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	06/26/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review the facility failed to appropriately assess one (Resident #60) out of four residents reviewed for safe self-administration of medication clinically appropriate. Findings include:All times are in Eastern Daylight Time (EDT) unless otherwise notedResident #60 (R60)On 6/24/25 at 2:37 PM, an observation and interview were conducted with R60 in their room. R60 was asked if they had any pain and R60 responded, Yes, normally at night and I take aspirin at night because of the pain from my recent shingles. R60 stated that she keeps the medication in her purse that her daughter brought in for her. R60 then showed this surveyor the medications that they had in their purse which contained acetaminophen 500 mg (milligrams), a stool softener, and a laxative. R60 then stated that she could take the acetaminophen every four hours if she wanted, and their clothing often irritated her skin where the shingles had been. On 6/25/25 at 9:10 AM, during an interview with R60 who was asked how their pain was today, replied, During the night the whole side of my body just aches. I take two acetaminophen's every four hours just to get some sleep. R60 was asked what her pain level was currently and replied, It is a 5. On 6/25/25 at 10:00 AM, an interview was conducted with Registered Nurse (RN) T who was asked if R60 had an order or assessment to self-administer medication or if RN T was aware R60 had medication in their room and replied, No. I was not aware that the resident (R60) had medication in their room. R60 lacked an assessment to self-administer medications for the acetaminophen, bisacodyl (stool softener), and bismuth subsalicylate (stomach and diarrhea relief) they were in possession of. Review of R60's physician order, dated 1/17/25, revealed an order for acetaminophen 325 mg, give 650 mg by mouth every 4 hours as needed for pain, and do not exceed 3 grams/day. Review of R60's medication administration record, dated 6/1/25 through 6/26/27, revealed acetaminophen 650 mg was administered on 6/5/25 at 7:44 AM and no other administrations were recorded.On 6/26/25 at 12:35 PM, an interview was conducted with the Nursing Home Administrator (NHA) who was asked if residents were able to self-administer medications and replied, Yes, but they need an assessment, a physician order and it also needs to be care planned. Review of policy titled, Medication Self-Administration, dated 6/25/24, read in part, Policy Overview: Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Guidelines: Each resident is offered the opportunity to self-administer medications. If the resident requests to do so, the interdisciplinary team (IDT) assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident .The Medication Self-Administration Safety Screen in (computer electronic medical record name) will be completed by the licensed nurse .If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the physician orders, medical record, and the care plan . Self-administered medications are stored in a safe and secure place, which is not possible in the resident's room, (i.e. locked box, lockable drawer, lockable cabinet, etc.) .Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party .

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review the facility failed to maintain a clean, comfortable environment throughout the facility and maintain clean sanitary linens and shower rooms for shared resident use. This resulted in a potential decreased satisfaction of living conditions and an increased potential for a bacterial harborage for residents residing in the facility.All times are in Eastern Daylight Time (EDT) unless otherwise notedFindings include:In an observation on 6/24/25 at 12:15 PM., upon entering the facility for annual recertification it was noted walking through the main door into the main common area that a strong smell of urine and musty warm air was evident. There were multiple residents in the main common area watching TV. The carpet was noted to be heavily soiled throughout the common area and the entire 2nd floor carpeting along the corridors/units had multiple stains, and an overall dirty appearance. There were floor box fans blowing warm air through the building.During an environmental tour on 6/25/25 at 3:21 PM., prompted by initial observations on entrance and comments made during a private resident council meeting held by the survey team, residents voiced frustrations about a strong urine smell in the facility, soiled carpeting, soiled linens and overall dissatisfaction with the cleanliness of the facility. Observation of the lower 1st floor shower room noted the following: a cart with multiple random items strewn about including adult pull up briefs, soiled wash cloths, rolls of clear garbage bags, random pieces of paper. Located in the 2nd stall shower/bath area was a shelf unit with different types of adult briefs strewn about not organized to style or size of briefs. 2 shower chairs made of white PVC with blue and pink mesh backing had strong odor of urine, underneath the bottom of the shower chairs were visible yellow/dark orange discoloration in the crevasses and along the frame underneath the seats. The shower/bathroom it was noticed there were no bath towels, hand towels or washcloths. There were approximately 6 flat sheets, 6-8 pillowcases. The shower/bathroom showers had shower curtains hanging that were yellowing at the top (mesh) torn and tattered in various spots on the curtain itself. The shower curtains appeared dated and worn.Further environmental observations on 6/25/25 at 4:07 PM., the 1st floor linen room had approximately 12 bath towels, all which were noted to be dingy white/gray in color, thin in texture and heavily stained. 13 hand towels noted which were all dingy white in color, thin in texture and multiple stains were noticed during the inspection. The washcloths which were all noted to be very dingy white/gray in color, stained and could not differentiate if they were used for cleaning or resident care.Further environmental observations on 6/25/25 at 4:14 PM., the 2nd floor clean linen room inspection revealed resident clothing protectors were like bath towels in texture and were dingy white/gray in color with multiple stains observed on them. The bath towels were old in appearance, abrasive to the touch and dingy white/gray in color along with multiple stains. Hand towels inspected were all heavily used in appearance and color, dingy white/gray with stains. A stack of clean wash clothes inspected were very tattered/torn and dingy in color. This surveyor could not differentiate whether the washcloths were used for cleaning, or they were actual resident washcloths. The linens in the linen room were all in poor condition. Bed sheets, blankets and covers inspected in the linen room on the 1st floor also were noticed to be worn and old in appearance, along with the linen room having a muggy/malodorous smell to it.In an interview on 6/25/25 at 4:30 PM., Certified Nurse Aide (CNA) D reported he was unsure when new linens are ordered. CNA D reported the linens are used for all residents and they are not separated from what areas of the body wash their faces, or peri-areas. CNA D reported residents share linens including washcloths which seem quite old and dingy as well as rough/abrasive on the skin.In an interview on 6/25/25 at 4:45 PM., CNA C reported the linens which are stocked in the linen rooms/shower rooms are where the staff get towels, sheets, washcloths and other linen items. CNA C reported he has noticed many linens, towels and clothing protectors were in an older condition, he was not sure when and how often the facility gets new linens. During a second environmental inspection on 6/26/25 at 10:30 AM., the 1st floor shower room was observed again with no change. The room and equipment/resident shower chairs and shower curtains were noted to not unchanged/cleaned from the first inspection on the environmental tour on 6/25/25 at 3:21 PM. The pink mesh/PVC shower chair first noticed was now in a shower and was noted to have long dark strands of hair on the seat.Further environmental inspections conducted on 6/26/25 at 10:41 AM., noted a linen cart in the 1st floor shower room which housed multiple thin bath towels which were dingy white/gray in color, abrasive to the touch and multiple stains were noted on them. The hand towels were all noted to be dingy/stained in appearance, and the washcloths were noted to be stained, dingy and tattered/thin and abrasive to the touch. In an interview on 06/26/25 at 10:47 AM., Laundry/Housekeeping Manager (Staff) L reported she and one

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** All times are in Eastern Daylight Time (EDT) unless otherwise noted.Based on interview and record review, the facility failed to ensure three Residents (#14, #18, & #57) of four residents reviewed for hospitalizations were provided with written notification of the bed hold policy when the residents were transferred to the hospital. Findings include:Resident #18 (R18) During an interview on 6/25/25 at 11:17 AM, R18 indicated they had been out to the local hospital during their stay at the facility a couple times, however they were not sure of the exact date. The medical record for R18 revealed a transfer to the hospital on 1/31/25 with a readmission on [DATE] and a second transfer to the hospital on 5/1/25 with a readmission on [DATE]. The medical record did not indicate a bed hold policy for either transfer was provided to R18 or their responsible party.Resident #57 (R57) During an interview on 6/24/25 at 12:54 PM, R57 indicated they had been out to the local hospital during their stay at the facility a few times, however they were unsure of the exact date.The medical record for R57 revealed a transfer to the hospital on 1/8/25 with a readmission on [DATE] and a second transfer to the hospital on [DATE] with a readmission on [DATE]. The medical record did not indicate a bed hold policy for either transfer was provided to R57 or their responsible party.Review of the policy titled, Transfers and Discharges, dated 4/18/25, read in part, Policy Overview: The purpose of this policy is to provide guidelines for the safe transfer and discharge of a resident across the continuums of care. General Guidelines .If the resident is admitted to the hospital the Admissions Director or designee will send the resident's representative a copy of the bed hold policy and transfer notice . Resident #14 (R14) R14 was admitted to the facility 11/13/24. The medical record revealed R14 was transferred to the hospital on 2/16/25, 3/20/25, and 6/9/25. The medical record did not indicate the facility provided written notice of the bed hold policy, including the duration of the bed hold, to R14 or the Resident Representative (RR) of R14 at the time of transfer to the hospital.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** All times are in Eastern Daylight Time (EDT) unless otherwise noted.Based on observation, interview, and record review, the facility failed to provide grooming and hand hygiene to one Resident (R30) of two residents reviewed for Activities of Daily Living (ADL). Findings include: All times are in Eastern Daylight Time (EDT) unless otherwise noted.Resident #30 (R30) was admitted to the facility 1/23/25 with diagnoses that included but were not limited to: metabolic encephalopathy (brain dysfunction), liver cancer, and muscle weakness.On 6/24/25 at 2:20 PM, R30 was observed sleeping in a recliner next to his bed. R30 was noted with visibly soiled hands with a brown-colored substance encrusted under the fingernails of each finger of both hands. The brown substance was embedded around the edges of each fingernail on both hands. A Minimum Data Set (MDS) assessment dated [DATE] documented R30 had impaired functional range of motion to both upper extremities and both lower extremities. The MDS indicated a Brief Interview for Mental Status (BIMS) score of 12 indicating R30 had moderate cognitive impairment. Further review of the MDS revealed R30 received chemotherapy for cancer treatment and required moderate assistance with personal hygiene tasks. The MDS documented R30 was frequently incontinent of bowel and bladder.The care plans for R30 included a care plan for ADLs. The care plan disclosed R30 had an ADL self-care performance deficit related to weakness, decreased mobility, fall with lower back strain and left ankle sprain resulting in altered mobility and pain. The care plan indicated R30 refused assistance at times with transfers, ambulation, wound treatments, and incontinence care and brief changes. The ADL care plan documented R30 required one-person staff assistance with personal hygiene. An intervention for bathing and showering read: BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. R30's Kardex (a summary of information provided to Certified Nurse Aides (CNA) to direct resident-care needs, including ADL needs) also documented BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. The Electronic Medical Record (EMR) of R30 was reviewed on 6/24/25 and disclosed a form dated 6/18/24 that documented a skin assessment. Section 3 of the form read: Bathing/Shower offered and the documented response was yes. The following portion read Bathing/Shower response and the answer was received. The form did not include documentation of fingernail appearance or hygiene. CNA Tasks in the EMR did not include documentation of fingernail hygiene. Progress notes in the EMR did not document regarding hand or fingernail hygiene.Behavior documentation tasks in the EMR of R30 were reviewed. There were no documentation entries of R30 refusing care. The documentation response was none of the above observed for each entry including the rejection of care section. R30 was interviewed on 6/25/25 at 2:37 PM. Both hands and all fingernails remained visibly soiled with the brown-colored substance remaining under the nails of both hands and around the nail perimeter of each nail of both hands. R30 was asked if he was provided hand hygiene prior to eating meals or when needed. R30 said, No, they don't help me much. R30 was agreeable when asked if he would like his hands and fingernails cleaned. CNA C was outside R30's room in the hallway. CNA C was asked on 6/25/25 at approximately 2:45 PM if R30 refused to allow staff to clean his hands and fingernails. CNA C said R30 refused care at times, but did not recall R30 ever refusing hand and fingernail hygiene. CNA C was asked when R30 last had his hands and fingernails cleaned. CNA C said he did not know. CNA C was requested to visualize the hands of R30. CNA C said they had not noticed how dirty R30's hands and nails were and said the hands and fingernails of R30 would be cleaned immediately.On 6/26/25 at 11:36 AM, the hands and fingernails of R30 appeared to be clean. R30's hands were no longer visibly soiled, and the brown substance under and around his nail beds was no longer visualized.06/26/25 12:47 PM DON interviewed. She said nail care should be provided during showers and PRN when soiled or nails are long. said shower sheet documents if nail care was provided. The policy Activities of Daily Living (ADL) dated as revised 12/7/23 read, in part: .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.Appropriate care and services will be provided for residents who are unable to carry out ADL independently. 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.

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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. Based on observation, interview, and record review the facility failed to ensure intravenous (IV) site procedure was documented, dated when initiated and orders were in place to ensure the site was changed per standards of practice for one (Resident #18) of one resident reviewed for quality of care. All times are in Eastern Daylight Time (EDT) unless otherwise notedFindings include: Resident #18 (R18)Review of R18's electronic medical record (EMR) revealed initial admission to the facility on 4/30/25 with diagnoses including diabetes mellitus, dementia, urinary tract infection with indwelling urinary catheter, and heart failure. On 6/25/25 at 3:13 PM, an observation was made of R18 during medication pass. R18 was observed to have an IV site in their left lower extremity in their forearm that had a dressing that was not dated. On 6/25/25 3:20 PM, an interview was conducted with Licensed Practical Nurse (LPN) U who was asked if the IV site needed to be dated and replied, Yes, and the current one needs to be replaced if there is no date because I don't know how long it has been there. Review of progress note, dated 6/22/25 at 12:27 AM, read in part, Resident peripheral IV placed in left forearm by integrity . The progress note lacked the size, attempts, and resident comfort of the IV placement process. Review of R18's physician orders, dated June 2025, revealed the lack of an order to change the IV site every 72 hours. On 6/26/25 at 12:30 PM, an interview was conducted with the Nursing Home Administrator (NHA) who was asked what their expectations were for IV management and replied, The dressings needed to be dated and the IV site should be changed every 72 hours or sooner if it appears infected or is not flushing properly. Review of the policy titled, Catheter Insertion and Care, date revised July 2016, read in part, Policy: Administration sets and tubing will be changed at specific intervals in order to prevent infections associated with contaminated IV therapy equipment. General Guidelines .

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Deficiency Text Not Available

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement safety measures during transportation to an outside appointment for 1 Resident (#22) of 3 residents reviewed for accidents/hazards. This deficient practice resulted in harm for Resident #22 who sustained 4 fractures (both bones in lower legs broken), and a large laceration requiring sutures on right footAll times are in Eastern Daylight Time (EDT) unless otherwise notedFindings include:Resident #22 (R22)Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed admission to the facility on 3/15/18 with active diagnoses that included: dementia, depression, and type 2 diabetes mellitus. R22 scored 8 of 15 on the Brief Interview for Mental Status (BIMS) assessment reflective of moderate cognitive impairment. During an interview on 6/24/25 at 3:41 p.m., R22 reported that her legs hurt and were painful.Review of Incident report titled Injury dated 2/3/25 read in part, .incident description per Registered Nurse (RN) N. Van driver had alerted this nurse that resident had fallen in the van .resident sitting on her butt with wheelchair on top of her and her feet extended out with ankles turned in against the front of the console area of van. Resident (R22) was wearing her boots when she left but those had fallen off when she fell Resident unable to give full description as she was in so much pain . R22 experienced facial grimacing, loud moaning or groaning, crying, short period of hyperventilation, and occasional labored breathing .injuries report post incident. Injury type and location: fracture to left lower leg and right lower leg . Further review of Incident report titled Injury dated 2/3/25 revealed a statement from Maintenance Worker/Van Driver (Staff) O read in part, . I was transporting [R22] to her appointment .Resident positioned upright in broda (type of high back wheelchair) chair .the chair tipped forward .the seatbelt was not placed (unbuckled). When the chair is reclined far back the seatbelt would not buckle.Review of progress notes revealed the following:2/3/25 at 8:30 PM Resident returned to facility via Emergency Medical Service (EMS) .Her legs are both wrapped with splints .She has bilateral (both legs) lower extremity fractures of the fibula/tibia with laceration under toes of right foot with 5 stitches .2/4/25 at 12:48 AM R22 returned from emergency room (ER) with new order for Norco . one or two tablets every six hours as needed for pain . Further review of the progress notes revealed that prior to surgery that was scheduled to occur on 2/12/25, R22 received Norco 18 times between 2/4/25 thru 2/10/25 at 7:24 AM for pain. Review of facility incident report titled Injury dated 2/3/25 read in part, Resident had ortho appointment on 2/7. Casting unable to be completed in office and resident was scheduled for closed reduction with casting on 2/12/25 to be completed in the Operating Room (OR) under anesthesia .Review of the facility progress notes dated 2/12/25 indicated R22 had returned from the hospital where R22 had to undergo casting under anesthesia due to her cognitive function to address the injuries sustained from the incident. Review of Document titled Operative Note dated 2/12/25 read in part, . [Orthopedic Surgeon's Name] . Operation: closed reduction and cast application of right tibia and fibula fractures. Closed reduction and cast application of left tibia and fibula fractures .[R22] .sustained injuries to bilateral lower legs when she fell out of her wheelchair during medical transport on 2/3/25. She was transported to the emergency department, where she was diagnosed with displaced oblique fractures of bilateral distal tibia shafts and roughly transverse fractures of bilateral distal fibula shafts . (bilateral lower leg fractures)During an interview on 6/26/25 at 1:57 p.m., the Nursing Home Administrator (NHA) acknowledged the seatbelt was not in place at the time of the incident and the seatbelt would have held the resident in place in the wheelchair when the brakes were applied. During an interview on 6/26/25 at approximately 2:00 p.m., the Director of Nursing (DON) reported that R22 screams out in pain quite often since the incident due to the bilateral lower leg fractures. During an interview on 6/26/25 at approximately 3:30 p.m., the NHA requested Past Non-Compliance (PNC) for the incident involving R22. The NHA reported she had provided the PNC to this surveyor including the incident report titled Injury.During an interview on 6/26/25 at 3:45 PM. Registered Nurse (RN) N. reported he was called by the driver of the van when [R22] fell forward in her wheelchair. The van driver came into the facility yelling that he needed help. I ran out there, and [R22] was in the back of the van. The wheelchair was on top of her, she was seated on the floor of the van both legs extended in front of her, her ankles and toes were turned inwards. It was difficult to get the wheelchair off her. R22 was moaning and in a lot of pain, both her boots had come off and her toes had been sliced and bleeding. We were able to finally get the wheelchair (which was a broda-high back style) off her. I noted at that time she had wet herself pretty good and defecated on herself. She was in pain, she had some scratches on her forehead, legs, and

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to appropriately maintain and store respiratory equipment in a sanitary manner for one (Resident #31) of one resident reviewed for respiratory care. All times are in Eastern Daylight Time (EDT) unless otherwise noted.Findings include:Resident #31 (R31)Review of R31's electronic medical record (EMR) revealed initial admission to the facility on 1/7/25 with diagnoses including dementia, respiratory failure, depression, and heart failure. On 6/24/25 at 2:17 PM, an observation was made of R31 lying in their room in their bed. R31 was wearing a nasal cannula (soft plastic tubing to deliver oxygen to the nose) delivering oxygen from a concentrator at two liters and had a humidifier connected that was empty and not dated. R31 had a nebulizer lying on their bed with condensation and a small amount of medication in the cup.On 6/24/25 at 2:20 PM, an interview was conducted with R31 who was asked if the staff rinse out their nebulizer and replied, The nurse just comes in and puts the medication in it and turns it on and leaves. R31 was asked how long their humidifier had been empty and replied, I am not sure. Yesterday I had a couple drops of blood on my pillow. R31 was asked if they had a bloody nose and replied, Yes. On 6/24/25 at 2:27 PM, an interview was conducted with Registered Nurse (RN) T who was asked how often the humidifiers are replaced on the oxygen concentrators and replied, Once a week. On 6/24/25 at 3:35 PM, an observation was made of R31's respiratory equipment. R31's humidifier was not dated when the last time it was replaced, and their nebulizer was left intact with visible condensation in the medication cup on their bedside table. Review of R31's physician order, dated 6/21/25, revealed ipratropium-albuterol inhalation solution 0.5-2.5 (3) mg(milligrams)/3 ml(milliliter), 1 vial inhale orally four times a day for dyspnea (shortness of breath), 0800, 1200, 1700, and 2100. Review of R31's physician order, dated 3/10/25, revealed oxygen delivered via NC (nasal cannula), liter flow: 2 liters, duration: continuous, every shift for breathing.On 6/26/25 at 9:45 AM, an observation was made of R31's respiratory equipment. R31's nebulizer was left intact with visible condensation in the medication cup on their bedside table. On 6/26/25 at 12:30 PM, an observation was made of R31's respiratory equipment. R31's nebulizer was left intact with visible condensation in the medication cup on their bedside table. On 6/26/25 at 12:35 PM, an interview was conducted with the Nursing Home Administrator (NHA) who was asked what their expectation were for respiratory equipment sanitation and maintenance and replied, The bubblers should be inspected every shift, and the nebulizers should be rinsed out after every use and set to dry and then stored in a bag for sanitation. Review of policy titled, Oxygen Equipment: Cleaning, Masks, Updraft/Nebulizer, Oxygen Concentrator Filter and Tubing, dated 8/8/22, read in part, Policy: It is the policy of the Facility to maintain oxygen concentrator equipment in a clean manner. Compliance Guidelines .3. Oxygen humidifiers will be checked daily and replaced weekly and PRN (as needed). All humidifiers shall be dated .Cleaning updraft nebulizer: 1. After each use, remove nebulizer T-piece and mouthpiece or mask. Disassemble nebulizer chamber by turning clockwise. 2. Rinse T-piece and mouthpiece or mask with clear hot tap water. Air-dry on clean towel at bedside .

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	235267	A. Building B. Wing	06/26/2025

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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All times are in Eastern Daylight Time (EDT) unless otherwise noted.Based on observation, interview, and record review the facility failed to appropriately maintain and store respiratory equipment in a sanitary manner for one (Resident #31) of one resident reviewed for respiratory care. All times are in Eastern Daylight Time (EDT) unless otherwise notedFindings include:Based on observation, interview, and record review the facility failed to appropriately assess one (Resident #60) out of three residents reviewed for pain management. Findings include:Resident #60 (R60) On 6/24/25 at 2:37 PM, an observation and interview were conducted with R60 in their room. R60 was asked if they had any pain and R60 responded, Yes, normally at night and I take aspirin at night because of the pain from my recent shingles. R60 stated that she keeps the medication in her purse that her daughter brought in for her. R60 then showed this surveyor the medications that they had in their purse which contained acetaminophen 500 mg (milligrams), a stool softener, and a laxative. R60 then stated that she could take the acetaminophen every four hours if she wanted, and their clothing often irritated her skin where the shingles had been. On 6/25/25 at 9:10 AM during an interview with R60 who was asked how their pain was today and replied, During the night the whole side of my body just aches. I take two acetaminophens every four hours just to get some sleep. R60 was asked what her pain level was currently and replied, It is a 5. On 6/25/25 at 10:00 AM, an interview was conducted with Registered Nurse (RN) T who was asked if R60 had an order for to assess for pain each shift and if staff were monitoring R60's pain related to their recent shingles outbreak and replied, Each resident is assessed for pain each shift and R60 should have a pain assessment at least once a day. RN T was asked if they were aware that R60 had pain from their shingles that made it difficult for them to fall asleep at night and their clothing irritated their skin and replied, No, but I will go and check on them now. Review of progress note, dated 6/4/25 at 11:11 AM (Central time), read in part .res (resident) reports ‘terrible' pain in shingles areas. Areas located on chest and upper back. Review of progress note, dated 6/17/25 at 3:51 PM (Central time), read in part .stated that she if feeling better and has pain. The area is now scabbed over. Review of progress note, dated 6/25/25 at 4:16 PM (Central time), read in part .Resident is alert and oriented, with a Brief Interview for Mental Status (BIMS) score of 15. Resident is asking that she be able to keep the following meds at bedside and self-administer: [name brand acetaminophen]. Review of progress note, dated 6/26/25 at 6:37 AM (Central time), read in part, Resident reports having pain from her shingles.She requests to only take ES (extra strength) [name brand acetaminophen] and scheduled Aspirin for pain relief . Review of progress note, dated 6/26/25 at 6:41 AM (Central time), read in part, .My rash (points to the shingles area on chest) hurts, especially at night and the [name brand acetaminophen] helps me sleep. Review of R60's physician order, dated 1/17/25, revealed an order for acetaminophen 325 mg, give 650 mg by mouth every 4 hours as needed for pain, and do not exceed 3 grams/day. Review of R60's physician order, dated 5/27/25, revealed an order for valacyclovir, give 500 mg by mouth two times a day for Shingles for 7 days. Review of R60's medication administration record, dated 5/1/25 through 6/26/27, revealed administered acetaminophen 650 mg on 5/27/25 at 7:02 PM, 5/31/25 at 7:59 AM, 6/5/25 at 7:44 AM and no other administrations. Review of R60's pain level, dated 5/27/25 through 6/5/25 revealed the following: 6/5/2025 11:14 0 Numerical 6/5/2025 07:44 4 Numerical 5/31/2025 10:06 0 Numerical 5/31/2025 07:59 4 Numerical 5/27/2025 20:41 2 Numerical 5/27/2025 19:02 7 Numerical No other pain evaluations recorded and R60 continued to experience pain. Review of R60's physician order, dated 5/24/25, revealed an order for pain evaluation, but under order type indicted no documentation was required. Review of R60's care plan, dated 7/15/24, read in part, .Focus: At risk for pain r/t (related to) impaired mobility. Goal: Pain goal is a zero until next review. Target date: 7/21/25. Interventions: Administer pain medication as ordered. Monitor for effectiveness. Review of R60's care plan, dated 5/27/24, read in part, .Focus: The resident has Shingles. Goal: The resident will be free from complications related to infection through the review date. Interventions: Administer anti-viral as per MD (medical doctor) orders. R60's care plan lacked any interventions or acknowledgment of pain from having shingles. Review of policy titled, Pain Management, dated 4/18/24, read in part Policy: The purpose of this policy is to provide guidelines to prevent and/or manage both acute and chronic pain. General Information: Pain is a highly subjective and personal experience which is impacted by one's previous experiences with pain.Recognition and Evaluation of Pain: Pain is evaluated and documented.When the resident has a new pain or worsening of existing pain utilizing the Pain Evaluation UDA within the resident's electronic health record.Treatment and Management: The individualized comprehensive care plan addresses

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	235267	A. Building B. Wing	06/26/2025

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All times are in Eastern Daylight Time (EDT) unless otherwise noted Based on observation, interview, and record review the facility failed to store medication in a secure and safe manner and ensure expired medication was disposed of in the active medication cart for three (Residents #33, Resident #57, and Resident #60) of 18 reviewed and one of two medication carts reviewed for medication storage.Findings include:Resident #33 (R33) Review of R33's medication administration record (MAR), dated June 2025, revealed a physician order for insulin glargine subcutaneous solution pen-injector 100 units/ml (milliliter), inject 14 units subcutaneously at bedtime for DMII (diabetes mellitus type 2), start date 3/10/25 at 1900 (7:00 PM), and administered on 6/24/25 at 7:00 PM. On 6/25/25 at 10:15 AM, a review of the medication cart for the South second floor end, revealed an insulin glargine subcutaneous solution pen-injector 100 units/ml with an opened date of 5/26/25 and an expiration date of 6/23/25 in the active medication cart. This insulin pen should have been discarded and was used on 6/24/25 for R33 at 7:00 PM. The medication cart for the South second floor end also had one loose pill that was round, orange, and with imprint of 20 that was unable to be identified and three small pieces of a white pill that were broken and lying in the base of the second drawer. On 6/25/25 at 10:20 AM, an interview was conducted with Registered Nurse (RN) T who was asked if any loose medications or outdated medications should be left in the medication carts and replied, No, the night shift nurse should have cleaned and discarded any loose or expired medications. RN T confirmed that R33 received the insulin glargine 14 units on 6/24/25 when the pen should have been discarded and replaced. On 6/26/25 at 12:00 PM, a follow-up review of the medication cart for the South second floor end was conducted and found to still contain the insulin glargine subcutaneous solution pen-injector 100 units/ml with an opened date of 5/26/25 and an expiration date of 6/23/25 in the active medication cart. RN T was asked if R33 had another insulin pen and why the expired insulin pen remained in the cart and replied, I don't know, but I am throwing this out and will see if there is another pen. RN T confirmed that R33 received the insulin glargine 14 units on 6/25/25 again when the pen should have been discarded and replaced. Resident #57 (R57) On 6/24/25 at 12:54 PM, an observation was made of R57 lying in their bed resting. R57's room was observed to have a small bottle of Nystatin powder on the dresser with their name on the bottle. R57 was unable to recall why the bottle was there. Review of R57's order recapitulation, dated 1/30/25 through 6/25/25, revealed an order for Nystatin powder, apply to groin topically every shift for incontinence; rash, dated 2/6/25 and discontinued on 2/7/25. Another order for Nystatin powder on 2/7/25 to be applied topically every evening shift for fungal/yeast and to discontinue once resolved and apply to groin topically every day shift for fungal/yeast and to discontinue once resolved and discontinued on 3/11/25. A third order for Nystatin powder started on 3/14/25 for the same reason and discontinued on 3/27/25. R57 did not have any further orders for the Nystatin powder and should have been discarded and not left in their room. Resident #60 (R60) On 6/24/25 at 2:37 PM, an observation and interview were conducted with R60 in their room. R60 was asked if they had any pain and R60 responded, Yes, normally at night and I take aspirin at night because of the pain from my recent shingles. R60 stated that she keeps the medication in her purse that her daughter brought in for her. R60 then showed this surveyor the medications that they had in their purse which contained acetaminophen 500 mg (milligrams), a stool softener, and a laxative. R60 then stated that she could take the acetaminophen every four hours if she wanted, and their clothing often irritated her skin where the shingles had been. On 6/25/25 at 9:10 AM during an interview with R60 who was asked how their pain was today and replied, During the night the whole side of my body just aches. I take two acetaminophens every four hours just to get some sleep. R60 was asked what her pain level was currently and replied, It is a 5. On 6/25/25 at 10:00 AM, an interview was conducted with Registered Nurse (RN) T who was asked if R60 had an order to self-administer medication or had an assessment to self-administer medication or if they were aware that R60 had medication in their room and replied, No. I was not aware that the resident (R60) had medication in their room. R60 lacked an assessment to self-administer medications for acetaminophen, stool softener, and laxative. Review of R60's physician order, dated 1/17/25, revealed an order for acetaminophen 325 mg, give 650 mg by mouth every 4 hours as needed for pain, and do not exceed 3 grams/day. Review of R60's medication administration record, dated 6/1/25 through 6/26/27, revealed administered acetaminophen 650 mg on 6/5/25 at 7:44 AM and no other administrations. On 6/26/25 at 12:35 PM, an interview was conducted with the Nursing Home Administrator (NHA) who was asked if medications should be stored in resident rooms and if expired medication should be left in the active medication cart supply and replied, No, expired

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: effectively date mark potentially hazardous ready-to-eat food products, effectively clean food service equipment resulting in cross-contamination, bacterial harborage, and the increased potential for resident foodborne illness.Findings include:During a dining observation on 6/25/25 at 8:27 AM., noted in the main dining room found in one of the cabinet drawers was a individual small cup of what appeared to be brown sugar uncovered, open to air. The drawer had multiple individual packages of jellies, straws, and random condiments. The inside of the drawers along the cabinet wall were noted to be soiled with food crumbs and sticky substances. In a cupboard above the refrigerator a was clear storage container of yellow popcorn kernels. The container was noted to be yellowing, sticky, and grimy/greasy to the touch there was no date or label on the popcorn. Continued observations of dining on 6/25/25 at 8:59 AM., noted multiple packages of cubed swiss cheese, cheddar cheese and pepper jack cheese, multiple packages (tubes) of summer sausage on the refrigerator shelves. In the bottom of the refrigerator right side drawer was a gallon size baggie of sliced summer sausage which was approximately half full. The baggie of summer sausage had no label, date or use by date. There was no description of food item (summer sausage), and the pieces of sliced sausage appeared dried out. Also noted in the bottom right drawer was 1 bag of each type of cubed cheese in the bottom drawer (swiss cheese, pepper jack and cheddar) were noted to have no open date or use by date on them. In an interview on 6/25/25 9:10 AM., Activity Director (AD) K reported she the summer sausages and cubed cheese was in the refrigerator in the main dining room because it was used for residents and family for a Father's Day celebration (6/15/25). AD K reported she did not know she was supposed to label and date any food item that she used and had ordered through the kitchen for activities. AD K reported she would throw away the summer sausage and cheeses that had no open date on them. On a return visit to the main dining room [ROOM NUMBER]/26/25 at 2:34 PM., noted in the bottom right drawer was 1 bag of each type of cubed cheese in the bottom drawer (swiss cheese, pepper jack and cheddar) were noted to have no open date or use by date on them. Review of a facility Policy & Procedure with a revision date of 12/26/22 revealed: Department: Food and Nutrition Services It is the policy of this facility to provide sufficient storage to keep foods safe, wholesome and appetizing, according the USDA Food Code guidelines .Compliance Guidelines It is the responsibility of the Dietary staff and supervisors to ensure that food is stored, labeled and used within the recommended time guidelines to prevent food borne illness. a. Temperatures of the food storage areas, including dry storage, refrigeration and freezers shall have thermometers and be monitored and recorded daily.b. Foods must be rotated using the FIFO method in all storage areas.c. Guidelines for food labeling and dating must be adhered to by all food service personnel and closely monitored by the food service manager. All employees who provide patient/resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illnesses 10. All foods removed from original packing and must have an arrival date. If food has a manufacturers expiration date, an open date will be added to the label, which includes food like: cottage cheese, bulk yogurt, sour cream etc11. All food packaging that is open for use and returned like deli meat must be labeled with arrival date and open date. 12. Leftover foods must be immediately frozen, labeled and dated for later use. If refrigerated, the food must be discarded within 72 hours .