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	06/17/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 22347 Based on observation, interview and record review, the facility 1) Failed to ensure that five residents' (Resident #11, Resident #14, Resident #33, Resident #58 and Resident #62), call lights were available, within reach, and answered in a timely manor, 2) Failed to ensure that two residents (Resident #33 and Resident #62) were treated in a respectful and dignified manor, 3) Failed to ensure that one resident's (Resident #17) bedding was clean and the urinal emptied, 4) Failed to ensure that one resident (Resident #14) had a phone available for use, and 5) Failed to ensure that two residents' (Residents #11 and Resident #58) food requests were honored, resulting in verbalization of anger regarding phone availability and undignified communication from staff, having no call light available or within reach for requests or emergencies with the likelihood of injury due to no assistance available, and feeling down and depressed from lack of dignity. Findings Include: Review of the facility copy of Rights of Residents in Michigan Nursing Facilities, Health Care Association of Michigan, 2022 revealed all resident's have the right to be treated with dignity and respect. Call lights, Resident Phone Availability, and Food Preference: Review of the facility Call Light Policy dated 5/1/2017, stated Call lights will be placed within reach of the resident. During an interview done on 6/17/24 at 8:23 a.m., with Social Worker M stated We do rounds on call light's, and we put it on a call light sheet. I have heard complaints from residents about staff taking long to answer call lights. We get together in a meeting and talk about it. I think within 15 minutes the light needs to be answered. Review of a blank copy of the facility Call Light Audit form (un-dated) revealed management was auditing 5 residents daily for 10 weeks for call light response times, call light available, light within reach, and staff communication (was it respectful). During an interview done on 6/12/24 at 3:43 p.m., the Administrator stated that resident's call lights should be answered within 15 minutes. (continued on next page)

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 - Some	During an interview done on 6/12/24 at 3:40 p.m., the facility educator/Infection Control Nurse C stated that resident's call lights should be answered within 15 minutes, but 5 (minutes) would be best. Resident #11-Food Preference: Review of the Face Sheet, Minimum Data Set/MDS (assessment tool dated 4/24), progress notes dated 5/1/24 through 6/12/24, revealed Resident #11 was [AGE] years old, alert and their own person and admitted to the facility on [DATE]. The resident's diagnosis included, acute respiratory failure, heart failure, kidney disease, pneumonia, major depression, metabolic disease, and required staff assistance with all Activities of Daily Living/ADLs'. Review of Resident #11's facility Nutritional care plan dated 4/4/24, stated honor food preferences. Review of the resident's meal ticket dated 6/12/24, revealed regular diet and no dislikes. During an interview done on 6/12/24 at 9:06 a.m., Resident #11 stated I don't get any eggs. The resident said they got eggs only once a week and had requested to have them more often. During an interview done on 6/17/24 at 8:23 a.m., Registered Dietitian N said the resident did not have any dietary restrictions, and he could have eggs. We have a dietary aide that goes around a couple of times of week and asks all the resident's what they would like to eat that week; she goes over the menu with them. RD N said there was no food preference policy or procedure that she was aware of. Review of the facility Culinary Concierge job description stated, This job is responsible for providing assistance in all food functions as directed and in accordance with established food policies. During an interview done on 6/17/24 at 10:13 a.m., the Administrator stated, they go around and see what they (resident's) want to eat. The Administrator did not know if the facility had a policy. No one gave this surveyor a policy/procedure for the Culinary Concierge job. Resident #14-Call Light-Phone availability: Review of the face Sheet, MDS dated [DATE]/2024, progress notes dated 5/25/2024 through 6/12/2024, and physician orders dated 5/25/2024, revealed Resident #14 was [AGE] years old, alert and his own person, non-ambulatory and was admitted to the facility on [DATE], from acute care and required staff assistance with all ADLs'. The resident's diagnosis included, falls, hematoma (bruising) of soft tissue, Parkinson's Disease, morbid obesity, muscle weakness, Lymphedema, reduced mobility, anemia (low iron), Acute Kidney Disease, high blood pressure, Diabetes, fluid overload, heart disease, and Atrial Fibrillation. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview done on 6/12/24 at 9:21 a.m., Resident #14 stated Sometimes it takes hours for them to answer my light, they say they were out to lunch, or they were helping somebody else. I don't have a phone I can use to call anyone because It's hard for me to get out of bed and to the nurse's station. They said the only phone available was the one at the nurse's station, it's hard for me to get out of bed to use that phone (resident was a Hoyer lift for transfers and had chronic pain with wounds). During an interview done on 6/17/24 at 10:55 a.m., Social Worker #1 M stated The only phones available are the two phones at the desk (at the 100/200 nursing station; both landlines). During an interview done on 6/17/24 at 10:58 a.m., Nurse, RN A stated, There should be one (portable phone for resident use) available, but I don't know where it is, I am new here. Nurse A was not aware of any policy or procedure regarding resident phone usage. During an interview done on 6/17/24 at 11:00 a.m., Nurse, LPN B stated, There was a phone available (portable phone for resident use); they took it, we don't have it anymore. Social Worker #1 M and nurse's A and B looked at the 100/200 hall nursing station and none of them were able to find a portable resident phone. Resident #58-Call Light-Food Preference: Review of the Face Sheet, MDS (dated 5/24), progress notes dated 5/15/24 through 6/12/24, revealed Resident #11 was [AGE] years old, alert and their own person, required staff assistance with all ADLs', and was admitted to the facility on [DATE]. The resident's diagnosis included, seizures, sacral pressure ulcer, disorder of the brain, left sided hemiplegia due to stroke, contractures of left upper arm, and social exclusion with rejection. Review of the care plan dated 5/15/24, revealed the resident was unable to use the left side due to a stroke. During an observation and interview done on 6/12/24 at 9:08 a.m., Resident #58 stated Sometimes I lay on it (call light), I can't find it. Observation revealed the resident's call light was clipped to his bottom sheet under his pillow, he was unable to reach it when asked, due to left sided weakness and contractures. Observation done on 6/12/24 at 12:00 p.m., the resident called the surveyor into the room and asked if they could get his call light off the floor because he wanted his lunch. During an interview done on 6/12/24 at 9:02 a.m., the resident stated, I asked for eggs, and they said there was no eggs; I complained and then she got me some. During an interview done on 6/17/24 at 8:25 a.m., Registered Dietitian N said there was no reason why Resident #58 could not have eggs, we serve them daily. Review of the facility Nutritional care plan dated 5/15/24, revealed the resident's food preferences were to be honored. 37668 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #62: On 6/12/24 at 11:18 AM, an interview was completed with Resident #62 in their room. When queried how long they had been at the facility, Resident #62 replied they had been there for approximately a year and a half. When asked the reason they came to the facility, Resident #62 replied, I am 92 (years old) and revealed they came to the facility from the hospital. When queried regarding the care they were receiving at the facility, Resident #62 stated, Not enough help here. When my cath (indwelling urinary catheter drainage bag) is full I have to call them (staff) and tell them because the pee goes all over the floor. When asked if they were saying the staff do not routinely empty their catheter drainage bag, Resident #62 confirmed that was what they were saying. Resident #62 then stated, The nurses and aides (Certified Nursing Assistants- CNA) are rude. When asked how the staff are rude, Resident #62 stated, (Staff) don't have time to treat people like human beings. When asked what they meant, Resident #62 replied, I'm scared to say anything. Resident #62 was asked why they were scared to say anything and revealed they were scared that the staff would take it out on them if they spoke out. Resident #62 then stated, They don't like it when I speak back to them. I took care of patients for [AGE] years and revealed they were a direct patient care provider, had family who also worked in health care, and knew what should happen. With further inquiry, Resident #62 stated, They say to me, 'What do you want?' in a mean way from the doorway. When asked to say the phase to this Surveyor, in the same way that staff speak to them, Resident #62 spoke in a very demeaning and rude tone and manner. Resident #62 then stated, They don't answer my call light, I see them walk right by. Resident #62 verbalized their call light is their lifeline and reinforced how important is to them to know that someone will answer it and be there if they need help. When asked if the staff come back to answer their call light if they walk past, Resident #62 replied sometimes and stated, I put my light on and instead of answering it, they (staff) yell from the doorway. Resident #62 revealed they felt not entering their room and yelling from the doorway was very disrespectful. Resident #62 verbalized they are able to do things for themselves and indicated they worry for the other Residents who cannot talk. When asked what they meant, Resident #62 stated, I just wish (the staff) would be more polite and treat them like they are human. They just leave them who can't talk. Resident #62 them became tearful and stated, I just want them to treat people like they are human. They need help. Resident #62 continued, I have to get my own water out of the faucet in my bathroom and revealed water is not routinely passed to Residents. When queried what they do if the staff do not answer their call light, Resident #62 revealed they walk to the nurses' station to tell the staff what they need. Record review revealed Resident #62 was originally admitted to the facility on [DATE] and most recently readmitted on [DATE] with diagnoses which included falls, depression, Transient Ischemic Attack (TIA- sometimes called a mini stroke), seizures, unspecified dysfunction of the bladder, and legal blindness. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was moderately cognitively impaired and required supervision with toileting, bathing, and ambulation. The MDS further detailed the Resident had an indwelling urinary catheter. At 12:11 PM on 6/12/24, Resident #62's call light was on, and the Resident was observed exiting their room and walking towards the nurses' station. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was completed with Resident #62 in their room on 6/13/24 at 2:57 PM. When queried how their day was, Resident #62 verbalized the same concerns regarding treatment by facility staff as on 6/12/24 and stated, The Aides are mean and nasty. They come to the door and say, what do you want? Resident #62 revealed the staff will also ask them what their problem is. When asked how that makes them feel, Resident #62. An interview was completed with Resident #62's Family Member Witness U on 6/17/24 at 8:01 AM. When queried regarding Resident #62's care in the facility, Witness U stated, They are short staffed. Witness U revealed it is good that (Resident #62) can get up and go to the bathroom themselves because of the facility being short staffed. When queried if they had any concerns regarding the Resident's care, Witness U stated, No way to make private phone calls. (Resident #62) had to go to the nurses' station. When asked if the facility had a cordless phone that Residents could use, Witness U replied they did not and calls had to be made from the phone at the nurses' station where everyone was able to hear what was being said. Witness U was then asked if they had seen staff ask the Resident, What do you want? in a rude manner and/or not come into their room when responding to the call light and replied, Yes. Witness U stated, I've seen that saying that from the door. They (staff) will ask (Resident #62), 'What is your problem?' Resident #33: In 6/12/24 at 2:08 PM, Resident #33 was observed sitting in their wheelchair in their room with their head down and chin on their chest. Upon knocking and entering the room, Resident #33 looked up and an interview was completed. When queried how they are treated by facility staff, Resident #33 revealed the staff do not always treat them respectfully. When asked what they meant, Resident #33 replied, Those girls (staff) had to get out. When asked what they meant, Resident #33 revealed they had told staff to leave their room on several occasions because they were being rude and disrespectful to them. When queried what happened when they told the staff to leave, Resident #33 revealed they did not get any help. When queried what the staff said to them, Resident #33 did not reply. When asked how it made them feel, Resident #33 revealed it made them upset enough to tell them to get out of their room. Record review revealed Resident #33 was admitted to the facility on [DATE] with diagnoses which included falls, dementia, and pain. Review of the MDS assessment dated [DATE] revealed the Resident was severely cognitively impaired and required supervision to total assistance to complete ADLs with the exception of set-up assistance for eating. 39059 Resident #17: On 6/12/24, at 8:58 AM, Resident #17 was lying in bed. Their urinal had 250 milliliters of urine inside. The urinal was sitting on their overbed table next to candy snacks and water. Resident #17 was asked if the staff empty it for them and Resident #17 stated, it will sit there all day and night. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/12/24, at 12:20 PM, Resident #17 was lying in their bed. Their urinal now had 450 milliliters of urine in it. Resident #17 was asked if they put their call light on would staff come empty it and Resident #17 stated, yeah if they come but that sometimes takes too long. Resident #17 was asked if they used it while is was full or urine and Resident #17 stated, yeah, I peed more in it. Resident #17 had a bandage to their left foot that was saturated with drainage that had leaked onto their bed sheet. The area was approximately 1 foot square and appeared dried. On 6/12/24, at 3:50 PM, Resident #17 was lying in their bed and the drainage to their bed sheet remained along with their saturated dressing to their left foot. Resident #17 offered that the nurse came in and was going to change it but that had been a couple hours ago. On 6/12/24, at 3:53 PM, Nurse Q entered Resident #17's room and was asked what was all over their bed sheet and Nurse Q offered that looks like drainage and it appears the dressing has moved up a bit. On 6/13/24, at 7:49 AM, Resident #17 was lying in their bed. The drainage on the bed sheet from their left foot wound remained. Resident #17 offered that they didn't change the bed sheet but changed their dressing. On 6/13/24, at 2:00 PM, a record review of Resident #17's electronic medical record revealed an admission on 4/24/2024 with diagnoses that included Osteomyelitis, Diabetes and history of Kidney transplant. Resident #17 required assistance with Activities of Daily Living and had intact cognition. A review of the Focus Risk for Urinary incontinence r/t (related to) .elevated PSA -reduced mobility Date Initiated: 05/20/2024 Goal Will attain/maintain as clean and dry dignified state as possible . Interventions/Tasks . Keep urinal in reach at bedside per his request and empty as needed. Date Initiated: 05/20/2024 . On 6/17/24, at 9:08 AM, Resident #17 was lying in their bed. Resident #17 lifted their foot up off the bed and their dressing to their left foot was dry and intact. There was a large amount of dried drainage to their bed sheet under their foot. Resident #17 now had a blue urinal holder attached to their overbed table with their urinal inside and empty. On 6/17/24, at 9:13 AM, Nurse O entered Resident #17's room and was asked what was all over the bed sheet and Nurse O stated, we will get your sheet changed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 39059 Based on observation, interview and record review, the facility failed to provide Activities of Daily Living assistance for two residents (Resident #9, Resident #47) of five residents reviewed for ADL assistance, resulting in overgrown toenails, lack of showers, missed lunch meal with the likelihood of decreased mood and hunger. Findings include: Resident #9: On 6/12/24, at 9:23 AM, Resident #9 was resting in their bed. Resident #9 was asked if they were comfortable and Resident #9 pulled their sheet and exposed their toenails and stated, ow, ow. Resident #9's toenails were grossly long and slightly curled over the ends of their toes. On 6/13/24, at 1:00 PM, a record review of Resident #9's electronic medical record revealed an admission on 03/07/2023 with diagnoses that included Stroke, Dysphagia and Muscle weakness. Resident #9 had severely impaired cognition and required extensive assistance with Activities of Daily Living. A review of the Task: Bath/Shower/Bed Bath Look Back: 30 (days) revealed . did the resident receive their bath, shower, or bed bath? The following dates were documented of a bed bath or shower: 5/20/2024 5/27/2024 6/3/2024 6/10/2024 On 6/17/24, at 8:16 AM, an observation along with the DON of Resident #9's toenails was conducted. The DON exposed their toenails as Resident #9 pulled back their feet. Resident #9 was asked if they hurt and Resident #9 stated, yes, yes. The DON was also alerted that Resident #9 had only been getting showers once a week for the last month. On 6/17/24, at 10:00 AM, Social Worker M was asked to provide the most recent podiatrist visit for Resident #9 and Social Worker M offered that the resident hadn't seen the podiatrist since they started their position and the next Podiatry visit was on July 1st. On 6/17/24, at 4:27 PM, the DON entered the conference room and offered a record review of the shower schedule. Resident #9 was listed for Mondays only. The DON offered that when the shower schedule got updated, Resident #9 had not been added to Friday's which would have been their second scheduled shower for the week. Resident #47: On 6/17/24, at 1:40 PM, an observation of the dining on the east end of the facility was conducted. There was a lunch tray sitting on top of a table, covered with plastic wrap for Resident #47. The tray appeared untouched. The meal ticket revealed ALERTS: 1:1 assistance. Nurse F was asked if Resident #47 refused their lunch and CNA J walked up and offered, I didn't know he didn't eat. CNA J offered that they were assisting another resident at the end of the hall and offered that Resident #47 had a hospice visit today and hadn't been eating lately. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/17/24, at 1:50 PM, the Director of Nursing was alerted of the untouched lunch meal for Resident #47 and entered the dining room as CNA J was exiting with Resident #47's lunch meal. CNA J stated to the DON that they were helping with another resident and didn't know he didn't get his tray. The DON instructed to have the kitchen make a new tray for Resident #47. On 6/17/24, at 2:28 PM, Resident #47 was sitting up in their bed. Nurse F was assisting with their lunch meal. Resident #47 had consumed half of their ice cream and was still taking bites.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement a comprehensive pressure ulcer prevention and skin management program for one resident (Resident # 66) of two residents reviewed, resulting in Resident #66 developing an unstageable (unknown depth) pressure ulcer, unnecessary pain, and the likelihood for a decline in health status. Findings include: 38471 Resident #66: During initial tour on 6/12/2024, Resident #66 was observed resting in bed enjoying a snack. She was pleasantly confused and not able to hold a conversation with this writer. On 6/12/2024 at approximately 2:00 PM, a review was conducted of Resident #66's medical records and it revealed she admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis, Hypertension, Atrial Fibrillation and Mood Disorder and required staff assistance with ADL (Activities of Daily Living)'s. Further review of Resident #66's records yielded the following results: Physician Orders: Cleanse left heel with wound cleanser, pay dry, skin prep to peri wound, cut aquacel ag to fit, place on wound bed place on wound bed cover with an aquacel heel cushion and change every other day. Ordered on 5/7/2024. Skin prep to right heel, two times a day. Ordered on 5/7/2024. Progress Notes: 5/1/2024 at 06:37: During skin assessment noted to see a starting pressure ulcer to right heel. Skin is intact with an outline of area of pressure. Skin prep applied and ordered twice a day. 5/1/2024 at 12:40: Daughter called and informed about red right heel. Blue heel floater is ordered to be used while in bed. Physician Progress Notes: 5/7/2024 at 19:19: No mention of left heel pressure ulcer. 5/26/2024 at 16:48: No mention of left heel pressure ulcer. 6/13/2024 at 21:24: No mention of left heel pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wound Evaluation Notes: May 7, 2024: 3.36 cm (centimeters)x 2.28 cm x 2 cm. Pressure, unstageable. 70% slough, 10% eschar, light serosanguineous drainage. Pt (patient) noted to have a pressure until the left heel. Cleansed with normal saline and applied skin prep to area. New orders for wound care to cleanse left heel with wound cleanser, pay dry, skin prep to peri wound, cut aquacel ag to fit, place on wound bed cover with an aquacel heel cushion and change every other day. May 13, 2024: 2.59 x, 2.05 cm x 1.72 cm. unstageable, in house acquired on 5/1/2024. Light serosanguineous drainage. Cleanse left heel with wound cleanser, pay dry, skin prep to peri wound, cut aquacel ag to fit, place on wound bed cover with an aquacel and covered with foam dressing. Pt tolerated well. May 24, 2024: 2.57 x, 1.8 cm x 1.65 cm x 0.1 cm. Unstageable in house acquired pressure ulcer on left heel. 50% granulation, 50% eschar. Light serosanguineous drainage .Wound bed pink with some necrotic tissue present, small amount of serouse drainage present no odor or s/s (signs and symptoms) of infection. June 4, 2024: 0.98 cm x 1.51 cm x 0.85 cm. Unstageable in house acquired pressure ulcer on left heel. Light serosanguineous drainage. Left heel, wound bed pink with some necrotic tissue present on lateral side, small amount of serous drainage present no odor or s/s of infection. June 11, 2024: 0.55 x 0.98 cm x 0.68 cm. Unstageable in house acquired pressure ulcer on left heel. Light serous drainage. Left heel, wound bed appears to be dark red. Scant amount of serosang noted. No odor or s/s of infection . On 6/17/2024 at 12:00 PM, an interview was conducted with Unit Manager T regarding Resident #66's facility acquired pressure ulcer. Manager T shared they noticed a reddened circle on her left heel on 5/1/2024 and it began to spread on 5/7/2204. On 5/1/2024 they implemented heels up, as she was not able to reposition herself in bed. Manager T continued the wound is from pressure and was acquired at the facility and has remained unstageable. This writer and Manager T reviewed Resident #66's care plan and there were interventions for prevention of pressure ulcers until after the wound developed. We further reviewed Resident #66's physician progress notes and could not find any documentation that indicated the wound had been assessed by him. Manager T expressed understanding of this writers' concerns.

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	235056	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive restorative nursing program for one resident (Resident #1) of one resident reviewed, resulting in a lack of consistent Range of Motion (ROM) joint measurements, a lack of a well-defined and planned interventions and implementation of ROM for a resident with contractures, inaccurate documentation of Passive ROM (PROM) exercises, Resident #1 verbalizing discontentment and experiencing a decline in ROM, worsening contractures/ROM, unnecessary pain, and the likelihood for further decline. Findings include: Resident #1: On 6/12/24 at 3:14 PM, Resident #1 was not observed in their room. An alternating air mattress was present on the Resident's bed. Certified Nursing Assistant (CNA) V entered the Resident's room. When asked where Resident #1 was, CNA V revealed the Resident was out of the building at a wound care appointment. Record review revealed Resident #1 was admitted to the facility on [DATE] with diagnoses which included Multiple Sclerosis (MS), functional quadriplegia (immobility from another medical condition), pressure ulcer (wound caused by pressure), and contracture, unspecified joint. Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed the Resident was cognitively intact, dependent upon staff for all Activity of Daily Living (ADL) completion and had impaired ROM in both upper and lower extremities. Review of Resident #1's Electronic Medical Record (EMR) revealed a care plan entitled, I have a potential/actual ADL deficit R/T (related to): MS, quadriplegia . contracture . muscle spasticity, muscle weakness . reduced mobility . (Initiated: 6/23/23; Revised: 6/12/24). The care plan included the interventions: - I want to get up at 6 am (Initiated: 8/15/23) - Nursing Rehab: Passive ROM to both upper and both lower extremities each am and each pm (Initiated: 7/6/23) - Ambulation: non-ambulatory (Initiated and Revised: 1/22/24) - Transfer 2 PA (Person Assist) total lift (Initiated and Revised: 7/6/23) - Bed mobility 2PA (Initiated and Revised: 7/6/23) A review of Resident #1's EMR revealed the following documentation: (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 7/6/23 at 4:15 PM: Restorative Note . Resident was recently admitted with MS with contractures of all extremities. Nursing restorative PROM (Passive Range of Motion- someone else moves the joint/extremity) program initiated-see tasks and CP (Care Plan). - 10/2/23 at 8:21 PM: Restorative Note . Resident reportedly has been accepting restorative ROM in am/pm . continues with contractures of all extremities with no change . remains dependent for all mobility and ADL care . Speech therapy is currently working with staff for . education for oral care. OT discharged ,d+[DATE] and has a panacea tilt and recline w/c (Med-[NAME] wheelchair) . at risk for further ROM declines . - 12/27/23 at 10:48 AM: Restorative Note . Resident reportedly has been accepting am/pm restorative most days . has had two refusals reported this month . continues with contractures of all extremities with no change . remains dependent for all mobility and ADL care . at risk for further ROM declines . - 3/18/24 at 9:01 PM: Restorative Note . Resident reportedly has been recently tolerating/accepting Restorative ROM daily . continues with contractures of all extremities with no change . remains dependent for all mobility and ADL care . at risk for further ROM declines . Review of Task documentation in Resident #1's EMR revealed the task, Nursing Rehab: Passive ROM (PROM) to both upper and both lower extremities each am and each pm. The task including the following sections for documentation: - Question 1: Amount of minutes spent providing Range of Motion (passive) - Question 2: Did Resident complete his/her goal? - Question 3: Did Resident exceed his/her goal? Note: The task did not include specific joints, exercises, and/or number of repetitions. Review of the ROM documentation for the prior 30 days revealed Resident #1 received an average of 4.35 minutes of ROM daily. The range of minutes of PROM provided ranged from zero (no documentation) to 15 minutes and the most frequent number of PROM documented when provided was three minutes. The EMR did not include a goal. However, the documentation indicated the Resident completed their goal 34 times and exceeded their goal 11 times in the prior 30 days. There was no documentation of minutes for 10 of the scheduled times. At 11:43 AM on 6/13/24, Resident #1 was observed in their room. The Resident was sitting in a Med-[NAME] brand (high back, reclining wheeled chair with solid leg and footrests) chair with their eyes closed. The back of the chair was reclined approximately 15 degrees with their legs down. Resident #1's feet and heels were positioned directly against the footrest of the chair. Their arms were bent at the elbows and crossed with their hands upward towards their chest. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/24 at 2:06 PM, Resident #1 was observed in their room, sitting in the same position in the chair. An interview was completed this time. When queried regarding their ability to move their extremities, Resident #1 revealed they were dependent upon staff for assistance and had contractures in all of their extremities. Resident #1 was asked if they were receiving Therapy services and revealed they were not. When queried if they were receiving Restorative Nursing and/or ROM exercises, Resident #1 stated, They only do it when I ask. Resident #1 then stated, I am only contracted like this because I forget to ask. Resident #1 was then asked about documentation in their EMR specifying staff were providing ROM once to twice daily and stated, That ain't true. When queried if they have pain, Resident #1 replied, I'm one pain patch. They started giving me morphine (narcotic medication for severe pain) and that worked for a while, but it stopped (working). When queried where they had pain, Resident #1 stated, My joints in general, legs and shoulders. Resident #1 then stated, It is the worst in the middle of the night. Review of therapy documentation in Resident #1's EMR revealed the Physical Therapy (PT) documentation present was from 2024. - PT Evaluation & Plan of Treatment . Certification Period: 1/25/24 - 1/25/24 . Reason for Referral . ROM assessment . Musculoskeletal System Assessment . PROM - (R) Wrist Flexion = 70 ; Extension = 75 . PROM - (L) Hip Flexion = 5 (degrees); Extension = 0 . PROM - (L) Shoulder: Flexion = 10 ; Extension = 0 ; Abduction = 45 . PROM - (L) Elbow /Forearm Flexion = 130 (Normal is 147-149); Extension = -140 (Normal Extension is -2 to -10) . PROM - (L) Shoulder: Flexion = 10 (normal 157.1-161.5); Extension = 0 (Normal 147. 7 to 151.5); Abduction = 45 (Normal 150) . Functional Limitations Present due to Contracture = No . - PT Evaluation & Plan of Treatment . Certification Period: 4/8/24 - 5/5/24 . Objective Progress / Short-Term Goals . #1 . Patient to tolerate PROM BLE (Bilateral Lower Extremities) and care giver education with PROM with care to enable to prevent further tightness . PLOF (Prior Level of Function): NT (Not Tolerated) . Baseline (4/8/24) Patient understands the plan for PROM BLE to be done by caregivers . Long-Term Goals . #1 . Patient to tolerate PROM BUE and care giver education with PROM with care to enable to prevent further tightness . PLOF: NT . Baseline (4/8/24) Patient understands the plan for caregiver education . Focus of Plan of Treatment = Restoration . Reason for Referral: To establish ROM program by floor staff . Musculoskeletal System Assessment . PROM - (L) Hip: Flexion = 5 ; Extension = 0 ; Abduction = 10 ; Adduction = 0 (Abduction and Adduction measurements not included on prior assessment) . PROM - (R) Elbow / Forearm: Flexion = 130 ; Extension = -125 ; Pronation = 0 ; Supination = 0 . PROM - (L) Shoulder: Flexion = 10 ; Extension = 45 (Abduction not included in documentation) . Functional Limitations Present due to Contracture = Yes . Will PT treat to address Contracture impairment? = no, Nursing is managing patient's contracture impairment . Exercise Prescription . Range of Motion . to Address Patient's ROM Limitations: PROM BUE and LE . - PT Discharge Summary . Dates of Service: 4/8/24- 5/3/24 . Patient was seen for 1 day(s) during the 5/2/2024 - 5/3/2024 progress period . Objective Progress . Long-Term Goals . #1 . Patient to tolerate PROM BUE and care giver education with PROM with care to enable to prevent further tightness . Baseline (4/8/24) Patient understands the plan for caregiver education . Previous (5/1/24): Patient able to tolerate PROM, at times c/o pain in UE . Discharge (5/3/24): Caregivers demonstrate understanding of providing PROM BLE and UE . Discharge Recommendations: Caregivers to continue with PROM BLE and UE with care . Restorative Program Established/Trained = Not Indicated at This Time . Functional Maintenance Program Established/Trained = Not Indicated at This Time . (continued on next page)

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	235056	A. Building B. Wing	06/17/2024

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of PT assessment documentation revealed N/A was documented for all AROM (Active Range of Motion). An interview was conducted with Therapy Director G on 6/13/24 at 4:18 PM. When queried regarding Resident #1's ROM, Director G relayed the Resident had Bilateral upper and lower extremity impairment. When queried regarding AROM, Director G indicated the Resident was completely dependent upon staff and did not have any AROM. Director G was queried if Resident #1 was currently receiving Therapy Services and revealed they were not. When asked the last time Resident #1 had been seen by therapy, Director G revealed they were seen in April 2024. When queried if the Resident had contractures, Director G replied they did. Director G was then queried regarding the facility Restorative Nursing program and stated, Yeah. We discuss in the morning meeting. Director G then stated, Range of Motion programs are just ROM with AM and PM care. When asked if Therapy services referred and/or were involved in developing a Restorative Nursing plan, Director G reiterated leadership staff discuss residents at the facility morning meeting and made determinations regarding Restorative Nursing. When queried if Therapy staff complete a referral and/or recommendation form for Restorative Nursing, Director G revealed there was no form completed and information was discussed verbally in the morning meeting. Director G was then asked why Resident #1 was referred to Therapy in April 2024 and replied, Range of Motion. When queried if Resident #1 was receiving Restorative/ROM when they referred to Therapy, Director G stated, Yes. When asked if the reason Resident #1 was referred to Therapy was due to a decline in ROM, Director G stated, We picked (Resident #1) up to make sure that it (Restorative/ROM) was appropriate and effective and revealed they were unable to recall if the Resident had a decline without reviewing the Resident's EMR documentation. When asked if Therapy services obtain ROM measurements, Director G replied they do and stated all ROM measurements are obtained by the Physical Therapist. With further inquiry regarding Resident #1's ROM measurements, Director G proceeded to print and review several EMR assessments. When asked to see the assessments, as not all PT documentation was available in the EMR, Director G declined and would not allow this Surveyor to review the therapy documentation. When queried the reason Resident #1 was picked up by Therapy in January 2024, Director G verbalized it was related to ROM concerns. When queried if the Resident was receiving Restorative/ROM prior to January 2024, Director G indicated they were. Director G was then asked to review Resident #1's ROM measurements. When asked if the Resident had a decline in ROM, Director D stated they had. Director D was then queried regarding the task in Resident #1's EMR specifying, Passive ROM to both upper and both lower extremities each AM and each PM. When asked what joints and what specific PROM exercises (flexion, abduction, extension, etc.) were supposed to be completed as part of the Restorative Program, Director G was unable to provide a response. When asked if a specific number of repetitions were supposed to be completed for each joint/PROM exercise and if the joint was supposed to be held for a specific number of seconds, Director G did not provide a response. When queried if purposeful PROM exercises are more beneficial in preventing decline in ROM and/or contractures, Director G confirmed they were. When asked why purposeful and detailed PROM exercises were not ordered, provided, and documented for Resident #1, Director G reiterated ROM is completed by floor staff during care. When queried if ROM measurements were completed prior to January 2024 upon the Resident's admission to the facility, Director G indicated they would need to look. When asked if the Resident had a decline in ROM since their admission, Director D confirmed some of the Resident's PROM measurements have decreased. Director G verbalized the Resident decreased ROM when they were admitted to the facility. When queried why ROM was not measured for the same joints in the January and April PT Evaluation assessments, an explanation was not provided. When queried why Resident #1 experienced a decline in ROM necessitating Therapy in January and April 2024 if they were receiving PROM twice daily, Director G was unable to provide an explanation. Resident #1's Therapy Documentation and ROM measurements were requested at this time but not received by the conclusion of the survey. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Certified Nursing Assistant (CNA) W on 6/17/24 at 1:58 PM. When queried regarding Restorative Nursing Services in the facility, CNA W revealed the facility did not a dedicated Restorative CNA. When asked if Resident #1 was on a Restorative Program and/or receiving any ROM exercises, CNA W stated, I do ROM when I get them dressed. With further inquiry, CNA W revealed the Resident is unable to move their arms and/or legs by themselves. When queried regarding completion of Resident #1's PROM exercises, CNA W indicated they move the Resident's arms and legs to put clothes on. CNA W was asked if they do any specific PROM/stretching exercises and stated, I don't know what (Resident #1) can do. CNA W was then asked about documentation of PROM in the EMR. When queried what the total number of minutes signified in the PROM task documentation, CNA W stated, However long I was in the room. When asked to clarify if they were saying they documented the total number of minutes they were in Resident's room providing care or if they documented the total number of minutes spent providing ROM. CNA W verbalized they document the total number of minutes they spend in Resident #1's room. When asked if they are providing PROM the entire time they are in the room, CNA W verbalized they are not. On 6/17/24 at 2:50 PM, Resident #1's Restorative Nursing/PROM Task documentation, included in the Survey Documentation Report, was requested from the Director of Nursing (DON). The requested documentation was not received by the conclusion of the survey. An interview was conducted with the Director of Nursing (DON) on 6/17/24 at 3:55 PM. When queried what should be included documentation of the number of minutes spent providing PROM to Residents, the DON indicated documentation should reflect the actual number of minutes that ROM was provided. The DON was informed of CNA statement regarding documentation as well as Resident #1 stating staff did not provide PROM unless asked to do so while documenting completion. The DON confirmed Resident #1 was cognitively intact and able to verbalize concerns. When queried regarding the lack of specific joint and PROM exercise identification in the task, as well as confirmation of decline in an area of Resident #1's PROM by Director G, the DON did not provide an explanation. A policy/procedure related to Restorative Nursing was requested from the facility Administrator on 6/13/24 at 11:39 AM but not received by the conclusion of the survey. References: Zwerus, E. L., Willigenburg, N. W., [NAME], V. A., Somford, M. P., Eygendaal, D., & van den Bekerom, M. P. (2019). Normative values and affecting factors for the elbow range of motion. Shoulder & elbow, 11(3), 215-224. https://doi.org/10.1177/1758573217728711 [NAME] LR, [NAME] P, Varacallo M. Anatomy, Shoulder and Upper Limb, Glenohumeral Joint. [Updated 2023 [DATE]]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2024 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK537018/

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	235056	A. Building B. Wing	06/17/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 This Citation pertains to Intake Number MI00144673 for Resident #51. Based on observation, interview and record review, the facility failed to ensure a safe shower for one resident (Resident #14), care plan and ensure a functioning wander guard for one resident (Resident #43), ensure proper supervision for one resident (Resident #67) who was smoking in his room, and ensure a safe transportation to a medical appointment for one resident (Resident #51), resulting in an unsafe shower with the likelihood for a fall with injury and verbalization of pain during the shower, an unsafe Wanderguard with the likelihood of elopement and injury, a dangerous environment for a census of 76 residents due to a resident smoking in the facility, and a resident being dropped off for a medical appointment at the wrong facility, with the likelihood of injury, and fear of being driven to further appointments. Findings Include: Resident #14: Review of the face Sheet, MDS dated [DATE]/2024, progress notes dated 5/25/2024 through 6/12/2024, and physician orders dated 5/25/2024, revealed Resident #14 was [AGE] years old, alert and his own person, non-ambulatory and was admitted to the facility on [DATE], from acute care and required staff assistance with all ADLs'. The resident's diagnosis included, falls, hematoma (bruising) of soft tissue, Parkinson's Disease, morbid obesity, muscle weakness, Lymphedema, reduced mobility, anemia (low iron), Acute Kidney Disease, high blood pressure, Diabetes, fluid overload, heart disease, and Atrial Fibrillation. Review of the resident's facility weight's dated 5/28/24 through 6/12/24, revealed at the time the resident was showered (on 6/13/24), his was was 314.4 Lbs. (continued on next page)

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	235056	A. Building B. Wing	06/17/2024

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation was made on 6/13/24 at 10:51 a.m., of 4 Nursing Assistants/CNA's (CNA's H, I, J and K) giving Resident #14 a shower in the 100/200 shower room. The resident was lifted using the Hoyer lift from his bed to his wheelchair using the blue with purple sling. The right and left side of the residents hips, buttocks and lower back had a hangover of approximately 4 to 5 inches on either side; the sling was to small for the residents size. When the resident got to the shower room, the CNA's using the Hoyer lift transferred him to the shower chair. When the CNA's were attempting to remove the sling from underneath the resident, he almost slid out of the shower chair twice. The resident yelled in pain several times while staff were removing the sling. Then the resident had a large bowel movement and there was no bucket that went under the shower chair available so staff continued to start his shower until several minutes later another staff came to clean up the shower floor. During the shower the resident was sidling down in the shower chair. One CNA was left with the resident while in the shower, the others left the room. The resident began to slide out of the shower chair and all the CNA's picked him up using his arms and legs and had to quickly put him back in the chair before he fell . The resident was large and was unable to get himself back into the shower chair by himself. When his shower was completed, it took 3 CNA's and a manger team member to get the sling back under him; he was sidling out of the shower chair. A larger sling was used to put him from the shower chair back into his wheelchair after the shower was completed. All the CNA's in the shower room agreed the sling was to small for a safe transfer. Observation of the original sling used for the resident revealed no written guidance for weight or size of resident on the tag. Observation of the shower room used for the residents shower done on 6/13/24 at 11:00 a.m., revealed no sign, or guidance for Hoyer sling size posted. Review of the facility residents Kardex (un-dated), revealed Transfer 2PA (2 person) Hoyer lift. No documentation of sling size was found. During an interview done on 6/13/24 at 11:00 a.m., CNA H stated That's the biggest one (Hoyer sling) we have; the one he was using was to big and he didn't like it. No one told us which one to use (which sling to use for the resident). 6/13/24 at 10:45 a.m., Interview done with Therapy Director G stated nursing does sling assessments. During an interview done on 6/13/24 at 11:15 a.m., the Administrator stated Therapy does not do sling assessments, nursing does it. The Administrator and this surveyor reviewed the resident's electronic medical record and were unable to find an assessment for appropriate sling size. No directions were given to the staff regarding which sling to use until 6/13/24, after the shower observation. Review of the facility Hoyer used for Resident #14 guidance for sling usage stated, Sling sizes range from Small to XL, and have a weight capacity 1,000 lbs. Keep in mind that the sling must fit the body style and size of the person, and the person using the Able to put on or remove from a chair or seated position Available with head support Multiple loop sizes Instructions Sling Care Instructions Accessory Inspection Checklist Sling Sizing Chart Sling with Head Support Sizing Chart Spacer Fabric Flyer Wipeable Sling www.exsling.com 38471 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #51: During initial tour on 6/12/2024, Resident #51 was observed in her bedroom. The resident was pleasantly confused but appeared to be in good spirits. On 6/13/2024 at approximately 1:30 PM, a review was completed of Resident #51's medical records and it indicated the resident admitted to the facility on [DATE] with diagnoses that included Hemiplegia, Vascular Dementia, Heart Disease, Aphasia and Major Depressive Disorder. Further review of Resident #51's records yielded the following: Progress Notes: .transportation dropped mom off wrong place and then a new guy picked mom up dropped her off to the correct place for her scheduled appointment .if we can put a plan together with transportation that's suitable for safety . On 6/12/2024 at 2:15 PM, the Administrator was queried regarding Resident #51 being dropped off at the wrong location for her appointment. The Administrator explained the contracted transportation company driver did drop Resident #51 off at the wrong medical office. Shortly after his departure, the office contacted the driver to alert him he dropped off the resident at the incorrect location and the driver circled back to pick up the resident and transported her to the correct facility. The administrator stated they provide the company with a form that has the time of the appointment, address and if family is meeting them there, which in their case Resident #51's daughter met them at the office. The Administrator Review was completed of Transportation Form sent to the transportation company and the grievance from the Transportation Form, indicated the resident name, date of appointment/time (5/22/24) , pick up address, destination address, suite number and stated, daughter will meet. The grievance filed stated the following, Mom (Resident #51) was transported to incorrect place. Scheduler didn't answer my call. Staff member had poor customer service .Transportation did go to wrong building driver took resident to correct building and resident attended appt . The driver was not aware Resident #51 was dropped off at the wrong facility until he was alerted to this fact and subsequently went back to pick her up and drop her off at the correct location. On 6/17/2024 at 3:26 PM, the Administrator was asked the procedure when transporting residents to appointments upon arrival. It was explained the driver would assist the resident into the facility, alert the front desk of their arrival and provide required documentation (if applicable). The administrator was asked if this was the process how did the situation with Resident #51 occur and an answer was unable to be provided. The Administrator asserted the resident still made her appointment and now a staff member will always ride with her to appointments even if her daughter is meeting them there. The administrator was asked if the drivers from both contracted companies received training on the expectations of the facility when transporting their residents. It was explained a discussion was held with the owner of the company involved regarding procedures but not their other contracted transportation company nor were the drivers educated on their procedure. (continued on next page)

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	235056	A. Building B. Wing	06/17/2024

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility resolved the concern for Resident #51 but not for their resident population that utilizes both transport companies. The facility does not have a process/procedure for transportation of residents nor do the drivers have instructions from the facility (that was able to be produced) when dropping residents off at their scheduled appointments. It's a high probability this could occur again as a process change was not fully enacted. Review was completed if the facility's, Contract Agreement for Transportation, the contact was executed on November 10, 2021. The agreement did not address the expectations of the transportation drivers upon dropping the residents off at their appointment. Resident #67: On 6/12/2024 at 1:09 PM, Resident #67 was observed in his room resting in bed. He stated the staff took his smokes, and he was confused as to why. It can be noted his room had an odor of cigarettes. On 6/13/2024 at approximately 7:30 AM, Resident #67 was observed preparing to smoke on the sidewalk directly in front of the facility. Resident #67 was observed attempting to light the cigarette and trembling greatly as he lit the cigarette and proceeded to smoke. After about 5 minutes he leaned over t the right, extinguished the cigarette in the rocks and placed the cigarette butt in his pocket. On 6/13/2024 at approximately 11:00 AM, a review was completed of Resident #67's medical records and it revealed he admitted to the facility on [DATE] with diagnoses that included, Bradycardia, Schizoaffective Disorder, Dementia, Cocaine abuse and pulmonary disease. Further review was conducted of Resident #67's medical records and it showed the following: Smoking Assessment: 2/5/2024: Resident states he cannot safely cross the street on his own, but he will have family assist at times of visits to assist. He was deemed safe to smoke. 4/30/2024: Deemed safe to smoke. 6/13/2024 at 10:31 AM: Deemed unsafe to smoke with burns to his fingers, hands shakes or tremble. Progress Notes: 6/12/2024 at 11:04: Pt (patient) was found in his room lying flat on his back smoking a cigarette, doing room rounds. It was noted that he also has uncontrollable shaking. Pt was informed that its a no smoking facility. Pt was confused. He was unaware of where he was and who this writer was of whom he speaks to daily by name. Smoking assessment to be completed and education was also done with patient. 6/13/2024 at 11:09: Smoking assessment complete and pt was found unsafe at this time. Cigarettes was removed from his room and several cigarette buts. Patient was informed on change and did not agreed with the change . Care Plan: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was nothing in the resident's care plan related to him smoking. On 6/13/2024 at 3:00 PM, an interview was conducted with Unit Manager T regarding Resident #67's ability to safely smoke. The manager report they conduct daily rounds and when she entered his room on 6/12/24 he was flat on his back in bed, smoking a cigarette. He seemed to be more confused during this encounter and stated to the manager, why are you doing this to me, even after she explained the safety risks with him smoking in the room. Today, Manager T completed a smoking assessment on the resident and found burns on his thumb and his tremors are increased. In his room she found two lighters, two packs of cigarettes, 8 cigarette butts and one single cigarette. Manager T was unsure as to how he had these in his possession as he was supposed to give them to the nurse upon completion of smoking. Manager T was asked where Resident #67 is supposed to smoke at, and she reported he should self-propel to the end of the sidewalk off campus. The manager was provided with the observation from earlier this morning of the resident smoking in front of the building at 7:30 AM. She was further informed that after he extinguished the cigarette, he placed it in his pocket. Manager T that is not where he is supposed to smoke at as they are a non-smoking facility, and he should dispose of the cigarettes in the appropriate cigarette refuse. Review was completed of the facility policy entitled, Resident Non-Smoking Centers/Staff Smoking Policy, revised 10/20/2023. The policy stated, .Document in the EMR the education of the resident/representative on the Nonsmoking policy to include prohibiting possession or storage of cigarettes, e-cigarettes, lighters or any other tobacco products in the facility. The facility will not provide supervised smoking at any time .Smoking is prohibited in any room, ward, or individual enclosed space where flammable liquids, combustible gases, or oxygen is used or stored . 39059 Resident #43: On 6/12/24, at 11:36 AM, Resident #43 was sitting in their wheelchair in the common area near the nurse station. Resident #43 had a wander guard bracelet to their left ankle. On 6/12/24, at 1:26 PM, a record review of Resident #43's electronic medical record revealed an admission on 3/17/2024 with diagnoses that included Dementia, Rib fractures and history of falling. Resident #43 required extensive assistance with Activities of Daily Living and had severely impaired cognition. A review of the progress notes revealed 5/26/2024 09:08 Behavior Note DOCUMENT BEHAVIOR, PRECIPITATING FACTORS, INTERVENTION AND RESPONSE:: Resident up walking. Went to south side 300 hall exit and went out. Nurse at resident side and brought back inside. Wander guard placed on left ankle. There was no other documentation noting the wander guard that was placed. A review of the Physician orders revealed no order to check placement nor function of the wander guard that was placed on the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the care plans revealed the wander guard nor exit seeking/wandering was care planned for Resident #43. On 6/13/24, at 2:06 PM, Nurse R was asked if Resident #43 wandered and was an elopement risk and Nurse R stated, he has a wander guard and the sign on his door so he knows that's his room. On 6/17/24, at 11:44 AM, Resident #43 was sitting in the common area near the nurses station. Nurse P was asked if they could ensure their wander guard was working and Nurse P came back with a hand held digital machine. Nurse P placed the machine near the wander guard and revealed the wander guard was functioning. Nurse P was asked how often they check wander guard function and Nurse P stated, we check for placement but maintenance staff checks for function. On 6/17/24, at 3:40 PM, Maintenance staff S was asked how they check the wander guards for function and Maintenance Staff S stated, we check the doors but not the wander guards.

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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. 39059 Based on observation, interview and record review, the facility failed to provide a safe subcutaneous injection for one resident (Resident #14), resulting in the likelihood of decreased efficacy, unwanted side effects of an intramuscular injected blood thinner (Heparin) into the abdomen, bruising and/or a hematoma. Findings include: Resident #14: On 6/17/24, at 1:20 PM, during medication administration task, Nurse F prepared medications for Resident #14. Nurse F gathered 3 oral medications and then gathered a vial of Heparin 5000 units for subcutaneous injection. Nurse F looked in the top drawer for a syringe and needle. Nurse F offered that they needed to get a syringe and needle from the medication room. Nurse F entered the med room and searched in multiple boxes for a needle and syringe. Nurse F pulled out a syringe with a 1 and 1/2 inch needle, cleaned the heparin vial and drew up the medication into the syringe. Nurse F did not replace the cap and held the syringe in their left hand while they reached over the exposed needle and grabbed another syringe. Nurse F then replaced the exposed needle with a new 1 and 1/2 inch needle. Nurse F was asked where the Heparin injection was going and Nurse F stated, in his belly. Nurse F entered Resident #14"s room and offered to the resident they had their heparin injection. Nurse F exposed the left side of Resident #14's abdomen, cleaned the area with alcohol pad, uncapped the syringe and was about to inject with the 1 and 1/2 needle. Nurse F was asked if they were sure they had the right sized needle and Nurse F stated, after a short pause, Oh, I was thinking of an IM (intramuscular) and left out of the room. Nurse F walked to the med cart and disposed of the prepared injection. Nurse F gathered an insulin syringe and prepared a new dose of heparin. Nurse F then entered Resident #14's room, used an alcohol pad and injected the heparin into the left side of the abdomen. After exiting the residents room, Nurse F was asked what sized needle is required for a subcutaneous injection and Nurse F stated the bigger the number the lower the needle. Nurse F was asked what length needle is required for a subcutaneous injection and what length needle is required for an intramuscular injection and Nurse F stated, I can't think of it off hand. On 6/17/2024, at 2:00 PM, the Director of Nursing was alerted that Nurse F was about to inject a subcutaneous medication with an intramuscular needle into Resident #14's abdomen. On 6/17/2024, at 3:00 PM, a review of the facility provided competency for Nurse F revealed the Nurse was competent in injections in November, 2023. On 6/17/2024, at 3:10 PM, a record review of Resident #14's electronic medical record revealed a physician order Heparin Sodium (Porcine) Injection Solution 5000 Unit/ML (Heparin Sodium (Porcine)) Inject 5000 unit subcutaneously every 8 hours for preventive . Active 05/25/2024 . According to medlineplus.gov, Heparin should not be given intramuscularly because of the danger of hematoma formation.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37668 Based on observation, interview and record review, the facility failed to implement and operationalize a comprehensive infection control program, encompassing outcome and process surveillance, and failed to ensure appropriate hand hygiene during care resulting in lack of accurate and comprehensive infection control tracking, surveillance and data monitoring/analysis and the likelihood for spread of microorganisms and illness to all 67 facility residents. Findings include: An interview and review of the facility Infection Control (IC) program was completed with IC Registered Nurse (RN) C on 6/17/24 at 10:50 AM. When queried regarding monitoring and tracking of residents with potential infections and residents with infectious organisms who are not receiving an antibiotic, RN C stated, Not and revealed they do not maintain documentation of tracking. 22347 Resident #14: Proper Hand Hygiene: Review of the face Sheet, MDS dated [DATE]/2024, progress notes dated 5/25/2024 through 6/12/2024, and physician orders dated 5/25/2024, revealed Resident #14 was [AGE] years old, alert and his own person, non-ambulatory and was admitted to the facility on [DATE], from acute care and required staff assistance with all ADLs'. The resident's diagnosis included, pressure ulcer on coccyx, hematoma (bruising) of soft tissue, Parkinson's Disease, morbid obesity, muscle weakness, Lymphedema, reduced mobility, chronic pain, Acute Kidney Disease, high blood pressure, Diabetes, and heart disease. An observation was done on 6/13/24 at 12:05 p.m., of wound care done by Nurse, LPN F. During the wound care, Nurse F cleaned the resident's coccyx wound, removed her dirty gloves and immediately put on a new pair of gloves. The nurse did not wash her hands or use alcohol after removing her dirty gloves. Review of the facility hand washing policy dated 4/29/20, stated hand hygiene (wash hands or use alcohol antiseptic) before and after applying gloves. Review of the facility Infection and Control Program dated 11/22/19, the facility was to comply with Federal regulations related to infection control. During an interview done on 6/17/24 at 2:24 p.m., the Infection Control Nurse, RN C stated remove gloves, wash hands and put more gloves on, diffidently wash in between (changing gloves). 39059 Medication Administration Task (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/13/2024, at 8:00 AM, Nurse P prepared and administered medications for a resident returned to the medication cart and began preparing medications for Resident #55 who was in enhanced barrier precautions. Nurse P did not perform hand hygiene prior to medication preparation. Nurse P gathered the medications to include 3 inhalation medications and entered the room. Nurse P did not perform hand hygiene, donned gloves and administered all 3 inhalation medications. Upon exit, Nurse P removed gloves and did not perform hand hygiene. Nurse P walked to the medication cart opened up the drawer and placed the inhalation medications into the corresponding boxes and closed the drawer. Nurse P still had not performed any form of hand hygiene. On 6/13/2024, at 8:35 AM, Nurse P began to prepare medications for Resident #65 which included 6 oral medications. Nurse P entered the room handed them to the resident who spilled the medications onto their gown and bedding. Nurse P donned gloves and picked up the pills and placed them back into the plastic med cup. Nurse P removed the gloves and left out to their computer to that ensure the medications were all accounted for. Nurse P entered the room and handed the med cup with the 6 spilled medications to the resident who consumed them. Nurse P exited the room, moved their medication cart and planned to continue medication pass. Nurse P was asked how they clean their hands during med pass and during glove use and Nurse P quickly used alcohol hand sanitizer.