

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235267	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/21/2025
NAME OF PROVIDER OR SUPPLIER Optalis Health and Rehabilitation of Kingsford		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49397</p> <p>Intake #MI00149612</p> <p>Based on interview and record review the facility failed to ensure the accuracy and confidentiality of resident records for one Resident (#9) of two residents reviewed for confidentiality of medical records, resulting in the release of incorrect resident information accompanying a deceased resident's remains to the funeral home.</p> <p>All times are in Eastern Standard Time.</p> <p>Findings include:</p> <p>Resident #6 (R6)/Resident #9 (R9)</p> <p>On [DATE], the facility transferred the body of R6 to the funeral home of choice with documentation that incorrectly identified the deceased as R9. The records sent included R9's face sheet with full name, date of birth, and medical history.</p> <p>Review of the Electronic Medical Record (EMR) for R6 and R9 revealed they were located in rooms on different hallways within the facility and their names did not begin with similar letters or sound the same.</p> <p>A phone interview on [DATE], at 3:49 PM, with Funeral Home Representative I revealed the the error was identified Representative I contacted the facility to clarify discrepancies in the records provided by the facility, to the funeral home's information for who they were instructed to pick-up. Staff at the funeral home noted that the information provided did not coincide with R6, who the facility had instructed to pick-up and take to the funeral home. Representative I stated they did not know why the facility provided the incorrect face sheet, but stated it was the middle of the night and wondered if that was the cause.</p> <p>On [DATE] at 4:00 PM, while conducting an interview with Unit Manger/Registered Nurse D (RN D), RN D stated that it was the primary nurse's responsibility to print off the information to go with the resident to the funeral home.</p> <p>(continued on next page)</p>

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with Licensed Practical Nurse (LPN) A on [DATE] at 4:30 PM, revealed that the mistake occurred due to a failure to verify the identity of the deceased and cross-check documentation before releasing the body. LPN A stated, there were two of us that printed the paperwork to go with R6 to the funeral home. LPN A could not verify who double-checked the paperwork.</p>		