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	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adira Nursing and Rehabilitation	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2976205. Based on interview and record review the facility to implement a process for receipt of and reconciliation of home medications for one resident (Resident #701) of two residents reviewed for pharmacy services. Findings Include:On [DATE] at 10:00 AM, Complainant K shared his father (Resident #701) admitted to the facility for short term rehabilitation after an extended hospital stay. Upon admission he provided the facility with his father's anti-rejection (immunosuppressant) medications to cover the duration of his stay. He gave the facility the following:Tacrolimus 1 mg (milligram)- 2 bottles (30 capsules in each bottle)Tacrolimus 4 mg - 2 bottles (30 capsules in each bottle)Complainant K started he was supposed to receive 5 mg per day (1 mg tablet and 4 mg tablet). At discharge the medication order was for 5-1 mg Tacrolimus capsules which was confusing to him given he provided two bottles of 4 mg capsules. They received back one box of 4 mg (20 capsules) and an empty box of 1 mg Tacrolimus. The medication provided did not match the ordered dosage in their administration record and it had the appearance the medication was administered incorrectly to his father. On [DATE] at approximately 10:15 AM, a review was conducted of Resident #701's medical records and it revealed he was at the facility from [DATE] to [DATE] with diagnoses that included Atrial Fibrillation, Kidney Transplant, Heart Failure, Cardiomyopathy, and Immunodeficiency. Further review of the records yielded the following:Acute Care Medication Discharge List dated [DATE]: .Tacrolimus ER 1 MG- take 5 tabs by mouth daily. Handwritten note next to order Family supply bottle.admission Check List & Audit Form dated [DATE]: .Tacrolimus 1 mg fam (family) supplied) .Nursing admission assessment dated [DATE]:No mention of home medications provided to the facility for Resident #701.Inventory of Personal Effects:No mention of home medications provided to the facility for Resident #701. MAR (Medication Administration Record)Tacrolimus Oral Capsule 1 mg - give 5 capsules by mouth one time a day for kidneys.Based on the home medication provided by Complainant K if the facility only administered 1 mg capsules of Tacrolimus (60 capsules provided) throughout Resident #701's stay (20 days) they would have ran out of medications in approximately 12 days. Per the complainant he did not receive a phone call requesting additional medications. There is not a physician's order for a 4mg dosage of Tacrolimus. On [DATE] at 11:12 AM, an interview was conducted with Nurse E regarding Resident #701's home medications administered at the facility and his discharge. The nurse reported upon his discharge his son was upset because she could not find the remaining medications they provided at admission and how they were administering the medication to his father (5-1 mg capsule vs 1- 1 mg & 1-4 mg capsule). Nurse E stated she did locate the medication in the bottom drawer and contacted the family who picked them up. She recalled it being 1- bottle of 1 mg Tacrolimus and 1- bottle of another dosage. Nurse E stated she did count the medications but did not document the count in his medical record.Nurse E continued from what she can remember there were two bottles of Resident #701's home medications in the top drawer and she administered from both bottles as there were two different dosages- with one being 1 mg and she could not recall the other dosage. She stated when residents provide their home medications it should be documented in the chart what they bring in, but (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235250	A. Building B. Wing	04/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adira Nursing and Rehabilitation	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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they do not count the medications like they would do for narcotics. There is no actual reconciliation process for residents' home medications. On [DATE] at 11:47 AM, an interview was conducted with Nurse D regarding Resident #701's admission to the facility. Nurse D stated the resident did have home medication in the top drawer of the medication cart but she was not the nurse whom the family provided them too. She stated Resident #701 had a few bottles (of Tacrolimus) and there were two different dosages. Nurse D would take one capsule out of the 1 mg bottle and one capsule out of the higher dosage bottle. During Resident #701's stay they switched medication carts and she is not certain if this medication was moved around during the process.Nurse D stated there is no process in place to write down the number of home medications they come in with, the dosages or the number of medications in the bottle upon admission. On [DATE] at 1:50 PM, Infection Control Nurse I was queried regarding their admission process for residents with home medications and reconciliation of those medications. Nurse I stated it would be listed in their order set and on their personal inventory form. She stated the inventory sheet would only list the medication name and quantity of bottles provided. Nurse I was queried if staff would list the dosage of the medication or a count of how many pills were received and she stated they would not, as they do not count home medications and give the bottles back upon discharge.Nurse I stated the admission checklist did indicate Resident #701's family provided 1 mg tacrolimus bottle (did not state the quantity of bottles provided) but she was not able to locate any other documentation related to his home medications. Based on what was written on the form Resident #701 would have ran out of tacrolimus in about five days (Nurse I agreed). From Nurse I review of Resident #701's records it was unable to be ascertained what dosages, quantity of home medications were provided to the facility upon admission and what was given back to Resident #701 at discharge.Nurse I continued with the medications they receive from pharmacy they can reconcile non-narcotic medications and request the shipping manifest. She was asked was there a current process/procedure to receipt/reconcile home medications and she stated there was not. Review was conducted of the facility policy entitled, Medications Brought in the Facility by Physicians or Resident/Family Members, revised 08/2020. The policy stated, .Medications from Home.the medication has not expired, and the medication has been positively identified by the physician or pharmacist prior to use. The facility will have documentation that the identification has been made. Delivery and receipt must be documented as with any other medication, ion a common receipt log or in the individual resident's record. Review was conducted of the facility policy entitled, Reconciliation of Medications on Admission, reviewed 7/25. The policy stated, .The purpose of this procedure is to ensure medication safety by accurately accounting for the resident's medications, routes and dosages upon admission or readmission to the facility.Medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route.