STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235585	A. Building B. Wing	09/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Skilled Nursing and Rehab at Wellspring	5939 Shattuck Rd Saginaw, MI 48603

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** 38471 This Citation pertains to Intake Number MI00144619. Based on observation, interview and record review the facility failed to prevent the development and/or worsening of pressure injuries and complete accurate documentation and timely implementation of wound care treatments for two residents (Resident #201 and Resident #205) of two residents reviewed for wounds, resulting in Resident #201's Stage II pressure ulcers worsening, untimely initiation of treatment orders and inconsistent wound assessment documentation and the development of an avoidable Stage II pressure sore behind Resident #205's ear. Findings Include: Resident #201: On 9/17/2024 at approximately 1:00 PM, a review was conducted of Resident #201's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included, Right Femur Fracture, Atrial Fibrillation, Kidney Disease, Heart Failure, Reduced Mobility, Stage II Pressure Ulcer of Sacral Region. Resident #201 required staff assistance for her Activities of Daily Living and was able to make her needs known. On 9/16/2024 at 1:30 PM, an interview was conducted with Family Member L regarding Resident #201's wound progression during her time at the facility. It was reported the resident needed to be repositioned multiple times a day but that was not occurring. They continued the facility was not appropriately managing the wound and while Resident #201 was admitted with a pressure sore it worsened during her stay at the facility, as the wound did not receive the appropriate treatment. Family Member L stated while they do recall Resident #201 being evaluated by the physician, they do not recall them assessing the wound. They further stated upon discharge the resident had to be readmitted to the hospital due to the wound. Review was completed of Resident #201's medical records, and it revealed the resident was admitted with two wounds and an area of discoloration to her coccyx area. It was found the documentation of the location of the wounds and specific treatments were not consistent within the progress notes, wound notes and Treatment Administration Record TAR). It was difficult to ascertain which wounds were actively assessed and treated. Progress Notes: (continued on next page)

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	2/2/2024 at 12:01: Wound care following resident for stage II pressure injuries to left upper buttock . 2/5/2024 at 11:15: Wound care following resident for stage II pressure injuries to right upper buttock and coccyx . 2/8/2024 at 10:54: Resident has areas of pressure to coccyx and rt buttock . 2/12/2024 at 11:37: Wound care following resident for stage II pressure injuries to left upper buttock. Wound not progressing. Previous wound to coccyx has resolved . 2/26/20241 at 10:33: Wound care following for stage II pressure injuries to left upper buttock. Wound not progressing < wound bed to upper left buttock slough. Wound to lower left buttock no change . 3/4/2024 at 08:57: Wound care following resident for unstageable pressure injury to left upper buttock. Wound is not progressing., wound bed to upper left buttock slough. Wound to lower left buttock no changes . Practitioner Progress Notes: 2/2/2024 at 9:04 AM: . Unable to visualize coccyx wound . 2/5/2024 at 10:21 AM: .Unable to visualize coccyx wound . 2/16/2024 at 9:32 AM: .Unable to visualize coccyx wound . Skin Assessments: 2/1/2024 (admission): .Sacrum: Stage 2.3 x 0.5-inch purple/red open area with noted sheering proximal to wound; Left buttock: 15 x 11 discoloration (purple) to left buttock); Left buttock: 6 x 7 inch 2 open area . 2/2/2024: .Coccyx: open area treatment in place; Right buttock: shearing, treatment applied . During Resident #201's time at the facility the practitioners assigned to her team never physically assessed her wounds. On 9/16/2024 at 3:45 PM, an interview was held with Wound Nurse B regarding the progression and resolution of Resident #201's wounds. Nurse B reviewed the resident's record and stated the resident was admitted with a Stage II Sacrum wound, a Stage II Left buttock wound and left buttock discoloration. As the wound nurse perused the chart, she was able to ascertain Resident #201's coccyx wound healed on 2/12/2024 (although there were treatment orders after this date for coccyx wound treatment). As we attempted to follow the other wounds throughout the wound notes and subsequent treatment orders, we were unable to do so, due to the significant inaccuracies. It was found there was no treatment order for Resident #201's left buttock wound until 2/27/2024 (twenty-six days after admission) The following treatment orders were reviewed per wound in Resident #201's March 2024 TAR. Stage II Pressure Ulcer to Sacrum: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cleanse open area to sacrum with Normal Saline and cover with comfort foam dressing q-3 (every 3 days) days and PRN ((as needed). Initiated on 2/2/2024 and discontinued on 2/3/2024. Resident #201 received this treatment twice. Cleanse open area to sacrum with normal saline and cover with comfort foam dressing q-3 and PRN. Order initiated on 2/4/2024 and discontinued on 2/12/2024. Resident #201 received this treatment twice. Cleanse coccyx with wound cleanser, pat dry, apply Medihoney to wound and cover with comfort foam dressing. Change daily and PRN. Order initiated on 2/14/2024 and discontinued on 2/20/2024. Resident #201 received this treatment six times although the wound assessment notes stated this wound resolved on 2/12/2024. Cleanse coccyx with wound cleanser, pat dry, apply Medihoney to wound and cover with comfort foam dressing. Change every 3 days and PRN. Order initiated on 2/21/2024 and discontinued on 2/26/2024. Resident #201 received this treatment one time, although the wound assessment notes stated this wound resolved on 2/12/2024. Cleanse coccyx with wound cleanser, pat dry, apply Medihoney to wound and cover with comfort foam dressing. Change every 3 days and PRN. Every 24 hours as needed when missing or soiled. Order initiated on 2/20/2024 and discontinued on 2/26/2024. Resident #201 received this treatment one time although the wound assessment notes stated this wound resolved on 2/12/2024. Left Buttock: Cleanse open area to left buttock with wound cleanser, pat dry, apply Medihoney to wound and cover with comfort foam dressing. Change every 3 days and PRN. Order initiated on 2/27/2024 and discontinued on 3/11/2024. Resident #201 received this treatment once. Right Buttock: Cleanse wound on right buttocks with NS (normal saline), pat dry and cover with comfort foam dressing. Change q3 days and PRN. Order initiated on 2/9/2024 and discontinued on 2/12/2024. Resident #201 received this treatment once. Based on the TAR, Resident #201 was not receiving the appropriate wound treatments to manage her wounds as wound treatments indicated on the TAR did not align with the wound documentation. Pressure Ulcer Healing Assessment: 2/5/2024: Stage 2 Pressure injury to right upper buttocks;Right Buttock: 5.2 x 3.5 x 0.1 ; Stage II Coccyx: Pressure; 0.5 x 0.3 x 0.2; Stage II 2/12/2024: (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Left Buttock: 6.1 x 3.6 x 0.1; Stage II 2. Left Buttock (b): 2.7 x 3.7 x UTD (slough wound bed) Stage II pressure injury to coccyx: 0 x 0 x 0 - pressure injury healed (it can be noted it was labeled anatomically as left buttock but the header identified location as coccyx. 2/20/2024: 1. Left Buttock: 0.8 x 1.0 x 0.1; Stage II 2. Left Buttock: 1.0 x 0.6 x 0.1; Stage II 2/26/2024: 1. Left Buttock: 1.8 x 1.3 x 0.1; Stage II 2. Left Buttock: 3.9 x 2.5 x UTD: Stage- Unstageable 3/6/2024: Left Buttock: 2.2 x 1.3: Unstageable From the wound documentation it would appear Resident #201 admitted with one left buttock wound and a second left buttock wound developed during her stay at the facility. The location of the wounds was not specific and were labeled anatomically and descriptively the same. The documentation varied so much that the facility itself was unable to explain the progression of the wounds, the certainty of documented resolved wounds, the accuracy of wound treatment orders and wound assessments. Resident #205: On 9/17/2024 at approximately 2:45 PM, a review was completed of Resident #205's medical records and it revealed the resident was admitted to the facility on [DATE] with diagnoses that included COVID-19, Acute Respiratory Failure with Hypoxia, Congestive Heart Failure and Diabetes. Resident #205 was cognitively intact and able to make her needs known. The admission skin assessment denoted the following areas: Cellulitis on right lower font and left lower front leg, excoriation underneath bilateral breasts and abdominal fold was reddened. Further review yielded the following: Progress Notes: 8/20/2024 at 20:50: Patient admitted .for a fall and bilateral lower extremity cellulitis. Patient refused to let me remove her ace wraps tonight. Excoriation of bilateral breast and abdomen noted, Desenex powder applied. Patient is A&O x 4 (alert and oriented) and bed bound. Patient oriented to room, TV remote, call light, bed remote, and telephone .Placed on 2L (liters) of oxygen for low O2 (oxygen) level, was previously on oxygen at the hospital . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	9/6/2024 at 12:51: Res (resident) with stage II pressure ulcer noted to top of right ear measuring 0.3 cm (centimeter) x 0.3 cm x 0.1 cm .Res is dependent on 02. Order placed to add foam ear protectors to 02 tubing .Pressure relieving interventions evaluated. Foam ear protectors added to 02 tubing . Pressure Ulcer Healing Assessment: 9/6/2024: Onset date: 9/6/2024; Site: Right ear; 0.3 cm x q3 x 0.1 cm; Stage: II . Skin Assessments: 9/10/2024: .Open areas behind right ear from oxygen tubing . On 9/17/2024 at 3:27 PM, an interview was conducted with Wound Nurse B regarding the development of Resident #205's pressure ulcer. Nurse B stated the wound developed from the O2 tubing rubbing against the back of her ear. The resident initially complained of pain in the area and upon assessment they found the wound and added foam ear protectors and a hydrocolloid dressing. Nurse B was asked if the ear protectors are readily available in the facility, and she stated they were. It can be noted Resident #205 did not have any preventive measures in place prior to the development of the Stage II pressure ulcer. On 9/17/2024 at approximately 4:25 PM, Resident #205 was observed watching television in their room. The resident was observed to not have the foam ear protectors affixed to the oxygen tubing and when asked where they were she pointed to the bedside table. Resident #205 stated they had been off for awhile, but denied being in any current discomfort. On 9/17/2024 at approximately 1:00 PM, an interview was conducted with the administrator regarding Resident #201 and #205 pressure injuries. The wound assessment, progress notes and TAR was reviewed for Resident #201, and it was evident there were discrepancies across the three. It was also pointed out the treatment for the left buttock not being implemented until 27 days after admission. It was explained Resident #205's pressure injury was avoidable given the foam ear protectors were accessible to facility staff upon their admission. The administrator expressed understanding of the stated concerns. Review was completed of the facility policy entitled, Skin Management, reviewed January 2022. The policy stated, .Residents admitted with skin impairments will have: Appropriate interventions implemented to promote healing; A physician order for treatment; treatment record initiated; Wound location and characteristics documented .The licensed nurse (wound care nurse) will monitor all pressure ulcers, and will document on the Treatment Record in PCC verifying the completion of the treatment as ordered by the physician .