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	04/14/2026

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 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** This citation pertains to intake Number 2970791.Based on observation, interview and record review, the facility 1) Failed to ensure that residents were monitored per orders for weight change. 2)Failed to ensure that a change of condition assessment was documented when a significant weight loss was identified, and. 3) Failed to update and revise a resident-centered care plan; resulting in delayed care contributing to a 9.23% weight loss in 7 weeks for one resident (Resident #1) of three residents reviewed for quality of care with weight loss. Findings include: Resident #1 (R1):A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated R! was admitted to the facility on [DATE] with diagnoses: history of weakness, diabetes mellitus type 2, protein-calorie malnutrition, gastro-esophageal reflux disease (GERD), bipolar disorder, dementia and hypertension. The MDS assessment dated [DATE] indicated the resident had impaired cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 10/15 and needed assistance with care.A record review of the intakes 2970791 and 2978921 was completed regarding concerns involving R1. A record review of R1's chart revealed weight documentation of: October 23rd, 2025, at 10:41am, weight #141.0 November 2025, no weight recorded. December 30th, 2025, at 16:55PM (4:55PM), weight 132.8 That indicated a weight loss of 5.82% between October -December. January 2026, no weight recorded. February 4th, 2026, at 16:54Pm (4:45PM), weight 143.0 March 24th, 2026, at 09:48AM, weight 129.8 That indicated a weight loss of 9.23% between February - March. April 8th, 2026, at 09:48AM, weight 129.8 On 04/14/2026 at 9:38AM, Resident was observed resting in bed with eyes closed and under blankets wearing a gown, there was a full cup of water with lid and straw on her bedside table. CNA B was in the room with R1's roommate, CNA B was asked if R1 had breakfast and CNA B said that R1 required feeding with meals and that she had not fed R1 that morning another CNA had and she was unsure of what or how much R1 had eaten. On 04/14/2026 at 9:40AM, during resident observation, Nurse A was asked about the resident baseline she said that R1 is often sleepy after her morning medications and breakfast. When asked how much of her breakfast R1 had eaten, Nurse A said she was unsure that the CNA A had fed her. On 04/14/2026 at 11:48AM, during an observation of R1 in the dining room in a Geri chair, she was fed lunch by CNA C 100% of meal, she had a divided plate and cup with straw during meal service. ~100% of meal was consumed. On 04/14/2026 at 12:20PM, during an interview with CNA C he was asked about R1's diet and need for assistance. CNA C said R1 had been eating better since her diet changed to pureed about a week ago, that it was easier for her to eat. CNA C said R1 had been on a streak for about 3 days eating 100% of her meals and reported that R1 could not feed herself.A record review of R1's (bedside care plan) revealed: Eating/Nutrition: Eating: I need limited assistance with self-feeding with divided plate, 2 handle cup with Hot Liquids for safety, encouragement to complete, Encourage adequate fluid intake.A record review of R1's Nursing care plan revealed: Focus: ADL: Self-care deficit, require assist with ADLS .; interventions: Eating: I need limited assistance with self-feeding with divided plate, 2 handle cup with Hot Liquids for safety, encouragement to complete, revision on: 02/25/2026.On 04/14/2026 at 12:25PM, during an interview with Nurse A was observed administering medications to R1. R1 was unable to coordinate holding the cup to drink fluids offered and was a total assist. When Nurse A was asked about R1's need for (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	extensive assistance she said that R1 had some improvement a couple months ago when she had therapy but had required complete assistance with eating and drinking since that ended. When Nurse A was asked why R1 was no longer in therapy she said, ?she thought it was because of insurance'. Nurse A was asked about restorative therapy, she said I don't think so. On 04/14/2026 at 12:45PM, during an interview with R1 she said she eats enough most of the time, when asked to clarify most of the time she said that she liked some foods more than others and eats more at those times. When R1 was asked if she was able to eat better since they changed her diet to pureed, she nodded yes. A record review of physician assistant (PA) progress notes revealed: Date of service: 03/09/2026: History of Present Illness: Resident is a debilitated female seen today in regards to worsening ability to perform ADLs and generalized decline. She is resting in bed in no acute distress. Nursing staff relay resident is again a total feed and are concerned about her level of weakness. Plan: Weakness/debility. Order resident to be weighed, check labs and reassess upon completion for further recommendations. According to records, resident is eating approximately 50% of meals with assistance. Date of service: 03/18/2026: History of Present Illness: Resident is a female seen today in regards to debility and decreased oral intake per nursing staff request. She is resting in bed appearing quite weak. Resident has been consuming approximately 25-50% of meals as of late which is concerning. Last documented weight noted on 2/4/2026 at 143 pounds. Resident refusing to get. Plan: Anorexia (loss of appetite) Resident to be weighed, further evaluation to follow. Date of service: 03/26/2026: History of Present Illness: Resident is a female seen today in regards to weight loss.Last documented weight noted on 3/24/2026 at 129.8 pounds as compared to a previous weight of 143 pounds on 2/4/2026. It is noted that resident is eating approximately 25-50% of meals and sometimes 0% as of late. Plan: Weight loss Discussed with resident option of adding Remeron (antidepressant with side effect of improved appetite) which she agrees. Start Remeron 15 mg daily and monitor for efficacy. Registered dietitian to follow to increase caloric intake, continue 2 cal.A record review of Dietary progress notes revealed: no notes after October 25th, 2025, to February 25th; and no notes after February 25th, 2026, until April 1st, 2026. ?4/1/2026 15:03 Dietary Progress Note. WEIGHT WARNING: Value: 129.8 Vital Date: 2026-03-24 . -7.5% change [9.2%, 13.2]. LCS (low concentrated sugar) puree, thin liquids, res downgraded to puree for pocketing and SLP (speech language therapist) picked up. PA reviewed on 3/26 Remeron added for weight loss and possible to help with appetite.' ?4/8/2026 11:10 Dietary Progress Note. WEIGHT WARNING: Value: 129.8.-7.5% change [9.2% , 13.2] Weight loss x 2 months noted, and stable x 2 weeks at this time. RD did review PA at this time and will increase Remeron.'A record review of Dietary review notes revealed the most recent note dated 02/13/2025: 2/13/2026 09:33; Dietary Review: This dietary review has been completed due to Monthly. Resident is eating 51-100% of LCS, Mechanical soft diet. Weight hx (history): 2/4 - 143#, 12/30 - 132.8#. Receives Mech Soft/2 calorie supplement 2x day. Resident receiving supplement to encourage weight gain.Continue 2 cal BID.RDN will monitor po intake, weight, and labs.On 04/14/2026 at 3:30PM, during an interview with registered dietician (RD) F was asked about R1's weight history and missing months of November 2025 and January 2026, she said it was a standard of practice that residents are weighed monthly unless otherwise needed/ordered. RD F' sad that she only worked at the facility on Wednesdays. She said that she was unsure of why R1 had no recorded weights for November 2025 and January 2025 and stated, I was on maternity leave and clarified her leave was from November until the end of February. RD F said she was not aware of R1's weight loss in December, it would have been addressed by another RD. RD F said that she talked to the PAG about R1's weight loss in March and that the PA G ordered Remeron 15mg once a day for R1 on 03/27/2026 for major depression and appetite. RD F said that on 04/01/2026 that she increased R1's 2 cal supplement for 2 times a day to 3 times a day and ordered that R1 had weekly weights. RD F said that on 04/08/2026 she downgraded R1's diet to pureed and changed it to a liberated diet. When asked what a liberated diet meant she explained it was a regular diet and no longer was an LCS diet. RD F said that on 04/08/2026 PA G increased R1's Remeron to 30 mg daily. RD F said ?we are (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring R1's weights for stability now'.A record review of R1's Diet and supplement orders revealed: Revision date 04/01/2026: 2 calorie per ml Supplement; directions: three times a day 4oz. and Revision 01/12/2026: LOW CONCENTRATED SWEETS diet, Mechanical Soft texture, Thin consistency Revision 03/27/2026: LOW CONCENTRATED SWEETS diet, PUREED texture, Thin consistency Revision date 04/14/2026: Standard Diet., PUREED texture, Thin consistency; directions: total assistA record review of medication orders revealed: start date 03/28/2026: Remeron Oral Tablet 15 MG (Mirtazapine) daily and start date 04/09/2026: Remeron Oral Tablet 30 MG (Mirtazapine) dailyA record review of R1's orders for weights revealed: revision 10/7/2024: Weigh weekly and record x4 weeks. There were no additional orders for weight in the current medical record. A record review of the facilities guideline weight revealed: GUIDELINE:1. All residents will be weighed on admission, readmission, weekly for the first 4 weeks and then at least monthly. 2. Weekly weights will also be done with a significant change of condition, food intake decline that has persisted for more than one week, or with a physician order. The facility may weigh residents using the same scale, at the same time of day and in the same way each time they are weighed .A record review of the facilities guideline weight change investigation revealed: GUIDELINE:1. The weight change investigation will be initiated with the following: a. A significant weight change of 5% or more in one month, 7.5 % or more in 3 months and/or 10% or more in 6 months. b. An insidious weight change of 5 pounds or more in 2 consecutive months. The weight change investigation will occur each month until the weight has stabilized .A record review of R1's orders for dietician revealed: revision 12/31/2025: Dietitian to assess weight loss and poor nourishment.A record review of R1's orders for speech therapy (ST) revealed: revision date 12/31/2025. ST to evaluate dysphagia and pocketing. revision 04/01/2026: ST evaluation and ST to treat 3x/wk for 90 days to address. Dysphagia, oropharyngeal phase (involves tongue and pharyngeal muscles to propel food)A record review of R1's dietary care plan created on: 10/09/2024 with revision on: 01/19/2026 revealed: Focus: (R1) is at risk for malnutrition MNA=10. significant weight loss x 1mo, decreased mobility with interventions: Monitor/record/report to MD PRN s/sx of malnutrition: Emaciation (Cachexia),muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. Date Initiated: 10/09/2024; Obtain and monitor weight report for any significant change. Date Initiated: 10/09/2024; RD to evaluate and make diet change recommendations PRN. Date Initiated: 10/09/2024; Weigh at same time of day and record: monthly or as needed. Date Initiated: 10/09/2024. There were no revisions in R1's care plan Department: Dietary when evaluated and documented as revised on 01/19/2026. Care plan also revealed diet/supplements and medication related to appetite in care plan as revealed in the dietary care plan interventions: Administer medications as ordered. Monitor/Document for side effects and effectiveness. Date Initiated: 10/09/2024; Provide and serve diet as ordered. Date Initiated: 10/09/2024.A record review of the facilities guideline Nutritional Assessment revealed: GENERAL: To determine which residents the dietician will see; RESPONSIBLE PARTY: RN, LPN Dietician, Diet Tech; GUIDELINE: 1. Nutritional assessments are completed on residents and include body mass index, usual body weight, height, weight, ideal body weight, and diagnosis . 3. Medical conditions include but are not limited to: Significant Weight Changes.A record review of R1's Nursing progress notes and SBAR (situation, background, assessment, recommendation) assessments (completed for a change in condition) revealed: There were no SBAR or change in condition documentation related to R1's significant weight loss. There were no nursing notes assessments documented about the residents' weight loss.On 04/14/2026 at 3:41PM, During an interview with the DON, she was asked about R1's weight history and missing months of November 2025 and January 2026, she said she I can not account for them and said she was new to her DON position since January 2026. DON was asked about if weight change such as R1's was considered a significant change and she said, yes. The DON was asked if there should be a change of condition (CoC) assessment and she said, yes. DON was asked to review chart for the assessment by the nursing staff, she agreed it was not in the medical chart. The DON was asked if a nursing note could (continued on next page)

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