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	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caretel Inns of Tri-Cities	6700 Westside Saginaw Road Bay City, MI 48706

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure food palpability and preferred temperature for a total of 8 resident's (Resident's #2, #13, #22, #26, #63 and #66), and follow provided food menu for a census of 53 of 53 resident's, resulting in the potential for weight loss, dislike of facility served foods, anger towards dietary department and management, refusing to eat served foods, and relying on family member's to bring in favored foods. Findings Include: Observation made on 8/6/25 at 10:26 a.m., in the main dining room revealed the facility food menu posted was dated July, 2025. Resident #26:Review of Face Sheet and Minimum Data Set/MDS dated 3/25, revealed Resident #26 was admitted to the facility 3/25, and was alert and able to be interviewed.During an interview done on 8/5/25 at 12:19 p.m., the resident revealed she did not like what the facility served, she often requested a cheeseburger which was overcooked and hard to chew. The resident said the facility serves the same foods over and over again.Resident #2:Review of Face Sheet and Minimum Data Set/MDS dated 2/25, revealed Resident #2 was admitted to the facility 2/11/25, and was alert and able to be interviewed.During an interview done on 8/5/25 at 9:53 a.m., Resident #2 said he hates the food, and the staff do not give him anything else if he does not like the food. The resident was upset about the food; he said it was often cold.Resident #13:Review of Face Sheet and Minimum Data Set/MDS dated 5/25, revealed Resident #13 was admitted to the facility 5/15/25, and was alert and able to be interviewed.During an interview done on 8/5/25 at 10:23 a.m., the resident stated, I don't like the food, it's the same thing all the time.Observation of the noon meal done on 8/6/25 at 12:15 p.m., revealed the following: -The majority of residents had 1 toco on their plate with rice. The toco's of several residents had grease dripping out of them when picked up to eat; plates were noted to have an excessive amount of pooling dark amber colored grease on them. There was 1 to 2 pieces of lettuce on each toco, and several observed had wilted lettuce. During an interview done on 8/6/25 at 11:00 a.m., Dietary Manager V stated Some did not get eggs this morning, she (one of the cooks) never told me we did not have eggs. We did have eggs, but they were frozen. I did see the grease (on toco's) yesterday (on 8/5/25). I did tell her (cook) to drain the meat. Review of the facility Resident's Council notes revealed the following: -On 3/27/25: Chef will come put and see what food is served.-On 4/24/25: Wrote up concern about meat, not having items, getting what ordered.-On 6/5/24: Tastes bad (served food), often cold, dislikes options.-On 7/10/25: Portion sizes questions, options for diabetics, wonder if too many carbs.During an interview done on 8/6/25 at 1:20 p.m., Director of Activities N stated We do hear complaints in the meeting (Resident Council meeting), I believe we are down in the kitchen. (Kitchen Manager V) does come to the meetings (Resident Council).Review of the facility Food & Nutrition Services Organization & Staff Competency Checklist Dining Observation Meal Services checklist (un-dated), revealed staff were to ask and address if the food served was the residents preference.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare and store food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food in the kitchen.Findings include: On 08/05/2025 at 9:30AM During the kitchen tour with the Manager of Kitchen V, observed the inside of the ice machine visibly soiled with black residue in the sub kitchen in [NAME] hallway. When interviewed about the cleaning schedule of the ice machine, the Manager of the Kitchen V stated Maintenance is supposed to clean it. and proceeded to tell staff not to use the ice in that machine. On 08/05/2025 at 11:45AM during lunch observation, observed [NAME] W removing gloves and then proceeding to don gloves without washing hands while preparing lunch. According to the 2022 Food Code 4-602.11 Equipment Food-Contact Surfaces and Utensils, Surfaces of utensils and equipment contacting food that is not time/temperature control for safety food such as . ice makers, and ice bins must be cleaned on a routine basis to prevent the development of slime, mold, or soil residues that may contribute to an accumulation of microorganisms.Record review of facility policy Food & Nutrition Services/Sanitation and Food Safety states Food and nutrition services employees will thoroughly wash their hands and exposed areas of their arms with soap and water in the designated hand-washing sink at the following times: .Between removing gloves or aprons and before putting on new gloves or aprons. According to the 2022 Food Code, 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single -use articles and . before donning gloves to initiate a task that involves working with food.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to 1) maintain clean wheelchairs for 5 resident's (Resident's #6, #15, #38, #41 and #44), 2) ensure a clean and comfortable environment for randomly selected resident rooms and 3 of 4 hallways (Hall's 100, 200, and 400), and 3) maintain plumbing in good repair, for a census of 53 resident's, visitors and staff, resulting in the potential for cross contamination, resident illness, complaint's of resident environment cleanliness, and flooding concerns regarding plumbing. Findings Include: DPS 2 Based on observation and interview the facility failed to maintain plumbing in good repair. This deficient practice increases the likelihood of contamination of the water supply, potentially affecting any or all staff, residents, and visitors in the facility. Findings include: Observation of 100 hall was done on 8/5/25, starting at approximately 9:20 a.m., the following was found: -In the hallway (at 10:07 a,m,), numerous black scuff marks on walls and resident doors. -Room103 had food and pieces of paper on the floor, the walls had scuff marks on them and the corners of the wall molding had paint chipped off. -room [ROOM NUMBER] had pieces of paper on it, walls were scuffed up and bathroom floor was dirty. -room [ROOM NUMBER] (at 9:57 a.m.) had food under and on the right side of the bed, and pieces of paper on it. The bedside table had a “sticky” substance on top of it and a urinal was on the floor partly under the bed. Part of the wallpaper above the white rail was torn off and the bathroom floor was dirty. Observation of 400 Hall was done on 8/6/25 at 1:30 p.m., revealed a large gray trash bin with food and dirty medical gloves inside, sitting in the hallway in front of the office, with no lid on it. During an interview done 8/6/25 at 10:30 a.m., Housekeeper “L” stated We do surfaces, dust, vacuum or mop in the resident's rooms. In the bathrooms we clean the toilet, sink and floor. I come in at 7am, we get in the rooms at around 10am. Housekeeper “L” said they have to do public area's first before they start on resident's room's and they only have 2 Housekeepers for all resident's rooms. During an interview done on 8/5/25 at 1:41 p.m., Housekeeping Supervisor “M” stated “Yes, there are complaints about the room's (resident room's) about wallpaper, marks on wall's, dirty carpet's; our carpets are stained and nasty. The problem is we need new floors. We are trying to get the wallpaper down; the public area's first. They (Housekeepers) are supposed to be in the resident's room about 9:00 a.m.; I have 2 housekeepers for the LTC (Long Term resident room's, census: 53). They (Housekeepers) clean about 25 to 26 rooms plus public areas. I have asked for more Housekeepers; I don't understand how they think two Housekeepers can do everything. The families came to me with complaints about the rooms. We shouldn't have any trash cans in the hallways, and they need tops.” (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility Morning Run 7-3 Person sheet (undated), revealed Housekeeping were to vacuum, clean public bathrooms, the movie theater, breakroom, therapy's, cottage, therapy, and family dining room. Review of the facility resident room list of what to clean in each room list (given to the Housekeepers daily) revealed staff were to clean daily the toilet, bathroom mirror, sink, showers, dusting, floor, bed table, TV, TV stand, marks off walls, vacuum floors, mop floors, spot clean carpets, window as needed, window seals, empty trash. During an interview done on 8/7/25 at 12:49 p.m., Infection Control, RN Nurse “S” stated “I do daily morning sweeps and I look into the resident's rooms. I do tell them at the Infection Control meeting that Housekeeping should do a better job, but they don't have the money to hire more.” Infection Control Nurse S said she did not document any observations of IC rounds on hallways nor resident rooms. On 8/5/2025, during initial screening of facility residents, it was observed that some of their wheelchairs were soiled with strands of hair, dried on/sticky substances and dust/debris. The residents reported their wheelchairs had not been cleaned during their time at the facility. The following residents were observed: Resident #6 Was observed in his room watching television, both footrests were observed with a layer of dust, debris and sand like particles building up at the back of footrests. Other outer areas of the wheelchair were also soiled, with the crevices of the chair with particle buildup. The Resident reported he does not believe his chair has been cleaned since he admitted to the facility. Resident #38 Was observed in his room after morning care was completed. His chair was observed to have red, tacky substance on the wheels, the crevices of the chair were riddled with unknown built up material. The area by the wheelchair brakes had built-up particles. Resident #15 Was observed in her room finishing breakfast. She reported her wheelchair has not been cleaned in the 1.5 years that she has been a resident of the facility. She stated she was informed staff are supposed to clean her wheelchair when is showered. Her chair was observed to have unknown debris particles in some areas. During Resident Council on 8/6/2025 at Resident #41 was asked when the last time her wheelchair had been cleaned. She reported it is not routinely cleaned by facility staff. On 8/6/2025 at 4:00 PM, the DON (Director of Nursing) was asked who is responsible for cleaning resident wheelchairs. She reported the aides are responsible for cleaning the resident chairs. The DON observed the soiled wheelchairs of Resident #6 and #38. Resident #44 was observed sitting by the nurses' station in her wheelchair was observed to be riddled with a slew of unknown particles, hair and dust. The DON reported she will enact a process to ensure resident chairs are cleaned going forward. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/7/2025 at approximately 10:30 AM, a review was conducted of Resident #6's medical records. It revealed the resident admitted to the facility on [DATE] with diagnoses that included, Major Depressive Disorder, Diabetes, Ataxia, Anxiety, Insomnia and Heart Disease. On 8/7/2025 at approximately 10:45 AM, a review was conducted of Resident #15's medical records. It revealed the resident was admitted to the facility on [DATE] with diagnoses that included Diabetes, Hypokalemia, Syncope and Collapse and Orthostatic Hypotension. On 8/7/2025 at approximately 11:00 AM, a review was conducted of Resident #38's medical records. It revealed the resident was admitted to the facility on [DATE] with diagnoses that included Ataxic Cerebral Palsy, Hyperlipidemia, Hemiplegia and Hemiparesis. On 8/7/2025 at approximately 11:10 AM, a review was conducted of Resident #41's medical records. It revealed the resident admitted to the facility on [DATE] with diagnoses that included, Bipolar, Anemia, Major Depressive Disorder and Paroxysmal Atrial Fibrillation. On 8/7/2025 at approximately 11:15 AM, a review was conducted of Resident #44's medical records. It revealed the resident was admitted to the facility on [DATE] with diagnoses that included, Delusional Disorder, Alzheimer's Disease, Adjustment Disorder, Dementia and Hypertension. It can be noted there was no documentation located in the above charts related to wheelchair cleaning. DPS 2 On 08/05/2025 at 12:26 PM, observed the atmospheric vacuum breaker missing from the top of the utility sink in Bay 1, leaving the water system open to the environment. When the utility sink was turned on, water began to spew out from the top where the missing vacuum breaker was supposed to be. On 08/05/2025 at 12:26 PM, during an interview with Maintenance Director T on the broken atmospheric vacuum breaker, he stated the vacuum breaker has been ordered and when asked about the policy and procedure of when things are repaired, he stated whenever they notice it's broken, they'll fix it.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Bassed on observation, interview and record review, the facility failed to ensure a dignified dining experience and follow care planned interventions for 6 residents (#22, 27, 28, 29, 33, 38 and 44) out of 10 residents reviewed during dining task, resulting in no assistance offered, food spills on clothing, fluids not offered, meals not served timely and in a dignified manner with the likelihood of overall decreased nutritional intake. Findings include:On 8/05/2025, at 12:20 PM, During dining task in the small dining room the following observations were made: On 8/05/2025, at 12:18, during dining task, Resident #38 was sitting at table alone asking if he can have some more pop. Resident #33 had a cup of soup that had spilled down his shirt, pants and all over the table. Resident #33 did not have on a clothing protector. There were no staff in the area. On 8/05/2025, at 12:19, Resident #33 was sitting alone at another table. There was an empty cup of soup with a spoon and no napkin. Resident #33 had spilled soup onto their clothing and face. Resident #33 was using the tablecloth for a napkin. Resident #33 did not have a clothing protector on. There were still no staff in the area. On 8/05/2025, at 12:20 PM, Residents #27, 28, 29 and 44 were sitting in their wheelchairs. They were not offered any food items. On 8/05/2025, at 12:25 PM, Resident #33 was observed using the tablecloth to wipe their nose. On 8/05/2025, at 12:33 PM, Resident #44 now had their meal and quickly drank their cup of lemonade. Resident #44 had a second glass of lemonade out of reach. Residents #27, 28 and 29 still do not have their meals. On 8/05/2025, at 12:36 PM, Resident's #27, 28 and 29 still do not have their meals and were offered a glass of juice each which was placed in front of them on the table. No sips were offered. On 8/05/2025, at 12:39 PM, Resident #27 was being assisted with their shoes by CNA X. CNA X was asked if Resident #27 was going to eat lunch and CNA X stated, yes, but she's an assist. On 8/05/2025, at 12:41 PM, CNA H placed clothing protectors on Resident #33 and #38 walked over to Resident #44 cut their taco in half and walked away. Resident #44 was picking up their taco meat with their fingers. CNA H did not provide Resident #44 with their second glass of lemonade which remained out of reach. On 8/05/2025, at 12:43 PM, Resident #28 and Resident #29 were offered their meals and two staff sat down and assisted with their meals. On 8/05/2025, at 12:45 PM, Resident #44 continued to use their fingers to eat. No staff assistance was offered. Resident #44 still was not offered additional fluids to drink. On 8/05/2025, at 1:03 PM, Resident #44 remained seated at the lunch table. They were using their napkin to cover up spilled liquid from a plastic cup which appeared to be a supplement drink. The second full cup of lemonade remained out of reach. Resident #44 continued to consume their lunch with their fingers. On 8/06/2025, at 12:24 PM, during dining task in the small dining room the following observations were made: On 8/06/2025, at 12:24 PM, CNA H brought in silverware for Resident #38 although did not offer any to Resident #33. Resident #44 was offered a glass of milk. Resident #44 drank their milk and set their glass down. Resident #44 lifted their empty glass numerous times and attempted to sip milk from the empty glass. On 8/06/2025, at 12:38 PM, Resident #44 remained at the lunch table with no assistance. They continued to attempt to drink milk out of their empty glass. Moments later, Resident #44 placed their butter packet into their empty milk glass. Resident #44 ate their meal with their fingers and were not assisted by any staff. The resident did not receive any more fluids to drink and continued to pick up the empty glass as if there was a drink in it. The glass was filled with a butter packet and no fluids. On 8/06/2025, at 12:40 PM, the DON was asked if a certain staff member was assigned to the residents in the dining area and the DON provided the assignment sheet. The DON explained that the hall trays are passed first and the residents who are feeds are passed last. The DON was alerted of the lack of assistance noted in the dining room during the survey. On 8/06/2025, at 12:45 PM, Resident #44 was observed trying to eat their butter packet that they had removed from their milk glass. Unit Manager (UM) A was sitting behind the nurses' desk and was alerted that Resident #44 was trying to eat garbage out of their (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	empty glass. On 8/06/2025, at 1:30 PM, the following record reviews were conducted: Resident #27: A review of Resident #27's electronic medical record revealed a readmission on [DATE] with diagnoses that included Dementia, need for assistance with personal care and protein calorie malnutrition. Resident #27 required assistance with all ADL's and had severely impaired cognition. A review of the care plan I need help with my ADL's because I am confused and don't remember how to perform my ADL's . Interventions . EATING: I need assistance to feed myself. Date Initiated: 10/03/2020 . Resident #28: A review of Resident #28's electronic medical record revealed an admission [DATE] with diagnoses that include Alzheimer's disease, Dementia and Stroke. Resident #28 required assistance with all ADL's and had severely impaired cognition. A review of the care plan I have a nutritional problem r/t Dementia . Interventions . I need total assist with all meals Date Initiated: 11/07/2022 . Resident #29: A review of the electronic medical record revealed an admission on [DATE] with diagnoses that included Dementia, Alzheimer's disease and Dysphagia. Resident #29 had severely impaired cognition. A review of the ADL: Self-care deficit, require assist with ADLS . Interventions .Eating: I need assistance with eating. Date Initiated: 01/03/2025 . Resident #33: A record review of Resident #33's electronic medical record revealed an admission on [DATE] with diagnoses that included Parkinson's disease, Dementia and Need for assistance with personal care. Resident #33 required assistance with all Activities of Daily Living (ADL's) and had severely impaired cognition. A review of the care plan SKILLED THERAPY/ADL: Self-care deficit, require assist with ADLS . Interventions . Eating: I need limited assistance with eating please place all my liquids in a covered mug I would also like to use weighted silverware for my meals. Provide clothing protector for every meal. Date Initiated: 04/02/2025 . Personal hygiene: I need extensive assist of 1 to help me . Resident #38: A record review of Resident #38's electronic medical record revealed an admission on [DATE] with diagnoses that included Cerebral Palsy, Hemiplegia affecting left side and cognitive communication deficit. Resident #38 required assistance with all ADL's and had impaired cognition. A review of the care plan SKILLED THERAPY/ADL: Self-care deficit, require assist with ADLS r/t (related to) mobility, debility and impaired balance . Interventions . Eating: I am independent, set up my tray covered lids on all liquids. Date Initiated: 05/08/2025 . Please offer me a clothing protector at meals as I will allow. Date Initiated: 05/28/2025 . Resident #44: A review of the electronic medical record revealed an admission on [DATE] with diagnoses that included Dementia, Alzheimer's disease and a history of significant weight loss. Resident #44 had severely impaired cognition. A review of the care plan Risk for malnutrition . Interventions . Staff to assist with guest at meals to provide encouragement. Date Initiated: 01/02/2024 . Resident #22: On 8/05/2025, at 9:49 AM, Resident #22 was resting in their bed on their back. There was a plastic cup of water and a glass of water with a straw. On 8/06/2025, at 8:38 AM, Resident #22 was in bed flat. Their breakfast meal was on their overbed table and slightly pushed in front of them. Resident #22 complained they couldn't eat their oatmeal because I need milk. There was no egg on their breakfast sandwich and no milk on their tray. There was a regular coffee cup with a plastic lid. On 8/07/2025, at 8:20 AM, Resident #22 was in bed lying flat. Their breakfast was untouched. There was a strong urine smell in the room. There was a coffee cup and a small juice cup without handles on the tray. The cups did not have lids. On 8/07/2025, at 8:22 AM, the Nurse Manager (NM) C entered Resident #22's room. A record review of their meal ticket revealed mug with lid for all liquids. NM C was asked why Resident #22 did not have the lidded mug for their liquids and NM C offered, I am thinking the aides should be getting that. NM C was alerted the resident was resting all three mornings and hadn't appeared to have assistance with their breakfast meals. NM C offered, they would get the resident cleaned of urine and assist with their meal. A review of the facility provided policy Dignity DATE REVIEWED 4/24 revealed Each resident shall be care for in a manner that promotes and enhances quality of life, dignity, respect and individuality . Residents shall be treated with dignity and respect at all times .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to consistently provide scheduled showers to four (#15, #35, #35, #37) residents of four reviewed for Activities of Daily Living. Resulting in, unmet care needs and feelings of frustration. Findings Include: Resident #15On 8/6/2025 at approximately 8:20 AM, Resident #15 reported her shower days are Mondays and Thursdays, but she did not receive one this Monday. She continued if she does not ask if she is being showered on her scheduled day, many aides will not mention anything about it. Resident #15 stated she did refuse one shower as it was closer to midnight when the aide offered.On 8/6/2025, a review of the last 30 days of Resident #15's showers were completed. Within the 30-day period, Resident #15 was provided with one shower on 7/20/25. There was one progress note related to a shower provided on 8/1/2025 that was not listed in the 30-day look back document. On 8/7/2025 at approximately 3:45 PM, a review was conducted of Resident #15's medical records. It revealed the resident was admitted to the facility on [DATE] with diagnoses that included Diabetes, Hypokalemia, Syncope and Collapse and Orthostatic Hypotension. Further review yielded the following:Kardex: .I prefer a shower twice a week.Monday/Thursday night shift. During resident council on 8/6/2025 at 1:00 PM, Resident #35 & #37 stated they are not regularly receiving their showers as scheduled. They explained they have to ask staff for their showers and it is rare they will come in and say its their shower day.Resident #35On 8/6/2025 at approximately 3:30 PM, review was conducted of Resident #35's medical records and it indicated she was admitted to the facility on [DATE] with diagnoses that included, Dysphagia, Hypertension, Social Phobia, Major Depressive Disorder and Diabetes. Further review of the records yielded the following: 30-day Shower lookback:Over the last 30 days Resident #35 only received one shower on 7/31/2025.Kardex: .Bath: Wed/Sat night . Resident #37:On 8/6/2025 at approximately 3:45 PM, record review was conducted of Resident #37's chart and it revealed the resident admitted to the facility on [DATE] with diagnoses that included Obstructive Pulmonary Disease, Major Depressive Disorder, Hemiplegia, Hypertension, Polyneuropathy and Diabetes. Further reviewed yielded the following: 30-day Shower lookback:Resident #37 received a shower on the following days- 7/9/25- 7/16/25- 7/29/25- 7/30/25- 8/6/25 Resident #37's showers were not consistent and skipped weeks. Resident #4108/05/2025 at 3:50 PM, Resident #41 stated she is supposed to receive showers on Wednesdays and Saturdays, but she does not regularly receive them as scheduled. The resident stated she will ask about showers the day prior to remind them and typically when it's time for her shower the staff cannot be located. Resident #41 stated she should be able to be showered twice a week and it's frustrating that it does not occur. On 8/6/2025 at approximately 11:30 AM, a review was conducted of Resident #41's medical records and it indicated she was admitted to the facility on [DATE] with diagnoses that included, Atrial Fibrillation, Anemia, Bipolar Disorder and Hyperlipidemia. Further review yielded the following:30-Day Shower Look Back:Review was conducted of Resident #41's showers over the last 30 days and she only received three showers. It can be noted there is also progress note documentation of showers that is not listed in the look back document provided. It appears there is also a documentation issue surrounding resident showers. Kardex: Bathe: Every Wednesday and Saturday.I prefer a shower twice a week.On 08/06/2025 at 10:00 AM, Unit Manager A reported there was a recent staff meeting with the aides and they were informed of their responsibility to complete showers and subsequent shower sheet. Manager A now reviews all of the shower sheets and inputs a progress note, but this process just began recently.On 8/6/2025 at 1:15 PM, the DON (Director of Nursing) stated she recognized there was an issue with showers, and they are working on holding staff accountable. They are working on an actionable plan to rectify resident showers.Review was conducted of the facility policy entitled, Shower and/or Bathing, approved 7/25. The policy stated, .All residents will be offered the opportunity to bathe twice weekly. A complete shower will be taken under staff supervision at least weekly.document giving the shower/bed bath in (continued on next page)

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	08/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caretel Inns of Tri-Cities	6700 Westside Saginaw Road Bay City, MI 48706

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the medical record. If the resident refuses their shower and/or bed bath notify their nurse and try again later.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview the facility failed to ensure 3 of 4 medication carts were maintained clean and sanitized, free of crushed pills, pieces of loose papers and dust in the drawers, resulting in the likelihood of cross contamination, low medications count with increased cost and missed resident medications. Findings Include: Observation was made on [DATE] at 11:32 a.m., with Nurse, LPN I of the 300 Hall medication cart. During the observation the following was found: -Resident's #1 and #16 had partly used insulin pen's with no expiration date written on the sticker (sticker with open and expiration date spaces to fill in) on the pen. During an interview done on [DATE] at 11:32 a.m., Nurse I was unable to tell this surveyor when the insulin's expired, and why there was no expiration date on the resident's insulin pens. Nurse I stated yes, they need a expiration date. -In the med cart's third drawer on the bottom was a large area of a sticky substance, crushed medication, dust, small pieces of paper, 1 whole blue oval pill, and 1 round whole peach pill. Observation was made on [DATE] at 11:40 a.m., with Nurse, LPN J of the 200 Hall medication cart. During the observation the following was found: -In the second drawer was found 1 loose tan colored pill, crushed medications, small pieces of paper and dust on the bottom. -In the fourth drawer there was observed an area of a sticky substance on the bottom. During an interview done on [DATE] at 11:40 a.m., Nurse, LPN J stated We all clean the carts Observation was made on [DATE] at 11:45 a.m., with Nurse, LPN K of the 400 Hall medication cart. During the observation the following was found: -In the second drawer there was two cream colored round pills found on the bottom. During an interview done on [DATE] at 11:45 a.m., Nurse K said the nurses on third shift clean the medication carts. During an interview done on [DATE] at approximately 11:30 a.m., the Administrator revealed the nurse's on the night shift clean the medication carts. On [DATE], at 2:30 PM, Nurse “Y“ was observed pushing the medication cart behind the nurses station. Nurse “Y” then walked into the locked mediation room with another staff member. The medication cart was unlocked and facing outward towards the main lobby. Nurse “J” was standing at another medication cart in the lobby and was asked if the medication carts are supposed to unattended while unlocked and Nurse “J” looked at the unlocked medication cart and stated, No. The Director of Nursing (DON) was walking up the hallway and was asked if medication carts were to be left unattended while unlocked and the DON, stated, no. Nurse (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	“Y“ walked out of the medication room, stood in front of the medication cart and engaged the lock.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to maintain general cleanliness of clean linen and sanitary supply storage. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living, for any residents in the 100 and 300 hallways. Findings include: On 08/05/2025 at 12:26PM during the environmental tour with the Housekeeping Manager M and Director of Maintenance T, the cleaning supply room floor was visibly soiled with debris. During the interview with the Housekeeping Manager M, when asked what the cleaning schedule is, they stated they are coming in and sweeping the floor on a regular basis. On 08/05/2025 at 1:00 PM observed clean linens stored on the floor of the clean linen room in 300 hall. Housekeeping Manager M proceeded to pick up the clean linens from the floor and removed them from the clean linen closet. On 08/05/2025 1:05PM observed unused urinal on floor along with other trash in the clean linen closet in the 100 hall. The Housekeeping Manager M proceeded to pick up the urinal and trash and removed them from the clean linen closet. While removing the urinal from the closet, the Housekeeping Manager M commented I'm not even sure how that got in here.

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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** Based on interview and record review the facility failed to ensure one resident (#6) of one reviewed for behavioral health had an accurate mental health diagnosis.Findings Include:On 8/7/2025 at 10:40 AM, Social Worker P was queried regarding Resident #6's diagnosis of paranoid schizophrenia and current medication regime. She reported he is not prescribed any medications for his schizophrenia diagnosis. She was asked to provide further documentation on if his diagnosis was long standing or newly added. We reviewed his diagnosis list that revealed the Paranoid Schizophrenia diagnosis was initiated upon admission and the physician note dated 5/3/24 that stated, history of paranoid schizophrenia. Social Worker P reported after investigation it was found it was an incorrect diagnosis as it was unsubstantiated from the Level II OBRA completed in May 2025 and unsubstantiated by their contracted psychiatric group who evaluated him as well. Social Worker P was asked why the diagnosis was indicated if it was inaccurate and why it was still listed in his record if they have known for three months that it was a mistake on their end. The Social Worker shared she as unsure where the physician garnered the information to make the diagnosis and it should have been removed from his medical record timely. On 8/7/2025 at approximately 11:00 AM, review was conducted of Resident #6' medical record and it indicated he was admitted to the facility on [DATE] with diagnoses that included, Paranoid Schizophrenia, Anxiety, Insomnia, Diabetes and Hypertension. MDS (Minimum Data Set) Assessment reviewed indicated the Paranoia Schizophrenia diagnosis in 2/14.2025, 5/13/2025 and 8/14/2025. Further review yielded the following:Physician Notes:5/6/2024: .(Resident #6) is a [AGE] year old right handed divorced male with PMH of acute coronary artery disease s/p PTCA.generalized anxiety, major depressive disorder, paranoid schizophrenia.5/9/2024: .(Resident #6) is a [AGE] year old right-handed divorced male with PMH of acute coronary artery disease s/p PTCA.generalized anxiety, major depressive disorder, paranoid schizophrenia. 5/13/2024: .(Resident #6) is a [AGE] year old right handed divorced male with PMH of acute coronary artery disease s/p PTCA.generalized anxiety, major depressive disorder, paranoid schizophrenia. 5/16/2024: .(Resident #6) is a [AGE] year old right handed divorced male with PMH of acute coronary artery disease s/p PTCA.generalized anxiety, major depressive disorder, paranoid schizophrenia.5/26/2024: .(Resident #6) is a [AGE] year old right handed divorced male with PMH of acute coronary artery disease s/p PTCA.generalized anxiety, major depressive disorder, paranoid schizophrenia. Level II OBRA 6/2/2025 DSM Diagnoses: Major Depressive Disorder, Recurrent episode, Moderate - Primary, Generalize anxiety disorder, Unspecified Personality Disorder.(facility) sent (Community Mental Health) change in condition 3877 form due to facility social worker reporting that while reviewing his medical records, it was discovered that he had been psychiatrically hospitalized in November 2024. Moreover, there have been behavioral health medications changes since his admission and additional mental health diagnoses. According to the CIC received on May 7, 2025, (Resident #6) is diagnosed with anxiety disorder, unspecified: paranoid schizophrenia; claustrophobia: major depressive disorder, recurrent, unspecified; insomnia; anxiety disorder.Nursing facility staff reported (Resident #6) diagnosis of Paranoid Schizophrenia was given to him by a medical physician from the nursing facility. A review of (Resident #6's) admission note from is physician at (the facility) dated May 3, 2024, states history of paranoid schizophrenia. Nursing facility staff are uncertain why he was given this diagnosis and what his symptoms were that led to the diagnosis.(Resident #6 stated he received a diagnosis of paranoid schizophrenia last year but does not know how he got this. (Resident #6) reported he feels this is an inaccurate diagnosis. He denied having delusions and/or hallucinations. Psychiatric Evaluation 5/30/2025: .Major Depressive Disorder, recurrent, severe with psychotic symptoms, Generalized Anxiety Disorder, Claustrophobia. Resident #6 does have mental health diagnoses but does not have Paranoid Schizophrenia, the facility physician diagnosed the resident and there was no further clarification or query regarding this. From the review of the record Resident #6 did not display persistent signs/symptoms of the diagnosis.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review, the facility failed to provide food items per scheduled menu for all residents and failed to provide milk per menu for Resident's #22, 63, 64, 65 and 66) of a census of 53 out of 53 residents who eat facility provided meals, resulting in frustration, no breakfast egg, no milk and overall likelihood of hunger. Findings include. Resident #63 On 8/06/2025, at 8:28 AM, Resident #63 was resting in bed with their breakfast tray on their overbed table untouched. There was no egg on their breakfast sandwich. There was no milk provided. A record review of their meal ticket revealed . EGG, SAUSAGE & CHEESE SANDWICH . 2% MILK . On 8/06/2025, at 8:38 AM, Resident #22 was in bed flat. Their breakfast meal was on their overbed table and slightly pushed in front of them. Resident #22 complained they couldn't eat their oatmeal because they needed milk. There was no egg on their breakfast sandwich. There was no brown sugar on the tray. A record review of their meal ticket revealed . EGG, SAUSAGE & CHEESE SANDWICH . [NAME] Sugar was written on the meal ticket. On 8/06/2025, at 8:39 AM, Resident #64 did not receive an egg on their breakfast sandwich nor any milk. On 8/06/2025, at 8:45 AM, Resident #65 complained they did not get an egg on their sandwich, milk or oatmeal. On 8/06/2025, at 8:49 AM, Resident #66 complained they did not get an egg on their breakfast sandwich. On 8/06/2025, 8:50 AM, an observation along with the Director of Nursing (DON) of Resident #66's breakfast tray in their room was conducted. There was no egg on their breakfast sandwich The DON was alerted it appeared there were more residents that didn't receive egg on their breakfast sandwiches. On 8/06/2025, at 9:11 AM, an observation of the kitchen refrigerators along with the Dietary Manager V was conducted. DM V was asked if they ran out of eggs for the breakfast meal and DM V was unaware. The refrigerator housed a large container of boiled eggs and a few bags of liquid eggs. DM V asked [NAME] W if they cooked eggs for breakfast and [NAME] W offered, no they were frozen. [NAME] W further explained they did their check the night before but a 6:15 AM during preparation for breakfast they realized the liquid eggs were still frozen. [NAME] W was asked if they cooked any eggs for any of the residents and [NAME] W stated, no. [NAME] W was asked if they notified anyone and [NAME] W offered, no. [NAME] W was asked if they sent anyone to the local store to get eggs so they could follow the menu and [NAME] W did not answer. DM V offered to [NAME] W If you called me, I could have stopped and grabbed eggs. [NAME] W was asked why some of the breakfast trays did not have milk and [NAME] W stated, they call out the meal ticket and the CNA's get the drinks.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to honor food preferences and food allergies for two (Resident #38 and 66) out of two residents reviewed for food allergies and preferences, resulting in frustration of allergy food items being served, the likelihood of food allergy reactions and overall decreased nutritional intake. Findings include. Resident #66 On 8/05/2025, at 12:49 PM, Resident #66 was sitting in their room and complained they get food items they are allergic to. Resident #66 stated they get strawberry jelly almost every morning for breakfast and they are allergic to strawberries. There were strawberry jelly packets on their over bed table. Resident #66 had their lunch tray of a taco with a flour shell. They complained they had a wheat allergy. On 8/06/2025, at 8:49 AM, Resident #66 complained they were provided an English muffin (wheat) and complained they have not been offered gluten-free food items. On 8/06/2025, 8:50 AM, an observation along with the Director of Nursing (DON) of Resident #66's breakfast tray in their room was conducted. There was no egg on their breakfast sandwich which was an English muffin (wheat). The DON was alerted the resident also received a flour tortilla the day prior. Resident #38:On 8/06/2025, at 12:22 PM, Resident #38 was sitting at the lunch table in the dining area. They had what appeared to be cream of broccoli soup. Moments later, Resident #38 was offered their lunch tray that consisted of ham, scalloped potatoes and spinach. The resident spoke out and stated, I don't like spinach. Resident #38 was asked if they wanted something else by the surveyor and Resident #38 stated, yeah, a hotdog. DM V was alerted Resident #38 received all three food items they disliked and DM V approached the resident asked the resident if they would like a hotdog or something else. A record review of Resident #38's electronic medical record revealed an admission on [DATE] with diagnoses that included Cerebral Palsy, Hemiplegia affecting left side and cognitive communication deficit. Resident #38 required assistance with all ADL's and had impaired cognition. A review of the care plan . has nutrition risk due to small appetite . Interventions . Provide and serve diet as ordered. Date initiated: 05/15/2025 . There was no care planned intervention to follow food preferences. A record review of Resident #38's meal ticket revealed: DISLIKES: Broccoli, Spinach, Potatoes.