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	06/13/2025

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 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** This Citation pertains to Intake Number MI00153516. Based on observation, interview and record review, the facility failed to prevent two (2) Stage II (blisters) pressure injuries for one resident (Resident #102) of 3 residents reviewed for pressure ulcers, resulting in two (2) upper left shoulder, Stage II pressure ulcers, pain/discomfort, wound treatments and the likelihood for a decline in overall health. Findings include: A Stage II pressure ulcer is partial-thickness skin loss involving epidermis or dermis, or both. The ulcer is superficial and presents as an abrasion, shallow center or blister. High risk residents (immobile, bed bound) should be assessed weekly, when a condition, change or as needed and preventive measures should be in place including pressure relieving devices, position changes, and dietary supplements. National Pressure Ulcer Advisory Panel (NPIAP). Resident #102: In an observation on 6/13/25 at 9:50 AM, Resident #102 was observed seated up in reclining Broda chair in the main area in front of nursing station. Dressed in red checked Pajama bottoms and a tan sweatshirt with pink sock on left foot and a gauze batting wrapped with an Ace bandage on the right foot/leg. Resident #102 appeared to be sleeping and did not respond to her name. Observed position to be leaning to the right side of chair with pillow between her legs curled in a fetal position with knees pulled upward with the right heel positioned in the leg extension crack between the blue padding of chair leg rest. An observation on 6/13/25 at 10:00 AM of room [ROOM NUMBER], revealed a clean room free of odors, bilateral fall mats on each side of bed, and a private bathroom, which was clean with no odors. No dirty laundry located in room. Observation in the closet revealed a white laundry basket with a few items were noted with no odors. Observation of upper shelves noted 2 Tide laundry pod packages noted on shelf in closet. Clothing Items hanging up, and a large round blue laundry bin noted in closet with clean clothes, no odors. Mattress on bed with contour edges, reviewed sheets to be clean with mint green lift pad on bed, bed is made. (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	Record review of Resident #102's Care plans revealed Resident #102 had a history of falls, behaviors related to dementia, and risk for alteration in skin. Review of the care plan revealed 'Risk for Alteration of Skin' care plan was last updated on 2/8/2025 with interventions of: Pressure reduction mattress, apply pressure reduction cushion when up in wheelchair, remind/assist resident to reposition frequently, provide peri-care after each incontinent episode and apply barrier cream, discuss plan of care with responsible party and notify MD (physician) of any significant changes. There were no new added interventions related to the development of left should pressure ulcer injuries. Observation on 6/13/2025 at 1:05 PM in the facility's main dining room of Resident #102 showed the resident seated in the same position of leaning to the right of Broda chair with knees drawn upward with right heel in the crack of the wheelchair footrest cushion, no change of position noted since early morning observation. Certified Nurse Assistant (CNA) H was seated at a table with 3 residents, Resident #102 and 2 others, feeding all residents. Resident #102's plate had: pureed fish, mashed potatoes, a vanilla pudding cup, coffee, and fruit punch. Record review of Resident #102's June 2025 Medication Administration Record (MAR) and Treatment Administration Record (TAR) revealed: Wound care left outer shoulder- cleanse with wound cleanser, apply xeroform and cover with border gauze daily and as needed every day-shift. The dressings started on 6/6/2025 and were signed out by nursing staff as done daily through 6/12/2025. Observation and interview was conducted on 6/13/2025 at 2:45 PM with Licensed Practical Nurse (LPN) F of Resident #102's left upper shoulder skin areas. LPN F stated that Resident #102 has contractures of the left arm, and the nurse had to undress/remove the shirt sleeve to get access. Left upper arm/shoulder dressing observed dated 6/9/2025 (4 days prior), Dressing removed, and the first left shoulder pressure wound was cleansed and measured 3.5 cm length X 3.0 cm wide no depth measured. Observation of the second left should pressure ulcer area was cleansed and measured 2.0 cm length X 2.0 cm in width, no depth measured. LPN F stated that the pressure areas were noticed after the right leg fractures and the resident was staying in bed more, the 2 weeks after the fractures. Observation of wound care: areas cleansed with wound cleaner, patted dry with gauze, xeroform Vaseline gauze treatment applied to wounds, covered with foam border dressing, and dated by LPN F 6/13/2025. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an interview and record review on 6/13/2025 at 3:50 PM with the Director of Nursing (DON), the State surveyor requested all pressure ulcer/skin policies of the facility. DON stated that the left shoulder wounds started last week on 6/5/2025 from blisters or denuded skin. DON acknowledged that there were two (2) separate wound sites on the left should area. The DON stated that he had just done wound measurements today, after the state surveyor had done the wound care treatment observation and measurements. The DON stated that he has no photos of the wounds nor any measurements prior to the state surveyor observation. Record review with DON of Resident #102's wound/skin tab in the electronic medical record revealed that on 6/5/2025 the left shoulder wound was noted as blister (8 days prior to interview). Record review of Resident #102's physician progress notes by the DON revealed that there were no doctor's progress notes since 3/11/2025 which were by a nurse practitioner. There were no notes about the right leg fractured tibia & fibula, nor the left shoulder pressure ulcer/wounds by physician. Record review of the nursing progress notes revealed a left shoulder note on 6/5/2025 at 4:00 PM the date of discovery and no other skin note related to pressure injuries of the left shoulder, no measurements and no photos. Record review of the facility 'Pressure Injury Treatment Guidelines' policy, dated 12/2019, revealed treatment guidelines for at risk individuals included: Activity/Mobility: assess resident for degree of physical activity. Provide appropriate pressure redistribution devices, teach resident to weight shift if appropriate, and ensure proper body alignment. Residents will be repositioned with consideration to the individual's level of activity, mobility and ability to independently reposition. Reposition/shifts the body position, and/or encourage repositioning as needed per the individualized plan of care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. This Citation pertains to Intake Number MI00153516. Based on observation, interview and record review, the facility failed to prevent an injury of unknown origin for one resident (Resident #102) of 3 sampled residents, resulting in Resident #102 sustaining a fractured tibia and fibula of the right leg while residing in the facility, unnecessary pain/discomfort, and likelihood for decline in overall health. Findings include: Record review of facility 'Abuse Prevention' policy, dated 2/2024, revealed abuse, neglect, mistreatment, exploitation, or misappropriation of resident property are not tolerated at any time. Resident #102: Record review of Resident #102's electronic medical record revealed a fragile elderly resident who received hospice services while residing in the long-term care facility. Medical diagnoses included protein malnutrition, dementia, Alzheimer's, urinary retention, impulsiveness, anxiety, palliative care and major depressive disorder. In an observation on 6/13/25 at 9:50 AM, Resident #102 was observed seated up in reclining Broda chair in main area in front of nursing station. Dressed in red checked pajama bottoms and a tan sweatshirt with pink sock on left foot and a gauze batting wrapped with an Ace bandage on the right foot/leg. Resident #102 appeared to be sleeping and did not respond to her name. Observed position to be leaning to the right side of Broda chair with pillow between her legs curled in a fetal position with knees pulled upward with the right heel positioned in the leg extension crack between the blue padding of chair leg rest. Record review of Resident #102's Care task documentation for Certified Nursing Assistants (CNA) revealed: 'Daily Skin Check' task, Daily moisturizing lotion/cream to skin as needed, and Right foot/heel/lower leg task documentation by certified nursing assistance revealed: On 5/28/2025 at 03:52 AM, 17:30 PM no concerns with positioning, lotion applied, and right foot/heel/lower leg task with no concerns. On 5/29/2025 at 2:20 AM and 16:50 PM no concerns with positioning, lotion applied, and right foot/heel/lower leg task with no concerns. On 5/30/2025 at 00:57 AM no concerns with positioning, lotion applied, and right foot/heel/lower leg task with no concerns. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #102's 'Incident' form, dated 5/30/2025 at 11:30 AM, revealed that a hospice staff member noticed some bruising to Resident #102's right ankle that had not been there previously. The facility nurse was notified, assessed the area and called the physician to obtain an order for a X-ray. Pain medication was ordered, but the family refused and requested Tylenol for discomfort. Resident #102 was sent to the local hospital for evaluation and came back with a boot to help stabilized the ankle. No apparent cause of the injury could be immediately identified. The facility management along with resident's family believe the injury could have come from resident's legs not being adequately secured while moving her in the Broda chair. It is possible that the facility or hospice staff could have bumped her foot/ankle while being taken to the dining room or back to her room. Record review of Resident #102's progress notes, dated 5/30/2025 at 11:36 AM. revealed the nurse was called to resident's room to assess the right ankle. Yellow/purple bruising was noted to right ankle In an interview and observation on 6/13/2025 at 11:00 AM, Hospice aide D stated that she was Resident #102's regular hospice aide, because she speaks Spanish and English. Hospice aide D revealed that she was at the facility on Wednesday 5/28/2025 and had Hospice Registered Nurse E with her as a joint visit. Hospice aide D stated, On that Wednesday Hospice Registered Nurse E and I did give Resident #102 a bed bath, changed her brief and cleaned her up. I did see Resident #102's foot because I put on her socks. I didn't see anything on her foot at all on that day, there was no bruising and no redness. I wrote notes that Resident #102 didn't cry out much during her care, and I repositioned her. I keep in contact with the daughter about my visits. Resident #102 doesn't like her feet touched. Our staff on 5/29/2025 was a different aide and on 5/30/25 was another hospice aide. I was off for a funeral. I provide the care 5 days a week to feed her one time a day and provider care. The hospice RN ordered a foot cradle for the end of the wheelchair. In an observation and interview on 6/13/2025 at 11:05 AM, Resident #102 was observed seated up in Broda chair in her room, leaning to the right side of chair with the feet drawn upward in the fetal position. Resident #102 was asked by surveyor what happened to her foot, no response. In an observation and interview on 6/13/25 at 11:30 AM, Certified Nurse Assistant (CNA) G stated that Resident #102 was an extensive assist of 2 with a Hoyer/mechanical lift transfer. The hospice company is separate from us, and they will transfer with only one staff using the Hoyer/mechanical lift. We don't, we use 2 people for Hoyer transfers. The daughter is very particular, we make the bed many times a day each time we get her up and out of bed. Her eating depends on her mood and behaviors. She gets very emotional and cries a lot, has behaviors of upset/anxiety. Observation of the white laundry basket in the closet revealed there was a white towel with dirty food items on it from the hospice aide feeding. Certified Nurse Assistant (CNA) G stated that the Hospice staff do not have access to our utility rooms, and they will bag up the dirty clothes in plastic bags and put in the corner by the door, so when they leave, we have to come and get the bags and take care of them. The Hospice aide today (Hospice aide D), did not stop to talk or touch base with me on the care provided, she just walked out. We have to trust that the bath is given and sometimes I will pop in to see that the care is being done, they bring her into the room and close the door. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/13/2025 at 11:40 AM, Hospice RN E, stated: On Wednesday 5/28/25 at 11:29 AM I did a visit with Hospice Aide D, it was a supervisory visit to check the aide's work. When we came, she was in bed, we undressed her, cleaned her up and changed her brief and socks. We always change the socks, because the daughter wants that done. Resident #102 has anxiety and calls out, yells out You're killing me, she speaks both Spanish and some English. That day she didn't yell out, she was calm. We put her socks on, and she had no pain or anxiety. Then on Friday 5/30/2025 the hospice aide assigned was providing care and removed the socks off and the right leg/foot was swollen and bruised. That was on 5/30/25 at 7:36 AM there was a note. Then I got a call on 5/30/25 at 10:00 AM and I came into the building to see Resident #102's right leg. Resident #102 was in pain, the right leg/ankle was swollen and bruised with a yellow/greenish color bruise, it was an old bruise by the color. So, I figured it happened days prior. I ordered a stat X-ray and pain medication. Resident #102 became more anxious and was yelling out. I called the daughter and notified her. My supervisor came to the building and spoke with the daughter, because I got called out to a different hospice situation. Resident #102 was sent to the hospital for evaluation. I called the facility back and the X-ray was positive for fractured tibia & fibula of the right leg. As I was leaving, I asked the facility registered nurse about the bruising and she stated that she had not gotten to it yet. I asked for the wound care nurse/DON (Director of Nursing) to come and assess the leg. I had the RN and the wound care nurse, and another staff member come into the room and the DON took a photo of the leg and stated that it needed an X-ray. I talked to the daughter and her feet did hang over the edge of the wheelchair end platform and they will bump on the door frame and the daughter thinks that is how her leg got broken. We don't know how it got broken or when. Resident #102 does eat better in her room; in the dining room the facility staff are feeding 2-3 residents at a time. In an interview and record review on 6/13/2025 at 12:30 PM, the Director of Nursing (DON) interim/Wound Care, stated, that it was a couple of Fridays ago, on 5/30/2025 that staff were informed by the hospice nurse to look at the right leg. The DON stated I did go the resident room and assess the resident. I was informed her right leg was yellow/greenish colored bruising noted. I took a photo of the leg (wound/skin) as it was a new concern on 5/30/25 at 2:05 PM. The bruising was a yellow/greenish color measuring 8cm length X 5cm Width with no depth, there was a little purple color also. The surveyor asked what happened to the leg? The DON stated No, we do not know what happened to the leg. The leg was a greenish/yellow color and that would be greater than 24 hours old or longer. Resident #102 is a frail, 73 pounds weight, and there was a new hospice aide, because her regular hospice aide was off. We think that the new aide from hospice had an issue with the leg. But we don't know. It is an unknown injury, and we don't know how it occurred. Her foot pedals could hit/bump the door frame. We did investigate and we don't believe that it was purposeful or malicious. We did report it Friday 5/30/2025 to the state agency via email. We held a care conference on 6/11/2025 with the daughter earlier this week with hospice also, we had a sign in sheet, but we don't have any notes in the progress notes or anywhere. Hospice increased their visits, and the daughter was able to vent about her concerns. Yes, the daughter was notified on the day we found the bruising. Record review of photo taken 5/30/2025 at 2:05 PM printed off by DON revealed a yellow/green with very light purple color bruising with measurements of 8cm length X 5cm width with no depth noted. The DON stated that he took the photo on that day printed on the photo of Resident #102's right leg.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that food served to residents was palpable, had a good appearance and was at a preferred temperature for 2 residents (#104 and #105) of 4 residents observed at the noon meal, and per the facility's confidential Resident Council Group notes dated 3/21/25, 5/20/25, and 6/5/25. Findings Include: Observations made on 6/13/25 at 12:20 p.m., at the noon meal in the main dining room: Resident #104: Review of the Face Sheet and care plans dated 5/25, revealed Resident #104 was [AGE] years old, admitted to the facility on [DATE], was alert and able to be interviewed, and dependent on staff for ADL's. The resident's diagnosis included, Cognitive communication deficit, metabolic encephalopathy, anxiety, adjustment disorder and lack of coordination. Observation done on 6/13/25 at the noon meals revealed Resident #104 had requested a hamburger instead of the served fish. The hamburger bun was smashed, with the meat patties being very small; her meal ticket said gravy and onions), no onions were given for the burger and no gravy for her mashed potatoes. The resident tried to put condiments on the burger, the meat stuck to the bun, she was unable to put ketchup on her hamburger. The resident stated, This is what we get, sometimes I can't even eat it. Resident #105: Review of the Face Sheet and care plans dated 4/25, revealed Resident #105 was [AGE] years old, admitted to the facility on [DATE], was alert and able to be interviewed, and dependent on staff for Activities of Daily Living/ADL's. The resident's diagnosis included heart failure, protein-calorie malnutrition and major depression. Observation done on 6/13/25 at the noon meal revealed, the resident said she did not want the fish being served so she requested a cheeseburger from the Always Available Menu Items. The facility served the resident a hamburger with a small piece of cheese on it that had the appearance of a smashed bun with very small meat patty. She also had a very small portion of mashed potatoes with no butter or gravy. Resident #105 was very up-set and complained to this surveyor stating, This is the s--- they serve us, the food is not tolerable here. The resident complained the food was cold but did not want to send it back to re-warm. The resident said she was hungry; however, she did not want to eat her lunch. This surveyor immediately requested the facility Administrator to observe the food served to Resident' #104 and #105. When the Administrator saw the resident's hamburgers she stated, I know food is a problem here, I just got here, I will fix it. Review of the facility confidential Resident Counsel Meeting Notes: (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility resident counsel note dated 3/21/25, stated Dietary: Not getting what ordered. Review of the facility resident counsel note dated 5/20/25, stated Dietary: Tastes bad, often cold, dislike options. Review of the facility resident counsel note dated 6/5/25, stated Clarification for asking for more 1 items (food). During an interview done on 6/13/25 at 1:56 p.m., with the Director of Activities revealed she was aware of the aware of the continuous food complaints; stated I feel sorry for the residents, I know they don't like the food, it's like gas station food. I was given a taste of biscuits and gravy, and I wouldn't eat it. Review of the facility Dignity policy dated 4/24, stated Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Review of the facility Buffet Style Dining policy dated 2017, stated Food is attractively presented and palatable. Review of the facility Client Satisfaction policy dated 2017, stated Periodically, selected clients may be surveyed to determine their satisfaction with the food served.