

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 09/16/2025
NAME OF PROVIDER OR SUPPLIER Adira Nursing and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 3200 State Street 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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (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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<p>F 0686</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2607357. Based on observation, interview and record review, the facility failed to prevent the development of pressure ulcers for one resident (Resident #1) of three residents reviewed for skin alterations, resulting in Resident #1 developing three facility-acquired pressures ulcers- one Stage 3 pressure ulcer (full- thickness skin loss with exposure of the subcutaneous tissue layer beneath) to his coccyx: unstageable wound (full- thickness loss where the depth of the wound is obscured by necrotic tissue or eschar) to his left heel and a deep tissue injury (pressure related injury to subcutaneous tissues that appears as deep bruise under intact skin) to his left lateral malleolus and inconsistencies in classification of the wounds. Findings Include Resident #1: On 9/16/2025 at approximately 12:15 PM, Resident #1 was observed resting in bed watching television. He was well dressed in a knitted shirt and black slacks. His left lower leg was observed to be bandaged above his socks with the date of 9/11. When Resident #1 was asked if he had any other open areas on his body he pointed to coccyx area. CNA (Certified Nursing Assistant) G entered the room and when asked about the resident's wounds she expressed, he has three (pressures ulcers) - left ankle, left heel and coccyx and all were facility acquired. It can be noted Resident #1 did not have soft heel boots on and his bilateral heels were resting on the bed. On 9/16/2025 at 1:30 PM, Wound Nurse F was interviewed regarding Resident #1's three wounds. He stated they were all facility acquired but two they believe are vascular and they are awaiting testing. The three wounds were reviewed: Resident #1's left malleolus was discovered on 7/29/2025 with classification as stage 2 pressure ulcer; on 7/31/2025 it was classified as unstageable. Wound Nurse F expressed he was unsure what the true classification was currently as they are awaiting testing. Left heel opened on 8/7/2025 and was initially classified as pressure DTI (deep tissue injury) but around 8/28/25 is when it was changed to other as it appeared more vascular in nature. He reported the wound was worsening and now it appears to be healing. Coccyx was discovered on 8/7/2025 and the current treatment is triad cream. It is classified as MASD (moisture associated skin damage) which is due to incontinence related moisture. Nurse F stated the wound is associated from Resident #1 sweating or being urine. On 9/16/2025 at approximately 2:00 PM, a review was conducted of Resident #1's medical record and it revealed he was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, diabetes, dementia, hypertension, kidney disease and heart disease. Resident #1 was deemed incompetent but can express his needs to facility staff. Further review revealed the following: admission Skin Assessment 5/26/25:- No skin issues present on admission Care Plan: I have an ADL (Activities of daily Living) self-performance. ambulation. I am non ambulatory. Transfer: I require assistance by (1) staff to move between surfaces with use of sliding board. Bed Mobility: I require 1 assistance to turn and reposition in bed. Use of incontinence products- brief. daily skin inspections. Report abnormalities to the nurse. Kardex: Off-loading heels boots as I will tolerate. Bladder Continence and Toilet Use 30-day look back: Most of the lookback, Resident #1 was incontinent and changed about once on each shift, with 8+ hours between episodes and the resident being incontinent 95% of the time. MDS (Minimum Data Set Assessment) dated 8/27/2025 check MDS date for accuracy Number of Stage 3 pressure ulcers: 1 Number of unstageable pressure ulcers due to coverage of wound bed by slough and/or eschar: 1 Number of unstageable pressure injuries presenting as deep tissue injury: 1 Progress Notes: 7/15/2025 04:39: Resident was observed expressing discomfort during check and change. Resident verbally complained of pain in both legs and refused to be touched during care. 7/29/2025 10:45: Upon entering the patient's room this morning, stage 2 pressure ulcer was noted to left lateral malleolus, along with a DTI to left heel. 8/1/2025 at 14:46: Resident noted to have stage 3 coccyx, unstageable left lateral malleolus, DTI left heel. 8/12/2025: 14:11: Ulcer of sacral region, stage 3 Sacrum. Frequent incontinence checks. Pressure injury of deep tissue of left heel Left heel: Offload left heel Recommend NWB (none weight bearing) to the left foot doppler ordered for left lower leg. Decubitus ulcer, ankle, left, unstageable Left lateral malleolus. Pt (patient) is bowel incontinent yes. Pt is urinary incontinent yes. Stage 3 pressure injury - Sacrum Wound Length x Width x Depth: 2.4cm x 1.8cm x 0.1cm. Deep Tissue Injury - Left Heel Wound Length x Width x Depth: 2.4cm x 1.5cm x 0.1cm. Unstageable Pressure Injury - Left Lateral Malleolus Wound Length x Width x Depth: 1.4cm x 1.1cm x 0.1cm. 9/9/25 at 10:48: Recommend ordering CT angiogram to further evaluate vascular status given non-healing foot ulcer. The wound service is consulted for evaluation and treatment of:- Moisture associated skin damage (MASD) to the sacrum, previously coded as Stage 3 Pressure injury. Surface area has</p>		