

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Covenant Skilled Nursing and Rehabilitation at Wel		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 Shattuck Road 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.

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a clean and safe environment for 5 of 8 residents' room observations (resident rooms: #22, #26, #32, #34, and #40), and for 4 of 6 residents from the confidential resident group meeting which took place on 03/24/36, resulting in verbalization of frustration and anger regarding condition of resident rooms, and an increased risk for cross contamination, risking resident health and welfare. Findings Include: This citation pertains to Intake Number 2806043. Review of the facility Maintaining a Clean Environment policy, dated March 2021, stated Cleaning a resident's room both daily cleanings and upon discharge includes the following: Cleaning all horizontal surfaces, cleaning of all contact points, decontaminating the telephone, remote control, light switches and other high touch areas with a wet cloth and germicide; wet mop floors daily using a detergent germicide (bathroom floor). During the confidential Resident's Group Meeting held on 3/24/26 at 1:00 p.m., 4 of 6 attendee's verbalized frustration and anger regarding staff not cleaning their rooms daily or since admission. During the initial tour done on 3/23/26 from 9:30 a.m. through 11:30 a.m., and at 2:45 p.m. and 3:00 p.m., for 5 of 18 resident rooms observed with interview's revealed, facility staff had not cleaned resident rooms daily (vacuum, bathroom toilet, sink and floor and touchable surfaces disinfected), or at all since admission. -room [ROOM NUMBER] Resident had a BIMS (cognitive assessment 1-15) of 15: Observation and interview done on 3/23/26 at 2:45 p.m., revealed small pieces of dried food and papers on room floor, and the bathroom floor corners were noted to be dirty and the toilet had dried BM inside the rim. The resident stated, they clean my room only once a week. -room [ROOM NUMBER], resident alert and able to answer questions asked: Observation and interview done on 3/23/26 at 10:25 a.m., revealed the floor was dirty at the bottom of the bed, under the bed, and under her wheelchair with food crumbs and with small pieces of tissue and papers. The resident stated I have never seen them (staff) clean yet, they don't vacuum or do the bathroom. -room [ROOM NUMBER], had a BIMS of 14: Observation and interview done on 3/23/26 at 3:00 p.m., revealed small pieces of paper on the floor, dust under the bed, and on the bathroom floor. The resident stated They (staff) don't clean my room at all. -room [ROOM NUMBER], had a BIMS of 10: Observation and interview was done on 3/23/26 at 10:48 a.m., revealed the floor was dirty and had pieces of paper on it, and the bathroom floor had dirt in corners with dried BM on the inside of the toilet rim and bowel. The resident said they had only vacuumed one time since she was admitted , and stated They have never cleaned the toilet.-room [ROOM NUMBER], had a BIMS of 15: Observation and interview was done on 3/23/26 at 10:08 a.m., revealed the floor was dirty with a lot of small pieces of tissues and papers near the side of the bed. The resident stated, They have only vacuumed once or twice, they mop my floor (in bathroom) once a week.Observation done on 3/23/26 at 9:25 a.m., revealed room [ROOM NUMBER] had cold air coming out of the heater and staff had put 3 large bath blankets on top of the heater vents to block the cold air. The wheatear on 3/24/26, was snow; the resident was complaining of being cold. During an interview done on 3/24/26 at 8:17 a.m., Maintenance Staff Member G said that staff changes (the heater/cooling setting) on second shift; it gets cold in resident rooms when they turn the heater down (continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>and air on. During an interview done don 3/24/26 at 8:56 a.m., Director of Maintenance F stated The system, the heat to AC balancer goes from hot to cold. I do not know why they (staff) were changing the heaters (turning the heater down and air on during second shift), I had to lock them out this morning (on 3/24/26, after this surveyor saw the bath blankets in room [ROOM NUMBER] on top of the heater). Director of maintenance F had to lock the heater so staff would not turn it down on second shift. During an interview done on 3/24/26 at 3:15 p.m., Infection Control, RN A said that he was new at the facility and had not done and documented environmental rounds.</p>		

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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** This citation pertains to Intake Number 2806043. Based on observation, interview and record review, the facility failed to ensure that 3 residents' care plans (#16, #55 and #56) of 22 residents' care plans reviewed were up to date with resident specific interventions, resulting in the high risk for improper or non-specific nursing interventions with poor continuity of care. Findings Include: Resident #16: Review of the Face Sheet, Diagnosis Sheet, nursing notes dated 3/26, and care plans dated 2/25/26 and 3/10/26, revealed Resident #16 was 88 years-old, alert and able to make own healthcare decisions, required staff assistance with all Activities of Daily Living (ADL's), and was non-weight bearing. The residents diagnosis revealed, sepsis, fall with fracture of right fibula (leg bone), fracture of right ankle, and facility acquired pressure ulcer (PU) on right foot. Review of the residents facility physician orders dated 3/10/26, stated Air Cast with tube sock when out of bed, Cleanse Right foot inner bunion with NS (normal saline), pat dry cover with foam dressing. Review of the facility Comprehensive Care Plans policy dated April, 2023, stated Review care plans and revise as needs change; Include physician orders. Review of the residents Potential/Actual Impairment to Skin care plan dated 2/25/26, up-dated 3/10/26, stated as the Focus/Problem Actual Stage 1 pressure to the inner right ankle and right bunion, small red areas to right small toe. No documentation of any interventions on the care plan regarding care of the newly quired PU on the right inner ankle was found. The new pressure ulcer/PU was documented on 3/10/26, however no interventions were added to the Skin care plan regarding the newly developed PU. During an interview done on 3/24/26 at approximately 2:40 p.m., and per review of all resident #16's facility care plans (done with this surveyor and the Director of Nursing/DON); the DON said new interventions for an actual skin impairment (new PU) should have been added to the protentional Skin care plan. Resident #55: Record review of Resident #55's admission progress note dated 3/21/2026 at 4:45PM revealed a 16 French foley catheter with milky discharge observed at foley insertion site of penis. 03/23/2026 9:47 AM Resident seated up on side of bed working with Speech therapy person, observed a clear hard plastic Urometer and urine collection catheter bag hanging at the bedside from (continued on next page)		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>the doorway. No privacy bag or covering noted, clear yellow urine noted in urine meter on the bag. Bag and spout touching the floor. Surveyor will continue to monitor the catheter bag placement.</p> <p>In an interview on 03/23/2026 at 11:25 AM with Resident #55's family member revealed that the resident was at another long-term care facility and went to the hospital for dehydration and came to the current facility with urinary foley catheter, Observation of the catheter is a clear bag with a Urometer, no privacy bag was in place. The family member stated that the resident came from the hospital on Saturday, and his catheter has been hanging there just like that since he arrived and does switch sides of the bed from time to time. The family member also stated that there has not been a covering bag on it. Everyone comes in looks at it and leaves.</p> <p>Observation and interview on 03/24/2026 at 11:40 AM with Registered Nurse (RN) Q observed Resident #55's foley catheter on the floor again clear plastic Urometer and catheter bag with clear yellow urine noted, with the catheter tubing under the bed. The state surveyor asked RN Q why the catheter is on the floor. RN Q stated that she was told because the bed needs to be in lowest position, because he was a fall risk.</p> <p>In an interview on 03/24/2026 at 11:47 AM with the Infection Control Preventionist (ICP) A about Resident #55's Urinary catheter, the ICP A stated that the urinary catheter should not be resting on the floor. and that a privacy bag should be in place. ICP A stated that the facility does have Privacy bags for urinary catheters and that the nurses are aware to change the bags out when the residents admit with a catheter. ICP A acknowledged that Cross contamination from floor organisms to catheter and potential infections that can occur. The ICP A was asked if he did resident room rounds for new admission and he stated that he tries to round every day and that he had not gone into Resident #55's room.</p> <p>Record review of Resident #55's Care plans initiated on 3/21/2026 revealed that on 3/23/2026 indwelling catheter related to urinary retention was added to the care plans. Per nursing progress noted dated 3/21/2026 Resident #55 was admitted to the facility with a 16 French indwelling catheter with a milky discharge at the penis opening.</p> <p>Record review of the facility 'Indwelling Cather Care' policy dated 10/2027, revealed staff should inspect the catheter and tubing periodically to detect compression or kinking that could obstruct urine flow. Ensure tubing is secured using a leg strap (securement device). Keep the drainage tube and collection bag lower than bladder at all times. Ensure bag and tubing is not lying on the floor. Drainage bags should be placed in a privacy bag.</p> <p>Record review of Resident #55's care plans pages 1-9, developed on 3/21/2026 revealed that on 3/23/2026 an indwelling catheter related to urinary retention care plan was initiated. Resident #55 was admitted on [DATE] with milky white drainage noted in progress notes.</p> <p>Resident #56:</p> <p>Record review of Resident #56's medical record revealed medical diagnoses of: acute kidney failure, anemia, diaphragmatic hernia, chronic kidney disease, prosthetic heart valve, congestive heart failure, pressure-induced deep tissue damage of sacral region, Kyphosis thoracic, intervertebral disc degeneration .</p> <p>Record review of Resident #56's admission assessment dated [DATE] skin integrity section noted (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>two open areas with dressings to the left knee and scattered bruising.</p> <p>Observation and interview on 03/23/2026 at 9:29 AM with Resident #56 were observed with her heels resting on the footboard of the bed and the Resident stated that both her heels hurt and that's what woke her up today and she told a nurse and they put some cream on them. Observed at this time with both heels resting on the footboards and the head of the bed elevated high up and the resident's position as scrunched down to the end of the bed, while eating breakfast. Resident stated that She also has a sore on her tail bone also. There are no extra pillows noted in the room for her heels to be off the mattress. Family member was in the room and stated that they just put the tray down and leave.</p> <p>In an interview on 3/23/2026 at 9:32AM with a Family member of the resident #56 interview was performed. The family member stated that the Resident had leg swelling at home and went to the hospital and then came here for strengthening. One of the family comes every day to take care of her, and this is why. They don't assist with the basics, and the bathroom is dirty all the time.</p> <p>Observation and interview on 03/23/2026 at 11:38 AM of Resident #56 revealed she was observed with her feet away footboards, but flat on the mattress (not an air mattress) there were no pillows noted for positioning the resident off her tail bone or raising the heels off the mattress. Resident #56 stated that both heels still hurt, but that she got out of bed and stood on them and was up in for a while.</p> <p>Observation and interview on 03/24/2026 at 10:16 AM Resident #56 were observed with a family member giving a shower to her mother because she was sweaty and gross. The family member stated that she just wheeled (the resident) into the shower and started the water. There were no staff present because they could not find any aid to assist.</p> <p>Observation and interview on 03/24/2026 at 10: 50AM the surveyor observation of resident #56's bilateral feet with nurse Registered Nurse (RN) Q of the back of the heel on each foot, noted red areas the estimated size of golf ball. The resident #56 stated that both were sore and painful to the touch. Resident #56 had told the surveyor yesterday that her heels were sore and that was new since she came to the facility.</p> <p>Record review of Resident #56's care plans pages 1-10, developed on 3/17/2026 revealed potential/actual impairment to skin integrity related to fragile skin. Actual open areas to lower left extremity with scattered scabbing dated 3/18/2026. Interventions included: During review of my skin status work to help determine potential contributive factors and alert the physician/resident representative to implement approaches to address them and document the information 3/17/2026. Help me avoid scratching; keep hands and body parts from excessive moisture as much as possible. Keep fingernails short and filed or without jagged edges 3/17/2026. Keep skin clean and dry. Use lotion on dry skin 3/17/2026. Use facility protocols for treatment od skin treatment 3/17/2026. There were no interventions for an air mattress, positioning devices or a turning schedule noted.</p> <p>Record review of the facility 'Skin Management Facility Guidelines' policy dated 1/2022, revealed staff are to conduct a baseline head to toe skin assessment on each resident upon admission .</p> <p>Record review of the facility 'Comprehensive Care Plans' policy dated 4/2023, revealed it is the policy of the facility to initiate care plans on all residents in accordance with federal regulations and identified needs of the residents. (1.) Complete a full assessment on admission. (2.) Identify (continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>resident's problems, risks, needs, and strengths. (3.) Considerations for care and interventions for resident will be included when developing the baseline and comprehensive care plans . (5.) At a minimum a baseline care plan must be developed and implemented within 48 hours of admission. The baseline care plan must include instructions needed to provide effective person-centered care for the resident. (8.) Review care plans and revise as needs change and in coordination with the MDS schedule.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2806043. Based on observations, interview and record, the facility failed to ensure proper handwashing was done during dining and medication pass observations, ensure that 1 resident's (Resident #16) of 1 resident reviewed for CPAP, mask was properly stored when not in use, and ensure that 1 resident (Resident #55) of 2 residents reviewed for urinary catheter use, catheter bag was off the floor, resulting in an increased risk for cross contamination and respiratory infection, and an increased risk for contamination during meals and medication administration from lack of handwashing, with risk of resident illnesses and hospitalization. Findings Include:</p> <p>Resident #16:</p> <p>Review of the Face Sheet, Diagnosis sheet, Nursing notes dated 3/26, and care plans dated 2/25/26 and 3/10/26, revealed Resident #16 was 88 years-old, alert and able to make own healthcare decisions, required staff assistance with all Activities of Daily Living (ADL's), and non-weight bearing. The residents diagnosis revealed, sepsis, fall with fracture of right fibula (leg bone), and fracture of right ankle.</p> <p>Review of the facility BIPAP/CPAP Therapy policy dated July, 2024, revealed the CPAP mask was to be cleaned by staff weekly.</p> <p>Review of the facility Respiratory Equipment Care & Handling policy dated December 2008, stated After drying, place in a plastic bag.</p> <p>Observation made on 3/23/26 at 9:00 a.m., revealed a dry CPAP mask sitting on the nightstand next to the bed, directly next to a dirty urinal. There was a dated clear plastic bag hanging on the wall above the head of the bed for the mask to be stored in when not in use.</p> <p>During an interview done on 3/23/26 at 9:00 a.m., resident #16 stated he had use it (CPAP mask) last night, and I took it off early this morning.</p> <p>During a second observation done on 3/24/26 at 8:00 a.m., the same dry CPAP mask was again sitting on the nightstand next to the bed. The same dated clear plastic bag was just above the mask hanging on the wall.</p> <p>During a second interview done on 3/24/26 at 8:00 a.m., Resident #16 stated I took it off at 5:00 a.m. this morning, no one puts it in the bag. The resident informed this surveyor that his (Family member) #1 comes in and cleans his CPAP mask, no staff clean it.</p> <p>During a phone interview done on 3/25/26 at 2:30 p.m., Family Member #1 said she was the only one who cleaned the residents CPAP mask, and she verbalized it needed to be put in the plastic bag when not in use.</p> <p>During an interview done on 3/24/26 at approximately 2:00 p.m., Infection Control Nurse, RN A said all CPAP masks were to be cleaned and stored in a sated plastic bag when not in use.</p> <p>Medication Pass Administration: (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observation on 03/23/2026 at 8:59 AM with Registered Nurse (RN) R, pushed the medication cart to room [ROOM NUMBER] for medication administration. RN R stated that she did have medications to pass in room [ROOM NUMBER]. Observation of RN R went into room [ROOM NUMBER], unlocked the in-room med cabinet, brought out the plastic medication packs to the med cart in the hallway, reviewed the medications against the computer and punched out the medication packets into a clear med cup and went back into room [ROOM NUMBER] and administered the medications to the resident. RN R then went back out to the medication cart in the hall.</p> <p>Observation on 03/24/2026 at 6:59 AM with Registered Nurse (RN) M, walked away from the 'Team Room' she is the night shift nurse, waiting for her day shift replacement. Medication cart left unlocked in team room, nurse walked out of sight, Surveyor waited for any staff to present. At 03/24/2026 at 7:00 AM RN/MDS staff P came into the 'Team Room' the state surveyor explained that the nurse left the room, and the medication cart was left unlocked, and the treatment cart was left unlocked.</p> <p>Observation and interview on 03/24/2026 at 7:13 AM on the Superior unit Shift change, Night shift nurse License Practical Nurse (LPN) S gave report to oncoming Registered Nurse Q and counted the controlled medications in the medication cart and the Marinol in fridge. Record review of the Superior Unit 2026 'Controlled Medication Shift Change Log' noted that on 3/23/2026 signature of off-going nurse was blank. On the form it is clearly stated that discrepancies are to be reported to Nursing Administration. LPN S stated that we put a yellow sticky note on the Superior Unit 2026 'Controlled Medication Shift Change Log' so the nurse would know to sign the form next time she works.</p> <p>Observation and interview on 03/24/2026 at 7:26 AM on the Lake [NAME] unit with Licensed Practical Nurse (LPN) N the nurse walked into the team meeting room placed his backpack in the room. Observation of LPN N medication pass began with no hand hygiene done. LPN N pushed medication cart to room [ROOM NUMBER], used keys to unlock in room medication cabinet, pulled plastic baggies of medications back out to the med cart, meds placed in cup. LPN N then entered room [ROOM NUMBER] and administered medications for the residents. LPN N then went back to medication cabinet for eye drop medication and then gloved and administered eye medication. LPN N removed the gloves and went back to the in-room medicine cabinet and locked up the cabinet and went out to the medication cart to start the next resident's medication administration.</p> <p>Observation and interview on 03/24/2026 at 8:06 AM with the Lake [NAME] unit Licensed Practical Nurse (LPN) H was moving the medication cart to room [ROOM NUMBER]. LPN H began to chat and explained that the resident in room [ROOM NUMBER] took the medications whole pills with water, and had two antibiotics that were oral, and two nasal sprays. LPN H performed no hand hygiene prior to medication prep, went into the resident's room to unlock the med cabinet and returned to the medication cart. Medications were removed from the plastic baggies and reviewed, punched out of the med packs and placed in a clear medication cup. LPN H then went into room [ROOM NUMBER] administered the medications and then did wash after administration of oral medications. LPN H then gloved for nasal spray application, used the remote control to change the channel for residents, switched gloves but did not wash hands, LPN H stated that the call lights are at 15 minutes now, she was watching the monitor on the unit. LPN H stated that there was a call in for the aide today and we are splitting an agency aide between 2 units. LPN H stated Call lights are going off stated that her unit was a heavy use call light unit.</p> <p>Record review of the facility 'Medication Pass Guidelines dated 9/2023, revealed to assure the most complete and accurate implementation of physician's medication orders and to optimize drug therapy (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>for each resident by providing the administration oof drugs in an accurate, safe, timely, and sanitary manner and to systematically distribute medications to residents in accordance with state and federal guidelines. Procedure: (1.) Follow infection control practices- complete hand hygiene prior to medication preparation for each medication pass, between resident medications administrations, after direct resident contact and at the completion of medication pass. (10.) Ensure medication and/or treatment cart is locked when unattended.</p> <p>Dining Observation:</p> <p>Observations on 03/23/2026 at 11:33 AM kitchen staff were Observed loading the meal trays in the main dining room, into the insulated rolling boxes. thermal plate warmers and lids are being used. Staff wear gloves for the plating of the food items. Beverages are added to the trays currently also.</p> <p>No residents eat in the dining room area; all were in room trays and taken to the resident rooms. Dining area is well lite, and there are plenty of tables and chairs. area is well ventilated. Will observe sample residents during meals. Observation of residents' meals in rooms, trays were passed with no hand hygiene offered to residents.</p> <p>03/24/2026 7:44 AM Observation of breakfast trays prepped and placed in thermal boxes and then taken to the resident units and passed by staff members. meal tickets are checked for proper diet, texture and choices. Meals are made in the kitchen across the road and brought into the facility from outside and then the trays are made up and taken to the resident rooms.</p> <p>Observation on 03/24/2026 at 8:40 AM During medication pass meal trays observed as being passed with no hand hygiene offered to residents by staff. Will observe again at noon meals.</p> <p>Observation and interview on 03/24/2026 at 12:05 PM with dietary side V server stated that the dietary staff take the trays to the rooms. Dietary aide V observed to take lunch tray into room [ROOM NUMBER], the tray was delivered, the resident was lying in bed, and no hand hygiene was offered. Dietary aide V moved items on the overbed table and arranged items to make room for the meal tray and then went back to the thermal tray box and got the next tray to pass. Observation on 03/24/2026 12:13 PM Observation of meal tray delivery meal tray delivered by dietary aide W to room [ROOM NUMBER], the dietary aide set the meal tray on the table and did not remove the lid, left the room. Dietary aide W stated that their staff delivering trays was usually only 2 people from the kitchen to deliver the meals, but today they gave us an extra person so there are 3 of us today to make it go quicker. No hand hygiene was observed during the meal tray passing.</p> <p>Observation and interview on 03/24/2026 at 12:19 PM with the resident in room [ROOM NUMBER] who had in room meal. Observation of the meal delivery the resident was asked about hand hygiene and replied that no they have not ever offered me hand washing before the meals. Observation of noon meal tray was a piece of fish and white rice; she did not want it. The resident Was noted eating a small salad from the facility and she stated that it was mostly lettuce and not that good and that 4 out of 5 days the food is not that good.</p> <p>Record review of the facility 'hand Hygiene' policy dated 8/2023, revealed hand hygiene shall be regarded by the organization as the single most important means of preventing the spread of infections. All personnel shall follow our established hand hygiene procedures to prevent the spread of infection and disease to other personnel, patients, and visitors. (continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235585	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/25/2026
NAME OF PROVIDER OR SUPPLIER Covenant Skilled Nursing and Rehabilitation at Wel		STREET ADDRESS, CITY, STATE, ZIP CODE 5939 Shattuck Road 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #55:</p> <p>Record review of Resident #55's admission progress note dated 3/21/2026 at 4:45PM revealed a 16french foley catheter with milky discharge observed at foley insertion site of penis.</p> <p>03/23/2026 9:47 AM Resident seated up on side of bed working with Speech therapy person, observed a clear hard plastic urometer and urine collection catheter bag hanging at the bedside from the doorway. No privacy bag or covering noted, clear yellow urine noted in urine meter on the bag. Bag and spout touching the floor. Surveyor will continue to monitor the catheter bag placement.</p> <p>In an interview on 03/23/2026 at 11:25 AM with Resident #55's family member revealed that the resident was at another long-term care facility and went to the hospital for dehydration and came to the current facility with urinary foley catheter, Observation of the catheter is a clear bag with a urometer, no privacy bag was in place. The family member stated that the resident came from the hospital on Saturday, and his catheter has been hanging there just like that since he arrived and does switch sides of the bed from time to time. The family member also stated that there has not been a covering bag on it. Everyone comes in looks at it and leaves.</p> <p>Observation and interview on 03/24/2026 at 11:40 AM with Registered Nurse (RN) Q observed Resident #55's foley catheter on the floor again clear plastic urometer and catheter bag with clear yellow urine noted, with the catheter tubing under the bed. The state surveyor asked RN Q why the catheter is on the floor. RN Q stated that she was told because the bed needs to be in lowest position, because he was a fall risk.</p> <p>In an interview on 03/24/2026 at 11:47 AM with the Infection Control Preventionist (ICP) A about Resident #55's Urinary catheter, the ICP A stated that the urinary catheter should not be resting on the floor. and that a privacy bag should be in place. ICP A stated that the facility does have Privacy bags for urinary catheters and that the nurses are aware to change the bags out when the residents admit with a catheter. ICP A acknowledged that Cross contamination from floor organisms to catheter and potential infections that can occur. The ICP A was asked if he did resident room rounds for new admission and he stated that he tries to round every day and that he had not gone into Resident #55's room.</p> <p>Record review of the facility 'Indwelling Cather Care' policy dated 10/2027, revealed staff should inspect the catheter and tubing periodically to detect compression or kinking that could obstruct urine flow. Ensure tubing is secured using a leg strap (securement device). Keep the drainage tube and collection bag lower than bladder at all times. Ensure bag and tubing is not lying on the floor. Drainage bags should be placed in a privacy bag.</p>		