STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235113	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saginaw Senior Care and Rehab Center, L L C	4322 MacKinaw Road Saginaw, MI 48603

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - 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** 37668 This Citation has two Deficient Practice Statements. Deficient Practice Statement 1: This Citation Pertains to Intake Numbers MI00137515 and MI00141236. Based on interview and record review, the facility failed to ensure that timely and appropriate care was provided, per professional standards of practice and Health Care Provider orders, for one resident (Resident #802) of three residents reviewed for assessment and monitoring, resulting in a lack of accurate infection control surveillance, Resident #802 not receiving medications as ordered for Covid-19, a lack of comprehensive assessment, documentation, and a timely response to an acute change in condition, and death. Findings include: Resident #802: Review of intake documentation dated received [DATE] revealed concerns that Resident #802 had contracted Covid-19 and that the facility did not notify the family, and did not implement appropriate infection control procedures related to Covid-19. The intake detailed, On Wednesday, (Resident #802) complained to the nurse about difficulties breathing, but (facility staff) didn't call 911. (Licensed Practical Nurse [LPN] D) gave (Resident #802) albuterol (inhaled medication used to prevent and treat bronchospasm in individuals with obstructive airway diseases), then left the room for an hour or so, when (LPN D) returned, (Resident #802) was unresponsive. Per the intake, Resident #802 died in the facility. Review of a separate intake for the facility revealed concerns that appropriate infection control precautions to prevent the spread of Covid-19 were not being implemented and/or followed. Facility Infection Control (IC) data was requested from the facility Administrator and Corporate Registered Nurse (RN) W on [DATE] at 11:03 AM. Upon request for infection control data from [DATE], RN W revealed the facility (IC) angrily quit employment with the facility the prior week and were unsure of the location of prior data. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Record review revealed Resident #802 was originally admitted to the facility on [DATE] with diagnoses which included Multiple Sclerosis (MS), paraplegia (paralysis of the lower body), neuromuscular disfunction of the bladder, and depression. Review of the Minimum Data Set (MDS) assessment, dated [DATE], revealed the Resident was cognitively intact and required limited-to-total assistance to complete Activities of Daily Living (ADL). Per the Electronic Medical Record (EMR), Resident #802 died in the facility on [DATE]. Any Incident and Accidents (I and A) and/or concern forms pertaining to Resident #802 were requested from the facility Administrator on [DATE]. On [DATE] at 9:00, the Administrator stated there were no I and A and/or concern forms for Resident #802. A review of Resident #802's EMR revealed the Resident made their own medical decisions but preferred to have their family involved in their care. Witness F was listed as Resident #802's Emergency Contact # 1. A form dated [DATE], entitled, Authorization List for PHI (Personal Health Information) included Witness F and specified to Please release medical information to whomever asks for it. A Code Status Form dated [DATE] was present in the EMR. The form specified Resident #802 was full code and wanted to receive Cardiopulmonary Resuscitation (CPR). Further review revealed a Physician . Progress Note dated [DATE] which specified the Health Care Provider (HCP) discussed code status with Resident #802 and the Resident wants everything to be done. The note indicated the (HCP) explained in detail what everything being done entails, and that Resident #802 wanted all resuscitation efforts made in a medical emergency. Review of progress note documentation in Resident #802's EMR revealed the following: - [DATE] at 3:07 PM: Nurses Note . Nursing staff was having a conversation with this resident it was noticed that responses were delayed and had a dry cough. A rapid covid test was performed and the Resident tested positive for Covid-19 this am. (Physician E) and family notified. New orders were monitor and follow protocols. - [DATE] at 4:10 PM: Nurses Note . Resident isolated in room and PPE staged. - [DATE] 12:37 AM: eMar (Electronic Medication Administration Record) -Medication Administration Note . Ventolin (albuterol) HFA Inhalation Aerosol Solution . 2 puff inhale orally every 4 hours as needed for Shortness of Breath for 14 Days PRN (as needed) - [DATE] 12:37 AM: eMar-Medication Administration Note . Acetaminophen (Tylenol) Tablet 325 mg (milligram) Give 2 tablet by mouth every 4 hours as needed for Generalized discomfort. Resident c/o (complain of) of discomfort. - [DATE] at 2:23 AM: Nurses Note . Walked into resident room around 1:10 AM, (Resident #802) was unresponsive performed OPR (sic) (CPR- Cardiopulmonary Resuscitation). Called 911. EMS took over. DON (Director of Nursing) and family called. EMS pronounced resident (deceased) at 1:59 AM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- [DATE] at 4:03 AM: eMar -Medication Administration Note . Ventolin HFA Inhalation Aerosol Solution . 2 puff inhale orally every 4 hours as needed for Shortness of Breath for 14 Days PRN (as needed) Administration was: Ineffective - [DATE] at 4:03 AM: eMar-Medication Administration Note .Give 2 tablet by mouth every 4 hours as needed for Generalized discomfort PRN Administration was: Unknown. - [DATE] at 4:21 AM: Nurses Note . family was here to visit around 3:30 AM . (Funeral Home) here to pick up body. A review of assessment documentation in Resident #802's EMR revealed no assessments had been completed related to the Resident testing positive for Covid-19, a change in condition, and/or to the Resident's death in the facility on [DATE]. A review of Resident #802's EMR revealed no HCP visit notes and/or documentation indicating the Resident was assessed by the Physician/HCP after testing positive for Covid-19 and before their death in the facility. Review of Census documentation revealed Resident #802 was moved from the 400 hall of the facility to a room on the 200 hall of the facility on [DATE] at 9:15 PM. Review of Resident #802's Health Care Provider Orders in the EMR revealed the following: - Covid Test PRN (as needed) (Ordered: [DATE]) - Normal Saline Flush Intravenous Solution 0.9 % (Sodium Chloride Flush). Use 75 milliliter (mL) intravenously (IV) one time only for COVID . 1 liter to infuse at 75mL/hr . (Ordered: [DATE]) - Resident was actively assessed for symptoms of COVID - 19 (fever, shortness of breath, cough, sore throat, chills/shaking, loss of tastes/smell, muscle aches, headaches confusion, nausea, vomiting and diarrhea) three times a day. The patient did not display any of these symptoms during my shift. Document in a nurse's note if the patient experienced any of these signs or symptoms of COVID every shift for Monitoring (Ordered: [DATE]) - Ventolin HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 4 hours as needed for Shortness of Breath for 14 Days (Ordered by Phone: [DATE]). The order was signed by Physician E on [DATE] at 8:53 PM. - Paxlovid (,d+[DATE] [mg]) Oral Tablet Therapy Pack (antiviral medication used to treat Covid-19 - treatment should be initiated as soon as possible after Covid diagnosis) . Give 3 tablet by mouth two times a day for COVID 19 for 5 Days . (Ordered by Phone: [DATE]; Start Date: [DATE]; Discontinued: [DATE]) - Paxlovid (,d+[DATE] [mg]) Oral Tablet Therapy Pack (antiviral medication used to treat Covid-19 - treatment should be initiated as soon as possible after Covid diagnosis) . Give 3 tablet by mouth two times a day for COVID 19 for 5 Days . (Ordered by Phone: [DATE]; Start Date: [DATE]). The order was signed by Physician E on [DATE] at 8:53 PM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	- Monitor patient for side effect r/t Paxlovid: anaphylaxis type reaction, hives, rash, diarrhea, high blood pressure, muscle aches, changes in smell. Three times a day for Paxlovid Therapy for 7 Days (Ordered by Phone: [DATE]; Start Date: [DATE]) - CBC (Complete Blood Count- blood test), BMP (Basic Metabolic Panel - blood test), CRP (C-Reactive Protein- blood test to identify inflammation in body) to be drawn next lab draw (Ordered and Discontinued: [DATE]) - Chest X-Ray 2-view .: (Ordered and Discontinued: [DATE]) Review of Resident #802's HCP orders revealed no orders related any type of Transmission Based Precautions (TBP) pertaining to Covid-19 diagnosis on [DATE]. However, discontinued orders for specific type of TBP were noted in the orders for 2020, 2021, and 2022. Further review revealed the Resident had not previously had an order for an inhaler and did not have an order for supplemental oxygen. A review of Resident #802's EMR revealed no results for the laboratory testing ordered on [DATE]. A Chest X-Ray was completed on [DATE] at 8:39 PM. The report detailed, Results . The lungs demonstrate no consolidation, masses or effusions . no evidence of significant pneumothorax (collapsed lung) . No focal airspace disease (abnormalities) . The report was signed by the facility Physician on [DATE]. Results of Covid-19 testing, including a PCR (polymerase chain reaction - more reliable/accurate test often used to confirm positive Point of Care [POC]/rapid test) were not present in Resident #802's EMR. Review of Resident #802's Electronic Medication Administration Record (eMAR) for [DATE] revealed the following: - Acetaminophen (Tylenol) 650 mg was administered on [DATE] at 2:06 PM and on [DATE] at 12:37 AM. A pain level of four (out of 10) was documented for both administrations. - Ventolin Inhaler was administered one time on [DATE] at 12:37 AM. - The ordered Paxlovid was never administered to the Resident. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was completed with Family Member Confidential Witness F on [DATE] at 9:15 AM. When queried regarding Resident #802, Witness F stated, On Sunday, Mother's Day 2023 ([DATE]), (Resident #802) tested positive for Covid. Witness F revealed they, along with other family members, went to visit the Resident in the afternoon on Mother's Day ([DATE]) and were informed by the nurse that (Resident #802) tested positive for Covid and they were unable to see them. Witness F stated, We asked why they (facility) didn't tell us that. When asked what the staff said in response, Witness F replied, The one nurse said, well you can probably go in there (Resident #802's room). Witness F verbalized the staff weren't wearing no masks or nothing in the hallways even though there were multiple residents who were Covid positive. When asked if Resident #802 was in the same room they had been in, Witness F replied, Yeah. (Resident #802) was in the same room so we stuck our head in there and (a female staff member) was in there feeding (Resident #802). Witness F revealed the staff member in Resident #802's room told them they could not come in and expressed confusion related to why one nurse said they could visit, and another said they could not. When asked what they did, Witness F replied, So we left. With further inquiry, Witness F revealed Resident #802 was moved to the Covid hall of the facility finally on Tuesday [DATE]th, 2023. When asked if they were saying Resident #802 tested positive for Covid-19 on Sunday [DATE] but was not moved to the Covid hall of the facility until Tuesday ([DATE]), Witness F confirmed. When queried if they knew why the Resident was not moved to the Covid unit [DATE], Witness F revealed they were unsure. Witness F then stated they were contacted by Licensed Practical Nurse (LPN D) in the evening, I wanna say 10:00 or 11:00 (PM) O'clock at night on [DATE]. Witness F revealed LPN D called to inform them that Resident #802 was having difficulty breathing and they were going to give them albuterol. With further inquiry regarding the phone call, Witness F stated they asked LPN D to keep an eye on (Resident #802) and send them to the ER if needed. When asked if they knew what type of albuterol, Witness F replied, Inhaler, like for asthma. Witness F continued, (LPN D) gave (Resident #802) albuterol and I don't even know if they even called the Doctor to approve (albuterol administration) or to inform them that (Resident #802) was having difficulty breathing. Witness F then stated, (Resident #802) shouldn't have died . You don't leave a patient who is having difficulty breathing, give them albuterol, and not go back to check and see if they are okay. (LPN D) didn't go back until an hour later. When asked to clarify if LPN D told them Resident #802 was short of breath, Witness F replied, Yes. (LPN D) called and said that (Resident #802) was complaining of shortness of breath and they were going to give them albuterol. Witness F was asked if Resident #802 contacted them and replied, No (Resident #802) can't call, can't use their phone (without assistance). Witness F revealed the Resident had limited mobility and could not use their hands very good. Witness F continued, Then (LPN D) called me and told me (Resident #802) passed. Witness F divulged they were shocked and asked LPN D what they were talking about. LPN D responded, (Resident #802) complained about having breathing problems, I gave them albuterol and then about an hour or so later I went back and (Resident #802) was unresponsive. Witness F indicated they had worked in the medical field and immediately had concerns regarding the care Resident #802 received. Witness F stated, You don't leave a patient who is having respiratory failure or a respiratory problem for over an hour, you just don't do that. Witness F verbalized further concerns that LPN D did not check to see the effectiveness of the albuterol in a timely manner and did not do their job. Witness F stated, It should be an RN (Registered Nurse) doing that stuff. When asked what they meant, Witness F revealed they did not think LPN's were able to complete assessments. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Witness F revealed they went to the facility after informing other family members. When asked what happened when they got to the facility, Witness F revealed they were able to see the Resident when they arrived. When queried if they spoke to the nursing staff at the facility, Witness F indicated they spoke to LPN D and asked them why they did not call 911 and get the Resident to the hospital right away when they couldn't treat Resident #802 there after they started having difficulty breathing. Witness F was asked if LPN D responded and replied, Just to say they were sorry and (LPN D) started crying. Witness F stated they asked LPN D why they did not call 911 and LPN D responded, Well I did. Witness F verbalized they replied, Yeah after the point that (Resident #802) was unresponsive and (LPN D) said yes. LPN D then told them that Resident #802 didn't meet criteria to be critical to send them to the hospital. When queried if they asked LPN D what the criteria for critical was, LPN D verbalized they did but did not answer them. Witness F then stated, I asked how long (Resident #802) was unresponsive for and (LPN D) said I don't know. When queried if they had any additional concerns, Witness F stated, At that time, we were in the Covid (hall) and (LPN D) was walking around and not even wearing a mask. Witness F indicated they were concerned that the facility staff's lack of appropriate use of Personal Protection Equipment (PPE) contributed to the spread of Covid-19 in the facility. Review of Resident #802's EMR revealed a care plan entitled, Actual Infection r/t Covid Positive . [DATE] (Initiated: [DATE]; Revised: [DATE]). The care plan included the interventions: - Precautions other than standard: Transmission Based Precautions (Initiated and Revised: [DATE]) - Labs/diagnostics as ordered (Initiated: [DATE]; Revised: [DATE]) - Monitor and document response to treatment (Initiated: [DATE]; Revised: [DATE]) - Monitor me for s/sx (signs/symptoms) of an Adverse drug reaction every shift (Initiated: [DATE]; Revised: [DATE]) A second care plan in Resident #802's EMR entitled, Resident is at risk for psychosocial wellbeing concern r/t medically imposed restrictions r/t COVID-19 precautions . (Initiated: [DATE]; Revised: [DATE]) included the interventions: - Educate staff, resident, family and visitors of COVID-19 signs and symptoms and precautions (Initiated: [DATE]) - Follow facility protocol for COVID-19 Screening/Precautions (Initiated: [DATE]) A review of Resident #802's documentation in the EMR revealed the Resident was on Room Air and not receiving supplemental oxygen. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	An interview was completed with Certified Nursing Assistant (CNA) A on [DATE] at 11:45 AM. When queried if they recalled Resident #802, CNA A verified they did. CNA A was asked if they recalled the Resident being diagnosed with Covid-19, CNA A stated, I didn't even know he had it the last time until when I came in and they said (Resident #802) had passed. When asked if Resident #802 had a history of breathing difficulties and if they wore oxygen, CNA A replied, No and stated they were a pleasant person. On [DATE] at 4:35 PM, LPN D was contacted via phone. When queried if they recalled Resident #802, LPN D verbalized they did. LPN D was then asked if they were working the night Resident #802 passed and replied, Yeah. When queried what happened, LPN D stated, I can't talk to you know. LPN D was asked if there would be a more convenient time for them to talk and replied, I don't know. A review of LPN D's Human Resource file was completed on [DATE] at 4:50 PM with Staff G. LPN D's last Annual check off competency was dated [DATE]. When queried if they had a more recent annual competency, Staff G reviewed the file and verbalized they did not. When queried if annual competency education is supposed to be completed, Staff G confirmed it should be and was unable to provide further explanation. The facility schedule/assignments for [DATE] and [DATE] were requested from LPN D at this time. Review of a facility-provided schedule for [DATE] revealed CNA H, CNA I, CNA V, LPN D and LPN J were working when Resident #802 passed. On [DATE] at 7:56 AM, RN W provided a Monthly Infection Control Analysis form for [DATE]. The form did not provide Resident specific information but detailed 10 residents developed facility acquired Covid-19 infection. The line listed data was requested again at this time. CNA H was attempted to be contacted via phone on [DATE] at 8:18 AM. A voicemail message was unable to be left and a text message requesting a return phone call was sent. At 8:23 AM on [DATE], CNA I was contacted via phone. A voicemail and text message requesting a return phone call was left. On [DATE] at 8:26 AM, CNA V was attempted to be contacted via phone and a voicemail message was left requesting a return phone call. LPN J was attempted to be contacted via phone on [DATE] at 9:20 AM. A voicemail message was left requesting a return phone call. Return phone calls were not received from CNA H, CNA I, and CNA V. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 9:41 AM, an interview was completed with LPN D. When queried if they recalled Resident #802, LPN D confirmed they did and were the Resident's assigned nurse the night they passed. When asked what happened, LPN D stated, I remember when I went in the room, (Resident #802) said they had a headache. When asked, LPN D revealed they gave (Resident #802) Tylenol for their headache. LPN D continued, When I went back to check on their headache, (Resident #802) appeared short of breath. When asked how the Resident appeared short of breath, LPN D indicated the Resident appeared to be having trouble breathing. When asked if Resident #802 verbalized they felt short of breath, LPN D replied they did. LPN D stated, I gave (Resident #802) their inhaler then. When asked if they gave the inhaler because the Resident was having difficulty breathing, LPN D confirmed they did. When queried if the contacted the Physician/HCP, LPN D indicated they did not contact them at that time. When queried if they assessed the Resident's vital signs, LPN D replied, SPO2 (oxygen saturation) was okay. When asked what they did then, LPN D indicated they left Resident #802's room after administering the inhaler. LPN D then stated, Went back to check on (Resident #802) and put the SPO2 and vital sign machine on and it read something, not sure what, then it went to zero. LPN D was asked if Resident #802 responded when they put the blood pressure cuff and SPO2 monitor on them and stated, I don't remember. When asked to clarify what they were referring to when they said the monitor read something, LPN D indicated the monitor lit up like it was working. When queried if it was just the machine turning on, LPN D revealed they were unsure. When queried regarding the length of time following the inhaler administration until they went back to check on Resident #802, LPN D revealed they were not completely sure but around and hour maybe. LPN D continued, I left and had the CNA go get the other nurse. When asked where the CNA was, LPN D verbalized they were at the nurses' station. LPN D was asked how far the nurses' station was from Resident #802's room and revealed Resident #802's room was midway down the hall. When queried if they were wearing Personal Protective Equipment (PPE) in Resident #802's room, LPN D indicated they were. LPN D was then asked if they removed the PPE prior to exiting the room and stated, Yes, of course. When queried what specific type of TBPs were in place, LPN D specified they did not recall. When asked if they checked Resident #802 for a pulse or respirations prior to exiting the room, LPN D replied, No, I went to get help. When asked why they did not use the call light in the room, LPN D replied, I don't know. When asked what happened when they left Resident #802's room, LPN D stated, I went to the CNA and told them that I need your nurse now and went back to (Resident #802). (LPN J) came in, tapped (Resident #802) and started compressions. When queried if Resident #802 was breathing or had a pulse at that time, LPN D stated, I don't know, I don't know. When queried if they or LPN J checked for a pulse or breathing, LPN D revealed they did not check for a pulse and were unaware of LPN J checking for a pulse. LPN D was asked about the Resident's color and temperature but was unable to provide a response. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	When queried what happened next LPN D stated, EMS came and took over. They kept doing compressions. LPN D stated, They were down there a long time. When asked if they stayed in the room with the Resident, LPN D revealed they did not as EMS had taken over. LPN D then stated, Once it was all said and done, they (EMS) pronounced them (deceased). LPN D revealed the contacted the family to inform them that Resident #802 had passed. When queried regarding the conversation with Resident #802's family went, LPN D verbalized the family was very upset. LPN D asked if they document medication administration in the eMAR at the time they remove a medication from the medication cart or when they return to the cart after administering the medication to the Resident takes the medication and replied, I go give it and then document. When queried if that was what they did when they administered Resident #802's medications on [DATE], LPN D stated, I don't know if I immediately documented it and indicated they recalled being busy and may not have documented the medications immediately following administration. When queried regarding the times on Resident #802's eMAR specifying the Tylenol and Ventolin inhaler were administered at the same time, LPN D stated, Yeah and they wasn't given at the same time. When asked to clarify if they were saying they did not administer the Tylenol and Ventolin inhaler at the same time but documented the medications were administered at the same time, LPN D verbalized confirmation. When queried if they listened to Resident #802's lung and heart sounds and/or completed a physical assessment when the Resident complained of shortness of breath, LPN D stated, I don't know. LPN D articulated that assessment findings such as lung sounds would be in a (progress) note. When queried why they did not document that Resident #802 was experiencing difficulty breathing and why no assessment documentation was completed, Resident #802 did not provide an explanation. When queried if supplemental oxygen was initiated for Resident #802 due to their difficulty breathing, LPN D replied that Resident #802 already had supplement oxygen in place via nasal cannula. When queried why there was no order for supplemental oxygen and vital sign documentation specified the Resident was on room air, LPN D was unable to provide an explanation. On [DATE] at 12:28 PM, RN W provided the IC Line Listing for [DATE]. The line list detailed Resident #802's onset date for Covid-19 was [DATE]. The line listing indicated the Resident did not have any orders and/or receive any medications for Covid-19 infection and did not move to the Covid hall of the facility. The signs and symptoms on the line list included, Cough, Resp > 25, Hoarseness or loss of voice, Difficulty breathing / Shortness of breath, Sore throat, Fatigue / Malaise, s/s (signs/symptoms) of common cold. Note: There was no documentation of Resp > 25, Hoarseness or loss of voice, sore throat, and/or Difficulty breathing / Shortness of breath in Resident #802's EMR. An interview was conducted with the DON on [DATE] at 1:45 PM. When queried regarding assessment and intervention expectations for a resident who develops difficulty breathing, the DON stated, I would expect a lung assessment and oxygen saturation. The DON stated they would attempt to sit them up, positioning, and apply oxygen if needed to improve oxygenation. The DON was then asked to review Resident #802's documentation in the EMR. When queried why there was no documentation related to the Resident having trouble breathing, the DON confirmed the lack of assessment and documentation. When asked, the DON verbalized documentation should have been completed. The DON was informed of interview completed with LPN D. When queried regarding the appropriateness of the care provided for Resident #802, the DON stated, If (a resident is) very short of breath, should pull call light to get the other nurse and call the Doctor to get an order to send out (to hospital). When queried regarding Ventolin inhaler administrator, the DON stated, I probably wouldn't give it they were short of breath because it is past that (medication being effective) (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235113	A. Building B. Wing	07/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saginaw Senior Care and Rehab Center, L L C	4322 MacKinaw Road Saginaw, MI 48603

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F 0684 Level of Harm - Actual harm Residents Affected - Few	When queried regarding facility policy/procedure related to TBPs and if there should be an order in the EMR specifying the specific type of precautions, the DON replied, Yes. When queried if there was an order in Resident #802's EMR, the DON reviewed and stated there was no order. When asked why there was not an order, the DON communicated that they did not work at the facility during Resident #802's stay and were unable to provide an explanation. The DON was then asked when Paxlovid should be initiated for an individual diagnosed with Covid-19 and indicated as soon as possible. When queried why Paxlovid was not ordered for Resident #802 until [DATE] when they tested positive for Covid-19 on [DATE], the DON was unable to provide an explanation. The DON was then asked to review Resident #802's eMAR. When queried if Resident #802 received any doses of Paxlovid, the DON replied, Never administered. When queried why Resident did not receive the ordered medication, the DON stated, I can't answer that because there is no note. When queried if the Resident's Physician/HCP should come to see and assess them following a change in condition, such a being diagnosed with Covid-19, the DON replied, Yeah. The DON was then asked if Resident #802 was assessed by their Physician/HCP following their diagnosis. The DON reviewed Resident #802's EMR and confirmed they were not. When asked, the DON verified concerns related to Resident #802's assessment, monitoring, and treatment. Resident #802's Certificate of Death was obtained and reviewed. Per the Death Certificate, Resident #802 died on [DATE] AM at 1:59 AM due to a. Covid-19 . Approximate Interval Between Onset and Death > 3 day; b. Respiratory Failure Approximate Interval Between Onset and Death ,d+[DATE] minutes . The Manner of Death was listed as Natural and the Medical Examiner was not contacted. Facility Physician E is listed as the Certifying Physician on the Death Certificate. An interview was competed with the facility Administrator on [DATE] at 8:45 AM. Resident #802's change in condition, lack of medication administration as ordered, nursing assessment, timely response, and death in the facility were reviewed. When queried, the Administrator stated, I'm not sure what happened. On [DATE] at 12:00 PM, the Administrator provided an investigation folder pertaining to Resident #802. The folder contained the following: - Typed Statement specifying, (LPN D): After receiving vitals and report from the nursing assistant at 12:15 AM or a little later, I went to assess. Resident was short of breath and in some discomfort while talking to them. (SPO2) 92 % . I gave Tylenol, albuterol and made sure oxygen was in their nose about 12:30 or 12:40. About ,d+[DATE] minutes later I went into reassess, I couldn't get a pulse, so I asked the nursing assistant for the other nurse . The typed statement was dated [DATE] and signed but the signed by LPN D. - Typed Statement specifying, 2nd Nurse, (LPN J). When I came back from my break at 1:10 AM, I was notified by the CNA that the Resident nurse was looking for me and was in (room number), when I entered the room, (LPN D) was trying to get vital signs. I noticed (Resident #802 wasn't breathing. I started CPR, (LPN D) called 911 and got the crash cart . The typed statement was dated [DATE] and signed but the signature was illegible. - Typed Statement specifying, (CNA I): I got vitals on residents around 10:30 and 11:00 PM, (Resident #802) was alert and knew I was in the room, (Resident #802) sounded really congested so I told the nurse their breathing sounding like they were having and hard time breathing . The typed statement was dated [DATE] and signed by CNA I. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 10:27 AM, Physician E was contacted via phone and a message with return number was left. A return phone call was not received. Review of EMS Run documentation for Resident #802 revealed the following: - Prehospital Care Report . Incident Date: [DATE] . Complaint . Cardiac Arrest/Death . Call Date/Time: [DATE] 1:23:50 (AM) . Arrived at Patient . 1:29:00 (AM) . Cardiac Arrest: Yes, Prior to EMS Arrival . First Monitored Arrest Rhythm of the Patient: Asystole (no electrical activity in heart/no heartbeat) . Impressions: Apnea (lack of respirations) . cardiac arrest . General Assessment . 1:29 AM . Skin: Cyanotic (bluish or purplish discoloration of the skin caused by lack of oxygen), Cold . Narrative .Per the patient nurse, she gave the patient a breathing treatment of albuterol at 1230 . the patient complained of breathing discomfort. Per the patient nurse, she went to go check on (Resident #802) at 1:10 AM and found the patient pulseless and not breathing . On [DATE] at 11:13 AM, RN W provided the facility Covid-19 LTC Respiratory Surveillance Line List for [DATE]. This line list indicated there were 12 Residents who tested positive for Covid-19 during the month and two of the 12 Residents died . Review of Resident #802's infection surveillance information