STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235267	A. Building B. Wing	11/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Kingsford	1225 Woodward Avenue Kingsford, MI 49801

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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 - 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** 35103 This deficiency pertains to Intake #MI00147846. Based on interview and record review, the facility failed to timely obtain and process physician orders for respiratory assessment, treatment, and radiology diagnostics for one Resident (R1) of three residents reviewed for quality of care. This deficient practice resulted in harm when R1 was hospitalized related to severe respiratory distress and fluid volume overload. Findings include: All times documented are Eastern Standard Time (EST) unless otherwise noted. Review of R1's Minimum Data Set (MDS) Admission assessment, dated 10/15/24, revealed R1 was admitted to the facility on [DATE] with active diagnoses that included heart failure, renal insufficiency, diabetes mellitus, anxiety disorder, and encounter for surgical aftercare following surgery on the circulatory system. R1 was documented as having had a major surgical procedure in the 100 days prior to admission that required active care during the SNF (skilled nursing facility) stay. R1's noted admission weight was 141 pounds, and they were not documented as having received a diuretic (medication for removal of excess fluids) upon admission. R1 scored 14 of 15 on the Brief Interview for Mental Status (BIMS) assessment, reflective of intact cognition and R1 was their own responsible party for health care. R1 was able to make their needs known. During a telephone interview on 11/12/24 at 11:13 a.m., Complainant D said R1 was very cognitively intact. Complainant D stated, I know [R1] had been coughing and it (the cough) had continued to progress. They [Nurse Practitioner (NP) F] put in an order for the (chest x-ray), and it never got done. It was the weekend, and [NP F] had put [R1] on lasix (diuretic) for three days. [R1] continued to retain fluid, and they chalked it up to [R1's] congestive heart failure. Fluid retention had never been a part of that (R1's physical concerns) since the heart valve had been replaced. The following Monday, [R1] asked [NP F] about the x-ray . and [NP F] was surprised that it had not been done. [R1] asked about blood work, and the NP said they only do blood work if there is something unusual. I told [R1] the cough and the fluid retention were unusual. Overnight on Monday and Tuesday [R1] got pretty sick. They sent [them] to the ED (emergency department) because [their] O2 (oxygen saturation in the blood) was in the 80's . Complainant D said staff should have listened to R1's lung sounds, or the chest x-ray should have been performed prior to R1's significant decline in condition requiring hospitalization . Complainant D stated, [R1] was very close to dying. Review of R1's Progress Notes revealed the following documentation related to their 13- day stay in the facility, in part: (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Effective Date 10/9/24, Date of Service 10/10/24, Visit Type: Acute . CHIEF COMPLAINT: Admission . I saw the patient, (R1) who has no acute pain or distress. She is alert and oriented . We discussed the treatment plan and hopefully wean off the use of oxygen . Respiratory Negative: Respiratory distress . Authored by NP F. No weight was documented within this initial admission provider visit. Effective Date 10/11/24, Date of Service 10/11/24, Visit Type: Acute. No weight was documented. Effective Date: 10/12/24 04:07 a.m. [Central Standard Time (CST)]- Resident (R1) awoke and felt like [they were] choking causing [them] to experience a panic attack with high respiration and heart rate (108). SpO2 (measurement of the percentage of oxygen in your blood relative to its' maximum capacity) 92% with O2 continuous at 3 L(liters)/min (minute) via mask . Effective Date 10/15/24 23:00 (11:00 p.m. CST) - Date of Service: 10/16/24. Visit Type: Follow Up . [R1] says [they are] congested and has had phlegm that [they] cannot get rid of quickly . REVIEW OF SYSTEMS: . Respiratory Positive: Cough . PHYSICAL EXAM Findings: Respiratory Positive: Respiratory distress . Authored by NP F. Effective Date 10/17/24 23:00 (11:00 p.m. CST) - Date of Service 10/18/24. Visit Type: Follow Up . [R1] said [they] would like to know daily weight due to CHF (congestive heart failure). I will check her weight daily . Significantly diminished lung sounds on continuous oxygen, with CHF chest congestion. I will send her for x-rays of the chest for chest congestion . Respiratory Positive: Shortness of Breath (SOB) . Weight: 140.6 (this weight measured on 10/14/24) . PHYSICAL EXAM: Respiratory Positive: Respiratory distress . Authored by NP F. Effective Date: 10/20/24 23:00 (22:00 p.m. CST) - Date of Service 10/21/24, Visit Type: Follow Up . I saw the patient for a follow-up. [R1] complained of edema in [their] legs/feet. I advised [them] to elevate [their] legs in the chair. Also, use compression stockings for comfort . Chest X-ray for chest congestion is pending . PHYSICAL EXAM: Vital Signs Heart Rate 53 bpm (beats per minute) . Edema Positive: non-pitting, Edema in lower left extremities, Edema in lower right extremities, Respiratory Positive: Respiratory Distress . ASSESSMENTS and PLANS: Chronic Systolic (Congestive) heart failure: Check daily weight in the morning. Will give her Lasix 40 mg daily with K (Potassium)10 mEq (milliequivalents) daily . X-ray of chest for chest congestion pending . Authored by NP F. 10/22/24 10:43 a.m. CST - Resident (R1) very anxious this AM. Received PRN (as needed) alprazolam (anti-anxiety medication) with no relief . nothing effective at this time, oxygen saturation 70% on room air, oxygen mask applied on 3 L saturation brought up to 93%. Pulse 118, crackles throughout lungs, using accessory muscles to breathe. Notified provider and received telephone orders to send to ED for eval (evaluation)/treat (treatment) . Authored by RN/Wound Care Nurse H. 10/22/24 10:44 a.m. CST - Resident (R1) noted to be hypoxic 78% on 2-liter N/C (nasal cannula). Lung sounds rhonchi and crackle throughout. Resident placed on 4 liters per simple mask. MD (Doctor of Medicine) updated will send to ED for CXRAY (chest X-ray) and eval (evaluate) . Authored by RN/ADON (Assistant Director of Nursing) G. 10/22/24 11:18 a.m. CST - Resident exited the facility via ambulance. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	10/22/24 23:21 (11:21 p.m.) CST - Resident was admitted to the . hospital for, respiratory distress, fluid volume overload, and Covid. Resident is being treated with Bi pap (non-invasive breathing machine used by individuals who find it hard to breathe.) and bumetanide (diuretic medication) . No weights were documented in the Weight Summary documentation between 10/14/24 and 10/21/24. Review of R1's October 2024 EMAR (electronic medication administration record) and ETAR (electronic treatment administration record) on 11/12/24 at 12:03 p.m., revealed no physician orders for daily weights, supplemental oxygen therapy, or a chest x-ray for R1. Review of a handwritten Telephone Order dated 10/21/24, on 11/12/24 at approximately 1:05 p.m., revealed the following physician order: X-ray of chest for clarification: 2 views for DX (diagnosis) R09.89 (Other specified symptoms and signs involving the circulatory and respiratory systems). Physician/Prescriber was NP F. The physician order was signed by RN (Nurse Manager) I. This handwritten telephone order prepared by RN I was never added onto R1's ETAR, leaving nursing staff and appointment/transportation scheduling staff unaware of any physician order for the chest x-ray ordered for R1. Review of the Radiology and Diagnostic Services Policy & Procedure, issued 9/7/2023, revealed the following, in part: The facility will obtain radiology and other diagnostic services to meet the needs of its' residents . Review of R1's Weight Summary on 1/12/24 at 1:20 p.m., documented weights taken during their entire 13-day stay (from 10/9/24 through 10/22/24) in the facility included weights on the following dates: 10/13/24, 10/14/24, and 10/21/24. No weights were documented on the Certified Nurse Aide (CNA) Task - Weights in the EMR between 10/14/24 and 10/21/24. R1 was prescribed [furosemide] (diuretic medication) 40 mg, BID (twice daily) with a Start Date of 10/16/24, for three days for CHF. No weights were documented during this time period to show efficacy of the treatment. Review of R1's October 2024 EMAR and ETAR on 1/12/24 at approximately 1:25 p.m., revealed the following physician orders and associated documentation of completion/administration, in part: Daily weight every day shift. Start Date: 10/20/24 0600, D/C (discontinue) date 10/23/24 10:29. Documented as completed on 10/20/24, and absent nursing initials on the ETAR on 10/21/24 and 10/22/24. R1 had requested the performance of daily weight as documented with NP F on the 10/17/24 (Effective Date) Provider Visit Note. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During an interview on 11/12/24 at 1:35 p.m., Confidential Staff A was asked to review R1's EMR and provide the location of a physician order for a chest x-ray for R1. Staff A said there was not a physician order for a chest x-ray in R1's EMR. Staff A stated, It (physician order for R1's chest x-ray) was not in the EMAR (or ETAR), and added that specifications related to a chest x-ray for R1 were also not present. Staff A stated, There was a miscommunication . As far as I can see it, we never put it (chest x-ray order) in the EMAR, and it was marked 'No further documentation needed', so no action was needed by the nurse. When asked about R1's decreased heart rate of 53 on 10/20/24 at 4:50 a.m., Staff A stated, Heart rate at 53 should have been a send to the ED right there. She was compensating . I think they (facility staff) waited too long .If it (physician order for R1's chest x-ray) had gotten on the EMAR the nurse would have been responsible (to ensure it was performed), and the scheduler would have set it up for the van and the driver . It should have been on the ETAR. How does a nurse know if it is not in there? It doesn't come up automatically . It is just a quick run to the hospital. We did not have a mobile x-ray unit at that time, (but) .[R1] would have been able to go out (for the x-ray). When asked about daily weights for a resident with a CHF diagnosis, Staff A stated, There should have been daily weights X (times) 3 (days) upon admission. Staff A reviewed R1's EMAR and said daily weights (per physician order) started on the 20th . (They) should have listened to [R1's] lungs every shift. On 11/12/24 at 2:23 p.m., the Nursing Home Administrator (NHA) and Director of Nursing (DON) were interviewed. The DON was asked for evidence of a physician order for a chest x-ray as specified in NP F's Provider Visit Notes dated 10/17/24 and 10/21/24. The DON reviewed R1's EMR and said there was no physician order present in R1's EMAR or ETAR. The DON noted a telephone order was written and noted on 10/21/24 but acknowledged the physician order was never placed in R1's ETAR for nursing and scheduling staff to complete. When asked about the lack of routine lung sound assessments for R1, the DON stated, I definitely would have listened to her lungs if she was having issues. During an interview on 11/12/24 at 3:35 p.m., Therapy Staff B said [they were] concerned about R1's respiratory status and had documented respiratory concerns in therapy notes and on the Eagle Daily Interdisciplinary Room Report. Therapy Staff B confirmed they had discussed the possibility of a chest x-ray with R1, validating R1's similar report to this Surveyor. On 11/12/24 at approximately 3:40 p.m., review of the Daily Interdisciplinary Room Report revealed the following line item, dated 10/17/24: [R1's Name] - Just wondering if pt (patient R1) should get chest x-ray. Aware [they are] going on mucinex, but [they] got SOB (shortness of breath) all the time. Spitting up thick secretions w (with)/bloody tint. Worried there's something more happening. On 11/12/24 at approximately 3:45 p.m., review of . Therapy Treatment Encounter Note (s) provided by Staff B included the following regarding R1, in part: 10/15/24 signed 12:59 p.m. (CST); .baseline breathing is clavicular. Breaths are extremely shallow and weak . 10/16/24 signed 12:56 p.m. (CST): . Pt (patient) was already exhibiting SOB and short shallow breathing that would lead to hyperventilating. 10/18/24 signed 1:28 p.m. (CST): .Intervention also being provided atom (sic) improved expiratory strength needed for ability (to) create a productive cough to clear airway of secretions. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	10/22/24 signed 1:24 p.m. (CST): .Clinical (staff) found patient R1) in distress. Slumped down in bed. Hyperventilating. [Therapy Staff B] gained assistance to prop [R1] up. [Took their] O2, (saturation level) it was at 70% on 3 L. Notified RN immediately. Retrieved a face mask. Instructed [R1] in slow and controlled breathing. Pt tried to be comply (sic) but could not regain control. O2 (saturation) raised to 86% but no higher. Staff B waiting for response from nursing. Had to seek out admin (administrative) nursing staff during morning meeting to get attention. [When] proper staff was retrieved, [Staff B] removed self from situation. Response to TX (treatment): Decline in general health and well-being. Required hospitalization . Review of R1's Care Plans revealed the following, in part: FOCUS: Altered cardiovascular status r/t (related to) CHF, mitral valve insufficiency, CAD (coronary artery disease), aortic stenosis, HLD (high density lipoprotein), ischemic cardiomyopathy (heart muscle that can't pump well because of damage from a lack of blood supply to the muscle), murmur, a-fib (atrial fibrillation), hx (history) of MI [myocardial infarction (heart attack)] and recent cardiac surgery, Date Initiated: 10/14/24, Created by RN (Nurse Manager) I. A GOAL of The resident will be free from s/sx of complications of cardiac problems through the review date, was initiated on 10/14/22, however all Interventions/Tasks including the following, in part, were initiated on 10/22/24 (date of transfer to ED/Hospital). Monitor/report to MD changes in lung sounds on auscultation (i.e. crackles), edema and changes in weight . Monitor/report to MD s/sx (signs/symptoms) of CAD: chest pain or pressure especially with activity, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema . and Obtain vital signs and notify physician as needed. Focus: The resident has altered respiratory status/Difficulty Breathing r/t decreased oxygenation d/t cardiac insufficiency, OSA (obstructive sleep apnea), Date Initiated: 10/14/24. Created by RN (Nurse Manager) I. Goal: The resident will have no complications related to SOB. Date Initiated: 10/14/24 by RN (Nurse Manager) I. All of the following interventions were initiated and created by RN C on 10/22/24; date of R1's transfer to ED/Hospital: Evaluate lung sounds and vital signs . Monitor changes in orientation, increased restlessness, anxiety, and air hunger. Monitor for s/sx of respiratory distress and report to MD PRN: Increased Respirations, Decreased Pulse oximetry; Increased heart rate (Tachycardia); Restlessness; . Hemoptysis (bloody sputum); Cough; Pleuritic pain; Accessory muscle usage . Monitor/report abnormal breathing patterns to MD: increased rate, decreased rate, periods of apnea (absence of breathing), prolonged inhalation, prolonged exhalation, prolonged shallow breathing prolonged deep breathing, use of accessory muscles, pursed-lip breathing, nasal flaring. O2 at 3 Liters via nasal cannula or mask. (Lack of physician order for intervention) (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Obtain labs as ordered. Position resident with proper body alignment for optimal breathing pattern. Review of R1's Pulse Summary report on 11/12/24 at 1:21 p.m., revealed the following heart rates outside of the normal range (60-100 beats per minute [bpm]): 10/10/24 21:18 (9:18 p.m.) CST - 46 bpm. 10/11/24 00:53 (12:53 a.m.) CST - 5 bpm. (Sic) 10/11/24 02:58 (2:58 a.m.) CST - 50 bpm. 10/11/24 10:24 a.m. CST - 106 bpm. 10/11/24 12:30 p.m. CST - 106 bpm. 10/11/24 20:50 p.m. CST - 102 bpm. 10/12/24 01:15 (1:15 a.m.) CST - 102 bpm. 10/12/24 13:39 (1:39 p.m.) CST - 101 bpm. 10/12/24 19:36 (7:36 p.m.) CST - 108 bpm. 10/13/24 12:43 p.m. CST - 105 bpm. 10/20/24 04:50 (4:50 a.m.) CST - 53 bpm. 10/20/24 21:59 (9:59 p.m.) CST - 58 bpm. 10/22/24 10:54 a.m. CST - 118 bpm. Review of the Radiology and Diagnostic Services Policy & Procedure, issued 9/7/2023, revealed the following, in part: The facility will obtain radiology and other diagnostic services to meet the needs of its' residents . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	During a telephone interview with R1 on 11/12/24 at 3:05 p.m., R1 was asked to describe their stay in the facility. R1 stated, I was not happy while I was there at all . One of the OT (Occupational Therapy) people had first suggested a chest x-ray. She said it would be a good idea to get a chest x-ray because of the cough and things that were going on (with my lungs). [Therapy Staff B)]was going to relay it (concern for need for x-ray) to someone else. I spoke to [NP F] a couple of times, and it (chest x-ray) was never taken care of. It was close to a week later when I talked to [NP F] who said, 'Hasn't it been taken care of yet.' At that time my pneumonia was starting .My clothes were not fitting me. I believe I started swelling up, and it didn't register (with me then) . (The 22nd) I had been having some panic/anxiety attacks. When I woke up that morning, I felt like I could not breathe. I thought it was a panic attack, but it just wouldn't go away . I had called for a xanax, and it was over an hour before the nurse finally came, and by that time I was in a full-blown attack. That is when she (the nurse) called the ambulance, and they rushed me to the hospital. Once I got to the hospital, they were very concerned. I could not breathe. The doctor told me that you really couldn't breathe (because my lungs were filled with fluid) . I know he was very concerned because he questioned me about resuscitation and what my wishes were. That was really scary . I had filled up completely with fluid and the pneumonia and COVID set in .If they would have done the x-ray when the first OT person suggested it, I think they would have caught the lung issues . During the Exit Conference on 11/12/24 at approximately 4:45 p.m., the NHA and DON acknowledged R1's EMR documentation revealed NP F had not completed a physician order, prior to 10/20/24 for daily weights although R1's request for daily weights was noted within the 10/17/24 (effective date) provider progress note. The NHA and DON confirmed NP F did not complete a physician order for a chest x-ray for R1, prior to 10/20/24, and no order (including the 10/20/24 order) was ever added to the ETAR for completion to evaluate R1's worsening chest congestion and potential fluid volume overload based on R1's progression of symptoms.