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	10/09/2024

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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(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** 49944 Based on interview and record review the facility failed to treat residents with dignity and respect for 10 of 10 residents in a confidential meeting and R317, resulting in long call light wait times, humiliation from incontinence and fear of reprisal. Findings include: Resident #317 (R317): R317 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include acute respiratory failure, hypertension, anemia and endocarditis. R317 has a BIMS (Brief Interview for Mental Status) score of 15, indicating R317 is cognitively intact. On 10/07/24 at 12:56 PM an interview was conducted with R317. R317 was asked how their stay has been so far at the facility. R317 stated over the previous weekend (10/5 and 10/6), there were only 4 CNA's (Certified Nursing Aides) for the entire building. R317 stated they had to wait an hour for their call light to be answered and said they had an accident(incontinent of urine). R317 stated they were very humiliated, and they had guests visiting that day. R317 became tearful when discussing the incident. R317 then went on to say they turned on the call light their first night in the facility and staff never arrived to help them to the bathroom, R317 was incontinent of urine at this time and had to sit in urine for 6 1/2 hrs. Record review of the care plan for R317 revealed they require one staff assistance with a two wheeled walker to transfer. 38471 During Resident Council held on 10/8/2024 at 2:00 PM, the ten residents in attendance agreed unanimously with their concerns voiced about third shift staff. The attendees at the council reported the following: - 3rd shift waters are not passed consistently and there are many times when they will go without water until 1st shift arrives. -They act as if they do not want to be bothered to meet the needs of the residents. (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	- When answering their call lights they will state, What do you want? - The staff are curt and do not treat them like human beings. - They are on their phones most of shift and when a call light goes off they grumble. - Nurses are not directing the aides throughout the shift and allowing them to have poor performance. - They are not comfortable advocating for themselves in these situations due to fear of reprisal from staff and being labeled as trouble. They expressed they would take longer to meet their needs and their quality of care would be lowered. 22927 In an interview on 10/07/24 at 11:28 AM, Resident #33 revealed that the third shift make the resident feel like she's a burden, and they have attitude. Resident #33 stated that the nurse aides have no compassion for the residents, and They (the aides) don't want to work. If (the Resident) need her brief changed and puts the call light on and they come in and say, 'What do you need now', it's awful, or (the Resident) have to lay in a wet/dirty brief for hours. In an interview on 10/09/24 at 08:08 AM, Resident #317 stated that the third shift the first couple of nights resident was admitted she felt ignored. Resident #317 stated putting on the call light at 3:00 am to use the bathroom, and no one came. Resident #317 stated they had to wet their brief, and no one came to change or assist until 10:00 am. Resident #317 stated they asked during the morning breakfast pass for staff assistance with a wet brief and staff stated that they could not change the resident right then because they were passing breakfast trays and then they came back in half hour. In an interview on 10/09/24 at 08:13 AM, Resident #44 when asked about concerns with third shift staff revealed that she tries to sleep through it, if she uses the call light on it takes a long time to get anyone (staff). The nurses are good, but the aides I don't care for. In an interview on 10/09/24 at 10:58 AM with the Human Resource (HR) Staff D, when asked about third shift staff concerns, revealed that the facility did have complaints on the 3rd shift staff being disrespectful, not being nice and with the attitude. HR D revealed that the facility had two Certified Nurse Assistance (CNA's) of concern. Management team have been having to do pop up visits at off hours in the night and the facility's still getting complaints, but we have to go through the proper format of disciplines and write ups before we can terminate a staff. We are watching the 3rd shift and are aware of concerns.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview, and record review, the facility failed to implement and distribute baseline care plans for three residents (Resident #38, Resident #63, Resident #65), resulting in Resident #38 hand contractures with no interventions, Resident #63 had falls, and Resident #65 required hospitalization with the potential for lack of care related to unmet care needs. Finding includes: Record review of the facility 'Baseline Care Plans' policy dated [DATE], revealed the facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered and care of the resident that will meet professional standards of quality care. The baseline care plan must- (i.) be developed within 48 hours of a resident's admission. (ii.) Include the minimum healthcare information necessary to properly care for a resident Resident #63: Record review of Resident #63's admission Minimum Data Set (MDS) dated [DATE] revealed an elderly male cognitively intact. The MDS assessment noted the Resident #63 had a fall within the last month prior to admission. The MDS assessment noted a fracture related to a fall in the six months prior to admission marked as yes. Record review of Resident #63's Activity of Daily Living (ADL) care plan was missing the facility general statement of: I have been provided a copy of my baseline care plan within 48 hours of admission. Record review of Resident #63's medical diagnosis list revealed the resident was a full cardiopulmonary resuscitation (CPR). Medical diagnosis included: wedge compression fracture of first lumbar, gastro-esophageal reflux disease, repeated falls, long term use of anticoagulants, hypertension, benign prostatic hyperplasia, atrial fibrillation, atherosclerotic heart disease, heart failure, insomnia, angina pectoris and obstructive uropathy. In an observation and interview on [DATE] at 01:22 PM with Resident #63 and spouse revealed the left-hand thumb was purple in color with swelling noted. Resident #63 stated that he fell in the hallway. Resident #63's spouse was visiting stated that she did not know until she came into visit, The spouse stated that she did not get a phone call or notification at the time of the fall. Resident #63 stated that the facility just took an x-ray to see if it was broken. In an interview on [DATE] at 01:11 PM with the Director of Nursing (DON) revealed that Resident #63 had a fall, and the state surveyor requested incident report and x-ray report. The DON stated that the facility did not have the spouse phone number, and we did not ask the resident either, so she was notified yesterday when she came into the building to visit (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on [DATE] at 01:29 PM of Resident #63's fall care plan revealed there were no new interventions implemented and care plan was not updated. Resident #65: Record review of Resident #65's closed electronic medical record revealed the resident was admitted on [DATE]. Medical diagnosis included post concussional syndrome, unspecified head injury, fall, orthostatic hypotension, disease of pancreas, vascular implants, atrial fibrillation, chronic kidney disease stage 4, atherosclerotic heart disease, peripheral vascular disease, mastopathy of breast, osteoarthritis, anxiety, hypertension, personal history of pulmonary embolism and headaches. Record review of Resident #65's Activity of Daily Living (ADL) care plan was missing the facility general statement of: I have been provided a copy of my baseline care plan within 48 hours of admission. In an interview and record review on [DATE] at 03:33 PM with Licensed Practical Nurse/Social Service Designee E revealed that resident baseline care plans start upon admission with the MDS assessment nurse puts the initial baseline care plan into the electronic medical system. The baseline care plan general statement: ' I have been provided a copy of my baseline care plan within 48 hours of admission' statement is located in the Activity of Daily Living (ADL's) and develops the Mood, Discharge, Skin, Diet, Falls, the main care plans, she puts them in based on the referral and interview upon admission and those are printed out and given to the resident and/or family within 48 hours. Social services designee E revealed that staff check that interventions on the care plan as given to resident or family. Record review of Resident #65's care plans revealed that the Resident and/or family did not have a baseline care plan. 49944 Resident #38 (R38): R38 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include progressive supranuclear ophthalmoplegia (a disorder that affects the way the brain controls movement, including eye movement), dementia, depression and anemia. Resident #38 has a BIMS (Brief Interview for Mental Status) score of 0, indicating severe cognitive impairment. On [DATE] at 01:18 PM, R38 was observed sitting in a reclining chair, their right hand was noted to be contracted and a rolled towel was placed in that hand. There was a glove observed on left hand. On [DATE] at 03:00 PM, record review of the MDS (Minimum Data Set), section G dated [DATE] revealed that R38 admitted with impairment on both sides. On [DATE] at 03:03 PM, record review of the EMR (Electronic Medical Record) for R38 revealed there was no physician order present for the treatment of the right-hand contracture and no care plan present for the contracture or therapy services being provided. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 03:04 PM, an interview was conducted with Therapy Manager A. Manager A was asked what therapy services were being provided to R38. Manager A stated that R38 is currently on a maintenance (restorative) program for range of motion. Manager A stated that R38 receives OT (Occupational Therapy) two times a week and PT (Physical Therapy) once a week. Manager A was asked about the towel in the right hand and glove on the left hand for R38. Manager A stated the rolled towel is for the contracture and the glove on the left hand is a family request, but they were unsure why R38 needed it. Manager A stated the family is now requesting to not have a towel for the right hand. Manager A was asked if there should be an order and a care plan for the towel and therapy services being provided. Manager A stated yes there should be. Record review of the policy titled, Restorative Program, revised [DATE] revealed: Process: 1. Following identification of need, the interdisciplinary team will put a plan in place that identifies the restorative approaches that will support the resident needs/choices. 2. The applicable restorative interventions will be assigned, which may include: ROM, ambulation, transfer, ADL's, adaptive equipment, splinting, bed mobility, bathing, dressing, oral care, toileting, communication and/or dining. 3. The program(s) will be identified in the resident's medical record. 4. Periodically the Restorative Nurse or designee will review and discuss progress or lack of progress toward restorative goals with caregivers and the resident/ representative. The resident's plan of care and restorative program will be revised as indicated. 5. Monthly, the Restorative Nurse or designee will document a summary of the resident's participation and progress and determine the need to continue, revise, or discontinue the program based on the resident's needs, choices, and goals.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review the facility failed to revise and update care plans for four residents (R15, R18, R33, R63) of 20 residents reviewed for care plan revision, resulting in an inaccurate oxygen flow rate, inaccurate wound documentation, the physician not being notified of weight changes in a dialysis resident and no new interventions after a fall. Findings include: Resident #18 (R18): R18 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include heart failure, dementia, peripheral vascular disease and chronic pain syndrome. R18 has a BIMS (Brief Interview for Mental Status) Score of 0, indicating severe cognitive impairment. On 10/07/24 at 12:32PM, R18 was observed sleeping in their bed, R18 had a nasal cannula in place and was receiving oxygen via a concentrator at a flow rate of 4 liters per minute. The oxygen tubing was dated 10/6/24. On 10/08/24 at 09:57AM, R18 was observed in bed, receiving oxygen via a nasal cannula and concentrator at a flow rate of 4 liters per minute, the oxygen tubing was dated 10/6/24. On 10/08/24 at 03:55PM, record review of R18's medical record revealed a care plan dated 06/27/24 that R18 was to receive oxygen via nasal cannula at a rate of 2 liters per minute On 10/08/24 at 04:02PM, R18 was observed sitting up in a geri chair, oxygen was being administered at 4 liters per minute via a nasal cannula. This surveyor informed CCC (Clinical Care Coordinator) B that R18's concentrator was set to 4 liters per minute instead of the physician's order and care plan for 2 liters per minute. CCC B verified the rate of 4 liters per minute and stated they would check R18's oxygen level and notify the physician to see if R18 needed the increase in oxygen. Record review revealed that R18's oxygen administration care plan was updated on 10/8/24, after being informed of the discrepancy. Review of the policy titled, Care Plan-Comprehensive revealed: 8. Assessments of resident are ongoing and care plans are revised as information about the resident and the resident's condition change. 9. The care planning/interdisciplinary team is responsible for the review and updating of care plans: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c. When the resident has been readmitted to the facility from a hospital stay; and d. At least quarterly. 22927 Resident #15: In an interview and record review on 10/09/24 at 09:56 AM with the Director of Nursing (DON) of Resident #15's admitted [DATE] skin assessment was good with no concerns of bilateral feet/heels. Record review of Resident #15's electronic medical record 'Wound Evaluation' tab on 2/21/24 revealed the right heel with eschar with dead necrotic skin The DON was asked what happens or when the blackened cap falls the wound? The DON stated that the wound becomes an open wound, and potential for infections. The state surveyor inquired about care plan intervention of Certified Nurse Assistance's are to review skin daily, was it done? DON stated that Both Resident #15 and Resident #33's right heel pressure ulcers were preventable, with floating heels, prafo boots, repositioning, and getting the resident out of bed for few hours. Venous wounds would have done a Doppler at the time development of the wounds, not months later. Record review of Resident #15's care plans pages 1-49 revealed that 'Skin Management related to atherosclerotic heart disease, Parkinson's, dementia, diabetes, anemia, idiopathic neuropathy, sigmoid volvulus post-surgery, limited mobility and fragile skin. initiated on 12/9/2021 revealed interventions of: Certified Nurse Assistants (CNA's) will check my skin daily with care and report anything unusual they notice to the nurse: Date initiated 12/9/2021. Resident #33: Record review of Resident #33's care plans pages 1-38 revealed that 'Skin Management related to obesity, chronic kidney disease right heel wound. initiated on 5/30/2024 revealed interventions of: Certified Nurse Assistants (CNA's) will check my skin daily with care and report anything unusual they notice to the nurse: Date initiated 5/30/2024. In an interview and records review on 10/09/24 at 09:42 AM with Director of Nursing (DON) of Resident #33's electronic medical record revealed the admission assessment on 5/30/24 did not have any foot heel skin concerns. Wound/skin tab revealed Right heel wound started on 7/17/24 as a blacked eschar unstageable before anyone found it? Director of Nursing (DON) stated that Resident #33 was originally in her room on the 100 hall and the Certified Nursing Assistant (CNA) did skin assessment and found the wound as eschar and reported it to the nurse. The CNA's are to check skin each day and report, they should have reported a reddened area before it became eschar. Eschar is a blackened skin, necrotic and dead. We could have placed an intervention prior to the eschar. Resident #63: Record review of Resident #63's Minimum Data Set (MDS) dated [DATE] revealed a male with a Brief Interview of Mental status (BIMS) score of 14 out of 15, cognitively intact. MDS section J revealed a fall history resulting in fracture in the last six months: Yes. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/07/24 at 01:22 PM with Resident #63 revealed that he took a spill (fell) last night, I had something in front of me, and I fell and sprained left thumb, they took an x-ray today. The spouse of the resident was at the bedside visiting and was surprised to hear that the resident fell , and she stated that she was not notified. Record review of Resident #63's 'Risk for Fall' related to history of falls, medication use, and pain. Initiated on 9/17/2024. Interventions included: wear non-skid footwear for all transfers and walking 9/17/2024. Record review of Resident #63's Fall incident report dated 10/6/2024 at 10:00PM revealed that the resident stood up from his wheelchair at the exit door by his room and lost his balance and fell . The situation factors noted: Footwear not in place. In an interview and record review on 10/08/24 at 01:11 PM with the Director of Nursing (DON) the state surveyor requested incident report and x-ray report. The DON stated that we did not have the spouses phone number and we did not ask the resident either, so she was notified yesterday when she came into the building to visit Record review on 10/08/24 01:29 PM with the DON revealed review of fall care plan revealed there were no new interventions implemented and care plan was not updated until 10/8/2024 to have staff perform frequent rounds on resident throughout the day.

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F 0686 Level of Harm - 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** 49944 Based on observation, interview and record review the facility failed to prevent the development of and worsening of pressure ulcers for 3 residents (Resident #15, Resident #25, Resident #33) of five residents reviewed for pressure ulcers resulting in the development of facility-acquired pressure ulcers, including a Stage 3 pressure ulcer, and the worsening of pressure ulcers. Findings include: Resident #25 (R25): R25 is [AGE] years old and admitted to the facility on [DATE] with diagnosis that include encephalopathy, cerebral infarction and pressure ulcer of unspecified buttock, unspecified stage. R25 has a Brief Interview for Mental Status (BIMS) score of 3 as of 09/10/24 indicating severe cognitive impairment. On 10/07/24 at 09:30AM, R25 was observed lying supine in bed, a wedge cushion was noted to be at the end of the bed but not currently in use. R25 had protective boots on both feet. On 10/07/24 at 12:00PM, R25 was observed lying supine in bed, there was a wedge cushion noted on the bed but still not in use. On 10/08/24 at 10:12AM, R25 was observed lying supine in bed. R25 was also observed to have protective boots on both feet. On 10/08/24 at 01:30PM, an interview was conducted with Certified Nursing Assistant (CNA) K. CNA K was asked why R25 was positioned on their back so often during the day. CNA K stated that R25 often refuses to be turned off of their back and even when they try to place pillows under their sides for positioning R25 will throw them on the floor. CNA K stated they try to reposition him often while they are working. On 10/08/24 at 02:44PM, an interview was conducted with the DON (Director of Nursing). The DON was asked if R25 had all of their wounds present on admission or if any developed in the facility. The DON stated that the wounds were present on admission. The DON was asked if they feel the wounds have improved, worsened or remained stable. The DON stated they feel that some of the wounds have remained the same and fairly stable. On 10/09/24, R25 was observed to be discharged from the facility. On 10/09/24, record review revealed that R25 had developed an in-house acquired pressure ulcer on their left ischial tuberosity(an area on the buttocks) on 10/02/24 measuring: length 2.31cm, width 0.61cm, depth 1. 0cm and was categorized as MASD(Moisture Associated Skin Damage). On 10/09/24, record review revealed that on 10/08/24 the same pressure ulcer measured: length 2.13cm, width 2.11cm and depth 3.0cm and was categorized as a Stage 3 wound (indicating full thickness tissue loss). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 10/09/24, record review revealed that R25 was admitted with a wound on the peri-anal area, classified as unstageable. On 10/02/24 the wound measured length 1.59cm, width 1.04cm and depth 1.04cm. On 10/08/24 the wound measured length 9.74cm, width 7.03cm and depth 4.0cm and was classified as unstageable. On 10/09/24, record review of R25's care plan titled, Skin Management revealed an intervention, please help me get turned and repositioned every 2 hours as allowed. 22927 Resident #15: An interview on 10/07/24 at 02:36 PM with Resident #15 revealed that her right heel had a sore on it and that she did not recall/remember how it developed/started. Record review of Resident #15's Minimum Data Set (MDS) dated [DATE] section M: Skin conditions- had no unhealed pressure ulcers noted. Record review of Resident #15's electronic medical record (EMR) revealed an admission skin assessment dated [DATE] revealed no skin issues with bilateral feet/heels. Record review of Resident #15's 'Wound Evaluation' form dated 2/21/2024 at 7:50AM revealed a pressure ulcer unstageable (slough and/or eschar) located on the right heel, as new, and in-house (in facility) acquired. Dimensions/measurements: area 3.45cm, length 2.01cm x width 2.05cm. Observation of wound photo located in the medical record revealed a dark/blackened area of good size to Resident #15's right heel. Record review of Resident #15's Minimum Data Set (MDS) dated [DATE] section M: Skin conditions- noted one unstageable pressure ulcer due to coverage of wound bed by slough and/or eschar. Record review of Resident #15s 'Skin & Wound- Total Body Skin Assessment' dated 2/20/2024 revealed skin assessment with good turgor, normal skin color, warn temperature, normal moisture, normal condition and no new wounds. Record review of Resident #15's nurse progress note dated 2/22/2024 noted blood-filled blister to right heel. 10/08/24 02:54 PM Record review of the skin care plan noted to observed skin daily and report to nurse any findings dated 2021. How did the right heel blood blister start if it would have been pink/red before it became blackened. Record review of the Point Click Care wound definitions: Suspected Deep Tissue Injury- Purple or Maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Unstageable- Full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Observation and interview on 10/08/24 at 01:02 PM with Resident #15 and Licensed Practical Nurse (LPN) F revealed observation of Resident #15's right heel wound heeled with scar tissue noted. Resident #15 stated that it (right heel wound) would hurt and burn something awful and that it was a big old hole in my foot/heel. In an interview and record review on 10/09/24 at 09:56 AM with the Director of Nursing (DON) of Resident #15's admitted [DATE] skin assessment was good with no concerns of bilateral feet/heels. Record review of Resident #15's electronic medical record 'Wound Evaluation' tab on 2/21/24 revealed the right heel with eschar with dead necrotic skin The DON was asked what happens or when the blackened cap falls the wound? The DON stated that the wound becomes an open wound, and potential for infections. The state surveyor in quired about care plan intervention of Certified Nurse Assistance's are to review skin daily, was it done? DON stated that Both Resident #15 and Resident #33's right heel pressure ulcers were preventable, with floating heels, prafo boots, repositioning, and getting the resident out of bed for few hours. Venous wounds would have done a doppler at the time development of the wounds, not months later. Resident #33: In an interview on 10/07/24 at 11:31 AM with Resident #33 revealed that when she came into the facility, she did not have a right heel sore. Observation on 10/07/24 at 11:31 AM the state Surveyor observed right foot/heel dressing of gauze wrap that soaked through the dressing and onto the sheets with brown ring, dressing dated 10/6/2024. Record review of Resident #33's Admission Skin Assessment form dated 5/30/2024 revealed skin concerns to chest of implanted port, left hand blister, right neck old access site, coccyx redness, right arm bruising. There was no skin concern related to bilateral foot heels noted. Record review and Interview on 10/7/2024 with Resident #33 revealed that she does hemodialysis on Mondays/Wednesdays/Fridays and was waiting to go to dialysis. Observation and interview on 10/07/24 at 12:21 PM with the Director of Nursing (DON) was requested to observed Resident #33's right foot/heel dressing dated 10/6/2024. Observation of drainage tan to brown in color was noted onto sheets through the dressing. The DON stated that Resident #33's dressing is to be changed daily in the mornings by the night shift nurse before leaving their shift, yes, she would have gone to dialysis with that dressing if you hadn't brought me into see the dressing. The DON stated that the facility Wound Care nurse/Infection Preventionist had resigned Friday, she took photos every Wednesday, and on admission. We just ordered soft boots for the resident; we don't have them yet. The state surveyor observed no boots in the closet or in the room. In an interview on 10/07/24 at 12:25 PM with Resident #33 with the DON present stated that the right foot/heel dressing was not changed this morning. The DON stated that Licensed Practical Nurse (LPN) F will be in to dress the wound before she goes to dialysis. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 10/07/24 at 12:32 PM with Licensed Practical Nurse (LPN) F and Director of Nursing (DON) applied spray derma cleanse with 4x4 gauze, wiped the surface of the wound. The state surveyor observed an open wound with puss drainage noted by the DON, treatment of Santyl (debride). Wound measurement with tape measurement revealed a 1cm X 0.5cm open wound with hole in the back of resident's heel measurement. Santyl ointment into the opening, covered with a telfa non-stick 3x2 dressing gauze and gauze wrap. In an interview on 10/08/24 at 10:08 AM with Licensed Practical Nurse (LPN) F Observation of Resident #33's right heel dressing was changed at 6:00AM the dressing was clean and intact; a smaller brown ring was noted again on the sheet under the heel. no drainage noted on dressing. Sheet was not changed after dressing. In an interview and records review on 10/09/24 at 09:42 AM with Director of Nursing (DON) of Resident #33's electronic medical record revealed the admission assessment on 5/30/24 did not have any foot heel skin concerns. Wound/skin tab revealed Right heel wound started on 7/17/24 as a blacked eschar unstageable before anyone found it? Director of Nursing (DON) stated that Resident #33 was originally in her room on the 100 hall and the Certified Nursing Assistant (CNA) did skin assessment and found the wound as eschar and reported it to the nurse. The CNAs are to check skin each day and report, they should have reported a reddened area before it became eschar. Eschar is a blackened skin, necrotic and dead. We could have placed an intervention prior to the eschar. In an interview and record review on 10/09/24 at 10:09 AM with the Registered Nurse (RN) Clinical Care Coordinator B performed a record review of the wound & skin tab in electronic medical record to review right heel wound progression. RN B stated that the heel would have start out getting boggy/soft, redden and turn white, then we gradually start to see the breakdown of the tissue until it starts to die, when it dies it becomes eschar blackened. Unstageable. cap falls off under then it broken down and open, seeping a smell. The Certified Nursing Assistant (CNA) are to review skin daily, and report to nurse skin changes. While reviewing a photo of Resident #33's right heel wound RN B stated depending on the resident and their circulation that wound would take 2-3 weeks to develop into eschar.

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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** 22927 Based on observation, interview and record review, the facility failed to maintain supervision of one resident (Resident #63) when up in the wheelchair, and notify a spouse of a fall/accident, resulting in an injury to the left thumb, pain, and the potential for continuous falls and injuries. Findings include: Record review of the facility 'Fall Reduction Program' policy dated [DATE], revealed the purpose was to provide a safe environment for residents, modify risk factors, and reduce risk of fall-related injury. Procedure: (1.) Identify/analyze risk for fall . (2.) Implement and indicate individualized interventions on care plan/Kardex Record review of the facility 'Unusual Occurrence' policy dated [DATE], revealed an unusual occurrence is any situation that involves harm or potential harm to a resident that is outside of the usual and expected. These include, but are not limited to falls, injuries, bruises Procedure: (5.) The charge nurse notifies the responsible party immediately . Record review of the facility 'Baseline Care Plans' policy dated [DATE], revealed the facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered and care of the resident that will meet professional standards of quality care. The baseline care plan must- (i.) be developed within 48 hours of a resident's admission. (ii.) Include the minimum healthcare information necessary to properly care for a resident Resident #63: Record review of Resident #63's admission Minimum Data Set (MDS) dated [DATE] revealed an elderly male cognitively intact with a Brief Interview of Mental status (BIMS) of 14 out of 15 score. The MDS assessment noted the Resident #63 had a fall within the last month prior to admission. The MDS assessment noted a fracture related to a fall in the six months prior to admission marked as yes. Record review of Resident #63's Activity of Daily Living (ADL) care plan was missing the facility general statement of: I have been provided a copy of my baseline care plan within 48 hours of admission. Record review of Resident #63's medical diagnosis list revealed the resident was a full cardiopulmonary resuscitation (CPR). Medical diagnosis included: wedge compression fracture of first lumbar, gastro-esophageal reflux disease, repeated falls, long term use of anticoagulants, hypertension, benign prostatic hyperplasia, atrial fibrillation, atherosclerotic heart disease, heart failure, insomnia, angina pectoris and obstructive uropathy. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation and interview on [DATE] at 01:22 PM with Resident #63 and spouse revealed the left-hand thumb was purple in color with swelling noted. Resident #63 stated that he fell in the hallway. Resident #63's spouse was visiting and stated that she did not know about the fall or injury to the thumb until she came into visit, The spouse stated that she did not get a phone call or notification at the time of the fall. Resident #63 stated that the facility just took an x-ray to see if it was broken. In an interview on [DATE] at 01:11 PM with the Director of Nursing (DON) revealed that Resident #63 had a fall, and the state surveyor requested incident report and x-ray report. The DON stated that the facility did not have the spouse phone number, and we did not ask the resident either, so she was notified yesterday when she came into the building to visit Record review on [DATE] at 01:29 PM of Resident #63's fall care plan revealed there were no new interventions implemented and care plan was not updated.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 22927 Based on observation, interview and record review, the facility failed monitor and document the weight loss of a hemodialysis resident, and to ensure timely re-weighs for weight loss for one resident (Resident #33), resulting in Resident #33 to have weight loss monitoring completion, follow-up of abnormal weights, and the potential for unidentified nutritional deficiencies and decline in overall health. Findings include: Record review of the facility 'Policy: Obtaining Weights and Re-weight Policy' undated, revealed each individual's weight will be determined and documented upon admission to the facility. Procedure: 1.) Nursing will be responsible for the initial determination of each individual's weight. Subsequent measurements for weight will be documented on the appropriate designated form or tracker in the computer database. Weight will be documented on the individual assessment instrument (MDS for nursing facilities), and in the medical nutrition therapy (MNT) assessment. Weight will be obtained weekly for 4 weeks after admission. Subsequent weights will be obtained monthly. unless physician orders or individual condition warrants frequent determinations. Re-weights will be done for a weight change of +/- (gain/loss) of 3# (pounds) for anyone under 100# pounds and for +/- (gain/loss) of 5# (pounds) for anyone 100 pounds and over. (2.) The Registered Dietitian (RD) or designee will be responsible for determining the desirable weight range Resident #33: In an interview on 10/07/24 at 11:32 AM with Resident #33 revealed that she received hemodialysis on Monday/Wednesday/Fridays. Resident #33 stated that her Dialysis port was infected and that she gets Vancomycin antibiotic at dialysis while receiving her dialysis treatment in the chair. In an interview and record review on 10/09/24 at 09:00 AM with Corporate Registered Dietitian (RD) R of Resident #33's weight log inconsistencies revealed admission beginning weight (wt.) was 281.0 pounds wheelchair on 5/30/2024, then on 6/29/2024 wt. 240.3 pounds wheelchair, that's a 40-pound wt. loss, there was no dietary note or review. RD R was asked about the weight fluctuation and stated that dialysis and Lasix, we go off the dialysis weights and we do review the dialysis communication forms, but that there was no dietary note or no re-weight performed by the facility. Record review of Resident #33's weight on 8/3/24 was 230.0 pounds mechanical lift and on 8/27/24 Resident #33's weight dropped to 208.0 pounds. Record review of Resident #33's progress notes and dietary notes revealed there was no mention of a 22-pound weight loss in a 24-day period. Registered Dietitian (RD) R reviewed the medical record for an answer, and none was found. RD R stated that the resident goes to dialysis 3 times a week and gets weighted at each treatment. The facility only documented one weight per month in May, June, July and august 2024 had few weights then in September. Registered Dietitian (RD) R revealed that a new dietitian started, and the process should be with each dialysis treatment sheet (3 times a week) are monitored, and then she reviews weights once a week. Record review of the physician progress notes 8/12/2024 RD F stated notified the physician and wrote note dated 7/30/24, but then the weight loss on 8/27/24 there was no notification of the physician.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the failed to administer tube feeding per professional standards for one resident (Resident #8) of three residents reviewed for enteral nutrition, resulting in Resident #8 readmission enteral nutrition order being inputted incorrectly and facility staff administering the enteral feed without a physician's order. Findings Include: Resident #8: On 10/8/2024 at 8:15 AM, Resident #8 was observed asleep in bed with his tube feed infusing. The infusion rate was observed at 60 ml (milliliters) per hour, with the Jevity 1.5 formula being hung at 3:40 AM. Review was completed of Resident #8's enteral feed order and it indicated Jevity 1.5@ 65ml/hr flush of 45ml/hr water continuous to begin on 10/8/2024 at 3:00 PM. On 10/8/2024 at 8:45 AM, a review was conducted of Resident #8's records which revealed the resident readmitted to the facility on [DATE] with diagnoses that included, Acute Cystitis, Sepsis, Dementia, Dysphagia, Atrial Fibrillation, Hypertension and Major Depressive Disorder. Further review yielded the following results: Progress Notes: 10/2/2024 at 15:38: Pt (patient) came back from the hospital . 10/5/2024 at 18:10: .Peg feeding is up and running as ordered . MAR (Medication Administration Record) September MAR: Enteral Feed Order PEG tube: Jevity 1.5 60cc x 24 hour- free water flushed 45cc x 24 hours. initiated on 9/14/2024 and discontinued on 10/2/2024. October MAR: Jevity 1.5@ 65 ml/hr flush of 45ml/hr water continuous- ordered to begin on 10/8/2024 at 3:00 PM. Physician Orders: Jevity 1.5 @65ml/hr flush of 45ml/hr. Initiated on 10/2/2024 at 3:28 PM but this order was not categorized correctly and did not propagate to the MAR for daily administration. It was unknow if Resident #8 received enteral nutrition over the past seven days as there was no physician order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/8/2024 at 9:15 AM, Resident #8's enteral nutrition orders were reviewed in the presence of Corporate Registered Dietitian R. This morning, she directed nursing staff to stop the tube feed to provide his gut a rest, with the plan to restart at his new infusion rate of 80 ml per hour at 11 AM. It was explained when she was in the resident's room his tube feed was infusing at 60 ml per hour and she thought it was running at 65 ml per hour since his readmission. Upon review of Resident #8's MAR there were no enteral nutrition orders from 10/2/2024 (readmission) to 10/8/2024 (with begin time of 3 PM). It was unknown how Resident #8's order was missed, if he received any enteral nutrition and why it was infusing this morning without a physician order. Dietitian R stated she would follow up with this writer. On 10/8/2024 at 9:43 AM, Corporate Registered Dietitian R, followed up with this writer and explained the readmission tube feed order was located and explained the order did not carry over to the MAR, as it was categorized under other. The order was for 65 ml per hour with 45ml/hr flush. Prior to Resident #8 being discharged to the hospital his infusing rate was 60 ml/hour. Dietitian R was alerted by a facility nurse this morning, that it appeared the resident did not have a tube feed order. The dietitian further provided 72-hour history from Resident #8's pump that indicated he received enteral nutrition over the last 72 hours. It can be noted facility nurses were administering his tube feeding without an order nor documentation. The pump 72-hour lookback indicated the following: 24-hour history: 915 mL feed 630 mL flush 48-hour history: 2072 mL feed 1642 mL flush 72-hour history: 3412 mL feed 2723 mL flush On 10/9/2024 at 9:40 AM, an interview was conducted with Clinical Care Coordinator B regarding Resident #8's tube feed orders. Coordinator C shared prior to his discharge he was being administered tube feed and an oral diet. Upon his return he was still being administered his tube feed and if there was no hospital discharge order for enteral nutrition the nurses would have contacted the physician for an order. Coordinator C reviewed Resident #8's chart and stated while the order was inputted incorrectly upon admission all nurses that provided care to him should also have caught that he did not have a tube feed order. Furthermore, they should not have administered the Jevity without and order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review was completed of the facility policy entitled, Enteral Nutrition Feeding, revised 9/23/2019. The policy stated, .To provide liquid nourishment and adequate hydration through a tube, into the stomach . Administration of tube feeding, and water flushes will be documented in the medical record. Review was completed of the facility policy entitled, Medication Administration- General Guidelines, dated September 1, 2023. The policy stated, Medications are administered in accordance with written orders of the prescriber.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation, interview and record review the facility failed to revise and update a physician's order for one resident (Resident #18) of two residents reviewed for oxygen administration, resulting in the improper flow rate of oxygen being administered. Findings include: Resident #18 (R18): R18 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include heart failure, dementia, peripheral vascular disease and chronic pain syndrome. R18 has a BIMS (Brief Interview for Mental Status) Score of 0, indicating severe cognitive impairment. On 10/07/24 at 12:32PM, R18 was observed sleeping in their bed, R18 had a nasal cannula in place and was receiving oxygen via a concentrator at a flow rate of 4 liters per minute. The oxygen tubing was dated 10/6/24. On 10/08/24 at 09:57AM, R18 was observed in bed, receiving oxygen via a nasal cannula and concentrator at a flow rate of 4 liters per minute, the oxygen tubing was dated 10/6/24. On 10/08/24 at 03:55PM, record review of R18's medical record revealed a physician's order for oxygen at a flow rate of 2 liters per minute via nasal cannula created on 06/27/24. On 10/08/24 at 04:02PM, R18 was observed sitting up in a geri chair, oxygen was being administered at 4 liters per minute via a nasal cannula. This surveyor informed CCC (Clinical Care Coordinator) B that R18's concentrator was set to 4 liters per minute instead of the physician order for 2 liters per minute. CCC B verified the rate of 4 liters per minute and stated they would check R18's oxygen level and notify the physician to see if R18 needed the increase in oxygen. Record review revealed that R18's physician order for oxygen administration was updated on 10/8/24 after being informed of the discrepancy. Record review of the policy titled, Oxygen Administration and Safety, effective 6/7/17 revealed: PURPOSE: Safe administration of oxygen therapy to the resident POLICY: Oxygen administration will be provided per physician's order observing appropriate safety measures. PROCEDURE: (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Check physician's order for liter flow and method of administration. 2. When using oxygen cylinders, secure oxygen cylinder in appropriate holder. 3. Explain safety precautions to resident, family and any visitors. 4. Oxygen tubing will be labeled with date, changed weekly and as needed. The tubing will be stored in a plastic bag or similar storage device when not in use. 5. Apply humidification if ordered- Label and date if using prefilled disposable containers. Utilize sterile or distilled water for refillable humidification bottles. 6. If using a concentrator, change or clean filters as needed. 7. Resident's respirations and oxygen saturation levels will be monitored as ordered and as needed based on resident assessment. 8. Oxygen will not be utilized in the beauty shop, while a resident is smoking, or in other areas/events that may pose a potential risk. 9. If a resident wishes to participate in activities where oxygen is prohibited, a physician order will be obtained for intermittent removal of oxygen therapy.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to respond timely to pharmacy recommendations and follow parameters and/or check blood pressure prior to administration of medication for one resident (Resident #6) of five residents reviewed for unnecessary medications, resulting in Resident 6's pharmacy recommendations not being acknowledged by the facility and ensuring their blood pressure was taken and constraints followed prior to administration of medication. Findings Include: Resident #6: During initial tour on 10/7/2024 Resident #6 was observed resting in bed watching television she did not report any pressing concerns. On 10/8/2024 at 1:30 PM, a review was completed of Resident #6's medical records and it revealed she admitted to the facility on [DATE] with diagnoses that included, Heart Failure, Anxiety, Schizoaffective, Hypertension, Gastro-Esophageal Reflux Disease, Major Depressive Disorder and Nonpsychotic Mental Disorder. Review was conducted of Resident #6's Medication Regime Review's (MRR) from January 2024 to September 2024. It was found there were three reviews the facility failed to respond too. 1-24-2024 at 21:15: Pharmacist Recommends: Pantoprazole 40 mg QD (every day) (12-8-2022) Long term PPI (Proton Pump Inhibitors) therapy changes the pH and flora of the GI (gastrointestinal) tract, increasing risk of Clostridium difficile infections, pneumonias, iron-deficiency anemia, hypomagnesemia and osteoporotic fractures. Please consider the risks vs benefits and if reducing to pantoprazole 20 mg QD is applicable. 2/14/2024 at 17:00: Pharmacist Recommends: Cozaar Tablet 25 MG (Losartan Potassium) Give 1 tablet by mouth one time a day Hold for sbp (systolic blood pressure) < 120. Please add BP under supplementary documentation on the order to document/compare BP against hold parameter prior to administration. 2/14/2024 at 17:00: Pharmacist Recommends: Obtain CBC (complete blood count) with Diff, CMP (comprehensive metabolic panel), Carbamazepine, magnesium/vit B12, and Vitamin D level, TSH (thyroid), A1c, and Lipid Panel on next scheduled day then q 6 months. Please obtain these labs or upload the recent results. 5/8/2024 at 15:20: Pharmacist Recommends: Cozaar 25 MG 1 tab QD Hold for sbp < 120. Please add BP under supplementary documentation on the order so it can be documented on MAR ((Medication Administration Record). This will help compare to hold parameter prior to administration and retroactive review of holding trends. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/8/2024 at 15:26: Pharmacist Recommends: Standing lab order: Obtain CBC with Diff, CMP, Carbamazepine, magnesium/vit B12, and Vitamin D level, TSH, A1c, and Lipid Panel on next scheduled day then q 6 months. Found a lipid panel, sodium, and a pending A1c lab report from 2-13-24. However could not find the other labs above. Please upload recent results or obtain a CBC with Diff, CMP, Carbamazepine level, magnesium, vitamin B12, vitamin D level, TSH. The CBC with Diff, CMP, Carbamazepine level, magnesium, vitamin B12, vitamin D level, TSH were not completed until August 2024 when the initial request was in January 2024, with two follow- up requests in February and May 2024. Pantoprazole 40 mg QD order remined unchanged from order date of 12/8/2022. The recommendation for supplemental documentation in the MAR for Cozaar was not added. While facility staff were documenting Resident #6's blood pressures, the hold parameter was not being adhered too and/or the blood pressure was not documented prior to administration. There were 21 times (as listed below) when this occurred. 9/18/2024 09:02 118 / 62 mmHg 9/16/2024 14:04 118 / 62 mmHg 9/16/2024 09:03 117 / 63 mmHg 5/23/2024 11:39 118 / 60 mmHg 5/21/2024 11:22 116 / 60 mmHg 5/20/2024 01:05 114 / 60 mmHg 5/7/2024 13:49 118/72 mmHg 4/28/2024 13:12 119 / 69 mmHg 4/17/2024 12:44 118 / 70 mmHg 4/14/2024 13:08 106 / 50 mmHg 4/13/2024 14:22 106 / 50 mmHg 4/12/2024 05:37 106 / 50 mmHg 4/5/2024 13:17 118 / 72 mmHg 4/4/2024 13:10 118 / 72 mmHg 4/2/2024 13:31 117 / 70 mmHg 3/31/2024 11:06 117 / 70 mmHg (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	10/09/2024

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/30/2024 14:29 118 / 69 mmHg 3/28/2024 13:17 118 / 69 mmHg 3/27/2024 13:56 118 / 69 mmHg 3/19/2024 14:11 118 / 72 mmHg 3/10/2024 13:13 118 / 77 mmHg Review was completed of the facility policy entitled, Consultant Pharmacist Reports, revised December 2022. The policy stated, .Recommendations are acted upon and documented by the facility staff and/or the prescriber. Prescriber accepts and acts upon suggestions or rejects and provides and explanation for disagreeing . The Director of Nursing or designated licensed nurse address and document recommendations that do not require a physician intervention .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 Based on observation, interview and record review the facility failed to document the clinical rationale for triple drug therapy for one resident (Resident #6) of five residents reviewed for unnecessary medications, resulting in Resident #6 being prescribed three antidepressant medications related to her Major Depressive Disorder diagnosis. Findings Include: Resident #6: During initial tour on 10/7/2024 Resident #6 was observed resting in bed ,watching television she did not report any pressing concerns. On 10/8/2024 at 1:30 PM, a review was completed of Resident #6's medical records and it revealed she admitted to the facility on [DATE] with diagnoses that included, Heart Failure, Anxiety, Schizoaffective, Major Depressive Disorder and Nonpsychotic Mental Disorder. Further review yielded the following results: Physician Orders: Sertraline HCl Tablet 100 MG (milligrams) for Major Depressive Disorder Trazadone HCl Tablet 50 MG for Major Depressive Disorder Wellbutrin XL Oral Tablet Extended Release 300 MG for Major Depressive Disorder Resident #6 was prescribed three antidepressants for her diagnosis of Major Depressive Disorder. There was no documented clinical rationale that confirmed the benefits of multiple medications from the same class or with similar therapeutic effects. On 10/8/2024 at 3:55 PM, an interview was conducted with Social Worker E regarding Resident #6's three antidepressant medications. Social Worker E expressed the resident is currently stabilized on the medication regime as when reductions were completed, she began to isolate, needed extensive encouragement to get out the bed and was more tearful. The social worker was asked where the documentation from the provider to this fact was located. After searching the notes, the documented rationale was not able to be located. Review was completed of the facility policy entitled, Use of Psychotherapeutic Medications, revised 11/2/2016. The policy stated, .Duplicative drug therapy will be discouraged and closely monitored . The policy did not address the need for clinical rationale if multi drug therapy is utilized.

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	10/09/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49944 Based on observation the facility failed to dispose of expired supplies and supplements located in the medication storage rooms on the 100 Hall and 400 Hall, resulting in expired supplies and supplements being available for use and consumption. Findings include: On [DATE] at 12:28 PM, the 100 Hall medication storage room was reviewed and revealed the following expired items: -A case of purple top vacutainers (tubes used to collect blood for lab testing) had expired on [DATE]. -Eight Ensure Plus supplement drinks had expired on [DATE]. -Nine sterile gauze pads had expired on [DATE]. These findings were verified with RN (Registered Nurse) C. On [DATE] at 12:40 PM, the 400 Hall medication storage room was reviewed and revealed the following expired item: - A box of lubricating jelly had expired [DATE]. This finding was verified with the NHA (Nursing Home Administrator). The policy provided by the facility titled, Medication Storage in the Facility does not address expired supplies and supplements.