

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235635	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Caretel Inns of Tri-Cities		STREET ADDRESS, CITY, STATE, ZIP CODE 6700 Westside Saginaw Road Bay City, MI 48706	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059</p> <p>This citation pertains to intake Numbers MI00149500 and MI00149604.</p> <p>Based on observation, interview and record review, the facility failed to implement appropriate interventions timely to prevent a pressure ulcer for one resident (Resident #1) of three residents reviewed for pressure ulcers, resulting in an unstageable coccyx pressure injury (full-thickness pressure injury where the base of the wound is covered by a layer of dead tissue, making it impossible to determine the stage of the injury), pressure ulcer infection and hospitalization .</p> <p>Findings include:</p> <p>Resident #1:</p> <p>On 1/17/25, at 12:30 PM, a record review of Resident #1's electronic medical record revealed an admission on 12/16/24 with diagnoses that included aftercare following surgery on the circulatory system, need for assistance with personal care and Dysphagia. According to the Minimum Data Set assessment on admission, Resident #1 required 2-person assistance for bed mobility and had moderate cognitive impairment.</p> <p>A review of the Braden Scale admitted : 12/16/2024 revealed a Score of 16.0.</p> <p>A review of Minimum Data Set assessment Section M . Signed . Fri [DATE] . Is this resident at risk of developing pressure ulcers/injuries? . Yes . Does this resident have one or more unhealed pressure ulcers/injuries? . No .</p> <p>A review of WOUND ASSESSMENT DETAILS REPORT Coccyx Assessment Date 01/06/2025 3:49 PM . Facility Acquired . Date Identified 01/02/2025 . Clinical Stage Partial Thickness . Tissue Types Deep Maroon=10%, Slough Loosely Adherent=40%, Necrotic Soft, Adherent=50% . Exudate Amount - Moderate Type - Serosanguinous . Pain Scale 8 Odor Yes Signs of Infection Present Yes . Size (centimeters) 12.00 x 14.00 x Unknown (L x W x D) .</p> <p>A review of the Collection Date: 01/05/2025 . Culture Source Wound Heavy Growth Proteus Penneri . Heavy Growth Escherichia Coli .</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the progress note 1/8/2025 02:10 (2:00 AM) . Observe guest skin clammy and sweaty . Guest was shaking and had chills. When conversing with guest, guest could not converse back appropriately due to confusion . DR gave order to send to hospital .</p> <p>A review of the Focus Potential/At Risk for alteration in skin integrity due to risk factors associated with impaired mobility. Date Initiated: 12/16/2024 Created on: 12/16/2024 Revision on: 12/16/2024 Goal Resident will have no complication thru next review date Date Initiated: 12/16/2024 Created on: 12/16/2024 . Interventions Pressure redistribution mattress Date Initiated: 12/16/2024 . Apply pressure redistribution cushion when up in chair/wheelchair Date Initiated: 12/16/2024 . Remind/Assist resident to reposition frequently Date Initiated: 12/16/2024 . Float heels off mattress Date Initiated: 12/16/2024 . Encourage ambulation/mobility Date Initiated: 12/16/2024 . Provide peri-care after each incontinent episode and apply barrier cream Date Initiated: 12/16/2024 . Check skin daily Date Initiated: 12/16/2024 . Keep linens dry and wrinkle free Date Initiated: 12/16/2024 .</p> <p>A review of the Focus Alteration in skin integrity - Resident has Pressure Injury. site coccyx. factors that may inhibit wound healing: Immobility, Incontinence. AEB: Wound is considered unavoidable at this time due to poor intake and refusal to reposition. Date Initiated: 01/03/2025 Created on: 01/03/2025 . Revision on: 01/03/2025 Goal Resident will be free from complications thru next review date. Date Initiated: 01/03/2025 . Interventions Administer pain medication as ordered Date Initiated: 01/03/2025 . 01/03/2025 Apply specialty mattress when in bed. Date Initiated: 01/03/2025 . 01/03/2025 Apply pressure redistribution cushion when up in a chair/wheelchair. Date Initiated: 01/03/2025 . Reposition/Shift weight at frequent intervals to resident's comfort. Date Initiated: 01/03/2025 . Assess and document wound status weekly and PRN (as needed) Date Initiated: 01/03/2025 . Daily Skin checks during care. Date Initiated: 01/03/2025 . Discuss plan of care with resident and responsible party. Date Initiated: 01/03/2025 . Monitor for infection: Peri-wound swelling - Exposed bone - Pressure wound deterioration. Date Initiated: 01/03/2025 . Notify MD and responsible party of any significant change in wound status. Date Initiated: 01/03/2025 . Peri-care after each incontinent episode and apply barrier cream. Date Initiated: 01/03/2025 . Treat as ordered per MD. Date Initiated: 01/03/2025 .</p> <p>A review of the progress notes prior to pressure ulcer development on 1/2/2025 revealed no mention of Resident #1 refusing to be repositioned in bed.</p> <p>On 1/21/25, at 2:21 PM, a record review along with the Administrator of Resident #1's record was conducted. The administrator offered, the wound went bad real fast and the day he went to the hospital he was supposed to sign onto hospice. The administrator offered, the resident quit eating, they added supplements and assisted with meals to aide with the weight loss. A record review of the admission assessment revealed no coccyx wound on admission. The administrator offered that the resident had malnutrition and had lost weight in the hospital before admitting to the facility. The administrator was asked what interventions they placed to reduce the risk of development of pressure ulcers and the Administrator offered, a pressure reduction mattress. The Administrator was asked with Resident #1's history of weight loss, recent Heart surgery and illnesses why they wouldn't implement all interventions, such as an air mattress on admission and the Administrator offered, absolutely, I agree.</p> <p>(continued on next page)</p>		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of the facility provided Skin Management Program DATE REVIEWED 7/24 revealed . Residents with wound 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 . A Braden Scale will be completed upon admission . Appropriate preventative measures will be implemented on residents identified at risk (a score of 18 or less on the Braden Scale) and the interventions documented on the care plan .		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059</p> <p>Based on observation, interview and record review, the facility failed to ensure proper Personal Protection Equipment (PPE) use and ensure hand hygiene during care for one resident (Resident #2) of one resident who required enhanced barrier precautions, resulting in cross contamination of uniforms, no hand hygiene, gloves being stored in uniform pockets and no gown use.</p> <p>Findings include:</p> <p>Resident #2:</p> <p>On 1/21/25, at 9:40 AM, Resident #2 was resting in on their back in their bed. They had on bilateral heel boots and their feet were hanging over the edge. Resident #1 said they had a sore, but it's gone away.</p> <p>On 1/21/25, at 10:00 AM, a record review of Resident #2's electronic medical record revealed a Physician Order Maintain enhanced barrier precautions to prevent infections r/t knee incision every shift Start Dart 10/18/2024 .</p> <p>On 1/21/25, at 11:08 AM, Resident #2 was resting on their back in bed. Resident #2 was asked if they ever rest on their sides and Resident #2 stated, never, I don't like it. CNA A and CNA B entered Resident #2's room with no PPE on. There was no PPE cart nor any gowns in the room. CNA B had an ace bandage on their left hand; entered the bathroom and donned a pair of gloves without performing hand hygiene. CNA A pulled out some blue gloves from their left pocket, donned a pair and placed the rest back in their pocket without performing hand hygiene. Resident #2 had bloody drainage on their bilateral hands and had open sores to their right arm that were actively bleeding. There was bloody drainage on their gown, sheets and pillowcase. CNA B offered their linen key to CNA A with their gloved hands. CNA A pulled out their gloves and left out of the room for linen. CNA A did not perform hand hygiene. At 11:15 AM, CNA A reentered Resident #2's room with a pile of clean linen. CNA A set the linen down, pulled a pair of gloves out of their pocket and donned the gloves without performing hand hygiene. CNA A was asked why they carry gloves in their pocket and CNA A offered, I have my own and I like to keep them in my pocket. CNA B was on the right side of the bed and CNA A was on the left side of the bed. CNA B assisted Resident #2 to their left side for peri care. During this time, Resident #2 had placed their bilateral hands on CNA B's uniform top. Their hands were still bloody. Both CNA A and CNA B performed peri-care, bed linen change, gown change all without gowns on with both their uniforms touching the resident and the bed.</p> <p>On 1/21/25, at 11:21 AM, Nurse C entered Resident #2's room to apply dressings to their right arm which was still bleeding. Nurse C did not perform hand hygiene prior to donning gloves and did not don a gown. Nurse C removed Resident #2's bilateral heel boots to reveal no open skin to their right heel and a bandage to their left heel. During this time, Nurse C's front of their uniform pants and top was touching the bed. Nurse C offered, that resident goes to the wound clinic for their dressing changes and didn't remove the dressing. Nurse C removed their gloves, performed hand hygiene prior to donning a new pair of gloves to apply the arm dressing although did not don a gown. Resident #2's wounds were actively bleeding.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 1/21/25, at 11:27 AM, CNA A left out of the room with the dirty linen and garbage. CNA A used their key from their pocket to access the dirty utility room, discarded the dirty linen and used alcohol hand gel located in the hallway.</p> <p>On 1/21/25, at 11:35 AM, CNA B was asked why they didn't wear a gown during the cares for Resident #2 and CNA B offered, they have them locked up and that they used to be in carts outside the rooms. CNA A was asked why they didn't wash the blood off Resident #2's hands and CNA A offered they will after the Nurse puts the new dressing on.</p> <p>On 1/21/25, at 11:40 AM, the Administrator was asked where the Personal Protection Equipment was located for the enhanced barrier (Resident #2)'s room and the Administrator stated, it should be inside.</p> <p>On 1/21/25, at 11:41 AM, an observation along with the Administrator of the entry to room [ROOM NUMBER] was conducted. There was an enhanced barrier sign taped to the left of the door. There were no gowns, and no PPE cart located outside the doorway or inside the room. The administrator offered, I will have to get the Infection Control nurse. Upon entry into the room, CNA A was observed pulling blue gloves out of their left pocket and donned them for care. Upon exit, The Administrator was asked if they saw CNA A pull gloves out of their pocket and put them on and the Administrator offered, I seen that. The Administrator offered the PPE is usually stored in a plastic cart in the hallway, but the confused residents push them down the hall and that they needed to purchase more carts.</p> <p>On 1/21/25, at 11:45 AM, an observation of the linen closet which was only accessible by a key revealed approximately twenty-five gowns in a plastic container. The Administrator was alerted of the observations of CNA A, CNA B and Nurse C performing tasks for Resident #2 all with no gowns on, pulling gloves out of their pocket and not performing hand hygiene. The Administrator was also alerted that Resident #2 had blood all over their linens and that their right arm wounds were actively bleeding during the care.</p> <p>On 1/21/25, at 11:50 AM, the administrator entered the conference room and offered the CNA A , CNA B and Nurse C were getting one on one education by the infection control nurse.</p>		