STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235504	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springcreek Rehabilitation and Nursing Center	130 Sand Creek Highway Adrian, MI 49221

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. Based on observation, interview, and record review the facility failed to prevent the development of a pressure ulcers for two resident (#2, #8) of three residents reviewed for the development of pressure ulcers. Findings Included: Resident #2 (R2) Review of the medical record revealed R2 was admitted to the facility 11/21/2024 with diagnoses that included acute kidney failure, Alzheimer's disease, lack of coordination, difficulty walking, Peripheral Vascular Disease (PVD), stage 3 kidney disease, cognitive communication deficit, abnormal posture, protein-calorie malnutrition, congestive heart failure (CHF), insomnia, obesity, anxiety, depression, type 2 diabetes, hypertension, hyperlipidemia (high fat content in blood), atrial fibrillation, and arthropathy (any disease of the joints). The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 02/02/2025 demonstrated R2 had a Brief Interview for Mental Status (BIMS) of 08 (moderate cognitive impairment). During observation and interview on 05/28/2025 at 07:28 a.m. R2 was observed sitting up in her wheelchair at the bedside. R2 could not answer if he currently had any pressure ulcers or skin alterations. Review of R2's medical record revealed a care plan that stated Resident has potential/actual impairment to skin integrity r/t (related to) poor safety awareness secondary to Alzheimer's Dementia, Diabetes with insulin orders, anticoagulant use, morbid obesity, incontinence, PVD (Peripheral vascular disease) thin/fragile skin. The only intervention for pressure ulcer prevention prior to the development of R2's pressure ulcer stated, Pressure reducing mattress and cushion to wheelchair for comfort and protection. Pressure ulcer to right trochanter (hip) which was last updated 03/31/2025. Review of R2's Minimum Data Set (MDS), with an ARD of 02/02/2025, Section M- Skin Conditions revealed that R2 did not have a pressure ulcer during the MDS assessment period. Review of R2's Skin Observation Tool, dated 03/24/2025, did not reveal R2 had any new skin issues. Review of R2's Skin Observation Tool, dated 03/28/2025, revealed R2 had a wound to his right thigh (rear) and was documented as pressure. (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
	235504	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springcreek Rehabilitation and Nursing Center	130 Sand Creek Highway Adrian, MI 49221

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	Review of R2's Skin & Wound Evaluation V7.0 document, dated of 03/31/25, revealed an unstageable (obscured full-thickness skin and tissue loss) to his right trochanter (hip) that measured 8.4cm2 (centimeters squared) surface area, 3.4 cm (centimeters) in length and 3.2 cm in width. Review of R2's most recent Skin & Wound Evaluation V7.0 document, dated 05/20/2025, revealed a stage 3 (full-thickness skin loss) to his right trochanter that measured 2.7cm2 in surface area, 1.8cm in length, and 2.1cm in width, and depth was marked as not applicable. R2's treatment record for May 2025 revealed a treatment order that stated, Cleanse pressure ulcer to right trochanter area with normal saline, pat dry, apply medihoney/triad mix then cover with boarder foam dressing every day shift for pressure ulcer. In an interview on 05/28/2025 at 08:37 a.m. Wound Nurse (WN) E explained that she was responsible for all wounds that were being managed at the facility. WN E explained that she was wound certified. WN E explained that if a resident was identified to have a wound on admission or anytime during their stay at the facility she would be notified. WN E then explained that she would observe the wound, stage the wound if pressure, measure the wound, make sure appropriate orders are in place to treat the wound, and update the plan of care. WN E explained that R2 had an unstageable wound to his right trochanter that was first identified by nursing staff on 03/28/2025. WN E explained that she assessed the wound on 03/31/2025. WN E was asked what interventions were in place prior to the development of R2's pressure ulcer. WN E replied that R2 continually like to lie on his right side, but WN E could not provide information as to what interventions were in place to prevent the development of a pressure ulcer. WN E was asked if the facility had performed a root cause analysis to determine the cause of R2's pressure ulcer. WN E explained that the facility had not. When asked why a determination of cause was not completed WN E could not provide an answer. In an interview on 05/28/2025 at 08:51 a.m. Director of Nursing (DON) B explained that it was her expectation that Wound Nurse (WN) E would be notified of all wounds identified by the nurses during weekly skin sweeps. DON B explained that she would expect that WN E would then conduct an assessment of the wound to include measurements and staging. DON B explained that she was aware of R2's pressure ulcer to his right trochanter. DON B was asked if a root cause analysist had been conducted regarding R2's pressure ulcer. DON B explained that the team reviewed the root cause but did not record anything in R2's medical record. DON B explained that it was her opinion that R2's pressure ulcer was avoidable, and the facility should have included interventions, such as an air mattress, to minimize the potential of R2 obtaining a pressure ulcer. DON B explained that an air mattress was initiated 04/01/2025. During observation of R2's pressure dressing change on 05/28/2025 at 10:10 a.m. Licensed Practical Nurse (LPN) G was observed to obtain the supplies for R2's dressing change. R2 was observed lying down in his bed on his back. LPN G proceed to ask R2 to roll to his left side and LPN G was observed to pull R2's pants down to his buttock. It was then observed that R2 did not have dressing covering his right trochanter pressure wound. LPN G was observed to use appropriate contact isolation personal protective equipment. R2's right trochanter wound had appeared to be a stage 3 pressure ulcer that was round, and the bed of the wound appeared to have red granulation tissue present. No drainage was observed. Observation of the wound measurement conducted by LPN G, revealed the wound was 1.5 cm (centimeters) in length and 1.5 cm in width. LPN G was unable to ascertain the temp of the wound. LPN G was then observed to cleanse pressure ulcer to right trochanter area with normal saline, pat dry, applied medihoney/triad mix then covered with boarder foam dressing. LPN G was observed to follow appropriate contact precautions during the pressure ulcer treatment. R2 denied any pain to the area. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235504	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springcreek Rehabilitation and Nursing Center	130 Sand Creek Highway Adrian, MI 49221

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	Resident #8 (R8) Review of the medical record revealed R8 was admitted to the facility 03/12/25 with diagnoses that included fracture of right tibia (the larger of the two bones of the lower leg), fracture of right fibula (the smaller of the two bones of the lower leg), benign prostatic hyperplasia (enlarge prostate), seizures, cerebral palsy (congenital disorder of movement, muscle tone, or posture), developmental disorder, cognitive communication deficient, stroke, anxiety, difficulty walking, and abnormal posture. The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3 (severe cognitive impairment). Review of R8 medical record revealed a Skin & Wound Evaluation V7.0 document, dated 04/04/2025 that demonstrated R8 had Deep Tissue Injury (Persistent non blanchable deep red, maroon or purple discoloration) to his right heel. The same document revealed measurement of the wound to had a surface area of 9.0cm 2 (centimeters squared), a length of 3.3 cm (centimeters) and a width of 3.7cm. The most recent Skin & Wound Evaluation V7.0 document, dated 05/27/2025 revealed R2 still had a pressure ulcer classified as deep tissue injury. The measurements of the wound revealed a surface area of 1.9cm2, a length of 1.4cm, and a width or 1.8cm. Review of the current physician orders stated, Cleanse resident right heel with betadine, allow to dry. Then apply thick layer of A&D ointment directly to wound bed. Leave open to air. Review of Review of R8's weekly skin observation document dated 04/02/2025 did not list any skin alterations. Review of R8's plan of care, last updated 04/04/2025) revealed Resident has potential/actual impairment to skin integrity r/t (related to) surgical incision to right tibia and fibula, pressure ulcer right heel. The only intervention listed prior to the development of the deep tissue injury revealed, elevate heels off bed surface while at rest in bed as tolerated. During observation and attempt interview on 05/28/2025 at 02:57 p.m. R8 was observed lying down in bed. R8 did not respond to questions regarding his skin condition. R8's feet could not be observed at that time because they were under the covers. During observation on 05/28/2025 at 03:23 p.m. R8 was observed lying down in bed. Licensed Practice Nurse (LPN) I was observed collecting items to perform R8's wound treatment. LPN I removed R8's sock and was observed to measure R8's right heel wound. The measurements observed to be 2.0 cm (centimeters) in length and 2.25 cm in width. The wound was observed to be scabbed which appeared dark purple in color. LPN I was then observed to wipe the wound with betadine, observed to let that dry, and then observed to apply A&D ointment. R8 denied any pain. During an interview on 05/29/2025 at 07:44 a.m. Director of Nursing (DON) B explained that she was aware of R8's facility acquired deep tissue injury to his right heel. DON B explained that the facility had not completed a root cause analysis of R8's wound. DON B also explained that thought R8's deep tissue injury was avoidable, and more interventions should have been in place because of R8's diagnoses, risk, and medical history. DON B' could not explain why interventions were not in place prior to R8 acquiring a suspected deep tissue injury to his right foot.