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	12/04/2024

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22347 This citation pertains to Intake Numbers MI000147442 and #MI00147989. The facility failed to ensure professional quality of care regarding timely treatment, transfer to acute care for evaluation and treatment of an infected wound for 1 resident (Resident #104) of 3 residents reviewed for pressure ulcers, resulting in sepsis (severe infection throughout body), hospital admission with treatment for infected pressure ulcer, and antibiotic usage. Findings Include: Resident #104: Review of the Face Sheet, care plans and physician orders dated 5/31/24 through 6/29/24, physician and nursing progress notes dated 5/31/24 through 6/29/24, revealed Resident #104 was [AGE] years-old, alert with communication deficit due to stroke, admitted to the facility on [DATE] and discharged to acute care for evaluation and treatment of an infected coccyx pressure ulcer. The resident's diagnosis included, diabetes, amputation of right leg below knee, Acute respiratory failure with hypoxia, facial weakness, communication deficit, metabolic encephalopathy, facial weakness post stroke, orbital hemorrhage, feeding tube, hemiplegia and hemiparesis of left side, tracheostomy, and left coccyx pressure ulcer stage II. The resident was not living at the facility at the time of the survey. Review of the facility Pressure Score Risk assessment dated [DATE], revealed he had a score of 11, he was at high risk for development of a pressure ulcer. Review of the resident's hospital notes dated 6/30/24, stated Sepsis (severe infection), due to unspecified organism (from pressure ulcer on coccyx), Pt. (patient) brought in from nursing home due to fever and foul smelling coming from coccyx wound, shivering as well. ID (Infectious Disease) consulted for abx (antibiotic) management. The resident was admitted to the hospital for treatment of sepsis from the infected pressure ulcer. Review of the facility Pressure Ulcer care plan dated 6/11/24, stated Monitor and report signs of localized infection (localized swelling, redness, pain or tenderness, heat at the infected area, purulent drainage, loss of function. This includes reporting to the physician any changes in the resident's pressure ulcer or signs of infection in a timely manner. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility Wound Management Detail Report dated 6/25/24, stated Declining unstageable eschar pressure wound that merged to one lg wound r/t increased time in w/c (wheelchair). Wound edges not attached and rolled under. Surrounding skin is red/non blanchable and warm to touch. Review of all facility physician orders dated 5/31/24 through 6/29/24, revealed no antibiotic order. There was a total of 22 days from the first identification of a pressure ulcer and a blister on the resident's left coccyx, until he was transferred to the hospital. Review of Resident #104's facility nursing notes: -Nursing notes dated 6/8/24 at 4:12 p.m., stated Yesterday this resident up in wheelchair from 930 (9:30 a.m.) until 7:00 p.m. -Nursing notes dated 6/8/24 at 8:00 p.m., stated Stage 2 found last night on coccyx and tonight blister found, blister on right buttock. -Nursing notes dated 6/17/24 at 4:20 p.m., stated Wound-Wound is a lot bigger (pressure on left coccyx area) than the last time this author saw it. No details or measurements of ulcer was found. The physician was not informed of wound change. -Nursing notes dated 6/20/24 at 3:08 p.m., stated Resident has declining unstageable wound to BIL buttock/Coccyx area that is 80% narcotic with 20% slough. 11 x 6 x 3.2 with tunneling of 1.5 cm at 1 o'clock. -Nurse's notes dated 6/23/24 at 4:29 p.m., stated Residents dressing completed. Residents wound is getting worse. Resident has a wound appointment with wound clinic next Friday. There is a foul smell to wound culture sent, old dressing contained ser sang (clear fluid) and bloody drainage. Will email wound nurse. -Nursing notes dated 6/24/24 at 2:58 p.m., stated It does have an odor present. -Nursing notes dated 6/25/24 at 10:10 p.m., stated increased pain r/t (related to) BIL (bi-lateral) wound, increased grimacing and fidgeting. -Nursing notes dated 6/27/24 at 3:49 p.m., stated resident coccyx and buttock wound was bleeding, bleeding controlled, the Eschar (dead tissue) on his ulcer has loosen on the sides and he now has bright red blood present. -Nursing notes dated 6/27/24 at 4:26 p.m., stated Wound was bleeding as the necrotic flap is coming off. Site contains slough and odorous. -Nursing notes dated 6/28/24, revealed the resident had gone to the wound clinic with wound care orders given. -Nursing notes dated 6/29/24 at 11:26 p.m., stated Resident with elevated temp. 101.0 auxiliary, overall red and very warm to touch. Heart rate 112 and s/s (signs & symptoms) of elevated pain with repositioning as resident became very anxious, pulling at tube and squeezing staff's hands. Large amt. of foul drainage noted from coccyx wound. Resident left unit via stretcher with MMR. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview done on 12/2/24 at 2:10 p.m., Nurse, RN E stated I should of sent (Resident #104) out or called the doctor; I should of assessed better; there was a delay in treatment. During an interview done on 12/3/24 at 10:28 a.m., Infection Control Nurse, RN F stated I would have called the doctor on him. Review of the facility Pressure Ulcers: Standard of Care for Prevention & Treatment policy #106.3 dated 2/2017, stated Consult with physician regarding any underlying medical problems that may impede the healing process. If there is absence of wound healing or evidence of wound regression, consult with the physician for alternative interventions. During an interview done on 12/2/24 at 1:30 p.m., Wound Nurse, LPN D stated I thought we had to go by Doctor orders, we got an order for the wound clinic. No, I did not call the doctor back and up-date her (on worsening condition of pressure ulcer). During a phone interview done on 12/3/24 at 11:10 a.m., Physician, MD B said staff should have called her regarding the resident's pressure ulcer's worsening condition. During an interview done on 12/3/24 at 9:48 a.m., the Director of Nursing and ADON (Assistant Director of Nursing), RN A both said it's a insufficient problem (not reporting the worsening condition of the pressure ulcer that delayed treatment to the physician).