry, remove soiled triad paste and apply a dime-thick layer of triad paste and leave open to air, twice a day. According to R703's Medication Administration Record (MAR) for 10/2025 that treatment was administered 3 of 6 prescribed treatments: only once a day on 10/24/25, 10/25/25, and 10/26/25. On 10/27/25 the order was discontinued.On 10/27/25 the skin treatment order for R703's pressure ulcer was changed to; cleanse open area to coccyx with normal saline, apply oil emulsion and alginate then apply dry dressing three times a week on Mon, Wed, and Sat. According to R703's MAR for 10/2025 that treatment was administered 1 of 2 prescribed treatments on 10/27/25. On 10/30/25 the order was discontinued.On 10/27/25 a second skin treatment for R703's pressure ulcer was ordered to include: cleanse peri wound with wound cleanser, pat dry. Remove soiled Triad paste. Apply a dime-thick layer of Triad and leave it open to air. According to R703's MAR for 10/2025 that treatment was administered 2 of 4 prescribed treatments on 10/27/25 and 10/28/25. On 10/30/25 the order was discontinued.On 10/29/25, (14 days after admission) an initial wound care note documented the following: stage 3 coccyx wound with 40 % necrotic tissue (dead blackened skin/tissue) measurements; length 3.5 cm (centimeter) x width 6.0 cm x depth 0.2 cm.On 10/30/25 the skin treatment order for R703's pressure ulcer was changed to apply Manuka Honey after coccyx cleanse with normal saline, pat dry, then apply Manuka Honey and alginate (absorbent wound covering). Cover with foam dressing 3 times a week Mon, Wed, and Friday. According to R703's MAR the treatment was administered 2 of 4 prescribed treatments on 10/31/25 and 11/3/25. On 11/8/25 the order was discontinued.On 11/8/25 the skin treatment order for R703's pressure ulcer was changed to apply Santyl (a chemical debriding agent) after cleansing coccyx with normal saline followed by alginate cover with dry dressing daily and prn (as needed). R703's MAR for 11/2025 indicated the treatment was administered 7 of 8 prescribed treatments: daily from 11/8/25 - 11/13/25. No skin treatments were administered on a prn (continued on next page)

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