

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 01/14/2025
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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927</p> <p>This Citation pertains to Intake Number MI00149011.</p> <p>Based on observation, interview and record review, the facility failed to supervise and prevent a fall for one resident (Resident #1) with a history of anticoagulants and falls, of 3 sampled residents, resulting in the lack of meaningful interventions to prevent repeated falls and the lack of ongoing supervision of a resident, who was a known fall risk, resulting in Resident #1 sustaining a fall from wheelchair and suffering a subdural hematoma with hospitalization and death.</p> <p>Findings include:</p> <p>Record review of the facility Assessment: Nursing' policy, dated 6/2021, revealed all residents will receive nursing care based on a documented assessment of individual needs/problems. The purpose is to identify residents' needs at time of admission and throughout hospitalization , to provide individualized care, a written plan of care, implement interventions and positive outcomes, provide monitoring and evaluation of care, and begin the process of discharge planning.</p> <p>Resident #1:</p> <p>Record review of Resident #1's hospital discharge documents, dated 11/18/2024 through 12/3/2024, revealed that Resident #1 presented to the hospital with an ecchymosis (bruising) to the left side of the face from a fall. Review of Resident #1's medications included Plavix (clopidogrel) 75 mg oral daily and Aspirin 81 mg oral daily (both have blood thinning effects). Hospital documents noted that the current condition would worsen with another fall resulting in significant head trauma, coma, end organ damage and death may occur.</p> <p>Record review of Resident #1's hospital CT of the head due to head injury and being on anticoagulation therapy dated 11/18/2024 revealed no evidence of acute intracranial hemorrhage. On 12/3/2024 in the late afternoon Resident #1 was discharged to a long term care facility.</p> <p>Resident #1 no longer resided at the facility. Observation on 1/14/2025 at 8:00 AM revealed that room [ROOM NUMBER] was located on the Wheels rehab unit. room [ROOM NUMBER] was a private room with a restroom located a short walk from the nursing station.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's long-term care facility Admission nursing progress note, dated 12/3/2024 at 6:10 PM, noted: A/O (Alert & Oriented) 2-3, denies pain, daughter present. All consents signed, full code, transported by (ambulance). Recently fell while living in assisted living. No major skin issues some mild bruising. Lots of confusion. Will continue to assess.</p> <p>A record review of Resident #1's 'Admission Fall Assessment', dated 12/3/2024, revealed a history of one or more falls within the previous 6 months. Elimination pattern of incontinence, 2 or more high fall risk, drugs (Plavix and aspirin), requires assistance or supervision for mobility, transfer, or ambulation, lack of understanding of one's physical and cognitive limitations. Total fall risk score of 19 revealing high fall risk.</p> <p>In an interview on 1/14/2025 at 8:51 AM, admitting Licensed Practical Nurse (LPN) stated Resident #1 came from assisted living with a history of falls. Care plan is done by the charge nurse, which would have been Licensed Practical Nurse (LPN) F Charge nurse. I can't recall him, I read the notes but can't recall a face to the name. He was in the 280's hallway he had a daughter. They were very nice people. He seemed alert and oriented. They had conversations, and she was worried about him falling, he had a history of falls. I did come in the next day and was told he was sent out for falling.</p> <p>Resident #1's nursing progress note, dated 12/3/2024 at 9:03 PM, by Registered Nurse I stated 'resident observed laying on his back on the floor next to his bed, (Resident) reports that he was attempting to pick-up the candy/chips he had spilled on the floor and lost his balance. He was reported to be confused and impulsive upon admission. He is a fall risk (Resident) had on his own fuzzy thick socks on, that had grippy on the bottom. He denied hitting his head and other injury. No visible new injury noted'.</p> <p>Record review of Resident #1's 'Occurrence Reporting Worksheet', dated 12/3/2024 at 9:03 PM, revealed the resident was observed on his back on the floor next to bed, attempting to reach chips and lost his balance. No injury. Call light was in reach, new admit. Call light was on at time of fall. Did have on non-skid footwear. Last observed lying in bed at 8:30 PM. Staff to ensure all items are on overbed table next to resident before leaving room.</p> <p>During an interview on 1/15/2025 at 8:10 AM, Registered Nurse (RN) I stated I remember that night, the first fall he fell out of bed or was found on the floor. He was restless attempting to get out of bed. I was sitting at the nursing station and heard a loud smack noise. The Certified Nurse Assistant (CNA) (I don't know which one) got him up and brought him out to the day room. I looked up he was on the floor. I only had a couple of hours with him, he was a new admit. I saw his black glasses, because I had removed them from his pocket earlier. The CNA had told me that she put him in the dining/day room earlier because he was attempting to get out of bed. She didn't tell me why she put him there. I can't remember who the CNA was. I can't say for sure who it was. Yes, CNA J was assigned to him. I started neuro checks, (no Neuro checks were found in documentation) I don't know where they are. The second fall occurred in the Dining/day room. I didn't see his fall; I only heard the landing. I assessed him he had a large knot on his forehead with bleeding and laceration to forehead. The goose egg was the size of a baseball or an egg. I called the doctor and she said to just restart the neuro checks and to send him out if he falls again. He was still on the floor because he did not want to get up because he his head hurt. At the beginning of the shift, he was rational and could hold a conversation, but he was still confused. He was impulsive. I called the daughter and told her you should send him out and she agreed. Surveyor asked if Certified Nursing Assistant (CNA) was the CNA who placed the resident in the day room and RN I stated not sure.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident #1's Nursing progress notes, dated 12/3/2024 at 9:41 PM, revealed 'Observed to have arrived with purple bruise to left cheek area, small, scattered scabbing to left top of forehead, some healing non-scabbed abraded areas to both knee and scattered bruising to bilateral upper extremities/lower extremities, right upper extremities dialysis fistula with blood shadowed pressure dressing left intact. Positive brill/thrill. Wearing brief that is dry at this time. Head circumference 22.25 inches. Bilateral top half rails. Bed in lowest position. Many empty bags of chips and candy wrappers observed in trash at bedside. Black rimmed eyeglasses observed on bedside table. Cell phone, charging box and charging cord observed at bedside. Medications entered, misc. care orders entered, observations and consents completed'.</p> <p>Record review of Resident #1's Nursing progress note, dated 12/3/2024 at 10:29 PM, revealed '(Resident #1) was placed in wheelchair with bilateral foot pedals on and placed into the Day Room due to being restless and making attempts to get out of bed. This nurse heard a loud smack and looked over and observed resident lying face down in the floor. with legs tangled up into the foot pedals. Left side of face made contact with the floor. Pool of blood visible on the floor under left side of face. Very large hematoma bleeding to left forehead and left upper cheek bone. Bleeding controlled with pressure to left forehead. Hematoma to right chest. Left hip had bulge with new onset bruising. Bilateral lower extremities symmetrical. Resident is moving all extremities without signs or symptoms of pain. (Resident #1) was rolled onto his back with neck stabilized by nursing as positioned onto back. He did not lose consciousness. He is reporting pain to head. Doctor notified. New orders to monitor with re-starting neuro checks, left hip X-ray and to send to ER (emergency room) if he falls again. Daughter wants resident sent to hospital for evaluation'.</p> <p>Record review of Resident #1's 'Occurrence Reporting Worksheet', dated 12/3/2024 at 10:29 PM, revealed 'a fall in the dining room. Observed to have fallen in dining room lying on floor face down. Neuro checks started, X-ray of hip ordered. Resident was sent out to ER, will review fall and safety interventions with physical therapy'.</p> <p>An interview was conducted on 1/16/2025 at 11:22 AM with Certified Nursing Assistant (CNA) J, who called back. When asked about Resident #1 in room [ROOM NUMBER], she could not recall him. Surveyor described resident's fall from bed and WC. CNA J said that she could not remember that man and stated that was a month ago, I simply can't recall. When a resident is confused/restless it's my procedure to put the resident in the dining/day room, because the nurses sit at the nursing station. I put the residents in the dining/day room if confused/restless, so people can watch them. The dining/day room has TV and glass walls so people can watch the resident. The nurses can observe him in the dining/day room. I always report straight away to the nurse about things up with restless/confused resident. The Wheels Unit is short term rehab and gets lot of admissions. Afternoon CNA's have 8 residents each. I can't recall him.</p> <p>Record review of Resident #1's nursing progress note, dated 12/3/2024 at 11:14 PM, revealed 'Hematoma became larger, and blood pressure elevated to 157/102 prior to ambulance arrival. Resident would not allow nursing staff to attempt sitting him upright nor would he keep ice to his forehead. Complaint of pain to face/head. Ambulance arrived at approximately 10:05 PM for transport. Resident took his eyeglasses. Nurse order received for left hip X-ray not entered due to resident being transported out to hospital'.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Hospital record review of Resident #1's Hospital re-admission post fall on 12/3/2024 at 11:46 PM revealed resident presented post fall out of wheelchair. Resident has had two falls since arriving at long term care facility around 5:00 PM (approximately 6.5 hours ago). The resident fell out of his wheelchair tonight and hit his head. He is on Plavix (anticoagulant). CT head due to anticoagulant left front-parieto-occipital acute subdural hematoma with maximum width 1.2 cm, no midline shift. admitted with intracranial hemorrhage to ICU under trauma services .</p> <p>Record review of Resident #1's death certificate, dated 12/18/2024, revealed 'due to complications of acute traumatic subdural hematoma with antiplatelet therapy, repetitive blunt force head trauma and delirium vs dementia'. Date of injury 12/3/2024 fall from wheelchair, recurrent falls.</p>