

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Healthsource Saginaw, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347</p> <p>This Citation pertains to Intake Numbers MI00143547 and MI00144442.</p> <p>Based on observations, interviews and record review, the facility 1) Failed to ensure that privacy was maintained for one resident (Resident #56), 2) Failed to ensure that residents are receiving timely, polite, and dignified assistance, 3) Failed to ensure that female residents with facial hair were shaven, 4) Failed to ensure that call lights are within reach, and 5) Failed to respond timely to call lights for nine residents (#6, #11, #12, #26, #28, #56, #78, #135, and #136) and the Confidential Resident Group meeting conducted on 08/06/24, resulting in verbalizations of concern and anger, an unsafe environment, and the likelihood for decreased self-esteem, shame and isolation.</p> <p>Findings Include:</p> <p>Resident #6:</p> <p>Review of the Face Sheet and care plans, revealed Resident #6 was [AGE] years old, admitted to the facility on [DATE], alert and able to make own healthcare decisions, and dependent on staff for assistance with Activities of Daily Living (ADL), acute kidney failure, severe sepsis, open wound on right heel, demyelinating disease of central nervous system, quadriplegia, muscle spasm, dementia, and heart disease.</p> <p>Review of Resident #6's ADL Functional care plan dated 10/20/21, revealed she was totally dependent on staff for all ADL's, transferred with a mechanical lift and used an [NAME]. The resident was not able to get up out of bed without staff assistance.</p> <p>During an interview done during on 8/5/24 at 2:15 p.m., Resident #6 stated she (staff assigned on 8/5/24) got me up at 11:00 a.m., she was late, we are short of CNA's (Nursing Assistant's). The resident wanted to get up earlier then 11:00 a.m., but staff did not get her up for breakfast.</p> <p>Resident #11:</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Face Sheet, physician orders dated 6/11/24, care plans dated 6/11/24, BIMS dated 6/24/24, and nursing progress notes dated 7/1/24 through 8/5/24, revealed Resident #11 was [AGE] years old, alert and her own person, admitted to the facility on [DATE] with a return to the facility on [DATE], and dependent on staff for assistance with ADL's. The resident's diagnoses included, acute with chronic respiratory disease, pneumonia, diabetes, heart failure, chronic kidney disease, muscle weakness, collapsed vertebra, depression and anxiety.</p> <p>Review of Resident #11's fall and stroke care plans dated 2/15/24, stated Keep call light within reach.</p> <p>During an interview and observation done on 8/05/24 at 1:52 p.m., Resident #11 was in her bed. The resident said she could not find her call light, this surveyor found her call light wrapped around her left positional bar, hanging down toward the floor. The resident was not able to reach it.</p> <p>During an interview done on 8/5/24 at 1:52 p.m., Resident #11 stated, I don't have my call light, it's gone. It takes them (staff) about at least a half an hour, depends on if they are on a break. I don't call them to put me on the bed pan because it's too much for them, I don't call them until I wet my depends. It (having to go to the bathroom) happens to often to call them.</p> <p>Resident #28:</p> <p>Review of the Face Sheet, BIMS dated 5/17/24 (cognitive assessment), care plans dated 4/8/24 to current and physician orders dated 4/8/24 to current, revealed Resident #28 was [AGE] years old, admitted to the facility on [DATE], had impaired temporal orientation and was not able to make healthcare decisions, and was dependent of staff for all activities of daily living (ADL's). The resident's diagnosis included, Dementia, muscle weakness, Alzheimer's, anorexia, right hip contracture, depression and anxiety.</p> <p>Review of Resident #28's orientation care plan dated 4/8/24, revealed the resident had confusion and memory loss related to Alzheimer's.</p> <p>Review of Resident #28's Behavioral and ADL care plans dated 4/8/24, revealed staff were to encourage showers and do all ADL's for the resident.</p> <p>During an observation done on 8/06/24 at 10:13 a.m., revealed Resident #28 sitting in his wheelchair in the hallway and not shaven, with an excessive amount of hair on the chin area and his hair was not combed (it was sticking up on top).</p> <p>Resident #135:</p> <p>Review of the Face Sheet, and care plans revealed Resident #135 was [AGE] years old, admitted to the facility on [DATE], and she was confused; not able to make healthcare decisions, (Family Member #1 N) made all healthcare decisions and visited daily for 6 hours. The resident's diagnosis included dementia with severe agitation and psychotic disturbances, muscle weakness, anxiety, anorexia, Dysphagia (difficulty swallowing), decreased cognition and communication deficit, and depression. The resident was receiving Hospice services.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dignity</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #78 was admitted to the facility with diagnoses: Dementia, history of a stroke, diabetes, depression, weakness, COPD, obesity, pain, seizure disorder, dysphagia and left sided weakness. The MDS assessment dated [DATE] revealed Resident #78 had full cognitive abilities with a BIMS score of 15/15 and needed assistance with all care.</p> <p>On 8/05/2024 at 1:20 PM, Resident #78 was observed sitting in a chair in his room. He said he was upset because he felt sometimes the aides were snotty. He stated, I don't get to go to bed until later. I would like to go to bed after supper. All the other people are going to bed first. I spoke to a nurse at the desk about it, and she said, 'You have to talk to your doctor about going to bed early'. I usually I go about 8:00 PM. One time it was 10:00 PM. They will turn my light off, and say, 'I will get to you' and never come back.</p> <p>A review of the Care Plans for Resident #78 identified the following:</p> <p>ADL's (activities of daily living) Functional Status . (Resident 378) is limited in ability to perform ADL's/hygiene/transfers related to CVA (stroke) with left side hemiplegia, start date 4/6/2022 with Interventions including: (Resident #78) is partial/moderate assistance x 1 staff with bed mobility . Transfers with partial/moderate assist x 1 staff, both dated 4/6/2022.</p> <p>There was no mention of the resident's bedtime preference.</p> <p>39059</p> <p>Resident #12:</p> <p>On 8/06/24, at 9:45 AM, Resident #12 was resting in their wheelchair in the day room. Their head was resting on the table. There was a spilled Styrofoam cup of pineapple on the floor. Resident #12's feet were sitting in the spilled pineapple and pineapple juice.</p> <p>On 8/06/24, at 10:06 AM, Resident #12 remained in the same position with their head on the table and their feet in the spilled pineapple and juice.</p> <p>On 8/6/24, at 1:00 PM, a record review of Resident #12's electronic medical record revealed an admission on 11/15/2022 with diagnoses that included Dementia, Parkinson's Disease and Alzheimer's. Resident #12 had impaired cognition and required assistance with all Activities of Daily Living (ADL's).</p> <p>A review of the Problem Start Date: 11/17/2022 Category: Nutritional Status (the resident) is at nutritional risk due to requires 1:1 feeding assistance, multiple medical conditions including Parkinson's, dementia . Approach Start Date: 11/17/2022 1:1 feeding assistance</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 8/07/24, at 9:13 AM, Resident #12 was resting in their chair in the day room. Their head was resting on the table. There was a spilled plastic glass on the floor of orange drink. There was a white bath towel crumpled up over top of the spilled juice and plastic cup. Resident #12's bare feet were resting in the spilled mess. There were 2 staff members in the day room assisting another resident to a seated position. The 2 staff members walked out and did not help Resident #12.</p> <p>Resident #56:</p> <p>On 8/07/24, at 8:55 AM, this surveyor knocked on Resident #56's door. Upon opening the door, Resident #56 had their uncovered body exposed to the doorway. Shortly after the door was quickly closed, a nurse carrying medications opened the door and entered the room. There was no privacy separating the doorway to the exposed backside of Resident #56.</p> <p>A review of Resident #56's electronic medical record revealed an admission on 9/12/2020 with diagnoses that include Stroke, Depression and Anxiety. The resident required assistance with Activities of Daily Living.</p> <p>Resident Council</p> <p>On 8/6/24, at 4:00 PM, During resident council task, the group was asked if they get their needs met and the following complaints were voiced:</p> <p>It depends if they are shorthanded</p> <p>you have to be patient and wait</p> <p>they come in and cancel your light but never come back</p> <p>you have to put your call light on sometimes 2 or three times and then they say oh, I forgot</p> <p>they cancel the light, don't come back right away and then when they do they say I was doing someone else</p> <p>it depends on who is working</p> <p>they cancel the light quickly and then don't even give you enough time to say what you need</p> <p>they will talk and laugh loud and sometimes it's like they are at the bar in the hallway</p> <p>sometimes they will be discussing amongst themselves like you're not even there</p>

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>Based on observation, interview and record review, the facility failed to update/revise individualized, person-centered care plans to reflect changing care needs for three residents (Resident #12, Resident #16, and Resident #117), of 32 residents reviewed for care plans, resulting in the potential for unmet care needs.</p> <p>Findings Include</p> <p>Resident #16:</p> <p>Pressure Ulcer/Injury</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #16 was admitted to the facility on [DATE] and the most recent readmission of 4/16/2024 with diagnoses: History of brain injury, quadriplegia, seizures, hydrocephalus, dysphagia, multiple pressure ulcers, and anxiety. The MDS assessment dated [DATE] revealed the resident had severe cognitive decline and was dependent with all care.</p> <p>On 8/06/24 at 9:53 AM, Resident #16 was observed lying in bed. He had an air mattress set at 400 normal pressure; on the static setting. The resident was awake and alert, but unable to answer questions.</p> <p>On 8/08/24 at 12:28 PM, during an interview with Wound Nurse P she said Resident #16 had some chronic wounds and some newer wounds that had healed: right lateral foot older Stage IV- healed and reopened; right ischium Stage 4 recently healed- reopened; left ischium and sacrum- left ischium almost healed stage 4- sacrum unstageable now, prior stage 4. The Wound Nurse reviewed the wound measurements and orders in the electronic medical record/emr.</p> <p>During the interview on 8/8/2024 at 12:28 PM, the Wound Nurse P was asked what interventions were in place to aid in preventing skin breakdown for Resident #16 and she listed the following: low air loss mattress, turning wedge/left to right, heels off cushion/heel boots, bars to keep blanket off feet, foot extender.</p> <p>Upon review of the Care Plans for Resident #16 with Wound Nurse P on there were 3 skin care plans:</p> <p>10/11/2022 start date: (Resident #16) has alteration in skin integrity related to immobility, quadriplegia, and chronic osteomyelitis. Stage 4 pressure to coccyx and Left ischial tuberosity; Stage 2 pressure on bottom right foot x 2 and Right buttock.</p> <p>All of the interventions were dated 10/11/2022 (approach start date). All of the interventions were generic and did not mention the specific interventions identified by Wound Nurse P. The Care Plan indicated it was last reviewed/revised 8/5/2024, but there were no updated interventions specific to Resident #16.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666</p> <p>This Citation pertains to Intake Number MI00143547.</p> <p>Based on interview and record review the facility failed to monitor and treat blood glucose levels for one resident (Resident #165) of five residents reviewed for medication management, resulting in Resident #165 developing a change of condition due to low blood glucose levels and being transferred to the hospital.</p> <p>Findings Include:</p> <p>Resident #165:</p> <p>hospitalization</p> <p>A record review of the Face sheet and Minimum Data Set (MDS) assessment indicated Resident #165 was admitted to the facility on [DATE] with diagnoses: Diabetes, end stage kidney disease, renal dialysis, Alzheimer's disease, GERD, COPD, hypothyroidism, and hypertension. The MDS assessment dated [DATE] indicated the resident had full cognitive abilities with a Brief Interview for Mental Status (BIMS) score of 14/15 and needed assistance with all care.</p> <p>On 8/07/24 at 2:00 PM, during an interview with the Assistant Director of Nursing/ADON BB related to a facility reported incident for Resident #165, she said the resident was transferred to the hospital for a change of condition on 4/27/2024 related to low blood sugar. She said the resident had multiple instances of low blood sugar (CDC: Diabetes- About Low Blood Sugar (Hypoglycemia) May 16, 2024: . Low blood sugar can be dangerous if left untreated .Blood sugar below 70 mg/dl is considered low .). A review of the electronic medical record documentation with the ADON revealed that nurses continued to give insulin, after the resident's blood sugar was identified to be low. There were multiple episodes of low blood sugar between 4/20/2024 and 4/27/2024. It was noted some nurses continued to give insulin in the evening after having low blood sugar during the day with no documentation of contacting the physician. This also occurred on 4/26/2024 with a low blood sugar of 55 at 4:44 PM, and then insulin was given that evening. The residents blood sugar the next morning on 4/27/2024, was so low at 48, that she had decreased responsiveness and was transferred to the hospital.</p> <p>A review of an Event documentation dated 4/27/2024 at 6:58 AM revealed, Resident treated with insulin and needed administration of multiple glucagon (medication for low blood sugar) injections.</p> <p>A review of the physician orders revealed 4 orders for Glucagon Emergency Kit: (glucagon human recombinant) reconstituted solution; 1 mg; amt: 1mg; injection, Once-One time- PRN (as needed), dated: 4/11/2024, 4/24/2024, 4/26/2024 and 4/27/2024.</p> <p>There were also orders for insulin:</p> <p>Lantus U-100 Insulin (Insulin glargine) solution; 100 unit/ml; Amount to Administer: 16 units' subcutaneous; Once a morning, start date 4/3/2024.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235150	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/12/2024
NAME OF PROVIDER OR SUPPLIER Healthsource Saginaw, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Humalog U-100 Insulin (insulin lispro) solution; 100 units/ml; Amount to Administer: 4 units before meals; subcutaneous, start date 4/3/2024. The administration times were 6:45 AM, 11:00 AM, 4:00 PM and 9:00 PM. The resident's blood glucose (blood sugar) level was to be obtained and recorded prior to administering each dose.</p> <p>A record review of Resident #165's Medication Administration Record/MAR and Treatment Administration Record/TAR for April 2024 indicated there was no blood glucose level recorded 4 times between 4/19/2024-4/27/2024: 11:00 AM and 4:00 PM 4/20/2024, 11:00 AM 4/23/2024, 11:00 AM 4/25/2024.</p> <p>A review of the progress notes identified the following:</p> <p>4/27/2024 at 9:16 AM: Blood sugar check results 48, attempted to give sugar-milk mixture, unable to get resident to drink. Glucagon subq (subcutaneous) given. Rechecked BS (blood sugar) 58 . Called and Talked to (Physician AA) of changes in resident . ok'd for resident to be sent to be evaluated at (hospital).</p> <p>4/27/2024 at 6:40 AM: Humalog (insulin) not given, unable to amend administration. Lantus 16 units given as per order BS 111. Will continue to monitor.</p> <p>This entry was documented on 4/27/2024 at 12:16 PM after the resident was admitted to the hospital and it was intended for 4/26/2024 at 8:30 AM: 0730 (7:30 AM) resident not eating breakfast when I entered the room. Resident had a blank stare, not answering questions. BS checked with results of 38, oral sugar attempted, glucagon given subq. Resident becoming more awake, able to take a few sips of milk BS 50 .</p> <p>4/24/2024 at 1:50 AM: Aide notified writer Patient not responding Patient sweating profusely. Blood sugar 31 mg/dl. Dose of glucagon administered. Blood sugar began to trend to 67 mg/dl and then dropped back to 48 mg/dl. Another dose of Glucagon 1mg administered and patient eventually trended to 86 mg/dl. At this point patient became responsive . 4/24/2024 at 8:07 AM: (Physician AA) notified of patient hypoglycemic episode. No new orders at this time.</p> <p>The physician was notified on the morning of 4/24/2024 of Resident #165's very low blood sugar levels and not again until 4/27/2024 when the resident was transferred to the hospital. The nurses were not notifying the physician of the repeated low blood glucose levels and the resident's need for repeated doses of Glucagon in response to the low levels, so the physician could assess the resident and determine if a change in medications or care was needed.</p> <p>A review of the Care Plans for Resident #165 provided the following:</p> <p>(Resident #165) has alteration in metabolic status related to Diabetes type 2, start date 3/29/2024 with Interventions: Administer medications: Humalog 4 units AC (before meals) and HS(at bedtime): hold Humalog for blood sugar less than 150; Lantus at HS; If blood glucose is less than or equal to 60 mg/dl follow orders and notify PCP (primary care provider); Monitor for signs of hypoglycemia (blood glucose <60 mg/dl; sweating, cold, clammy skin, numbness of fingers, toes, mouth, rapid heartbeat, nervousness, tremors, faintness, dizziness). All interventions were dated 3/29/2024.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Healthsource Saginaw, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 3340 Hospital Rd Saginaw, MI 48603	
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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy titled, Resident Change in Condition, dated initiated June 2006, reviewed May 2008 and revised December 2022 provided, To ensure each Extended Care Center resident receives treatment at the time of a condition change. The facility will contact the Physician at the time of a resident's condition change that is unrelieved with nursing interventions or requires a medical intervention that is not available by Standing order. Such contact shall be documented in the medical record. Condition change shall include: . A change in the resident's physical, mental, or psychosocial status in either life threatening conditions . or clinical complications . Notification of the physician is the responsibility of the Licensed Nurse .</p>		

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NAME OF PROVIDER OR SUPPLIER Healthsource Saginaw, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39059</p> <p>This Citation pertains to Intake Number MI00143547.</p> <p>Based on observation, interview and record review the facility failed to ensure Infection Prevention and Control standards of practice were followed for 1) Personal Protection Equipment/PPE use, 2) Hand Hygiene for Residents #56 and #143 and 3) Linen transport for a census of 162 residents, resulting in the potential for the spread of infection.</p> <p>Findings Include:</p> <p>On 8/05/24, at 1:35 PM, the in-room sanitizer for room [ROOM NUMBER] was not working.</p> <p>Resident #56:</p> <p>On 8/07/24, at 8:55 AM, an observation of Resident #56's incontinence care along with CENA X was conducted. CENA X had gloves on and assisted the resident with perineal care and placed a new incontinent brief on the resident. Resident #56 asked for a drink and CENA X picked up the bedside cup with their gloved hand and offered the bedside cup to the resident. CENA X did not remove their dirty gloves and perform hand hygiene prior to assisting with the fluids.</p> <p>On 8/05/24, at 2:08 PM, an observation of CENA CC who had gown and gloves on. CENA CC left out of room [ROOM NUMBER] without doffing the PPE or performing hand hygiene and walked down the hall into room [ROOM NUMBER]. A moment later, CENA CC left out of room [ROOM NUMBER] and reentered room [ROOM NUMBER] with the same PPE on.</p> <p>On 8/06/24, at 10:04 AM, an observation of CENA EE on [NAME] Lane who had a pile of clean linen on their left arm. The linen was touching their uniform. CENA EE was asked how they are supposed to carry the clean linen and CENA EE stated, I know I should have had a barrier.</p> <p>On 8/07/24, at 1:24 PM, CENA FF was observed with a pile of clean linen on their left arm walking toward a resident room. The clean linen was exposed to their uniform and was uncovered.</p> <p>On 8/08/24, at 12:52 PM, Resident #143 was lying in their bed. CENA DD entered to assist with bed mobility and perineal skin observation. CENA DD did not perform hand hygiene on entry. CENA DD pulled a pile of gloves out of their right pocket, removed two and placed the remaining gloves back into their right pocket.</p>		