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	01/15/2026

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's right to adequate care and treatment for one resident (Resident #101) of 4 residents reviewed, resulting in the resident having received the wrong medications during morning medication administration. Findings include: Record review of the Michigan Ombudsman website https://mltcop.org/know-your-rights, nursing home provider to promote and protect the rights of each resident. Every person requiring nursing home care should be able to enter a nursing home and receive appropriate quality of care, be treated with courtesy, and enjoy continued civil & legal rights. Record review of facility 'Patient/Resident [NAME] of Rights' policy undated revealed the purpose of the resident bill of rights is to communicate to residents their right to be treated with dignity and confirm that their human needs and rights will be respected by all with whom they come in contact with while at the facility. Record review of facility 'Abuse, Neglect, Mistreatment, Involuntary Seclusion. and Misappropriation of property' policy dated 8/2022 revealed neglect is the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. All employees will report abuse, neglect, mistreatment, involuntary seclusion, or misappropriation of property whenever such a circumstance has been verbalized, alleged, or observed. Resident #101 [R101]:In an observation and interview on 1/15/26 at 7:50AM, Resident #101 was observed seated up in a wheelchair in his room watching television. Resident #101 revealed that a nurse came into his room, not the regular nurse, and the nurse gave him a hand full of pills, 4-5 pills one was blue. Resident #101 was asked if the nurse asked him his name. No, she did not ask my name, and no there are no bracelet on my arm (no ID bracelet observed by surveyor), then she gave me a chocolate boost and a nasal spray. I told her I don't get a nasal spray, and I don't like chocolate boost. And she was looking for my port/IV and an IV stand/pump. There was a man next door in the next room with the same first name also, I believe he had an IV pole in his room. Then she left. Later I was down to therapy, and my regular nurse came to the therapy room with my regular medications. I stayed at therapy for an hour or so, and then I went back to my room. My brother was with me. I told him that I felt higher than a [NAME]. He said that I don't look good, you look high. I stated that I had got extra medications that morning. I let the staff nurse know (LPN F) that morning, I don't recall because I was high in la, la, la land. I don't remember what happened because I was out of it. I fell in my kitchen, I cracked my hip, I came for therapy. I heard the nurse denied that she gave me the wrong meds. I felt lightheaded, high as a [NAME], like I had smoked 3-4 Marijuana cigarettes. My brother stayed with me for the day. I am alright now but it scared the crap out of me.Record review of the facility investigative report dated 1/7/2026 noted that the family was concerned about a medication error on 1/6/2026 the resident stated that he had received medications on 1/6/2026 at 6:00AM from a nurse. Then another nurse came and gave him his morning medications, and he felt it was weird because he thought he just got them. Resident did state that both nurses (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

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 01/15/2026
NAME OF PROVIDER OR SUPPLIER Healthsource Saginaw, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 3340 Hospital Rd Saginaw, MI 48603	

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	called him (first name) but that he knew (the regular nurse) but did not know the other nurse, she was new. The report went on to explain to the family that the Assistant of Director of Nursing (ADON) had just become aware of the situation of this possible (medication) error from the staff on January 6, 2026, around 7:30PM and that the physician was aware. The ADON reported that she watched the video tape and that one nurse entered the resident #101's room at 7:47AM and walked into room with a cup of medications. Reported video scenario by the ADON: upon review of the tape on January 6, 2026, it was noted that Licensed Practical Nurse (LPN) G did have her medication cart by room [ROOM NUMBER] and LPN G did take a cup of medications into Resident #101's room around 7:47AM. A telephone phone interview on 1/15/2026 at 11:40AM with Licensed Practical Nurse (LPN) G revealed that she picked up an extra shift that day 1/6/2026, volunteered for the extra shift. LPN G stated I came in at 7:00AM on 1/6/2026 to work until 4:00 PM and I left at 4:45PM. I had to pick up my daughter after work. I came in at 7AM and I got report from night shift on the wheel unit. I usually work at the Garden unit. I was the 3rd nurse for the shift and had Medication cart #2 rooms 243 through 271. I went to verify the name of the resident on the skilled wheels unit they go to therapy. The rooms were side by side, both named (*****). I made a mistake to pass the wrong medications to the wrong resident; the other resident didn't get the medications. I realized that there was an order in the computer to administer Vancomycin antibiotic via a mid-line to the right upper arm. I noticed that I made a mistake after I left my shift at 4:00PM. I feel terrible, I now do the 5 resident rights with each med pass. I usually have 23-24 residents on the Garden unit to pass meds for in 2 halls on the garden unit, but on the wheels unit I had 16-17 residents. The medication carts at split up: Cart #1 was LPN F rooms 220s hall and rooms 240, 241, 242. Cart #2 was me (LPN G) Rooms 243 to 271, and Cart #3 was another LPN for rooms 260, 261, 262 and 280s hall. I went to room [ROOM NUMBER] and gave the wrong medications to the wrong resident with the same first name. I have worked the Wheels unit before, I pick-up any floor/unit and any shift. The last time I worked the Wheel unit the halls were not split up that way for medication pass. In an interview on 1/15/2026 at 12:20PM, the Unit manager Licensed Practical Nurse (LPN) Wheels unit manager revealed I was notified of a medication error by the nurse LPN F for resident #101. I went into a skilled care conference with family on 1/7/2026, and they were very upset of possible wrong medication the previous day. I was told about it on the 1/6/26 by LPN F that she thought there was something that occurred. I launched a full investigation on 1/7/26 with the Assistant Director Of Nursing (ADON), we moved the like name resident to another room, we changed the name plates to the last name with first initial. Instead of the first name only. Then I spoke with LPN G on the 5 rights of medication administration. There was no harm to him, vitals were stable and the physician was notified. Resident #101 received blood pressure medications and cardiac medications. His vital signs were stable on 1/7/2026, that's when we started the monitoring. Record review of Resident #101's vital sign report for dates 1/6/2026 at 1:37 AM through 1/7/2026 at 8:41 PM revealed: 1/6/2026 at 1:37AM- blood pressure 113/70, pulse 95, respirations 19 per minute. There were no other vital signs on 1/6/2026 until 6:40PM: blood pressure 106/59, pulse 99, respirations 16 per minute. Blood sugar 159. Record review of Healthcare Association of Michigan (HCAM) HB4885/4923 form https://www.hcam.org/wp-content/uploads/2023/11/medication-Aide-Fact-Sheet.pdf identified the 'Five Rights of Medication Pass' checking that it is: (1.) the right resident, (2) the right medication

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that one resident (Resident #103) of 3 residents reviewed for implementation of care plan interventions (one-one-one for Resident #103), resulting in no one-on-one intervention leading to a resident-to-resident interaction with Resident #106 and scratches incurred by Resident #103. Findings Include: Resident #106:Review of the Face Sheet, and care plans dated 2021, revealed Resident #106 was 82 years-old, admitted to the facility on [DATE]/21, was cognitively impaired with a BIMS of 3 (Cognitive assessment score, 4 being impaired), and required staff assistance with all Activities of Daily Living/ADLs. The resident's diagnoses included, Alzheimer's, Dementia, Parkinson's, Schizophrenia, Bipolar stroke and Agitation.Resident #103:Review of the Face Sheet, and care plans dated 10/25, revealed Resident #103 was 79 years-old, admitted to the facility on [DATE]/21, was cognitively impaired with a BIMS of 3 and required staff assistance with all ADLs. The resident had a strong history of behavior when agitated at the facility. The resident's diagnoses included, Alzheimer's, Dementia, Psychotic disturbances, Agitation, and Depression.Review of Resident #103's Cognitive care plan dated 10/21/25, stated Calm resident if signs of distress develop.Review of Resident #103's Behavioral care plan dated 10/21/25, stated I will have 1:1 (one-on-one staff member) supervision for safety. This intervention had not been discontinued; it was still active at the time of the incident on 12/21/25. The resident should of had a staff member with her at all times, not just sitting in the hallway on a personal phone.Review of the facility Incident Report dated 12/21/25, revealed on 12/21/25, Resident #103 went in Resident #106's room, he yelled for her to get out, and she scratched him in the face. Observation of the facility video done on 1/15/26 at approximately 1:00 p.m., of the incident on 12/21/25, revealed both residents' rooms were next to each other, a shadow of Resident #103 was seen at her door going into his room. Nursing Assistant/CNA C was sitting in a chair with the portable computer next to her blocking the view of her from the nursing station. CNA C was observed on her personal cell phone texting someone and scrolling the whole time Resident #103 went in resident #106's room. The CNA was sitting next to both residents' rooms in the hallway. Resident #103 was care planned to be a one-on-one (a staff member with her at all times for safety) at the time. During an interview done on 1/15/26 at CNA C was asked why she was texting and scrolling on her phone in the hallway on 12/21/25, and she stated I don't know, I was texting my husband. I should not have been on my phone.During an interview done on 1/15/26 at 9:50 a.m., with Social Worker E stated, There doesn't seem to be a pattern with (Resident #103), she is not predictable. I do care conferences every 3 months or as needed with MDS; we look at all the care plans. It should of been DC' d (discontinued); we should have followed the care plan (had 1:1 staff with the resident). During an interview done on 1/15/26 at 9:45 a.m., the unit manager, RN stated on 12/21/25, She (Resident #103) went in his (Resident #106) room at 1930 evening, the nurse was doing med pass. (CNA C) got a write up on this, she was scrolling and texting on her phone, we saw the video. It could have been avoided 100%.Review done on 1/15/26, of CNA C's HR file revealed she was given a write-up for the incident on 12/21/25, by management, with her signature. During an interview done on 1/15/26 at 12:30 p.m., the Director of Nursing and Assistant Director of Nursing A both agreed CNA C should not have been on her phone, and the facility should have had a one-on-one with Resident #103 per care plan or discontinue the intervention.Review of the facility Interdisciplinary Care Plan policy dated 11/22, stated The Extended Care Team will formulate a written individualized Plan of Care based on acomprehensive assessment of the resident's needs. The interdisciplinary team will meet at an identified time each quarter to develop and review (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	each resident's Interdisciplinary Plan of Care.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to prevent significant medication errors for two residents (R101 and R102) of 4 residents reviewed for medication errors, resulting in a staff nurse administering five (5) medications to the wrong resident (R101), which could have resulted in a negative outcome for the resident and for the uncertainty of the other resident (R102) receiving the prescribed doses of medication. Findings include:Record review of the facility 'Medication Administration General Guidelines' policy dated 1/2023 revealed pharmacy will provide medication administration instructions as required to assure medications are administered as prescribed, in accordance with good nursing principles and practices and only by legally authorized personnel. To assure the safe administration of medications. Procedure: 1.) Nursing will follow nursing policies to administer medications. (none were received when requested for nursing medication administration) 8.) Residents/patients are identified before medication is administered using a minimum of two identifiers per nursing policy. (no policy was received when requested for nursing medication administration) 16.) Medication supplied for a specific resident/patient is not administered to others. Resident #101:Record review of Resident #101's face sheet form revealed admission to the facility on [DATE] with medical diagnosis of: prosthetic left hip joint fracture, nondisplaced subtrochanteric fracture of left femur, abnormal gait and mobility, chronic kidney disease, benign prostatic hyperplasia, and asthma. Record review of Resident #101's Minimum Data Set (MDS) dated [DATE] assessed for cognitive abilities of Brief Interview of Mental status (BIMs) score of 15 out of 15, cognitively intact. Record review of Resident #101's 'Advance Directives' form signed on 12/24/2025 by the resident revealed the resident chose full code status for resuscitation in a health emergency. Resident #102:Record review of Resident #102's 'Face Sheet form' revealed admission to the facility on [DATE] with medical diagnosis of: Methicillin resistant staphylococcus aureus (MRSA), sepsis, bacteremia, pneumonia, long term use of antibiotics-3 weeks intravenous Vancomycin from 12/22/2025, embolism and thrombosis, cardiomyopathy, left bundle branch block, tachycardia, heart failure, hypertension, hyponatremia, dysphagia, autistic disorder, epilepsy, anemia and anxiety disorder. Record review of Resident #102's 'Advance Directives' form verbally signed on 12/29/2025 by the guardian/representative revealed the resident chose no code status (DNR) for resuscitation in a health emergency. Incident/Event:Record review of Resident #101's 'Healthcare Safety zone' report dated 1/6/2026 revealed that an administration of medication error occurred for the wrong patient. The resident stated he was given medications twice by two different nurses, stating one nurse gave him the wrong medications and asked where his (medication access) port was. Resident stated that he felt lightheaded, high and not right. In an observation and interview on 1/15/26 at 7:50AM, Resident #101 was observed seated up in a wheelchair in his room watching television. Resident #101 revealed that a nurse came into his room, not the regular nurse, and the nurse gave him a hand full of pills, 4-5 pills one was blue. Resident #101 was asked if the nurse asked him his name. No, she did not ask my name, and no there are no bracelets on my arm (no ID bracelet observed by surveyor), then she gave me a chocolate boost and a nasal spray. I told her I don't get a nasal spray, and I don't like chocolate boost. And she was looking for my port/IV and an IV stand/pump. There was a man next door in the next room with the same first name [NAME] also, I believe he had an IV pole in his room. Then she left. Later I was down to therapy, and my regular nurse came to the therapy room with my regular medications. I stayed at therapy for an hour or so, and then I went back to my room. My brother [NAME] was with me. I told him that I felt higher than a [NAME]. He said that I don't look good, you look high. I stated that I had got extra medications that morning. I let the staff nurse know (LPN F) that (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	morning, I don't recall because I was high in la, la, la land. I don't remember what happened because I was out of it. I fell in my kitchen, I cracked my hip, I came for therapy. I heard the nurse deny that she gave me the wrong meds. I felt lightheaded, high as a [NAME], like I had smoked 3-4 Marijuana cigarettes. My brother stayed with me for the day. I am alright now, but it scared the crap out of me. Record review of the facility investigative report dated 1/7/2026 noted that the family was concerned about a medication error on 1/6/2026 the resident stated that he had received medications on 1/6/2026 at 6:00AM from a nurse. Then another nurse came and gave him his morning medications, and he felt it was weird because he thought he just got them. Resident did state that both nurses called him (first name) but that he knew (the regular nurse) but did not know the other nurse, she was new. The report went on to explain to the family that the Assistant Director of Nursing (ADON) had just become aware of the situation of this possible (medication) error from the staff on January 6, 2026, around 7:30PM and that the physician was aware. The ADON reported that she watched the video tape and that one nurse entered the resident #101's room at 7:47AM and walked into room with a cup of medications. Reported video scenario by the ADON: upon review of the tape on January 6, 2026, it was noted that Licensed Practical Nurse (LPN) G did have her medication cart by room [ROOM NUMBER] and LPN G did take a cup of medications into Resident #101's room around 7:47AM. A telephone interview on 1/15/2026 at 11:40AM with Licensed Practical Nurse (LPN) G revealed that she picked up an extra shift that day 1/6/2026, volunteered for the extra shift. LPN G stated I came in at 7:00AM on 1/6/2026 to work until 4:00 PM and I left at 4:45PM. I had to pick up my daughter after work. I came in at 7AM and I got report from night shift on the wheel unit. I usually work at the Garden unit. I was the 3rd nurse for the shift and had Medication cart #2 rooms 243 through 271. I went to verify the name of the resident on the skilled wheels unit they go to therapy. The rooms were side by side, both named (*****). I made a mistake to pass the wrong medications to the wrong resident; the other resident didn't get the medications. I realized that there was an order in the computer to administer Vancomycin antibiotic via a mid-line to the right upper arm. I noticed that I made a mistake after I left my shift at 4:00PM. I feel terrible, I now do the 5 resident rights with each med pass. I usually have 23-24 residents on the Garden unit to pass meds for in 2 halls on the garden unit, but on the wheels unit I had 16-17 residents. The medication carts at split up: Cart #1 was LPN F rooms 220s hall and rooms 240, 241, 242. Cart #2 was me (LPN G) Rooms 243 to 271, and Cart #3 was another LPN for rooms 260, 261, 262 and 280s hall. I went to room [ROOM NUMBER] and gave the wrong medications to the wrong resident with the same first name. I have worked the Wheels unit before, I pick-up any floor/unit and any shift. The last time I worked the Wheel unit the halls were not split up that way for medication pass. An interview on 1/15/2026 at 12:20PM with the Unit manager Licensed Practical Nurse (LPN) Wheels unit manager revealed I was notified of a medication error by the nurse LPN F for resident #101. I went into a skilled care conference with family on 1/7/2026, and they were very upset about possible wrong medication the previous day. I was told about it on the 1/6/26 by LPN F that she thought there was something that occurred. I launched a full investigation on 1/7/26 with the Assistant Director of Nursing (ADON), we moved the like name resident to another room, we changed the name plates to the last name with first initial. Instead of the first name only. Then I spoke with LPN G on the 5 rights of medication administration. There was no harm to him, vitals were stable and the physician was notified. Resident #101 received blood pressure medications and cardiac medications. His vital signs were stable on 1/7/2026, that's when we started the monitoring. Record review of Resident #101's vital sign report for dates 1/6/2026 at 1:37 AM through 1/7/2026 at 8:41 PM revealed: 1/6/2026 at 1:37AM- blood pressure 113/70, pulse 95, respirations 19 per minute. There were no (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	other vital signs on 1/6/2026 until 6:40PM: blood pressure 106/59, pulse 99, respirations 16 per minute. Blood sugar 159. An interview was conducted on 1/15/2026 at 12:31PM with Pharmacist B regarding the January incident with Resident #101 and Resident #102 medication errors. The surveyor requested the medication administration record for Resident #102's medications that were given to Resident #101 in error. The medications administered in error included: Eliquis 5mg tablet/anticoagulant, Entresto 24-26mg tablet/antihypertensive cleared through kidneys, Jardiance 10mg tablet/diabetes/heart failure cleared through kidneys, Lopressor 50mg tablet/antihypertensive beta blocker, Spironolactone 25mg tablet/diuretic antihypertensive cleared through kidneys. Resident #101 received his regular medications of: Aspirin 81mg tablet chewable/prevent blood clumping, finasteride 5mg tablet/benign prostatic hyperplasia (BPH), Hydrochlorothiazide 12.5mg tablet/diuretic, Crestor 5mg tablet/statin. Resident #101 does have chronic kidney disease with Creatin clearance of 46 EGFR 52. The state surveyor asked if this was a significant medication error. Pharmacist B stated that it was subjective, simple mistake. We do our best to avoid errors. Overall, by severity of the reaction/harm to residents. He was not sent out for evaluation, no accumulation of medications in his system. Medications cleared with half-life, take 3 days to become therapeutic levels. Resident rights of medication administration is a nursing issue at point of administration.Record review of facility 'Administrative Manual Occurrence Reporting' policy undated revealed the purpose was to promote resident safety by analyzing and developing processes to reduce or mitigate the risk of errors, and to outline the requirements and procedures for reporting, investigating, and tracking safety concerns and incidents that may result in harm, errors, or dissatisfaction affecting patients, staff, or visitors. Serious adverse events that result in patient harm shall be reported as soon as possible by whomever discovers the incident or adverse outcome. Staff shall report the following incidents: Any harmful, unintended result caused by taking medications- adverse drug reaction Any medication related incidents. Any staff member who is aware of an unusual occurrence or potential safety issue shall be responsible for notifying his/her immediate supervisor of any medication error, fall, loss or theft, patient or visitor complaint, allegations of abuse or neglect, or other significant event, including near misses.