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	02/11/2026

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 0686 Level of Harm - 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 record review, the facility failed to prevent the development of a Stage 3 pressure injury for one Resident (R57) of one resident reviewed for pressure injuries, resulting in wound treatments, increased pain and discomfort, and the potential for further wound deterioration. Findings include: On 2/09/26 at 1:46 p.m., R57 was observed in their room in their hospital bed, lying on their left side, directly on the trochanteric (hip) area, with their legs bent at their knees. There was no offloading device behind them, including pillows or a wedge to support their back on their bed. No offloading devices were observed in their room. It was noted R57 was positioned on an air mattress. The bed had no footboard. On 2/09/26 at 1:47 p.m., R57 stated, You can see the bed does not fit my frame . R57 reported they had asked staff for a new bed as long as I have been here, and said staff did not get them one. R57 explained their legs were curled to stay on the bed. R57 said they laid on their left side as it was too painful to lay on their right side, where they had a surgical wound. R57 said when they laid on their back their legs came off the foot of the bed which was uncomfortable for them, since they were tall. R57 said sometimes they had pain on their left hip and back as well as their right hip. R57 confirmed they had a pressure injury and said they believed it was on their back (on their bottom). On 2/09/26 at 1:48 p.m., R57 demonstrated stretching out their legs out to lay on their back. Their legs were observed hanging about a foot off the foot of the bed, from their mid-calf to their toes, which were covered by yellow gripper socks. R57 said this was uncomfortable for them. R57 reiterated they struggled to be comfortable in their hospital bed during their stay for rehabilitation and said they were not sleeping well because their bed was uncomfortable. Review of the facility matrix, accessed 2/09/26, revealed R57 was marked as having a Stage 3 pressure injury. Review of R57's wound care nursing progress notes in the EMR (Electronic Medical Record) revealed R57 developed a facility-acquired new Stage 2 pressure ulcer to their left hip (trochanter) on 2/02/26, which deteriorated and progressed to a Stage 3 pressure ulcer to their left hip (trochanter) on 2/09/26. Review of R57's MDS assessment, dated 1/28/26, revealed R57 had been admitted to the facility on [DATE], with diagnoses including right femur (hip) fracture, interstitial lung disease (inflammation of lung tissue which may result in shortness of breath), insomnia (difficulty sleeping), depression, and anxiety. The assessment revealed that R57 required one-person assistance for toileting, transfers, and bed mobility, was incontinent of bladder and bowel, and had no behaviors. The BIMS assessment showed a score of 15/15, which showed R57 was cognitively intact. The assessment showed R57 was 73 tall (6'1 tall) and weighed 260 pounds. The skin assessment showed R57 was at risk for developing pressure ulcers and had no pressure ulcers upon admission. Review of R57's Care Plan revealed no interventions or education for offloading or positional supports to assist R57 to stay off (applying direct pressure to) their left hip with the new pressure injury. The interventions revealed a pressure reduction mattress, dated 2/02/26, a pressure relieving cushion when up in wheelchair, dated 2/02/26, and to remind resident to reposition frequently on 2/02/26. It was noted there was also no intervention for R57 to alternate laying on their back to offload their left hip, given their right hip (surgical wound) was reportedly painful for them to lay on. There was no mention of bed concerns or attempts at obtaining a replacement bed or mattress, given R57's (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	concerns. Review of R57's Electronic Medical Record (EMR) including all progress notes, accessed 2/09/26, revealed no interventions or education for offloading R57 to stay off their left hip other than the pressure reduction mattress and cushion, and reminders to change positions (unspecified), as well as no interventions to replace or accommodate R57's bed, given their taller size. Review of R57's Braden Skin Assessment, dated 1/27/26, revealed a score of 18, which showed R57 was at risk for developing a pressure injury. Review of R57's Physical Therapy treatment note, dated 1/30/26, revealed R57 required supervision or touching assistance for bed mobility, including rolling, lying to sitting, and sitting to lying positions. On 2/10/26 at 2:47 p.m., the Wound Care Nurse, Registered Nurse (RN) J, was asked to review R57's wound care documentation, as there was no initial wound care assessment describing R57's pressure injury including a root cause, whether it was avoidable, or any wound care pictures. RN J clarified they were unaware if R57's pressure ulcer was avoidable or unavoidable and confirmed no outside wound care provider was seeing R57. RN J stated, I don't know if I can justify it (the wound) being unavoidable, as (R57) continuously favors the left side.(R57) doesn't have an underlying diagnosis for unavoidable. (R57) is choosing to lie on his left side. I got (R57) an air mattress . RN J said they did not look at R57 as a high risk for a pressure ulcer since R57 moved around. Surveyor asked why R57 could not be positioned on their back or offloaded. RN J stated, (R57) is too uncomfortable . however did not explain why. On 2/10/26 at approximately 3:00 p.m. RN J clarified the Nurse Practitioner (NP) followed R57's wounds in-house. RN J shared a wound section in their EMR, which was not accessible to surveyor. RN J reviewed their wound care documentation notes with Surveyor and confirmed R57's left hip pressure injury was a facility-acquired Stage 2 pressure injury, discovered and treated on 2/02/26, which deteriorated to a Stage 3 pressure injury on 2/09/26. RN J said they believed the NP had documented R57's pressure injury as unavoidable, although this was not found in the EMR with RN J. Review of R57's Care Plan with RN J during the interview showed no documentation regarding R57's pressure injury being unavoidable, or R57 being non-compliant with repositioning. There was no documentation of any education provided to R57 or by staff to offload their left hip by offering positional supports, or more frequent position changes, such as lying on their back or being up in a chair or wheelchair verses in their bed. Review of R57's Wound Care Picture report, printed and provided by the Wound Care nurse, Registered Nurse (RN) J, not accessible to surveyor in EMR, revealed: 2/02/26: A new Stage 2 pressure ulcer, partial thickness skin loss, in-house acquired, on their rear left trochanter. The wound report showed R57 had dull, aching pain, and they recommended positional changes, relaxation, and distraction techniques. The measurements were 1.75 cm (centimeters) length by 2.25 cm width, and 2.82 cm area, with 100% granulation, light exudate (drainage) and no tunneling. 2/09/26: Deteriorating Stage 3 pressure ulcer, full thickness skin loss, in-house acquired on their left rear trochanter. The wound report showed no pain. The measurements were 1.47 cm length, 1.14 cm width, and no depth, and 1.29 cm area, with 50% granulation (healing tissue), and 50% slough (necrotic tissue) with moderate exudate (drainage), no signs of infection. Review of R57's wound care nursing progress note, dated 2/09/26, showed R57's pressure injury deterioration to a Stage 3, revealed offloading with the air mattress only and a pressure relief wheelchair cushion (which was observed as a foam cushion), with no documentation of any offloading devices/methods being offered or recommended. The note further revealed R57's right hip was too painful to lay on, with no education on repositioning provided to lay on their back, as an alternate rotation positioning option. Review of R57's incident report, dated 2/02/26 at 1:30 p.m., revealed, .Nursing Description: Open area noted to L (left) hip with redness surrounding peri-wound. Resident Description: I noticed that it was starting to feel sore but my R (right) side is more sore (from surgery).Wound assessment performed. Would care provided. Low Air loss mattress ordered due to poor mobility.Injury location: Left trochanter (hip).The report showed R57 was alert and fully oriented to person, place, situation, and time.Other info: Recent R hip surgery 1.5 weeks ago. Guest favoring L side when lying in bed due to R hip discomfort s/p (status post) surgery. Guest is a side-sleeper and is not comfortable lying on his back. Writer encouraged (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	guest to rotate sides while in bed, however, guest stated that it was too sore to lay on R (surgical) site. Low air loss mattress ordered. Review of R57's pain assessment report, dated 2/03/26 revealed, .Wound care treatment to left hip was cleansing with normal saline and (Name brand) wound treatment and cover with a bordered foam dressing, changing every other day and as needed. The report revealed R57's pain was 6/10 at worst (moderate) and 3/10 at best, with acceptable pain level of 2/10 (with 10 the worst pain), with no pain reported at that time. The interventions included repositioning and heat, with no positioning supports or education documented as provided. The report revealed R57 was receiving Acetaminophen pain medication and Oxy 5, a controlled narcotic pain medication, which they received since admission. Review of R57's Incident Note, dated 2/02/26 at 1:41 p.m., in the EMR, revealed, Objective Description: Open area noted to L hip.Interventions to Prevent Reoccurrence: Low air loss mattress ordered due to poor bed mobility and risk for further skin breakdown . The note showed the Director of Nursing (DON) was notified along with the physician, nurse practitioner, dietician and family member. There was no documentation of communication to therapy services or the rehabilitation director when R57's pressure ulcer was discovered. On 2/10/26 at 3:24 p.m., R57 was observed in their room on their back. R57 reported nursing staff had just educated them to lay on their right (surgical wound) side or their back, and not to lay on their left side. R57 said they would listen to them (nursing staff). R57 indicated they had not been educated to lay on their back prior. R57 again mentioned their bed was too short, and said it bothered them when their legs were hanging off the bed. During this observation, their legs were on the bed, as the head of bed was not elevated. R57 said they were made aware by RN J something was ordered to elongate their bed. R57 agreed to an observation of their left hip pressure injury care by nurse surveyor. R57 said they understood the pressure ulcer was on their left hip, not their back. On 2/10/26 at 3:45 p.m., RN J completed R57's pressure injury wound treatment, with nurse surveyor observing: Dressing change supplies were observed removed from treatment cart: normal saline (NS) vial, (name brand) paste-hydrophilic paste (to keep the wound moist) for light to moderate wound exudate (wound drainage), 4x4 gauze (pad), and foam pad bandage. R57 was placed on their right side in bed. Dressing was removed- left trochanter area revealed an approximate 1.5 centimeter (cm) square shallow ulcer with red granulated wound bed perimeter, and center observed with a small soft textured white colored material. Per wound care nurse (RN J) this was slough (a type of necrotic (dead) tissue that accumulates in a wound bed). Wound was observed cleansed with NS, (brand name wound) paste applied, 4x4 gauze layered on top, and large square foam bandage was applied. Further review of R57's Care Plan revealed new interventions, dated 2/10/26, which showed R57 preferred to lay on their left side while in bed, application of a specialty air mattress when in bed, and to offload their heels. There were no updated interventions for positional supports to offload R57 from directly applying pressure to their left trochanteric area, education to lay on their back, or to address their bed concerns. Review of R57's Nurse Practitioner (NP) progress note, dated 2/10/26 at 11:10 a.m., revealed R57 was an [AGE] year-old male recent hospitalization for a right femoral neck fracture after a fall following up today related to.pressure ulcer to left trochanter measures 1.4 (cm) x 1.1 (cm). This is a pressure injury wound (sic) bed 50% yellow slough and 50% granulation tissue (sic).(wound) is being cleaned with NS (normal saline) and (name brand wound) paste (showing a new wound treatment).Wound to left trochanter pressure (injury) -offload pressure, encouraged to turn every 2 hours .Chronic pain - pain management. There was no documentation about R57's bed being a concern, or interdisciplinary communication. On 2/11/26 at approximately 9:55 a.m., R57 was observed up and dressed in the Physical Therapy department on an exercise bike, supervised by their physical therapist. On 2/11/26 at 10:06 a.m., R57's bed was observed while R57 was out of the room. A beige foam bed extender was observed at the foot of their bedframe, which was about a foot long. The air mattress did not extend over this new bed extender. The top of the air mattress was about a foot above (depth) and in front of the attached foam extender. The new foam support would have provided no additional length for the bed occupant's legs, as the bed had the same air mattress length. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	There was no positioning wedge, supports, or pillows observed on R57's bed or in R57's room. On 2/11/26 at approximately 10:09 a.m., Physical Therapist Assistant (PTA) H was observed assisting R57 back to bed from their wheelchair after therapy. PTA H provided stabilizing assistance to R57 to transfer back into bed. R57 positioned themselves on their left side, directly on their left hip (trochanter), where they had the Stage 3 pressure ulcer. PTA H observed R57 and then left R57's room. No offloading to R57's pressure ulcer was completed or discussed. There were no offloading devices such as a wedge on their bed or in their room, and no pillows placed behind R57's back to offload their pressure ulcer. On 2/11/26 at approximately 10:15 a.m. PTA H was asked about R57's positioning in their bed, directly on their left hip, and if they were aware if R57 had any skin concerns. PTA H reported they had not heard of any new skin concerns during R57's stay, other than their right hip surgical wound. PTA H understood the positioning concern upon learning R57 had a left hip pressure injury. PTA H indicated they would ask R57 to lay on their back to offload their left hip to prevent pressure to an existing pressure injury. On 2/11/26 at approximately 10:23 a.m., PTA H was observed with R57, who confirmed they had a pressure injury on their left hip and agreed to repositioning. R57 repositioned themselves onto their back, after being asked by PTA H, to offload their left hip, and understood the concern. No pressure was observed to R57's left hip (trochanteric area) when they laid on their back. PTA H had cued R57 to move up higher when getting into bed, so their feet were not hanging off the mattress. On 2/11/26 at 10:33 a.m., the Director of Rehabilitation Services (DOR), Speech Language Pathologist (SLP) I, confirmed they did not recall being made aware R57 had a Stage 2 or Stage 3 pressure injury by the facility clinical staff, although they recalled hearing R57 had a new wound on 2/10/26. SLP I acknowledged they did not know the extent of this wound. SLP I was asked if they would have expected the clinical /nursing staff to have communicated to therapy R57 had a Stage 3 pressure injury. SLP I respectfully declined to comment. On 2/11/26 at 10:36 a.m., SLP I was asked how a new Pressure ulcer for a facility resident would typically have been communicated to them. SLP I said they attended the morning care coordination meetings routinely, where this would be conveyed. SLP I acknowledged a Stage 3 pressure injury for a resident would be a multi-disciplinary concern. SLP I explained R57 had not been reeducated by therapy staff to offload their left side until after R57's PT session on 2/11/26 when they became aware. SLP I confirmed (when asked) they or the treating therapy staff should be made aware of a new pressure injury, to incorporate any alterations or positioning education into R57's treatment. Review of R57's physical therapy / therapy documentation revealed no reflection of R57 having a pressure injury on their left trochanter (hip bone), or any education related to offloading, positioning, or positional changes. There was no documentation of R57's bed not accommodating their height. Review of R57's February (2026) Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed a missing wound care treatment on 2/08/26, which showed as a blank box, without an administration marked or initialed. Review of R57's EMR including nursing progress notes showed no documentation of why their daily wound treatment was not provided on 2/08/26, when the physician orders changed to an alternative wound care treatment on 2/09/26. On 2/11/26 at 11:09 a.m., concerns were reviewed with the DON related to R57's observed positioning themselves directly on their left hip (trochanteric area), their self-reporting their bed was too short from them, both observed, the lack of appropriate offloading measures, or documented attempts, such as onto their back, the use of positional wedges, supports, or pillows, and no clear documentation of education to R57, or nursing staff. Additional concerns were reviewed including lack of related care planning concerns showing no attempts or noncompliance, no clear documentation of pressure injury avoidability, care coordination concerns with therapy, and the progression of R57's pressure ulcer from a Stage 2 facility acquired pressure injury to a Stage 3 pressure injury, given the bed size concerns. The DON responded that R57 positioned themselves on their left side per their preference and said they had added a care plan intervention today (2/11/26) to reflect their positioning preference. The DON shared R57 was receptive to education when reminded, and concurred this was (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	not found in the EMR and understood the concern. The DON concurred there was no documentation found of the pressure ulcer being unavoidable, per their record review, although R57 positioned themselves on their left hip. The DON shared they would have expected the rehabilitation director to have been aware of R57's pressure injury, since they attended the daily care coordination meetings. The DON reported they understood the concerns regarding lack of documentation of R57 being educated to offload their left hip, onto their back or being offered positional wedges, pillows, or positional supports. The DON shared they had not been made aware of the concerns with R57's bed size until 2/10/26 during the survey. The DON concluded this pressure injury was likely unavoidable and concurred this was not documented on a form or found in the EMR, as well as education not being clearly documented. Surveyor shared R57's concerns related to their bed not fitting them properly, and the likelihood of R57's left hip pressure injury resulting from side lying directly on their left side, as they self-reported they were uncomfortable laying on their back with their legs hanging off the standard sized bed, due to their height, and R57 reporting they had told multiple staff. The DON reported they had not been made aware, and declined to comment, as they wished to follow-up further. Review of R57's Care Plan on 2/11/26 showed updated interventions dated 2/11/26, as follows: .Behavioral problem r/t (related to) not performing self-repositioning in bed, continuously favoring L (left) side, leading to pressure wound.Assist/encourage guest to perform self-repositioning to relieve pressure from L (left) hip. Explain to guest the benefits of repositioning while in bed. Monitor behavior episodes and document behavior and potential causes. Praise guest when progress/improvement in behavior is observed. All interventions were dated 2/11/26. On 2/11/26 at approximately 12:20 p.m., concerns were reviewed with the DON regarding R57's MAR/TAR showing a wound care treatment was marked as not administered on 2/08/26, prior to their wound care treatment being changed on 2/09/26. The DON reviewed the MAR/TAR with Surveyor, and explained the facility had changed their documentation system, and this may not have been an omission. The DON reviewed the nursing schedule for the time of the documentation omission and identified the nurse who had worked on the night shift on 2/08/26 when R57's wound treatment was scheduled. The DON attempted to reach the scheduled nurse during the interview without success. The DON explained this was typically caught by them in an audit report, however they had not had the opportunity to review this report during the current annual survey. The DON acknowledged there was no other documentation found in R57's EMR to explain the blank MAR/TAR entry on 2/08/26. The DON did not believe this would have had an outcome for R57. It was discussed R57's wound progressed to a Stage 3 pressure ulcer on 2/09/26. On 2/11/26 at approximately 1:00 p.m., R57 was observed in their room in their hospital bed, lying on their back, with the Director of Nursing (DON) and the Maintenance Director, Staff G , present. It was observed that the air mattress was not supported by the bed frame extender. The air mattress appeared to be the same mattress, which was not any longer. R57's feet were positioned near the end (foot) of the air mattress. On 2/11/26 at approximately 1:01 p.m., R57 was asked about their hospital bed with the DON and Staff G present. R15 shared they had concerns with their bed, and stated, What it amounts to is this (bed) is not conducive to sleep for a person of my height. I am 6 foot, 3 inches (tall). R57 said the bed had weakened them. R57 was asked to explain and said their legs were hanging off the bed when they sat up (in their bed). It was discussed that R57 was in their bed more often than their wheelchair. R57 did not deny this. The DON shared with R57 they would be getting them a longer bed, and Staff G would be getting them a longer air mattress. R57 said, I am sorry. The DON explained this was not their fault and to let nursing management know of any concerns in the future, as they had not been made aware. Observations of R57 during the survey (2/09/26 through 2/11/26) showed they were lying in their hospital bed, except when they were in therapy or at an appointment. R57 was observed sitting up in physical therapy during treatment, and had the ability to sit up, which offloaded their left hip. Review of R57's psychiatric consult, dated 2/10/26, showed R57 had insomnia and symptoms of depression, with a score of 10/27 on the PHQ-9 (standardized depression assessment), which showed moderate (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	symptoms of depression, which was ongoing. The report revealed R57 was hospitalized after their fall and fracture with acute alcohol intoxication. It was shown that R57 had ongoing nightly insomnia due to the environment (unspecified) and distractions and concluded gradual dose reductions of their psychiatric medications were contraindicated at that time, given their symptoms. Review of R57's 2/11/26 health status/progress note, at 7:05 (a.m.), revealed, Writer met with resident and inspected air mattress and bed extender. Equipment is in appropriate working condition. Resident was observed laying on his left side. Writer explained to the resident that his wound would benefit with little pressure applied during the healing process and that laying in a different position would benefit him. The resident stated that he prefers to lay on this left side and will do just fine. Writer inquired if the bed extender made his positioning more comfortable. Resident stated, 'No'; There were no offloading or positioning supports documented as offered, no asking R57 to sit up in their wheelchair or lounge chair in their room, and no documentation of follow-up when R57 said the bed extender was not more comfortable. Review of R57's nursing progress note, dated 2/11/26 at 10:46 a.m., confirmed R57 preferred to lay in their hospital bed throughout the day, and spent little time up in their wheelchair, except when they went to therapy. The progress note described it was resident preference to lay directly on their left hip. Further review revealed only the low-air loss mattress was noted for offloading, with no education or other offloading measures. Review of R57's Physical Medicine and Rehabilitation (PM & R) practitioner note, dated 2/11/26 at 9:38 a.m., revealed no documentation of R57's Stage 3 pressure ulcer, and no offloading of their left hip. The note showed to offload R57's right hip from their right hip surgical wound, with no mention of their left hip wound. Review of R57's additional PM & R visits during their stay showed no documentation related to R57 having a pressure injury since their admission. On 2/11/26 at approximately 1:05 p.m., both the DON and Staff G were asked about R57's air mattress not being supported by the bed extender. Both reported they understood the concerns after observing R57 in their bed and R57's interview. The DON shared a longer air mattress had been ordered by Staff G . Staff G clarified after they had not yet ordered a longer air mattress and would do so after the interview. Staff G described the hospital beds/mattresses were 80 long, and R57 was laying on a standard-length bed and mattress since their admission. Staff G explained R57 would benefit from a longer (tall) bedframe and air mattress per their observation. When asked about the process of bed and mattresses provision for newly admitted residents, Staff G said residents were typically placed on a standard bedframe and mattress upon admission, and nursing staff would let them know if an alternate bedframe and mattress was needed. Staff G confirmed this was the same standard bed/bedframe R57 had since their admission. Review of the policy, Care Standards, revised 4/25 (2025), 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 to the medical record according to state and /or federal regulations Review of the policy, Equipment Care Policy, revised 2/2025, received 2/11/26, revealed, .POLICY: It is the policy of this facility that Guest care equipment will be inspected toensure that it is maintained to promote a safe environment for guests.PROCEDURE:1. All facility owned equipment that directly supports guest care is inspected prior toinitial use. Equipment is inspected to assure physical condition, functionality,guest/operator safety, and electrical safety if applicable.2. Equipment inspection will occur as stated in this policy and will be tracked throughthe equipment identification system stated in this policy. Review of the policy, Skin Management, revised 9/2024, revealed, POLICY: It is the facility's policy that a resident does not develop (a) pressure injury unless clinically unavoidable.GOALS: Residents with wounds and /or pressure injury and those at risk for skin compromiseare identified, assessed, and provided appropriate treatment to promote healing. Ongoingmonitoring and evaluation are provided to ensure optimal resident outcomes.PROCEDURE:1. Upon admission/readmission, all residents are assessed for skin integrity by completing abaseline head to toe skin assessment documented in the electronic medical record (EMR).2. A Braden Scale (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	will be completed upon admission, weekly for 4 weeks, quarterly andwith any significant change of status by a licensed nurse to determine the risk of pressureinjury development.3. Appropriate preventative measures will be implemented on residents identified at risk (ascore of 18 or less on the Braden Scale) and the interventions documented on the careplan.4. Residents admitted with skin impairments will have:Appropriate interventions implemented to promote healing.A physician's order for treatment.Wound location, measurements and characteristics documented weekly.5. The licensed nurse is responsible for documentation in the EMR, including a descriptionof the pressure and non-pressure injury as follows: Skin assessment with measurements to be completed weekly.Skin/wound progress note to be completed weekly until healed with description ofwound and any updates and/or changes to plan of care.Care plan to be updated as necessary with any plan of care changes.6. The interdisciplinary team considers whether the resident exhibits conditions or isreceiving treatments that may place the resident at higher risk of developing pressureinjury or complicate their healing process. Such conditions may include:Cognitive impairments.Drugs such as steroids that may affect skin integrity and wound healing.Impaired/decreased mobility and decreased functional ability.Comorbidities such as end stage renal disease, thyroid disease, or diabetes.Impaired, diffuse, or localized blood flow, for example, generalized atherosclerosis, lower extremity arterial or peripheral insufficiency.Bowel and/or bladder incontinence.Abnormal labs, malnutrition, or hydration deficits.Guest behaviors/refusal of some aspect of care or treatment.A previous healed area of injury.7. An initial plan of care is developed upon admission if the resident is at risk or has a or has acurrent pressure or non-pressure injury, areas that should be addressed are as follows:Identifying the contributing risk factors for breakdown, including history of skin impairment.HydrationNutritionPreventative devices, including support surfaces for bed and chairsPreventative skin carePainPhysical activityPositioning requirementsProper body alignmentEducation, when appropriate8. The clinician will document preventative measures on the care plan.9. The licensed nurse will monitor, evaluate, and document changes regarding skincondition (to include dressing, surrounding skin, complications, and pain) in the medicalrecord.15. An At Risk meeting will be conducted weekly by the Interdisciplinary Team (IDT). During the meeting, the IDT will evaluate resident skin changes, review treatment modalities, interventions and will make recommendations as needed. Plan of care, orders,and resident accordingly, and a progress note documented under the heading of Plan of Care. 17. If the identified wound is a stage 3 or 4 and fails to show improvement or deteriorates, orif the individual guest has co-morbidities requiring consult of a wound care specialist, theattending physician or designee may recommend consult with local wound care clinic.Pressure Injury Evaluation of Avoidability1. The Director of Nursing or designee is responsible for ensuring that the Evaluation ofPressure InjuryResidents who should be reviewed for skin alterations are as follows:Newly developed vascular, diabetic/neuropathic and pressure injuries.Any pressure or non-pressure area that has shown no signs of healing within a two-three-week time frame.New admissions and readmissions with skin conditions (pressure related, non-pressure related, arterial, venous insufficiency and/or diabetic/neuropathic, surgical sites, rases, dermatologic conditions, skin tears, etc.).Pressure Injury Evaluation of Avoidability1. The Director of Nursing or designee is responsible for ensuring that the Evaluation ofPressure Injury form is completed accurately and timely if applicable to thecondition.Significant changes in conditionDecline in overall health statusHospice, Palliative and/or Comfort care is initiatedAnticipated development of pressure injuryFacility acquired pressure injuryWorsening condition of a pressure injury2. The completed form will be scanned into the patient's medical record under documents.3. The Evaluation of Pressure Injury form should be completed annually for anyunavoidable pressure related injury.

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	02/11/2026

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

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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 maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen.Findings Include:On 02/11/26 at 8:14 AM observation of the kitchen two door cooler found a package of opened hot dogs with a facility marked date of 1/21/26. An interview at this time with Dietary Manager (DM) F found they use a seven-day discard for ready-to-eat, time/temperature control for safety foods.According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.According to the 2022 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) .On 02/11/2026 at 8:25 AM observation of an out of order two door cooler in the kitchen found an accumulation of residue on the shelving racks and bottom surface.On 02/11/2026 at 8:40 AM observation of the clean equipment storage revealed wet food residue on the surface of a sheet pan. DM F removed the sheet pan to be cleaned at the dish machine.On 02/11/2026 at 8:55 AM observation of the dining room service kitchen (sub kitchen) juice machine found built up colored residue on the upper portion of the nozzle dispensing area. During this observation, when asked how often the nozzle is cleaned, DM F stated that it is cleaned daily and a deep clean happens weekly. On 02/11/2026 at 8:57 AM observation of the sub kitchen ice machine found a black and green substance on the white ice guide in the dispenser where ice is released and drops into the cup. An interview at this time with DM F confirmed the presence of the buildup and said it would be mentioned to maintenance.According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.On 02/11/2026 at 9:07 AM observation of a sub kitchen cabinet under the sink adjacent to the ice machine revealed an actively dripping leak from a drainpipe. A pool of water was observed on the surface of the cabinet floor with a towel placed at the cabinet edge absorbing some of the pooling water. Standing water was observed at the base of the cabinet and moving to the floor drain under the ice machine.According to the 2022 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair.On 02/11/2026 at 9:11 AM observation of the sub kitchen found soiled buildup under all fixed in place equipment and the floor drain beneath the ice machine was observed with black residue on and around the floor drain where drain water had leaked and pooled. According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accommodate the needs of two Residents (R57 and R77) when appropriate durable medical equipment was not provided to accommodate their functional medical care needs. Findings include: R77 On 2/09/26 at 1:56 p.m., R77 was observed dressed, seated upright in their wheelchair in their room. On 2/09/26 at 1:58 p.m., R77 reported they had notified staff since yesterday (2/08/26) their toilet safety frame over their toilet was crooked and said, nothing was done. R77 explained they felt nervous using their toilet. R77 described they sometimes waited extended periods (30 or more minutes) for assistance with toileting needs, which made them feel scared, being seated on an uneven commode seat. On 2/09/26 at 2:01 p.m., R77's bathroom was observed. There was a toilet safety frame which was worn and rusted at the base of one commode leg, on the right rear side. This caster was about a 1-inch difference in height (higher) than the others, so it did not rest on the ground. The legs were observed set to the same height. The commode seat/frame moved back and forth, and would be wobbly for the occupant, placing them at risk for falls. On 2/09/26 at approximately 2:15 p.m., Licensed Practical Nurse (LPN) L was asked to observe R77's toilet safety frame. LPN L saw the commode base was uneven and worn and reported they understood the concern. On 2/09/26 at 2:21 p.m., LPN K was asked about R77's toilet safety frame when they were removing the toilet safety frame from R77's bathroom. LPN K reported they understood the safety concerns. LPN K clarified the commode would be replaced. During this interaction, R77 was heard to state loudly, I don't want to fall. On 2/10/26 at approximately 1:20 p.m., the Director of Nursing (DON) was made aware of the concerns related to R77's toilet safety frame being worn and in disrepair. Surveyor shared R77 reported feeling unsafe and said they could fall as it was unstable. The DON reported they understood the concern and were made aware R77's toilet safety frame had been replaced. Review of R77's Minimum Data Set (MDS) assessment, dated 2/24/26, showed R77 was admitted on [DATE] with a femur fracture, dementia, and insomnia. The assessment revealed that R77 required moderate assistance for toileting hygiene, and supervision or touching assistance for transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 12/15, which showed R77 had moderate cognitive impairment. R77 was always continent bladder and bowel. Review of R77's Physical Medicine and Rehabilitation (PM & R) Practitioner Note, dated 2/5/26, revealed R77 had been placed on posterior hip precautions (avoiding hip flexion beyond 90 degrees) after their hip fracture. This would have justified the use of a toilet safety frame over their toilet seat, to raise the height for safe transfers within their hip precautions. R57 On 2/9/26 at 1:46 p.m., R57 was observed in their room in their hospital bed, lying on their left side, directly on the trochanteric (hip) area, with their legs bent at their knees. There was no offloading device behind them, including pillows or a wedge to support their back on their bed. No offloading devices were observed in their room. It was noted R57 was positioned on an air mattress. The bed had no footboard. On 2/9/26 at 1:47 p.m., R57 stated, You can see the bed does not fit my frame . R57 reported they had asked staff for a new bed as long as I have been here, and said staff did not get them one. R57 explained their legs were curled to stay on the bed. R57 said they laid on their left side as it was too painful to lay on their right side, where they had a surgical wound. R57 said when they laid on their back their legs came off the foot of the bed which was uncomfortable for them, since they were tall. R57 said sometimes they had pain on their left hip and back as well as their right hip. R57 confirmed they had a pressure injury and said they believed it was on their back (on their bottom). On 2/9/26 at 1:48 p.m., R57 demonstrated stretching out their legs out to lay on their back. Their legs were observed hanging about a foot off the foot of the bed, from their mid-calf to their toes, which were covered by yellow gripper socks. R57 said this was uncomfortable for them. R57 reiterated they struggled to be comfortable in their hospital bed during their stay for rehabilitation and said they were not sleeping well because their bed was uncomfortable. Review of the facility (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	matrix, accessed 2/9/26, revealed R57 was marked as having a Stage 3 pressure injury. Review of R57's wound care nursing progress notes in the EMR (Electronic Medical Record) revealed R57 developed a facility-acquired new Stage 2 pressure ulcer to their left hip (trochanter) on 2/2/26, which deteriorated and progressed to a Stage 3 pressure ulcer to their left hip (trochanter) on 2/9/26. Review of R57's MDS assessment, dated 1/28/26, revealed R57 had been admitted to the facility on [DATE], with diagnoses including right femur (hip) fracture, interstitial lung disease (inflammation of lung tissue which may result in shortness of breath), insomnia (difficulty sleeping), depression, and anxiety. The assessment revealed that R57 required one-person assistance for toileting, transfers, and bed mobility, was incontinent of bladder and bowel, and had no behaviors. The BIMS assessment showed a score of 15/15, which showed R57 was cognitively intact. The assessment showed R57 was 73 tall (6'1 tall) and weighed 260 pounds. The skin assessment showed R57 was at risk for developing pressure ulcers and had no pressure ulcers upon admission. Review of R57's Care Plan revealed no interventions or education for offloading or positional supports to assist R57 to stay off (applying direct pressure to) their left hip with the new pressure injury. The interventions revealed a pressure reduction mattress, dated 2/2/26, a pressure relieving cushion when up in wheelchair, dated 2/2/26, and to remind resident to reposition frequently on 2/2/26. It was noted there was also no intervention for R57 to alternate laying on their back to offload their left hip, given their right hip (surgical wound) was reportedly painful for them to lay on. There was no mention of bed concerns or attempts at obtaining a replacement bed or mattress, given R57's concerns. Review of R57's Electronic Medical Record (EMR) including all progress notes, accessed 2/9/26, revealed no interventions or education for offloading R57 to stay off their left hip other than the pressure reduction mattress and cushion, and reminders to change positions (unspecified), as well as no interventions to replace or accommodate R57's bed, given their taller size. Review of R57's Braden Skin Assessment, dated 1/27/26, revealed a score of 18, which showed R57 was at risk for developing a pressure injury. Review of R57's Physical Therapy treatment note, dated 1/30/26, revealed R57 required supervision or touching assistance for bed mobility, including rolling, lying to sitting, and sitting to lying positions. On 2/10/26 at 3:24 p.m., R57 was observed in their room on their back. R57 reported nursing staff had just educated them to lay on their right (surgical wound) side or their back, and not to lay on their left side. R57 said they would listen to them (nursing staff). R57 indicated they had not been educated to lay on their back prior. R57 again mentioned their bed was too short, and said it bothered them when their legs were hanging off the bed. During this observation, their legs were on the bed, as the head of bed was not elevated. R57 said they were made aware by RN J something was ordered to elongate their bed. R57 said they understood the pressure ulcer was on their left hip, not their back. On 2/11/26 at 10:06 a.m., R57's bed was observed. A beige foam bed extender was observed at the foot of their bed, which was about a foot long. The air mattress did not extend over this new bed extender, which extended about a foot in length beyond the air mattress, at the end of the air mattress (length). It appeared these new interventions would not have provided any additional support to R57's legs per prior observation of R57 in their bed. The top of the air mattress was about a foot above (depth) the attached foam extender. The new foam support would have provided no additional length for the bed occupant's legs, as the bed had the same air mattress (length) which was well above the positional extender. There was no positioning wedge or support pillows observed on R57's bed or in R57's room. Review of R57's Electronic Medical Record (EMR) revealed no education was provided to staff or any implementation of interventions related to R57 positioning themselves directly on their left hip (trochanteric area), to prevent progression/deterioration of their left hip pressure ulcer, such as an offloading wedge, offloading pillows, lying on their back, or other options to assist them, given R15 was cognitively intact. There was no documentation of these types of interventions being declined by R15. On 2/11/26 at approximately 1:00 p.m., R57 was observed in their room in their hospital bed, lying on their back, with the Director of Nursing (DON) and the Maintenance Director, Staff G , present. It was observed that (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the air mattress was not supported by the bed frame extender. The air mattress appeared to be the same mattress, which was not any longer. R57's feet were positioned near the end (foot) of the air mattress. On 2/11/26 at approximately 1:01 p.m., R57 was asked about their hospital bed with the DON and Staff G present. R57 shared they had concerns with their bed, and stated, What it amounts to is this (bed) is not conducive to sleep for a person of my height. I am 6 foot, 3 inches (tall). R57 said the bed had weakened them. R57 was asked to explain and said their legs were hanging off the bed when they sat up (in their bed). It was discussed that R57 was in their bed more often than their wheelchair. R57 did not deny this. The DON shared with R57 they would be getting them a longer bed, and Staff G would be getting them a longer air mattress. R57 said, I am sorry. The DON explained this was not their fault and to let nursing management know of any concerns in the future, as they had not been made aware. Observations of R57 during the survey (2/9/26 through 2/11/26) showed they were lying in their hospital bed, except when they were in therapy or at an appointment. Review of R57's psychiatric consult, dated 2/10/26, showed R57 had insomnia and symptoms of depression, with a score of 10/27 on the PHQ-9 (standardized depression assessment), which showed moderate symptoms of depression, which was ongoing. The report revealed R57 was hospitalized after their fall and fracture with acute alcohol intoxication. It was concluded R57 had ongoing nightly insomnia due to the environment (unspecified) and distractions and gradual dose reductions of their psychiatric medications were contraindicated at that time. R57's reporting of not being able to be comfortable in their hospital bed may have contributed to their insomnia during their stay. Review of R57's 2/11/26 health status/progress note, at 7:05 (a.m.), revealed, Writer met with resident and inspected air mattress and bed extender. Equipment is in appropriate working condition. Resident was observed laying on his left side. Writer explained to the resident that his wound would benefit with little pressure applied during the healing process and that laying in a different position would benefit him. The resident stated that he prefers to lay on this left side and will do just fine. Writer inquired if the bed extender made his positioning more comfortable. Resident stated, 'No'. There were no offloading or positioning supports documented as offered, and no documentation of follow-up when R57 said the bed extender was not more comfortable. Review of R57's nursing progress note, dated 2/11/26 at 10:46 a.m., confirmed R57 preferred to lay in their hospital bed throughout the day, and spent little time up in their wheelchair, except when they went to therapy. The progress note described it was resident preference to lay directly on their left hip. Further review revealed only the low-air loss mattress was noted for offloading, with no education or other offloading measures. On 2/11/26 at approximately 1:05 p.m., both the DON and Staff G were asked about R57's air mattress not being supported by the bed extender. Both reported they understood the concerns. The DON shared a longer air mattress had been ordered by Staff G . Staff G shared they had not ordered a longer air mattress and would do so after the interview. Both reported they understood the concerns. On 2/11/26 at approximately 1:10 p.m, Staff G confirmed the hospital beds/mattresses were about 80 long, and R57 was on a standard-length bed and mattress (not a tall bed or mattress) since their admission and would benefit from a longer (tall) bedframe and air mattress. A policy for Accommodation of (Resident) Needs was requested twice during the survey. The following two policies were received: Review of the policy, Care Standards, revised 4/25 (2025), 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 to the medical record according to static and /or federal regulations Review of the policy, Equipment Care Policy, revised 2/2025, received 2/11/26, revealed, .POLICY: It is the policy of this facility that Guest care equipment will be inspected toensure that it is maintained to promote a safe environment for guests.PROCEDURE:1. All facility owned equipment that directly supports guest care is inspected prior toinitial use. Equipment is inspected to assure physical condition, functionality,guest/operator safety, and electrical safety if applicable.2. Equipment inspection will occur as stated in this policy and will be tracked throughthe equipment identification (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	system stated in this policy .Repairs: 11. Equipment identified to be in need of repair will immediately be removed from useuntil the repair can be performed.12. All repairs are prioritized and performed in a timely manner. To ensure thecontinuation of guest care in the event of equipment failure (facility owned as wellas guest owned), the equipment will be removed and backup devices may beprovided .

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2677940Based on observation, interview and record review, the facility failed to ensure ancillary services were provided in a timely manner for three residents (R6, R20 and R64) of three residents reviewed for medically related Social Services. Findings include: R6 On 2/9/26 at approximately 11:03 AM, R6 was observed lying in bed. The resident was alert and able to answer questions asked. When queried as to the care provided by the facility, R6 reported that they needed follow up with their hearing aid and outside dental care. They also reported that they had been seen by an ophthalmologist that recommended they needed cataract surgery, and nothing had been scheduled. They further noted that they were supposed to see an outside dentist and something happened with transportation and the appointment was cancelled. They were not aware that it had been rescheduled. With respect to the hearing aid, they noted that they were seen last year and were told that they were getting a new hearing aid. A review of R6's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: COPD (chronic obstructive pulmonary disease), type II diabetes and kidney failure. A review of R6's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 12/15 (moderately cognitively impaired). Continued review of R6's record did not indicate any scheduled follow-up appointments with dental and cataract surgery. A document from Audiology was located and documented, in part: Patient (R6).Date: 11/11/2025 .Reason for Visit: Hearing Exam, Hearing Aid Eval: The patient was referred by the facility for decreased hearing.Hearing tests were performed.testing showed mild to moderate hearing loss in both ears. The hearing loss and options for hearing aids were discussed. He would like to begin a trial with binaural receiver in the ear hearing aids.Follow-up: Hearing aid fitting in 1 month. R20 On 2/9/26 at approximately 11:13 AM, R20 was observed sitting in a wheelchair in their room. They were alert but not able to answer questions asked. R20's representative was interviewed and asked about the care provided by the facility. The representative noted that they were concerned that R20 had not been seen by podiatry and dental care since admission. A review of R20's clinical record revealed the resident was admitted to the facility on [DATE] with diagnoses that included: cerebral palsy and epilepsy. Review of R20's MDS noted the resident had a BIMS score of 0/15 (severely cognitively impaired). There was no indication in R20's clinical record that they had been seen by podiatry and/or dental services since their admission 9/14/25. A consent form for ancillary services was signed by their legal guardian in January 2026. On 2/10/26 at approximately 10:50 AM, an interview and record review were conducted with TCC B. TCC B reported that they are responsible for scheduling ancillary services for residents that are long term care. They further reported that they provide consent forms for ancillary services to the residents/resident representatives upon admission. When queried about R6's concerns, TCC 'B recalled there was an issue concerning transportation to an outside appointment. On 2/10/26 at approximately 11:41 AM, TCC B was able to provide scheduling dates for outside dental care (March 2026) and cataract (May 2026). With respect to auditory services and new hearing aids, TCC B stated (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the last visit indicated the resident did not have any hearing concerns. The form dated 11/11/15 was reviewed with TCC B and they reported that they did see the portion that talked about the hearing aid. TCC B was further queried about R20. They indicated that they were not certain if R20 was going to be a long-term resident, so they did not obtain consent until January 2026. The facility policy titled, Providing Ancillary Services (4/2025) was reviewed and documented, in part: Policy- it is the policy of this facility that ancillary services such as dentistry, audiology, podiatry, vision, etc., will be provided to the residents.Procedure: At the time of move in to the facility, the resident/responsible party will be given information regarding who is providing ancillary services. R64 On 2/9/26 a concern submitted to the State Agency was reviewed which alleged R64 had an issue with having long toenails. On 2/10/26 the medical record for R64 was reviewed and revealed the following: R64 was initially admitted to the facility on [DATE] and had diagnoses including Dementia and Congestive heart failure. A review of R64's MDS (minimum data set) with an ARD (assessment reference date) of 10/23/25 revealed R64 needed assistance from facility staff with most of their activities of daily living. R64's BIMS score (brief interview of mental status) was six indicating severely impaired cognition. A Physicians order dated 10/29/25 revealed the following: please place on list to be seen by podiatry A progress note dated 11/3/25 revealed the following: spoke to daughter regarding follow up with labs (laboratory diagnostics). Concerned for UTI (urinary tract infection). UA (urine analysis) dipstick negative. negative WBC (white blood cell count). no UTI suspected at this time. Was also asking about podiatry to see resident. Social work made aware. On 2/11/26 at approximately 10:39 a.m., during a conversation with the facility Transitional Care Coordinator-Social Services B (TCC B) was queried regarding the podiatry order for R64. TCC B indicated that R64 did not see the facility podiatry provider because they believed only the long term care residents were eligible for podiatry services. At that time, a request for the ancillary service contract was requested for review. On 2/11/26 at approximately 1:00 p.m., during a conversation with the Director of Nursing (DON), The DON was queried regarding R64's podiatry consult ordered by the Physician. The DON reported they were uncertain on how podiatry services were arranged. On 2/11/26 the contract for the facility's ancillary service provider contract was reviewed and did not dictate the provision of care for a resident's expected length of stay. No further documentation was provided by the end of the survey that documented R64 was provided podiatry services or that any podiatry services had been arranged for them per the Physicians order.

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	02/11/2026

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

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than five percent when two medication errors were observed (R3, R79) from a total of 29 opportunities resulting in an error rate of six percent.On 2/10/26 at 7:51 AM, Licensed Practical Nurse (LPN) C was observed for medication administration. R3 was ordered Miralax (medication to treat irregular bowel movements and constipation)17 grams. LPN C was observed pouring the medication granules into the measuring cap and was asked how to confirm the measure was 17 grams. LPN C was observed pointing to the inside of the measuring cap and indicated the white thread halfway in the white part of the cap cup was 17 grams.On 2/10/26 at 8:18 AM, LPN D was observed for medication administration. R79 was ordered Aspirin 81 milligrams (mg) oral tablet delayed release. LPN D was observed preparing Aspirin 81 mg chewable and administered to R79.On 2/10/26 at 10:45 AM, The Director of Nursing (DON) was asked to demonstrate how nurses measure 17 grams of Miralax. The DON retrieved a bottle of Miralax from the medication cart in the 100 hallway and proceeded to remove the cap. The DON pointed to the inside of the measuring cap and indicated the white thread halfway inside white part of the cup was 17 grams. The DON was shown the stamped measuring line with an arrow pointing upward indicating 17 grams. This measurement was the entire white portion of the cup, up to the purple part of cap. The DON acknowledged that measurement shown to the white thread of the cap was incorrect and not the full 17 grams of medication as ordered. The DON was informed the observation of chewable aspirin administered and order on the Medication Administration Record was documented as delayed release. The DON indicated both observations were opportunity for medication administration reeducation.Record review of the policy titled Medication Administration-General Guidelines dated November 2021, documented: .FIVE RIGHTS-Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away.