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	02/06/2025

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 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 This citation pertains to Intake Number MI00149908. Based on observation, interview and record review, the facility failed to 1) Ensure that staff were educated on the in-house procedure during a full code while CPR (Cardio Pulmonary Resuscitation) was being performed, (Resident #102 had no pulse or respirations), 2) Ensure proper use of Automated External Defibrillator (AED) equipment during a code, and 3) Ensure only designated and current CPR card holders participated in chest compressions during CPR for 1 resident (Resident #102), resulting in confusion during a code, no documentation taken, improper placement of the AED pads, and uncertified Nursing Assistant/CNA performing chest compressions during a full code while doing CPR. Findings Include: Every minute counts in CPR; the person doing chest compressions should switch out (hand over to another person if available) every 2 minutes or when they get tired. The compressor (person doing compressions) calls for a position change by saying switch and them switches positions. AHA American Heart Association. Resident 102: Review of the Face Sheet, physician orders, nurse's notes, and care plans, dated [DATE] through [DATE], revealed Resident #102 was [AGE] years old, alert and able to make her own healthcare decisions, dependent on staff for all Activities of Daily Living (ADL) and was admitted to the facility on [DATE]. The resident's diagnoses included, Acute and Chronic respiratory failure, pneumonia, heart failure, diabetes, fracture of the vertebra with healing, morbid obesity, alcohol abuse, mood disorder, anxiety disorder and depression. (continued on next page)

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

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The the nursing notes, dated [DATE], stated This nurse walking by resident room at approximately 0019 (12:19 a.m.) and observed patient appeared to be sleeping and noticed patient didn't have CPAP in place. I entered into her dark room to tell her to let's get CPAP (noninvasive ventilation) on and noticed patient appeared to not be breathing. This nurse called out to patient and touched patient, and some coolness was felt, and resident also appeared to have had an nemesis, and I didn't feel a pulse. I walked out to nurses' station to retrieve crash cart and told my CENA (nursing assistant) that patient appeared deceased and made a overhead page to call a CODE BLUE (called a full code). Staff responded immediately and I started to call police as I hurried back to room and started CPR immediately. CPR continued continuously even after EMR (Emergency Medical Response) arrived. EMR called time of death (TOD) at 1240am (12:40 a.m.). Emergency contact (sister) was notified and the on-call NP (Nurse Practitioner) and manager notified. Police and medical examiner arrived per this being an unexpected passing. Patient was examined and picked up by Medical Examiner staff. During an interview done on [DATE] at 8:00 a.m., Nurse LPN B stated I found the resident. I was walking by and she did not have her Bi-Pap on. I could see a dark pinkish color (on the residents face), I assessed her pulse (the resident had no pulse). I grabbed the crash cart and announced code blue. I yelled out to call 911, a CNA called 911. I put one pad on the chest and (Nurse A) put the other one on. The machine told us to stop and EMS told us to disregard the machine and keep going. Nurse B continued doing chest compressions per EMS instructions when the facility AED machine said to stop. During an interview done on [DATE] at 1:10 PM, Nurse LPN A stated No one at the facility trained me on the AED (Facility Automated External Defibrillation machine). I was on the other side of building and heard the Code Blue. I put the pads on (the AED pads on the resident). In 1 to 2 minutes I asked if somebody would take over. Nurse A said there were 3 EMS (Emergency Medical Services) staff, and 2 nurses in the room along with a total of 4 CNA's. The nurse said she told CNA F to document what was going on during the code. The nurse said she did not tell the CNA F what to write down as it was happening. The nurse said there was no notes, and she did not document anything at all. The EMS staff asked CNA C to do CPR, and she did it; no facility nurse intervened or took over (CNA's had not been educated at all regarding a code or CPR procedure and their role during the code). Nurse A stated I believed CNA's do not do CPR, I was shocked. EMS told me to slow down; they gave me instructions on how to do CPR during the code. I feel we did an excellent job; I will be sure to document next time. During an observation done on [DATE] at approximately 1:30 p.m., Nurse A was requested to put the AED machine pads on the manikin that was in the room. She misplaced the chest pad per the picture that was on the pad. During an interview done on [DATE] at 2:20 p.m., Nursing Assistant/CNA C said she did chest compressions during the code on Resident #102. CNA C stated My CPR card expired in ,d+[DATE]. My nurse's were out of breath, neither nurse (Nurse B or Nurse C) told me I could not do it (CPR). During an interview done on [DATE] at 2:40 p.m., CNA D denied she did anything in the room. She was not able to recall who did what and she took no notes. CPR was done on Resident #102 on [DATE] (6 days before the interview was done). (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview done on [DATE] at 7:00 a.m., CNA F stated The EMS told me to do CPR, so I did it, no one stopped me. They (EMS personnel) told me to move, your not doing it right. I was not educated on CPR at the facility. I was asked by (Nurse B) to take notes. She didn't tell what to write. I left the notes on the bedside table. No one asked me about the notes; I left the notes in the room, I don't remember what I wrote down. Any notes that CNA F said she had done were not found by staff. During an interview done on [DATE] at 10:04 a.m., Nurse, RN G (Nurse on-call/MDS Nurse on [DATE]) stated she (Nurse B) called me at 2:30 a.m., I missed the call and I called the facility back at 5:00 a.m. I told (Nurse B) to make a statement. Nurse G entered nursing notes dated [DATE]; the only documentation of the whole full code CPR that was done. During an interview done on [DATE] at approximately 11:01 a.m., the Director of Nursing said she was informed of the incident (could not recall date), and did not start an investigation because I was off. The DON did not call anyone at the facility to initiate an investigation. I should of told someone to investigate. During an interview done on [DATE] at 11:45 a.m., Nurse, RN H stated It would be the Administrator or the DON who initiates an investigation, and stated CNA's can't be doing CPR at the facility (unless done per policy or procedure and education has been given by facility).