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	01/02/2025

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

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 0684 Level of Harm - Minimal harm or potential for 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** 41978 This citation pertains to intake MI00149149. Based on observation, interview, and record review, the facility failed to ensure appropriate and consistent assessment of a penile tear for one Resident (#2) of three residents reviewed for wound care, resulting in the potential for unidentified worsening of the wound and delay in treatment. Findings include: All times recorded in Eastern Standard Time (EST), unless otherwise noted. Review of the Minimum Data Set (MDS) assessment, dated 11/7/2024, revealed R2 was admitted to the facility on [DATE] and had diagnoses including obstructive uropathy, benign prostatic hyperplasia (enlargement), and dementia. Further review of the MDS assessment revealed R2 required substantial/maximal assist (helper does more than half the effort) for toileting hygiene and was dependent (helper does all the effort) for showering and bathing. R2 scored eight out of 15 on the Brief Interview for Mental Status (BIMS), indicating he had moderate cognitive impairment. Review of R2's Skin - Total Body Eval (evaluation), dated 12/31/2024, revealed R2 was evaluated as having no skin abnormalities. Review of R2's physician orders revealed the following: Lidocaine external cream 3% [topical anesthetic]. Apply to penis topically every 8 hours as needed for pain. Start date: 10/31/2024, 0830 [8:30 a.m. Central Savings Time, CST]. During an interview on 1/2/2024 at 12:29 p.m., Licensed Practical Nurse (LPN) D reported R2 was prescribed topical lidocaine as needed for pain related to a slit on the head of his penis caused by chronic use of an indwelling, urinary catheter. LPN D was asked how often assessments of the wound were documented, to which she stated she was unsure because the facility wound care nurse completed all wound evaluations. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/2/2024 at 2:06 p.m., the Director of Nursing (DON) reported the facility wound care nurse was not available. At the time of the interview, the DON was asked to provide all wound care evaluations related to R2's penile wound. At 2:30 p.m., the DON reported she was unable to find documentation of wound evaluations for R2's penile tear. The DON stated all wounds should be evaluated routinely to track the progression of healing or to identify worsening and the need to alter treatment. An observation on 1/2/2024 at 2:45 p.m., revealed LPN D preparing R2 for application of the topical lidocaine cream. R2 was observed to have indwelling catheter tubing leading from his penis to a catheter securing strap attached to his right upper thigh. Further observation revealed R2 had a penile tear through the dorsal aspect of the glans (head of penis). The tear appeared to extend through the entire glans, stopping at the shaft of the penis. At the time of the observation, R2 reported pain at the wound site and was observed to be wincing during LPN D's application of the lidocaine cream. Review of the electronic medical record (EMR) revealed R2's wound was first documented on 8/15/2024 in a Telephone Contact Summary, dated 8/15/2024. Review of the Summary revealed the following: 8/15/2024, 11:33 a.m. [CST]. Fax received from [Facility] . Does have pain to penis. Noted with some redness plus slight brown discharge . 8/15/2024, 3:14 [CST]. Call back from [Registered Nurse, RN G] who went to assess resident. [R2] has a 1.5 cm [centimeter] slit of the penis glans . Further review of R2's EMR for the period of 8/1/2024 through 12/30/2024, including progress notes, provider notes, evaluations, assessments, point of care documentation and miscellaneous documents was conducted on 12/30/2024 at 2:19 p.m. It was noted the EMR did not contain any weekly evaluations of R2's penile wound to include measurements, wound description or signs and symptoms of infection such as peri (tissue surrounding wound)-wound conditions or presence of exudate. Review of the facility policy titled, Skin and Wound Guidelines, revised 3/20/2024, revealed the following: Skin alterations . are evaluated and documented by the licensed nurse: Weekly evaluation of the skin alteration in the resident's medical record by the wound team or licensed nurse per state and federal regulations . Treatment options are selected based upon the type of wound, tissue type, exudate, condition of the peri-wound, pain, the need for protection of the wound bed, the goal of treatment .

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F 0686 Level of Harm - Minimal harm or potential for 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** 41978 This citation pertains to intake MI00148886. Based on interview and record review, the facility failed to ensure consistent skin and risk assessments were completed according to professional standards of practice and facility policy, for one Resident (#7) at risk for pressure injuries of three resident reviewed, resulting in the potential for unidentified wounds and delay in treatment. Findings include: All times recorded in Eastern Standard Time (EST), unless otherwise noted. Resident #7 (R7) Review of the Minimum Data Set (MDS) assessment, dated 12/19/2024, revealed R7 was admitted to the facility on [DATE] and had diagnoses including Parkinson's Disease. Further review of the MDS assessment revealed R7 was at risk for the development of pressure injuries and required substantial/maximal assistance (helper does more than half of effort) for rolling left to right, sitting to lying and lying to sitting. R7 was dependent (helper does all the effort) for all transfers and had severe cognitive impairment. Review of R7's electronic medical record (EMR) revealed a Skin & Wound Evaluation, dated 12/26/2024 at 1:34 p.m. Central Standard Time (CST). Further review of the evaluation revealed R7 was evaluated as having a Stage 3 (full-thickness tissue loss) sacral pressure injury. The evaluation revealed the injury was new and in-house acquired, measuring 1.5 centimeters (cm) long by 1.1 cm wide. Review of R7's Braden Scale for Predicting Pressure Sore Risk, dated 12/26/2024 at 5:10 p.m. CST, revealed R7 was evaluated as being at high risk for developing pressure injuries. It was noted in review of the EMR for the period of 8/1/2024 through the date of the survey on 1/2/2025, there were no other documented assessment tools used to evaluate R7's risk for pressure injuries prior to 12/26/2024. Further review of R7's EMR for the period 8/1/2024 through 12/26/2024, prior to the identification of the sacral pressure injury, revealed the following order: Skin assessment weekly every evening shift, every Mon [Monday] for [monitoring]. Start date 6/10/2024, 1400 [2:00 p.m. Central Daylight Time, CDT]. D/C [discontinue] date 1.01.2025 1239 [12:39 p.m. Central Standard Time]. Review of R7's EMR revealed no documented skin assessments from 12/09/2024 through the date of the Skin & Wound Evaluation dated 12/26/2024. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 1/2/2025 at 3:04 p.m., the Director of Nursing (DON) was asked to provide all skin assessments for R7 for 12/9/2024 through 12/26/2024. At 3:55 p.m., the DON reported the nurse signed off on the skin evaluation for 12/15/2024 as completed on the Treatment Administration Record (TAR) but no evaluation was documented in the EMR. The DON reported there was a risk of unidentified skin issues, worsening of wounds and miscommunication of resident's needs when evaluations were not appropriately documented for residents at risk of developing pressure injuries. The DON confirmed all skin evaluations should be fully documented. Review of Section M - Skin Conditions for the MDS assessment dated , 10/4/2024, provided by the DON, revealed R7 was marked as at risk for developing pressure injures. It was noted the question included with the assessment Formal assessment instrument/tool (e.g. Braden, [NAME], or other) was marked No. Review of the facility policy titled, Skin and Wound Guidelines, issued 3/5/2024, revealed the following: Skin alterations and pressure injuries are evaluation and documented by the licensed nurse: . Using the Braden Scale for Predicting Pressure Sore Risk UDA [User-Defined Assessment], weekly x 3 after admission for a total of 4 weekly evaluations, then quarterly . Body audits are completed: By the licensed nurse routinely and documented in the resident's electronic medical record.

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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** 49310 This deficiency pertains to intake MI00148886. All times are in Eastern Daylight Time (EDT) unless otherwise noted. Based on observation, interview, and record review, the facility failed to ensure a urinary catheter securement device was utilized, proper placement of a urinary collection bag, and timely drainage of urine from a urinary catheter collection bag for two Residents (R2 and R4) of three residents reviewed for catheters. Findings include: Resident #4 (R4) On 1/2/25 at 11:25 a.m., R4 was observed with a urinary catheter collection bag touching the floor next to his bed without a barrier beneath it. R4 said he had a catheter due to difficulty urinating and was scheduled to see the urologist. R4 was asked if they had a securement device to prevent pulling on the catheter. R4 said no securement device was in place. Certified Nurse Aide (CNA) A entered R4's room and was asked if R4 ever had a securement device for the urinary catheter tubing. CNA A said R4 had a securement device in place. CNA A picked up the urine collection bag and placed it on R4's bed. CNA A and R4 pulled back the blanket covering for R4. There was no securement device present to prevent potential dislodgement of the catheter or to prevent trauma and damage to the urethra. CNA A said, He ain't got one. CNA A picked up the urine collection bag from the bed and placed it on the floor after replacing the blanket over R4. CNA A was asked where the urine collection bag should be positioned. CNA A responded, It hooks onto the bed, it must have fell off. CNA A picked up the collection bag and hooked the bag onto the bottom frame of the bed, but the bag continued to touch the floor. R4's care plan included the intervention: Anchor catheter to prevent tugging or tension on the catheter. The Director of Nursing (DON) was interviewed on 1/2/25 at 1:58 p.m. The DON said the facility utilized adhesive securement devices for urinary catheter tubing. The DON said, Our nurses should be monitoring the securement devices .drainage bags shouldn't be touching the floor because of the risk for infection. The policy Catheter Use Overview dated as issued 8/24/23 read, in part: .the facility will provide appropriate care for the catheter in accordance with current professional standards of practice .care practices include . Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodging the catheter . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Centers for Disease Control (CDC) Guideline for Prevention of Catheter-Associated Urinary Tract Infections (https://www.cdc.gov/infection-control/hcp/cauti/index.html) read, in part: .Properly secure indwelling catheters after insertion to prevent movement and urethral traction .Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor . 41978 Resident #2 (R2) Review of the Minimum Data Set (MDS) assessment, dated 11/7/2024, revealed R2 was admitted to the facility on [DATE] and had diagnoses including obstructive uropathy, benign prostatic hyperplasia (enlargement), and dementia. Further review of the MDS assessment revealed R2 had an indwelling, urinary catheter, required substantial/maximal assist (helper does more than half the effort) for toileting hygiene and was dependent (helper does all the effort) for showering and bathing. R2 scored eight out of 15 on the Brief Interview for Mental Status (BIMS), indicating he had moderate cognitive impairment. An observation on 12/30/2024 at 2:31 p.m., revealed R2 lying with his right leg positioned slightly over the right side of his bed. Further observation revealed a urinary drainage leg bag secured to R2's right lower leg. The 1,000 milliliter (mL) capacity drainage bag was observed to be taut, and completely full of urine, with urine visible in the catheter tubing leading up R2's right leg until no longer visible under the right leg of his pants. An observation on 1/2/2025 at 11:17 a.m., revealed Certified Nursing Assistant (CNA) E preparing to empty R2's urinary catheter bag. CNA E pushed R2's right pant leg up toward his knee revealing a urinary drainage leg bag attached to R2's right lower leg. The drainage bag was completely full of urine and urine was observed in the tubing leading from the bag up R2's right leg toward the Resident. Inspection of the bag with CNA E revealed the urinary drainage bag had a capacity of 1,000 mL. CNA E emptied the urine from the bag into a graduated cylinder with a 1,200 mL capacity. Upon emptying the drainage bag, the graduated cylinder was observed to contain more than 1,100 mL of urine. When asked how much urine was emptied from the drainage bag, CNA E reported the graduated cylinder was completely full. During an interview on 1/2/2025 at 12:29 p.m., Licensed Practical Nurse (LPN) D reported R2's urinary drainage leg bag held one-half of what a general dependent drainage bag holds, and therefore it needed to be emptied more frequently. LPN D stated R2 was not appropriate for the general type of drainage bag as the Resident often removes his catheter anchor device and is known to drag the drainage bag on the ground behind him when he walks. LPN D was alerted to the observations of R2's drainage bag at full capacity to which she acknowledged the concerns of the weight of the urine pulling on the catheter anchor and the potential for infection and discomfort related to urine not being able to drain completely from R2's bladder due to the full bag and tubing. Review of the facility policy titled, Catheter Care, issued 8/24/2023, revealed the following: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care . General Guidelines: . Empty drainage bag when it is half to three-fourths full and as needed .