| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 094012 | A. BUILDING _____ B. WING _____ | 2/27/2025 |

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| CARETEL INNS OF TRI-CITIES | 6700 WESTSIDE SAGINAW ROAD BAY CITY, MI 48706 |

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| F0000 SS= | INITIAL COMMENTS<br><br>Caretel Inns of Tri-Cities was surveyed for a Revisit to an Abbreviated Survey exiting on 02/27/2025.<br><br>Event ID: DIOZ12<br><br>Census: 50 | F0000 | | |
| F0686 SS= G | Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation, interview and record review, the facility failed to operationalize policies and procedures for skin/wound assessments/treatments and prevent the development of a pressure ulcer for one resident (Resident #4) of three residents reviewed for pressure ulcers, resulting in Resident #4 developing a facility-acquired Stage III (full thickness tissue loss that can | F0686 | 1. Resident #4 resides in the facility, it was identified that the residents wound was in fact a Kennedy Ulcer and the resident has been placed on hospice for additional support.<br><br>2. Like residents are identified as those with a Braden scale of 16 or less. A sweep was completed on 3/17/25 of all current residents to assess their current Braden scale. Like resident's medical records were reviewed between 3/17 through 3/20/25 to ensure their plan of care includes appropriate interventions for prevention of skin breakdown, all future residents admitted with a Braden score of 16 or lower will have appropriate interventions implemented in their plan of care timely.<br><br>3. The Policy on Skin Management has been reviewed and deemed appropriate. Licensed nurses were educated by the DON/designee on appropriate process for initiating timely interventions upon admission and with any change of condition between 3/13 and 3/20/25.<br><br>4. The QAPI committee has directed the DON/designee to perform random weekly audits to ensure interventions for skin prevention are initiated timely upon admission or any change of condition. The Administrator is responsible for ensuring that substantial | 2/13/2025 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 03/20/2025 |

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.

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| | extend into subcutaneous tissue layer) pressure ulcer in the coccyx area, a delay in wound assessment and treatment, and a worsening of the wound.<br><br>Findings include:<br><br>Resident #4:<br><br>A review of Resident #4's medical record revealed an admission into the facility on 2/5/13 and readmission on 7/14/22 with diagnoses that included muscle weakness, difficulty in walking, diabetes, and Alzheimer's disease. A review of the Minimum Data Set (MDS) assessment dated 1/8/25, revealed a Brief Interview of Mental Status score of 6/15 that indicated severe cognitive impairment and the Resident needed substantial/maximal assistance with oral hygiene, toileting hygiene, upper body dressing, personal hygiene, roll left and right, sit to lying, lying to sitting on side of bed, and chair/bed-to-chair transfer.<br><br>Further review of the MDS, dated 01/8/25, revealed, Section E0800. Rejection of Care-Presence & Frequency. Did the resident reject evaluation or care (e.g., bloodwork, taking medications, ADL assistance) that is necessary to achieve the resident's goals for health and well-being?... documented as "Behavior not exhibited." Section M-Skin Conditions, M0210. Unhealed Pressure Ulcer(s), Does this resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher? Documented as | | compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow up and review.<br><br>Date of Compliance 3/27/2025 | |

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| | "No."<br><br>A review of Resident #4's Wound Assessment Details Report, assessment, dated 02/19/25, included the following:<br><br>-Site: Coccyx<br><br>-Type: Pressure<br><br>-Source: Facility-acquired<br><br>-Date Identified: 2/17/25<br><br>-Identified by: Wound Care Nurse "A"<br><br>-The picture was dated 1/19/2025<br><br>-Assessment History: 2/19/25 at 1:11 PM; Clinical Stage: Stage 3; Tissue Types: Pale Pink Non-granulating=25%, Pink or Red Non-granulating=25%, Bright pink or Red=25%, Bright Beefy Red=25%; Length 12.00 cm, Width 7.00 cm, Depth Unknown.<br><br>There was no documentation found in the medical record of a wound assessment or treatment on 2/17/25. The first assessment was completed by the Wound care Nurse "A" on 2/19/25.<br><br>A review of Resident #4's Wound Assessment Details Report, assessment, dated 2/26/25, included the following:<br><br>-Site: Coccyx | | | |

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| | -Type: Pressure<br><br>-Source: Facility-acquired<br><br>-Date Identified: 2/17/25<br><br>-Identified by: Wound Care Nurse "A"<br><br>-Assessment History: Date/Time 2/26/25 9:42 AM; Clinical Stage: Stage 3; Tissue Types: Pale Pink Non-granulating=5%, Pink or Red Non-granulating=5%, Bright Pink or Red=10%, Bright Beefy Res=10%, Slough White Fibrinous=30%, Necrotic Soft, adherent=40%; Exudate: Light - Purulent; Odor Yes<br><br>-Measurement Length 11.5 cm, Width 9.00 cm, Depth unknown.<br><br>-Area: 103.50 cm2<br><br>-Current Plan & Comments: 2/26/25 9:42 AM, "Worsening wound".<br><br>A review of the Treatment Administration Record (TAR) revealed that a weekly skin assessment completed on 2/17/25, documented as "-" that indicated "no new skin alteration". An order revealed, "Wound B/L (bilateral) Buttocks: Cleanse with Dakins, pat dry, apply hydrogel to wound bed and cover with lightly moist gaue (gauze) then cover with 4x4 stratasorb, daily and prn," with a start date 2/21/25 at 6:00 AM, documented as first dressing completed on 2/21/25. Another order revealed, "B/L Buttocks: | | | |

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| | Cleanse with soap and H2O, apply triad wound dressing ointment every shift, every shift for Prevention, start date on 11/24/25 and discontinued on 2/19/25 with the last documented treatment as administered on 2/18/25 in the PM. Order "Wound B/L Buttocks: Cleanse with Dakins, pat dry, apply silvasorb gel to wound bed and cover moist to dry gauze, as needed," with a start date on 2/19/25 and discontinued on 2/20/25, there were no documented treatments completed. The dressing to the coccyx wound was documented as first administered on 2/21/25.<br><br>A review of the facility document titled, "New Facility Acquired Pressure Injury and Clinical Documentation Checklist", revealed the wound was identified on 2/17/25, IDT discussion/report to team occurs the business day following completion of the weekly wound assessment, dated as week 1 "2/25/25," this was eight days after the wound was identified.<br><br>A review of the facility document titled, "Root Cause Analysis-Wound Referral," included the following:<br><br>-Chair pressure reduction cushion in good condition, working, and used appropriately? Written in "New one ordered,"<br><br>-Date Dietitian notified of new pressure injury "2/25/25".<br><br>-Analysis of Lab Results: "Last labs were | | | |

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| | competed on 12/30/24. She will frequently refuse labs."<br><br>-Were wound care orders obtained and implemented at time of wound identification? Marked "entered in TAR (treatment administration record)."<br><br>-Med staff notified: 2/25/25.<br><br>-Family/Guardian/Resident (if not own decision maker) notified: 2/25/25-Son.<br><br>-Wound is: New<br><br>-Wound Description: Open Area Stage III<br><br>-Assessment: Length 12 cm (centimeters), Width 7 cm, Depth unknown<br><br>-Wound Bed: Red, Pale Pink, Purple, Black or Brown, Yellow.<br><br>-Exudate: Moderate<br><br>-Level of Mobility: Chairfast<br><br>A review of Resident #4's progress notes, dated 02/25/25 at 1:30 PM, revealed a Nurse Practitioner Narrative/Physician Assistant note, " ...Patient does have a change in condition with a stage III pressure ulcer to the sacrum. She has weight loss and poor appetite. Patient is incontinent of bowel and bladder which leads to the potential for increased moisture exposure to the sacral | | | |

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| | wound ... Skin/Wound: Stage III pressure ulcer to sacrum; There is a moderate amount of serosanguineous exudate without odor. 40% of the wound bed covered with firmly adherent yellow slough 10% firmly adherent brown slough and 50% smooth red tissue. Wound edges are defined and attached, with some maceration present. Surrounding tissue is erythematous, blanchable ...Wound Car for Stage III Sacral Pressure Ulcer-May be a Kennedy Ulcer. Wound healing will be impeded by incontinence, decline in condition, poor nutritional status and rejection of care ..."<br><br>On 2/26/25 at 2:52 PM, an interview was conducted with the Assistant Director of Nursing, Wound Care Nurse (WCN) "A" and the Administrator (NHA). The WCN was asked about the origination of Resident #4's coccyx wound and who identified the wound with the concern or no documentation in the medical record of the wound assessment on 02/17. The WCN reported that the origination was 2/17/25 and stated, "It was brought to our attention on 2/17, not sure by who. It was identified on 2/17 by a nurse, but I don't know who. I did an assessment on 2/19."<br><br>The NHA reported the nurse practitioner thought it might be a Kennedy ulcer and that it was determined the wound was unavoidable. When asked if the Resident was on hospice or end of life care, the NHA reported she was not and that they were "going to reach out to family." | | | |

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| | The NHA reported she had a Past Non-compliance for pressure ulcers but indicated they were not in compliance. The NHA reported the date of compliance to be 03/14/25 and stated, "I went out another 30 days because I added her (Resident #4) to it." The NHA was asked when the Resident was added and the NHA reported Resident #4 was added on 2/17. The NHA reported that on 1/15/25, the past non-compliance was started for the origination of wounds, and stated, "We are not in compliance right now."<br><br>On 2/26/25 at 3:57 PM, an observation was made of Resident #4 lying in bed resting. The air mattress was on with setting for alternating, 10-minute intervals and softness/firmness set at 3.5. An observation was made of a seat cushion in the Resident's wheelchair. The cushion was worn on the edges, ripped and had indentation of where the resident would sit.<br><br>On 2/27/25, a review of Resident #4's care plan revealed a Focus for "Alteration in skin integrity-Resident has Pressure Injury to coccyx related to decreased mobility, and incontinence of bowel and bladder," with date initiated 2/17/25, created on 7/25/22 and revision on 2/25/25. Care planned interventions were created in 2022 and 2023 and lacked new interventions for the origination of the coccyx wound with the interventions revised on 2/25/25. The interventions for "Pressure redistribution | | | |

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| | mattress, APM (air pressure mattress) mattress," created on 7/25/24 with a date of initiated and revision on 2/25/25, lacked the settings for the air mattress that was observed on the Resident's bed. The intervention was changed with the added "APM mattress" on 2/25/25.<br><br>On 2/27/25 at 1:40 PM, an interview was conducted with the Director of Nursing (DON). Resident #4's origination of the pressure wound was reviewed with the DON. The care plan was reviewed, and the DON was asked about the intervention "Reposition/Shift weight at frequent intervals to resident's comfort," initiated 7/25/22 and revision without changes on 2/25/25. The DON was asked about the resident's ability and what did the resident actually need. The DON reported that she could shift herself, but she could not turn herself. When asked when the Resident gets up and how long was she in the wheelchair and when should staff be repositioning the Resident, the DON reported the Resident was up for meals but the intervention was not identified in the care plan and frequent intervals lacked as a measurable intervention. The intervention to "Assess wounds with each dressing change," was reviewed with the DON, and was identified that a lack of assessments with dressing changes had been completed. The DON reported that the Nurse would assess for changes. Reviewed with the DON were revisions on the care plan which revealed a lack of new interventions for the newly- | | | |

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| | developed pressure ulcer.<br><br>Resident #4's wheelchair seat cushion was reviewed with the NHA and the DON. The NHA reported that the seat cushion was ordered but not here yet. The NHA reported that the "new cushion was on back order." The observation made of the seat cushion with compression of the cushion and not in good repair was reviewed with the NHA and DON.<br><br>At 2:09 PM, an observation was conducted with the DON of Resident #4 lying in bed. The air mattress was observed to be functioning with the setting set at alternating, 10-minute intervals and set at 3.5 soft/firmness. The wheelchair cushion was observed, and the seated area was sunken in. The edges were worn and had a rip. The DON indicated that the Resident was in need of a new wheelchair cushion.<br><br>Upon return from the observations with the DON, the lack of care planned interventions updated with the new onset of the coccyx ulcer was reviewed with the NHA. The NHA was asked how staff were made aware of what the settings were for the air mattress and who sets the settings. The NHA reported that the company sets it up when they come and stated, "We usually have them on the care plan and in the orders, we have not gotten to them yet."<br><br>On 2/27/25 at 2:45 PM, an observation was | | | |

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| | made of Nurse "B" and CNA "C" performing a dressing change to the coccyx area for Resident #4. The Resident was lying supine in bed and refused to turn to have her dressing completed. When the Nurse and Surveyor stepped away from the bedside, the CNA was able to convince the Resident to roll onto her side for the dressing change. An observation was made of loose stool up into the dressing where the dressing was lifted. The loose stool partially covered the exposed wound bed. The Resident did not resist with wound care once positioned on her side. The old dressing prior to removal was observed to have covered part of the left buttock open wound area with the adhesive edge of the dressing. It was reviewed with Nurse "B" of the top of the dressing adhesive attached to the skin and the edge of the dressing went over part of the open area of the wound bed so the far wound edge on the left buttock would have had adhesive over open wound bed. The adhesive on the side of the wound was adhered to skin with the adhesive lifted, not adhered, over the wound bed with feces up and into the wound. The wound on the coccyx area extended to the bilateral buttock, with opened reddened, pink, and blackened areas. The drainage on the old dressing was not visible due to loose stool on the dressing.<br><br>On 2/27/25 at 2:56 PM, an interview was conducted with WCN "A" regarding Resident #4's coccyx pressure ulcer and the observation of the adhesive over the wound bed. The WCN was asked if the dressing | | | |

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| | needed to be larger in size. The Nurse indicated that if the dressing was placed correctly, it would be big enough to encompass the wound bed. The development of a Stage III pressure ulcer with a lack of assessment completed on 2/17/25 with the observation of the wound, lack of documentation of a wound dressing until 2/21/25, the physician and resident's representative not notified until 2/25/25 was reviewed with the WCN. The WCN reported when he had seen the wound on 2/19/25 (when he completed the assessment), a dressing was placed at that time.<br><br>On 2/27/25 at 3:20 PM, an interview was conducted with the DON regarding the observation of the dressing change. The DON reported they did have larger dressings, if needed, and reported adhesive tape should not be on the open area of the wound.<br><br>The facility was asked for the policy for pressure ulcers, but was not received prior to exit. The policy received titled, "Skin Care Prevention," with a revision date 10/16, revealed, "General: All resident will receive appropriate care to decrease the risk of skin breakdown ... 3. Dependent residents will be assessed during care for any changes in skin condition including redness (non-blanching erythema) and this will be reported to the nurse. The nurse is responsible for alerting the Health Care Provider and the wound care coordinator ... Residents unable to reposition themselves will be repositioned at least every | | | |

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| | two hours ... 9. Clean ski at time of soiling and at routine intervals ... 13. For residents who are bed or chair bound consider using a pressure-reducing device."<br><br>A review of document titled, "New Facility Acquired Pressure Injury and Clinical Documentation Checklist," revealed, "Licensed Nurse Responsibilities", "Document a clinical note to include: skin assessment, wound location, wound appearance, wound odor, baseline approximate measurements, medical staff notification, family/guardian notification/education, treatment orders obtained/implemented, nutrition/hydration status, pain related to pressure injury/ulcer ..." This was documented as dated on the form "2/17/25", but a review of the medical record lacked the documentation on 2/17/25. | | | |