STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235056	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hoyt Nursing & Rehab Centre	1202 Weiss St Saginaw, MI 48602

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 22927 This Citation pertains to Intake Number MI00151907. Based on observation, interview and record review, the facility failed to notify a resident's responsible party of a roommate change for one resident (Resident #102) of 2 residents reviewed, resulting in Resident #102 having a new roommate moved into his room without the responsible party's notification prior to the move, which resulted in a resident-to-resident injury. Findings include: Resident #102: Observation was made on 4/10/2025 at 8:46 AM of Resident #102, who was lying in bed asleep with the head of bed elevated. He did not respond to his name. The state surveyor observed a black eye and bruising to the left side of face. Soft touch call light was clipped to gown within reach. No roommate was noted in the room and only one name was on the room door. Observed bilateral hand contractures, and bilateral amputee lower extremities. Record review of Resident #102's electronic medical record revealed that the resident had a legal guardian in place and had a medical diagnosis of vascular dementia. Record review of Resident #102's Behavioral Care consult visit notes revealed diagnoses of bipolar disorder, dementia, depression, schizophrenia, encephalopathy and other medical conditions of a bilateral lower limb amputation. Record review of the facility incident report, dated 4/4/2025 at 8:30 AM, revealed that Resident #102 stated another resident made contact with his eye. The other resident denies doing so. In a record review of the facility-provided timeline on 4/4/25 at 8:30 AM, the Nursing Home Administrator (NHA) was notified that Resident #102 had a swollen eye and bruising. Resident #102 was noted to state he hit me and pointed toward the window (next bed over). The timeline noted Resident #102's Brief Interview of Mental Status (BIMS) score was 5 out of 15, indicating severe cognitive impairment. The timeline noted that Resident #104 was noted to have bruising on the right fingers/hand. The timeline noted Resident #104 Brief Interview of Mental Status (BIMS) score of 11 out of 15, slight cognitive impairment. (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

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on 4/11/2025 at 8:46 AM with the Nursing Home Administrator revealed there was no Bed transfer policy we do not have a policy on bed changes, we would follow the regulation guidance. Guidance state that we must notify the family of the moving roommate and the family of the receiving roommate. We kind of go by request, or concerns. We decide in the IDT team meeting and coordinate with resident and family members. We had an Interdisciplinary team (IDT) meeting and decided to move (unsampled resident) out of 411-2, why? He is Hard of hearing, and a resident that is typically louder running his TV and that would not affect (unsampled resident). I asked Registered Nurse/Unit Manager C to arrange Resident #104's transfer, and Resident #102's roommate transfer would be by Assistant Director of Nursing/unit manager B notification. Resident #104 was a former policeman and moved him into Resident #102's room, we talked about how Resident #104 would exit seek and become very upset and, if the wife was present, she will tell him he is staying permanently. He has triggers to his behavior. He is clearly upset about being here. It was a failure to notify the family member of Resident #102, I should have checked that it was done . Record review of the Health Care Association of Michigan (HCAM) 'Rights or Residents in Michigan Nursing Facilities' 2022 booklet revealed 'You have the right to designate a representative, in accordance with state law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law . Respect & Dignity: The right to receive written notice, including the reason for the change, before your room or roommate in the facility is changed.

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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 0600 Level of Harm - 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** 22927 This Citation pertains to Intake Numbers MI00151907 and MI00152097. Based on observation, interview and record review, the facility failed to prevent resident-to-resident abuse/assault of one resident (Resident #101), resulting in Resident #101, who was totally dependent for all care and had bilateral lower limb amputations and upper extremities contractures, receiving a black eye with facial contusions while residing in the facility. Findings include. Record review of the Health Care Association of Michigan (HCAM) 'Rights or Residents in Michigan Nursing Facilities' 2022 booklet revealed 'You have the right to designate a representative, in accordance with state law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law . Respect & Dignity: The right to receive written notice, including the reason for the change, before your room or roommate in the facility is changed. Safe environment: You have the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living. Record review of facility 'Abuse/neglect and/or Misappropriation of Resident Funds or Property' policy dated 3/15/2023 revealed the purpose was to assure each resident in the center (facility) is free from abuse, neglect and exploitation. (vi) Neglect: is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect occurs when the facility is aware of, or should have been aware of goods or services that a resident requires but the facility fails to provide . Physical abuse: includes hitting, slapping, punching and kicking . Resident #102: Observation was made on 4/10/2025 at 8:46 AM of Resident #102 lying in bed asleep with the head of bed elevated. He did not respond to his name. The state surveyor observed a black eye/bruising to the left side of face. Soft touch call light was clipped to gown within reach. No roommate was noted in the room and only one name was on the room door. Observed bilateral hand contractures, and bilateral amputee lower extremities. Record review of Resident #102's electronic medical record (EMR) revealed that the resident had a legal guardian in place and had a medical diagnosis of vascular dementia. Record review of Resident #102's Behavioral Care consult visit notes revealed diagnoses of bipolar disorder, dementia, depression, schizophrenia, encephalopathy and other medical conditions of bilateral lower limb amputations. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the facility incident report, dated 4/4/2025 at 8:30 AM, revealed that Resident #102 stated another resident made contact with his eye. The other resident denies doing so. Record review of the facility-provided timeline on 4/4/25 at 8:30 AM showed that the Nursing Home Administrator was notified that Resident #102 had a swollen eye and bruising. Resident #102 was noted to state he hit me and pointed toward the window (next bed over). The timeline note Resident #102 Brief Interview of Mental Status (BIMS) score was 5 out of 15, indicating severe cognitive impairment. The timeline also noted that Resident #104 had bruising on the right fingers/hand. The timeline noted Resident #104's Brief Interview of Mental Status (BIMS) score of 11 out of 15, indicating slight cognitive impairment. In an observation and interview on 4/10/2025 at 9:24 AM, Resident #104 was observed on the long-term care side of the building, private room with only one bed noted in the room. Resident #104 was observed walking from the therapy gym to his room with therapy staff. Resident #104 stated I was in another room; I had a doctor in to see me yesterday, to look at my right hand. No, I did not hit anyone, the roommate talked so bad, about that when he was in prison and how he would stab white people in the prison. He had his feet cut off. He treated women terrible, and I asked him to please don't talk that way, I asked him if he had any compassion for the human race. I was standing up in the room, and he started talking about how he would stab white mother fuckers like me in prison. The way he talked about women and white people. I told him he was disgusting to the human race. No, I did not hit him. The conversation was bad from him. No, I did not hit him in the eye. I just pushed him away. The Saginaw Police came originally, and he looked at my hand and my hand was all red. My right hand was red from I don't know I was a police officer. Record review of Resident #104's 'Bed Transfer Form', dated 4/2/2025, revealed that Resident #104 was to move to room [ROOM NUMBER]-1 but was placed in room [ROOM NUMBER]-2 instead. An interview on 4/10/2025 at around 10:00 AM with the social services designee K revealed that Resident #102 is pretty much laid back and stays to himself, listens to music, and he will sit out in the common area. Not much to say about Resident #102. Resident #104 is very aggressive and I only seen that when he got very verbally aggressive with his wife, he was addressing his talking to her but approaching me. His demeanor was toward his wife, she was just explaining how he gets upset. I did go into speak with Resident #102 after the incident, and he stated I don't know why, I don't know why he (Resident #104) was hitting him (Resident #102). Resident #102 said that he was yelling out, why are you doing this, why are you doing this man. I don't know why any staff didn't hear him. Resident #104, I did talk to him with his wife, and he did not say anything. Resident #104 is manipulative and will turn the conversation as to what he wants to talk about. Placement for Resident #104 was moved to a private room and staff has been keeping their eyes on him. He only really comes out for meals. We are keeping everybody safe. We did referral him to another facility and they declined him. He does need a secured unit. Because he does threaten to leave, is on a wander guard. My safety thing is to get him placement in a secure memory facility, in the meantime I do know my staff are to watch him and keep him in sight. (continued on next page)

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	235056	A. Building B. Wing	04/11/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/10/2025 at 1:50 PM via phone, Certified Nurse assistant (CNA) G revealed, I was Resident #102's aide that day, I noticed that he had a swollen eye, he began to tell me what happened that he was hit in the eye stating He hit me looking toward the window where the roommate was. Resident #102 has hand contractures, and his Range of motion and arm extension is limited. He does not feed himself; we assisted him with meals. The roommate (Resident #104) was in the room getting dressed. I brought in his breakfast tray and Resident #104 was sitting up on the edge of the bed, but he wanted his meal in the dining room. So, I took the tray to the 500-hallway dining room and the resident was in his wheelchair and went in that direction. No, I did not hear any shouts or yelling come from that room. I start my day at 6:30 AM, we do a walk through with off going staff Certified Nursing Assistance's and then pass trays at 7:00 AM. I took Resident #102's tray into the room and turned on his light and he turned his head and there was a black eye. I told my nurse. In an interview on 4/10/2025 at 1:59 PM via phone, Certified Nurse Assistant (CNA) H revealed, It wasn't my hall, CNA G told me about it. I went to look at the left eye was swollen with dry blood on his nose and on the pillow. Resident #102 kept saying He kept hitting me, I told him to stop. Resident #102 has hand contractures and could not hit back. At the time the roommate was out of the room. The nurse also was in the room and asked him about being hit. The Roommate (Resident #104) was up in Wheelchair in the hallway and was asked if he hit Resident #102 and he shook his head yes. The Nursing Home Administrator took the Roommate #104 to the conference room, and he had a bruised right hand. In an interview on 4/10/2025 at 2:04 PM, Licensed Practical Nurse (LPN) I revealed that The Certified Nurse Assistant (CNA) G came to me ask me if I'd seen Resident #102's black eye. CNA G was going to feed Resident #102 and seen a black eye. She let me know and I went to the room and Resident #102 told me he wants to press charges. I asked him what happened, he stated that man over there, kept hitting me. Resident #102 has bilateral hand/arm contractures, and he can't hit back. I saw his left eye was swollen closed, with a bloody dry nose and blood drops on the pillow. I went and notified the Nursing Home Administrator; the Infection Control nurse D was with me. Resident #102 just said that he wanted to press charges. Resident #102 will talk crap with the staff or to himself. Resident #102 has been to prison for 4 years and talks prison crap and that could have upset the roommate, because he was a police office. Resident #102 does not like the police, he says they killed his brother and he was in prison. I don't know why they moved Resident #102's original roommate out of that room and moved this new guy Resident #104 into the room. On 4/10/2025 at 2:15 PM, the Nursing Home Administrator presented 5-day investigation for resident-to-resident assault on 4/4/2025. Attempt for past non-compliance, which was rejected due to no time of compliance by team manager. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/10/2025 at 2:50 PM, Registered Nurse (RN) Infection Control Preventionist D revealed, I did go to the resident room that morning with Licensed Practical Nurse (LPN) I. We went in and turned on the light and Resident #10 had a left purple, swollen eye with dried blood on the nose and pillow. We did do an ice pack to his eye and assessed it and went told the Nursing Home Administrator. At that time Resident #102 could not tell us what happened at that moment. We went to talk to roommate Resident #104 who was up in his wheelchair in the hallway. We asked him (Resident #104) to come to the conference room to assess his right hand. Resident #104 had a new bruise to his right hand with purple bruising to the 3 outer knuckles of the hand that was purple and warm to touch. Resident #104 stated that he was surprised someone did not do it sooner the way he was talking to people. No, I did not put the assessment in [NAME] medical chart about his purple bruised hand. I was just reviewing it for the Nursing Home Administrator and I just thought that the nurse would do the actual assessment of the resident post altercation and chart it. The Nursing Home Administrator and I went back to Resident #102's room and asked what happened? Resident #102 stated that he got hit by him (Resident #104). Resident #102 could not say when or what time. Resident #104 stated that Resident #102 was being mean to the girls/staff. Registered Nurse/Unit Manager C was also in the resident's room. Record review of police report, dated 4/4/2025, showed that the incident occurred with the victim being Resident #102 and an Assault and Battery by the suspect, Resident #104. Injuries: Resident #104 had a swollen right hand with obvious bruising. Resident #102 had a swollen left eye with obvious bruising. In an observation on 4/11/2025 at 8:12 AM, the state surveyor observed Certified Nursing assistant (CNA) N seated at bedside feeding Resident #102 with his breakfast meal. An interview and record review on 4/11/2025 at 8:15 AM with social services designee K revealed that she had hallways 300/400/500 long-term, right then she had the entire building. All 89 residents, the other social worker left almost 2 weeks ago. Procedure for Bed transfers: The Interdisciplinary team (IDT) bring it to the morning meeting, we discuss who would be a good fit for another room or area in building, who could we put together as a good fit. We then decide and reach out to the family members, both families are notified, I had (unsampled resident) that was in room [ROOM NUMBER]-2 and he was moved down the hall. They said that (unsampled resident) was moved to a doorway bed closer to the nurse station/cart for monitoring, just to make sure he doesn't roll out of bed, history of wanting to do things for himself, and falls. Resident #104 had just come over from the short term hall, the other social worker had him on the 100/200 hallway and transferred him to long-term care stay. The Nursing Home Administrator gives out task for room transfer/moves and the staff member is to notify the family members. The staff member once they notify family members then fill out a bed transfer form so that we know the transfer can happen. Resident #102 doesn't really bother anyone, he normally is asking where his daughter is, or he talks about [NAME], prison or smack/stuff. Resident #102 and Resident #104 were put together, I would say that it was not a good fit for them to be together. It was a team decision and bad choice. Resident #102 and (unsampled resident) had been roommates for a long time and there were no issues between them. It did not warrant a room move. (continued on next page)

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	235056	A. Building B. Wing	04/11/2025

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Record review of the 'Job Description' Social Services undated, revealed that the social worker provides social services to residents and their families to assist them in dealing with the impact of illness and extended care placement . (8.) Inform residents and/or responsible parties of change of roommate(s) and room changes. (11.) Follow federal and state skilled nursing facilities regulations and departmental policies and procedures. In an interview on 4/11/2025 at 8:31 AM with Nursing Home Administrator and Nurse Consultant F, the state surveyor requested the Bed Transfer policy, they stated there was none, but had a Pass Non-Compliance for bed transfers. Surveyor will let the manager know of PNC. Surveyor asked for PNC at this time and the NHA stated that she would need to review it before the surveyor could have it. In an interview on 4/11/2025 at 8:46 AM, the Nursing Home Administrator revealed there was no Bed transfer policy we do not have a policy on bed changes, we would follow the regulation guidance. Guidance states that we must notify the family of the moving roommate and the family of the receiving roommate. We kind of go by request, or concerns. We decide in the IDT team meeting and coordinate with resident and family members. We had an Interdisciplinary team (IDT) meeting and decided to move (unsampled resident) out of 411-2, why? He is Hard of hearing, and a resident that is typically louder running his TV and that would not affect (unsampled resident). I asked Registered Nurse/Unit Manager C to arrange Resident #104's transfer, and Resident #102's roommate transfer would by Assistant Director of Nursing/unit manager B notification. Resident #104 was a former policeman and moved him into Resident #102's room, we talked about Resident #102 would exit seek and become very upset and if the wife is present, she will tell him he is stay permanently. He has triggers to his behavior. He is clearly upset about being here. It was a failure to notify the family member of Resident #102, I should have checked that it was done. We do realize that there has not been a time of compliance. In an interview on 4/11/2025 at 9:10 AM on the bed transfer of Resident #104 on 4/2/2025, Registered Nurse/Unit Manager C stated, A bed transfer starts usually the Nursing Home Administrator (NHA) and Director of Nursing (DON) figure out who is going to Long Term Care (LTC) side from rehab, they inform us and we have to contact the family to ask if the room move is ok with them. We can't move them until we get their approval. We can get an email/on the dashboard and in morning meeting Interdisciplinary team (IDT) meeting, The NHA give us task to complete related to the moves. I had Resident #104 to be moved from my unit to the LTC unit. Record review of the bed transfer form dated 4/2/2025, I did fill that form out. room [ROOM NUMBER]-1, that was the room number that they had assigned to him, he did not go their because? I am not sure why he did not go to room [ROOM NUMBER]-1 that would be a housekeeping question? Resident #102's responsible party should have been notified by Unit manager of LTC or Social service designee about a new roommate. The state surveyor inquired about Resident #102 and Resident #104 should be put together. Registered Nurse/Unit Manager C stated I don't know if that would have been a good fit for those to be together. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/11/2025 at 9:43 AM, the Director of Nursing (DON) revealed that room transfers are discussed in morning meeting if a rehab resident is staying and converted to Long Term Care (LTC), we discuss it as a team to see if they are a good fit for the roommate, then it is tasked to the social worker to go and inform the resident and responsible party, the social workers are to notify. There is transfer forms in the electronic record, per our policy there is a form that will state there is a room change. As part of the regulation, we did inform the DPOA/Resident of incoming roommate. Should Resident #102 and Resident #104 be roommates? The DON Stated, I am not sure I was not here that week. I don't know anything about Resident #104. Resident #102 he does talk crap and tells the ladies they look good, and he does have contractures of the arms bilateral, bilateral amputee one BKA and one AKA. He could not defend himself from harm. I don't know why it was not heard by staff, I don't know when it occurred. In an interview on 4/11/2025 at 9:53 AM, the Nursing Home Administrator related the resident-to-resident investigation, it occurred 4/4/2025 and that she was notified at 8:30 AM. The NHA stated that during the investigation the facility narrowed down the time to a check and change at 6;00 AM there was no eye swelling or black eye. Then at 8;30 AM Certified Nursing Assistant (CNA) went into the room to assist with breakfast and turned on the light and noted the swollen eye and reported it to the nurse right away. NHA stated that sometime between 6-8:00 AM. NHA interviewed the staff, and they did not hear or observe any yelling or occurrence. The staff do go to the nurse station and then go out to the unit and do a room-to-room review, they should be laying eyes on each resident. Resident #102 was noted to be sleeping. The CNA stated that she did peek in and laid eyes on Resident #102, but she did not turn the light on before 830 AM. A resident-to-resident interaction there appears to be physical contact between the residents involved. Resident #104 had bruised knuckles to the right hand and had the ICP nurse do an assessment in the conference room. Resident #102 was sent out to the hospital and came back to us, there were no fractures, just broken blood vessels, we did Tylenol and ice pack prior to hospitalization , he left at 11:30 AM via ambulance to hospital. Record review of Resident #102's hospital record, dated 4/4/2025, revealed significant periorbital edema, ecchymosis (bruising) over the left eye. Atrophy of the hand muscles bilaterally. Below-the-knee amputation on the left,and above-the-knee amputation on the right. Left arm held in flexion and adduction had has clenched fist. Claw hand of the right hand. Diagnosis: (1.) Periorbital hematoma of left eye. (2.) Assault. (3.) subconjunctival hemorrhage of left eye. In an interview on 4/11/2025 at 10:41 AM, Nursing Home Administrator revealed the facility did not have a supervision policy for the monitoring of resident safety.

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F 0684 Level of Harm - 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** 22347 This Citation pertains to Intake Number MI00151904. Based on interview and record review, the facility failed to 1) Ensure that a timely, complete and accurate resident assessment was done for a change of condition and 2) Transfer a resident to the hospital in a timely manner for 1 resident (Resident #101) of 5 residents reviewed for quality of resident care, resulting in a failure to transfer to the hospital during an acute change of condition, decreased blood pressure, increased pulse rate, increased temperature, and, subsequently, death. Findings Include: Resident #101: Review of the Face Sheet, Minimum Data Set (MDS, resident assessment toll), dated [DATE], nursing and physician progress notes dated [DATE] through [DATE], and care plans dated ,d+[DATE], revealed Resident #101 was [AGE] years-old, alert, admitted to the facility on [DATE] from the hospital with a diagnosis of sepsis, and dependent on staff for Activities of Daily Living. The resident's diagnoses included, pneumonic, acute on chronic respiratory failure with hypoxia, atrial fibrillation, metabolic encephalopathy, schizophrenia, bipolar disorder, heart failure, hemiplegia and hemiparesis, stroke, occlusion and stenosis of bilateral carotid arteries, acute kidney failure, muscle weakness, major depressive disorder, anxiety, chronic heart and lung disease, diabetes, epilepsy, high blood pressure, migraine, heart disease, history of infections. The resident was on 3 liters of oxygen at the facility and had a feeding tube. Hospital Record Prior to Admission: Review of Hospital records dated [DATE] (day of discharge to the facility), stated 59 y old female patient presented on [DATE] with chief complaint of found unresponsive at (Nursing Home). Patient was initially started on Zosyn and Zyvox (antibiotics) and was admitted to ICU. Problem Based Management: Severe sepsis with Septic shock due to bilateral pneumonia form suspected aspiration. The resident had recently been readmitted to the facility after hospitalization due to severe sepsis with septic shock likely due to aspiration pneumonia. Review of the facility nursing notes, dated [DATE] at 17:35 (5:35 p.m.), stated Nurse and CNA (Nursing Assistant) went in the room, nurse looked at the resident and immediately went to check for a pulse not found. Nurse touched the resident and found that resident was cold to touch and unresponsive. Nurse went to call a Code blue as resident was a full code. CPR initiated by two nurses at 1645 (4:45 p.m.). Review of the facility electronic medication administration record (EMAR) dated ,d+[DATE], revealed on [DATE] at 1317 (1:17 p.m.), Nurse O gave the Resident #101 Tylenol 325 mg x 2 tabs for increased temperature/temp. of 101 (temp. taken at 9:00 a.m.,on [DATE]) by CNA P). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235056	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hoyt Nursing & Rehab Centre	1202 Weiss St Saginaw, MI 48602

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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 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the facility nursing notes dated [DATE] at 9:00 a.m. through 5:35 p.m., revealed no documentation of any physical or cognitive assessments (due to condition change, increase in temp. and pulse rate). During an interview done on [DATE] at 2:15 p.m., Nurse, RN O stated No, I did not do an assessment; yes I was supposed to. I know I should of charted better and done a assessment. During an interview done on [DATE] at 3:39 p.m., CNA P stated I told her (Nurse O) about her (Residents #101) temp. (101 F) and pulse (110) at 9:00 a.m. (on [DATE]); I know it was 9:00 a.m., because that's when I do vitals and if not normal, we report it to the nurses. I don't trust working with her (Nurse O), her responses are delayed. When I told her (Nurse O), she repeated the temp. and pulse back to me and said, I'll give her medication. During an interview done on [DATE] at 3:50 p.m., the Director of Nursing/DON stated I think she (Nurse O) did nothing after she was told the vitals; I think it's horrible. The Aide (CNA P) notified the nurse right away at 9:00 a.m., and she did not do anything until 1:17 p.m. (gave Tylenol, did not call doctor to inform of change of condition to send to ER). From 9:00 a.m. to 1:17 p.m., for 4 hours and 17 minutes she (Nurse O) did nothing. During a second interview done on [DATE] at 3:30 p.m., Nurse O stated I didn't call the doctor with the temp. and pulse change. The resident was not transferred to the hospital for evaluation when notified of an increased temperature and pulse with a known history of sepsis. During an interview done on [DATE] at 10:00 a.m., Infection Control/Education Nurse, RN stated She (Nurse O) should have first re-checked the temp. and called the doctor (to transfer to ER). During an interview done on [DATE] at 8:30 a.m., Social Service K stated The next day (on [DATE]) the CNA's told me she (CNA P) had told the nurse her temp. was high. The nurse did nothing; I told her if the nurse does not do anything go to another manager and tell them Review of the resident's facility Pain and Diabetes care plans dated [DATE], stated Notify physician if signs or symptoms of fluid imbalance such as neck vein distention, difficulty breathing, increased heart rate, monitor/document/report to MD s/sx (signs & symptoms) of hypoglycemia, sweating, tremor, increased heart rate. Review of the nursing notes dated [DATE], revealed the resident had a pulse of 110 on [DATE]. Review of the facility Registered Staff Nurse job description (un-dated) stated This position is responsible for performing the primary functions of nursing assessments, planning, implementing, and evaluating the care of all assigned residents. Assess resident condition, observe and evaluate resident symptoms, progress and reactions to treatments and medications and take correct action as necessary, accurately record resident observations in clinical records, strong critical thinking and decision-making skills, a high level of analytical abilities, ability to concentrate in performing and planning professional nursing care. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of the facility Assessment Resident policy dated [DATE], stated Procedure is a Head-to-Toe review of the resident's functional status. Purpose: To identify the resident's care needs, Procedure: Chief complaint, Pain, Level of consciousness, speech, palpate temporal and carotid pulses, assess for tenderness, palpate femoral pulses, condition of skin (includes color, dry, tacky), color of extremities, temperature of extremities, orientation to time, place and person, ability to follow instructions. Review of the facility Change of Condition policy dated [DATE], stated Family and/or responsible party are notified anytime there is a change in the resident's condition or plan of care. Any other time there has been a change in the resident's condition will be done in a timely manner. Notify appropriate party and record in resident's medical record.