

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 05/01/2025
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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103</p> <p>Based on observation, interview, and record review the facility failed to ensure medications were administered under nursing observation for one Resident (R6) of one resident reviewed for medication administration. This deficient practice resulted in the potential for delayed or non-administration of medications left unsupervised at bedside.</p> <p>Findings include:</p> <p>This deficiency pertains to Intake MI00152512.</p> <p>All times noted are Eastern Daylight Savings Time (EDST).</p> <p>Review of R6's Minimum Data Set (MDS) assessment, dated 1/16/25, revealed R6 was admitted to the facility on [DATE] with diagnoses that included: cancer, neurogenic bladder, anxiety disorder, depression, and unspecified mood disorder. R6 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition.</p> <p>During an interview/observation on 4/30/25 at 11:28 a.m., R6 was observed lying in bed with a plastic cup of red and orange gummies on the overbed table in front of them. Licensed Practical Nurse (LPN) A entered the room, per R6's request, and R6 told LPN A that she only had one red Vitamin D3 gummy in the cup, and yesterday she had three. R6 stated, I didn't want to eat them before I showed you. LPN A exited the room, with the cup, and returned with three red Vitamin D3 gummies in the cup. LPN A stayed in the room and said she needed to watch R6 eat the gummies. R6 stated, Why do you have to observe me? You have never observed me eat them before.</p> <p>During an interview on 4/30/25 at approximately 11:40 a.m., LPN A acknowledged R6 did not have a physician order for self-administration, and no Self-Administration of Medication Assessment was completed showing R6 had the capability and safety to administer their own medications.</p> <p>During an interview on 4/30/25 at 12:45 p.m., in the presence of the Nursing Home Administrator (NHA) and Assistant Director of Nursing (ADON)/Registered Nurse (RN) I, RN I reported LPN A had left R6's medications at the bedside without a physician order for self-administration of medication by R6. When asked if the self-administration of medication assessment and physician order had been implemented after this Surveyor's observation of R6's medications being left at the bedside, RN I confirmed the physician order and care plan had just been update today and no order or care plan intervention had been in place at the time of this Surveyor's observation on 4/30/25 at 11:38 a.m.</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 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R6s' Physician Order Summary, retrieved 5/1/25 at 11:53 CT (Central Time), revealed the following orders:</p> <ol style="list-style-type: none"> 1. Give one Vitamin B 3000 mg Gummy (Resident supplies), may hold if unavailable one time a day for supplement. Start Date: 3/11/20245 2. Start Date: 5/1/2025. Per Resident's request it is acceptable to leave her supplemental Gummies for her to take at her pace every shift. <p>Review of R6s' initial Medication Self-Administration Safety Screen, with a lock date of 4/30/25 at 16:48 (4:48 p.m. CT) revealed the following instructions: Complete this assessment prior to resident initiating self-administration of medication and with any medication order changes . Ongoing assessment should occur at a minimum or quarterly .</p>

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103</p> <p>This deficiency pertains to Intake MI00151603.</p> <p>Based on interview and record review, the facility failed to promptly resolve grievances for one Resident (R6) of three residents reviewed for grievances. This deficient practice resulted in resident frustration and dissatisfaction when missing personal items were not found or replaced.</p> <p>Findings include:</p> <p>All times noted are Eastern Daylight Savings Time (EDST).</p> <p>Review of R6's Minimum Data Set (MDS) assessment, dated 1/16/25, revealed R6 was admitted to the facility on [DATE] with diagnoses that included: cancer, neurogenic bladder, anxiety disorder, depression, and unspecified mood disorder. R6 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition.</p> <p>During an interview on 4/30/25 at approximately 11:30 a.m., R6 reported the following items were missing and had not been located by the facility: a small pouch, mother's engagement and wedding rings, two mother's rings, a ring her brother made for her, a tennis bracelet, a golden girls blanket, a light jacket, a sweater, a shirt, and a pair of sweat pants. R6 stated, I would guess it (jewelry) disappeared a couple of months ago. They (facility staff) tore this room apart, so I don't know what would have happened to it. When asked about the clothing, R6 stated, I distinctly remember the aide walking out (of the room) with it (clothing), and the laundry said it never came down . They took the blanket, jacket, sweater, and my pants. They were all together. R6 said she filed three complaints (Concern/Grievance Forms) and was told they (facility) was going to replace the things.</p> <p>On 5/1/25 at 9:36 a.m., the Social Services Coordinator (Staff) F provided two Concern Forms completed for R6 regarding missing items on the following dates:</p> <p>12/17/24: [R6] states items are missing from her room. Golden girls blanket with cartoon gold girls, black velvet jacket with red polka dots down the sleeves, Golden girls pouch - has her mother's wedding rings in it. [NAME] spiral notebook. She said these items have been missing for about a week. Spoke to laundry and looked around in laundry. [Laundry] says they never came down. 3 sports bras - also missing pink slipper with strap across the front.</p> <p>1/20/25 Replaced slippers. Signed by Staff F.</p> <p>1/18/25: Missing her Golden Girls blanket, nightgown - blue with seahorses is missing. Golden Girls makeup bag and contents of parents' wedding rings, tennis bracelet, hair pick etc. all missing and black polka dot jacket. Resolution: Yes - Describe resolution:</p> <p>1/20/25: Looked in laundry and patient room. Could not locate. Laundry never saw the stuff.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>1;30/25: [R6] told to pick out items and let Staff F know and facility will purchase items on her patient inventory list including, 1 night gown, 1 jacket, Golden girls blanket and pouch, hair pick, 3 sports bras.</p> <p>4/30/25: [Staff F] reminded [R6] about picking out items so facility can purchase for her.</p> <p>The method used to notify the complainant of resolution, date of resolution, and documentation of whether the complainant was satisfied with the resolution were all absent completion details.</p> <p>On 5/1/25 at 10:45 a.m., Staff F provided the Resident Personal Effect Inventory for R6, dated 1/20/25, Review of R6's complete medical record by Staff F, ADON/RN B and this Surveyor failed to locate any Personal Effect Inventory completed at the time of admission (10/14/24). R6's Resident Personal Effect Inventory was completed following the submission of two missing items concern forms to the facility.</p> <p>Review of the Resident Missing Items policy, dated 10/1/2007, revealed the following, in part: All missing items will be investigated . A report of loss will be filled out by the person who receives a complaint of loss from a resident or family member at the time it is reported . The Department Manager/Director is required to move the process towards resolution within the designated time frame of two weeks.</p> <p>During an interview on 5/1/25 at approximately 12:00 p.m., the NHA was asked about R6's missing items and concern forms. The NHA stated, If I get a concern form, I send it out to the department that it affects. It is up to each one of them (department heads) to investigate and resolve the concern form. Generally, if they are missing items they go to Staff F. R6's Concern Forms were reviewed with the NHA in relation to the facilities' Resident Missing Items policy. The NHA expressed understanding of this Surveyors concerns with the lack of resolution to R6's written concerns/grievances/missing items.</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35103</p> <p>Based on observation, interview, and record review, the facility failed to ensure a urinary nephrostomy drainage bag was maintained to prevent contact with contaminated surfaces or garbage for one Resident (R6) of one resident reviewed for catheter care. This deficient practice resulted in the increased risk of contamination of the urinary drainage bag and increased risk of urinary tract infection (UTI) for R6.</p> <p>Findings include:</p> <p>This deficiency pertains to Intake MI00152512.</p> <p>All times noted are Eastern Daylight Savings Time (EDST).</p> <p>During an interview and observation on 4/30.25 at 11:28 a.m., R6's nephrostomy urinary drainage bag was observed clipped to the bed linen on the right (exit) side of R6's bed, with the urinary drainage bag hanging down into R6's garbage can which contained various garbage items. No privacy/dignity cover was observed on the urinary drainage bag and the weight of the urine looked as though it continued to lower the bag into the garbage. When R6 was asked about the urinary drainage bag from their nephrostomy being in the garbage can, R6 stated, No, it should not be in there. When asked about UTI's, R6 stated, Oh God. I can't tell you how many I have had. I had one recently that was so bad that I had to have an IV (for antibiotics).</p> <p>Review of R6's Minimum Data Set (MDS) assessment, dated 1/16/25, revealed admission to the facility on [DATE], with diagnoses that included: cancer, neurogenic bladder, anxiety disorder, depression, and unspecified mood disorder. R6 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS) reflective of intact cognition.</p> <p>During an interview on 4/30/25 at 12:45 p.m., the Nursing Home Administrator (NHA) was advised of this Surveyors' observation of the nephrostomy urinary drainage bag being in R6's garbage can. The NHA acknowledged it would be an infection control concern as R6 was easily susceptible to UTI's. Assistant Director of Nursing (ADON)/Registered Nurse (RN) I entered the NHA's office and instructed RN I to go to R6's room and remove the nephrostomy urine drainage bag from the garbage can. RN I acknowledge this concern and indicated it would be an infection control problem.</p> <p>During an interview on 5/1/25 at 12:14 p.m., RN I confirmed they had gone into R6's room and the nephrostomy bag was placed in a dignity cover so it would lower into the cover instead of into the garbage can. RN I confirmed the bag was clipped to a sheet, but with the weight of the urine it had lowered into the garbage can.</p> <p>Review of R6's Altered Elimination Care Plans revealed the following interventions:</p> <p>.Be mindful of presence of nephrostomy tubes with cares . Dated 8/12/2024,</p> <p>.Ensure nephrostomy tubes are fully closed following flushing . Date Initiated: 10/10/2024.</p> <p>(continued on next page)</p>		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Provide a collection bag cover at all times . Date Initiated: 7/25/2024.		