STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235635	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caretel Inns of Tri-Cities	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)
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** This citation pertains to Intake Number MI00151886. Based on interview and record review the facility failed to timely and accurately complete a new resident's admission and administer medications timely for one resident (Resident #502) of one resident reviewed for admission procedures. Findings Include: Resident #502: On 5/8/2025 at approximately 12:00 PM, the administrator was asked for all of Resident 502's concern forms from admission (most recent) to discharge from the facility. The administrator had no concern forms on file for Resident #502. On 5/8/2025, review was conducted of Concern & Suggestions Form for Resident #502 completed on 2/24/2024 (attached to the complaint). It stated, .no meds until 10 PM .patient was sent from hospital on Sunday afternoon . patients meds arrived with night delivery . On 5/8/2025 at 2:20 PM, a record review was conducted of Resident #502's electronic medical record and it indicated she was admitted to the facility on [DATE] with diagnoses that included, Pneumonia, Sepsis and need for assistance with personal cares. Further review of her chart yielded the following: Hospital Discharge Medication List that would need to be administered the evening of the resident's arrival at the facility: Atorvastatin 40 MG (milligrams)- due at bedtime Benzonatate 200 mg capsule- as needed Clonazepam 0.5 mg- due in the evening Eliquis 2.5 mg- due in the evening Guaifenesin 600 mg 12 hr (hour) tablet- as needed (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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	Nystatin 100,000 unit/mL (milliliter) suspension- due in the evening and at bedtime MAR (Medication Administration Record): Review was conducted of Resident #502's MAR's and all the medications that were due for evening administration was inputted to start being administered on 2/24/2025. Facility Back up Medication: Eliquis tablet 2.5 mg- was available in the facility's back up but not administered to the resident. Packing Slip Proof of Delivery: Resident #204's medication was delivered to the facility on 2/24/2025 at 6:43 AM. On 5/8/2025 at 3:45 PM, the administrator shared that the resident arrived at the facility at 5:17 PM on 2/23/2025 and would have missed the cut off for the night medication drop. The nurse assigned could have pulled what was available from the back up to administer until her medication arrived from pharmacy. The administrator was asked if she was aware all her medications that were due to be administered on the evening of 2/23/25 were inputted to begin on 2/24/2024. The administrator stated she was not but explained Resident #502's admission process spanned across two shifts and some medications were not entered until after midnight. The administrator explained one nurse is supposed to input all the medications for the new admission and a second nurse reviews the medications for accuracy and then notifies the physician of the admission. The administrator was further questioned if she was aware Resident #502 expressed this concern to the facility, and she stated she was not. She explained when their previous DON (Director of Nursing) parted ways with the facility her office was cleared out and its possible those documents were taken with her. The administrator was read the concern form, and she stated she was not aware of the concern nor did she have a copy of it in her binder