

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 12/18/2025
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)
F 0693 Level of Harm - Actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. (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
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F 0693 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2677656. Based on interview and record review, the facility failed to reconcile enteral feeding (tube feeding) orders for one resident (Resident #1) of two residents reviewed for enteral feeding resulting in approximately 19 hours of no enteral feeding/nutrition and rehospitalization. Findings include: Resident #1: On 12/17/25, at 9:30 AM, a record review of Resident #1's electronic medical record (EMR) revealed a readmission on [DATE] with diagnoses that included Chronic Hypoxic Respiratory Failure, Severe protein-calorie malnutrition, Septic shock, Diabetes Type 2 and Gastrostomy. Resident #1 had severely impaired cognition. A review of the admission Assessment Date: 10/17/2025 12:46 . revealed Resident #1 was readmitted at 12:46 PM. There was no hospice documents scanned into the EMR that clarified when the hospice company/nurse visited the resident on 10/17/25. A review of the Physician orders revealed no order for enteral feeding/nutrition for Resident #1 and the following order NPO (Nothing By Mouth) . Start Date 10/17/2025 14:40 (2:40 PM) . A review of the MEDICATION ADMINISTRATION RECORD 12/1/2025 - 12/31/2025 revealed no documented administration of enteral feeding/nutrition on 10/17/25 or 10/18/25. A review of the Progress Notes revealed the following: 10/17/2025 14:30 . Note Text: Late entry: Resident returned from the hospital today and is now on (company) hospice . There was no documentation that clarified the tube feed/nutrition order. 10/18/2025 08:00 . Note Text: Received morning report from night nurse and was notified that resident had not received his Glucerna feed since he left the hospital. The feed was not hung when he made it to the facility. This writer research and made calls to confirm orders. Feed was hung @ approximately 0745 hours, Hospice nurse came in to visit resident, this writer confirmed med list with hospice nurse. Resident currently receiving feed and relaxed in bed with call light in reach. There was no clarification who the nurse called for the order and if the Medical Doctor and/or Physician was notified of the missed tube feeding. 10/18/2025 12:38 . Note Text: Late entry: Resident appeared lethargic and eyes were rolling back as this writer was assessing resident and asking questions to keep him alert. Resident O2 (oxygen) sats (saturation) decreased from 94% to 72%. This writer increased O2 up to 5L (liters), which is the max on the concentrator. His O2 sat held @ 88% 20 bs (glucose level) 600. (ambulance) (company) hospice, the On-call physician, management, and (guardian) were all contacted. Resident transported to the hospital. On 12/17/25, at 10:20 AM, a record review along with the Director of Nursing (DON) of Resident #1's EMR was conducted. The DON was asked to review the admission assessment dated [DATE] and was asked what time Resident #1 was readmitted and the DON stated, 12:46 around that time. The DON was asked for assistance to provide/locate any hospice documents for that day as the DON offered, that the hospice nurse was in and accidentally took the hospital discharge medication list with them when they left. No Hospice documents were located in the EMR. A review of the miscellaneous tab in the EMR for Resident #1 revealed no discharge instructions/medication list from their hospital discharge on [DATE] AM. The DON was asked to provide active Physician Orders for Resident #1 for the admission on [DATE]. On 12/18/25, at 11:24 AM, a record review along with the DON of the Active Orders as of: 10/17/2025 for Resident #1 was conducted which revealed no tube feeding/nutrition directions and/or orders. The DON was asked why Resident #1 did not receive tube feeding/nutrition the day of readmission and the DON offered, He got it the next morning when we got here. The DON clarified there was no physician's order for the tube feed/nutrition and or administration documentation on the MAR. The DON was asked if they were notified of the lack of tube feeding/nutrition for nearly 19 hours and the DON stated, No I was not and I just saw that note. The EMR revealed no notification to the physician of the missed tube feeding/nutrition and the DON was asked if the doctor was notified and the DON responded, they need to review the hospice documentation before they answer any more questions. The DON offered, they contacted the hospice company to get the records and there may have been a hospice reason as to why they did not provide the tube feeding. On 12/18/2025, at 11:35 AM, an interview with Assistant Director of Nursing (ADON) A was conducted with the DON present. ADON A was asked if they did see Resident #1 on 10/17/2025 and ADON A offered, that they did and assessed their wounds on their skin. ADON A offered, they do remember the hospice nurse at bedside with the discharge medication list/orders from the hospital and does believe the hospice nurse took them that day. ADON A was asked if they had to roll the resident to assess their skin and ADON A offered, yes. ADON A was asked if the resident had their tube feed/nutrition hooked up that day and ADON A along with the DON clarified that Resident #1 did not have tube feeding</p>		

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>(continued on next page)</p>

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<p>F 0726</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2677656. Based on interview and record review the facility failed to clarify admission orders, reconcile medications, provide medications timely, and coordinate with hospice and the physician for two residents (Resident #1, Resident #3) of three residents reviewed for nursing care resulting in delayed care and rehospitalization. Findings include. Resident #1: On 12/17/25, at 9:30 AM, a record review of Resident #1's electronic medical record (EMR) revealed a readmission on [DATE] with diagnoses that included Chronic Hypoxic Respiratory Failure, Severe protein-calorie malnutrition, Septic shock, Diabetes Type 2 and Gastrostomy. Resident #1 had severely impaired cognition. A review of the . admission Assessment Date: 10/17/2025 12:46 . revealed Resident #1 was readmitted at 12:46 PM. There was no hospice documents scanned into the EMR that clarified when the hospice company/nurse visited the resident on 10/17/25. A review of the Physician orders revealed no order for enteral feeding/nutrition for the Resident #1 and the following order NPO (Nothing By Mouth) . Start Date 10/17/2025 . A review of the MEDICATION ADMINISTRATION RECORD 12/1/2025 - 12/31/2025 revealed no documented administration of enteral feeding/nutrition on 12/17/25 or 12/18/25. A review of the Progress Notes revealed the following: 10/17/2025 14:30 . Note Text: Late entry: Resident returned from the hospital today and is now on (company) hospice. This wound care nurse performed a skin assessment on resident since returning from (hospital). Resident has DTIs to b/l buttocks and his rt heel, per hospital documentation these DTI's were formed while resident was in their hospital. Foam dressings were applied to each DTI at this time. Resident does continue to have lt great toe wound and lt medial foot wound that were present prior to medial foot wound that were present prior to hospitalization. Both of these wounds are stable and left OTA, but will continue to be monitored. Resident agreed to assessment and photographic documentation of his wounds. Resident agreed to have staff continue to monitor and treat wounds, as well as allow staff to reposition him every 2 hours and PRN. Resident was education on the importance of wearing his prafo boots while in bed. This RN placed prafo boots on resident at this time. Resident's nurse, (name) aware of all these findings. 10/18/2025 08:00 . Note Text: Received morning report from night nurse and was notified that resident had not received his Glucerna feed since he left the hospital. The feed was not hung when he made it to the facility. This writer research and made calls to confirm orders. Feed was hung @ approximately 0745 hours, Hospice nurse came in to visit resident, this writer confirmed med list with hospice nurse. Resident currently receiving feed and relaxed in bed with call light in reach. There was no clarification who the nurse called for the order, what rate and the type of enteral nutrition and if the Medical Doctor was notified of the missed tube feeding. 10/18/2025 12:38 . Note Text: Late entry: Resident appeared lethargic and eyes were rolling back as this writer was assessing resident and asking questions to keep him alert. Resident O2 (oxygen) sats (saturation) decreased from 94% to 72%. This writer increased O2 up to 5L (liters), which is the max on the concentrator. His O2 sat held @ 88% 20 bs (glucose level) 600. (ambulance) (company) hospice, the On-call physician, management, and (guardian) were all contacted. Resident transported to the hospital. There was no progress note that documented any contact to the Physician, the hospital for discharge medication list/orders and no contact to the hospice company who was accused of taking the hospital discharge paperwork. On 12/17/25, at 10:20 AM, a record review along with the Director of Nursing (DON) of Resident #1's EMR was conducted. The DON was asked to review the admission assessment dated [DATE] and was asked what time Resident #1 was readmitted and the DON stated, 12:46 around that time. The DON was asked for assistance to provide/locate any hospice documents for that day as the DON offered, that the hospice nurse was in and accidentally took the hospital discharge medication list with them when they left. A review of the miscellaneous tab in the EMR for Resident #1 along with the DON revealed no discharge instructions/medication list from their hospital discharge on [DATE] AM. The DON was asked to provide active Physician Orders for Resident #1 for the admission on [DATE]. On 12/18/25, at 11:24 AM, a record review along with the DON of the Active Orders As Of: 10/17/2025 for Resident #1 was conducted which revealed no tube feeding/nutrition directions and/or orders. The DON was asked why Resident #1 did not receive tube feeding/nutrition and the DON offered, He got it the next morning when we got here. The DON clarified there was no physician order for the tube feed/nutrition and or administration documentation on the MAR. The DON was asked if they were notified of the lack of tube feeding/nutrition for nearly 19 hours and the DON stated, No I was not and I just saw that note. The EMR revealed no notification to the physician of</p>		