

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  07/24/2025
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 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>Based on observation, interview and record review, the facility failed to update and/or revise individualized, person-centered care plans to reflect the changing care needs for 1 resident (Resident #106), of 8 residents reviewed for care plans, resulting in the potential for unmet care needs. Resident #106: Record review of Resident #106's electronic medical record revealed and elderly female with medical diagnoses of: muscle weakness, dysphagia, protein calorie malnutrition, diabetes, mood disorder, insomnia, major depressive disorder, Alzheimer's, gastro-esophageal reflux disorder, hypertension, peripheral vascular disease, irritable bowel syndrome, osteoarthritis, heart disease. Observation and interview on 7/22/2025 at 11:58AM with Resident #106 in regard to her tibia and fibula (leg bones) fractures revealed: I don't know what happened, it just started hurting. It was hurting so bad, and then they sent me to the hospital. It hurt so badly, I couldn't stand it anymore. Observation of Resident #106's right leg/foot gray plastic orthopedic boot to immobilize the right foot/leg. Resident resting in bed with spouse at bedside and daughter visiting. In an interview on 7/22/2025 at 12:04PM with Resident #106's family member G revealed that the family was called on Friday to see if Resident #106 could go to emergency room (ER). The family member stated that they had called ER around 10:30PM that night and they told them it was a fractured leg and they asked the ER how that could happen. The family member told them Resident #106 can't turn herself or roll over and could not stretch out her legs (contractures bilateral lower extremities), was non-weight bearing and basically bedridden. The family member stated that the ER stated that they did not know how this happened because the resident was non-mobile. They had stated that they had asked the facility/nursing home, and no one knew anything. The family member stated that if it was brittle bones the ER and x-rays would have stated so. The family member G stated that So, we have no clue what happened. We were here last Tuesday (7/15/2025) visiting, and she complained of her leg hurt. Usually, her right leg is folded under her left leg at the knee and contracted in that position. She is totally bedridden with a Hoyer lift, but does not get out of bed. Record review of Resident #106's Emergency/hospital record dated 7/18/2025 revealed the resident came from nursing home facility due to concerns for right lower extremity ankle swelling. The nursing home facility staff was unable to tell emergency transport when the ankle first started swelling, however they just noticed it today. Unsure of the length of time since the injury. Musculoskeletal assessment: Contractures bilateral lower extremities, pulses intact bilaterally, right ankle swollen, obvious deformity, bruising. Lateral X-ray results: There is acute distal right tibial fracture as well as distal fibular fracture. Record review on 7/22/2025 of Resident #106's Care plans pages 1-29 revealed that there were no updates or revisions for interventions related to the care needs that included the fractured right tibia and fibula or the orthopedic boot that was on the resident. Record review of the chronic pain care plan had no new interventions to address the acute fracture of the right ankle, positioning of resident or follow up care for fracture.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  235635	Facility ID:  235635  If continuation sheet Page 1 of 14

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview and record review, the facility failed to 1) Prevent bruising and sling indentations on both thighs during a mechanical transfer for 1 resident (Resident #102), and 2) Ensure that 1 resident (Resident 106) was free of injury of an unknown origin (fracture of the leg) of 2 residents observed for transfer and injury of unknown origin, resulting in 2 sling indentations on the thighs and a bruise on the outer right knee with the possibility of developing skin breakdown and a fracture of the leg, pain and hospitalization. Findings Include:Resident #102:</p> <p>Review of the face Sheet, care plans dated 6/25, nursing notes dated 7/23/25 and physician orders dated 7/23/25, revealed Resident #102 was [AGE] years old, alert but not able to make her own healthcare decisions, immobile, and totally dependent on staff for all Activities of Daily Living/ADL's. The resident was receiving Hospice services at the facility and malnourished weighing 74.6 pounds. The resident's diagnosis included, protein-calorie malnutrition, fracture of the right tibia, impulsiveness, Alzheimer's disease, Dementia, pelvic and perineal pain, degeneration of brain, anxiety, mood disturbance, major depression, adjustment disorder and Dysphagia (difficulty swallowing).</p> <p>Review of the facility ADL care plan dated 1/25, stated "use mechanical lift for all transfers, small sling size."</p> <p>Observation was made on 7/23/25 at 9:50 a.m., of Hospice staff members (Nurse, LPN "F"; and Aide "E") transferring Resident #102 from bed to the shower chair. When this surveyor entered the resident's room, the resident was not covered and then Hospice Aide "E"; quickly covered her with 2 small white towels (a bath blanket was folded sitting in the chair) to the left of the resident's bed. As Nurse "E"; and Aide "F"; were lifting the sling with the Hoyer, Resident #102 was talking Spanish and said the word "shoulder"; and then the rest was in Spanish (the resident had documentation of pain in her right shoulder due to osteoarthritis), the resident was crying/winning with facial grimacing of pain noted. This surveyor noticed a red indication mark on the resident's left thigh, the same indication shape as the sling material.</p> <p>A second observation of Resident #102 was done on 7/23/25 at 10:05 a.m., with Nurse Managers, RN's "C"; and "D"; she was in the shower with Hospice Aide "E"; giving her a shower. An irregular round shaped bruised area on her right outer knee was observed at this time. The bruise was red/blue in color, and it matched up to the pattern of the large sling she was sitting on; unable to do an observation of all skin due to being transferred into the shower chair.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility New Skin Condition form dated 7/23/25, at 10:15 a.m. (after this surveyor observed a bruise and lift indication on leg), stated "This writer was notified that this patient had been observed transferring from wheelchair to shower chair by hospice nurse and hospice in a Hoyer sling around the back of the thighs indenting into skin. No bath blanket present. Bruise noted above lateral right knee 4.5 cm x 3 cm blue in color (newly acquired). Attempted to assess while patient was still in shower chair. Unable to fully assess areas where sling was with patient in chair. Intervention: Smaller Hoyer sling brought into room for transfers. Hospice Aide and Hospice Nurse transferred patient to bed. Skin assessment completed at this time. Bruise noted above lateral right knee 4.5 cm x 3 cm blue in color. Left 4th toe bruise dark purple 1 cm x 0.5 cm. Sling indentation noted to the back left thigh and right thigh. Left hip red indentation measuring 4.5 cm x 0.2 cm. Right hip red indentation 12 cm x 0.2 cm."</p> <p>Review of facility nursing progress note dated 7/23/25 at 11:21 a.m., stated "This writer was notified that this patient had been observed transferring from wheelchair to shower chair by hospice nurse and hospice in a Hoyer sling around the back of the thighs indenting into skin. No bath blanket present. Bruise noted above lateral right knee 4.5 cm x 3 cm blue in color (newly acquired). (Family Member #1), Administrator, DON (Director of Nursing) notified. Intervention small Hoyer sling in room."</p> <p>During an interview done on 7/23/25 at approximately 10:10 a.m., Nurse Manager "D" had gone and gotten a size small Hoyer sling; when asked where she got it, she stated "in the laundry room." The facility had available a size small sling and it was documented to use a small sling on her ADL care plan dated 1/25.</p> <p>Review of a physician's order, dated 7/23/25, stated "Monitor bruising q (every) shift until healed to left 4th toe and above lateral right knee until healed."</p> <p>Review of the facility Altercation in skin integrity care plan updated on 7/23/25, stated "Bruise to lateral rt (right) knee, 6/13/25 (previously, the resident had a bruise the same location as on 7/23/25), ensure size small sling is used for all transfers."</p> <p>Review of facility staff education dated 7/23/25, revealed the Director of Nursing educated nurse's and Nursing Assistant's/CNA's regarding proper Hoyer sling size usage.</p> <p>Review of the facility Transfer Using a Lift policy dated 7/17/25, stated "Ensure the proper size sling is used based on the resident's size and weight."</p> <p>Resident #106:</p> <p>Record review of Resident #106's "Injury of unknown origin" incident report dated 7/18/2025 at 4:28PM revealed Resident #106 had right ankle bruising, swelling and was hot to the touch. In facility Xray was ordered with acute fracture of the fibula and tibia bones with displacement and soft tissue swelling. Pain assessment noted occasional moan or groan, facial grimacing, rigid, fist clenched, knees pulled up, pulling or pushing away and striking out. Both lower extremities with severe contractures and overlap each other.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #106's electronic medical record revealed and elderly female with medical diagnoses of: muscle weakness, dysphagia, protein calorie malnutrition, diabetes, mood disorder, insomnia, major depressive disorder, Alzheimer's, gastro-esophageal reflux disorder, hypertension, peripheral vascular disease, irritable bowel syndrome, osteoarthritis, heart disease. A Brief interview of mental status (BIMs) score of 4 out of 15, severe cognitive impairment was noted. Record review of Resident #106's medical record revealed the resident was non-ambulatory/non-weight bearing and had bilateral lower extremities contractures.</p> <p>Observation and interview on 7/22/2025 at 11:58AM with Resident #106 regarding her tibia and fibula (leg bones) fractures revealed: "I don't know what happened, it just started hurting. It was hurting so badly, and then they sent me to the hospital. It hurt so badly, I couldn't stand it anymore". Observation of Resident #106's right leg/foot gray plastic orthopedic boot to immobilize the right foot/leg. Resident #106 was lying in bed with family members at bedside visiting.</p> <p>In an interview on 7/22/2025 at 12:04PM with Resident #106's family member "G"; revealed that the family was called on Friday to see if Resident #106 could go to emergency room (ER). The family member stated that they had called ER around 10:30PM that night and they told them it was a fractured leg, and they asked the ER how that could happen. The family member told them Resident #106 can't turn herself or roll over and could not stretch out her legs (contractures bilateral lower extremities), was non-weight bearing and basically bedridden. The family member stated that the ER stated that they did not know how this happened because the resident was non-mobile. They had stated that they had asked the facility/nursing home, and no one knew anything. The family member stated that if it was brittle bones the ER and x-rays would have stated so. The family member "G"; stated that "So, we have no clue what happened. We were here last Tuesday (7/15/2025) visiting, and she complained of her leg hurt. Usually, her right leg is folded under her left leg at the knee and contracted in that position. She is totally bedridden with a Hoyer lift for transfers but chooses not to get out of bed".</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 7/22/2025 at 2:00PM Certified Nurse Assistant (CNA) &amp;ldquo;H&amp;rdquo; revealed that she was changing Resident #106&amp;rsquo;s brief on that 7/18/2025 in the morning and noted the resident&amp;rsquo;s right ankle/leg was swollen and the way she was laying you could not see any coloration. I did notice it had swelling and then when she turned Resident #106 that was when she noticed the color of bruising, color of yellow, purple and green, that was not a fresh bruise. CNA &amp;ldquo;H&amp;rdquo; called nurse, licensed Practical Nurse (LPN) &amp;ldquo;l&amp;rdquo;. CNA &amp;ldquo;H&amp;rdquo; stated &amp;ldquo;LPN &amp;ldquo;l&amp;rdquo; took forever to go to the room, so I snap a photo of just the ankle to take to the LPN &amp;ldquo;l&amp;rdquo;, at the end of my shift, we work 6AM to 6PM, only LPN &amp;ldquo;l&amp;rdquo; was leaving early that day around 2:00PM, to go to a casino or something. CNA &amp;ldquo;H&amp;rdquo; stated that she brought the photo to the LPN &amp;ldquo;l&amp;rdquo; to visualize that she needed to go look at the bruising. LPN &amp;ldquo;l&amp;rdquo; then went to the Resident #106&amp;rsquo;s room to look at the leg, CNA &amp;ldquo;H&amp;rdquo; went with the LPN &amp;ldquo;l&amp;rdquo; and nurse said it was from the mattress, a red pressure area. So LPN &amp;ldquo;l&amp;rdquo; put soft Provalon boot on Resident #106, to relieve the pressure, and did not report the change of condition, but reported to the next nurse (Registered Nurse &amp;ldquo;D&amp;rdquo;) it was just a red mark. CNA &amp;ldquo;H&amp;rdquo; went up to Registered Nurse &amp;ldquo;D&amp;rdquo; to make sure that LPN &amp;ldquo;l&amp;rdquo; reported it to her. LPN &amp;ldquo;l&amp;rdquo; had only stated a red spot and did not report any bruising. Once again CNA &amp;ldquo;H&amp;rdquo; showed the photo to RN &amp;ldquo;D&amp;rdquo; and then to the Director of Nursing (DON) and Nursing Home Administrator (NHA) and that&amp;rsquo;s when things got moving. The DON/NHA all went to the resident room and looked at the leg, got x-rays, and sent her out to the hospital. CNA &amp;ldquo;H&amp;rdquo; stated that Resident #106 does not stand, does not walk, cannot roll over by herself, cannot move her legs or spread them.</p> <p>Record review of the electronic medical record revealed that there was no documented physical assessment on 7/18/2025 for the bruising or red marks by LPN &amp;ldquo;l&amp;rdquo;. Under the skin/wound tab there were no photos of the bruising or of skin monitoring.</p> <p>In an interview on 7/23/2025 at 9:23 AM with the Director of Nursing (DON) there is no nursing assessments policy, in the electronic medical record program there is an admission assessment in the program. We use the nurse&amp;rsquo;s judgement to assess the resident condition and document the changes. The skilled rehab residents are assessed daily, and the Long-Term Care (LTC) are done monthly. Any change in condition is the responsibility of the nurse&amp;rsquo;s education and judgement. We train the staff and nurses to identify the changes in residents.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 7/23/2025 at 9:36AM with Registered Nurse (RN) D regarding Resident #106's fracture ankle incident: The Certified Nurse Assistant (CNA) H came up to me and stated that Resident #106's leg was red, we had 3 nurses for all halls and so I did not have her until the previous nurse Licensed Practical Nurse (LPN) I, left the shift early around 3PM. Licensed Practical Nurse (LPN) I, in report very vaguely stated that Resident #106's leg was red from laying on the leg. It was a weird report from her, and not 10 minutes later the Certified Nurse Assistant (CNA) H came and asked me what did (LPN) I tell you about Resident #106's foot? I stated that (LPN) I told me it was red in a spot from the resident lying on the foot. I went to the room with Certified Nurse Assistant (CNA) H, and there was a soft Prevalon boot on the foot/ankle which had no order for the boot. Licensed Practical Nurse (LPN) I had not gotten an order for the boot. I peeled back the Velcro straps on the right foot/ankle and saw it was swollen, warm to the touch and bruising of yellow/purple/green in color. As soon as I touched the boot Resident #106 moaned n pain, so I did not take the boot off. I went to get the Director of Nursing and then the wound nurse and the unit manager were in the office when I went to tell them what was going on. So then I stated it looks broke, and I want an Xray, they assisted in getting the order from doctor, and then I was still present when the Xray tech/guy came and I sent in Certified Nurse Assistant (CNA) H to assist him, and the Xray guy stated unofficial report of fracture and not to move her. There was another resident here that had a fracture, and she was immobile also. They got the Xray results and sent Resident #106 out after I left at 6PM, Resident #106 has contracture of the legs and had no other areas of concern, for me her legs are a fragile spot; to turn her we have to use the lift sheet and assist both legs. Resident #106 is basically bed bound so it has to have been with her turning.</p> <p>Record review of Resident #106's Emergency/hospital record dated 7/18/2025 revealed the resident came from nursing home facility due to concerns for right lower extremity ankle swelling. The nursing home facility staff was unable to tell emergency transport when the ankle first started swelling, however they just noticed it today. Unsure of the length of time since the injury. Musculoskeletal assessment: Contractures bilateral lower extremities, pulses intact bilaterally, right ankle swollen, obvious deformity, bruising. Lateral X-ray results: There is acute distal right tibial fracture as well as distal fibular fracture.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This Citation Pertains to Intake Numbers 1256062 and 2564418. Based on observation, interview, and record review, the facility failed to implement and operationalize policies and procedures for fall prevention for two residents (Resident #101 and Resident #105) of three residents reviewed, resulting in a lack of planned interventions, a lack of implementation of meaningful interventions to prevent falls, resulting Resident #101 and Resident #105 experiencing falls with injuries necessitating emergency medical treatment, unnecessary pain, and a decline in overall health status.</p> <p>Findings include:</p> <p>Resident #101:</p> <p>Review of Intake documentation revealed concerns that on 6/24/25 a staff member was giving Resident #101 a bed bath and the Resident rolled out of the bed because there was only one staff member assisting the Resident when they required the assistance of two staff per their care plan. As a result of the fall, Resident #101 suffered a broken hip which required emergency surgery.</p> <p>On 7/22/25 at 12:50 PM, Resident #101 was not in their room. The Resident's bed was positioned against the wall and a fall mat was in place on the floor beside the bed.</p> <p>At 1:00 PM on 7/22/25, Resident #101 was observed sitting in a Broda chair (specialized wheeled, reclining chair with solid footrests used for individuals with limited mobility). Certified Nursing Assistant (CNA) "J" was feeding the Resident lunch. When queried regarding care in the facility, Resident #101 stated, "I fell, and they had to put screws in me. I broke my hip";</p> <p>A follow-up interview was completed with Resident #101 on 7/22/25 at 1:23 PM in their room. When queried what happened when they fell, Resident #101 stated, "I rolled out the bed real hard. Landed on the floor real hard." When queried if the fall mat was in place beside the bed when they fell, Resident #101 replied, "Didn't have that mat there then. They just put that mat down." Resident #101 was queried regarding the height of the bed when they fell and stated, "About a foot higher than it is now." The bed was noted to be at waist height. When asked why the bed was so high, Resident #101 replied, "I don't know." Resident #101 was then asked if there were staff in the room at the time of the fall and responded that a CNA was in the room. When asked what they were doing, Resident #101 stated, "Supposedly cleaning me up but only had one person (CNA). They were supposed to have two (CNAs)." Resident #101 was asked why only one CNA was cleaning them up if there are supposed to be two staff to assist them and replied, "I don't know. That what they do around here." When queried what happened after they fell, Resident #101 stated, "(The CNA) went screaming and the nurses came in and they had to get a lift to get me off the floor." Resident #101 was asked if they went right to the hospital and stated, "I went to (one hospital) and they didn't find nothing wrong so I went to (different hospital) and they said they needed to do emergency surgery and that's what they did." When queried what was broken, Resident #101 revealed they broke their hip and had to get a plate and screws. Resident #101 revealed (Family Member "L") would be able to provide additional information regarding the care they received and requested they be contacted.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review revealed Resident #101 was originally to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included displaced intertrochanteric right hip fracture, falls, chronic kidney failure with dialysis dependence, heart failure, left below the knee amputation (LBKA), and weakness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, dependent upon staff for bed mobility, and required total assistance from staff for transfers.</p> <p>Review of Resident #101's Electronic Medical Record (EMR) revealed a care plan entitled, "Skilled Therapy/ADL: Self-care deficit, require assist with ADLs r/t (related to) limited mobility, debility, and impaired balance"; (Initiated: 1/17/25). The care plan included the intervention:</p> <ul style="list-style-type: none"> <li>- "Bathing: I need extensive assist with 2 people to help me"; (Initiated: 1/17/25)</li> <li>- "Bed mobility: I need extensive assist of 2 to help me"; (Initiated: 1/17/25)</li> <li>- "Toileting: I need extensive assist of 2 to help me"; (Initiated: 1/17/25)</li> <li>- "Transfers: I need extensive assist of 2 to help me"; (Initiated: 1/17/25)</li> </ul> <p>Review of progress note documentation in Resident #101's EMR revealed the following:</p> <ul style="list-style-type: none"> <li>- 6/24/25 at 10:00 AM: "Follow-up/Monitoring"; Has the resident reported changes in their experience of pain? Yes, pain in right shoulder and right hip. Has the resident reported changed in their ability to perform ADL tasks or mobility? Yes, cannot flex right shoulder; Have any new orders been received; Yes, X-rays for nasal, right shoulder, and right hip.</li> <li>- 6/24/25 at 10:14 AM: "Health Status/Progress Note"; Resident observed lying on back, next to bed. Head against nightstand. Resident stated doesn't know what happened. He also stated that fell on the right side of body before lying on back; pain in right shoulder and right hip; answered yes when asked if hit head; Swelling noted to left nare. Hand grasp equal and strong but cannot flex right shoulder. Movement in lower extremities. Complaints of pain noted; Orders for x-ray of the nasal bones, right shoulder, and right hip have been placed. To prevent future falls during dressing, care plan will be updated to extensive two assist for dressing.</li> <li>- 6/25/25 at 3:44 AM: "Health Status/Progress Note"; Guest just returned from (Hospital) for right sided pain. X-Ray of 2 View right ankle and right shoulder complete were all negative of fracture and breakage;</li> <li>- 6/25/25 at 10:17 AM: "Plan of Care"; IDT met to review fall. Resident was receiving care from the aide and was rolled on to side when the aide turned to get more needed items (Resident #701) lost grip on the side of the bed and rolled out of bed. Resident was assessed and reported right hip and shoulder pain; Intervention is to have care plan updated to have 2 person assistance with self care to reduce the risk of falls.</li> <li>- 6/25/25 at 9:00 PM: "Health Status/Progress Note"; Guest transferred to hospital on stretcher; Guest demanded be sent to hospital; stated The pain medication is the same medication I was taking already. It's not helping. I want to go to (different Hospital) .</li> </ul> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Caretel Inns of Tri-Cities		STREET ADDRESS, CITY, STATE, ZIP CODE  6700 Westside Saginaw Road Bay City, MI 48706	
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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>- 6/25/25 at 2:35 PM: "Health Status/Progress Note"; Dr into see guest. New order given for Baclofen (muscle relaxer) 5 mg (milligrams) q (every) 8 hours for muscle spasms;"</p> <p>- 7/8/25 at 4:37 PM: "admission Note"; Client arrived to facility via (ambulance), on stretcher"; Wound vac to right hip, catheter in place and draining yellow fluid"; Client c/o pain in hip;"</p> <p>- 7/10/25: Physician "History and Physical"; Chief Complaint / Nature of Presenting Problem: Fall"; presents to the hospital after a fall. The patient was found to have been treated for right lesser trochanteric fracture, fall, urinary tract infection with MDRO (Multi Drug Resistant Organism) "; Upon my exam"; admitting to pain of the right hip"; patient has profound weakness"; moves left upper extremity with severe weakness of the right upper extremity"; does not move the right lower extremity"; has a left above-knee amputation"; toes were amputated from right foot"; Plan: right lesser trochanteric fracture: Pain management"; Follow-up with orthopedic surgery as indicated. "</p> <p>Resident #101's Census List documentation in the EMR revealed the Resident was transferred to the hospital on 6/25/25 and returned to the facility on 7/8/25.</p> <p>Upon request for Resident #101's Incident and Accident (I and A) reports and facility investigations, one I and A with investigation documentation was provided. Review of the I and A revealed:</p> <p>- "6/24/25 9:45 AM"; Incident Location: Resident's room"; Nursing Description: Resident observed lying on back, next to bed. Head against nightstand. Resident Description: Resident stated doesn't know what happened"; stated fell on the right side of body before laying on back, pain in right shoulder and right hip"; answered yes when asked if hit head"; Injuries Observed at Time of Incident"; Injury Type: Unable to Determine"; Location: Face";</p> <p>- Undated, Signed Statement by CNA "K": "I was doing a routine bed bath on (Resident #101) and I had finished washing front and turned (Resident) on left side towards me to make sure they were securely on their side. Once I knew (Resident #101) was secure and holding the side of the bed, I walked around to the opposite side of the bed and went to wash their back. I noticed (Resident #101) reach down and before I could say anything or at least try and catch them, they rolled off the bed and landed on right side going down. Nurses were notified."</p> <p>- Printed EMR progress note and assessment documentation</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted with Family Member &amp;ldquo;L&amp;rdquo; on 7/23/25 at 8:28 AM. When queried regarding Resident #101&amp;rsquo;s fall at the facility, Family Member &amp;ldquo;L&amp;rdquo; stated, &amp;ldquo;(Facility) called me on 6/24 or 6/25 and told me that (Resident #101) was getting washed up and the CNA told them to turn over to get the other side but (Resident #101) can&amp;rsquo;t turn because they are paralyzed.&amp;rdquo; Family Member &amp;ldquo;L&amp;rdquo; then stated, &amp;ldquo;How do you wash somebody up yourself and turn them when you don&amp;rsquo;t have no body on the other side?&amp;rdquo; When queried regarding Resident #101&amp;rsquo;s mobility including ability to use their arms to help reposition themselves, Family Member &amp;ldquo;L&amp;rdquo; revealed the Resident can use one arm &amp;ldquo;most of the time&amp;rdquo; but not consistently. Family Member &amp;ldquo;L&amp;rdquo; verbalized Resident #101 did not have anything to hold on to if they were on their side and indicated the Resident may be able hold a bed rail if there was one. When queried if the facility had ever assessed or discussed enabler bars or bed rails for Resident #101 to assist with positioning, Family Member &amp;ldquo;L&amp;rdquo; responded they were told they could not have any rails on beds because of State regulations. Family Member &amp;ldquo;L&amp;rdquo; was asked if the facility provided any other information related to how Resident #101 fell and indicated they did not. Family Member &amp;ldquo;L&amp;rdquo; stated, &amp;ldquo;I know (Resident #101) didn&amp;rsquo;t roll over themselves.&amp;rdquo; Family Member &amp;ldquo;L&amp;rdquo; then stated, &amp;ldquo;(Resident #101) fractured their hip and leg.&amp;rdquo; When queried when the facility sent the Resident to the hospital, Family Member &amp;ldquo;L&amp;rdquo; revealed Resident #101 went to the ER at two different hospitals. With further inquiry, Family Member &amp;ldquo;L&amp;rdquo; revealed the first hospital ER the Resident went to &amp;ldquo;couldn&amp;rsquo;t find anything&amp;rdquo; wrong and sent the Resident back to the facility. Family Member &amp;ldquo;L&amp;rdquo; was queried what happened after Resident #101 returned to the facility and replied, &amp;ldquo;That same night (Resident #101) kept calling me and saying they were having pain. I called (the facility) and said I wanted them to send (Resident #101) out&amp;rdquo; to a different hospital.&amp;rdquo; Family Member &amp;ldquo;L&amp;rdquo; continued, &amp;ldquo;The nurse said they had to talk to the Director of Nursing (DON) before they could send (Resident #101) out&amp;rdquo; to a different hospital. When asked if Resident #101 was transferred to the other hospital ER then, Family Member &amp;ldquo;L&amp;rdquo; revealed the Resident was not sent to ER until the night of 6/25/25. Family Member &amp;ldquo;L&amp;rdquo; revealed they were informed Resident #101 needed to have emergency surgery in the morning when they got to the hospital. Family Member &amp;ldquo;L&amp;rdquo; then stated, &amp;ldquo;(Resident #101) had to rod in their leg and screws in their hip.&amp;rdquo; When asked, Family Member &amp;ldquo;L&amp;rdquo; revealed Resident #101 was in the hospital for over a week following the fall and surgery to repair the fracture.</p> <p>On 7/23/25 at 10:05 AM, an interview was conducted with Licensed Practical Nurse (LPN) &amp;ldquo;M&amp;rdquo;. When queried regarding Resident #101&amp;rsquo;s fall on 6/24/25, LPN &amp;ldquo;M&amp;rdquo; verbalized they were not working when the Resident fell. LPN &amp;ldquo;M&amp;rdquo; was then queried regarding the Resident&amp;rsquo;s upper extremity mobility and revealed the Resident has some &amp;ldquo;gross motor skills but not fine motor skills.&amp;rdquo; When queried if the Resident is able to grasp items and hold them, LPN &amp;ldquo;M&amp;rdquo; replied, &amp;ldquo;Some days (Resident #101) can feed themselves and some days can&amp;rsquo;t.&amp;rdquo; When queried if Resident #101 would be able to hold and/or grasp an enabler bar in bed to assist with positioning, LPN &amp;ldquo;M&amp;rdquo; indicated they may be able to. LPN &amp;ldquo;M&amp;rdquo; was then asked if Resident #101 had been assessed for enabler bars and replied, &amp;ldquo;We don&amp;rsquo;t have that stuff here.&amp;rdquo;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was completed Registered Nurse (RN) on 7/23/25 at 10:13 AM. When queried if they were working on 6/24/25 when Resident #101 fell, RN confirmed they were. When asked what happened, RN stated, "I was on the hall. (Resident #101) fell when I was passing meds." RN continued, "During med pass one of the CNAs came out and let me know; Resident #101 fell. RN was asked what happened and stated, "The CNA said they were doing hygiene care and (Resident #101) lost their grip on the side of the bed." When queried what they observed when they entered the Resident's room after being notified of the fall, RN replied, "(Resident #101) was on the left side of the bed with their head by nightstand. I documented everything in the EMR. When asked how high the bed was and how far the Resident fell, RN replied, "Like waist high." When queried regarding their assessment following the fall, RN revealed the Resident complained of pain in their leg and hip. With further inquiry, RN revealed they put "muscle rub" on Resident #101's hip and put in orders for a nasal and hip x-ray. When asked why a nasal x-ray was ordered, RN replied, "Looked like it was swelled." When asked if they noted any abnormalities in Resident #101's leg, RN replied, "(Resident #101) landed on right on their hip" and indicated they did not observe any signs/symptoms of obvious fracture. When queried, RN revealed the CNA was providing care to Resident #101 by themselves. RN was asked if Resident #101 was care planned to be one assist for bed mobility and ADL care and revealed they were supposed to be two -assist. RN revealed they reviewed the care plan following the fall and made Resident #101 an "extensive two assist for everything."</p> <p>On 7/23/25 at 10:17 AM, an interview was conducted with CNA. When queried regarding Resident #101's fall from their bed on 6/24/25, CNA stated, "I was just doing a routine bed bath." CNA verbalized they turned the Resident and told them to hold onto the metal bed frame. CNA revealed the Resident fell when they went to walk to the other side of the bed to wash the Resident. CNA stated, "(Resident #101) was reaching for something and let go (of the metal bed frame)." When asked if there was something on the floor that the Resident was reaching for, CNA replied, "No." When asked how they knew the Resident was reaching down when they were walking to the other side of the bed, an explanation was not provided. CNA was then asked if Resident #101 was supposed to be a one assist with bathing and bed mobility and replied, "Always do one assist for bed bath." When queried why they asked the Resident to hold the metal bar/bed frame under the mattress, CNA responded, "That is how we always did it." When asked if the Resident was care planned to be a one assist with bathing and bed mobility, CNA stated, "I didn't know (Resident #101) was a two assist until after (the fall)." When queried how they know what level of assistance residents require for care, CNA indicated it is in their care plan/Kardex (care guide). CNA was then asked if they reviewed Resident #101's care plan/Kardex before providing care on 6/24/25 and stated, "I did afterwards and saw (Resident #101) was supposed to be a 2 (assist)." When queried why they did not review the care plan/Kardex prior to providing care, CNA stated, "I just did what I was trained to do by another CNA."</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was completed with CNA &amp;P&amp; on 7/23/25 at 10:25 AM. When queried regarding Resident #101's upper extremity strength, CNA &amp;P&amp; replied, &amp;Has good days and bad days&amp; and indicated the Resident's ability fluctuates. CNA &amp;P&amp; was asked if they were working on 6/24/25 when Resident #101 fell and revealed they were but were not assigned to Resident #101's area. When queried regarding the level of staff assistance Resident #101 required for bathing and bed mobility prior to the fall, CNA &amp;P&amp; stated, &amp;(Resident #101) has always been a two (assist).&amp;</p> <p>A review of CNA &amp;K&amp;'s employee file and disciplinary actions revealed an Employee Coaching Form dated 7/16/25. The Employee Coaching Form specified, &amp;The following employee is in violation of the following rule: Did not check residents Kardex (care plan guide) before providing care. Description of Incident: Employee was providing bed bath and did not ask for assistance&amp;.&amp;</p> <p>On 7/23/25 at 2:35 PM, an interview was completed with the DON. When queried they were involved in the investigation of Resident #101's fall on 6/24/25, the DON replied, &amp;I knew that (the Resident) was sent out. It wasn't brought to my attention that we were doing a bed bath with only one assist.&amp; When asked to clarify, the DON revealed they were not immediately notified that the Resident's fall occurred during care and that the care plan was not being followed. When asked what happened, the DON stated, &amp;(Resident #101) was sent to one hospital and they sent them back. Then (Resident #101) was sent to a different hospital, they found a fracture and then came back over a week later.&amp; The DON revealed they were unaware Resident #101 had suffered a fracture until they returned to the facility from the second hospital. When queried what they identified as the cause of the fall, the DON verbalized CNA &amp;K&amp; did not follow the Resident's care plan and provided a bed bath with one staff when the Resident required two staff for care. When asked why two staff were not providing care, the DON stated, &amp;(CNA &amp;K&amp;) admitted they didn't check&amp; the care plan/Kardex. A policy/procedure related to expectation for staff to review the care plan/Kardex prior to providing care was requested at this time and the DON revealed they did not know if that information would be in a policy/procedure. The DON stated, &amp;I feel like that is common sense for them to check the Kardex.&amp; When queried regarding CNA &amp;K&amp; having the Resident grab the metal bar/frame of the bed when they were turning them, the DON revealed they &amp;have seen that before.&amp; The DON continued, &amp;I think it is more that (Resident #101) is grabbing for something to hold themselves when they are being turned. When queried if the Resident had been evaluated for an enabler bar, to provide them something to grab while being turned, the DON replied, &amp;I don't know.&amp; When queried if they understood the concern, the DON replied, &amp;Yes.&amp; No further explanation was provided.</p> <p>Review of Hospital documentation for Resident #101 revealed the following:</p> <ul style="list-style-type: none"> <li>- 6/25/25 at 11:55 PM: &amp;ED Provider Note&amp; Physical Exam&amp; Right Lower Extremity Significant tenderness to palpation of the lateral aspect of right hip&amp; unable to move the leg at baseline&amp; Decreased sensation from the midcalf distally&amp; Right upper extremity&amp; Passive range of motion is severely limited due to pain&amp; Admit&amp; symptomatic with right subtrochanteric hip fracture and had not achieved medical stability&amp; Condition: Guarded&amp;.&amp;</li> <li>- 6/26/25 Right Femur X-Ray: &amp;Acute nondisplaced subtrochanteric fracture right femur&amp; probably also chip fracture of the lesser trochanter&amp;.&amp;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #101 had surgery on 6/26/25.</p> <p>Resident #105:</p> <p>Record review of Resident #105's electronic medical record progress note revealed an admission date of 6/25/2025 from the hospital setting. Medical diagnosis included: Urinary tract infection, chronic obstructive pulmonary disease, hypertension, spondylosthesis, alcohol abuse, transient ischemic attack (TIA), dementia, low back pain, metabolic encephalopathy, insomnia, retention of urine, myocardial infarction.</p> <p>Record review of resident #105's previous hospital medical record dated 6/24/2025 revealed the resident was treated for pneumonia with no mention of fractured rib.</p> <p>Record review on 7/23/2025 of Resident #105's "Incident by incident types" of report revealed 5 (five) "Fall" incidents had occurred:</p> <p>6/25/2025 at 8:30PM</p> <p>6/26/2025 at 6:15AM</p> <p>6/26/2025 at 8:00PM</p> <p>6/28/2025 at 4:40AM</p> <p>6/29/2025 at 9:40PM</p> <p>Record review of Resident #105's "Incident report" dated 6/28/2025 at 4:40AM revealed the nurse was alerted to the resident being on the floor next to his bed. When entering the room, the resident was back in bed. When the nurse asked the Certified Nurse Assistant (CNA) how the resident got up, the CNA stated, "He did it himself". The nurse noted that the resident #105 stated he jumped on the floor and that he wants his Pepsi. No injuries observed at the time of incident.</p> <p>Record review of Resident #105's nursing progress note dated 6/28/2025 at 5:01AM revealed: Nurse alerted to resident being on the floor next to his bed. When the writer entered the room the resident was back in bed. When writer asked the CAN how resident got up, she stated "He did it himself". The resident stated he jumped on the floor and that he wanted his Pepsi. Vital signs taken, skin assessed and intact, Range of Motion (rom) assessed and present in all extremities, denies pain, neuro (checks) initiated physician notified, family to be notified in the morning, management notified.</p> <p>Record review of the next nursing progress note dated 6/28/2025 at 9:49AM revealed: Interdisciplinary team met to review fall. Resident was observed on the floor by the Certified Nurse Assistant (CNA) and while the nurse was coming for assessment resident got himself up and got back in bed. Resident was sent out to the hospital, and he noted to have a rib fracture and Urinary Tract Infection (UTI) returned from ER with antibiotic. Resident stated he was trying to get his Pepsi. Intervention will be to keep drinks on side table within reach to reduce the risk of falls.</p> <p>(continued on next page)</p>		

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F 0689  Level of Harm - Actual harm  Residents Affected - Few	Record review of Resident #105's hospital emergency room record dated 6/28/2025 revealed resident was sent for a fall with rapid heart rate. emergency room work up revealed a Urinary Tract Infection (UTI) and right 7th rib fracture without any callus and likely an acute fracture.		