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	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Adira Nursing and Rehabilitation	3200 State Street 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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to initiate timely pain interventions for two residents (Resident #13 & Resident #81) of two residents reviewed for pain, resulting in both Resident #13 and Resident #81 experiencing documented increased pain after falls (which resulted in femur fractures requiring surgical repair), without any pharmacological or non-pharmacological interventions provided and a12 + hour delay in transferring both residents to the hospital for proper evaluation and treatment.Findings Include:Resident #13:Review was conducted of Resident #13's chart and it revealed she admitted to the facility on [DATE] with diagnoses that included, Alzheimer's Disease, Diabetes, Asthma, Dementia, Heart Failure and Hypertension. Resident #13 required assistance of facility staff for daily care. Further review of her chart yielded the following:Progress Notes: 10/3/2025 at 14:43: CNA informed nurse that was resident was on the floor. Nurse went into room to assess and resident was observed on the right side of the bed. ROM (range of motion) complete and able to move all extremities without difficulty. No new injuries or bruising noted. Resident two person transferred with mechanical lift back into bed. Physician, family, and nurse manager notified of fall. Neuro check and fall charting initiated. 10/3/2025 at 21:13: Resident indicated her right foot and ankle area were hurting her post fall. Notified the physician and an x-ray of foot and ankle ordered. 10/4/2025 at 01:14: Received a critical result for the x-ray of her foot and ankle, the 5th metatarsal has a hairline, no displaced fracture. Notified the OnCall manager and the physician. 10/4/2025 at 05:06: During morning care resident noted to be grimacing and crying out stated her hip hurt. At that time it was noted that the right leg is bent at knee and is externally rotated. order received for xray to hip and knee (right). 10/4/2025 at 13:45: Phone call placed to.x-ray due to status of technician for STAT x-ray that has been ordered. Message sent to technician and tech to call back. 10/4/2025 at 20:12: Left hip/leg x-ray results received w/ right femur intertrochanteric fracture with mild upward displacement of the distal segment. (physician) notified Resident to be sent to the ER. On call notified. 10/4/2025 at 20:56: (EMS) arrived at approximately 8:50pm to transfer resident via stretcher to (hospital). Diagnostic Orders: 10/3/2025 at 19:36: Right ankle, complete,, 3+ view, right foot, complete, 3+ views. Stat order.10/4/2025 at 04:33: Right hip, unilateral w/ pelvis when performed, 2-3 views, right knee, 1/2 view. Stat order. Pain Assessment:10/3/2025 at 08:36: 610/4/2025 at 14:23: 5 MAR (Medication Administration Record):Resident #13's October 2025 MAR was reviewed and there were no entries that indicated the resident was offered or administered any pain medications after her fall and indications of pain. It reasonable to ascertain Resident #81 was experiencing pain. There were no medications administered or nonpharmacological interventions provided to manage her pain prior to be transferred to the hospital approximately 31 hours later. X-Ray Results:10/3/2025: Right Foot-2 views .Post fall complaints of foot pain, acute pain due to trauma .hairline non-displaced fracture of distal fifth metatarsal. Hospital Records: .Closed right intertrochanteric femoral fracture, nondisplaced hairline fracture of right 5th metatarsal.X-Ray and CT of the right hip, pelvis, femur personally reviewed. There is a comminuted intertrochanteric hip fracture in the setting of pre-existing osteoarthritis.Per report she had an unwitnessed fall at her nursing home. She had immediate right hip pain. We were also told the x-rays were obtained at the nursing home that (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 0697 Level of Harm - Actual harm Residents Affected - Few	revealed a right 5th metatarsal fracture.Plan for right hip cephalomedullary nail.She does endorse pain over palpation of the right hip.pain to palpation elicited on light palpation of the right hip. Review was conducted of incontinence care and turning/repositioning of the resident post fall:Bladder Continence and Toilet Use:10/3/2025 at 19:2410/3/2025 at 08:4010/4/2025 at 16:43Turning and Repositioning in bed/chair resident lays/sits in every two hours ass resident will tolerate:On 10/3/2025 Resident #13 was turned and repositioned at 19:12On 10/4/2025 Resident #13 was turned and repositioned at 12:03 and 16:45. On 01/20/2026 at 2:06 PM, an interview was conducted with Nurse I regarding Resident #13's fall and subsequent fracture. Nurse I stated the resident required a mechanical lift for transfers as she could not get in/out the bed alone. She was dependent on facility staff for most of her daily cares. Nurse ?I recalled the CNA (Certified Nursing Assistant) observed her on the floor to the right of her bed. Resident #13 was flat on her back with her head toward the top of the bed and upon going into the room, the bed was at knee height to the nurse (the nurse is 5'9). The resident was unable to verbalize what occurred but the last time Nurse I saw the resident she was in the center of the bed. It was assumed from her position on the floor she rolled out of bed. Nurse I continued Resident #13 was assessed prior to being placed back in bed and there were no outward expressions of pain with range of motion and transferring her back into bed. There was no redness, swelling and nothing appeared to be externally rotated at this time. Nurse J worked the night shift on 10/3/2025 and that is when Resident #13 began to express signs of pain. On 1/20/2026 at 2:17 PM, an interview was conducted with Nurse J regarding Resident #13's pain and fracture discovery. The nurse said she was not as familiar with the resident, but it appeared she was in pain. Upon assessment Resident #13 would grimace with touching of her ankle/foot area. The 1st set of X-rays for her foot/ankle were ordered afte4r this initial assessment and conducted during her shift. Later in the shift the CNA went in to change her, and Nurse J was able to assess her hip area, and it appeared to be externally rotated. As the resident was being changed, she was grimacing and crying out. The CNA was quite familiar with her and stated while her being vocal during care is normal this was different type of crying out. Nurse J was asked if she recalled administering pain medications to Resident #13 during her shift for her outward expressions of pain, the nurse stated to refer to the MAR given the amount of time that had lapsed. The MAR showed that no pain medications were administered to the resident during Nurse J s shift. The nurse stated if they did not move the resident, she did not have any expressions of pain and check, and changes were every two-three hours. After the assessment of Resident #13's hip is when she contacted the physician and requested the 2nd set of x-rays. The x-ray of the resident's hip did not occur prior to the conclusion of her shift, but the initial x-ray resulted which indicated a metatarsal hairline fracture. On 01/22/2026 at 1:00 PM, the DON (Director of Nursing) was interviewed regarding the lack of pain interventions, delay in onsite imaging and transfer to the hospital. The DON reported from the fall investigation they found Resident #13 leaned to the right to watch television and fell out of bed. The CNA observed the resident on the floor and promptly reported it Nurse I. During the next shift, pain in the resident's ankle/foot was reported and the 1st set of x-rays ordered and indicated a hairline 5th metatarsal fracture. She was downgraded to hoyer transfer and was to avoid activity that would place pressure on her foot.The DON reported the 2nd set of X-rays were ordered about 5:00 AM but were not completed for an extended period of time. The x-ray company was contacted at approximately 1:45 PM on 10/4/25 for an update (8 hours after the stat order was placed). The DON was queried if the resident was administered any pain medications or if other non-pharmacological interventions were provided for Resident #13 prior to being transferred to the hospital. The DON stated from the review she does not see that any pain medications were administered to the resident nor other non-pharmacological interventions. The DON further stated the resident only cried out in pain when she was changed or repositioned. The DON was unable to provide an explanation as to why they waited 9+ hours for a stat x-ray to be completed,16 hours to transfer a resident with evident pain and externally rotated leg without any pain interventions indicated. On 1/22/2026 at 2:34 PM, an interview was conducted with CNA K regarding Resident #13. CNA K (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	reported the resident was a two person assist prior her fall in October 2025 and did not like to be touched. The resident required assistance with daily care as she could not roll and did not utilize her call light. CNA K stated they were aware she had fallen earlier in the day and as they began to roll the resident from side to side during the check and change it was evident her side was causing her a great deal of pain. The resident was acting differently from her baseline. When they were getting into position to change her CNA K barely placed her hand on the resident and she was saying ouch-ouch, and yelling out as they were completing her incontinence care. Resident #13 was a heavy wetter and was always changed about every two -three hours, they would have to also change her sheets as well as those were urine saturated. During each encounter that night for check and changes the resident was crying out in pain. It can be noted that Resident #13 was discovered on the floor next to her bed at approximately 1:45 PM on 10/3/2025. She indicated right foot and ankle pain post-fall and an x-ray was ordered around 7:36 PM. X-ray results received indicated non-displaced fracture of the 5th metatarsal. Durning morning care on 10/4/2025, the resident was grimacing, and crying out stated her hip hurt. It was noted her right leg was bent at the knee and externally rotated. Stat x-rays were ordered at 4:33 AM. X-ray results were received at 8:12 PM on 10/4/2025 that showed right femur intertrochanteric fracture. The resident was transferred to the hospital at 8:50 PM. Resident #13 remained in the facility for about 31 hours post fall and approximately 20 hours after documentation of increased pain. During those 20 hours facility staff provided incontinence care which required turning and repositioning who was noticeably in pain with light touching, yet there was no pain interventions documented. Resident #81: On 1/20/20/2026 at approximately 11:00 AM, Resident #81 was observed in bed with the covers pulled over his head. He appeared to be resting and did not answer this writer when his name was called multiple times. On 1/20/2026 at approximately 1:30 PM, a review was conducted of Resident #81's records and it revealed he was admitted to the facility on [DATE] with diagnoses that included, Dementia, Alcohol Cirrhosis of the Liver, Alcohol induced Dementia, Anxiety, Major Depressive Disorder and Mood Disorder. Resident #81 required some assistance with his daily care but was able to transfer between his bed/wheelchair and toilet independently. Further review was conducted of his chart, and it yielded the following: Care Plan: .Ambulation: I require assist of 1 with use of RW.Wheelchair: Standard wheelchair with auto locking brakes independent with wheelchair mobility.Toilet use: I am independent; Transfer: Independent between bed and wheelchair with use of assist rail. Independent with toilet transfers. 1 assist showers chair no device.I am at risk for falls r/t impaired cognition incontinence, hx UTI's, hypotension, hx fall with fracture, anxiety. I have poor safety awareness with impulsive but I have a strong attempt to remain as independent as possible. I will continue to attempt to self- transfer.Have commonly used articles within easy reach. I have a lightweight dresser in my room.Wheelchair to be left at bedside. I have left femoral neck fracture r/t Fall 9/26/25 surgical percutaneous screw fixation of left femoral neck fracture. Kardex: .Frequent check while resident in on bed; keep room well lit; Maintain bed at transfer height as I tolerate with wheelchair next to bed with brakes locked.Brief use: disposable briefs. Change prn (as needed). Progress Notes: 9/24/2025 at 19:05: Was alerted by CNA (Certified Nursing Assistant) that resident placed his call light on to report that he fell and has left hip pain. Resident stated he was by his dresser and fell on his left side, states his left hip hurts and can hardly move it. When asked when he fell he stated about an hour or so ago. Assessment completed and revealed a skin abrasion to the left knee. ROM (range of motion) appropriate in all extremities except the left lower leg, ROM is limited and resident reports having increased pain with movement. Provider notified new order received for STAT x-ray of the left hip and knee, orders placed. On call notified. 9/25/2025 at 01:23: X-ray results available and faxed to (physician) for review. Impression: Faint linear lucency in the neck region of the left femur, which is suspicious for fracture. Awaiting response from provider.9/25/2025 at 07:06: Physician notified of recent x-ray results and wants resident sent to (Hospital) for evaluation. (EMS) notified and awaiting transfer. Pain Assessment: 9/24/2025 at 19:17: 8 - pain level entered by Nurse G X-Ray Findings:Date of Service: 9/24/2025: Left hip, unilateral (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	w/pelvis when performed, 1 view: .Faint linear lucency in the neck region of the left femur, which is suspicious for fracture. Recommended clinical correlation and further evaluation with MRI left hip. MAR (Medication Administration Record):Resident #81s' September 2025 MAR was reviewed and there were no entries that indicated the resident was offered or administered any pain medications after his fall. The resident pain was assessed at an 8 and it's reasonable to ascertain Resident #81 was experiencing pain. There were no medications administered or nonpharmacological interventions provided to manager his pain prior to be transferred to the hospital where he underwent repair of his femur. Hospital Records: admission Date 9/25/2025: .The patient is a [AGE] year-old make who presented to the ED after a fall.He rolled out of bed last night.Diagnostic Studies: Acute nondisplaced fracture left femoral neck. He reports he was attempting to exit his bed and fell. He is complaining of pain to the left hip that is worse with any movement and better with rest and medication. On exam he reports left hip and knee pain.underwent percutaneous screw fixation of the fracture on 9/26. Resident #81 remained in the facility for approximately 12 hours with any documented pain interventions from facility staff. Fall Incident and Accident Report:Statement from CNA H: Resident was moving the [NAME] drawer to barricade the door.I unbarricaded the door and ask if he needed help. Rounded on the patient more frequently. Statement from Nurse G: Lost balance and fell while by dresser. orthostatic to be done on falls in proper order: sitting- not done r/t hip pain. On 1/22/2025 at approximately 12:55 PM, a phone call was attempted with Nurse G there was no answer and voicemail was left requesting return phone call. On 01/22/2026 at 1:30 PM, an interview was conducted with the DON (Director of Nursing) regarding Resident #81's fall. The DON reported he is the same level of care he is now that he was prior to his fall. He was on a different unit when the fall occurred and had barricaded himself in the room. The CNA was able to enter the room and move the dresser back into the correct location. About 45 minutes later he pressed his call light and reported he had fallen but was lying in bed. The nurse completed an assessment, and he complained of left hip and knee pain; the nurse received ordered for an X-ray which were completed and showed a fracture. The nurse contacted the physician about 1 AM but did not receive a response until 6 AM with orders to transfer to the hospital for further evaluation. While at the hospital he did undergo surgery to repair his hip. The DON was asked what the timeframe for Stat X-rays and she is reported it's 3-4 hours depending on the company and they will call the facility with any findings. A review was conducted of Resident #81's MAR and the DON was queried if pain medications were administered at any point from discovery of the fall with verbalization of pain to his transfer. The DON reported there was no documentation located that he was provided pain medications. It can be noted Resident #81 alerted staff to his fall at approximately 7:00 PM, he was assessed as an 8 for pain and stated his left hip hurt and he could barely move it. He remained in the facility for an additional twelve hours without any pain intervention implemented for his hip fracture. Review was conducted of the facility policy entitled, Pain Assessment and Management, revised April 2025. The policy stated, .Observe the resident (during rest and movement) for behavioral signs of pain. Possible behavioral signs of pain include: negative verbalizations and vocalizations such as groaning, crying, screaming.facial expressions such as grimacing, frowning, clenching of the jaw, etc. behavior such as resisting care, distressed pacing, irritability, depressed mood, or decreased participation in usual physical and/or social activities. Establish a treatment regimen that is specific to the resident based on consideration of the following. Non-pharmacological interventions may be appropriate alone or in conjunction with medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area, resulting in the potential to spread food borne illness to all residents who consume food from the kitchen. Findings include: On 01/20/2026 at 11:40am-12:20pm during lunch observation, observed [NAME] B remove and don gloves without washing hands before taking temperatures and prepping food during lunch observation in the kitchen. On 01/20/2026 at 11:40am-12:20pm observed [NAME] B don gloves without washing hands before taking temperatures of food on the steam table in the kitchen. On 01/20/2026 at 11:40am-12:20pm observed [NAME] B touch her face with her finger then open trays at the steam table and proceeded to don gloves without washing hands in the kitchen. On 01/20/2026 at 11:40am-12:20pm observed [NAME] B don gloves without washing hands before prepping food trays in the kitchen. On 01/20/2026 at 12:20pm interviewed Dietary Manager C on when kitchen staff should be washing their hands, and he stated that kitchen staff should wash their hands any time their hands can be contaminated. He also acknowledged that he witnessed [NAME] B not washing her hands during lunch preparation. According to the 2022 Food Code, 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms.immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and.Before donning gloves to initiate a task that involves working with food.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate care of an indwelling catheter for one resident (R2) of one resident reviewed for indwelling catheters. Findings include: Resident #2 (R2): R2 is [AGE] years old and admitted to the facility on [DATE] with diagnoses that include infection and inflammatory reaction due to indwelling urethral catheter, obstructive and reflexive uropathy, chronic kidney disease and retention of urine. R2 has a brief interview for mental status (BIMS) score of 15, indicating they are cognitively intact. On 01/20/2026 at 11:33AM, while conducting an interview with R2, it was observed that the urine collection bag for the catheter was hanging on the left arm rest of the wheelchair, it was observed to be hanging above the level of the bladder. On 01/21/2026 at 9:43AM, R2 was watching tv in his room, the urine collection was observed below the wheelchair and touching the floor. On 01/21/2026 at1:49PM, R2 was observed in the therapy gym, the urine collection bag is below the wheelchair and on the floor. On 01/21/2026 at 2:12PM, an interview was conducted with Unit Manager (UM) A. Unit Manager A was made aware that R2's urine collection bag was observed hanging on the armrest of the wheelchair. UM A stated that R2 will do that himself from time to time, but that it shouldn't be up there. UM A was asked if the urine collection bag for R2 should be resting on the floor under the wheelchair. UM A stated, no and I will take care of that right now. Record review of the policy titled, Catheter Care, Urinary, revealed, Maintaining Unobstructed Urine Flow3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder. Infection Control2. Maintain clean technique when handling or manipulating the catheter, tubing, or drainage bag.b. Be sure the catheter tubing and drainage bag are kept off the floor.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure safe narcotic storage, narcotic reconciliation and the discarding of expired medications for two medication carts of three medication carts reviewed, resulting in unreconciled narcotic medications with key exchange and expired medications. Findings include. On 1/22/2026 at 8:07 AM, Harbor Medication Cart was observed in the presence of Nurse M. The following medications were found to expired or improperly stored: 2 -bottles of Brimonidine Tartrate Ophthalmic Solution with no open or use by date Rocklatan Ophthalmic Solution Opened on 8/25/2025 and per the label may store up to 6 weeks. Vial of Tuberculin (stored with the eye drops) no open/use by date and stored improperly. 1 Timolol Maleate Ophthalmic Solution with no open or use by date Nitroglycerin expired on 9/2025 Atropine Sulfate 1% sublingual oral drops that expired on 11/2025 but was opened 1/1/2026 Lantus Insulin Pen with open date of 12/18 and no use by date. Nurse M attempted to contact the facility pharmacy for guidelines for duration of use for the eye drops but they were unable to provide the requested information. Nurse M reported the nitroglycerin, atropine, rocklatan eye drops should have been discarded as they were expired. She stated the vial of tuberculin is not supposed to be stored in the refrigerator not their medication cart. On 1/22/2026 at 9:02 AM, Unit Manager N was interviewed regarding the Harbor medication cart. Manager N shared night shift nurses are supposed to go through the cart. She continued the immunization vial should not have been in the cart and the Lantus is good for 28 days (with the open date of 12/18 it was expired). According to the package insert for Lantus, it stated, .once you take your SoloStar out of cool storage, for use or as a spare, you can use it for up to 28 days . According to the package insert for Tuberculin, .Store at 35 degrees to 46 degrees F. Do not freeze.a vial of Tubersol which has been entered and in use for 30 days should be discarded. According to the package insert Rocklatan,.after opening, the product may be kept.for up to 6 weeks. Per The International Pharmacopeia- Thirteenth Edition, 2025, stated, Multidose ophthalmic drop preparations may be used for up to 4 weeks after the container is initially opened. Review was conducted of the facility policy entitled, Storage of Medications, revised 5/25Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dispensing pharmacy or destroyed. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications are stored separately from food and are labeled accordingly. On 1/22/2026, at 1:06 PM, Nurse F was observed asking Nurse E for their keys. Nurse E pulled a set of keys out of their bag and handed the keys to Nurse F. Nurse F was asked if they normally do that and Nurse F stated, I go home for lunch and leave my keys here just in case someone needs something. Nurse F walked down the hallway passing by their medication cart. On 1/22/2026, at 1:16 PM, Nurse F was asked if Nurse E was available. Another staff member stated they thought Nurse E was on break. Nurse F stated, she must not have left because she didn't give me her keys. On 1/22/2026, at 2:24 PM, the Director of Nursing (DON) was alerted of the observation of Nurse E and Nurse F passing medication cart keys with no narcotic reconciliation and the DON stated, you don't share narc (narcotic) keys. The DON was asked for a narcotic reconciliation observation. On 1/22/2026, at 2:37 PM, Nurse E and Nurse F began reconciling narcotic medications along with Unit Manager A. When they were counting the narcotic (ABH gel) for Resident #75 Nurse E stated, (four) for Resident #75 and Nurse F set out 3 packets of ABH gel and quickly began to write the number 3 in the AMOUNT REMAINING column on the CONTROL SUBSTANCE RECORD. Nurse F stated, I gave him one. Unit ManagerA gathered the document to obtain a copy. Nurse E stated, we've worked together for fifteen years and I would only do this with this nurse. A review of the facility provided CONTROL SUBSTANCE RECORD for Resident #75 revealed 1/23/26 . AMOUNT USED 1 ADMINSTERED BY . AMOUNT REMAINING 3 The administered by column was signed by Nurse F. A review of the facility policy Storage of Medications revealed The facility stores all drugs and biologicals in a safe, secure, and orderly manner . Access to controlled medications is limited to authorized personnel. Personnel access to controlled medications is recorded .