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	02/11/2025

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** 49944 This citation pertains to intake Number MI00149682. Based on interview and record review, the facility failed to provide adequate post fall assistance to one resident (R1) of three residents reviewed for falls, resulting in feelings of sadness and tearfulness. Findings include: Resident #1 (R1): R1 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include aphasia, cerebral infarction affecting the right side, anxiety and depression. R1 is non-verbal, however, they can respond to yes/no questions. On 2/7/25 record review of recent falls revealed that R1 sustained an unwitnessed fall on 1/19/25 at 5:50pm. R1 was observed sitting in an upright position on the floor mat next to the bed. On 2/7/25 at 1:01pm, an interview was conducted with Licensed Practical Nurse (LPN). LPN 'F' was asked where they were at during the time R1 was observed on the floor. LPN 'F' stated, I was in the room next to the resident. LPN 'F' was asked what alerted them to go into R1's room. LPN 'F' stated, I heard all this yelling, a man yelling and a woman yelling, that is why I entered the room. LPN 'F' was asked where R1 was in the room and what was her mood. LPN 'F' stated, R1 was on the fall mat next to the bed; her son was in the room with her at the time. R1 was seemingly upset and tearful, she was crying loudly. LPN 'F' was asked what the family members mood was. LPN 'F' stated, The son was angry and yelling. LPN 'F' was asked if there were any injuries. LPN 'F' stated, I went to assess the resident, she slapped me, was combative and didn't want me there. The son ended up putting her back into bed. LPN 'F' was asked if the door to R1's room was closed prior to entering. LPN 'F' stated, when I went to enter R1's room, the door was closed, the son was in the room, but I didn't know that. (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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(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	On 2/7/25 at 1:08pm, an interview was conducted with Certified Nursing Assistant (CNA) 'A'. CNA 'A' was asked how the resident was when they last checked on them. CNA 'A' stated, I checked on the resident and her door was open, I saw the resident was sitting on the floor mat next to the bed. The lady that was across the hall was upset, so I went over to calm the lady across the hall and closed the door to R1's room. CNA 'A' was asked what alerted them to come back across the hall to R1's room. CNA 'A' stated, Her son came in and he was cursing and yelling, very enraged. The son was very upset that his mother was on the mat next to the bed. CNA 'A' was asked why they didn't stay with R1 when you observed her sitting on the floor and have someone find help. CNA 'A' stated, We need two people to get her up and we need the nurse to get her back into bed and we didn't know where the nurse was at. So, I went across the hall to calm the other lady down and in that time the son came in. CNA 'A' was asked again why didn't you stay with R1 and send someone else to get help. CNA 'A' stated, there was no one else to help me, I had to tend to the lady across the hall because she was in need of help. CNA 'A' was asked if they should've stayed with the resident that was on the floor. CNA 'A' stated, I was trying to diffuse two things at one time, I just shut the door to R1's room so they couldn't see each other. CNA 'A' never answered yes or no to whether they should have stayed with the resident on the floor. CNA 'A' was asked why did you shut the door when R1 was on the floor. CNA 'A' stated, I did it to diffuse the situation between her and the lady across the hall. On 2/7/25 at 1:41pm, an interview was conducted with CNA 'D'. CNA 'D' was asked if they were aware of the incident from 1/19/25. CNA 'D stated, Yes, I am. This is something that R1 do all the time, this was her second time doing that for the day. My understanding is that when CNA 'A' checked on R1, R1 was on the floor. CNA 'D' stated, Before the son entered the room, we already knew she was on the floor. I overheard the staff out there saying she was on the floor in her room. On 2/7/25 at 2:01pm, an interview was conducted with CNA 'C'. CNA 'C' was asked, when you checked on R1 with CNA 'A' where was R1 in the room. CNA 'C stated, R1 was on the mat by the bed, R1 was just laying down on the mat. CNA 'C stated, I was the primary CNA. When me and CNA 'A' left the doorway of R1's room I went down the hall to check on another resident who was yelling. CNA 'C' was asked if was their understanding that CNA 'A' was going to stay with R1. CNA 'C' stated, Yes, CNA 'A' was by R1's door and watching R1. CNA 'A' told me to go help the other resident I never saw the door get closed; I was down checking on another resident who was upset. When I came back out into the hall, I noticed that the son was mad. I was confused as to what was going on, I didn't know (CNA 'A') shut the door. CNA 'C' was asked if CNA 'A' told them they shut the door. CNA 'C' stated CNA 'A' told her and LPN 'F' she shut the door. On 2/7/25 at 2:46pm, an interview was conducted with the Director of Nursing (DON). The DON was asked what their expectation is if a staff member observes a resident on the floor. The DON stated, I expect the staff to get help, call for help and to leave that resident in the position they were found in until the nurse gets there.