STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235643	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Ann's Home	2161 Leonard NW Grand Rapids, MI 49504

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a person-centered care plan related to hospice services for 1 (Resident #10) of 12 residents reviewed for person-centered care planning resulting in the potential for unmet care needs.Findings include:Resident #10Review of an admission Record revealed Resident #10 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses including: Alzheimer's disease and dementia.Review of Order Summary for Resident #10 revealed .ADMIT to (Name Omitted) hospice dx: (diagnosis) Alzheimer's disease. with a start date of 10/31/25Review of Care Plan for Resident #10 revealed no noted care plan related to collaboration of care between the facility and (Name Omitted) hospice services.In an interview on 1/22/26 at 2:13 PM, Hospice Registered Nurse (H/RN) DD reported Resident #10 had been on services for a few months this time, he had previously had services as well. H/RN DD reported Resident #10 had a separate care plan that was completed by hospice and provided to the facility. H/RN DD reported she did not have access to Resident #10's care plan for the facility and could not update any information in the care plan. In an interview on 1/23/26 at 1:20 PM, Director of Nursing (DON) B reported Social Services Coordinator (SSC) M created the initial care plan for hospice services. DON B reported the care plan provided to the facility by hospice was reviewed and incorporated into the facility's care plan. DON B reported there was no separate care plan that indicated a resident received hospice services. In an interview on 1/23/26 at 1:23 PM, SSC M reported she assisted with the hospice start of care for a resident, but she did not make any changes in the care plan to reflect the start of hospice care. SSC M reported hospice provides a care plan and it is located the resident's record.

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 - 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 prevent the development of a pressure ulcer in 1 (Resident #9) of 2 reviewed for pressure ulcers, resulting in the development of a pressure wound on Resident #9's right ankle.Findings include:Resident #9Review of an admission Record revealed Resident #9 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses including: Alzheimer's disease (progressive mental deterioration), dementia (loss of cognitive function), and anxiety disorder.Review of a Minimum Data Set (MDS) assessment for Resident #9, with a reference date of 8/4/25 revealed a Self-Care Assessment - Mobility- roll left to right- Substantial/maximal assistance, sit to laying substantial/maximal assistance, and laying to sitting on bed side dependent.Review of Care Plan for Resident #9 revealed .has an ADL (activities of daily living) self-care performance deficient r/t (related to) Alzheimer's, dementia.intervention: bed mobility; one person min assist initiated on 6/12/25.has potential impairment of skin integrity of the r/t fragile skin.will maintain.intact skin.revised on 11/19/25.Interventions: keep skin clean and dry.pressure relieving/reducing cushion to protect the skin while in bed.has pressure relieving/reducing mattress, and pillows for comfort.Revised on 6/12/25.Review of Braden Scale- for Predicting Pressure Ulcer Risk Evaluation for Resident #9 dated 8/4/25 at 10:31 AM, revealed .sensory perception: very limited, moisture: very moist, Activity: chairfast, Resident is slightly limited: makes frequent though slight changes in body or extremity position independently, nutrition adequate, friction and shear: problem: Braden score 13.0 (moderate risk for developing pressure ulcers).Review of Alert Note for Resident #9 dated 8/10/25 at 15:21 (3:21 pm) revealed . Resident has an open area on right ankle that measures 0.5 cm. The open area has a white base. Areas cleaned with NS (normal saline) and a 3x3 adhesive dressing applied.Review of encounter for Resident #9 dated 8/12/25 at 01:00 (1:00 am) revealed .wound care.wound on right ankle.is seen today to evaluation wound on her right ankle.Wound 1 Type: pressure, Location: right lateral ankle (outer ankle) size (cm) (centimeters) 0.4 x 0.4 cm, There is a depth of 0.1 cm though this is not a true depth due to the presence of slough (dead tissue that accumulates on the wound surface).unstageable.exudate: scant serous (minimal clear to yellow in color and watery consistency drainage).Plan.small unstageable pressure injury to the right lateral ankle, will have staff cleanse the wound with saline and gauze, apply MediHoney gel to the wound base and cover with a 3x3 silicone foam border dressing. Change every other day and prn (as needed) if disrupted. She does have pressure relieving boots in her room, recommend she have them on whenever she is in bed. On 1/22/26 at 2:23 PM, Resident #9 was observed in bed positioned on her right side with the wound on her right ankle positioned directly on the mattress, pressure relieving boots observed on the dresser.Review of Order Summary for Resident #9 revealed .Right lateral ankle wound: cleanse with saline and gauze, apply MediHoney gel to the wound base and cover with a 3x3 silicone foam border dressing, change every other day and prn if disrupted. Monitor for signs of infection with a start date of 8/12/25 .Please avoid putting the tight black stocking on her RLE (right lower extremity) until her ankle wound is healed.every shift for pressure relief.with a start date of 8/26/25.Pressure relieving boots to BLE (bilateral lower extremities) when in bed.every shift for pressure injury right ankle. with a start date of 8/14/25.with position changes do not position on her right ankle. Has open blister. Area measures 0.5 cm. every shift with a start date of 8/11/25.In an interview on 1/23/26 at 12:30 PM, Certified Nurse Assistant (CNA) CC reported she would review the care plan for Resident #9 to determine specific needs related to positioning, mobility, transfers, and personal care. When queried, CNA CC reported she applied Resident #9's pressure relieving boots to her feet when she laid Resident #9 down because she saw them in her room and assumed she needed them on. CNA CC accessed Resident #9's care plan and Kardex (a summary of the care plan used for easy access to information), and CNA CC reported there was nothing on the care plan or Kardex regarding Resident #9 wearing pressure relieving boots. When CNA CC was further queried regarding (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #9's ankle wound, CNA CC reported Resident #9 did not have a wound, and there was no information in her care plan indicating she had a wound.In an interview on 1/23/26 at 12:40 PM, Licensed Practical Nurse (LPN) W reported she was unable to locate a care plan or interventions related to Resident #9's ankle wound. LPN W reported there were orders in Resident #9's record related to positioning and pressure relieving boots. LPN W reported the CNAs cannot access a resident's orders. When queried, how the CNAs knew to complete Resident #9's orders related to positioning and applying pressure relieving boots when in bed, LPN W stated that's a good question, unless the nurse tells them, they do not know. In an interview on 1/23/26 at 12:54 PM, Assistant Director of Nursing (ADON) Q reviewed Resident #9's record and confirmed there was not a care plan related to her ankle wound. ADON Q reported, if an intervention was not listed on the care plan and in the task section of the Kardex the CNAs could not access the information. ADON Q confirmed there were orders in place for Resident #9's positioning and the application of her pressure relieving boots. CNAs carried out the tasks, but the nurse assigned was responsible for the task. ADON Q reported Resident #9's pressure relieving boots were implemented after the wound was discovered on her right ankle which ADON Q reported was a boney prominence.In an interview on 1/23/26 at 12:59 PM, Director of Nursing (DON) B reported Resident #9 should have a care plan in place with interventions related to the wound on her right lateral ankle. DON B confirmed positioning and pressure relieving boots were not addressed in Resident #9's care plan for skin integrity.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain infection control practices and implement enhanced barrier precautions (EBP) related to wound care for 1 (Resident #9) of 3 resident reviewed for wound care resulting in the potential for cross contamination, disease transmission, and the introduction of infection.Findings include:Resident #9Review of an admission Record revealed Resident #9 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses including: Alzheimer's disease (progressive mental deterioration), dementia (loss of cognitive functioning), and anxiety disorder.Review of Centers for Disease Control and Prevention (CDC) dated March 20, 2024, revealed, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) that employs targeted gown and glove use during high contact resident care activities .EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .EBP are indicated for residents with any of the following: 1. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or 2. Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Effective Date: April 1, 2024 .On 1/23/26 at 11:49 AM, Certified Nurse Assistant (CNA) CC was observed providing incontinent care, a brief change, and transferring Resident #9 from bed to wheelchair. CNA CC did not wear a gown during the care she provided. When queried, CNA CC reported Resident #9 did not have a wound and she was not in enhanced barrier precautions. Review of Order Summary for Resident #9 revealed .Right lateral ankle wound: cleanse with saline and gauze. Monitor for signs of infection with a start date of 8/12/25.No order was noted for enhanced barrier precautions.No signage was observed outside Resident #9's room indicating she was in enhanced barrier precautions.Review of Care Plan for Resident #9 revealed no noted care plan related to a wound, wound care, nor enhanced barrier precautions.On 1/23/26 at 12:02 PM, Licensed Practical Nurse (LPN) W was observed providing wound care to Resident #9 right lateral ankle wound. LPN W was not wearing a gown during wound care. LPN W reported Resident #9 was not in enhanced barrier precautions.In an interview on 1/23/26 at 12:13 PM, Director of Nursing (DON) B reported enhanced barrier precautions were implemented for a resident with a wound only if the wound had drainage. DON B reported she was unaware that Resident #9 had a wound with a dressing. DON B reported the facility had followed the guidance of ?if there was no drainage, there was no need for EBP. DON B reviewed Resident #9's record and reported she was not started on EBP when the wound was noted on 8/10/25 and she had not been placed on EBP at all.Review of Encounter for Resident #9 dated 8/12/25 at 01:00 (1:00 am) revealed .wound care.wound on right ankle.Wound 1 Type: pressure, Location: right lateral ankle (outer ankle).unstageable.exudate (a mass of cells and fluid that has seeped out of the body): scant (traces, minimal amount) serous (clear to yellow in color and watery consistency drainage).In an interview on 1/23/26 at 1:13 PM, Assistant Director of Nursing (ADON) Q reported Resident #9's wound had no drainage and the dressing remained intact, without becoming dislodged. ADON Q reported there was no need for Resident #9 to be in EBP.Review of facility policy Enhanced Barrier Precautions with a revision date of 7/1/25 revealed .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organism. Enhanced barrier precautions refers to the use of gown and gloves for use during high-contact resident care activates.clear signage will be posted on the door or wall outside of the reside room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves.an order for enhanced barrier precautions will be obtained for residents with any of the following: Wounds (e.g. chronic wounds such as pressure wounds.).High contact care activities include:.transferring.providing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hygiene.changing briefs.wound care: any skin opening requiring a dressing.Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until the wound heals.