STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235150	A. Building B. Wing	03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthsource Saginaw, Inc	3340 Hospital Rd 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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38471 This Citation pertains to Intake Numbers MI00143243 and MI00143245. Based on interview and record review the facility failed to complete a comprehensive fall investigation and notification to a physician of X-ray results for one resident (Resident #602), resulting in; 1. Resident #602 falling on 02/26/2024, X-rays being completed on 02/27/2024 with the resident sustaining a nasal bone fracture, left side of maxilla (bone that forms upper jaw) fracture with recommendation for CT (computed tomography) scan; 2. Facility's failure to notify physician of x-ray results and recommendations.; 3. Taking seven days for the facility's physician to review x-ray results and assessing Resident #602 seven days after the fall, after which Resident #602 was again sent to emergency room for evaluation with findings of subacute bilateral subdural hematomas and; 4. Lack of clear and consistent documentation surrounding Resident #602 subdural hematomas. Findings include: Resident #602: On 3/25/2024 at 5:00 PM, an interview was conducted with Nurse H regarding Resident #602's fall on 2/26/2024. Nurse H explained the CNA (Certified Nursing Assistant) assisted Resident #602 to the restroom and once he was situated on the toilet the CNA tuned around to change the position of the walker. In those moments the CNA's back was turned the resident attempted to readjust himself on the toilet, fell and hit his face on the floor. The CNA yelled out the door for assistance and the resident was observed laying on his left side on the bathroom floor, his nose was bleeding with bruising over this eyebrow and bridge of nose. A head-to-toe assessment was completed, ice compress provided for his forehead and pressure applied to his nose to stop the bleeding. Nurse H reported he was not sent to the hospital nor was imaging ordered. On 3/25/2024 at approximately 10:00 AM, a review was completed of Resident #602's medical records and it indicated he was admitted to the faciltiy on 2/21/2024 with diagnoses that included, Dehydration, Acute Metabolic Acidosis, Acute Kidney Failure, Heart Disease and Atrial Fibrillation. Resident #602 was assessed as being cognitively intact and able to make his needs known. Further review yielded the following: Care Plan: (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 0600 Level of Harm - Actual harm Residents Affected - Few	(Resident #602) has increased risk for bleeding related to anticoagulant therapy .Provide one assistance for bathing, hygiene, and toileting daily . On 3/26/2024 at 11:00 AM, an interview was conducted with Family Member P regarding Resident #602's fall. Family Member P stated facility staff informed their mother that Resident #602 had no fractures from the fall, yet he was sent to the hospital a week after. The emergency room staff informed them he had a brain bleed, nose fracture and his Eliquis would be discontinued until a CT scan was completed. Family Member P added Resident #602 shared with them, the CNA left the bathroom (prior to fall) as he requested privacy and once he readjusted on the toilet, that was when he fell and hit his head. On 3/26/2024 at 1:20 PM, an interview was conducted with Family Member Q regarding Resident #602's fall. Family Member Q stated Resident #602 stated his physician was rounding a week after his fall and observed that his nose was broken and wanted him sent to the emergency room for evaluation and CT scan. When facility staff initially called, they informed Family Member Q that nothing appeared to be broken but upon a family visit it appeared to them that Resident #602's nose was broken. On 3/26/2024 at approximately 3:45 PM, further review was completed of Resident #602 medical record. Fall Event Report: The event was created by Nurse L on 2/26/2024 at 12:15 PM and closed by ADON (Assistant Director of Nursing) on 2/27/2024 at 8:09 AM. The reported indicated the following: .fall in bathroom . Resident left alone in bathroom for less than 5 seconds while nursing assistant obtained wheelchair. fell off toilet onto L (left) side, hitting L arm and L temple. Developed nose bleed which resolved with pressure. Returned to bed and vital signs/neuros checks initiated. Bruising noted to L forehead and L cheek. Complaining of pain only on L cheek .IDT (interdisciplinary team) met and reviewed fall in which resident attempted to transfer self while in bathroom and lost balance and fell . Resident was times two assisted back onto the toilet. The aide turned around to get wheelchair and resident attempted to rise without assist .will care plan for resident not be left alone when in bathroom due to decline in mobility . It can be noted the report does not indicate the CNA involved in the incident identity or statement of events, Resident #602's statement, or the statement of the second nurse that assisted after the fall statement. Furthermore, the report failed to indicate that x-rays were ordered, fractures were reported from the x-ray with recommendations for a CT scan and there was no physician notification of the results. Lastly, the following sections within the fall event report were incomplete: - Event Details - Pain Observation - John Hopkins Observation - Body Observation - Neurological Check (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	- Mental Status - Possible Contributing Factors - Interventions X-Ray Results: Reported on 2/27/2024 at 12:35 PM: .There is evidence of a nasal bone fracture. There is a possible fracture of the anterior maxillary spine as well .Consider CT scan for confirmation. emergency room Records: .Patient arrives with x-ray results from prior fall on 2/27/2024 .He reports 3 days ago he had 2 people assisting him off the commode when he fell to the ground and hit his face. He had several x-rays at that time which showed nasal fracture .Mild edema with ecchymosis along the nasal bridge with dependent ecchymosis below the eyes which appears in healing stage .According to his paperwork that he arrives with this fall was at least 1 week ago when he had x-rays. X-rays recommended CT scan for confirmation of nasal fracture .There is subacute bilateral subdural hematoma on CT head .Volume loss in brain. Interval development of low attenuated extra-axial fluid collections as described above without midline shift .fractures involving the bilateral nasal bones and the fracture involving the frontal process of the maxilla on the left side . Subdual hematomas were discussed with .neurosurgery .He reviewed CT images and recommends outpatient follow up for repeat CT scan. Recommends discontinuing Eliquis until repeat CT imaging and follow up in 1 week .Neurosurgeon progress note .Patient has a very small chronic possibly epidural hematoma in left frontal regional and possibly streaks of blood along the tentorium with no mass effect. Would suggest repeat CT in 1 week and follow up in office after .EMS (Emergency Medical Services) .Upon arrival to (facility) we received information from the nurse. She stated the patient had fallen 2 days ago but was not sent to the hospital. They stated the patient is on blood thinner and received an X-ray today and found he has facial fractures. The nurse stated their doctor said he is not able to stay at facility without going to ER with the fractures. She stated her doctor talked to (receiving hospital) and that he has to go for head CT .proceeded to the patient who was in the sun room in a wheelchair with bruises on left cheek, left chin and above left eyebrow. The patient stated he had fallen because the nurses didn't set him back far enough . Progress Notes: 2/26/2024 at 15:03: Resident left alone in bathroom for less than 5 seconds while nursing assistant obtained wheelchair. fell off toilet onto L side, hitting L arm and L temple. Developed nose bleed which resolved with pressure. Returned to bed and vital signs/neuro checks initiated. Bruising noted on L forehead and L cheek. 3/5/2024 at 13:32: PCP rounds gave or to send resident to ER for CT scan. For possible fracture of Maxillary. 3/5/2024 at 21:35: Patient return Back with Family transport from Hospital. Patient Eliquis to Be Dc until he see his neurologist .Hospital report indicated patient has some brain Bleed . (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Practitioner Notes: 3/5/2024: The patient had a fall with facial trauma. He had x-rays done, which came back positive for nasal fracture and fracture in his maxillary spine area. The patient is complaining of pain in his nasal area. He has bruising and some ecchymosis around his nose and periorbital area .nose is slightly curved to the left and he has bruising around his nose with tenderness in the nasal area and maxillary .I have discussed with nursing to send him to the ER for CAT scan to evaluate his fracture and involvement of his maxilla for possible treatment at this time . 3/7/2024: The patient was sent recently to the ER after he had a fall and developed periorbital hemorrhages and nasal fractures. X-ray of head came back positive for nasal fracture. He was sent to the ER for and he had a CAT scan, which came back positive for nasal bone fracture, small fracture of the maxilla with extra-axial bleeding noted on the CAT scan likely acute, small, subdural hemorrhage .He was seen by neurosurgery in ER. At this time, Neurosurgery recommended the patient to be discharged back to facility. He will repeat CT scan in 1 week to evaluate the bleeds. At this time his Eliquis has been discontinued. We will continue to monitor him closely. Patient will follow with neurosurgery and will obtain CT head in 1 week . 3/14/2024 at 9:00: .Patient reports left facial pain after falling last week and being found to have fractures. Son also reports possible brain bleed and will need to follow up with Neurosurgeon .X-ray nasal bones and x-ray orbits 2/27: There is evidence of a nasal bone fracture. There is a possible fracture of anterior maxillary spine . It can be noted there were no progress noted related to Resident #602's x-ray results that were received by the facility on 2/27/2024, subsequent nose fracture, CT recommendation nor physician notification until 3/5/2024 when Physician J completed facility rounding. Nursing notes indicated a brain bleed, but there was no further clarity or correction made regarding these notations. On 3/26/2024 at 2:10 PM, an interview was conducted with CNA M regarding Resident #602's fall on 2/26/2024. CNA M explained the resident was in the Day Room and his wife asked if she could assist him to restroom. CNA M wheeled Resident #602 back to his room and into the bathroom where she proceeded to assist Resident #602 to stand from the wheelchair, pull down his pants and sit on the toilet. Resident #602 requested privacy from CNA M stated she obliged and stepped right outside the door. About two minutes later she heard the thud and found the resident to the side of the vanity and his nose was bleeding. When CNA M asked Resident #602 what happened and he responded he tried to readjust himself on the toilet and fell in the process and his head on the floor. CNA M stated the nurse quickly responded and assessed the resident prior to placing him back in bed. On 2/26/2024 at 4:35 PM, an interview was conducted with ADON (Assistant Director of Nursing) Unit Manager C, regarding Resident #602's fall. They were asked the process when X-ray results are received and explained upon receipt of the results the nurse would be responsible to inform the physician of the results and then receive further instruction. They were informed there was no documentation from facility staff related to his X-ray results and notification to the physician of Resident #602's fractures and the recommendation for CT scan. Manager C and ADON stated they would follow up with his writer on any further information they can locate regarding this. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	They were queried regarding the specifics of the fall and Manager C explained CNA M turned to grab Resident #602's wheelchair and as the CNA was turned the resident readjusted himself on toilet, fell and hit his face on the floor. Manager C was asked if there were statements from the CNA or nurses regarding their fall and they stated there were not. A discussion was held regarding the facility's investigation related to the fall. It was explained their Event Report for Resident #602's fall did not have any statements from facility staff (Nurse H, CNA M and Nurse L), it was not able to ascertained from the report who the CNA was in the bathroom or the other nurse that assisted following Resident #602's fall, no mention of the X-ray order, findings of X-ray or notification to physician regarding the findings, subsequent emergency room visit and CT results. It was further explained the investigation lacked thoroughness and completeness. The DON and Unit Manager C expressed their understanding. On 3/26/2024 at 5:10 PM, an interview was conducted with Nurse L regarding Resident #602's fall on 2/26/2024. The nurse reported she observed CNA M wheel Resident #602 back onto the unit and into his bathroom, as she was right outside his door with the medication cart. Nurse L stated she could hear their conversation with one another and head the CNA state she was going to move something. The CNA turned her back and then she heard a bump noise and knew Resident #602 had fallen. Nurse L ran into the bathroom and observed Resident #602 laying on this left side, with an abrasion/raised bump on his head and bleeding nose. They were able to stop the bleeding and applied an ice pack as well. Nurse L she contacted the physician and talked over the fall with him. There was no emergent need to send him to the emergency room and they ordered x-ray's for the following day as nothing appeared to be broken at the time of his fall. On 3/27/2024 at 9:20 AM, Unit Manager C, ADON and DON (Director of Nursing) explained upon Resident #602's return from the emergency room they, too, questioned the brain bleed, and completed further review of the hospital records and found it was an epidural hematoma. They were queried on where the documentation from their nursing staff and Nurse Practitioner derived from and they stated from Resident #602's children. This writer expressed concern over the lack of clarification within the residents' medical records related to this incident and delay in treatment as the Physician was never notified of the x-rays/recommendations. It was also conveyed the account of events provided in their fall event versus staff statements did not align. They expressed understanding of this writer's concern. On 3/27/2024 at 12:20 PM, Physician J reported he was aware Resident #602 as he did recall the facility contacting him. Upon arriving to the facility on [DATE] to complete his rounds, Resident #602's x-ray results were in his mailbox. He stated the facility did not contact him upon receipt of the results and he sent the resident to the emergency room based on the recommendation from the x-rays and his clinical judgment. Physician J stated the CT found subdural hematomas. Review of facility policy entitled, Resident Change in Condition, revised December 2022. The policy stated, . The facility will contact the Physician at the time of residents condition change that is unrelieved with nursing interventions or requires medical intervention that is not available by Standing Order .Notification of the physician is the responsibility of the Licensed Nurse . Review of facility policy entitled, Fall Prevention, revised June 2020. The policy stated, .(Facility) has devised a specific data collection form to be completed upon a resident falling . The policy does not mention fall investigations.