STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235442	A. Building B. Wing	02/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Great Lakes Rehab Center	4180 Tittabawassee Road Saginaw, MI 48604

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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

Provide appropriate treatment and care according to orders, resident's preferences and goals.

22927

This Citation pertains to Intake Number MI00150127.

Based on observation, interview and record review, the facility failed give prompt treatment for several fractures related to a roll/fall out of bed for one resident (Resident #301).

Findings include:

Record review of the facility Abuse Prevention Program policy, dated 1/2025, defined 'Neglect' as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

Resident #301:

Record review of Resident #301's hospital Emergency Department note, dated 2/3/2025 at 9:17 PM, noted acute left 5th through 10th rib fractures and medial left clavicle fractures. The emergency department noted that the resident was symptomatic with multiple rib fractures and left clavicle fracture and has not achieved medical stability for safe discharge from hospital . the current condition would worsen and an adverse event like worsening pain, pneumonia may occur .

Record review of Resident #301's progress notes, dated 1/31/2025, documented pain medication administered. The next progress note was dated through 2/2/2025 at 5:02 AM related to insulin administration. Record review of 2/3/2025 Progress note written by Registered Nurse B was strike out of documentation. A late entry progress note dated 2/3/2025 noted that the resident complained of back pain. Resident told CNA she was dropped, and writer went to speak with her and assess her .

Record review of Resident #301's Minimum Data Set (MDS) assessment, dated 1/2/2025, revealed an elderly female with Brief Interview of Mental Status (BIMS) score of 12 out of 15. Medical Diagnosis included: Medically complex conditions, anemia, hypertension, renal insufficiency, diabetes, hyponatremia, other fracture, cerebrovascular accident (CVA), hemiplegia/hemiparesis, malnutrition, depression and osteomyelitis of left foot. Section GG: functional abilities: Dependent- helper does all of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity for toileting hygiene, shower/bathe, upper body dressing, lower body dressing, rolling left and right, sit to lying, lying to sitting, and chair/bed-to-chair transfer.

(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: 235442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/18/2025
NAME OF PROVIDER OR SUPPLIER Great Lakes Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4180 Tittabawassee Road Saginaw, MI 48604	

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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	Record review of Resident #301's care plans, page 1- 27, revealed Activity of Daily Living (ADL) care plan related to self-care performance deficit secondary to cardiovascular accident (CVA) related to left hemiparesis, left hand contractures, left lower extremity contracture, left side neglect, osteomyelitis of left foot, surgical amputation of left great toe. The care plan noted limited mobility, limited range of motion (ROM), decreased mobility . Interventions: Bed Mobility dated 11/10/2023: The resident requires extensive 2 staff to turn and reposition in bed. Dressing dated 11/10/2023: The resident requires extensive 2 staff to dress. Toilet Use dated 11/10/2023: The resident requires extensive 2 staff for bed pan/brief change. Record review of the facility 'Activity of Daily Living (ADL), Supporting' policy dated 1/2025 revealed residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. (2.) Appropriate care and services will be provided for residents who are unable to carry out ADL's independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: hygiene, mobility, elimination . Definitions: Total Dependence- Full staff performance of an activity with no participation by resident for any aspect of the ADL activity Observation and interview was conducted on 2/14/2025 at 11:30 AM with Resident #301 and family member at bedside. Resident #301 stated again that she was dropped and flat on her back. Observation with assist of family member of Resident #301 dressed in a hospital gown revealed left upper should/chest front view of a large bruising area of a green/yellow color, estimated to be the size of a basketball that went down the left side under the arm pit area. Observation of the left hip area visible through a brief the surveyor noted a dark purple in color bruising estimated 3 inches wide by 6 inches in length. Resident #301 stated that she does get back pain and shoulder pain with hiccups and coughing or being moved. Sleeping at night hurts also. The state surveyor observed black bilateral soft boots on while in bed, observed a right upper arm PICC (Peripheral Inserted Central Catheter) line with dressing dated 2/1/2025. A dressing was noted to the left lower arm estimated 2 inch wide by 3 inch in length with date of 2/13/2025. The family member stated that the resident spent 7 days in the hospital related to her fracture injuries and infection in her foot. (continued on next page)

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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	An interview on 2/14/2025 at 1:07 PM with Registered Nurse (RN) B revealed that he was working when Certified Nurse Assistant (CNA) I called the nurse into Resident #301's room to see a skin tear on the left lower arm by the hand and then she mentioned that when she was getting Resident #301 ready for bed and giving a sponge bath that she said for me to look at the bruising from her left upper shoulder area that was blur in color. RN B stated 'It (the bruising) went from left upper chest to right upper chest. Around that time CNA I mentioned that the resident said that she was dropped from the bed. She fell or was dropped; it was around that time. She (Resident) stated to her grandson that she was dropped or fell . I was in the room doing assessment on Resident #301 and CNA I asked her about the bruising, and I heard Resident #301 say that she was dropped from the bed. Resident #301 said it, I heard her say it. Resident #301 was having a lot of back pain. The left upper arm had small bruising on her elbow and dark red color to arm. Resident #301 said severe back pain, left arm hurt and she hadn't ever complained of back pain before. I sent her to hospital around 8 PM that night (2/3/2025). CNA I had a couple of days off before this and saw the skin tear and asked if it was new. The skin tear was scabbed over with no dressing on it. I didn't know about the skin tear it was not given in report shift to shift, and not documented anywhere. The severe back pain, new bruising, scabbed skin tear, she was on Eliquis blood thinner, and I sent her to the hospital ER per protocol the black & blue was new with a blood thinner and an unwitnessed fall/drop?' Record review of facility 'Charting and Documentation' policy dated July 2017 revealed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medial, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. (2.) The following information is to be documented in the resident medical record: (a.) objective observations. (d.) Changes in the resident's condition. (e.) Events, incidents or accidents involving the resident . (8.) ADL (Activity of Daily Living) documentation shall be completed on each shift by Certified Nursing Assistants and will be monitored by nursing. An interview and record review on 2/14/2025 at 2:18 PM with the Director of Nursing (DON) about Resident #301's injuries revealed that she started staff education yesterday on 2/13/2025 for a change in elevation related to the incident. The DON stated, 'Residents Usually are lowered to the floor/ground. It was brought up last week about the change in elevation education. That's the only education that we have related to the incident. I put it out yesterday for the staff to sign the education. The Certified Nurse assistant (CNA) H reported to nurse Licensed Practical Nurse (LPN) E and the LPN went in and looked at the Resident #301 and then went to a second nurse, License Practical Nurse (LPN) G. LPN G went into the Resident #301's room and asked the resident about a fall. The CNA H explained that it was a roll out of bed. LPN G asked Resident #301 if she wanted to go to the hospital and she said no. CNA H stated that he was changing the resident while rolling her over from the bed he turned to get the wipes and she rolled from the bed, but that he caught her and she did not hit the floor. It happened on Sunday 2/2/2025 at around 8:56 PM. Then on 2/3/2025 at 8:01 PM Registered Nurse (RN) B received a report form CNA I that there was bruising to the left side of the resident's chest bruising and left hip bruising, left lower arm skin tear without a dressing. Record review of Resident #301's medical record with the DON of the resident assessments (skin, pain, and post injury of unknown origin) and progress notes from 2/1/2025 through 2/14/2025 revealed there was no assessment or progress notes written on 2/2/2025 the evening of the incident and not until on 2/3/2025 when the resident was sent to hospital. (continued on next page)

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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	The state surveyor reached out to Licensed Practical Nurses (LPN) E and G who were on duty at the time that Resident #301's injury of unknown origin occurred, but they did not respond to the phone calls or voice messages left to return the phone call. Record review of facility investigation witness statements revealed: Certified Nurse Assistant (CNA) H written statement dated 2/5/2025 revealed the CNA went into Resident #301's room to change her. The CNA proceeded to change Resident #301 rolling her towards his body to change her and turned to get the brief and wipes that he placed in the window sill and, as he was turning to grab the items out of the windowsill, he saw the resident falling. CNA H noted he quickly grabbed resident with a swift force, but she unfortunately hit her shoulder and head on a chair. CNA H noted he placed the Resident #301 back into bed and went and got the nurse. They checked her (Resident #301) out, took her vitals and was seeing if she was OK. We checked on her through the night. She was sleeping and toward the ending of my shift me and the nurse went to go change her again. Record review of Resident #301's Medication Administration Record for the month of February 2025 revealed the medication Eliquis (anticoagulant/blood thinner) 2.5 mg give 1 tablet by mouth two times day for prophylaxis started on 3/20/2024 . Record review of 'Nursing 2017 Drug Handbook' Wolters Kluwer 2017, page 148- 149, revealed black box warning: Monitor patient for neurologic impairment (midline back pain, sensory or motor deficit, such as numbness or weakness in lower limbs, bowel or bladder dysfunction. Treat impairment urgently Record review of Resident #301's progress notes, dated 1/31/2025, documented pain medication administered. The next progress note was dated through 2/2/2025 at 5:02 AM related to insulin administration. Record review of 2/3/2025 Progress note written by Registered Nurse B was struck out of documentation. A late entry progress note dated 2/3/2025 noted that the resident complained of back pain. Resident told CNA she was dropped and writer went to speak with her and assess her . Record review of facility investigation witness statements revealed: Certified Nurse Assistant (CNA) H written statement dated 2/5/2025 revealed the CNA went into Resident #301's room to change her and put her into bed. The CNA put the resident into bed with a lift machine and placed her into bed. The CNA proceeded to change resident #301 rolling her towards his body to change her and turned to get the brief and wipes he placed in the windowsill and as he was turning to grab the items out of the windowsill he saw the resident falling. CNA H noted he quickly grabbed resident with a swift force, but she unfortunately hit her shoulder and head on a chair. CNA H noted he placed the Resident #301 back into bed and went and got the nurse. they checked her (Resident #301) out, took her vitals and was seeing if she was OK. We checked on her through the night. She was sleeping and toward the ending of my shift me and the nurse went to go change her again. Record review of Resident #301's Medication Administration Record for the month of February 2025 revealed the medication Eliquis (anticoagulant/blood thinner) 2.5 mg give 1 tablet by mouth two times day for prophylaxis started on 3/20/2024 . (continued on next page)

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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	Record review of 'Nursing 2017 Drug Handbook' Wolters Kluwer 2017, page 148- 149, revealed black box warning: Monitor patient for neurologic impairment (midline back pain, sensory or motor deficit, such as numbness or weakness in lower limbs, bowel or bladder dysfunction. Treat impairment urgently

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 22927 This Citation pertains to Intake Numbers MI00150106 and MI00150127. Based on observation, interview and record review, the facility failed to prevent a fall with injury for one resident (Resident #301), of three residents reviewed, by not following the care plan which required 2 staff for all Activities of Daily Living (ADL) care. Only one staff member was attending to Resident #301 when she partially rolled out of bed and sustained a fracture of the left clavicle, several fractured ribs, extensive bruising, and back and rib pain, all of which resulted in an extended hospitalization . Findings include: Resident #301: Record review of Resident #301's hospital Emergency Department note, dated 2/3/2025 at 9:17 PM, noted acute left 5th through 10th rib fractures and medial left clavicle fractures. The Emergency Department noted that the resident was symptomatic with multiple rib fractures and a left clavicle fracture and had not achieved medical stability for a safe discharge from hospital . the current condition would worsen and an adverse event like worsening pain, pneumonia may occur . Observations and an interview were conducted on 2/14/2025 at 8:50 AM. Resident #301 in her room was lying in bed with a oxygen nasal cannula at 3 liters. Resident #301 was awake and able to answer questions. She stated that they dropped her from her bed. Resident stated that it was 2 days ago and later they took her to the hospital. The state surveyor observed a silver chrome bedside chair with black plastic arm rests in the corner of the room next to the head of the bed on the right side of bed, Also a right side bed fall mat and an air mattress were noted. A call light was within reach and the resident denied pain at that time. Record review of Resident #301's Minimum Data Set (MDS) assessment, dated 1/2/2025, revealed an elderly female with Brief Interview of Mental Status (BIMS) score of 12 out of 15. Medical diagnoses included: Medically complex conditions, anemia, hypertension, renal insufficiency, diabetes, hyponatremia, other fracture, cerebrovascular accident (CVA), hemiplegia/hemiparesis, malnutrition, depression and osteomyelitis of the left foot. Section GG: functional abilities: Dependent- helper does all of the effort. Resident does none of the effort to complete the activity. The assistance of 2 or more helpers is required for the resident to complete the activity for toileting hygiene, shower/bathe, upper body dressing, lower body dressing, rolling left and right, sit-to-laying, laying-to-sitting, and chair/bed-to-chair transfer. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident #301's care plans, page 1- 27, revealed Activity of Daily Living (ADL) care plan related to self-care performance deficit secondary to cardiovascular accident (CVA) related to left hemiparesis, left hand contractures, left lower extremity contracture, left side neglect, osteomyelitis of left foot, surgical amputation of left great toe. The care plan noted limited mobility, limited range of motion (ROM), decreased mobility . Interventions: Bed Mobility, dated 11/10/2023: The resident requires extensive 2 staff to turn and reposition in bed. Dressing dated 11/10/2023: The resident requires extensive 2 staff to dress. Toilet Use dated 11/10/2023: The resident requires extensive 2 staff for bed pan/brief change. Record review of the facility 'Comprehensive Care Plan' policy. dated 2/2024. revealed a comprehensive, person- centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. (4.) Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: (g.) Receive the services and/or items included in the plan of care . An observation and interview was conducted on 2/14/2025 at 11:30 AM with Resident #301 and a family member at her bedside. Resident #301 stated again that she was dropped and flat on her back. Observation was made with the assistance of the family member of Resident #301. Resident #301 was dressed in a hospital gown. The observation revealed left upper shoulder/chest front view of a large bruising area of a green/yellow color, estimated to be the size of a basketball that went down the left side under the arm pit area. In an observation of the left hip area, visible through a brief, the surveyor noted a dark purple in color bruising estimated 3 inches wide by 6 inches in length. Resident #301 stated that she does get back pain and shoulder pain with hiccups and coughing on being moved. Sleeping at night hurts also. The state surveyor observed black bilateral soft boots on while in bed. Also observed a right upper arm PICC (Peripheral Inserted Central Catheter) line with dressing, dated 2/1/2025. A dressing was noted to the left lower arm, estimated 2 inch wide by 3 inch in length with a date of 2/13/2025. The family member stated that the resident spent 7 days in the hospital related to her fracture injuries and infection in her foot. Record review of the facility 'Falls-Clinical Protocol' policy, dated 1/2025, revealed: 'Following a Fall Event/Suspected Fall Event', an incident report and fall investigation will be completed after a fall or suspected fall . Post-fall interventions will be initiated by the nurse on duty, after the fall risk assessment has been completed to reduce the likelihood for reoccurrence of falls. The Director of Nursing/Fall Prevention Designee will review the fall event the next business day to initiate an analysis of contributive factors and determine if additional interventions should be implemented ' (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	An interview on 2/14/2025 at 1:07 PM with Registered Nurse (RN) B revealed that he was working when Certified Nurse Assistant (CNA) I called the nurse into Resident #301's room to see a skin tear on the left lower arm by the hand. Then she mentioned that when she was getting Resident #301 ready for bed and giving a sponge bath she noticed bruising. She said for me to look at the bruising from her left upper shoulder area that was blur in color. RN B stated 'It (the bruising) went from the left upper chest to the right upper chest. Around that time CNA I mentioned that the resident said that she was dropped from the bed. She fell or was dropped. She (Resident #301) stated to her grandson that she was dropped or fell . I was in the room doing an assessment on Resident #301 and CNA I asked her about the bruising. I heard Resident #301 say that she was dropped from the bed. Resident #301 said it. I heard her say it. Resident #301 was having a lot of back pain. The left upper arm had small bruising on her elbow and a dark red color to arm. Resident #301 said she had severe back pain, left arm hurt and she hadn't ever complained of back pain before. I sent her to hospital around 8 PM that night (2/3/2025). CNA I had a couple of days off before this and saw the skin tear and asked if it was new. The skin tear was scabbed over with no dressing on it. I didn't know about the skin tear. It was not given in shift-to-shift report and not documented anywhere. Because of the severe back pain, new bruising, scabbed skin tear and she was on Eliquis blood thinner, I sent her to the hospital ER per protocol The black & blue bruising was new. She was on a blood thinner and had an unwitnessed fall/drop?' Interview and record review was conducted on 2/142025 at 2:18 PM with the Director of Nursing (DON) about Resident #301's injuries. The interview revealed that she started staff education yesterday on 2/13/2025 for a change in elevation related to the incident. The DON stated, 'Residents usually are lowered to the floor/ground. It was brought up last week about the change in elevation education. That is the only education that we have related to the incident. I put it out yesterday for the staff to sign the education. Certified Nurse Assistant (CNA) H reported to Licensed Practical Nurse (LPN) E and the LPN went in and looked at the Resident #301. LPN E then went to a second nurse, License Practical Nurse (LPN) G. LPN G went into the Resident #301's room and she asked the resident about a fall. CNA H explained that it was a roll out of bed. LPN G asked Resident #301 if she wanted to go to the hospital and she said no. CNA H stated that he was changing the resident while rolling her over on the bed. He turned to get the wipes and she rolled from the bed, but that he caught her. Resident #301 did not hit the floor. It happened on Sunday 2/2/2025 at around 8:56 PM. Then on 2/3/2025 at 8:01 PM, Registered Nurse (RN) B received a report form CNA I that there was bruising to the left side of the resident's chest. Also there was left hip bruising and a left lower arm skin tear without a dressing. Record review of Resident #301's medical record assessments and progress notes revealed there was no assessment or progress notes written on 2/2/2025, the evening of the incident. There was nothing written until 2/3/2025 when Resident #301 was sent to hospital. Record review of staff education forms revealed education for change in elevation. In an interview on 2/14/2025 at 4:46 PM, Certified Nurse Assistant (CNA) H, stated that he was changing Resident #301 and that she could only roll to one side. CNA H stated 'I rolled her up on the right side. I had to reach for the brief and wipes on the windowsill. I turned, saw her rolling and I had to catch her. No one was in there but me. I was in the room by myself. I caught her. No, she did not hit the floor. It was a hard catch. I notified the nurse (Licensed Practical Nurse E). They checked her out, got blood pressure and she was fine'. Record review of Resident #301's Kardex (resident care guide) on 2/14/2025 revealed that when toileting, the resident requires extensive 2 staff for a bed pan/brief change. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/17/2025 at 4:07 PM, Certified Nurse Assistant (CNA) C stated, 'I helped to transfer the resident (Resident #301) with a Hoyer lift machine to the bed. The process takes 2 people. I left the room after a successful transfer to the bed. No, I wasn't in the room when the incident happened. I heard about it later in the shift. She wasn't my resident to care for that night. No, he did not ask for help or for me to stay'.