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	09/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** Based on observation, interview and record review, the facility failed to ensure residents were treated in a respectful and dignified manner for 2 Residents (#22 and #59) from a facility census of 52 residents, resulting in missing items not being replaced in a timely manner for Resident #22 and some confidential group of residents were unable to reenter the building nor reach the facility by phone for reentry after hours or after outside visitation with family and friends. Findings include: Facility Resident Council On 09/04/2025 at 10:30 AM, seven (7) confidential group of residents and a family member (who wished to remain anonymous) attended the Resident Council (RC) Meeting. The council has invited a Family Member#8 (FM8) during the Resident Council Meeting to attend on 09/04/2025 at 10:53 AM. The FM8 expressed that the resident's prescription glasses had been missing for almost a year, and there has been no follow-up in finding the glasses, nor have there been any resolution or efforts made to replace the missing glasses. The resident was described by FM8 as unable to express or speak for himself but still able to see, watch TV, and wear his glasses. FM8 revealed that she had expressed this frustration to staff, but nothing has been done regarding his prescription glasses. FM8 and other confidential group of residents had expressed their frustration about the difficulty they experience when staff does not answer the facility phone. One resident reported, when the office is closed, and receptionist is gone, no one answers the phone. There are too many prompts on the answering machine, so you have to leave a message on the voicemail. They don't call back after 5:00 PM. Confidential Resident #2 expressed frustration during the Resident Council meeting about the visitation hours rules. Resident #2 recalled going out with her friend, who visited her from out of town, and returned after 5:00 PM. It took her over an hour to get her friend inside the building. Her visitor waited for her to get into the building and did not want to leave her outside. It was getting dark for her visitor to drive back home, and she was worried about her visitor's safety driving alone in the dark. She indicated that they had called the facility over and over, tried every prompt, and left messages, but no one replied until one of the staff members coming from outside let her in. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Confidential Resident #6 during the RC meeting .09/04/2025, 11:21 AM, revealed that he was unable to return to the building after he rang and rang the doorbell and called the after-hours facility phone number posted outside the locked back door for half an hour. The front door closes automatically after office hours. Residents are expected to use the back door after office hours. Confidential Resident #6 revealed that a couple of weeks ago, he visited his brother's house, and his brother signed him out. Resident #6 explained, It was around 10:30 PM. We were told we could stay out as long as we returned before midnight, so we made it back at 10:30 PM since my brother lives over an hour away. I had to go back to his house and come back the next day. I did not have my medications that night and morning. I did not return to the facility until the afternoon the following day because that's the only time his family was available to give him a ride. No one had called my brother to find out where I was or what had happened. The Social Services Director was interviewed on 09/04 2025 at 12:04 PM, confirmed that the resident had a court-appointed guardian and must have a preapproval to visit his brother and his family from his guardian. She stated that, 'no one is at the front desk after five. The doors are closed. After-hours Phone lines are supposed to be picked up by staff, and different units have prompts. Staff are supposed to answer them. The Administrator admitted to the surveyor on 9/4/25 at 12:30 PM, revealed the ongoing phone issue since he started as the facility administrator in January 2025, and they are working on it from the corporate level. The Administrator explained that the front door is locked from the outside after 5 PM, and no receptionist is scheduled to be by the front door after 5 PM. There is also no one to hear the backdoor buzzer (doorbell) because it only goes to the receptionist, and there's no one after 5 PM. The after-hours phone does not appear to be working effectively. They don't get answered. Facility policies were reviewed on 9/9/25 at 2:00 PM. It revealed: Resident Rights Policy (Last revised on 9/2018, Approved on 9/2018) Policy: It is the facility policy to implement procedures to protect residents' rights. GOAL: To ensure residents rights are protected. To ensure that all employees know and understand the resident's rights. To ensure each resident of the facility is provided a copy of his/her rights in writing upon admission… Spend time with Visitors; you have the following rights: to spend private time with visitors. To have visitors at any time, as long as you wish to see them, as long as the visit does not interfere with the provision of care and privacy rights of other residents… 2. The Visitation Hours Policy submitted by the facility (undated) revealed: (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Residents receive visitors when they wish to. Personal Property A record review of the Face sheet and electronic medical record/emr indicated Resident #22 was admitted to the facility on [DATE] ad readmitted on [DATE] with diagnoses: Multiple sclerosis, gait abnormality/stiffness, neuromuscular bladder dysfunction, history of urinary tract infections, glaucoma, and anxiety. The resident had a Brief Interview for Mental Status/BIMS score of 15/15 indicating full cognitive abilities. On 9/03/2025 at 12:05 PM, interviewed Ombudsman “K”, she said she was at the facility to talk to Resident #22” who said she was missing clothes amounting to $22.00. Ombudsman “K” said she had spoken to the Administrator several times about this. The Ombudsman was asked if she spoke with the Administrator on this day and she said she had not; She then met with him and came back and said nothing had been done about the resident's missing items. On 9/03/2025 at 12:27 PM, the Administrator was interviewed, and he was asked about Resident #22's missing items. He said she had missing clothes and forgot that he replaced them already. The Administrator was asked if he had a receipt that indicated he had replaced the resident's missing clothes or some form of documentation that he replaced them; He said he didn't have any but thought he might have an Amazon receipt. He was asked to see it. On 9/04/2025 at 9:30 AM, interviewed the Administrator and he said he did not have any documentation that he replaced the resident's items or what the items were. He could not say when they were replaced. On 9/05/2025 at 9:23 AM, Resident #22 was interviewed in her room. She was up in her wheelchair, alert and oriented x4. She said that she had a missing purple outfit from amazon- purple leggings and a purple sweatshirt that go together. She said she had spoken with the Administrator several times and he said he had already sent her an outfit, and she must not have received it; she said she did not receive a new outfit. She believed she was not being told the truth. On 9/05/2025 at 11:30 AM, Activities Director “L” was interviewed. She said she handled missing items for the residents. She said there was a Grievance form for missing items. The Activities Director said once an item was reported missing the information was placed on a Grievance form and she and her staff would look for the item in the resident's room, search their closet, laundry room, etc. and the item would be replaced if not located. During the interview with the Activities Director on 9/5/2025 at 11:30 AM, she said Resident #22, reported missing clothes a few months ago. She said the Administrator was aware that they could not locate it. She said she would look for a Grievance form for the missing clothes. On 9/05/2025 at 12:04 PM, the Administrator said he met with the resident and gave her $23.00 to replace her purple outfit. He said he did not have a receipt, Grievance form or proof that she received that. He said he would obtain a receipt. On 9/5/2025 at 1:30 PM, spoke with Resident #22, she said she received $23.00 for her purple outfit from the Administrator, and she said she would buy a new outfit. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, “Resident's [NAME] of Rights,” date reviewed 1/25 provided, “Policy: It is the facility policy to implement procedures to protect resident rights… You have the right to be treated with dignity and respect… Make Complaints: You have the right to make a complaint to the staff of the nursing home… The nursing home must address the issue promptly…”

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Numbers 2586675 and 2594091.Based on observation, interview, and record review the facility failed to provide a clean, comfortable and home like environment to ensure that resident rooms, bathrooms and common areas were clean, for residents on the 100 hall and for a Confidential Group of Residents on the 100, 200 and 300 halls, resulting in an unclean physical environment, resident dissatisfaction and complaints regarding the lack of cleanliness, and Infection Control practices. Environment During a tour of the building on 9/3/2025 at 7:45 AM, there were multiple observations of unclean resident rooms on the 100 hall. Several rooms were noted to have a strong, foul odor including room [ROOM NUMBER] and #114. Many rooms were cluttered with items, including items on the floor, windowsills and other surfaces. Several Resident rooms were noted to have wastebaskets overflowing onto the floor. Resident bathrooms were noted to have large rust stains coated in the sink and toilets. Some of the toilets were also soiled with brown/gray stains and feces. Several resident rooms had uncovered toothbrushes stored on the sink and in some of the rooms 2 residents shared the same bathroom. The following resident rooms had cleanliness issues: Rooms: 101- rusty sink and toilet; 104- urine smell in room, soiled clothes on the floor, bathroom soiled rust coated sink and toilet, toothbrush bare on the sink counter; room [ROOM NUMBER]- cluttered and soiled surfaces in room and bathroom, wastebasket in bathroom overflowing; room [ROOM NUMBER]- bathroom with soiled toilet and sink, wastebasket overflowing onto floor; room [ROOM NUMBER]- soiled toilet and sink; room [ROOM NUMBER]- bathroom toilet and sink soiled. On 9/03/2025 at 9:31 AM, during an interview with a Confidential Resident, they said their room was not cleaned, very often, It's pretty good except for the commode, they don't clean it. On 9/03/2025 at 9:48 AM, a Confidential Resident was interviewed and stated, They cleaned last Wednesday or Thursday, almost a week ago. They are supposed to do it twice a week, but recently it was 2 weeks before it was cleaned. The resident said their toilet was very soiled, trash overflowing, the sink was stained dark orange from rust. Another Confidential Resident said their room was last cleaned over one week ago on Monday (in August). On 9/3/2025 at 10:14 AM, Housekeeper I and Housekeeping Supervisor F were interviewed about cleaning the residents' rooms. Housekeeper I stated, We try to take care of it the best we can. Asked about the rust soiled sinks and toilets. Housekeeper I showed the product used to clean the bathroom and it said Disinfectant, asked if it was also able to remove the stains because the bathrooms were very soiled. Housekeeping Supervisor F said he would check into it. He also said the facility had hired a 3rd housekeeper who was in day one of orientation on 9/3/2025. He said there was a total of 3 housekeepers, We do the best we can. Reviewed the observations of waste baskets not emptied, and multiple resident complaints of trash overflowing on the floors in their rooms and no trash bag in the garbage can. Also on 9/3/2025 at 8:15 AM, soiled gloves with a pink stain were observed sitting on a counter in the small dining/day room and remained for several hours; toothbrushes noted in multiple rooms laying on the bare sink surfaces uncovered and several rooms with foul odors including a strong urine smell with soiled toilet bowls. Housekeeping Supervisor F said they were going to try to fix the issues. Copies of the Housekeeping cleaning schedule was requested. On 9/4/2025 at 8:45 AM, during an interview with Confidential Person J, she said she had visited the facility to see a family member on multiple occasions and the resident's room did not appear to be cleaned very often. She said the windowsills had someone's food on them, the floors were not cleaned, and the bathroom was soiled. She said she had spoken to someone about it and the uncleanliness did not change. A review of the facility cleaning schedule titled, Housekeeping Hall schedule undated had a list for Monday-Sunday. On it there was listed halls 100, 200, 300, 500 and 700. The facility only had halls 100, 200 and 300; 500, 700 and 800 were in the Assisted Living. Per the cleaning schedule Hall 100 was to be cleaned on Monday, Wednesday, Friday and Sunday. Hall 200 was to be cleaned on Monday, Tuesday, Thursday, Friday, and Saturday. Hall 300 was to be cleaned every day. In addition, the common areas were cleaned Monday, Wednesday, Friday and Sunday. The residents' rooms were not cleaned daily and per the residents they were not always cleaned on their scheduled days. The cleaning schedule also said the housekeepers would handle the laundry on the weekends between room cleaning. There was also a list of items to be cleaned for the 200 hall (that was to be cleaned almost daily), but there was no list for the 100 Hall.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation Pertains to Intake Number 2586675. Based on observation, interview and record review the facility failed to review and revise Care Plans to ensure a resident-centered comprehensive care plan for four residents (#21, #22, #60 and #67) of 40 residents reviewed, resulting in the residents (#21, #22, #60 and #67) lacking a Care Plan with resident specific interventions. Resident #21 Accidents Falls A record review of the Face sheet and electronic medical record indicated Resident #21 was admitted to the facility on [DATE] with diagnoses Dementia mood disturbance with anxiety, and weakness. Per the progress notes, Resident #21 was receiving Hospice services.On 9/03/2025 at 10:03 AM, Resident #21 was observed in the hallway with her legs hanging over the side of a broda chair. She was leaning forward and trying to move the chair. Nurse Aide M approached the resident and was asked if the resident was trying to get up out of the chair and she stated, Yes. She said the resident repeatedly tried to stand and they would try to lay her down and she would not stay in bed. A record review of the progress notes identified the resident had 2 recent falls on 8/29/2025 and 8/23/2025. Further review of the progress notes identified the following: 8/22/2025 at 22:58 PM, a Behavior note Resident is restless, unable to relax, sit still or sleep. Keeps trying to walk. 8/23/2025 at 12:20 PM, a Health status/Progress note, Resident was observed on floor of her bathroom on her left lateral thigh and hip, left hand was on the floor. She yelled help . It appears she was attempting to pull her pants up. Frequently incontinent, although will go on toilet if prompted. 8/25/2025 at 5:33 PM, a Behavior note, Resident found out of her w/c (wheelchair) without assistance @ around 1030. Was assisted back into her chair by writer. Resident also had to be redirected multiple times during shift to not get out of w/c without assistance (she was stopped multiple times by various staff as she was sliding forward in w/c seat. 8/29/2025 at 3:59 PM, a Health Status/progress note, Resident observed on floor in bathroom crying out for help. Resident was in bed prior to incident. Resident self-transferring without assistance. A review of the Incident and Accident Reports for Resident #21 revealed the times of her falls were: 8/23/2025 at 11:00 AM and 8/29/2025 at 9:45 AM. A review of the Care Plans for Resident #21 identified the following: The resident has a behavior problem r/t (related to) calling out at night, attempting to self-transfer, yelling at staff, resistive to care at times, date created and initiated 7/31/2025 and revised 8/26/2025 with one Intervention dated 7/31/2025, Caregivers to provide opportunity for positive interaction, attention. Stop and talk with him/her (did not specify this was a her) as passing by. There were no additional interventions related to the resident wanting to stand, walk and go into the bathroom. Potential for falls, Resident at risk for injury from falls. Weakness, Unsteady Gait, Poor safety awareness/impulsiveness, date created, initiated and revised 7/29/2025 with new Interventions: Hospice to complete med review to address increased restlessness, date created and initiated 8/26/2025 and Offer toileting after breakfast, date created and initiated 9/2/2025. The ADL, Care Plan said, Toileting or check and change every 2 hours and (as needed). The progress notes indicated Resident #21 was attempting to toilet herself on several occasions. There was no specific plan for toileting until 9/2/2025 and the resident had fallen twice. A review of the physician orders indicated Resident #21 began receiving Ativan 0.5 mg tab two times a day as needed on 8/12/2025 for anxiety. This was not mentioned on the Fall Care Plan, Behavior Care Plan or other Care Plan. The resident continued receiving the medication through 8/28/2025. On 8/27/2025 the Controlled Substance Proof of Use document indicated the resident received the medication 3 times in the same day: 7:00 AM, 3:00 PM and 9:00 PM. This was more than was ordered. On 9/5/2025 at 9:20 AM Resident #21 was observed in hallway in the Broda chair, smiling, alert. The CNA said the resident was doing good today, had a bad day yesterday, yelling, trying to stand from chair, would not lay down in bed. Resident #22 Urinary Catheter or UTI A record review of the Face sheet and electronic medical record/emr indicated Resident #22 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Multiple sclerosis, gait abnormality/stiffness, neuromuscular bladder dysfunction, history of urinary tract infections, glaucoma, and anxiety. The resident had a Brief Interview for Mental Status/BIMS score of 15/15 indicating full cognitive abilities. The resident needed some assistance with care. On 9/03/2025 at 10:20 AM, Resident #22 was observed lying in bed, she said she was taking an antibiotic for a urinary tract infection/UTI. She said she used a straight catheter by herself, as she could not urinate otherwise. A review of the physician orders revealed the following: Patient completes self-catheterization, Skilled nurse to educate and monitor patient ability and hygienic efforts, every shift, dated 8/18/2025. Skilled nurse to encourage and offer patient iodine swabs or antiseptic wipes for

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 1) Have an active plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all of the residents in the facility; 2) Complete routine resident and staff Infection Surveillance, including audits/environmental rounds, analyze data for trends and report findings and 3) Ensure the appropriate use of Personal Protective equipment, per Standards of Practice, which could lead to an outbreak of infectious organisms, and illness. Facility Infection Control On 9/09/2025 at 10:48 AM during an interview with IP/Infection Preventionist “H”, she said she was new to the role. She started in December 2024 and completed the CDC/Center for Disease Control and Preventions Certificate training course for Long Term Care/LTC on 4/6/2025. When asked to review the Infection Surveillance data for the prior year, September 2024 through September 2025, The IP “H” said she began collecting Infection Surveillance in April 2025, and surveillance prior to that was completed by someone else. During the interview with IP “H” on 9/9/2025 at 10:48 AM, it was noted that the Infection Surveillance for July 2025 with line listings, analysis and reporting, (to track resident infections, review data for trends and report findings to aid in preventing the development and spread of infection) was completed, but there was no additional monthly Infection Surveillance for the year with line listings, analysis and reporting per the following: October 2024, November 2024 and December 2024 was identified to have some Infection surveillance line listings, but no summary/analysis. January 2025, February 2025, March 2025, April 2025, May 2025, June 2025, did not have line listings, analysis or reports. Some months had individual Infection worksheets for some residents and some months had nothing. August 2025, no September 2025 surveillance data, no line listing, some resident surveillance, no summary report, no antibiotic stewardship reporting for months without Infection surveillance. There was limited staff surveillance for infections, beginning May 2025. On 9/9/2025 at 11:30 AM, the Infection Preventionist “H” was interviewed about the months with no Infection Surveillance data over the past year and she said that is how it was when she started in the role, and she was trying to learn, and July 2025 was the month she had the most up to date information. She said she was working on audits, but the audits were not in writing. She said she began Hand hygiene, PPE use, pericare education in August 2025. She said she began attending the QAPI/Quality Assurance Process Improvement meetings in June 2025 and started reporting at QAPI. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the interview with the IP “H” on 9/9/2025 at 11:45 AM, identified issues with environmental cleanliness during the survey was discussed, including cleanliness issues from a lack of cleaning found in resident rooms and in the building. The IP “H” said she wasn't performing environmental rounds but planned to start. She said she was not aware of the residents', families and visitors' complaints of uncleanliness in the building, including the 100 Hallway. Also, during the interview, IP “H” was asked what she had identified as an issue based on her Infection Surveillance, and she said “UTI's” (urinary tract infections). She said she had 2 residents with the same Multi-drug-Resistant Organism/MDRO of ESBL E.coli. Both residents resided on the same hall/100 and both residents had concerns with their bathroom and rooms not being routinely cleaned or disinfected. The IP “H” referenced Resident #22 as having ongoing UTI's. When asked about Infection Surveillance, she said she only had the July 2025 information. IP “H” also said Resident #3 was identified to have the ESBL E. coli in her urine identified in July 2025, there had not been monthly Infection Surveillance prior to this. A review of the July 2025 Infection Surveillance data revealed Resident #67 was transferred to the hospital on 6/30/2025 and readmitted on [DATE] with diagnoses UTI (7/1/2025) and sepsis (systemic infection response). Resident #67 was initially admitted to the facility on [DATE] prior to the discharge to the hospital with a change of condition. IP “H” confirmed the facility had not been continuously monitoring Infection Surveillance during Resident #67's stay at the facility. Resident #67 also resided on the 100 hall. A review of the facility policy titled, “Infection Surveillance,” dated 10/2014 and reviewed 12/21 provided, “Guideline: Surveillance of infection swill be completed to calculate baseline rates, detect outbreaks, track progress and determine trend to assist in preventing the development or spread of infections. The goal is to minimize the number of infections and to identify behaviors or environmental factors that may warrant further evaluation… Infection prevention will review the Infection Surveillance data to identify trends and outbreaks at least monthly. IP will conduct surveillance at least once per week. Monthly environmental rounds and review of physician orders for antibiotics and laboratory results should be included…” On 09/03/2025 at 7:11AM during the initial kitchen tour, observed dead end plumbing near the coffee machine. The dead-end plumbing was a water line with an attached backflow preventer for beverage machines. On 09/03/2025 at 8:36 AM record review of the facility's Water Management Plan is missing the following: a description of the building water system with both a text and flow diagram. The last Legionella meeting inside the Water Management Plan binder is dated 2/21/18. On 09/03/2025 at 8:51AM-9:25AM conducted interview with the Director of Maintenance F on chlorine residual testing, and he stated that chlorine residual is completed on site on a weekly basis. On 09/03/2025 at 8:51AM-9:25AM record review of the chlorine residual and water temperature log provided by the Maintenance Director F, there are several empty lines in the chlorine residual and the water temperature columns for Van Gogh room [ROOM NUMBER], [NAME] room [ROOM NUMBER], and [NAME] room [ROOM NUMBER]. Several of the chlorine residual are recorded to be very high at 116.2 111.2 and 77ppm. Conducted interview with the Maintenance Director F on the extremely high chlorine residual results and he stated that the water temperatures and chlorine residual must have been switched around. (continued on next page)

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	09/09/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the Centers for Disease Control and Prevention, Controlling Legionella in the Potable Water System dated January 3rd, 2025, Ensure disinfectant residual is detectable throughout the potable water system. and Eliminate dead legs, which are sections of no- or low-water flow. Resident #70 R70 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include dysphagia, heart failure, cerebral infarction and hemiplegia and hemiparesis. On 09/05/2025 at 9:56AM, it was observed that R70 is in enhanced barrier precautions related to their enteral tube. Licensed Practical Nurse (LPN) A was performing medication administration for R70. LPN A was observed not applying the proper personal protective equipment (PPE) for the clinical situation. LPN A applied gloves only. LPN A performed medication administration for R70 and exited the room upon completion. Upon exiting the room LPN A was asked if they should have applied PPE prior to administering medication for this resident? LPN A stated, yes, I should have applied a gown in addition to my gloves, prior to administration of the medication. LPN A' was asked why they didn't apply the proper PPE. LPN A stated, I just forgot, it was an oversight. On 09/05/2025 at 10:30AM, record review revealed a physician's order that read, Maintain enhanced barrier precautions to prevent infections r/t enteral feeding tube/history of klebsiella pneumoniae and ecoli, dated 09/02/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 and record review, the facility failed to ensure that the appropriate backflow prevention was installed on cross connections. This deficient practice increases the likelihood of contamination of the water supply due to a backflow event, potentially affecting all residents, staff, and visitors who consume water at the facility.Findings include: On 09/03/2025 at approximately 7:25 AM, observed a hose attached to a spigot without a hose bib vacuum breaker located in the [NAME] sub kitchen. On 09/03/2025 at approximately 9:15 AM, observed a chemical dispenser attached to a utility sink downstream of an atmospheric vacuum breaker (AVB) without a wasting tee, located in the janitor's closet in 300, 200, and 100 hallways. According to the 2008 Cross Connection Manual on atmospheric vacuum breakers, AVBs shall not be installed where they will be under continuous pressure for more than 12 hours (i.e. no downstream shutoff valve).According to the 2008 Cross Connection Manual on chemical feeder backflow prevention, Another concern with a hose being run from a faucet to the dispenser is that many times a valve is installed on the hose downstream of an AVB, which is not allowed since AVBs cannot be subject to continuous pressure.