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	07/31/2025

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

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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 - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide quality care and services for 4 residents (Resident's #1, #27, #166 and #181) regarding urinary catheter care, applying [NAME] Hose (Resident #1), assessing and monitoring for motorized wheelchair seat belt (Resident #27), assess and treat for a wound/boil (Resident #166), and assess and treat per orders regarding skin integrity (Resident #181), resulting in increased potential for infection, safety concerns regarding safety belt with a motorized wheelchair, increased urinary tract infections and trauma to urinary catheter, safe use of [NAME] Hose, and increased discomfort/pain with possible hospitalization. Findings Include: Resident #1 Review of the Face Sheet, nurses progress notes dated 7/29/25 through 7/31/25, Physician orders dated 2/25 through 7/25, and physician progress note, dated 2/21, revealed Resident #1 was [AGE] years old, confused and unable to make healthcare decisions, dependent on staff for all Activities of Daily Living/ADL's, and had a suprapubic catheter in place. The resident's diagnosis included, Alzheimer's dementia, Parkinson's disease, difficulty walking, bipolar disorder, paranoid type schizophrenia, Dementia, restlessness and agitation, violent behavior, frequent urinary tract infections, anxiety disorder, retention of urine, and usage of anticoagulants and long-term antibiotic use due to urinary tract infections. The resident had a supra pubic catheter in and used a leg urinary catheter bag which held approximately 250 cc's or urine and was ordered to have Teds hose (compression hose) on when out of bed. Ted Hose: Observations made on 7/29/25 at 10:30 a.m., 12:09 p.m., 3:00 p.m., and 4:00 p.m., revealed Resident #1 did not have the ordered Teds hose on; they were hanging over his walker in his room. During an interview done on 7/29/25 at 12:10 p.m., Family Member “F” said staff do not put the resident's Teds on, “they are always hanging on the walker.” Review of the facility physician order dated 9/26/2022, stated “Ted Hose on 6AM and off at HS (bedtime) 9PM.” Review of the resident's facility care plans, revealed there was no care plan for the use of [NAME] hose. During an interview done on 7/31/25 at 2:00 p.m., Nurse Manager, RN “O“ stated “No there is no care plan for Teds for him, there should be.” (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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility Guide to Nursing Assistants/CNA's sheet, found hanging in the resident's closet in his room, stated “Ted Hose on 6AM and off at HS 9PM.” This is the care guide staff use on a daily basis. Urinary Leg Bag: Observations done on 7/29/25 at 12:09 p.m., revealed the resident sitting in his chair in his room, his leg bag was strapped to his right leg below the knee; the tubing was taunt, and the bag was almost completely filled with urine. Throughout the survey (7/29/25, 7/30/25 and 7/31/25), this surveyor observed the resident's leg bag, and it was full of urine, the bag was bulging full of urine at times. During an interview done on 7/29/25 at 12:10 p.m., Family Member “F” said staff do not regularly empty the resident's leg bag and it's full of urine pulling on the tubing, and she must go to the desk and ask someone to empty it. Review of the facility physician order dated 4/5/2023, stated “Empty Foley bag every shift.” Review of the facility physician order dated 1/31/2025, stated “Supra public care every shift.” Review of the facility Guide to Nursing Assistants/CNA's sheet, found hanging in the resident's closet in his room, stated “Attempt to toilet every 2 hours. Special Instructions: Empty Foley bag.” Review of the resident's facility Urinary Tract Infections care plan dated 7/30/2025 (during survey), stated “Empty my catheter bag every 2 hours and check that the tubing is not pulling on my insertion site.” Review of the resident's facility Urinary Tract Infections care plan dated 9/26/2022, stated “Supra pubic catheter care every shift and prn (as needed, includes emptying the urinary leg bag).” During an interview done on 7/31/25 at 2:10 p.m., Nurse Manager “O” said the staff had not followed the resident's care plan regarding the urinary leg bag and he did not have a care plan regarding [NAME] Hose. Manager “O” said staff should follow all resident's care plan's, and if it is not any longer relevant, they should inform the Charge Nurse or Manager. Resident #27 On 7/29/2025 at 12:21 PM, Resident #27 was observed in his motorized wheelchair watching television. A seatbelt was observed affixed to his wheelchair and the resident explained it's for trunk support. The resident was able to unfasten his seatbelt without any assistance. Review was conducted of Resident #27's medical record and it indicated he admitted to the facility on [DATE] with diagnoses that included, Cerebral Palsy, Atrial Fibrillation, Peripheral Vascular Disease, Polyneuropathy and muscle wasting. Resident #27 is his own responsible party and able to make his needs known to facility staff. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was no documentation located in Resident #27's chart regarding initial evaluation, ongoing safety monitoring or reasoning for usage of the seatbelt. On 7/29/2025 at 3:30 PM, Nurse Manager “T” was queried regarding assessment, monitoring and reasoning for Resident #27's seatbelt. He reported the residents motorized wheelchair came from his home, and he does not believe there is an evaluation or corresponding care plan but will follow up. On 7/30/2025 at 4:05 PM, Nurse Manager “T” shared they completed a self-release evaluation, and the resident will be reevaluated every Thursday going forward. A care plan was also added to reflect his seatbelt usage. The Nurse Manager stated the evaluation and care plan were completed yesterday after initial inquiry. Resident #181: On 7/29/2025 at 9:55 AM, Resident #181 was observed resting in bed, there were four pink dressings observed on his arms. One dated 7/25/2025 and the other three were not dated or initialed. There was visible brown colored drainage underneath the dressings, and one was not adhering to his skin. On 7/29/2025 at approximately 3:20 PM, Nurse Manager “T” was queried regarding the bilateral dressing. He reported most likely the dressings are from the hospital, but he would follow up. On 7/29/2025 at 4:05 PM, Nurse Manager “T” reported their wound nurse completed a head-to-toe skin assessment on Resident #181 and found two of the areas were an old puncture wound and scabbed over skin tare. The other two areas required new treatment orders. Manager “Y” was asked how this was missed for four days, and he stated he was not sure. On 7/29/25, a review was conducted of Resident #181 medical record, and it indicated he admitted to the facility on [DATE] with diagnoses that included: Cachexia, Adult Failure to Thrive, Kidney Disease, Hypertension, and Chronic Obstructive Pulmonary Disease. Further review yielded the following: Progress Notes: 7/25/2025 at 18:40: “…Skin color is normal. Two skin tears on both arms…”. 7/29/2025 at 16:24: “…Head to toe skin assessment completed on 7/29/25… admitted with healing skin tears to bilateral upper extremities. Right upper arm has a 1x6cm scabbed over skin tear, no drainage and no odor. Surrounding skin is pink, thin, and warm to touch. Left wrist has 3x0.3cm scabbed over healing skin tear, no drainage, no odor. Surrounding skin is pink and warm to touch. Right wrist has a 1x1.8cm skin tear that is scabbed over with no drainage, and no odor. Surrounding skin is pink and warm to touch. Resident tolerated treatments well. No s/s of pain or discomfort. New orders to cleanse with NS, pat dry, apply border foam dressing QOD and PRN until healed. Resident has no redness to bony prominence areas and no visible rashes to body…” Physician Orders: Cleanse skin tear to left wrist with NS (normal saline), pat dry, apply boarder foam dressing QOD and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PRN. Initiated 7/29/2025 Cleanse skin tare to right wrist with NS, pat dry, apply boarder foam dressing QOD and PRN. Initiated 7/29/2025. It can be noted the wound care comprehensive skin assessment and subsequent treatment orders were completed after the facility was queried regarding his bilateral, undated dressings. On 7/29/2025, at 11:00 AM, Resident #166 was resting in their bed and complained they had a boil burst under their right arm. Resident #166 was able to lift their arm to reveal two open areas measuring approximately 1 centimeter round each. There was no dressing. Resident #166 complained the nurses don't always change the dressing and the night nurse did not do the treatment last night. Resident #166 offered some of the good nurses keep it up but the nurse the night before said it needed air and refused to put the dressing on it. Resident #166 said they needed antibiotics about a month ago for it and the last time they did get a dressing change was a couple days ago because the good nurse was working. Resident #166 offered that when the dressing doesn't get changed it makes them feel as if they don't matter. Resident #166 was asked when the doctor looked at it last and Resident #166 offered; it's been a while. On 7/30/25, at 9:05 AM, a record review of Resident #166's electronic medical record revealed an admission on [DATE] with diagnoses that included Stroke, Cutaneous abscess of right axilla and obesity. Resident #166 required assistance with all Activities of Daily Living (ADL) and had intact cognition. A review of the “Treatments Administration Record: 06/30/2025 – 07/30/2025” revealed a treatment order “Cleanse wound to right axilla with NS, pat dry, skin prep, apply thera honey to wound bed, cover with gauze and border dressing daily and PRN Once A Day Start/End Date 07/10/2025 – Open Ended … “ For the date, Mon 28 the initials “MR5” was documented with parenthesis which revealed not completed. The “Reasons/Comments” column revealed “Not Administered: Other Comment: .” There was no documented reasoning why the treatment was not completed on the Treatment record. A review of the progress notes revealed no explanation documentation why the treatment was not provided. A further review of the progress notes revealed: “05/30/2025 13:51 Notified Dr. (physician) of residents right axilla boil draining yellow, and odor, denies pain, continue to monitor and apply small dressing if continues to drain … “ “07/29/2025 20:36 Noted lack of improvement and more c/o discomfort to indurated lesion in R axilla. Area assessed by floor nurse and tx nurse and new treatment devised and ordered to site. PCP notified and new orders received for culture and gram stain then begin doxycycline 100 mg Q-12H x 7 days for ABT tx of boil. All orders explained to resident and she voiced understanding. Sample obtained and packaged to be sent to lab. Resident voiced discomfort and pain during procurement of lab sample but said she was “just fine” after dressing replaced”. There was no other documentation found in the electronic medical record of the boil assessment since the last progress note on 5/30/2025 that explained yellow drainage, odor and to continue to monitor. There (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was no physician visits noted in the electronic medical record for Resident #166's ongoing boil wound. On 7/30/2025, at 3:00 PM, the facility was asked to provide all physician visits and documentation for Resident #166's boil from 5/1/2025 through 7/30/2025, day of survey. On 7/31/2025, at 9:52 AM, the facility was again asked to provide all documents regarding Resident #166's boil including all physician assessments/visits. On 7/31/2025, at 12:18 PM, Infection Control (IC) Nurse “ E” was asked why Resident #166 was on doxycycline (antibiotic) and IC Nurse “E“ offered, that the preliminary culture of the boil came back positive for gram + cocci and that the final culture was not completed yet. On 7/31/2025, at 1:14 PM, A record review along with UM “T“ of Resident #166's record revealed no physician progress notes of the boil assessment since the resident had documented yellow drainage and odor to their boil on 5/30/2025 and only one new nurse progress note on “7/29/2025”. There was no nurse progress note for the correlating new treatment order dated “7/10/2025”. On 7/31/2025, at 2:14 PM, UM “T“ provided there were no additional physician or nurse progress notes for Resident #166's right axilla boil and offered they would educate the nurses on charting better. UM “T“ further offered, that the physician was notified on 7/10/2025 although there was no documentation proving such.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement control measures for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all of the residents in the facility. Findings include:Facility [NAME], [NAME] (52634) - Infection Control On 07/29/2025 at 2:00 PM An interview was conducted with the Facility Supervisor K on the Water Management Plan (WMP). When questioned about chlorine residual testing, the Facility Supervisor answered, Saginaw township has tested the chlorine a couple times at least since I've been here and they test monthly or every two weeks. On 07/30/2025 at 10:00 AM An interview was conducted with the Facility Supervisor K on current chlorine residual results. He answered that the results in the water management plan binder were the most recent. On 07/30/2025 at 10:10 AM Record review of the document Drinking Water Quality Report for the Saginaw Region located in the water management binder states, Below are the water quality test results from the Saginaw Water Treatment System during 2022, unless otherwise noted. The chlorine residual results are an average from each quarter of the year. Chlorine result average 1.06ppm. Range is 0.94 - 1.17 ppm. On 07/30/2025 at 11:42 AM Record review of the WMP states in response to legionella distal site positivity <30%, engineering controls (i.e. flushing, circulation, temperature increases, fixture sanitization), proactive clinical surveillance, additional environmental sampling. On 07/30/2025 at 11:45 AM Record review of the Legionella testing tracking sheet states in response to positive legionella sample from RM [ROOM NUMBER] shower on 7/14/25 was room taken offline, fixture changed out, increased flushing in and around area. In addition, in response to the positive legionella sample in RM [ROOM NUMBER] shower on 7/14/25 was Room taken offline, fixture changed out, increased flushing in and around area. On 07/30/2025 at 1:14 PM Interview was conducted with Facility Quality Assurance G on tracking chlorine residual onsite. She responded that they don't feel like they need to since the Township comes in and does it. In addition, she stated that they are in the process of removing additional water lines and remediation is still in progress. On 07/30/2025 at 1:47 PM Record review of the Legionella Environmental Assessment Form, states Saginaw Township samples for chlorine residual at the kitchen only. In addition, the Assessment states, list the range of disinfectant levels and the response from the facility was Saginaw County Health Department has these records. According to the Centers for Disease Control and Prevention, Controlling Legionella in Potable Water Systems dated January 3rd, 2025, Ensure disinfectant residual is detectable throughout the potable water system. In addition, Monitor temperature, disinfectant residuals, and pH frequently based on performance of water management program or Legionella performance indicators for control. Adjust measurement frequency according to the stability of performance indicator values.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to prevent the development of pressure ulcers for two residents (R15, R86) of 5 residents reviewed for pressure ulcers, resulting in Resident #15 and Resident #86 developing pressure ulcer/injuries while residing in the facility. Record review of the National Institue of Health (NIH) 2022 Pressure Ulcer staging:Stage 2: There is partial-thickness skin loss involving the epidermis and dermis. Stage 3: A full thickness loss of skin extends to the subcutaneous tissue but does not cross the fascia beneath it. Slough or eschar may be visible, and the lesion may be foul-smelling. Stage 4: Full-thickness skin loss extends through the fascia with considerable tissue loss. There may be muscle, bone, tendon, or joint involvement. Record review of the facility-generated CMS-802 Resident Matrix form on 7/29/2025 identified Resident #15 and #86 as 'High risk Pressure Ulcer Stage 2-4'. The facility did not identify 'New or Worsened Pressure Ulcer Stage 2-4' for either Resident #15 or #86. Resident #15: Record review of Resident #15's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 0 out of 15, severe cognitive impairment. Medical diagnosis included Neurogenic blader, aphasia, quadriplegia and seizure disorder. Review of Section M-skin assessment noted:Stage II pressure ulcers of 1. Number of stage II pressure ulcers that were present upon admission/entry or re-entry (0) zero.Stage III pressure ulcers of 1. Number of stage III pressure ulcers that were present upon admission/entry or re-entry (0) zero.Stage IV pressure ulcers of 3. Number of stage IV pressure ulcers that were present upon admission/entry or re-entry (3) three. Record review of Resident #15's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 0 out of 15, severe cognitive impairment. Medical diagnosis included Neurogenic blader, aphasia, quadriplegia and seizure disorder. Review of Section M-skin assessment noted:Stage II pressure ulcers of 1. Number of stage II pressure ulcers that were present upon admission/entry or re-entry (0) zero.Stage III pressure ulcers of 1. Number of stage III pressure ulcers that were present upon admission/entry or re-entry (0) zero.Stage IV pressure ulcers of 3. Number of stage IV pressure ulcers that were present upon admission/entry or re-entry (2) two. Record review of Resident #15's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 0 out of 15, severe cognitive impairment. Medical diagnosis included Neurogenic blader, aphasia, quadriplegia and seizure disorder. Review of Section M-skin assessment noted:Stage II pressure ulcers of 1. Number of stage II pressure ulcers that were present upon admission/entry or re-entry (0) zero.Stage III pressure ulcers of 1. Number of stage III pressure ulcers that were present upon admission/entry or re-entry (0) zero.Stage IV pressure ulcers of 3. Number of stage IV pressure ulcers that were present upon admission/entry or re-entry (2) two. An observation was made on 07/31/2025 at 7:37 AM with Licensed Practical Nurse (LPN) Wound Care Certified (WCC) L of Resident #15. LPN L stated that Resident #15 does have a Stage IV pressure ulcer to the coccyx which has been chronic long term. LPM L stated that Resident #15 does have new facility-acquired wounds on his abdomen, right lateral foot, and right lateral calf. The right lateral foot wound Stage IV is facility acquired. Observation of the right lateral foot revealed black/dark tissue to the back/side of foot area with eschar tissue noted. Observation of the left lateral/back of mid-calf revealed an open pressure ulcer with drainage noted. The pressure area was cleansed, and zero form dressing was applied and covered with 4x4 gauze boarder dressing. Observation of Resident #15's abdomen was made, and the mid-line dressing was removed to observe an open wound (Stage III) with serosanguinous drainage. The mid-line wound was cleansed, and calcium AG dressing was applied due to the drainage and covered with a gauze 4x4 boarder dressing. Observation Resident #15's peg tube area revealed peg tube drainage of green/yellow bile substance noted to split gauze drainage dressing to the peg site, also noted on the abdomen binder. A second right-side of abdomen wound was observed with small open area was cleansed and calcium AG dressing was applied and covered with 4x4 gauze boarder dressing. In an interview on 07/31/2025 at (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10:37 AM with Licensed Practical Nurse (LPN) Wound Care Certified (WCC) L of Resident #15's pressure ulcer observations with the state surveyor revealed that abdomen on the top revealed 2 open wounds that line up with abdomen binder. Binder use began in the beginning of July. Abdomen of wounds started in July. I just seen the wound yesterday. The wounds are facility acquired this month (July). LPN L stated that she took the physician into the resident #15's room to observe the wound and the physician believes the wounds started as abrasions from the abdomen binder. The wounds staged at III to mid-line abdomen are Facility acquired. Wounds progress from a stage I Un-blanchable, to a stage II top layer dermis is removed, and stage III is into the subcutaneous tissue with drainage. LPN L stated that she talked to the nurses and that they stated that they did not know when the mid-line abdominal wound started. LPN L could not locate any documentation for when the mid-line abdomen wound started, or when the dressings changes started to the wound. LPN L stated that she just observed the mid-line abdomen wound for the first time on 7/30/2025 and was not aware of the wound. LPN L stated that there should be nursing assessments to look under Resident #15's abdominal binder for integrity. Resident #86:Record review of Resident #86's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 3 out of 15, severely impaired never/rarely makes decisions. Medical diagnosis included diabetes and Alzheimer. Review of Section M-skin assessment noted:Stage II pressure ulcers of 0. Number of stage II pressure ulcers that were present upon admission/entry or re-entry (0) zero.Stage III pressure ulcers of 0. Number of stage III pressure ulcers that were present upon admission/entry or re-entry (0) zero. Record review of Resident #86's Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 3 out of 15, severely impaired never/rarely makes decisions. Medical diagnosis included diabetes and Alzheimer. Review of Section M-skin assessment noted:Stage II pressure ulcers of 0. Number of stage II pressure ulcers that were present upon admission/entry or re-entry (0) zero.Stage III pressure ulcers of 1. Number of stage III pressure ulcers that were present upon admission/entry or re-entry (0) zero. Observation and interview on 7/31/2025 at 8:15AM with Licensed Practical Nurse (LPN) Wound Care Certified (WCC) L of Resident #86 revealed the resident to be lying in bed on his back upon entry to the room. LPN L stated that Resident #86's right calf pressure ulcer was facility acquired, and she thought the wound came from his bilateral soft protective boots. Observation of the boots on the resident revealed that the boots could be a cause of pressure point. Observation of the bed adjustment done using the controls revealed that the foot of the bed tipped downward and the bend in the bed was at the point of the right calf pressure point to the leg. LPN L stated that someone may have left the resident in that position for too long causing the pressure ulcer to develop. Observation of the right calf wound bed revealed a stage III with visible tendon and red ring around the exterior of the wound on the skin. Wound Treatment was Thera honey, covered by a 4x4 gauze boarder dressing. In an interview on 07/31/2025 at 10:33 AM Licensed Practical Nurse (LPN) Wound Care Certified (WCC) L revealed that she did take the trainee into Resident #86's room last week on Wednesday and they looked at the wound, and the soft boots sit right at the wound area putting pressure on the wound. Licensed Practical Nurse (LPN) Wound Care Certified (WCC) L stated that she Talk to the housekeeping manager about the bed bowing at the foot of the bed and that there is a bar underneath the bed that will raze the foot of the bed to stop that downward movement of the foot of the bed. We did observe the bow downward position that rest right on wound. The housekeeper changed bed bars, and we will reassess the bed and the placement. Record review of the facility-provided form of 'In-house Pressure Ulcers' on 7/31/2025, showed that the facility had 7 in house acquired pressure/injuries. The Form revealed that Resident #15 was noted to have facility acquired have wounds Left foot stage 3 4/2/2025, Right bottom foot 7/4/2025, and two abdomen wounds un-staged on 7/30/2025. There was no documentation of the left mid-calf pressure ulcer to the lateral aspect of the calf.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assess, monitor and document continued seepage and nonadherence for one resident's (Resident #7) ileostomy appliance (Ileostomy is a surgical procedure in which an opening is made in the abdominal wall for stool to leave the body through a stoma. An appliance is worn over the stoma to collect stool) of two residents reviewed for ostomy care. Findings Include: On 7/29/2025 at 4:12 PM, Resident #7 was observed watching television in his room. He had a pleasant demeanor and shared some concerns with this writer. He stated his ileostomy is not adhering and is leaking. The residents' ileostomy site was observed to have leakage that was pooling on his abdomen. When asked when it was last changed, he reported this morning. Resident #7 was uncertain how long it had been leaking but stated it was sore.On 7/29/2025 at approximately 4:35 PM, Nurse DD stated she was informed in report there was an issue with Resident #7's ileostomy bag sealing and weeping. Nurse Manager T was alerted to the concern by Nurse DD and stated he was not aware of the sealing issues with Resident #7 ileostomy. The Manager stated he would speak to their wound care nurse about the next step and a different technique to maintain the seal. On 7/29/2025 at approximately 4:30 PM, a review was conducted of Resident #7's medical record and it indicated he was admitted to the facility on [DATE] with diagnoses that included Rectum cancer, Kidney failure, Diverticulitis, Malignant Ascites, Ileus and Depression.Further review yielded the following: I have an ileostomy r/t (related to) metastatic colon cancer.Progress Notes:There was no documentation located from nurses, management or the facility wound care nurse regarding any issues with his ileostomy.Physician Notes:There was no physician documentation located regarding concerns related to the issues with the resident's ileostomy appliance not sealing and the leakage.TAR (Treatment Administration Record):July 2025 Ileostomy dressing change every 3 days, cleanse around site thoroughly, pat dry, change wafer. Once a day every 3 days. Order initiated on 7/3/2025. The order set was marked off as completed as scheduled. There was no order for as needed dressing change and unable to ascertain the onset of his ileostomy issues. On 7/30/2025 at 4:05 PM, Nurse Manager T shared their treatment nurse was already aware of the concerns with Resident #7s ileostomy. She was using a crusting method, cream and powder for about 1 week when she completed the treatments. Manager T was queried as to where the notes related to this would be located. Record review was completed of progress notes, observations sections and wound management and there was no documentation located. He stated the treatment nurse informed him this was an ongoing issue that she was aware of.On 7/31/2025 at 8:45 AM, Resident #7 shared the wound nurse utilized cream and powder the last two times she changed his ileotomy. When his assigned nurse completed the dressing change, they did not use powder or cream. His ileostomy was observed, and it was leaking onto his skin and the appliance was not sealed.On 07/31/2025 at 10:51 AM, an interview was conducted with Wound Nurse L regarding Resident #7. Nurse L reported the resident alerted her on Monday his ileostomy was not adhering correctly. When she completed her assessment and treatment of the area, she utilized the crusting technique. On Tuesday, she followed up with the resident and again the ileostomy was not adhering and his skin in the area was reddened and slightly sore. This morning it was off again but the skin in the area was improving. Nurse L was asked if Resident #7's physician was aware of the continued issues surrounding his ileostomy and the nurse stated the physician was most likely not aware. Nurse L was further asked where the documentation from Monday (7/28/2025) until Thursday (7/31/2025) was regarding their assessment and treatments completed. She explained she was not certain what treatment they were going to put in place for the resident and the documentation was not entered today. It can be noted there was no communication between the treatment nurse and nurse manager surrounding these concerns. Additionally, there was no documentation from management or floor (continued on next page)

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Healthsource Saginaw, Inc	3340 Hospital Rd Saginaw, MI 48603

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staffReview was conducted of the policy entitled, Extended Care Weekly Bath and Skin Condition Report, revised February 2008. The policy stated, .any reddened or suspicions areas noted will be documented on this report and appropriate interventions started.in between weekly checks, the resident develops a skin condition such as a rash, skin tear, stasis ulcer, etc: notify the physician, obtain orders if appropriate; document the area involved on the existing sheet, dating the notation; document a brief description in the nursing progress notes.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, failed to 1) Ensure hydration fluids were within reach for Resident #13 and 2) Ensure nutrition status monitoring for 2 residents (#7, #10) of 10 residents reviewed for nutrition, resulting in potential for dehydration and thirst for Resident #13, and weight loss not being identified with the potential for further weight loss and decline in overall health and wellbeing. Resident #10: Record review of Resident #10's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental status (BIMs) score of 15 out of 15, cognitively intact. Medical diagnosis included hypertension, urinary tract infection, diabetes, hemiplegia, depression, bipolar and chronic obstructive pulmonary disease. Review of Section K: Swallowing/Nutrition status- noted weight of 183 pounds. Record review of Resident #10's quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental status (BIMs) score of 15 out of 15, cognitively intact. Medical diagnosis included hypertension, urinary tract infection, diabetes, hemiplegia, depression, bipolar and chronic obstructive pulmonary disease. Review of Section K: Swallowing/Nutrition status- noted weight of 158 pounds. that is a 25-pound weight loss in 90 days. Observation during the survey of Resident #10, revealed that the resident took all of her meals in her room in bed. Record review on 07/29/2025 of Resident #10's [NAME] log in the electronic medical record revealed weights: 176 lbs. 4/2/2025 176.0 pounds minus On 05/06/2025, the resident weighed 157.8 lbs. Thats an 18.2-pound loss in 30 days which is a -10.34% Loss. On 6/4/25 151.4 pounds = 3-month loss of 13.98%. In an interview and record review on 07/31/2025 at 10:20 AM with Registered Dietitian Z of Resident #10's medical record stated that we did a significant change of condition on 4/28/25 and then on 5/12/25 nutritional assessment change of care plan evaluation up dated preferences appetite, snacks, weight loss supplements, and she is on hospice. We could offer more portions and options. On 7/30/2025, at 9:44 AM, Resident #13 was resting in their bed awake with music playing. Their bedside table was pushed against the far wall out of reach. There was a full Styrofoam glass of water and a small container of juice on the bedside table. On 7/30/2025, at 12:05 PM, Resident #13 remained in their bed awake. Their bedside table remained across the room out of reach. The glass of water and juice remained full with no sips taken. On 7/30/2025, at 12:47 PM, an observation and interview with Nurse “W” was conducted in Resident #13's room. Resident #13 was sitting in their bed with their bedside table in front of them. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #13 was actively eating and drinking by themselves. Nurse “W“ was asked if Resident #13 is able to feed themselves and Nurse “W” offered that Resident #13 is able to feed herself food and fluids. On 7/30/2025, at 2:30 PM, a record review of Resident #13's electronic medical record revealed an admission on [DATE] with diagnoses that included Stroke (CVA) with hemiplegia, Dysphagia and Dementia. Resident #13 required assistance with all Activities of Daily Living (ADL) and had impaired cognition. A review of the care plan revealed “Problem … ADL's Functional Status/Rehabilitation Potential (the resident) is limited in ability to perform ADL's/hygiene/transfers related to: CVA with left side hemiplegia; debility; Alzheimer's … Approach Start Date: 02/13/2023 (the resident) eats meals in her room or café, Requires set up and supervision assistance for meals … “ On 7/31/2025, at 8:31 AM, Resident #13 was sitting up in bed. Their bedside table was pushed in front of them. Resident #13 was actively holding and drinking their nutritional drink. Resident #7 On 7/29/2025 at 4:12 PM, Resident #7 was observed watching television in his room. He had a pleasant demeanor and shared some concerns with this writer. He stated the food is “not good,” and on the weekends the portions served are smaller. He added since his admission he has lost a lot of weight and it's because he does not like the food. Resident #7 stated the dietitian came in last week and breakfast has been better. On 7/29/2025 at approximately 4:30 PM, a review was conducted of Resident #7's medical record and it indicated he was admitted to the facility on [DATE] with diagnoses that included Rectum cancer, Kidney failure, Diverticulitis, Malignant Ascites and Depression. Further review yielded the following: Weighs: 07/01/2025” Weight: 131.5 lbs (pounds) / Admission 07/07/2025: Weight: 125.8 lbs 07/16/2025 11:18: Weight: 110.6 lbs 07/22/2025 10:55: Weight: 103.0 lbs Resident #7 loss 28.5 pounds since admission into the facility. Nutrition Progress Note: 07/22/2025 at 15:20: “Reweight requested. RD visited & updated meal tracker with pt preferences to aid in intakes & wt gain…”. There was no documentation located regarding discussions on how to slow the expected weight loss from week to week with a resident centered approach. Week 1: -5.7 lbs (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Week 2: -15.2 lbs Week 3: -7.6 Care Plan: “I am at nutrition risk dt (due to) acute renal failure, poor appetite, pro-cal malnutrition, weight loss over past 3 years and cancer…Boose breeze BID (twice a date) to aid in weight gain. Monitor weights weekly…Provide diet as ordered, monitor intakes daily/weekly…” There was no facility documentation related to Resident #7's weekly weight loss until three weeks after admission when he was already down to 103 pounds from 131 pounds. Furthermore, there was no evaluation to determine the reasoning why Resident #7 has not eaten or looking at resident specific interventions and others food items that may peak his interest. On 7/30/2025 at 12:52 PM, Registered Dietitian “Y” was queried regarding the interventions put in place to maintain Resident #7's weight given his continuous weekly weight loss without evaluation. Dietitian “Y” expressed Resident #7 was high risk due to his current medical conditions and they monitor him weekly in their nutrition at risk meetings. He currently receives Boost Breeze which provides an additional 450 calories per day. A review was completed of Resident #7's care plan and it was pointed out it had not been updated since his admission to the facility. Dietitian “Y” stated those are the typical interventions they would utilize and added they began monitoring his food acceptance on 7/22/2025. Dietitian “Y” was asked if it weight loss was anticipated why there were no substantial interventions placed prior to his weight loss. He stated they wanted to ensure his weight was accurate which is why he had requested a reweight the week before (7/16/2025) prior to adding any additional interventions. On 7/31/2025 at 8:45 AM, Resident #7 reported after his preferences were reviewed with Dietitian “Y” last week, and since then breakfast has been more enjoyable. He added prior to 7/22/2025, he was never asked what his likes/dislikes were. He expressed he was being served grits or oatmeal with his breakfast daily, and he does not eat either. Resident #7 stated he lost weight as the food was “no good,” he stated many of the food items were too spicy or too sweet for his liking. The Boost Breeze was offered but it was difficult to become accustomed to it, as it was too sweet for him. He explained when he intentionally loss weight within the three years prior to becoming ill (went from 225 pounds to 177 pounds) he cut sugar from his diet, so it was difficult to reintroduce a supplement that was extremely sweet. On 7/31/2025 at approximately 11:45 AM, a discussion was held with the DON (Director of Nursing), ADON (Assistant Director of Nursing) and Nurse Manager “T,” regarding the lack of timely and meaningful nutritional intervention for Resident #7. It was discussed that although his weight loss was anticipated, that does not negate the fact that meaningful nutritional interventions to maintain current nutritional status/slow the anticipated weight loss and timely assessment of said weekly weight declines were still needed. They expressed understanding of the concern. Review of facility policy entitled, “Up to Scale Weight Monitoring,” policy is undated. The policy stated, “…Interventions will be identified, implemented, monitored and modified consistent with the residents assessed needed, choices, preferences goals.”.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide enteral tube feeding per nursing standards for one resident (Resident #107) of one resident reviewed for tube feeding, resulting in the infusion of expired solution and improper positioning of the head of the bed with the likelihood of gastrointestinal upset, infection and/or aspiration. Findings include: On [DATE], at 11:09 AM, Resident #107 was resting in their bed. There was a tube feeding pump with a tube feeding solution bag hanging that was dated 7/28 0500 am and was hooked to the resident's abdomen. On [DATE], at 11:12 AM, an observation along with Nurse X of Resident #107's tube feeding solution was conducted. Nurse X was asked what date was on the solution bag and Nurse X stated, the 28th at 5:00 am and actually it should say the 29th. Nurse X was asked to obtain the head of bed angle measurement. On [DATE], at 11:22 AM, Physical Therapist (PT) U entered Resident #107's room. PT U measured the angle of the head of the bed which revealed 22 degrees. On [DATE], at 11:26 AM, Unit Manager (UM) T entered Resident #107's room. UM T was asked what they saw on the tube feeding solution bag and UM T stated, it says 7/28 hung at 0500 am, at 45 an hour. UM T was asked how the staff knows if the head of the bed is safe for the resident while the tube feeding was infusing and UM T offered, she had the ability to use her bed control. UM T was asked where the bed control was located and UM T was unable to locate the bed control. CNA V entered the room and assisted UM T to locate the bed control. CNA V offered, she should have one and maybe it's balled up under her. Both CNA V and UM T could not find it and offered that the resident did not have a bed control. On [DATE], at 9:20 AM, Resident #107 was resting in their bed. The tube feeding solution was infusing into their abdomen. Resident #107 had a bed control within reach on top of their bed covers. The head of the bed appeared to be angled at 45 degrees. According to the manufacturer Nestle, Nutren 2.0 should be refrigerated and consumed within 24 hours after opening. If not used within this timeframe, it should be discarded. According to the facility provided policy NURSING MANUAL ENTERAL TUBE FEEDING, . PROCEDURE: . Elevate the head of bed 30-45 degrees during the feeding .

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to timely remove a peripheral IV (intravenous) for one resident (#169) of one reviewed for IV access. Findings Include:On 07/29/2025 at approximately 1:13 PM, Resident #169 was observed watching television in his room. The resident was asked what the peripheral IV (intravenous) in his right forearm was being utilized for. The resident stated, They don't use it for anything, it has not been used in over a week. The IV dressing was not dated nor initialed.On 7/29/2025 at approximately 3:10 PM, Nurse Manager T observed Resident #169's peripheral IV and was asked what it was being utilized for. He stated he believed it was for IV hydration. Resident 169's wife was in the room and explained he received IV hydration last week and was supposed to have follow up lab work, but was not certain if that had occurred. Manager T was asked if the dressing should be dated and initialed and he responded, yes. On 7/29/2025 at approximately 4:00 PM, a review was conducted of Resident #169's medical records and it indicated he admitted to the facility on [DATE] with diagnoses that included, Sepsis, Acute Kidney Failure, Dementia, Venous Insufficiency, Hyperlipidemia, Hypertension and Anxiety. Further review of his chart yielded the following: Progress Notes: 7/24/2025 at 12:33: Residents labs back (physician) notified and discontinued Bumex, wants one liter of normal saline infused at 80cc (cubic centimeter)/hr (hour). 7/24/2025 at 22:07: Residents wife at bedside when 22g PIV inserted and discussed with wife residents labs and discontinuing Bumex.Physician Notes:7/24/2025 at 15:09: The patient was evaluated for possible dehydration. Recent labs shos increased BUN (Blood Urea Nitrogen) and creatinine. Patient's wife reports the patient has poor oral intake.Mild dehydration, bumex discontinued, 0.9 saline 80cc/hour 1 liter, repeat BMP (Basic Metabolic Panel) 7/28/2025.MAR (Medication Administration Record):July 2025:Sodium chloride 0.9% parenteral solution: 1 liter to infuse at 80cc/hour, one time order. Order initiated and hydration on 7/24/2025. On 7/31/2025 at 2:45 PM, Nurse Manager T was asked whose responsibility it was to find out when Resident #169's IV should have been removed. The manager stated it would have bene the nurse's responsibility to obtain that information from the physician. Resident #169 IV was placed for an additional five days without assessment, monitoring nor timeframe on how long the IV was suppose to remain.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain best practices in the kitchen resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings Include:Facility [NAME], [NAME] (52634) - Kitchen On 7/29/2025 at 9:25AM A kitchen tour was conducted with the Regional Director of Operations I and the General Manager J. On 07/29/2025 at 9:42 AM Record review of the high temp dishwasher log temps had ranges at the rinse temp from 154-193 degrees Fahrenheit. The guidelines for temperature ranges at the top of the document state Rinse 180 degrees Fahrenheit. On 7/29/2025 at 9:45 Observed dishwasher temps at: final temp 184, wash 164, rinse 161, and dual rinse 173 degrees Fahrenheit. On 07/29/2025 at 9:55 AM Observed mixer visibly soiled with residue. In response to the soiled mixer, the Regional Director of Operations I commented Well this looks like it needs to be cleaned. It should be cleaned every day. On 07/29/2025 at 10:05 AM Observed the fridge in Gardens hallway behind the nurses' desk at 46 degrees Fahrenheit, according to the thermometer located in the fridge. The smart thermostat read 37 degrees Fahrenheit. On 7/29/2025 at 10:05AM Interview with the General Manager J on which temperature is recorded on the log. She answered, the smart thermostat. When asked if the thermometer inside the fridge was ever checked, she said No. On 07/29/2025 at 10:50 AM Observed the General Manager J and Executive Chef H searching for dish temp plate. On 07/29/2025 at 11:13AM Observed dishwasher temp with dish plate at 154 degrees Fahrenheit. On 7/29/2025 at 11:15AM Observed dishwasher temp with dish plate at 157.8 degrees Fahrenheit. On 07/29/2025 at 11:18AM Observed dishes being used on tray line. 07/29/2025 at 12:01 PM Interview conducted with the General Manager J if dish surface temps are ever taken, her answer was no. 07/29/2025 at 12:52 PM General Manager J presented a black test strip on dish demonstrating dish surface reached 160 degrees Fahrenheit. 07/30/2025 at 08:15 AM Dishwasher temp at dish surface level was 161 degrees Record review of the dishwasher temp log used by the facility states at the top of the document To verify the surface temperature is meeting the required temperature of 180 degree Fahrenheit use: Surface temperature adhesive Thermo-labels: adhesive label turns appropriate color to indicate that temperature has been reached .Use a digital, waterproof, thermometer using the temp hold feature. According to the 2022 Food Code U.S Food and Drug Administration Section 4-501.112 Mechanical Warewashing Equipment, Hot Sanitization Temperatures, The temperature of hot water delivered from a warewasher sanitizing rinse manifold must be maintained according to the equipment manufacturer's specifications and temperature limits specified in this section to ensure surfaces of multiuse utensils such as kitchenware and tableware accumulate enough heat to destroy pathogens that may remain on such surfaces after cleaning.The surface temperature must reach at least 71 C (160 F) as measured by an irreversible registering temperature measuring device to affect sanitization. According to the 2022 Food Code U.S Food and Drug Administration Section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding, (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained:^^(1) At 57 C (135 F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54oC (130oF) or above; P or^^(2) At 5 C (41 F) or less. According to the 2022 Food Code U.S Food and Drug Administration Section 4-602.11 Equipment Food-Contact Surfaces and Utensils, Microorganisms may be transmitted from a food to other foods by utensils, cutting boards, thermometers, or other food-contact surfaces. Food-contact surfaces and equipment used for time/temperature control for safety foods should be cleaned as needed throughout the day but must be cleaned no less than every 4 hours to prevent the growth of microorganisms on those surfaces.