STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235646	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caretel Inns of Linden	202 South Bridge Street Linden, MI 48451

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2792791.Based on observation, interviews and record review, the facility failed to protect the resident's right to be free from physical abuse for one resident (Resident #102) by another resident (Resident #103), who attacked the resident at the dining room of nine (9) residents reviewed for abuse, resulting in a skin tear to R102's right hand and possible infection of the open wound. Findings include:According to the facility's incident report dated 2/14/26 at 2:30 PM, a female resident (R102) from 100 Hall was seated in her wheelchair in the dining room. Resident #103 (R103) approached and began to push the resident's wheelchair. The resident (R102) extended her right hand and asked R103 to stop. At that time, R103 reached toward the resident's (R102) right hand and grasped the top of her hand, resulting in a skin tear to the dorsal (top) right hand. During the same timeframe, R103 was observed grabbing and shaking other residents' wheelchairs in the dining room area. No additional injuries were noted.Seven (7) staff members statements were obtained by the facility, and all 7 indicated that the event was unwitnessed.Nurse D stated during the facility investigation that the phone call statement was written on 2/16/26: I did not see the incident between R103 and R102, CNA C came to get me and said R102 was bleeding. When she approached R102, R103was in his room. I assessed R102's bleeding hand.Nursing Assistant C (CNAC) during the facility phone call statement dated 2/16/26, was reviewed. CNA C statement revealed, I did not see the incident happen. Shortly before dinner, R102 was in the Dining Room and called for help. I went to go help. I saw R103 in his wheelchair next to R102. She had a skin tear on her hand. I redirected R103 back to his room and notified the nurse (Nurse E).Nursing assistant F (CNA F) during the facility phone call statement, dated 2/16/26, revealed I didn't witness or hear the incident. I saw R102's hand bleeding and held a wet washcloth on it until the nurse arrived.An interview with R102 was conducted on 3/2/26 at 1:15 PM. R102 had told the surveyor the story when she was attacked recently by a person who lives in the building. When she was asked what happened to her hand? She immediately stated, That the man stabbed me, and caused a skin tear on her right hand. R102 showed her right hand with a dressing dated 3/1/26. R102 described the details of the encounter, which she said was unexpected. When R102 was asked how the man stabbed him? She yelled, He dug his fingers between my thumb and index finger, and it hurts. R102 expressed that she does not feel safe, and the facility is not doing anything because the man continues to live here and can hurt me again or others. That's why she is staying in her room, because it is where she feels safe. R103 denied feeling safe in the facility after the incident. She is afraid it will happen again, and if it does, she will fight back.Resident #102 (R102):According to the Electronic Medical Record (EMR), R102 was admitted to the facility on [DATE], with the diagnoses of muscle weakness (generalized), need for assistance with personal care and difficulty walking, major depressive disorder, and type 2 diabetes mellitus with unspecified complications in addition to other diagnoses. According to the BIMS assessment dated [DATE], R102's Brief Interview for Mental Status (BIMS) score was 11/15. A BIMS score of 11 indicates moderate cognitive impairment. The Minimum Data Set (MDS) dated [DATE] revealed that R102 is independent with eating, requiring setup for personal hygiene and supervision during transfers. R102 (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is frequently incontinent with bladder elimination pattern and occasionally incontinent with bowel movement.An interview with R103 on 3/2/26 at 3:53 PM. R103 denied recalling any incidents with another resident. When R103 was asked if he felt safe in the facility, R103 asked the question back and said, Do you?Resident #103 (R103):According to the Electronic Medical Record (EMR), R103 was admitted to the facility on [DATE] with the diagnosis of Type 2 diabetes mellitus, dementia, psychotic disorder with delusions, mood disorders, and generalized anxiety disorder. R103's care plan specific for behavior revealed that R103 can be combative at times, wandering at other residents' rooms.hitting out at other residents. The care plan initiation date was 10/21/2025, and although the revision date was noted on 2/18/26, it did not include a specific action to manage his combativeness and protect other residents from harm or injury. Care plan continued as, Goal: The resident will have no evidence of behavior problems by review date. The date the goal was initiated was 10/21/25. Revision date was 11/24/25. Interventions were: 1. Caregivers to provide an opportunity for positive interaction with him/her as passing by. Date initiated: 10/21/25. Created on 10/21/2025.R103's behavior care plan was not updated following the resident-to-resident altercation on 2/14/2026. The goal and intervention remained unchanged despite an actual incident with another resident. No intervention added.An interview with the wound nurse on 3/3/26 at 10:55 AM confirmed that she saw the wound during wound rounds on 2/16/26. See assessments belowWound assessment#1 dated 2/16/26, (no time specified). First assessed as a new wound: Right Hand skin tearOnset date: 2/14/26Presence of pain: YESMeasurement:Length: 1.9 cmWidth: 2.31 cmArea: 2.94 cmLight Sanguinous drainage Wound Assessment #2 dated 2/25/26 (no time specified) most recent assessment showedLength: 1.79 cmWidth: 1.71 cmArea: 2.13 cmLight, Serosanguinous drainageWound observation was conducted with the wound nurse on 3/3/26 at 10:45 am. R102 stated the wound still hurts. When the wound dressing was removed, a moderate amount of serosanguinous drainage was noted on the old dressing. The wound nurse cleansed the wound, applied treatment, and covered the wound with the dry dressing as ordered.During the Social Worker A interview on 3/3/26 at 11:45 AM, SW A denied that R102 expressed fear or felt unsafe during her visits with her. However, when we both entered R102's room at approximately 11:50 AM on 3/3/26, R102 expressed that she was angry that the man was still roaming the facility and worried that it could happen to her again. R102 stated that she feels unsafe outside her room, and if the man (R103) comes near, she has a plan to fight back. R102 also mentioned only one staff member, whom she trusted and felt would protect her, but the nursing assistant was off that day.The Director of Nursing DON was interviewed on 3/2/26 at 3:00 PM. The DON admitted that there were no witnesses to the incident; however, everything was captured in the camera until the two residents were separated. That was how they were able to account the date and time it happened and what actually happened. Staff responded to the commotion and R102 screaming. We informed their guardian/POA immediately and treated R102's wound.Administrator interviewed on 3/2/26 and stated that the Resident-to-Resident Altercation between R102 and R103 was reported to the state, and we have concluded that in our 5- day report that the Physical altercation was substantiated.Abuse Policy was reviewed on 3/3/26 at 4:00 PM.According to the facility policy entitled: Abuse Prevention and Reporting Abuse (undated) Residents have the right to be free from abuse, neglect, exploitation, misappropriation of property, or mistreatment. This includes corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.The facility's Residents Rights Policy (undated) was reviewed on 3/3/26 at 4:30 PM.The policy indicated: It is the facility policy to implement procedures to protect resident rights.Resident Rights specifies: What are my rights in a nursing home?Be Free from Abuse and Neglect: You have the right to be free from verbal, sexual, physical, and mental abuse. Nursing homes can't keep you apart from everyone else against your will. If you feel you have been mistreated (abused) or the nursing home isn't meeting your needs (neglect), report this to the nursing home, your family, your local Long-Term Care Ombudsman, or State Survey Agency. The nursing home must investigate and report all suspected violations and any injuries of unknown origin within 5 working days of the incident to the proper authorities.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Numbers 2741938 and 2745566.Based on observation, interview and record review the facility failed to prevent significant medication errors for one resident (Resident #101) of 7 residents reviewed for medication errors. Findings include:Medication Error #1 Cyclobenzaprine:During the Med Pass (Medication Administration) observation conducted on 3/3/26 at 1:00 PM, Nurse G told the surveyor that R101 did not have her muscle relaxer available at 1:00 PM. Nurse G stated that R101's medication is available except for her pain medication called Cyclobenzaprine or Flexeril. Nurse G revealed that she received a report from the nightshift nurse this morning, who told her it was not available for R101's 5:00 AM dose. The medication was not available in the emergency back-up box either. Nurse G continued to explain that she learned about it from the night shift nurse during morning report, that R101's last dose was given on 3/2/26, and that it was signed out as administered at 2100 (9:00 PM). The night nurse called the pharmacy last night but was told it was too early to fill, and the next delivery for R101's Flexeril is not until 3/11/26. The night nurse hung up with the pharmacy and reported to the day shift nurse that Flexeril was unavailable. Missed doses were 2: 1 at 05:00 AM and 1 at 1300. The surveyor asked whether the physician on call was notified, whether the DON was aware, and when. Nurse G said she notified the DON at 12:20 PM on 3/3/26 after learning that the surveyor had scheduled a Med Pass observation with her today. Nurse G informed the DON, and the DON called the Pharmacy at 12:20 PM.The order was: Cyclobenzaprine HCL oral tablet 10 mg. Give 1 tablet by mouth every 6 hours for a muscle relaxer related to Hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side. Scheduled times were: 0500 (5:00 AM), 1300 (1:00 PM and 2100 (9:00 PM).Resident #101 (R101):R101 was admitted to the facility on [DATE], with the diagnosis of pain, anxiety disorder, hemiplegia, and hemiparesis following cerebral infarction affecting the left non-dominant side and depression in addition to other diagnoses. R101 has an opioid pain management care plan related to hemiparesis and hemiplegia following a cerebral infarction, as well as suprapubic urinary catheter care. According to the most recent MDS Assessment, R101 was wheelchair bound for all mobility and required a Hoyer lift for transfers.Nurse G stated that Resident was not administered her Flexeril at the 5:00 AM and 1:00 PM doses on 3/3/26. The pharmacy will be in for delivery tonight.Nurses noted on 3/3/26 at 2:39 AM that the nurse notified the DON that the medication was not available but did not call the physician.According to the physician (MDH H), during a phone call on 3/4/26 at 2:37 PM, no one had informed him or his associates regarding R101's Flexeril. It is considered a medication error if R101 missed a pain reliever, especially if scheduled around the clock, and the physician was not aware of it otherwise. We could have given an alternative order if the medication was not available for refill. MD H continued, and stated, Med errors must be in the logbook so we can address them immediately and assess the resident. MD H confirmed that he did not receive a call regarding R101's Flexeril. A missed muscle relaxer should have been called to the on-call associate to check the pain level and provide a backup if Flexeril was not available. We could have Baclofen as a temporary substitute.Medication Error #2 Fentanyl patch: R101 did not have a current physician's order:On 3/3/26 at 1:30 PM, it was observed that Nurse G was asked what the patch on R101's chest was. R101 requested that it be removed because it had been there for weeks. Nurse G consulted with the DON, and they confirmed that it was a Fentanyl patch with a date of 2/10. When asked why it was on R101 when R101 did not have an order for a Fentanyl Patch. The DON stated that she was unaware that R101 's Fentanyl patch was discontinued on 2/16/26, and it was discovered on 3/3/26 at 1:30 PM, still on R101's chest.The Director of Nursing (DON) was interviewed on 3/3/26 at 2:10 PM, re: the findings during the Med Administration:The DON stated that the night-shift nurse verbally told her that R101 was out of Flexeril but that it was too early to refill.The DON stated no. Unfortunately, a call was not made to the physician to let them know that Flexeril was unavailable and to request any (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further orders or instructions.The DON explained the reordering process, but it was too early to refill. They could not deliver. The DON was asked to explain what too soon means. The DON replied, My guess is they may have wasted some of the Flexeril, so they ran out. The surveyor asked: How many tablets are we talking about ? The DON counted 9 days were missing, and it is 3 tablets every eight (8) hours per day, which means 3 tablets X 9 days is equal to 27 tablets that were missing. The DON indicated that they immediately called the pharmacy at 12:20 PM on (3/3/26), and it is now scheduled to arrive tonight.The DON confirmed that the Flexeril tablet was not available for the R101, and 2 doses were missed on 3/3/26. One at 5:00 AM and another at 1:00 PM.A phone interview was conducted with the Midnight Nurse I on 3/3/26 at 2:55 PM. The DON and the surveyor were present during the call. Nurse I admitted she did not call or notify any provider regarding the Flexeril. She only called the pharmacy, and they told her, It is not due until March 11th. They have delivered 90 tablets for a 30-day supply.R101 Medication Administration Record (MAR) indicated a missed (blank) dose of Flexeril at 0500 AM on 2/23/26. R101 Pain level was recorded to be at 8/10. The facility provided the Pharmacy consultant's number on 3/4/26 at 9:24 AM, when it was requested on 3/3/26. The Pharmacist stated that:1. Re: R101's Fentanyl patch found on her body. There was no active order for the Fentanyl Patch; the patch should have been discontinued, as it could have a reaction with other current medications.2. The surveyor asked the pharmacist what happens if the Fentanyl Patch has been on the resident since it was discontinued on 2/16/26.Reply: The pharmacist stated that after 48 hours, the ingredients are not as potent as the actual dosage.3. The pharmacist explained why Flexeril is not available:The surveyor asked, Why is Flexeril not in the pharmacy back-up list?The pharmacist replied: The facility will let us know what they want in their backup box. If they didn't ask for Flexeril to be there, we don't put it there.Explain what too early to fill means? What happened with R101's Flexeril? Too early to fill- (approx., 10 days missing (q 8 hours). According to the pharmacy record, the pharmacy dispensed a 30-day supply on [DATE]; therefore, there should be enough Flexeril to take 3x a day until March 11th. Insurance will not cover the medications that are too early. Our policy is for the facility to authorize an early fill, such as the DON.Is missing 2 doses of Flexeril 10 mg a medication error? Yes, if it is a doctor's order as scheduled pain relief/ pain management medication.What should the facility do when the scheduled medication runs out? Is there a Policy? Policy is to inform the Pharmacy and authorize a drop ship based on the number of days until the refill. Informing the Pharmacy of errors like this can help track any discrepancies or diversion.What time was the Flexeril delivered at the facility on 3/3/26 for R101? The pharmacist stated it was not delivered until 6:42 AM on 3/4/26.Policies were reviewed on 3/3/26 at 4:30 PM:The Pharmaceutical Policy entitled: Organizational Aspects: IA1: Provider Pharmacy Requirements (dated November 2020)Policy: Regular and reliable pharmaceutical services are available to provide residents with prescription and nonprescription medications, services, and related equipment and supplies. A written agreement with a provider pharmacy stipulates financial agreements and the terms of the services provided. If the provider pharmacy also provides consultant pharmacist services and/or infusion therapy products, Separate contracts/ agreements are maintained for each service Procedures: . D. The provider pharmacy agrees to perform the following pharmaceutical services, including but not limited to:11. Implement procedures for when medication delivery is delayed or medications are not available.12. Providing, maintaining. and replenishing an emergency medication supply in a sealed and properly labeled container in a timely manner.Policy: Preparation and General GuidelinesIIA2: Medication Administration-General Guidelines:Policy Medication is administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system, to ensure safe administration without unnecessary interruptions.Procedures:A. Preparation: .4. FIVE RIGHTS_ Right resident, right drug, right dose, right route, and right time are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process .B, Administration .2. Medications are administered in accordance with written orders of the prescriber