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	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Skilled Nursing and Rehabilitation at Wel	5939 Shattuck Road Saginaw, MI 48603

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to 1) Maintain food preparation and kitchen equipment in a sanitary and good working condition, and 2) Ensure that all partly used or opened foods had a use-by date, resulting in an increased likelihood for food borne illness with hospitalization, and cross contamination affecting a census of 32 residents who consumed oral nutrition from the facility kitchen. Findings Include: Review of the Public Health Service 2009 Food Code, adopted by the Michigan Food Law, effective October 1, 2012, Chapter 4-501.14 directs that equipment cleaning frequency is to be throughout the day at frequency necessary to prevent recontamination of equipment and utensils. 4-602.11 Equipment Food-Contact Surfaces and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be cleaned: Review of the facility Dietary Sanitation of Equipment policy, dated 2/13/25, revealed that staff were to clean kitchen equipment daily and stated Safety always come first. Review of the facility Labeling Food Product policy, dated 1/3/2023, stated All food service workers within the unit will be trained on proper labeling prepared foods and products stored for later use. All labels will contain the complete name of the product, the date the product was prepared or opened, the date the product must be utilized by. During the initial kitchen tour done on 3/23/26 at 8:30 a.m., accompanied by Dietary Manager D, the following observations were made and interviews were done: -At 8:38 a.m.: A large gray trash bin with trash filled to the rim, was observed sitting directly next to a food prep area with the top on the floor where [NAME] C was making the noon meal (pork ragu). -At 8:40 a.m.: Clean and ready for use pots and pans were observed sitting on the bottom shelf of a food prep table with pieces of food and crumbs inside several of them; the shelf they were on also had dried food pieces and dust on it. The pans were stacked face up on the shelf (should be face down to prevent contamination). During an interview done on 3/23/26 at 8:40 a.m., Dietary Manager D stated I have only been manager for 3 days -At 8:42 a.m.: A second large gray trash bin with trash in it was observed with the top on the floor, and it was next to the uncovered clean and ready for use floor food mixer. -At 8:43 a.m.: The clean and ready for use large floor mixer was observed to have flour and dried food (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	particles inside the bowel, on the handle and on the attachment area. There was no cover on it. Dietary Manager D stated they (staff) used it last week, they made meat loaf with it, it should be clean and have a cover over it. -At 8:45 a.m.: The clean and ready for use counter mixer was observed to have dried food on the attachment area (directly over the bowel). -At 8:50 a.m.: The large white plastic food container half full of Panco (breading), was observed to have dried yellow colored drippings inside and on the outside. -At 8:51 a.m.: The back food prep area was observed to have an excessive amount of crumbs, dried food particles and dust on it. During an interview done on 3/23/26 at 8:51 a.m., Dietary Manager D stated I agree (the food prep table was dirty). -At 8:52 a.m., another large gray trash bin was uncovered sitting right next to the flat grill with the top again sitting on the floor. Pieces of food, thick grease and papers were above the rim of the trash bin; [NAME] B was cooking and observed putting the extra grease from the flat top grill directly into the trash bin because the grease trap (under grill) was stuck and she could not get the drawer open. The grease trap was noted to have approximately an inch and a half of old grease and pieces of food in side of it. During an interview done on 3/23/26 at 8:52 a.m., [NAME] B stated The guy's (maintenance staff) usually clean it (the grease trap), we can't get it open, I already hurt myself trying. -At 8:55 a.m., several broken and loose floor tiles (one came right up) was observed in front of the flat grill; the floor was buckling under the tiles due to moisture. When this surveyor inspected them, one large whole floor tile came right up and the wood underneath was warped. During an interview done on 3/23/26 at 8:55 a.m., [NAME] B said the tiles had been broken for awhile and she had reported it to the manager, stating I almost tripped on them several times. -At 9:00 a.m., the flat top grill and stove hood metal vents were noted to be bent, with several of them missing exposing large gaps. -At 9:03 a.m., the microwave outsider sides, insider sides and top was found to have an excessive amount of dried food. During an interview done on 3/23/26 at 9:03 a.m., Dietary Manager D stated They (staff) are supposed to clean it daily. Dietary Manager D said the weekend staff did not do their cleaning duties the prior weekend. -At 9:04 a.m., two large plastic containers of peanut butter were observed with peanut butter on the top and down the sides of both of them. -At 9:05 a.m., the salad bar was observed to have dried lettuce and died shredded cheese covering the inside back area. The kitchen had not even served any salad yet (on 3/23/26 in the morning). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-At 9:06 a.m., 2 large containers of ice cream were observed in the ice cream freezer, both had been open and partly consumed with no dates on the tops at all; one had the top partly off with some freezer burn noted on the ice cream During an interview done on 3/23/26 at 9:06 a.m., Dietary Manager D said the ice cream containers should of had dates on them when they were open and a use-by date. -At 9:07 a.m., a clean and ready for use silver metal scupper were observed sitting in the clean utensil container with dried food inside of it. -At 9:10 a.m., the pop machine was noted to have dried pop all over the spicket areas. During an interview done on 3/23/26 at 9:10 a.m., Dietary Aid E stated the jobs are supposed to be done every day, it's on the job sheet. Review of the facility Dietary job/duty sheets dated 3/22/26 (Sunday), revealed 42 blank squares (missing staff initials indicating jobs were not completed). -At 9:19 a.m., under the working steamer was noted a large pool of water on the counter. -At 9:20 a.m., a large area of frozen condensation was noted directly above the cooling motor and fan in the walk-in freezer. During an interview done on 3/23/26 at 9:19 a.m., [NAME] C stated it's broken, it's been like that. During an interview done on 3/23/26 at 1:37 p.m., Infection Control Nurse A said he was new and he had done a walk-through (in the kitchen) with the Director of Nursing approximately a week before the State kitchen tour was done (on 3/23/26). During an interview done on 3/23/26 at 2:00 p.m., Maintenance Director F revealed no one had given him any work orders or informed him of the things that needed to be fixed in the kitchen (hood, grease trap, tiles and ice condensation in freezer). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/23/2026 at 12:46pm during the main kitchen tour, observed yellow residue in the interior walls of the ice machine in the main kitchen. During this observation, Dietary Manager D was interviewed on how often the ice machine is cleaned, and she answered it's cleaned by maintenance once a month. On 03/23/2026 at 12:48pm observed Pentair Everpure 7FC5-S filter dated 4/5/22, for the tea machine in the main kitchen. Another filter to the juice machine was dated 10/29/24. On 03/23/2026 at 12:56pm observed residue on the mixer. According to the 2022 Food Code, 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, Equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 03/23/2026 at 12:58pm, the wiping cloth sanitizer bucket was tested with quat strips and the result was zero. During this observation, Dietary Manager D was asked how often it's changed out and she stated it's changed out every 2 hrs. On 03/23/2026 at 1:02pm observed what appeared to be a bee flying above the food prep area. On 03/23/2026 at 1:04pm observed a utility sink with a hose attached and a chemical feed dispenser downstream of an atmospheric vacuum breaker (AVB) in the boiler room adjacent to the kitchen. According to the State of Michigan's 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve). According to the State of Michigan's 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure. On 03/23/2026 at 1:30pm interviewed Director of Maintenance F on whether there were cleaning logs for the ice machine in the main kitchen and he stated there weren't any cleaning logs. On 03/23/2026 at approximately 1:30pm interviewed Director of Maintenance F on how often the filters to the tea and juice machine are changed and he stated he wasn't sure if that was his job to do or not. On 03/23/2026 at approximately 1:30pm interviewed Director of Maintenance F on what the procedure is for when they see pests in the kitchen, and he stated they're supposed to call the pest control company and figure out where the pests could be coming from. According to the FDA 2022 Food Code, 6-501.111 Controlling Pests, The premises shall be maintained free of insects, rodents, and other pests. The presence of insects, rodents, and other pests shall be controlled to eliminate their presence on the premises by .Routinely inspecting incoming shipments of food and supplies .Routinely inspecting the premises for evidence of pests .Using methods, if pests are found, such as trapping devices or other means of pest control . Eliminating harborage conditions. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the facility's policy on pest control, Building management will ensure that pest findings are recorded in the log and that written reports are reviewed after each service. Other responsibilities including correcting sanitation and structural deficiencies, as detailed in the written reports, which may lead to pest problems, and compliance with applicable notification and posting requirements. On 03/23/2026 at approximately 1:45pm interviewed Dietary Manager D on what range the rag sanitizer bucket should result at, and she stated it should be between 200 and 400. According to the facility's policy on sanitizer, Sanitation buckets must be established with appropriate sanitizing solution, i.e., generally for bleach, 50-100ppm or Quaternary solution, 200ppm; however, follow manufacturer's recommended directions. According to the FDA 2022 Food Code, 3-304.14 Wiping Cloths, Use Limitation, Cloths in-use for wiping counters and other equipment surfaces shall be .Held between uses in a chemical sanitizer solution at a concentration specified under 4-501.114 and The sanitizing solution must be changed as needed to minimize the accumulation of organic material and sustain proper concentration. Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **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 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.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview and record review, the facility failed to ensure daily snacks were offered and delivered per 6 of 6 resident complaints during a confidential resident group meeting, resulting in resident verbalizations of anger and frustration with complaints, and the failure to offer and deliver snacks to residents documented to receive evening snacks. Findings Include:Review of the facility snack policy dated February 2014, stated the snacks were to be given to resident's Between-meal (and) are offered to resident's (daily), except when contraindicated; document snack consumption.During the confidential resident group meeting held on 3/24/26 at 11:10 a.m., 6 of 6 attendees verbalized anger and frustration regarding not knowing they could even have snacks, not being offered daily snacks, and not receiving any snacks.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and records review, the facility failed to ensure that 1 resident (R #35) had ADL care done daily, and that 1 resident (R#55) had a privacy bag covering the urinary catheter bag, of 22 Residents reviewed for dignity. Findings include: 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 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. 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. 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. Record review of the facility admission booklet 'Resident Rights' (undated) page 14, Dignity, Respect & Quality of Life noted the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents. On page 38, Privacy- a resident is entitled to privacy, to the extent feasible, in treatment and in caring for personal needs with consideration, respect, and full recognition of his or her dignity. Resident #35 Review of the Face Sheet, nursing progress notes dated 3/26, diagnosis sheet, and care plans dated 2/25/26 and 3/13/26, revealed Resident #35 was 92 years-old, admitted to the facility on [DATE], for end of life care and Hospice services, alert with confusion, and required staff assistance with all Activities of Daily Living (ADL's). The residents diagnosis included, kidney shutdown, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cardiomyopathies, heart failure, obesity, abdominal aortic aneurysm without rupture, and lung disease Resident #35 received Hospice services two times per week (for ADL care), had chronic pain and received as needed narcotic pain medication for end of life pain. The resident was unable to participate in any ADL care, nor express his needs. Review of Resident #35's ADL care plan dated 3/13/26, revealed staff were to assist with bed mobility, bathing, dressing and any personal hygiene. Review of the facility Abuse and Neglect Prohibition policy, dated July 2019, stated Residents have the right to free from neglect, exploitation, and misappropriation of resident property. The resident's were to be free from neglect and dignity was to be protected. Observation was made on 3/23/26 at approximately 10:00 a.m., of Resident #35 sleeping in his bed, family were present in the room. The resident had an odor, and his white tee-shirt had a large area on the top left side of dried food. The resident was unable to be interviewed at the time, due to being in the actively dying stage. During an interview done on 3/23/26 at 10:30 a.m., Family Member T stated that staff do not clean him up and they were told by staff (nurses and nursing assistants) that they wait for Hospice (scheduled x2 weekly) to come to do ADL care. A second observation was made on 3/24/26 at 7:50 a.m., the resident was sleeping in his bed with family members present. The same soiled white tee-shirt was on him and he still had an odor. During an interview with Family Members T and U, at 7:50 a.m., both said he had not been cleaned up yet (from 3/23/26), and they had been at the facility with him 24 hours a day; there was always a family member at the facility with the resident. Family Member T stated I can't leave him, I don't trust the staff; I have talked to the nurses about it. They told us they wait for the Hospice Aid to clean him up; no dignity, they won't clean him up at all. During an interview done on 3/24/26 at 7:58 a.m., Nurse, LPN I stated Yes, they should have cleaned him up; his family is confrontational, I did call the DON last night (Director of Nursing). Nurse I said staff were waiting for Hospice to come to clean the resident up. During an interview done on 3/24/26 at 8:10 a.m., Nursing Assistant/CNA B who was starting first shift stated I do clean everyone up (daily); they should clean everyone up daily. During an interview done on 3/24/26 at 9:20 a.m., the Director of Nursing said she had received a call from Nurse I during the night, and she instructed her to go into the residents room and care for him.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that two residents (#3 and #8) of 22 residents reviewed, were fully informed, per consent, of the dosage and frequency of the psychotropic and/or antidepressant medications they were receiving.Findings include: Resident #3: Record review of Resident #3's Minimum Data Set (MDS) dated [DATE] admission revealed a Brief Interview of Mental status (BIMs) score of 13 out of 15, with medical diagnosis of anemia, hypertension, peripheral vascular disease, gastroesophageal reflux disease, renal insufficiency, wound infection, diabetes, arthritis, malnutrition, depression, chronic obstructive pulmonary disease. Record review of Resident #3's March 2026 Medication Administration Record (MAR) and physician orders revealed an antidepressant Mirtazapine Tablet 7.5 MG orally at bedtime. The antidepressant started on 3/2/2026. Record review on 03/24/2026 at 11:20 AM of Resident #3's antidepressant Mirtazapine consent signed by the resident on 3/2/2026, see copy. There is no dosage noted on the consent, no frequency of administration/times per day, Resident #8:Record review of Resident #8's psychiatry notes dated 2/11/2026 revealed that resident was in the nursing home with bipolar and anxiety and depression.Record review of the March 2026 Medication Administration Record (MAR) noted medications of hydroxyzine Pamoate Oral Capsule 50 MG (Hydroxyzine Pamoate) for anxiety, trazodone HCl Oral Tablet 50 MG (Trazodone HCl) for depression, Lurasidone HCl Oral Tablet 20 MG (Lurasidone HCl) for mental disorder, Duloxetine HCl Oral Capsule Delayed Release Sprinkle 60 MG for depression.Record review of consent dated 5/6/2025 was one consent for 4 medications with no dosage or frequency of administration. The consent did not identify the side effects of antidepressants. Record review of the facility 'Psychotropic Medication Assessment & Monitoring' policy dated 4/2019, revealed psychotropic medications are any medications that affect brain activity associated with mental processes and behavior, including antipsychotics, antidepressants, anti-anxiety, and hypnotics. Record review of the facility 'Consent for Psychotropic Drug Use' form, dated 3/2024, revealed: Following a careful assessment of the resident's conditions and needs the physician for the above-named resident has ordered the following medication(s). Because the mood/behaviors observed in the resident are of detriment to the resident's well-being, or the well-being of others around the resident, it is felt the benefits outweigh the risks at this time. Ongoing monitoring of mood/behaviors will continue to determine if there is a continued need for the medication(s). Residents will be monitored for these side effects, and the medication(s) will be discontinued if serious effects develop.

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	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Skilled Nursing and Rehabilitation at Wel	5939 Shattuck Road Saginaw, MI 48603

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Interview and record review, the facility failed to ensure a safe discharge for 1 resident (Resident #53) of 3 closed records reviewed, resulting in the potential for ineffective or mismanaged continued care, an Adult Protective Services referral or safe placement and a facility discharge summary review. Findings include:Resident #53:Record review of Resident #53's hospital Discharge summary dated [DATE] revealed a medical diagnosis of dementia along with other chronic diseases of: chronic cellulitis of legs, chronic wounds, acute kidney injury, chronic heart failure with reduced ejection fraction of 45-50%, aortic stenosis, atrial fibrillation, heart block with pacemaker, history of deep vein thrombosis and pulmonary embolism and was discharged to long-term care facility. Record review of Resident #53's nursing progress notes revealed an admission on [DATE] at 1:54PM a Brief Interview of Mental Status (BIMs) was performed on the resident with a score of 6 out of 15, severe cognitive impairment. On 1/6/2026 at 2:23PM Resident #53 was seen by physician services with noted periods of confusion the spouse noted at bedside. Resident #53's progress health status note dated 1/8/2026 at 4:30PM noted that the resident was upset and refusing to take medications or let staff perform blood pressure tasks. Resident was noted stating he used the call light 47 times and has counted, resident was noted as having stated that he waited 3 hours for a toothbrush and was upset and that he was leaving the facility. Physician was notified and the Assistant Director of Nursing was notified and at bedside to witness Against Medical Advice AMA signature. On 1/8/2026 at 7:03PM Resident #53's daughter and ex-wife were notified and stated they are not picking the resident up. Resident signed AMA paperwork around 5 and still sitting at front doors. Writer had daughter on phone and went to check on resident at the front door. Resident stated he has a ride and does not want to talk anymore. Record review of Resident 53's medical record revealed that there were no referrals for adult protective services or community welfare check referrals for the resident. There was no discharge summary or home care referral found. In an interview on 3/25/26 at 10:07 am with the facility social worker J revealed that she could not recall who Resident #53 was. Record review of Resident #53's medical record revealed that Registered Nurse R had discharged the resident. Resident #53 was found on the facility discharge list and had discharged Against Medical Advice (AMA) with a dementia diagnosis with no follow-up. The social worker J stated that she was not at the facility at the time the discharge occurred and did not review the discharge when she came back to work. She just doesn't review discharges and there was no APS referral because she was not at the facility and RN R did the discharge. in an Interview done on 3/25/26 at 10:55 AM, Registered Nurse (RN) R stated I think I remember him (she did discharge due to SW being off). He did not want to be here; his family didn't want to pick him up. When I went in there, he said he pushed the call light 47 times and He said the red button fell off he pushed it so many times the [NAME] red button fell off. I assessed the call light, and it was working fine. He stated I waited 3 hours for a toothbrush; he did have one in his room. I notified him I would get him a toothbrush and he declined. He stated he was living and I said he was not discharged ; he still left. There was no documentation of what time the resident left the facility, who the resident left the facility with, how the resident left the facility or where the resident was going to live. There were no home care referrals, no adult protective services or community services referrals done by the facility.

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	235585	A. Building B. Wing	03/25/2026

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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 3/2426 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 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. 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 (continued on next page)

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	235585	A. Building B. Wing	03/25/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. Resident #56: 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 . Record review of Resident #56's admission assessment dated [DATE] skin integrity section noted two open areas with dressings to the left knee and scattered bruising. 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 (continued on next page)

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	235585	A. Building B. Wing	03/25/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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. 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 . 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 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.

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	235585	A. Building B. Wing	03/25/2026

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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 records review the facility failed to prevent facility-acquired skin injuries for 1 resident (Resident #56) of 22 residents reviewed, resulting in the development of bilateral heel redness with the verbalization for pain and discomfort and likelihood of prolonged illness. Findings include: Resident #56:Record review of Resident #56's admission assessment dated [DATE] skin integrity section noted two open areas with dressings to the left knee and scattered bruising. 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. 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. 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. 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. 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. 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. 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 . 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 resident's problems, risks, needs, and strengths. Record review of the facility 'Alignment and Pressure Reducing Devices' policy dated 1/2022 revealed it is the policy of the facility to provide residents with positioning and alignment support to minimize pressure, maximize comfort, and reduce the risk for further skin breakdown. Various assistive devises can be used to maintain correct body positioning and to help prevent complications that (continued on next page)

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	235585	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Skilled Nursing and Rehabilitation at Wel	5939 Shattuck Road Saginaw, MI 48603

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	commonly arise when a resident must be on prolonged bed rest . Record review of the facility 'Pressure Ulcer Preventive Measures Policy' dated 1/2022 revealed residents at risk of development of pressure ulcers receive interventions to reduce the risk of pressure ulcers. (18.) .Use devices that relives pressure on the heels, most commonly by raising the heels of the bed. Use pillows under the length of the lower leg, suspending the heels .

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	235585	A. Building B. Wing	03/25/2026

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F 0848 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide a neutral and fair arbitration process and agree to arbitrator and venue. Based on interview and record review, the facility failed to ensure that a venue that was convenient to both parties was clearly identified in the arbitration agreements for 2 residents (Resident #14 and Resident #43) of 2 residents reviewed, resulting in the likelihood for unresolved arbitration disputes. Findings include: An interview and record review on 03/24/2026 at 12:59 PM with Registered Nurse (RN) P revealed the facility had 2 residents in a binding arbitration agreement. RN P stated that she did not know if anyone has used the arbitration to resolve disputes she is to only get the signatures and not prevue to corporate legal information. RN P stated that she goes over the form and reads the agreement to them and ask if they know what that means and explains that she was not a lawyer so does not give legal advice and do not let them to sign or not sign. RN P stated that she explains to residents that the facility use a third-party mediator for legal disputes, there is a right to cancel agreement section that they cancel the arbitration or change it. Record Review of arbitration agreement documents with Resident #14 and Resident #43's signatures noted that the agreement did not clearly identify a convenient venue to both parties. There was no venue identified in the agreements. Record review of Resident #14's arbitrational agreement for was signed by the resident on 3/18/2026 and Resident #43 signed the arbitrational agreement on 3/2/2026. Record review of the facility 'Binding Arbitration Agreement Policy', dated 3/2024, revealed section 2.) the agreement must:(b.) Provide for selection of a venue that is convenient to both parties.

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	235585	A. Building B. Wing	03/25/2026

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Covenant Skilled Nursing and Rehabilitation at Wel	5939 Shattuck Road Saginaw, MI 48603

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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** 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 that1 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: 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 non-weight bearing. The residents diagnosis revealed, sepsis, fall with fracture of right fibula (leg bone), and fracture of right ankle. Review of the facility BIPAP/CPAP Therapy policy dated July, 2024, revealed the CPAP mask was to be cleaned by staff weekly. Review of the facility Respiratory Equipment Care & Handling policy dated December 2008, stated After drying, place in a plastic bag. 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. 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. 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. 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. 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. 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. Medication Pass Administration: (continued on next page)

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	235585	A. Building B. Wing	03/25/2026

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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 for each resident by providing the administration oof drugs in an accurate, safe, timely, and sanitary (continued on next page)

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	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Skilled Nursing and Rehabilitation at Wel	5939 Shattuck Road Saginaw, MI 48603

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Dining Observation: 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. 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. 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. 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. 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. Observation and interview on 03/24/2026 at12:19 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. 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. Resident #55: (continued on next page)

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	235585	A. Building B. Wing	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covenant Skilled Nursing and Rehabilitation at Wel	5939 Shattuck Road Saginaw, MI 48603

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. 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. 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. 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. 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.