STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235250	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adira Nursing and Rehab	3200 State St Saginaw, MI 48602

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 37666

This Citation Pertains to Intake# MI00150592.

Based on observation, interview and record review, the facility failed to ensure 1). Call light notifications were readily available to staff and 2). Call lights were responded to in a timely manner to meet residents' needs including Resident (#6), from a facility census of 82 residents.

Findings Include:

On 3/6/2025 at 11:45 AM, Nurse G was asked how the staff knew if there was a call light on and said there was a screen at the nurse's desk that showed which lights were on. The 200 unit had 2 halls, with one shorter and one much longer. The call light screen was not visible from either hall. Nurse G said the staff would need to walk to the nurse's desk to see if a call light was on. The nurse said there were no lights or sounds in the halls to indicate if a resident had their call light on.

On 3/6/2025 at 12:15 PM, during an observation on the locked dementia unit, 2 staff were observed assisting residents to eat in the dining room. A call light screen was around the corner from the dining room and not visible to the staff as they assisted the residents with the meal. The staff were asked who the nurse was on the dementia unit and they said it was Nurse F and she was at lunch. The 2 staff in the dining room were the only staff on the unit.

On 3/6/2025 at 4:15 PM, Nurse F was interviewed about the call light system in the dementia unit; she was sitting at a table on the other side of the dining room. She was facing towards the other hall where the call light screen was located, but the words on the screen were not readable from that far away. Nurse F said to read the screen, you had to walk over to it. She was asked if she would know if a resident's call light was on in a room near where she was sitting and she said not unless you walked over to the screen on the other hall and looked. The nurse showed a walkie talkie in her pocket, and she said if she saw a light was on, she could contact another staff member to answer it.

On 3/6/2025 at 5:00 PM, the Administrator and Director of Nursing/DON were interviewed related to the call light system and the one screen on each unit that listed the call lights that were on. They said there were no lights in the halls or call light alarms to notify staff when the resident turned the call light on. They said this was something they were looking at.

(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: 235250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Adira Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 State St Saginaw, MI 48602	

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy titled, Call light, Use of, reviewed 3/25 revealed the following, Procedure Purpose: To respond promptly to resident's call for assistance Facility personnel must be aware of call lights. Answer call lights in a prompt, calm, courteous manner . 22927 An interview on 3/6/2025 at 11:25AM with Resident #6 revealed he did not fall here, but was trying to walk, because no one comes to help him here. Resident #6 stated They say i fell here in my room, but he was trying to crawl to the bathroom, because no one comes to answer the call light. Yes, they came to help him up after he was on the floor for a while. Resident #6 was asked if there was enough Staffing? Resident #6 stated that was a good question; it takes them more than a while to come help him, resident stated he was talking 20-30 minutes or more. Resident #6 stated that when he needs to ask for something they leave the room and sometimes don't come back or come back in a half hour or more. Record review of Resident #6's Accident/Incident reports were reviewed: -On 2/3/2025 at 3:30PM resident #6 was observed on the floor on the right side of bed. Resident was noted stating he was looking for his urinal. -On 2/13/2025 at 7:20PM resident was observed laying on the floor in his room. Resident was noted stating he was trying to go to the bathroom. - On 2/18/2025 at 00:005AM resident was observed laying on the floor next to bed. Resident was noted stating he was trying to crawl to the bathroom. - On 3/3/2025 at 1:00AM resident was observed laying on the floor next to his bed. Resident was noted stating he was trying to go to the bathroom. In an observation on 3/6/2025 at 11:47AM the State Surveyor pressed the call light for Resident in room [ROOM NUMBER]-1, a small red dot light behind the bed came on, the surveyor walked out into the hallway. There was no over the room light noted and walked to the nursing station to observe a flat screen that showed that room [ROOM NUMBER] call light was on. In an interview on 3/6/2025 at 11:55AM with Registered Nurse/Unit Manager (RN) A was walking through the Coast Unit when the state surveyor stopped to ask about the resident call light system. RN A stated that there were no call light above resident rooms and that those were removed in the last remodel. RN A stated that the staff use walkie/talkies, and each Certified Nurse Assistant (CNA) is assigned a walkie talkie and are to bring with them to work. RN A also stated that CNAs/nurses can come to the nursing station on the unit and look at the flat screen. Observation and interview on 3/6/2025 at 11:58 of Certified Nurse Assistant (CNA) B who was walking down the Coast Hall when the state surveyor stopped the CNA and asked if she had a walkie talkie and why was it silent when a call light was on? The CNA B took the walkie talkie from her pocket and was noted to be turning the walkie talkie on or sound up. Once CNA B had turned up the volume on the walkie talkie static could be heard. The CNA B stated that she just looks at the screen at the nursing station. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 3/6/2025 at 12:02PM on the Harbor dementia unit clean utility room revealed 137 white/blue or brown wash clothes, towels, sheets, blankets and other items. The state surveyor stopped on the unit to listen to the sounds of the unit and there was no walkie talkies heard. In an observation and interview on 3/6/2025 at 1:15 PM in room [ROOM NUMBER]-1 with Resident #6, the call light was pushed, a small red light came on at the wall behind the bed. Resident #6 just wanted his right leg foot repositioned. Resident #6 stated that he hates living at the facility. He stated that first of all, no one comes when he presses the call light. Resident #6 stated that he has waited up to 20-30 minutes to get help, even when he pushes the red button repeatedly. Resident #6 stated that they are all rude and don't listen to him and They don't care about the people that need the care. The state surveyor walked to the room doorway and listened for walkie talkies to be going off related to the call light being activated, nothing was heard. At 1:23PM Staff member Licensed Practical Nurse (LPN) D walked to room [ROOM NUMBER] across the hall from the resident's room. There was no noise if the LPN had a walkie talkie and then she walked back up the hall. At 1:25PM maintenance Director C went into the room [ROOM NUMBER] across the hall. Resident #6 started to yell out to get help. Maintenance Director C did hear the resident and came into the room to ask what the resident needed. Then told the resident he would have to wait for a CNA to lift his leg up into the bed. At 1:27PM Licensed Practical Nurse (LPN) D walked past the room. At 1:28 PM Certified Nurse Assistant E came into the room to ask the resident what he needed. CNA E did not have a walkie talkie and stated that she left it at the nursing station.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37666 This Citation Pertains to Intake# MI00150592 This Citation has 2 DPS's Based on observation, interview and record review the facility failed to ensure appropriate interventions were in place to manage skin breakdown for Resident #2 and pressure ulcer treatment to aid in healing for one resident (Resident #3), of 4 residents reviewed for skin breakdown and pressure ulcers, resulting in Resident #2 developing a large, red, excoriated area on his bilateral buttocks and Resident #3 developing an unstageable pressure ulcer on the left lateral malleolus (ankle). Findings Include: Skin conditions Resident #2 A record review of the face sheet and Minimum Data Set/MDS assessment, revealed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: COPD, respiratory failure, stomach bleeding, history of a stroke, right sided weakness, urinary tract infection, hypertension, arthritis, history of falls and intervertebral disc degeneration. The MDS assessment dated [DATE] revealed the resident had full cognitive abilities with a Brief Interview for Mental Status/BIMS score of 15/15 and the resident needed some assistance with all care including bed mobility. Section H of the MDS assessment indicated the resident was always incontinent of bowel and bladder. Section M of the MDS assessment said the resident did not have a pressure ulcer or other type of skin condition. On 3/6/2025 at 11:40 AM, Resident #2 was observed during lying in bed watching TV. Wound Nurse J and Nurse G assessed the resident for skin breakdown. Wound Nurse J said Resident #2 was not on his list to be seen. He said the facility provided him names of residents to see once a week. He assessed their wounds, evaluated the treatments for healing and applied new dressings; he said he usually saw residents with pressure ulcers. During the skin observation of Resident #2 with Nurses J and G, it was identified that the resident had a large, excoriated area on both left and right buttocks (approximately 10 cm x 10 cm). The area was very dark red, thick, raised and peeling, with many small open areas. Wound Nurse J said it wasn't a pressure ulcer, probably caused from wetness and he would identify a treatment for it. The Wound Nurse was asked if the wound just happened that day and he stated, No. A record review of the physician orders for Resident #2 on 3/6/2025 revealed there was no wound treatment ordered for the red, open area on his buttocks. There was an order dated 2/20/2025 for Weekly Skin Assessment . A record review of Resident #2's Medication Administration Record/Treatment Administration Record (MAR/TAR) for March 2025, revealed there was no treatment to his buttocks documented. There was one entry for the Weekly Skin assessment dated [DATE] and it said the resident had 0 skin breakdown. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A record review of the February 2025 TAR's for Resident #2 identified 3 skin observations February 5th, February 12th, and February 19th, 2025. Each entry had a 1 documented for Previously identified wound/breakdown. In addition, there was a Skin observation on 2/26/2025 that listed 0 for No skin breakdown. A review of the Wound Evaluation dated 3/6/2025 for Resident #2, by Nurse J identified the resident's buttock wound as In-house acquired MASD (Moisture Associated Dermatitis)-IAD Incontinence Associated Dermatitis of the sacrum. A review of the Care Plans for Resident #2 identified the following: (Resident #2) has high risk to impaired skin integrity related to excoriation to buttocks due to B&B (bowel and bladder) incontinence and history of Stage 4 pressure ulcer to the right trochanter . dated initiated 6/14/2022 and revised 1/21/2025 with Interventions including: Follow facility protocol for treatment of injury; Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to MD. Dated 6/14/2022 and revised 12/15/2024. Another Care Plan titled, (Resident #2) is at risk for further pressure ulcer development and impaired skin integrity related to history of pressure ulcers and MASD, hemiplegia, hemiparesis affecting the right side . date initiated 6/29/2022 and revised 1/21/2024 with Interventions including: Daily wound assessments, dated initiated 10/29/2023d and revised 8/16/2024; and Treatments as ordered, date initiated 7/27/2022 and revised 5/2/2023. An additional Care Plan titled, I have impaired skin integrity related to excoriation to buttocks, date initiated and revised 1/14/2025 with Interventions including: Daily skin assessments, date initiated 7/16/2024 and revised 7/16/2024. The resident had no documented daily wound assessments and there was no treatment ordered for his skin breakdown. Resident #3 A record review of the Face sheet and MDS assessment indicated Resident #3 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses: Dementia, muscle wasting and atrophy, obsessive compulsive disorder, bipolar disorder, generalized anxiety, depression, and arthritis. The MDS assessment dated [DATE] indicated the resident had a memory problem and needed assistance with care. Section M of the MDS assessment revealed the resident had an unhealed, unstageable pressure ulcer and was at risk for pressure ulcers. The resident's prior MDS assessment dated [DATE] indicated the resident did not have any pressure ulcers, but was at risk for pressure ulcers. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/2025 at 12:35 PM, Resident #3's wound care was observed with Wound Nurse J and Hospice Nurse I. The resident was observed to have an undated/timed or initialed dressing on her left lateral ankle area. The wound nurse was asked if it was the appropriate dressing, and he said it was not; there was no calcium alginate on the wound bed- only a foam dressing. He said it was supposed to have calcium alginate in the wound bed and a foam dressing over top. When asked about it, he said he was told that someone had placed the dressing earlier that day, but it was unclear when. During the wound observation for Resident #3, on 3/6/2025 at 12:35 PM, Wound Nurse J said the wound bed had yellow slough (stringy dead tissue) and was unstageable. The wound was approximately 2 cm x 2 cm in size and had a large amount of serosanguinous (bloody) drainage under the foot on a pad. It had leaked through the dressing. Hospice Nurse I said the wound was not improving. The nurses said the wound was facility acquired. A record review of the physician orders revealed the following: Left malleolus unstageable pressure ulcer (Wound #1) Cleanse with (normal saline) and pat dry. Skin prep peri wound, place calcium alginate AG into wound bed. (Cut to fit). Cover with foam dressing. Change every day and PRN (as needed), revision date 2/27/2025 and start date 2/27/2025. A review of Resident #3's MAR/TAR for March 2025 revealed the following: Left malleolus unstageable pressure ulcer (Wound #1): Cleanse with ns (normal saline) and pat dry. Skin prep peri wound, place calcium alginate AG into wound bed. (Cut to fit). Cover with foam dressing Change every day and PRN, every day for wound care, Start date 02/28/2025. Each entry was marked Days. The 3/6/2025 wound treatment was initialed by Nurse F as being completed. On 3/6/2025 at 4:20 PM, during an interview with Nurse F she was asked if she had completed the wound dressing for Resident #3 that day. She stated, No, I didn't. Nurse F was asked if she signed the TAR that she did do the dressing and she stated, Yes, I signed it for the Wound Nurse at 11:55 AM. When asked if that was what she was supposed to do, she said she didn't know. Reviewed the Wound Nurse had changed the dressing at 12:35 PM; this was after Nurse F had documented she completed the dressing change. Further review of Resident #3's TAR for March 2025, identified an as needed entry for wound care to the resident's left malleolus. No one had documented additional dressing changes. A review of the facility policy titled Skin Management Guidelines: Prevention of Pressure Ulcers/Injuries, origination date 7/2017 and revised 11/2024 provided, The purpose of this procedure is 1) to identify residents at risk for developing alterations in skin including pressure ulcer/injury risk factors, and 2) to identify specific interventions to assist with prevention and management of skin alterations . Skin is assessed on admission to the facility and at least weekly to identify alterations in skin, and any wound assessments should be documented in the medical record . Review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable . DPS #2 (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	Based on observation, interview and record review, the facility failed to ensure a change of condition was assessed and monitored for one Resident #7, of one resident reviewed for a change of condition, resulting in Resident #7 developing a large, red, inflamed testicle that was causing discomfort. Findings Include: Resident #7 A record review of the Face sheet and MDS assessment indicated Resident #7 was admitted to the facility on [DATE] with diagnoses: Dementia, diabetes, liver cirrhosis, hypertension, heart disease, gout and hepatic [NAME]-occlusive disease. The MDS assessment dated [DATE] revealed the resident had poor memory with a BIMS of 0/15 and needed some assist with all care. A record review of the progress notes identified the following: 1/15/2025 at 1:45 PM, a nursing note Resident scrotum is observed to be red, warm/hard to the touch. No drainage is observed. Physician is notified with orders received for Keflex 500 mg every 8 hours x 7 days and Diflucan 100 mg daily for 7 days . 1/22/2025 at 5:39 PM, a nurses note Resident continues on antibiotics tolerated well. No adverse reactions noted. Will continue to monitor. A review of a physician note dated 2/5/2025 does not mention if the resident's testicular infection resolved. There was no additional documentation if the testicular redness and infection was resolved. On 3/6/2025 at 4:29 PM, Nurse F was interviewed about Resident #7 and asked if his testicular infection with redness had resolved. Nurse F reviewed the resident's orders and said his antibiotic had been completed and she assumed the infection was resolved. The nurse was asked if anyone had assessed the resident to determine if it was effective. Nurse F reviewed the resident's charting and said there was no note to indicate the resident's infection had healed. She said another nurse had asked about it and said she would assess the resident. On 3/6/2025 at 4:35 PM, a skin assessment was observed for Resident #7 with Nurse F and his Nurse Aide. The resident's left testicle was observed to be enlarged, bright red and swollen. The resident was asked about the testicle, and he stated, If I could show my family I would. He said it bothered him. Nurse F said she would contact the physician. A review of the physician orders did not identify any treatment or order for monitoring of Resident #7's testicle. A review of the Care Plans for Resident #7 identified the following: I have impaired skin integrity related to red, swollen and painful scrotum, dated and initiated and revised 1/16/2025 with Interventions including: Treatments as ordered; Float my heels while in bed; Weekly skin assessments . There were no treatments or monitoring after the antibiotic was completed. The weekly skin assessments did not mention the residents red, enlarged, painful scrotum. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/2025 at 4:15 PM, reviewed with Director of Nursing and Administrator wound care observations for Residents #2 and #3 and the lack of monitoring and treatment for Resident #7's reddened, enlarged, painful testicle and Resident #2's assessment, monitoring of the resident's buttock and sacral wounds and Resident #3's treatment and documentation issues. The Administrator said the Wound Nurse was new and the facility would look into the issues. A review of the facility policy titled, Change in a Resident's Condition or Status, date revised May 2017 and reviewed 12/24 provided, Our facility shall promptly notify the resident, his or her attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and or status .The nurse will notify the resident's Attending Physician or physician on call when there has been a (an): . significant change in a resident's physical/emotional/mental condition . The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status .

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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 - Minimal harm or potential for 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: MI00150592 . Based on interview and record review, the facility failed to prevent repeat falls for one resident (Resident #1) of 3 sampled residents, resulting in Resident #1 sustaining unwitnessed repeated falls with inconsistent neurological monitoring. Findings include: Record review of the facility 'Falls Program' policy review date 12/2024 revealed the purpose was to provide a safe environment for residents, modify risk factors and reduce risk of all-related injuries. Procedure: Implement and indicate individualized interventions on care plan/Kardex to minimize fall risk. If fall occurs: Charge nurse to complete the following: (f.) Neurological Assessment- completed when unwitnessed or if resident hits head, (h.) Document the complete incident in (electronic medical record). Resident #1: Record review of Resident #1's Minimum Data Set (MDS) 1/21/2025 revealed an elderly female with Brief Interview of Mental status (BIMs) score of 3 out of 15, severe cognitive impairment. Medical diagnoses included: Debility, anemia, hypertension, arthritis, dementia, malnutrition, and anxiety. Record review and interview of Resident #1's falls with the Director of Nursing (DON) from the beginning of the year 1/1/2025 revealed: -On 1/25/2025 at 5:35AM Resident #1 was observed on floor in resident's room (unwitnessed fall). Complaints of pain to forehead and a quarter size bump to forehead with bruising observed. Record review with the DON of Resident #1's progress notes dated from 1/24/2025 through 1/27/2025 revealed there were no nursing progress note of the residents fall with head injury, discomfort/pain date 1/25/2025 through 1/27/2025. On 1/27/2025 at 10:17AM the interdisciplinary team noted: Nursing description of event: Observed resident on the floor next to her bed. She was sitting on top of all her blankets. Complaints of pain to forehead. A quarter size bump on forehead with bruising observed. No other visible injuries observed. Current condition: Resident is at baseline with signs of latent injury. Root cause: Resident was recently placed on APM to promote skin integrity and rolled off the bed. Plan: Hospice contact to request perimeter APM mattress. Record review of Resident #1's fall report dated 1/29/2025 at 6:23 PM revealed: Resident #1 was observed on the floor (unwitnessed fall) in the dining room in front of her wheelchair. Record review with the DON of Resident #1's document folder in the electronic medical record revealed there were no neurological checks/monitoring documented for the unwitnessed fall. The DON stated that there should have been a 72-hour neurological monitoring post unwitnessed fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the facility 'Falls and Fall Risk, managing' policy revealed based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. (5.) If falling reoccurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. (6.) If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable Record review of resident #1's fall report dated 1/31/2025 at 3:36 AM revealed: Resident (#1) fell , possibly hitting her head, next to the bed by the bedside table. Record review with the DON of Resident #1's document folder in the electronic medical record revealed there were no neurological checks/monitoring documented for the unwitnessed fall. The DON stated that there should have been a 72-hour neurological monitoring post unwitnessed fall. - Record review of resident #1's fall report dated 2/2/2025 at 3:35 PM revealed: Resident (#1) observed on floor (unwitnessed fall) in resident's room. Skin tears noted to left arm. Record review and interview on 3/6/2025 at 4:05PM with the Director of Nursing (DON) of Resident #1's interdisciplinary team note dated 2/3/2025 at 11:10AM did not mention the fall or skin tear injury. Record review of facility 'Change in a Resident's Condition or Status' policy revision date 12/2024 revealed (2.) A significant change of condition is a major decline or improvement in the resident's status that: (c.) Requires interdisciplinary review and/or revision to the care plan ., (8.) The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status .

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NAME OF PROVIDER OR SUPPLIER Adira Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 State St Saginaw, MI 48602	

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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 37666 Based on interview and record review, the facility failed to ensure that a Registered Nurse was on duty for eight consecutive hours a day, seven days a week. Findings Include: On 3/6/2025 at 11:30 AM, posted nurse staffing sheets (a document listing all nurse staff by discipline (RN, LPN or Nurse aide working in the building on each shift- posted per federal guidelines) for the year 2025 was requested. A review of the Daily posted staffing sheets from 1/1/2025- 3/6/2025 identified a blank form, as well as a lack of 8 hour daily Registered Nurse (RN) coverage. There were several days in January 2025 that did not have an RN working for at least 8 consecutive hours: 1/1/2025 (0 RN hours), 1/9/2025 (4 RN hours) and 1/24/2025 (0 RN hours). There were several days in February 2025 that did not have an RN working for at least 8 consecutive hours: 2/5/2025 (0 RN hours) and 2/20/2025 was blank- the document identified the facility census and date, but the remainder was blank. On 3/6/2025 at 5:10 PM, the Daily Staff Postings binder was reviewed with the Administrator and Director of Nursing/DON. Discussed that there were several days indicated on the Posted staffing sheets that there was not an Registered Nurse/RN for at least 8 consecutive hours in a day. Reviewed there was LPN coverage, but not the required 12 RN hours/ per day. 1/1/2025 and 1/9/2025 were reviewed as examples; also reviewed 2/20/2025 was blank. The DON and Administrator said they were not sure what happened.