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	05/11/2026

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This Citation pertains to Intake Number 2995609.Based on interview and record review, the facility failed to ensure that quarterly care planning meetings were accomplished and that the resident and resident's representative were included in the care planning allowing them to make informed decisions regarding healthcare and treatment options for one resident (Resident #1) of one resident reviewed for care planning. Findings include:Resident #1 (R1):A review of R1's medical record revealed an admission into the facility on 5/9/24 and a readmission on [DATE] with diagnoses that included fracture of right femur, history of falling, unsteadiness on feet, abnormalities of gait and mobility. A review of the Minimum Data Set assessment, dated 3/4/26, for R1 revealed a Brief Interview of Mental Status score of 14/15 that indicated intact cognition and the Resident needed substantial/maximal assistance to roll left and right and was dependent on helper for transfers. On 5/7/26 at 10:44 AM, an interview was conducted with Resident Representative (RR) B regarding R1's care at the facility. The RR reported that the Resident had a fall in November of 2025 that he complained he was having pain in his leg that they did an x-ray of and the pain continued, they did another x-ray, but it did not show the fracture. The RR said, He kept telling them he was still in pain, and they just gave him pain medication. The RR reported the Resident called the ambulance himself, he was fed up with them not doing anything, he was hurting so bad that day, the hurt was so painful, and they would just give him pain pills and tell him he was getting better, but he wasn't. The RR reported the Resident called 911 to come get him, the Nurse told the RR that they would check him out and send him right back. The RR stated, He told them he was hurting but they didn't believe him. He has not stopped complaining of the pain since November. The RR reported he went to the hospital, and they found the fracture and had surgery. The RR reported that the fall happened in November of 2025 and he called the ambulance himself in April when he couldn't stand to be in pain all the time. The RR was asked if she had attended the care conference and brought up the issue of continued pain. The RR reported she was not familiar with what a care conference was. When asked if she had been invited to attend a meeting regarding R1's care, the RR reported she had not been asked to attend any meetings. When asked if she received a call about results of a care conference, the RR stated, they called when he fell, but did not indicate a call regarding care conferences. When asked if they had talked together with the Resident and staff members regarding his ongoing pain, the RR reported staff had not talked to her about his pain or a plan for care with the extended complaints of pain. On 5/7/26 at 12:58 PM, an observation was made of R1 lying in bed with the head of the bed elevated. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about his fall in November. The Resident reported he was doesn't remember where he fell but he remembered a CNA (Certified Nursing Assistant) helped him into bed and stated, I told the nurse afterwards, and expressed being in a lot of pain in his hip, I laid in the bed hurtin, hurtin, hurtin. The Resident reported that x-rays were done at the facility and stated, I got two sets from here. The Resident reported they said I didn't have anything wrong. The Resident stated, I told them I wanted more done, an MRI or something. The Resident reported calling the ambulance, getting a cat (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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scan, seeing the fracture, got more x-rays that confirmed a fracture, having surgery and returned to the facility. The Resident reported that he had pain from the surgery, but it was getting better and he was finally getting relief from pain.The Resident was asked about care conferences or meetings held to discuss his care with a team at the facility, the Resident reported not knowing what a care conference was and that they had no meetings and stated, They knew I was in pain. When asked if he had a meeting with staff and his Guardian, the Resident reported not having a meeting like that. When asked if they contacted his Guardian or left a note for them to have a meeting, the Resident reported that his Guardian would have come if she could but did not know of her being asked to come to a meeting to discuss his care. On 5/11/26 at 1:12 PM, an interview was conducted with the acting Director of Nursing (DON) regarding R1's care. The DON was asked about care conferences and facility policy on how often they were to be conducted. The DON reported that care conferences were held quarterly and as needed. The DON was asked about when the care conferences were for R1. The DON reviewed the medical record and stated, The last form I see was in September. The DON checked the progress notes for recent care conference notes and stated, It looks like September was the last one. When asked if the Guardian was informed of or attended the care conference, the DON reported she could not tell from the note. The DON confirmed that they should have had a care conference quarterly or every three months and the Guardian would be invited to attend. It was asked that had they had a care conference the concern of the resident's pain could have been a conversation and set a plan of care. The DON stated, I can't fix the past, going forward we are working on the processes. A review of the facility policy titled, Care Plan Conference: Scheduling and Residential/Family Invitation, revealed, Policy: The facility should involve the resident, resident's family or representative in the care planning. Their attendance and participation in the care plan conference must be encouraged through timely invitation. The Care Plan Conference for long term care residents must be scheduled at least seven (7) days after the ARD of scheduled MDS (Minimum Data Set assessment) . 3. The facility designee shall generate the following: a. Care Plan Conference letters addressed to the following recipients (as appropriate): i. Family Member/Responsible Party; ii. Guardian; b. Invitation addressed to the Resident. 5. The facility designee shall receive the phone call or verbal confirmation or regret from the Resident and/or Family Member/Responsible Party. 6. The facility designee shall communicate to the Social Worker if the Family Member/Responsible Party opted for the post-Care Plan Conference phone call and the anticipated date and time of phone call.