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	05/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the timely acquisition, administration, and disposition of oral targeted cancer medication for 1 Resident (R1) of 1 resident reviewed for pharmacy services. This deficient practice resulted in missed doses of an oncologist (cancer physician) prescribed medication, the potential of reduced efficacy and progression of disease, and resident dissatisfaction with care.Findings include:During an interview on 5/13/26 at 10:05 a.m., when asked about any facility concerns, Resident #1 (R1) stated, . I have been on cancer medicine for 8 years now - they used a medicine and that cancer medicine cost [thousands of dollars] a month. My [Native American] [NAME] furnishes that medicine for me . I got in here and I turned that medicine over to them. The new supply came in, and the post office reassured my provider that it reached the post office on May 1st. Now it is gone. For three days I have not had my cancer medicine. For 2,400 days before that I never missed a dose. I come to a professional health care facility and I miss three days .Review of R1's Minimum Data Set (MDS) assessment, dated 3/25/26, revealed R1 was admitted on [DATE] with active diagnoses that included prostate cancer, and secondary bone cancer. R1 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition, and was independent with mobility, self-care, and functional cognitive tasks.Review of R1's Medication Administration Record (MAR), for May 2026, revealed Abiraterone Acetate was not administered on 5/11, 5/12, or 5/13/26. The entry was documented with nurse's initials and a Chart Code of 07 which indicated Other/See Progress Notes.Review of R1's Face Sheet, printed 5/13/26, revealed R1 was his own responsible party, able to make independent medical and financial decisions.Review of R1's Physician Order Summary on 5/13/26, revealed the following, in part: Abiraterone Acetate Oral Tablet 500 MG (Abiraterone Acetate) Give 2 tablet by mouth one time a day for Antineoplastics (drugs that inhibit or prevent the growth and spread of tumors or malignant cells). Give 2 tabs one hour prior to breakfast Phone Active 3/13/2026, 3/14/2026 Start Date.Review of R1's Care Plan, on 5/13/26, revealed the presence of a Resident has an active Cancer diagnosis prostate cancer with secondary Bone CA (cancer) care plan, which did not include any intervention related to the administration of an oral chemotherapy agent while in the facility.During an interview on 5/13/26 at 12:18 p.m., the Director of Nursing (DON) was asked about R1's missing Abiraterone Acetate which was and not administered to R1. The DON said a Resident (R2) was discharged from the facility and the medication had gone home with R2 on Sunday, 5/10/26. The plan, per the DON, was to get R1's cancer medication from their pharmacy, but their pharmacy could not send a short-day supply because they do not keep that medication in stock. The DON did not know the name or location of the specialty pharmacy that needed to be used, nor was she aware of how many pills were sent home with R2 upon their discharge from the facility with R1's cancer medication. The DON confirmed the failure to administer R2's cancer medication would be considered a medication error, and stated, There is not a med error report completed.Review of R1's Progress Notes revealed the following notes related to R1's missing abiraterone acetate which was and not administered to R1, in part: 5/11/26 11:57 a.m. [Central Standard Time (CST)] - Call out to [Oncologist E] office informing that resident (R1) will (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

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	05/13/2026

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	miss 2 doses of Abiraterone on 5/11-5/12. 5/13/26 10:02 a.m. CST - Provider aware of missed doses of abiraterone. Pharmacy contacted and unable to obtain this medication as it is a specialty medication. Message left with [Oncologist E's'] office to update provider, awaiting call back. In house provider notified regarding missed doses.During an interview on 5/13/26 at 1:24 p.m., when queried regarding R2's missing cancer medication which was not administered to R1, RN/Unit Manager A, said on Monday 5/11/26, Licensed Practical Nurse (LPN) D could not find the abiraterone acetate to administered to R2. RN A stated, [LPN D] said, ?I wonder if it got sent home with a resident who was discharged ?' LPN D called R2's (Resident discharged on 5/10/26) son, who confirmed R1's cancer medication had been sent home with R2 on 5/10/26. RN A said there was no medication inventory completed upon R2's discharged showing which medications were given to them upon discharge. RN A said the facility could not get R1's cancer medication from their pharmacy and the mail order pharmacy was not able to ship it until that day 5/13/26. The mail order pharmacy said it would be delivered in a couple of days - Monday, 5/18/26, at the latest. RN A did not know what method of shipment was used for the abiraterone acetate. RN A stated, I asked [the DON] if we should send someone to get it and I was told ?no'. I did not talk to the Nursing Home Administrator (NHA) about [R1's missing cancer medication not administered] .Review of a Statement obtained via phone interview on 5/13/26 at 0900 CST [10:00 Eastern Standard Time (EST)] and typed by RN A, included the following two paragraphs: Statement regarding incident occurring on 5/10/26 where a resident's medications were inadvertently sent home with another resident who discharged to home. I did not know another resident's medications were sent home with the resident who discharged . I grabbed the medications and put them in a patient belonging bag along with the residents MAR to go home with the patient at discharged . Typed signatured of LPN C. During a telephone interview on 5/13/26 at 2:40 p.m., when asked about any concern with the omission of chemotherapy medication for R1, [Health System Name] Cancer Center RN J stated, If the medication (Abiraterone Acetate) was not taken as indicated, it's efficacy cannot be guaranteed because there is not clinical evidence to support non-compliance (with administration of) the oral-targeted chemotherapy. So theoretically the patient could be at greater risk for progression of disease if the medication was not administered as ordered.Review of the Medication Error Policy & Procedure, reviewed 2/3/26, revealed the following, in part: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors . A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders . and principles of the professional(s) providing services. Examples of medication errors include: Omission - a drug is ordered but not administered . In the event of a medication error . The following information is documented in an incident report/medication error report and in the resident's clinical record: Factual description of the medication error. Actions taken and the resident's response. Physician, Resident, and Family/Representative notification and response . Each incident report/medication error report is forwarded to: Director of Nursing, Administrator, Medical Director and Consultant Pharmacist .During the Exit Conference on 5/13/26 at approximately 3:00 p.m., the NHA and DON acknowledged the identified deficiency related to pharmacy services including the timely acquisition of R1's cancer medication, the failure to administer the cancer medication to R1 as prescribed, and the facility's error in disposition of the medication to R2 upon their discharge from the facility on 5/10/26.

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	05/13/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the medical record contained accurate and complete information related to the facility's loss of oral chemotherapy medication for one Resident (#1) of one resident reviewed for a complete medical record, Findings include: Resident #1 (R1)During an interview on 5/13/26 at 10:05 a.m., when asked about any facility concerns, R1 stated, . I have been on cancer medicine for 8 years now - they used a medicine and that cancer medicine cost [thousands of dollars] a month. My [Native American] [NAME] furnishes that medicine for me . I got in here and I turned that medicine over to them. Now it is gone. For three days I have not had my cancer medicine. For 2,400 days before that I never missed a dose. I come to a professional health care facility and I miss three days .Review of R1's Minimum Data Set (MDS) assessment, dated 3/25/26, revealed R1 was admitted on [DATE] with active diagnoses that included prostate cancer and secondary bone cancer. R1 scored 15 out of 15 on the Brief Interview for Mental Status (BIMS), reflective of intact cognition, and was independent with mobility, self-care, and functional cognitive tasks.Review of R1's Medication Administration Record (MAR), for May 2026, revealed Abiraterone Acetate was not administered on 5/11, 5/12, or 5/13/26.Review of R1's Physician Order Summary on 5/13/26, revealed the following, in part: Abiraterone Acetate Oral Tablet 500 MG . Give 2 tablet(s) by mouth one time a day for Antineoplastics (drugs that inhibit or prevent the growth and spread of tumors or malignant [cancer] cells). Give 2 tabs one hour prior to breakfast. Phone Active 3/13/2026, 3/14/2026 Start Date.During an interview on 5/13/26 at 12:18 p.m., the Director of Nursing (DON) was asked about R1's missing Abiraterone Acetate which was not administered to R1. The DON said a different Resident (R2) was discharged from the facility and the medication had gone home with R2 on Sunday, 5/10/26. When asked if this information was documented in R1's medical record the DON stated, No, that is not in there specifically. It was documented that the medication was not available .I don't see any documentation in the medical record that the medication went home with another resident upon discharge. I am also not sure when we identified that the med went home with another resident. When asked if the medical record documented how R1's cancer medication was going to be acquired, the DON stated, I don't have any interview or documentation yet about what we were working on for getting that (R1's abiraterone acetate cancer medication) here. The DON confirmed the failure to administer R1's cancer medication would be considered a medication error. When asked if a medication error report was completed, the DON stated, There is not a med error report completed. During an interview on 5/13/26 at 1:24 p.m., when queried regarding R1's missing cancer medication which was not administered to R1, RN/Unit Manager A confirmed R1's cancer medication had been sent home with R2 on 5/10/26. RN A said there was no medication inventory completed upon R2's discharged showing which medications were given to them upon discharge. RN A stated, .I called [the oncologist's office) Monday (5/11/26) around 9:00 a.m. (CST). I left a message. When asked if a progress note detailed the call to the oncologist on Monday, RN A stated, I did not put a note in on Monday. When asked if a medication error report was completed for the doses of R1's cancer medication not administered, RN A stated, I guess I just missed it (doing a medication error report) because I was under the impression he would be getting it from the pharmacy and that is why I didn't do a medication error report. When asked if there was any documentation of education provided to the involved nursing staff, RN A stated, No, [LPN C] has been off. I got a statement from her. I wrote it down. I will have to go find it. It was not put into any medical record. When asked if she had informed the Nursing Home Administrator (NHA) of investigation details and the medication errors, RN A stated, I did not talk to [the NHA] about this. When asked if there was documentation in R1's medical record that would show details of the loss of R1's medication and the lack of administration of that medication, RN A stated, I am pretty positive there is nothing in the medical record that would show (continued on next page)

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	05/13/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that the medication was sent home with another Resident (R2).Review of a Statement obtained via phone interview on 5/13/26 at 0900 CST [10:00 Eastern Standard Time (EST)] and typed by RN A, included the following two paragraphs: Statement regarding incident occurring on 5/10/26 where a resident's medications were inadvertently sent home with another resident who discharged home. I did not know another resident's medications were sent home with the resident who discharged . I grabbed the medications and put them in a patient belonging bag along with the residents MAR to go home with the patient at discharged . Typed signatured of [LPN C]. Review of the Medication Error Policy & Procedure, reviewed 2/3/26, revealed the following, in part: It is the policy of this facility to provide protection for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors . A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders . and principles of the professional(s) providing services. Examples of medication errors include: Omission - a drug is ordered but not administered . In the event of a medication error . The following information is documented in an incident report/medication error report and in the resident's clinical record: Factual description of the medication error. Actions taken and the residents' response. Physician, Resident, and Family/Representative notification and response . Each incident report/medication error report is forwarded to: Director of Nursing, Administrator, Medical Director and Consultant Pharmacist .During the Exit Conference on 5/13/26 at approximately 3:00 p.m., the NHA and DON acknowledged the identified deficiency related to a complete and accurate medical record related to the absence of progress notes detailing R1's cancer medications being given to another resident upon discharge and the lack of progress notes and medication error reports.