STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235615	A. Building B. Wing	02/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caretel Inns of Brighton	1014 E Grand River Brighton, MI 48116

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 40330 This citation relates to Intake #MI00149608. Based on interview and record review, the facility failed to provide dignified care to answer call lights timely for two Residents (R804, R806) of five residents reviewed for dignity. Findings include: On 2/05/25 at 12:08 p.m., R804 was observed seated in a manual wheelchair, dressed, with a full mechanical lift body sling underneath them. An air mattress was observed on their bed. R804 was asked if they had any pressure ulcers, and responded, Yes. R804 was frowning and appeared ready to cry. On 2/05/25 at 12:13 p.m., R804 reported they felt upset and angry as they were waiting too long for their call light to be answered. R804 explained they always waited at least 15 to 20 minutes and sometimes they waited for at least a half hour, including today. R804 stated, This morning I had an accident (incontinence episode). I am left wet and having to sit in it. This is happening all the time . R804 further clarified this occurred anytime during the day or night. R804 looked at their clock and was able to tell the time accurately. R804 was interviewable and oriented to themselves, place, situation, and time. On 2/05/25 at 12:15 p.m., the wound care nurse, Registered Nurse (RN) B, was asked if R804 had a pressure ulcer. RN B stated R804 had a Stage 4 pressure ulcer, and required the air mattress. On 2/05/25 at 1:15 p.m., the Nursing Home Administrator (NHA) was asked if there was any way to ascertain call light wait times for residents. The NHA responded there was no way to tell call light wait times, and no logs with the current call light system. The NHA conveyed they were exploring other options. On 2/05/25 at 2:15 p.m., R806 was observed in their hospital bed, wearing a gown, with an oxygen nasal canula in their nose. R806 was observed with a standard call light, with a small button to activate. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/05/25 at 2:17 p.m., R806 stated, Sometimes the (call) light wait is on forever. It is at least a half an hour wait. It was three hours .It happened during the night. I think it was yesterday .My diaper was full of poop. It burned for a while. I was yelling for help. I am blind. There was a lady across the hall who looked for the nurse .I tell time by how many shows are on the TV. I watched two shows; that's an hour, and then I watched another show. When asked how this made them feel, when their call light was not answered over an hour and a half, R806 responded, Let's just say it made me feel real inhuman .not real good . R806 was interviewable and oriented to themselves, their situation, and place. R806 had no vision accommodations, such as a talking watch, clock, or other alternate sensory aide observed in their room to assist them in telling time, which R806 confirmed. R806 reported it would be helpful to have assistance with telling the time, since their hearing and memory were fine. R806 knew the time of day was mid-afternoon by the television and mealtimes. On 2/05/25 at approximately 2:30 p.m., Certified Nurse Aide (CNA) C was asked about R804's report of waiting over 30 minutes for their call light to be answered earlier today (on 2/05/25). CNA C stated they were assigned a split room assignment on 2/05/25, which divided their residents and care responsibilities between two halls, the 200 and 300 hall. CNA C explained when they were caring for a resident down the 300 hall, they could not see some of the call lights on the 200 hall, and similarly when they worked down the 200 hall, they could not see some of the call lights on the 300 hall. CNA C reported they were giving a resident on the 300 hall a shower for a half hour earlier and could not see or answer their call lights during that time. CNA C stated, (R804) complained their call light was on, and I was in (another resident's room) giving them a shower .My hall partner (another CNA) said three (call) lights were going off (on the 200 hall), and explained they could not answer them. CNA C acknowledged they were aware of R804's call light concerns earlier, and they had apologized to them. CNA C acknowledged R804 had waited at least 30 minutes for their call light to be answered. CNA C stated, When staffing is really low .they (the residents) wait, and sometimes they will wait anywhere from 30 to 45 minutes .(R804) was really upset with me . On 2/05/25 at approximately 2:40 p.m., CNA C was asked about R806's reported longer call wait times, CNA C stated, (R806) was waiting about a half hour (on 2/05/25); it has been 30 to 40 minutes (at times). (R806) is having accidents too .We (the facility) need more staff, and I find myself apologizing (to residents). I am so sorry I was on the other side (another hall) .CNA C stated , (R806) was upset with them also with the longer call wait time (to have their brief changed). Review of the Electronic Medical Record (EMR) confirmed R804's and R806's rooms were both on the 200 hall. Review of the facility Floor Plan revealed many of the rooms on the 200 hall could not be visualized from the 300 hall. The same applied to many of the rooms on the 300 hall could not be visualized from the 200 hall. On 2/06/25 at approximately 11:15 a.m., the concerns were reviewed with the Director of Nursing (DON) regarding R804 and R806 reporting extended call light times, while CNA C was reportedly covering a split hall room assignment, and giving showers to residents, without assistance from another staff to cover their residents while in the shower room. The DON reported they understood the concerns, as some staff had been calling off, especially on the night shift. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/06/25 at approximately 11:45 a.m., the DON returned and reported R806 had told them they could not find their call light, and they were providing a larger touch pad call light for them, which would make it easier to find their call light. R806 had reported to this Surveyor they were waiting extended periods when pushing their call light, and had not mentioned they were without it, which was shared with the DON. The DON acknowledged the extended wait time would be of concern (at least an hour and a half, depending upon how long the TV shows were) and found R806 to be a credible reporter. The DON reported they had followed up with R804, who had expressed concerns to them regarding extended call light wait times, which were occurring during the day and night shifts, and they were following up on their concerns, and found them credible. Review of R804's Minimum Data Set (MDS) assessment, dated 9/30/24, showed R804 was admitted to the facility on [DATE], with diagnoses including stoke, depression, and kidney disease. The assessment showed R804 was dependent for toileting, bed mobility, and transfers, and had incontinence. The Brief Interview for Mental Status (BIMS) assessment showed a score of 13/15, which showed R804 was cognitively intact. The skin assessment showed R804 had a Stage 4 pressure ulcer. Review of R806's MDS assessment, dated 1/27/25, revealed R806 was admitted to the facility on [DATE], with diagnoses including pneumonia and malnutrition. The assessment showed R806 required maximal assistance with toileting, bed mobility, and transfers, and had incontinence. The BIMS assessment showed a score of 15/15, which showed R806 was cognitively intact. Review of the policy, Call Light Answering, dated 10/2021, revealed, To provide the staff with guidance on responding to resident's request and needs. Responsible: IDT (Interdisciplinary Team). Procedure: 1. Explain the call light to the new resident. 2. Demonstrate the use of the call light to the new patient or resident. 3. Assess the call light ability .5. When the patient or resident is in bed .provide the call light within easy reach of the patient or resident 7. Answer the patient's call light as soon as possible .11. If assistance is needed when you enter the room, summon help to the room. 12. After meeting the patient/resident's needs, turn off the call light . Review of the policy, Dignity, revised 4/2024, revealed, General: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Responsible Party: IDT. Policy. 1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted with maintaining and enhancing his or her self-esteem and self-worth .11. Demeaning practices and standards of care that compromise dignity is prohibited. Staff shall promote dignity and assist residents as needed by: .b. Promptly responding to the resident's request for toileting assistance . Review of the policy, Staffing, reviewed 3/2024, revealed, General: To have appropriate numbers of staff available to meet the needs of the residents. Responsible party: Administrator, DON, Nursing Supervisor. Guideline: 1. Staffing is based on the regulatory body (State and Federal) formula for determining numbers and levels of staff. 2. Staffing is then increased based on the needs of the resident population. 3. A schedule is made on a monthly basis and reviewed on an ongoing basis. 4. Staffing is supplemented as needed by outside agencies. 5. Staff are required to review their schedule and discuss any problems regarding their schedule with their supervisor. 6. It is the staff members responsibly to be at work when they are scheduled.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation relates to Intake #MI00149071. Based on observation, interview, and record review, the facility failed to demonstrate professional standards of care related to one Resident (R807) of one resident reviewed for quality of care, when they did not provide a wheelchair cushion for a resident at risk for skin breakdown, resulting in pain and the potential for skin breakdown. Findings include: On 2/05/25 at 2:59 p.m., R807 was observed in their room, seated in a manual wheelchair, and appeared thin and underweight. This Surveyor observed they had no wheelchair cushion underneath them. On 2/05/25 at approximately 3:04 p.m., R807 reported they were uncomfortable and their bottom was hurting when they sat in their wheelchair. R807's Family Member (FM) F, who was present, and R807 reported they had no wheelchair cushion in their wheelchair since their admission. FM F explained R807 was admitted about a week prior with a wound on their bottom, which was the size of a quarter currently. FM F stated R807 had received the air mattress on their bed earlier today, on 2/05/25. R807 was interviewable and oriented to person, situation, and their surroundings. Review the Electronic Medical Record (EMR) revealed R807 was admitted to the facility on [DATE], with diagnoses including muscle weakness, malnutrition, depression, dementia, rhabdomyolysis (muscle breakdown), and a hip fracture. Review of R807's Care Plan, accessed 2/05/25, revealed R807 required extensive two-person assistance for transfers and toileting. The Care Plan further revealed R807 was at risk for pressure ulcers and was revised on 2/05/25 to include a Roho air pressure-relieving wheelchair cushion, and specialty air mattress to their bed. Review of R807's progress note, dated 2/02/25 at 14:40 (2:40 p.m.), revealed R807 had a wound on their coccyx, which R807's son stated was present on admission. There were no measurements and no further description of the wound. It was unclear if R807 was admitted with the wound, the type of wound, or when the wound developed. Review of the EMR revealed no earlier documentation of R807's wound on their coccyx prior to 2/02/25. Review of R807's progress note, dated 2/03/25 at 14:57 (2:47 p.m.), revealed the Brief Interview for Mental Status (BIMS) cognitive assessment was administered, with a score of 9/15, which showed R807 had moderate cognitive impairment. Review of R807's progress note, dated 2/05/25 at 9:47 (a.m.), revealed, .Guest (R807 presents) with (a) 3.5 cm (centimeter) x 2.4 cm x UTD (Unable to Determine) pressure injury to coccyx . The note showed R807 also had an UTD pressure injury to their left heel and an UTD pressure injury to their left outer ankle. There were no measurements found prior in R807's progress notes, or assessments describing these wounds. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R807's progress note, dated 2/05/25 at 16:31 (4:31 p.m.) , revealed a bariatric low air low alternating pressure mattress was delivered on 2/05/25. On 2/05/25 at approximately 3:40 p.m., the Director of Nursing (DON) was interviewed with the Nursing Home Administrator (NHA) present; concerns were shared related to no wheelchair cushion underneath R807 six days after their admission, significant pain reported by R807, and the risk of skin breakdown. Both reported they understood the concerns. When asked who was responsible for the missing wheelchair cushion, the DON reported the Interdisciplinary Team, including nursing and therapy. The DON conveyed either nursing or therapy staff could have placed a pressure-relief cushion under R807 upon admission, per facility standards of care. On 2/05/25 at approximately 3:45 p.m., the wound care nurse, Registered Nurse (RN) B, with the DON and NHA present, was asked about R807 not having a wheelchair cushion. RN B acknowledged an air wheelchair cushion was a standard of care for a resident with a pressure ulcer, and they did not understand how this was missed. RN B acknowledged this would have been their responsibility, in part, as well as the Interdisciplinary team including nursing and therapy. RN B reported they had just placed a Roho air cushion underneath R807 prior to this interview when they learned of the concern. On 2/05/25 at approximately 4:00 p.m., the DON and Surveyor went to R807's room to interview R807. R807 was observed a second time with no wheelchair cushion underneath them. Both RN B and R807's nurse was present, and reported they were about to stand R807 and place the air wheelchair cushion underneath them, which was observed on their bed. R807 reported their left leg hurt, and showed this Surveyor and the nurses how their wheelchair fabric edge was cutting into the back of their left thigh. R807's left leg, which was fractured, was observed with marked edema (swelling) in a dependent position, with their heel on the ground, and a pressure contact point where the wheelchair fabric seat edge (which had no cushion) was cutting into their left thigh. No footrest was observed, such as an elevating footrest, or other apparatus to elevate and support R807's left leg to prevent their leg from hitting the wheelchair fabric. The DON reported they would follow-up with therapy and ensure R807 was positioned appropriately for comfort and safe positioning, per therapy recommendations. The concerns were shared with RN B and R807's nurse. On 2/05/25 at approximately 4:10 p.m., the DON was asked if they observed there was no wheelchair cushion underneath R807, given RN B reported they had placed a wheelchair cushion in R807's wheelchair during the earlier interview. The DON acknowledged the observation and reported they understood the concern. On 2/05/25 at 5:15 p.m., the Rehabilitation Director, Speech Language Pathologist (SLP) G, was asked about R807 not having a wheelchair cushion underneath them, given they had a pressure ulcer to their coccyx. RD G reported this would be a team effort, and confirmed R807 was receiving physical and occupational therapy. SLP G stated the expectation would be for a wheelchair cushion to be on the wheelchair for every resident, including R807. RD G reported they would be following up with the therapists who were treating R807. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/05/25 at 5:19 p.m., Physical Therapist (PT) H was asked about R807 having a pressure ulcer to their coccyx, and no wheelchair cushion. PT H stated this would be a typical standard of practice, for each wheelchair to have a wheelchair cushion, and especially given a resident with a pressure ulcer, as without a cushion there would be more pressure on the wound. When asked about a pressure ulcer on R807's coccyx, PT H stated a pressure ulcer on the coccyx was a high risk for breakdown without a cushion, as the coccyx is a concern as (R807 was) sitting on it, and there would be more pressure on the wound, verses a wound on a resident's sacrum (pelvis) or lumbar (back) region. PT H clarified the expectation would be every resident with a would be started with a pressure-relieving cushion in their wheelchair, and the wound care nurse would notify them if a more effective pressure-relieving cushion was needed. PT H explained a Roho brand air cushion would be used for a pressure ulcer, and this was a standard of practice for pressure ulcer care and healing, and clarified a gel cushion could be used until a Roho air cushion was obtained. PT H understood the concern with R807 not having a wheelchair cushion in their wheelchair, given their risk of skin breakdown, and already having a pressure ulcer. Review of the policy, Care Standards, dated 3/18/24, revealed, All residents shall receive necessary care and services to assist them in attaining or maintaining the highest practicable level of physical, mental, and psychosocial well-being in accordance with a comprehensive assessment and plan of care. Care is documented in the medical record according to state and/or federal regulations. Goals: To ensure all residents receive necessary care and services that are evidence-based and in accordance with accepted professional clinical standards of practice. The Director of Nursing ensures care and services that are evidence-based and in accordance with accepted professional clinical standards of practice .The Administrator and Health Information Manager or designee ensures that documentation of observations and evaluation of therapeutic interventions is filled in the appropriate section of the medical record. The Administrator, Health information manager, or designee ensures the medical record is maintained for each resident according to state and federal regulations. Review of the policy, Skin Management Program, revised 7/2024, revealed, It is the facility's policy that a resident does not develop pressure injury unless it is clearly unavoidable. Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, assessed, and provided appropriate treatment to promote healing. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. Policy. 1. Upon admission/readmission, all residents are assessed for skin integrity by completing a baseline head to toe skin assessment documented in the EMR .Pain: All residents with skin impairments will be assessed accurately for pain to assure appropriate regiment is in place.