STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235705	A. Building B. Wing	01/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Helen Newberry Joy Hltcu Golden Leaves Living Cent	502 West Harrie Street Newberry, MI 49868

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. (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 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This deficiency pertains to Intake #2694753Based on observation, interview, and record review, the facility failed to implement interventions consistent with recognized standards of practice to promote the healing of a pressure injury for one Resident (R1) of three residents reviewed for pressure injury. This deficient practice resulted in the worsening of stage 3 pressure injury on the right heel of R1. Findings include:Intake #2694753 was submitted to the state agency on 12/10/25. The intake alleged the facility failed to prevent worsening of a pressure injury (PI) to the heel of Resident #1 (R1).On 1/2/26 at 10:32 AM, 11:17 AM, and 12:19 PM, R1 was observed in her room sitting in her wheelchair at bedside with both feet placed directly on the floor without a support surface or pressure-reducing device.R1 was interviewed on 1/2/26 at 12:19 PM. A wound dressing was observed on her right lateral posterior calf. R1 said she had a wound on her calf but could not recall how long the wound on the calf had been present. R1 confirmed she also had a wound on her right heel. When asked if she had been provided with a pressure-reducing boot or similar device to offload pressure from the wound, R1 disclosed she did not wear any devices for her feet and said staff had never offered her any boots. When asked if she elevated her heels off the mattress when in bed, R1 said she had multiple sclerosis and was dependent on staff. R1 said staff did not elevate her feet on a pillow or use a heel wedge to elevate her heels off the mattress while in bed.Review of the electronic medical record (EMR) revealed R1 was admitted to the facility 2/22/25 with a primary diagnosis of multiple sclerosis. A Minimum Data Set (MDS) assessment dated [DATE] coded R1 with a Brief Interview for Mental Status (BIMS) score of 15 indicating R1 had fully intact cognition. The MDS indicated R1 had no impairment of short-term memory or long-term memory. Further review of the MDS divulged R1 had functional limitation in range of motion of the bilateral lower extremities. R1 was documented as being non-ambulatory and utilized a wheelchair for locomotion. R1 was identified as being at risk for developing PI but did not have identified or documented PI at the time of the MDS assessment.The EMR documented a stage 3 PI (full-thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present) was initially identified on 11/28/25. The most recent measurements of the PI were obtained on 12/26/25 and documented the PI measurements as 1.61 centimeters (cm) x (by) 1.24 cm x 0.2 cm (length, width, and depth respectively).A physician's order dated 11/28/25 read: Float heels at all times while in bed and assess resident while up in wheelchair to ensure pressure relief to right heel. A physician's order dated 12/5/25 read in part: Resident to dangle foot and offload heel while in wheelchair in room.A care plan focus dated as revised 11/28/25 read: I have a stage III [3] pressure ulcer [injury] to right heel. The care plan interventions included the following: Check resident every 2 hours to ensure pressure relief on right heel. Encourage resident to sit in recliner during the day to assist with off loading pressure from right heel. Float heels while in bed.The care plan did not include interventions to reduce pressure on the heel while R1 was in the wheelchair. The Kardex (a quick-reference guide that provides staff with pertinent information and interventions for a resident) did not include the PI or direct staff to provide any pressure reducing interventions to implement to alleviate pressure from the heel.The EMR contained a report from a consultant physician dated 12/11/25. The report documented the reason for the consultation was Right foot - pain wound. The consultant's report documented, in part: .[R1 name redacted] is a [AGE] year-old female that is wheelchair-bound with multiple sclerosis that has developed a pressure wound at the bottom of her right heel. she would benefit from a [brand name of a pressure-eliminating boot redacted] to remove all pressure at the bottom of the heel which she should wear at all times.A progress notes in the EMR dated 12/4/25 at 6:00 AM read: Note text: wound to RIGHT [sic] heel dressing was saturated, changed dressing. wound is worse than my previous evaluation of wound. odor [sic] from wound. wound [sic] size has also increased from my previous evaluation of wound with maceration [breakdown of the skin due to prolonged exposure to moisture] extended. Cleansed areas. Applied [antimicrobial wound dressing] as ordered to wound bed. Covered with foam dressing.A progress note dated 12/14/25 at 9:25 AM read, in part: . [name of consultant physician redacted] is ordering resident a brace.orders include. continuous offloading.A progress noted dated 12/22/25 at 6:02 AM read, in part: . wound has again progressively worsening [sic], dressing was saturated as it was last changed by myself at prior shift. Her socks were saturated as well. There is slough [non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture]. Odor present after cleansing wound, blanching [temporary whitening when pressure applied]