

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 07/31/2025
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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2564956. Based on observation, interview and record review, the facility failed to implement care plan interventions for fall safety prevention for 2 of 5 residents (R21 & R114) reviewed to be at risk for falls, accidents and hazards, by not consistently ensuring the resident's call light was within reach and the fall mat was in place as outlined in the residents' care plans. Facts and Findings include:</p> <p>Resident #21:</p> <p>Review of the Face Sheet, Care Plans dated 4/25, nursing progress notes and Hospice notes dated 7/25, and care guide for Nursing Assistants/CNA's found in the closet, revealed Resident #21 was [AGE] years old, admitted to the facility on [DATE], confused, unable to follow simple directions, had poor safety awareness with a history of falls in the facility. The resident's diagnoses included, Dementia, behavioral disturbances, cardiac pacemaker, bipolar disorder, depression, anxiety disorder, Alzheimer's disease, Dysphagia (difficulty swallowing), stroke and was receiving Hospice services at the facility.</p> <p>Review of the Falls for Facility sheets, dated 5/29/25 through 6/29/25, revealed Resident #21 was found on the floor on her floor mat on 6/7/2025.</p> <p>Review of all current facility physician's orders for Resident #21, revealed no order for a floor mat for the resident.</p> <p>Review of the resident's facility Falls Care Plan, dated 4/3/25, stated "Floor mat next to bed. A blue floor mat was to be placed next to the resident's bed in the low position while in bed.</p> <p>Observations made on 7/29/25, starting from approximately 11:20 AM at 1:05 PM, 1:14 p.m., and randomly throughout the day until 4:00 p.m., revealed the resident in bed with her blue floor mat leaning up against the wall at the end of her bed. On day shift, no floor mat was observed beside the resident's bed for safety.</p> <p>During an interview done on 7/30/25 at approximately 3:10 p.m., the Director of Nursing said the resident should have had her floor mat down per her care plan.</p> <p>Resident #114:</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of R114 Minimum Data Set/MDS dated [DATE] revealed a Brief Interview of Mental status/BIMs score of 6 out of 15, severe cognitive impairment. Medical diagnosis included: Cognitive communication deficit; Difficulty in walking, not elsewhere classified; Need for assistance with personal care; Alzheimer's disease, unspecified; Dementia in other diseases classified elsewhere, unspecified severity, with psychotic disturbance; adjustment disorder with mixed anxiety and depressed mood.</p> <p>On 7/29 at 10:47 am Interview and observation of R114, resident resting in bed with touch call light coiled around the grab bar on the right upper side at the head of the bed, button facing outward. Resident requested help opening her Ensure drink, when asked how she gets help from the staff if she needs it, she says she just yells out for help because she does not have a call light. She proceeded to call out nurse, nurse two times then stopped, no one came to the room. Observation that the residents room location is at the end of the hall in the last room, it is the farthest away from the garden neighborhood staff station.</p> <p>On 7/29 at 12:28 pm interview with R114's DPOA "Q" who states the resident was recently changed to hospice and has been on a decline over the past few weeks for comfort care. Observed resident resting with eyes closed, in bed with head of bed elevated. The call light remains coiled around the grab bar on the right upper side bed.</p> <p>On 7/31 at 10:18 am observed resident in room resting in bed eyes closed in gown, the door was closed (CNA "Z" stated it was due to a mock fire drill going on), touch call light remains in same position out of residents' reach, blue fall mat next to bed.</p> <p>7/31 at 10:19 am Interview Nurse "S" taking care of this resident today, when asked about what she knew about the residents fall, she states she is aware that she had fallen yesterday, and she has not been down there to see her today yet. She states, "I have been busy in the other hall" (points to the opposite end of the garden neighborhood hall) and have not had a chance to get there but I am almost to her. When asked, Nurse S was unable to give any information regarding the fall or resident current condition. Asked, what time did your shift begin today? she replied at 7am.</p> <p>7/31 at 11:20 am R114 is resting in bed with eyes closed. The right side of bed has a blue fall mat that is folded 1/3 up and pushed diagonally away from the bed about 3 ft away. The left side is fully unfolded and in place. The bed tray is over resident with open applesauce cup and water. The touch call light is coiled around the grab bar on the right upper side of bed at head level facing outward and out of reach of resident.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>7/31 at 11:22 am Interview in residents' room with CNA, R, asked about placement of fall mats for residents and stated, "well it shouldn't be like that, but they probably moved it out of the way for breakfast, but it should have been moved back into place after". When asked how this resident called for assistance, she responds "she has a soft touch call light". When asked where that is located, she responds "it is right there" (and points to the call light around the grab assist bar that has been located there all three days of the survey) "but it is not where it should be either". When asked where it should be? she replied, "in reach of the resident". When asked why the resident had that type of call light she stated "soft touch call lights" are used for our residents that do not have the ability to push the button on the regular call lights. When asked how often this resident used the call light CAN, R, replied "not often, about 25% of the time". She added that the residents with that type of call button should be monitored more frequently by staff because of their inability to fully use call lights. Observation of the CNA in resident room trying to untangle and uncoil the call button free from rail and it took over a minute for her to do so, stating it is "really stuck in there."</p> <p>Record review reveals R114 had a fall on 7/20/2025 and 7/30/2025, reviewed full fall reports, see reports in egress.</p> <p>According to the review of R114 Care plan: updated 7/28/2025 Resident started on hospice services d/t her declining state. Approach: Be available for resident/family. Assure resident/family that he/she will not be left alone; Manage pain and other uncomfortable symptoms.</p> <p>Revised 7/20/2025 I am at risk for falling R/T (related to) reduced mobility, Alzheimer's, anemia, psychotropic medications. Approach: Keep call light in reach at all times; Keep personal items and frequently used items within reach; Provide safety device/appliance: Floor mat next to bed with bed in lowest position.</p> <p>"Initial 3/26/2025: I have limitations in ability to perform ADL's/hygiene/transfers related to: Alzheimer's, reduced mobility, CKD 3, weakness. Approach: Call light within reach.</p> <p>Record Review according to the facilities fall prevention program In high-risk protocols that the facility will: Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status; That each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive care plan. The interventions will be monitored for effectiveness and the care plan will be revised as needed.</p>		