STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235249	A. Building B. Wing	09/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation St Francis	915 N River Rd Saginaw, MI 48609

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22927 Based on observation, interview and record review, the facility failed to prevent and document the occurrence of a skin abrasion and Deep Tissue Injury (DTI) for one resident (Resident #1) and the development of pressure ulcers for one resident (Resident #2), resulting in Resident #1 to be found with an abrasion to the left lateral hip and right heel deep tissue injury and Resident #2 developing a pressure ulcer to the left heel as a deep tissue injury and increased to a Stage III pressure ulcer and, also, the left foot 5th toe pressure ulcer to develop and increase in size to a Stage II pressure ulcer, resulting in skin breakdown, pain, the likelihood for infection and diminished overall health and wellbeing. Findings include: Record review of the facility 'Skin and Wound Guidelines' dated 3/20/2024 revealed to describe the process steps required for identification of residents at risk for development of pressure injuries, identify prevention techniques and interventions to assist with the management of pressure injuries and skin alterations. Stages of pressure injury: Stage II Partial thickness skin loss with exposed dermis .Stage III Full thickness skin loss . Deep Tissue Injury (DTI) persistent non-blanchable deep red, maroon, or purple discoloration .Skin alterations and pressure injuries are evaluated and documented by the licensed nurse. Body audits are completed routinely and documented in the resident's electronic medical record. The nursing assistant will inform the licensed nurse of any new areas of skin breakdown for evaluation and documentation. definition: Pressure Injury- Localized damage to the skin and underlying soft tissue, usually over a bony prominence or related to a medical or other device. Can present as intact skin or as open ulcer and may be painful. Injury occurs because of intense and or prolonged pressure or pressure in combination with shear and is classified by stage. Resident #1: (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 0686 Level of Harm - Actual harm Residents Affected - Few	Observation on 9/17/202 at 11:10 AM of Resident #1 who resided in room [ROOM NUMBER]-2, revealed no there was no roommate residing in room. Resident #1 was asleep with the head of bed elevated, and the resident slumped to the bottom of the bed. There was a breakfast tray set in front of resident still, thick fall mat noted at bedside, other side of bed against the wall. Upper half side rails noted to be in use bilateral. the TV was on. The Oxygen concentrator was set at 2 liters with nasal cannula looped over the concentrator and running. The oxygen concentrator was located across the room behind room divider curtain, not on resident, out of reach of resident. Resident #1's left leg was amputee, right leg/heel noted to be resting on the gray plastic mattress extender pieces at foot of the bed, there was no prafo boot noted to be visible in the room, Right post heel noted to have discoloration spot and dry flaky skin noted. Resident #1 did not arouse to her name. Record review of Resident #1's Minimum Data Set (MDS) dated [DATE] revealed a female resident with cognitive impairment. Brief Interview of Mental status (BIMS) score of 5 out 15, severe cognitive impairment. Medical diagnosis included: Debility, hypertension, peripheral vascular disease, diabetes, dementia, depression, respiratory failure. Review of the bowel/bladder assessment revealed always incontinent. Record review of section M: skin- revealed no pressure ulcers or skin issues. Record review of Resident #1's care plans pages 1- 30 revealed impaired skin related to history of right heel diabetic ulcer. Interventions: right heel allevyn foam dressing at all times for protection started on 8/26/2024. Bridge heels with pillows. Right Profa boot at all times. There was no mention of a left hip/abdomen abrasion, no treatment. Record review of Resident #1's cardiovascular care plan and other diagnosis care plans revealed that there were no interventions for the use of oxygen. Record review of Resident #1's physician orders revealed that on 8/15/2024 oxygen at 2 liters via nasal cannula while napping/sleeping to maintain oxygen saturation above 90% as needed. Observation on 9/17/2024 at 1:10 PM of Resident #1 revealed the resident was asleep with her lunch tray sitting on the bedside over table with lid off. Observed pork roast, carrots, potato cubes, chocolate ice cream. peaches or mandarin oranges in cup. Resident is sleeping with head of bed slightly elevated, noted right foot to be resting on the same spot of the gray plastic bed extensions, same as the last observation of resident. Observed a dark discolored area at back end of right heel, there were no Profa boot in place. The Profa boot was found in the closet. Resident care plan stated that Profa boot to be on. Observed Housekeeper C into room to clean, she swept and mopped the floor, wiped the tabletop and windowsill, Resident #1 did not wake up at all, loud snoring noted, oxygen noted to be left on the concentrator and running, not on or near the resident. Record review of Resident #1's 'Total body skin evaluation' dated 9/12/2024 revealed no skin abnormalities noted on assessment. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Observation and interview on 9/17/2024 at 1:30 PM the state surveyor requested Licensed Practical Nurse (LPN)/Unit manager A was brought into Resident #1's room by surveyor. Both the surveyor and LPN A Observed Resident #1 to be slumped over and to be in the same position as surveyor earlier observation, asleep with no oxygen on resident, but concentrator running with nasal cannula looped over the concentrator. Observed Resident #1 to be sleeping with head slumped to side with a whole baby carrot noted in her mouth. The state surveyor revealed that the resident had not been repositioned since the 11:10 AM observation. LPN A made several attempts to move the resident or to wake her up. LPN A left the room to get nurse registered Nurse (RN) B into the room to assist with positioning. Then Registered Nurse (RN)/Infection Control Nurse I came into the room and assisted with resident repositioning. Once repositioned, the state surveyor noted the resident to have a wet brief. The three nurses rolled the resident side to side to change the brief, when there was a noted abrasion to the left hip/abdomen area that was open and had scabbed edges and was not bleeding. The Registered Nurse/Infection control I nurse stated that it was new and that she would get wound care photo of open skin area. Record review of Resident #1's 'Wound & Skin Assessment' dated 9/17/2024 at 1:50 PM revealed an abrasion to left front trochanter (hip) that was in-house acquired, new on 9/17/2024 measuring 3.78 cm length X 0.73 cm width X 0.1 cm depth with granulation noted. Doctor notified. Resident #2: Record review of Resident #2's re-admission assessment dated [DATE] identified the resident to be a mechanical lift for transfers, skin assessment noted no left foot/heel skin issues or injury and to turn/reposition every 2 hours. Record review of Resident #2's physician progress note dated 1/23/2024 at 11:54 AM identified resident required total assistance with bed mobility, transfers, and Activities of Daily Living (ADL). Identified Resident #2 was high risk for developing contractures, pressure ulcers if not receiving adequate therapy . Record review of Resident #2's nursing progress note dated 1/24/2024 at 1:45 PM revealed resident had a medium purple/maroon discoloration to left heel. Heel injury measuring 0.9 cm X 0.5 cm in-house acquired. Record review of Resident #2's wound progress note dated 2/28/2024 revealed deep tissue injury measuring 5.2 cm X 4.0 cm to left heel . Record review of Resident's #2's wound progress note dated 7/9/2024 revealed left dorsum 5th digit (toe) lateral in-house acquired blister measuring 2.4 cm X 2.3 cm (new wound). Record review of Resident's #2's 'wound & skin evaluation' dated 9/10/2024 revealed left heel stage III pressure ulcer measuring 3.5 cm length X 1.9 cm width X 0.4 cm depth. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	In an Interview and record review on 9/17/2024 at 3:12 PM with Registered Nurse (RN) Infection Control nurse I Wound care- On 8/15/2024 the facility started a new PCC electronic records system for the new owner company. Resident #2's wounds left foot wounds/ulcers- The top of the foot lateral foot started on 7/9/2024 as a blister with dark discoloration area. Not sure how it started. The profa boots are to be worn daily at all times. Back in December Resident #2 went to the hospital for 3 weeks and came back, then on 1/24/2024 the left heel started as a discolored area from pressure.

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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** 22927 Based on observation, interview and record review, the facility failed to provide consistent incontinence care for two dependent residents (Resident #1, Resident #4), resulting in verbal complaints of incontinence care not received, frustration, embarrassment and the likelihood for skin breakdown. Findings include: Record review of the facility 'Incontinence Care- Urinary and Fecal' policy, dated 04/22/2024, provided guidelines for leaning the perineum and buttocks after an incontinence episode or with daily care. Residents who are incontinent of bowel and/or bladder will be provided incontinent care assistance as needed based on resident request and/or check and change, or as per resident preference or need . Report any skin alterations to the licensed nurse. Resident #1: Observation on 9/17/202 at 11:10 AM of Resident #1, who resided in room [ROOM NUMBER]-2, revealed no there was no roommate residing in the room. Resident #1 was asleep with the head of bed elevated, and the resident slumped to the bottom of the bed. There was a breakfast tray set in front of resident still, thick fall mat noted at bedside, other side of bed against the wall. Upper half side rails noted to be in use bilateral. the TV was on. The oxygen concentrator was set at 2 liters with nasal cannula looped over the concentrator and running. The oxygen concentrator was located across the room behind room divider curtain, not on resident, out of reach of resident. Resident #1's left leg was amputee, right leg/heel noted to be resting on the gray plastic mattress extender pieces at foot of the bed, there was no prafo boot noted to be visible in the room, Right post heel noted to have discoloration spot and dry flaky skin noted. Resident #1 did not arouse to her name. Record review of Resident #1's Minimum Data Set (MDS), dated [DATE], revealed a female resident with cognitive impairment. Brief Interview of Mental status (BIMS) score of 5 out 15 indicated severe cognitive impairment. Medical diagnoses included: Debility, hypertension, peripheral vascular disease, diabetes, dementia, depression, respiratory failure. Review of the bowel/bladder assessment revealed that the resident was always incontinent. Record review of Resident #1's care plans pages 1- 30 revealed 'Alteration in Elimination' with interventions of assist with toileting and hygiene needs as needed (PRN), and incontinence care per facility protocol. Record review of Resident #1's physician's orders revealed that on 8/15/2024 oxygen at 2 liters via nasal cannula while napping/sleeping to maintain oxygen saturation above 90% as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 9/17/2024 at 1:10 PM of Resident #1 revealed that the resident was asleep with her lunch tray sitting on the bedside over table with lid off. Observed pork roast, carrots, potato cubes, chocolate ice cream. peaches or mandarin oranges in cup. Resident was sleeping with head of bed slightly elevated, noted right foot to be resting on the same spot of the gray plastic bed extensions, same as the last observation of resident. Observed a dark discolored area at back end of right heel, there were no Profa boot in place. The Profa boot was found in the closet. Resident care plan stated that Profa boot to be on. Observed Housekeeper C into room to clean, she swept and mopped the floor, wiped the tabletop and windowsill, Resident #1 did not wake up at all, loud snoring noted, oxygen noted to be left on the concentrator and running, not on or near the resident. In an observation and interview on 9/17/2024 at 1:30 PM, the state surveyor requested that Licensed Practical Nurse (LPN)/Unit Manager A come into Resident #1's room. Both the surveyor and LPN A observed Resident #1 to be slumped over and to be in the same position as surveyor earlier observation, asleep with no oxygen on resident, but concentrator running with nasal cannula looped over the concentrator. Observed Resident #1 to be sleeping with head slumped to side with a whole baby carrot noted in her mouth. The state surveyor revealed that the resident had not been repositioned since the 11:10 AM observation. LPN A made several attempts to move the resident or to wake her up. LPN A left the room to get nurse registered Nurse (RN) B into the room to assist with positioning. Then Registered Nurse (RN)/Infection Control Nurse I came into the room and assisted with resident repositioning. Once repositioned, the state surveyor noted the resident to have a wet brief. The three nurses rolled the resident side to side to change the brief, when there was a noted abrasion to the left hip/abdomen area that was open and had scabbed edges and was not bleeding. Record review of Resident #1's 'Bladder elimination' task 30-day look back, dated from 8/20/2024 through 9/17/2024, revealed documentation of 1 to 3 incontinence changes daily. Resident #4: Record review of Resident #4's Minimum Data Set (MDS), dated [DATE], revealed a cognitively intact with Brief Interview of Mental Status (BIMS) of 15 out of 15 indicating that the resident was cognitively intact. Section H: Bowel/Bladder- assessment always incontinent. Medical diagnosis included: medically complex condition, anemia, hypertension, deep vein thrombosis, gastroesophageal reflux disease, renal insufficiency, diabetes, thyroid disorder, arthritis, osteoporosis, dementia, anxiety, depression, psychotic disorder. Record review of Resident #4's 'Bladder elimination' task 30-day look back, dated from 8/20/2024 through 9/17/2024, revealed documentation of 1 to 3 incontinence changes daily. An interview on 09/17/2024 at 12:20 PM with Resident #4, who resided in the room next door to Resident #1 and was alert and oriented, revealed that some call lights wait times are up to 30-40 minutes, usually on 2nd shift. Resident #4 stated that she did wear a brief, because she cannot walk and needs help while in bed. Resident #4 stated that it takes a while to get staff into the room to change her. On 1st shift they change her before lunch, and they don't change her again until 4:00 PM at the end of the shift. The staff get upset if she has a bowel movement and staff have to change her and the bedding. Resident #4 stated that she could not help it. Staff get so upset, that its embarrassing for her.