

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 03/26/2025
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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981</p> <p>This citation pertains to Intakes: MI00151324, MI00151372.</p> <p>Based on observation, interview, and record review the facility failed to provide necessary care to assist two Residents (#3 & #4) of five residents reviewed for activities of daily living (ADLs)care. This deficient practice resulted in residents who appeared unkept, disheveled, and being left wet and soiled for extended periods of time and potential for embarrassment and humiliation based on the reasonable person concept</p> <p>Findings include:</p> <p>Resident #3 (R3)</p> <p>Review of an Admission Record revealed R3, was originally admitted to the facility on [DATE] with pertinent diagnoses which included: hemiplegia-stroke affecting the left side.</p> <p>Review of a Minimum Data Set (MDS) assessment for R3, with a reference date of 3/6/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15, indicating cognition was intact.</p> <p>Review of R3's Care Plan revealed: Focus: (R3) has an (Activity of Daily Living) ADL self-care performance deficit related to: historical stroke .impaired mobility. Date Initiated: 12/10/2024. The resident had a cerebral vascular accident (CVA/Stroke) and has a diagnosis of vascular dementia affecting movement . Further review of R3's care plan and progress notes did not reveal a history of refusing ADL care.</p> <p>Review of R3's Kardex (Certified Nurse Aide [CNA] Care Guide) revealed: PERSONAL HYGIENE/ORAL CARE: 1 person assist. BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary .</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 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an observation/interview on 3/25/25 at 4:10 PM., R3 reported the staff at the facility is very short handed. R3 reported the shortage is bad on 2nd shift and weekends. R3 reported he has waited over an hour to get help to get up and out of bed, his catheter has not been emptied to the point it has leaked and left him wet and soiled. R3 reported many of the staff are agency and those staff will either not show up or call in and cancel their shift minutes before they are supposed to be at the facility. R3 reported the staff that pick up, stay over and work at the facility who are employed by the facility are very nice, and apologetic, but their hands are tied, and they have to cut corners. R3 reported he feels bad when this happens to other residents who cannot speak up about the issue or do anything for themselves. R3 reported he has no use of his left side of his body, so he needs assistance with showering, getting in and out of bed, and some help with brushing his dentures. R3 reported it has been 3 days since his dentures were brushed good and soaked overnight as they should be. R3 reported he often sees other residents who are put up in their wheelchairs placed in front of the nurse's station and left there all day, except for meals. R3 reports many of them do not get any attention, nor do they get cleaned up properly after meals and he notices their faces which at times still would have food dried and stuck on. R3 reported he does not always get his 2 showers a week, and sometimes he refuses his care so that other residents who cannot speak up get the time slot to be showered and assisted. R3 reports some of the agency staff will not help him with his dentures at all and will say you can do it yourself. R3 reported he can do some things himself, but with the use of only one arm/hand (right side) it is very difficult to clean his dentures thoroughly. It was noted R3's fingernails needed to be trimmed and cleaned; R3's left-hand fingernails were visibly soiled. R3 reported he cannot trim his own fingernails or lift his left arm to wash his hands in the sink. R4 reported he has mentioned many of these issues in Resident Council at the monthly meetings, but it does not seem to make anything better.</p> <p>Resident #4 (R4)</p> <p>Review of an Admission Record revealed R4 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: dementia.</p> <p>Review of a MDS assessment for R4, with a reference date of 1/20/25 revealed a BIMS score of 9/15, indicating moderate cognitive impairment.</p> <p>Review of R4's Care Plans revealed: Focus: (R4) ALTERATION IN ELIMINATION r/t: decreased mobility/risk for constipation, diuretic use, incontinence . Date Initiated: 09/13/2024 .(R4) has an ADL self-care performance deficit related to: left hemiplegia post (stroke) Date Initiated: 09/13/2024 .INTERVENTIONS: TOILET USE: 2 persons assist Date Initiated: 09/13/2024 . Further review of R4's care plan and progress notes did not reveal a history of refusing ADL care.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 3/26/25 at 2:35 PM., Registered Nurse (RN) B reported R4 needs assistance to get in and out of bed, take showers, perform oral care and provide overall daily grooming (ADLs). RN B reported R4 often reports to staff that he has not been helped, and residents are not getting their shower. RN B stated, this morning, staff member (CNA J) reported (R3) was heard crying out for help when walking into the facility to punch in (6:00 AM). RN B stated CNA J checked on R3 and found she was left wet and soiled. RN B stated they went with CNA J to assess R3, and when they entered R3's room, she was completely soaked from her upper thighs to the upper mid back. RN B stated, R3's bedding was wet and smelled of urine and her clothing appeared to be the clothing she had on the day before. RN B stated, they instructed CNA J to inform the unit manager. RN B stated, CNA J immediately cleaned R3 up and changed her linens. RN B stated, R3 was visibly upset when he entered the room, she appeared cold, and was crying that no one came for a long time. RN B stated, this occurs because the night staff will not stay over and do walking rounds with oncoming day staff.</p> <p>On 3/26/25 at 4:30 PM, R4 was observed in her bed asleep with the bedside table out of reach where a styrofoam cup with clear liquid was located. R4's lips appeared red, chapped, and peeling.</p> <p>On 3/27/25 at 9:38 AM., an observation and interview revealed R4 was in her wheelchair self-propelling her way downstairs via the elevator to go to the therapy gym. R4 was noted to have food particles on her shirt and her hair was not brushed. R4's lips were observed dry, red and chapped. R4 was observed with what appeared to be dried crusted substances around her mouth. R4's overall appearance was disheveled. R4's hands were visibly soiled on her fingers, and her fingernails were chipped, broken off and were different lengths. R4's fingernail tips were observed with heavy buildup of grime/dark substances. R4 reported the staff do not always help her clean up so well, and indicated it was difficult for her to brush her own hair and teeth, among other things independently because she had a stroke.</p> <p>On 3/27/25 at 11:52 PM., Physical Therapist (PT) H was interviewed and reported the facility has been short staffed and at times. PT H stated residents do complain the call lights take too long to get answered. PT H reported the staff at the facility are very nice, and work very hard, but the agency staff that are supposed to be filling in the shifts either don't show up, or they call in at the last minute. PT H stated her PT aide has mentioned issues with some residents who are not getting their oral care twice daily as they should be, and/or overall hygiene was not being completed. PT H reported she was aware management has been 'working' on some things, but stated she does not know all the details because she does not go to every daily meeting. PT H reported R4 could do some things on her own, but her memory/cognitive status does not allow her to retain information or remember sequences. PT H reported, R4 has been on therapy and has not been progressing. PT H reported, the facility has a restorative program and should be completed by nurses and CNA staff. PT 'H reported, she gives the recommendation to help residents keep their function, knowing these residents are at risk for decreased Range of Motion (ROM) and overall decline if they are not assisted with ADL's.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/27/25 at 2:00 PM., CNA J was interviewed and reported when she arrived at the facility yesterday morning for her shift, she overheard R4 crying out. CNA J stated, she was not assigned to R4 but has worked with R4 for years. CNA J reported the cry sounded different and more concerning from what she normally sounded like. CNA J stated, she went into R4's room, and found her crying out that she was wet and cold. CNA J reported, she calmed R4 down and let her know she would be staying to help her get clean and warm. CNA J reported, at first she didn't think it was that bad. CNA J indicated R4's linens were found damp when she pulled back the covers to assist R4 with rolling over. CNA J reported, at that time, she got an immediately noticeable odor of urine, and realized that most of the linen was wet. CNA J stated some of the linen had noticable areas which were previously wet and had dried urine stained areas. CNA J reported, she knew R4 had been laying in her urine a while just by the smell of it and stated the urine has a much more pungent smell when its damp/drying. CNA J stated she informed RN B and then assisted R4 with getting cleaned up. CNA J stated she felt the staffing problems were why R4 was left wet. CNA J stated, either agency staff just don't show up, or they call and cancel last minute. CNA J reported a few weeks ago she came into a shift from 3:00 am- 2:00 pm., that she had picked up because the facility was short. CNA J reported when she arrived, about 9 out of 15 residents were wet and soiled on the west unit, which CNA J stated is a heavy unit. CNA J reported, almost all of the residents on the west unit are a 2 person assist. CNA J stated, overall, most of the residents in the facility needed 2 person assist for one aspect of their care or another. CNA J reported residents often don't get their 2 showers a week, and many times staff have to cut corners with items such as nail care and grooming. CNA J reported both nurses and CNA staffing are very short handed, and it directly affects the quality of care provided to the residents.</p> <p>Review of a facility Policy titled Activities of Daily Living (ADL) with a revision date of 12/7/2023 revealed: POLICY OVERVIEW: Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene. GUIDELINES: Residents will be provided with care, treatment, and services to ensure that their activities of daily living .Appropriate care and services will be provided for residents who are unable to carry out ADL independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, and oral care) Mobility (transfer and ambulation, including walking) Elimination (toileting) Dining (meals and snacks) Communicator (speech, language, and any functional communication systems) The amount of assistance the resident needs to complete their ADL care will be documented in the resident's care plan and on the resident's Kardex</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35981</p> <p>This citation pertains to intake(s): MI00151324, MI00151372</p> <p>Based on observation, interview and record review the facility failed to provide sufficient staffing to ensure resident needs were met timely for three Residents (#4, #5, & #3) of five residents reviewed for staffing concerns. This deficient practice resulted in Resident #4 being left wet and soiled for extended periods of time and unmet care needs including oral care, and grooming with the potential to affect all 75 residents.</p> <p>Findings include:</p> <p>Resident #4 (R4)</p> <p>On 3/26/25 at 2:35 PM., Registered Nurse (RN) B was interviewed and reported R4 needs assistance to get in and out of bed, take showers, perform oral care and to be provided overall daily grooming (ADLs). RN B reported Certified Nurse Aides (CNA's) are extremely short staffed. RN B reported many residents do not get their grooming daily. RN B reported there are a lot of agency staff that don't show up, call in and/or cut corners on care for residents. RN B reported there were several times in the mornings where CNA staff have reported residents have been left wet and soiled, and that their night cares have not been completed. RN B reported R4 often reports to staff that he has not been helped, and residents are not getting their showers. RN B stated, this morning, CNA J reported R3 was heard crying out for help when walking into the facility to punch in (6:00 AM). RN B stated CNA J checked on R3 and found she was left wet and soiled. RN B stated they went with CNA J to assess R3, and when they entered R3's room, she was completely soaked from her upper thighs to the upper mid back. RN B stated, R3's bedding was wet and smelled of urine and her clothing appeared to be the clothing she had on the day before. RN B stated, they instructed CNA J to inform the unit manager. RN B stated, CNA J immediately cleaned R3 up and changed her linens. RN B stated, R3 was visibly upset when he entered the room, she appeared cold, and was crying that no one came for a long time. RN B stated, this occurs because the night staff will not stay over and do walking rounds with oncoming day staff. RN B reported some of these staff are agency staff and they walk out the door as soon as the morning shift comes in.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/26/25 at 3:00 PM., Agency Staff LPN E was interviewed and reported she works 50-60 hours a week at the facility. LPN E reported the facility is very short staffed. LPN E reported the schedule is always changing and staff are constantly being reassigned to different units than previously assigned for the day. LPN E stated staff are often pulled in many directions, filling holes wherever needed, and staff have to cut corners and are forced to prioritize what must be done versus what can wait. LPN E stated, earlier today there was only 1 CNA until 10:00 am for her unit which is a heavy unit and reported it was impossible to give all these residents 100% good quality care when everyone is constantly rushing between getting residents up for meals, showered, and changed. LPN E reported documentation and other things that come up such as emergencies, falls, admissions, and discharges are not able to be kept up either. LPN E reported there were no consequence for the agency staff who cancel, or no call/no show and they are still allowed to pick up the next day as if nothing happened. When asked about care not being able to be consistently provided, LPN E stated, . absolutely residents are missing their showers, ADL care, restorative ROM, oral care and genuine quality care that is not rushed. LPN E reported the facility admission department keeps admitting residents with high needs, including residents who required 2-person assist and mechanical lift assistance which always take 2 staff. LPN E stated it is nearly impossible to keep up.</p> <p>On 3/27/25 at 8:15 AM., in the main dining room was observed with approximately 16 residents seated at tables. No drinks, utensil or coffee were observed on the tables. CNA F was observed preparing juice, water and other drinks on a counter but was not passing any of the drinks out to residents. There were multiple residents observed appearing disheveled. Family Member (FM) N was observed coming into the dining room and looking around the cabinets/cupboards. FM N was then observed proceeding to enter the east unit looking for staff and asking where the clothing protectors were. Aat 8:32 AM., FM N was observed returning to the dining room with a stack of clean clothing protectors, went to his (mother-unsampled resident) and placed a clothing protector on her, then began putting clothing protectors on other residents in the dining room. At 8:45 AM., residents were observed remaining seated at the tables with no drinks or meals yet, and several residents were observed looking around, with some talking to one another asking, what is taking so long. At 8:52 AM., a meal cart was observed delivered to the dining room, and staff began to pass the trays. No residents were observed having coffee prior to the meal trays being passed at approximately 9:01 AM.</p> <p>On 3/27/25 at 9:10 AM., FM N was interviewed and reported the facility is very short staffed. FM N stated he comes in daily to assist with his mother's breakfast and help feed her because she is dependent on staff for meal assistance. FM N reported the staff are very nice and do the best they can, but with being short some corners get cut. FM N reported being aware many agency staff do not show up, or they call in last minute which leaves the staff working short with facility staff having to stay over to help out. FM N reported at times he does see some residents in the dining room who appear to not have had grooming and care completed.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/27/25 at 9:17 AM., CNA F was interviewed and reported the facility is very short staffed, especially in regard to CNAs. CNA F stated a lot of resident care is not completed to the standard the residents deserve, as well as her not being able to provide what she would like to be able to give. CNA F reported the shifts are typically 6:00 AM-2:00 PM, 2:00 PM-10:00 PM, and 10:00 PM -6:00 PM, and stated there were some shifts that currently are all over the place, such as 2:00 AM-2:00 PM to attempt to cover gaps. CNA F acknowledged agency staff do call/cancel last minute, no show and regular staff have been taking some days off because they have picked up so much overtime they are feeling burned out. CNA F reported the west unit is the heaviest (majority of residents-approximately 30 require 2 staff assist for care). CNA F stated, about 2-3 weeks ago she was working the late-night shift 2:00 AM-2:00 PM., and CNA J came in to help at 3:00 AM. CNA F reported her and (CNA J) started to do their rounds, and they found 9 of 15 residents on the west unit that were completely soaked in urine, and a couple residents who had BM (Bowel Movements). CNA F stated it was very sad to see, and deal with. CNA F reported 2 of the residents had to be showered in the middle of the night because of how soiled they were. CNA F stated there were only 2 CNAs prior to them coming in for the entire facility because agency staff didn't show up. CNA F reported, the hardest part was that so many residents are 2 person assists, and without enough staff, they are always behind, which directly affects resident care.</p> <p>On 3/27/25 at 9:38 AM., an observation and interview revealed R4 in a wheelchair self-propelling downstairs via the elevator to go to the therapy gym. R4 was noted to have food particles on her shirt and her hair was not brushed. R4's lips were observed dry, red and chapped. R4 was observed with what appeared to be dried crusted substances around her mouth. R4's overall appearance was disheveled. R4's hands had visibly soiled fingers, and her fingernails were chipped, and some broken off with varied lengths. R4's fingernail tips were observed with heavy buildup of grime/dark substances and reported the staff do not always help her clean up so well. R4 stated, it was difficult for her to brush her own hair and teeth, among other things independently because she had a stroke.</p> <p>On 3/27/25 at 11:52 PM., Physical Therapist Technician (PTT) I reported R4 is often disheveled and at times smells of stale urine. PTT I stated R4 comes to the therapy gym often and will work out with little supervision. PTT I reported the facility was very short staffed and stated it most definitely affects the care of the residents.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/27/25 at 2:00 PM., CNA J was interviewed and reported when she arrived at the facility yesterday morning for her shift, she overheard R4 crying out. CNA J stated, she was not assigned to R4 but has worked with R4 for years. CNA J reported the cry sounded different and more concerning from what she normally sounded like. CNA J stated, she went into R4's room and found her crying out that she was wet and cold. CNA J reported, she calmed R4 down and let her know she would be staying to help her get clean and warm. CNA J reported, at first, she didn't think it was that bad. CNA J indicated R4's linens were found damp when she pulled back the covers to assist R4 with rolling over. CNA J reported, at that time, she got an immediately noticeable odor of urine and realized that most of the linen was wet. CNA J stated some of the linen had noticeable areas which were previously wet and had dried urine-stained areas. CNA J reported, she knew R4 had been laying in her urine a while just by the smell of it and stated, the urine has a much more pungent smell when its damp/drying. CNA J stated she informed RN B and then assisted R4 with getting cleaned up. CNA J stated she felt the staffing problems were why R4 was left wet. CNA J stated, either agency staff just don't show up, or they call and cancel last minute. CNA J reported a few weeks ago she came into a shift from 3:00 am- 2:00 pm., that she had picked up because the facility was short. CNA J reported when she arrived, about 9 out of 15 residents were wet and soiled on the west unit, which CNA J stated is a heavy unit. CNA J reported, almost all of the residents on the west unit are a 2 person assist. CNA J stated, overall, most of the residents in the facility needed 2-person assist for one aspect of their care or another. CNA J reported residents often don't get their 2 showers a week, and many times staff have to cut corners with items such as nail care and grooming. CNA J reported both nurses and CNA staffing are very short handed, and it directly affects the quality of care provided to the residents.</p> <p>Review of an Admission Record revealed R4 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: dementia.</p> <p>Review of a Minimum Data Set (MDS) assessment for R4, with a reference date of 1/20/25 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated R4 was cognitively intact.</p> <p>Review of R4's Care Plans revealed: Focus: (R4) ALTERATION IN ELIMINATION r/t: decreased mobility/risk for constipation, diuretic use, incontinence . Date Initiated: 09/13/2024 .(R4) has an ADL self-care performance deficit related to: left hemiplegia post (stroke) Date Initiated: 09/13/2024 .INTERVENTIONS: TOILET USE: 2 persons assist Date Initiated: 09/13/2024 . Further review of R4's care plan and progress notes did not reveal a history of refusing ADL care.</p> <p>Resident #5 (R5)</p> <p>Review of an Admission Record revealed R5 was originally admitted to the facility on [DATE] with diagnoses including aphasia/dysphasia (difficulty with speech and comprehension) following a CVA/Stroke.</p> <p>Review of a Minimum Data Set (MDS) assessment for R5, with a reference date of 2/26/25 revealed a BIMS score of 99/15, indicating cognition was severely impaired and unable to be assessed.</p> <p>Review of R5's Care Plan revealed: Focus: (R5) has an (Activity of Daily Living) ADL self-care performance deficit related to weakness, unsteady gait, previous CVA/Stroke, aphasia, urinary frequency . noted to drool frequently when up in wheelchair Date Initiated: 12/10/2024 . Further review of R3's care plan and progress notes did not reveal a history of refusing ADL care.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R5's Kardex (Certified Nurse Aide [CNA] Care Guide) revealed: Resident Care Clothing protector at all times when up in wheelchair. Change when soiled and as needed for dignity PERSONAL HYGIENE/ORAL CARE: 1 person assist . Eating/Nutrition: Monitor for choking, coughing, any food or fluid being pocketed in mouth s/p each meal. Pt should be 100% eyes on supervision. Use tactile cueing, as needed, to cease rapid rate of feeding. If cueing does not work (work [sic]), staff are encouraged to move food item away to help indicate need to: wait-swallow food/clear oral cavity.</p> <p>On 3/27/25 at 11:52 PM., PTT I was interview and reported she works with many of the residents residing in the facility on a regular basis. PTT I reported R5 was not getting his oral care completed, and indicated his mouth is very dry with saliva buildup. PTT I stated, when she cares for him, she notices his mouth is rarely clean and often has dried saliva and/or food left around his mouth and in his teeth.</p> <p>On 3/27/25 at 2:55 PM., R5 was observed near a nurse's station on the main unit. When R5 was asked to open his mouth, there was dried food observed around his lips and mouth. R5's teeth had observed buildup of plaque and/or food stuck in and around his teeth. R5's mouth also appeared dry, with an accumulation of dried white saliva in the corners of his mouth and had an overall appearance of being disheveled.</p> <p>Resident #3 (R3)</p> <p>Review of an Admission Record revealed R3 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: hemiplegia-stroke affecting the left side.</p> <p>Review of an MDS assessment for R3, with a reference date of 3/6/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15, indicating cognition was intact.</p> <p>Review of R3's Care Plan revealed: Focus: (R3) has an (Activity of Daily Living) ADL self-care performance deficit related to: historical stroke .impaired mobility Date Initiated: 12/10/2024. The resident had a cerebral vascular accident (CVA/Stroke) and has a diagnosis of vascular dementia affecting movement . Further review of R3's care plan and progress notes did not reveal a history of refusing ADL care.</p> <p>Review of R3's Kardex (Certified Nurse Aide [CNA] Care Guide) revealed: PERSONAL HYGIENE/ORAL CARE: 1 person assist. BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary .</p> <p>(continued on next page)</p>		

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 03/26/2025
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.			
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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/25/25 at 4:10 PM., R3 was observed/interviewed and reported the staff at the facility is very short handed. R3 reported the shortage is bad on 2nd shift and weekends. R3 reported he has waited over an hour to get help to get up and out of bed. R3 added that his catheter has not been emptied to the point it has leaked and left him wet and soiled. R3 reported many of the staff are agency and those staff will either not show up or call in and cancel their shift minutes before they are supposed to be at the facility. R3 reported the staff who are employed by the facility that pick up, stay over and work are very nice, and apologetic, but their hands are tied, and they have to cut corners. R3 reported he feels bad when this happens to other residents who cannot speak up about the issue or do anything for themselves. R3 reported he has no use of his left side of his body, so he needs assistance with showering, getting in and out of bed, and some help with brushing his dentures. R3 reported it has been 3 days since his dentures were brushed good and soaked overnight as they should be. R3 reported he often sees other residents who are put up in their wheelchairs placed in front of the nurse's station and left there all day, except for meals. R3 reports many of them do not get any attention, nor do they get cleaned up properly after meals and he notices their faces which at times still would have food dried and stuck on. R3 reported he does not always get his 2 showers a week, and sometimes he refuses his care so that other residents who cannot speak up get the time slot to be showed and assisted. R3 reports some of the agency staff will not help him with his dentures at all and will say you can do it yourself. R3 reported he can do some things himself, but with the use of only one arm/hand (right side) it is very difficult to clean his dentures thoroughly. It was noted R3's fingernails needed to be trimmed and cleaned; his left-hand fingernails were visibly soiled. R3 reported he cannot trim his own fingernails or lift his left arm to wash his hands in the sink. R3 reported he has mentioned many of these issues in Resident Council at the monthly meetings, but it does not seem to make anything better.</p> <p>On 3/25/25 at approximately 5:20 PM., concern and grievance forms from R4 were requested related to care not given, and/or the above-mentioned concerns. A request was also made for Resident Council meeting minutes for the past 90 days.</p> <p>Review of Resident Council Meeting Minutes (RCMM) from 1/6/25 -3/3/25 revealed:</p> <p>An RCMM form dated 1/6/25 had no account of how many residents attended and showed a Discussion of Old Business: Area identified for Improvement . (Resident-name omitted) was in lift 2 hours. Action/Resolution: Speak with DON DON will come to next meeting. (2/2025) Miscellaneous: snack cart not seen in 3 days on west hall . Discussion of New Business: Nursing . 1/6/25 Nursing: Staffing not doing the job they signed up for. Action/Resolution: Speak with DON. Further review of 1/6/25 RCMM revealed no management signatures on the form.</p> <p>RCMM dated 2/3/25-11 residents attended including R4. Discussion of New Business: Nursing. Discussion of New Business: Administration: CNA's not completing jobs say they will be back and don't come back. Nursing: recommendations: more workers . Is there anything you would like to resolve? west on night only 1 aide (CNA) why can't there be 2 (two). Further review of 1/6/25 RCMM revealed no management signatures on the form.</p> <p>RCMM dated 3/3/25-12 residents attended including R4. Discussion of Old Business: Area identified for Improvement .CNA's not completing jobs, saying they will be right back and don't come back Issue Resolution: Still an issue Issue Resolved? . NO .Discussion of New Business: Nursing. Why is there no training for travelers (agency staff). Why is there only 1 CNA on the floor. Hire more people . Further review of RCMM's dated 1/6/25 -3/3/25 revealed no management signatures on any of the forms.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/27/25 at 3:00 PM., the Director of Nursing (DON) was interviewed and reported there are open staffing positions on all shifts for both nurses and CNA's. The DON confirmed there has been some difficulty with some of the agency staffing who do not show up and cancel at the last minute. DON reported she was unsure exactly how many staffing positions the facility had open, but stated she would provide that information.</p> <p>Review of the requested information titled, Nurse-CNA Staff open positions dated 3/27/25 revealed: CNA's . 3 open (Full time) FT 6am-2pm, 1 open FT 6-2pm, 4 open FT 2pm-10pm, 2 open (Part time) PT 2pm-10pm, 2 open PT 10pm-6am, (Currently Open CNA positions being filled by (Staffing Agency name omitted) Agency.</p> <p>A review of the open facility Nursing staffing shifts needed dated 3/27/25 revealed: Nurses: 3 open FT 6am-2pm 2 open FT 2pm-10pm 1 open FT 10pm-6am 2 open PT 10pm-6am Nursing positions currently filled by (Facility Name Flex staff) Licensed Practical Nurse (LPN) 2 LPNs and agency nurses 2 RNs</p> <p>Review of a facility Policy titled Staffing with a date of 4/13/22 revealed: POLICY It is the policy of this facility to ensure appropriate staffing levels to meet resident needs at all times 2.0 Compliance Guidelines 1. All employees of the facility are responsible for Residents and required to report to work when scheduled and to remain at work until replaced by someone else. 2. Regular staffing call-in policy remains in effect unless otherwise indicated by the Administrator.</p> <p>3. There will be a designated staff member listed at the front desk who is responsible to always ensure appropriate staffing at all times.</p> <p>4. Designated staff member will ensure that there is staff appropriate to care for all residents in the facility.</p>		