STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235558	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menominee Health Services	501 Second Street, Box 246 Menominee, MI 49858

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor and document wound assessments and measurements for one Resident (#5) of one resident reviewed for pressure injury.Findings include:Resident #5 (R5)On 4/20/26 at 1:51 PM, R5 was observed lying in bed on a low air loss mattress wearing an AFO (ankle foot orthotic - a medical device that supports the foot and ankle). R5 said he did not feel well and had pain in his lower extremity.The electronic medical record (EMR) of R5 disclosed an admission date to the facility on 4/1/22 with a primary diagnosis of paraplegia.A care plan for actual skin impairment dated as initiated 12/25/25 had a goal that read: Wound will show healing without complication as evidenced by decrease in measurements by review date.A Minimum Data Set (MDS) assessment dated [DATE] documented R5 was at risk for the development of pressure injuries but had no unhealed pressure injuries and had no venous or arterial ulcerations.A Nursing progress note dated 12/25/25 at 1:27 PM documented, in part: During routine cares resident is found to have a 1 cm [centimeter] x [by] 2 cm scabbed area to right outer ankle. New orders are received to apply Betadine bid [twice daily] to site until resolved.A progress note on 12/30/25 at 9:23 PM documented, in part: .Betadine applied to area on right lateral lower leg above malleolus [ankle].Area measures 1.0 cm x 0.5 cm and consists of intact dry, hard black skin present, with a non-blanchable with red peri wound [sic].A progress note on 3/22/26 at 9:53 PM documented, in part: .Dr. [physician's name redacted] saw [name of R5] today. Assessment included decubitus ulcer [outdated term for pressure injury] on right lateral leg over lateral boney area .Despite numerous progress notes from 12/30/25 through 4/7/25 that referenced the presence of a wound on the right lower lateral extremity of R5, there were no documented measurements, descriptions, or assessments of the wound from 12/30/25 until 4/7/26 when a document titled Pressure Injury Weekly Tracker - V3 was implemented. The pressure injury document on 4/7/26 assessed the wound on R5's right lower lateral extremity as a stage 3 pressure injury (full thickness loss of skin) measuring 6.4 cm x 2.5 cm x 0.5 cm (length, width, depth respectively). The wound was described as containing 30% slough (non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture) and 20% necrotic tissue (dead or devitalized tissue). The document revealed R5 was prescribed two, 10-day courses of antibiotics in March 2026 due to infection in the wound.A subsequent assessment of the pressure injury was completed on 4/14/26 and documented measurements of 6.4 cm x 2.6 cm x 0.5 cm with 75% slough and 25% necrotic tissue. Additionally, a new wound was identified in proximity to the pressure injury. The wound assessment documented, in part: .Scab area 1.8 cm long attached to wound.A pressure injury assessment dated [DATE] documented, in part: .RLE [right lower extremity] has contractures, manipulation of knee and ankle cause pain with repositioning. Wound painful with touch.On 4/22/26 at 11:55 AM, Licensed Practical Nurse (LPN) G and Registered Nurse (RN) E were observed completing an assessment and dressing change on R5's RLE pressure injury. The wound measured 6.5 cm x 2.6 cm x 0.6 cm with necrotic tissue evident in the wound bed. Tunneling (passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound) and undermining (destruction of tissue or ulceration extending under the skin edges) were evident.There appeared to be an eschar (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
	235558	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menominee Health Services	501 Second Street, Box 246 Menominee, MI 49858

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	covered wound superior to the area. LPN G said the wound was being reviewed as one total area. The superior eschar-covered wound was measured at 2.0 cm x 0.9 cm.The Director of Nursing (DON) and RN A were interviewed on 4/22/26 at 10:13 AM. When asked if wound assessments were completed prior to 4/7/26, RN A confirmed there were no documented wound assessments of the wound on R5's lateral RLE until 4/7/26. The DON said the expectation was for nurses to document wound assessments weekly. She said a past noncompliance (PNC - facility-identified noncompliance with regulatory requirements) was implemented on 4/10/26 to address the concern with wound assessment documentation.The PNC was reviewed. No documented audits or monitoring for compliance with the expectation had been completed. The DON said they did not have evidence of monitoring or a tracking form. The DON said the PNC had not yet been proposed to the QAPI (Quality Assessment Performance Improvement) committee (leadership team responsible for developing, implementing, and maintaining improvement programs for resident quality of care and quality of life).The policy Pressure injuries and Non Pressure Injuries dated as reviewed/revised 7/20/22 read, in part: . For those residents admitted with, or who subsequently developed a pressure injury or impaired skin integrity, they will receive care, treatment, and services that seek to promote healing, prevent infection, and prevent further development of pressure injuries/impaired skin integrity. Assess current wounds at least every seven days, or more frequently as needed .