STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235395	A. Building B. Wing	10/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Three Rivers	517 S Erie St Three Rivers, MI 49093

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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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 47955 Based on observation and interview the facility failed to honor resident choices in 2 (Resident #14 and Resident #42) of 7 residents reviewed for self-determination resulting in feelings of anger and frustration. Findings include: Resident #14 Review of an Admission Record revealed Resident #14 had pertinent diagnoses which included: Type 2 diabetes (a condition that occurs when the body is unable to use insulin resulting in persistently high blood sugar levels). Review of a Minimum Data Set (MDS) assessment for Resident #14, with a reference date of 9/22/24 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #14 was cognitively intact. On 9/26/24 at 9:26 AM., Resident #14 reported she was no longer able to access the vending machines and that made her angry. Resident #14 reported the vending machines were moved to the employee break room and residents no longer had access to them. Review of Order Summary for Resident #14 revealed .cardiac/diabetic diet, regular texture, thin consistent . ordered 9/23/2024 . Resident #42 Review of an Admission Record revealed Resident #42 had pertinent diagnoses which included: acquired absence of the right and left legs above the knee. Review of a Minimum Data Set (MDS) assessment for Resident #42, with a reference date of 8/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #14 was cognitively intact. (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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/26/24 at 8:30 AM., Resident #42 reported she was no longer able to access the vending machines. Resident #42 reported residents who had diabetes or high blood pressure were not following their diets, so management moved the machines into the employee break room and residents no longer have access. Resident #42 reported she was angry that she no longer had access to the vending machines. Review of Order Summary for Resident #42 revealed .regular diet, regular texture, thin consistency .ordered 3/19/2024 . On 9/26/24 at 9:45 AM., no vending machines were noted to be in the dining room of the facility. On 9/25/24 at 2:30 PM., Maintenance Manager (MM) 'HH reported the vending machines were relocated into the employee break room and the residents no longer had access to them. MM HH reported he did not move the machines, and he did not know why the machines were moved. In an interview on 9/27/24 at 9:04 AM., Clinical Coordinator (CC) UU reported she was unaware the vending machine were no longer accessible by residents. CC UU reported she did not know why they were moved. In an interview on 9/27/24 at 9:26 AM., Registered Dietitian (RD) DD reported the vending machines were relocated to the employee break room due to some residents not following their recommended diets. In an interview on 9/27/24 at 12:15 PM., CC UU reported that the vending machines were moved by the previous management team due to several residents accessing the machine with special diet due to conditions such as diabetes, or high blood pressure. CC UU reported she would work on moving the machines back into a common area where residents would have access to the vending machines again.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 47955 This citation pertains to intake MI00146657 Based on interview and record review the facility failed to ensure mail was delivered to 1 (Resident #42) of 1 resident reviewed for mail delivery resulting in feeling of anger and frustration. Findings include: Resident #42 Review of an Admission Record revealed Resident #42 had pertinent diagnoses which included: acquired absence of the right and left legs above the knee. Review of a Minimum Data Set (MDS) assessment for Resident #42, with a reference date of 8/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #14 was cognitively intact. In an interview on 9/26/24 at 8:30 AM., Resident #42 reported she did not have her mail delivered for 4 days in August, 2024. In an interview on 9/27/24 at 1:11 PM., Receptionist (R) KK reported the mail was delivered to her, she sorted it and then provided resident mail to the activities department. R KK reported in August of 2024 the mail was given to the nursing home administrator to be logged before the administrator gave the mail to the activities department who then distributed it to the residents. R KK reported she gives the mail directly to activities department to be distributed to the residents. In an observation on 9/27/24 at 1:17 PM., the mail was delivered to the front desk, R KK sorted the mail into three piles, R KK used a walkie talkie to notify the activities department mail had been delivered and was ready to be picked up. Activities Aide (AA) II responded on the walkie talkie. In an interview on 9/27/24 at 1:20 PM., AA II reported that all pieces of mail and packages are logged into the the activities log for the specific resident. AA II reported that mail was delivered every Monday, Wednesday, and Friday when the previous administrator was here. AA II reported the previous administrator would receive the mail first, and then give the mail to activities department. AA II reported on August 23, 2024, the activities department did not receive any resident mail as the previous administrator did not have time to sort it that day. AA 'II reported the mail was locked in the administrators office until the following week. AA II reviewed the log for the dates of August 23-27 2024, and reported that Resident #42 did have a package delivered to the building, but she did not receive the package until Monday. AA II reported since the previous administrator left on September 16, 2024, the mail and packages were delivered daily for residents.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 This citation pertains to intake: MI00146657 Based on interview and record review, the facility failed to ensure a resident was consistently provided with showers/bathing for 5 of 7 residents (Resident #27, #80, #28, #5, #57) reviewed for activities of daily living, resulting in unmet personal hygiene needs with the potential for isolation, psychosocial harm, skin breakdown, harboring infection, and decreased self-esteem. Findings include: Resident #27: Review of an Admission Record revealed Resident #27 was a male with pertinent diagnoses which included abnormalities of gait and mobility, diabetes, heart failure, kidney disease, repeated falls, acquired absence of left leg below knee. Review of current Care Plan for Resident #27, revised on 6/12/24, revealed the focus, .Resident has an ADL self-care performance deficit related to: Activity Intolerance, Amputation (Left BKA), Dementia . with the intervention .Resident will participate in ADLs within functional limitations .Resident will reach highest practicable physical, mental, and psychosocial well-being, and will continue to participate in ADLs daily x 90 days .Resident's ADL needs will be anticipated and provided by staff daily x 90 days .Resident and his wife prefer scheduled showers to be tuesday/saturday 2nd shift .Bathing/Showering: 1 person assist . BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse .DRESSING: 1 person assist .Locomotion: Up to wheelchair daily as tolerated. Assist with propelling around facility prn (as needed) .PERSONAL HYGIENE/ORAL CARE: 1 person assist . TOILET USE: 1 person assist . In an interview on 09/25/24 at 10:02 AM, Family Member (FM) VV reported the facility was not doing showers for the residents due to the COVID outbreak in the building. In an interview on 09/27/24 at 03:15 PM, Family Member (FM) VV inquired with CNA K if Resident #27's shower days had been switched to Saturday nights as they had church on Sundays. CNA K reported his shower days were Fridays and Tuesdays. During an observation on 09/27/24 at 03:27 PM, FM VV inquired with the nurse for Resident #27 when he had a shower last. She informed FM VV the resident would receive a shower tonight (which was a Friday) on second shift. FM VV reported to the nurse she wanted his shower day changed to Saturday for church on Sunday. Resident #80: Review of an Admission Record revealed Resident #80 was a female with pertinent diagnoses which included diabetes, stroke with left sided weakness, and high blood pressure. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of current Care Plan for Resident #80, revised on 10/1/24, revealed the focus, .At risk for falls due to history of falls, poor safety awareness, unsteady gait, hx (history) of CVA (cerebral vascular accident) . with the intervention .Bed in low position when resident is in bed . Review of Kardex for Resident #80 dated 10/1/24, revealed, .Safety: Bed in low position when resident is in bed .hipsters on at all times .signage at bedside to encourage resident to call for assistance prior to transferring .toilet frequently with cares .toileting x 1 person . In an interview on 10/01/24 at 01:03 PM, CNA J reported Resident #80 was incontinent and she doesn't use the toilet. She reported the CNAs reviewed the kardex to inform them of how to take care of the residents they were assigned to for the shift. Review of Important Resident Information posted on the wall above the head of Resident #80's bed revealed, .ADL FMP: Take (Resident #80) to the toilet first thing in the morning Allow (Resident #80) extra time to participate with dressing and toileting. She can help--needs minimal assistance . In an interview on 09/27/24 07:04 PM, Anonymous LLL reported Resident #80 had such long toe nails the nails were cutting her skin between the toes. Resident #80 was observed to be completely soaked in the morning and he(sic-her) bottom was red. She was care planned to be taken to the toilet first thing in the morning and if the staff took her to the bathroom regularly she would go. Anonymous LLL reported Resident #80 would use the toilet when staff assisted to the restroom, but staff would leave Resident #80 in her bed soaked, and then would need to change her and her bedding. Resident #28: Review of an Admission Record revealed Resident #28 was a female with pertinent diagnoses which included muscle weakness, diabetes, heart failure, acquired absence of right leg below knee, acquired absence of left leg below knee, and end stage renal disease. Review of a Minimum Data Set (MDS) assessment for Resident #28, with a reference date of 8/4/24 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated Resident #28 was cognitively intact. Review of current Care Plan for Resident #28, revised on 7/29/24, revealed the focus, .ADL Self-care deficit d/t impaired mobility, poor endurance and activity intolerance, ble amputee. Asthma, DM, Morbid obesity, CHF, Depression, CKD Stage . with the intervention .ADL Assist: 1 person assist bed mobility: 1 person assist .transfer: 1 person assist with slide board and gait belt, except for dialysis days which the transfer is 2-person assist with full mechanical lift. Please use white or gray sling for Dialysis .Assist to bathe/shower as needed .Assist with daily hygiene, grooming, dressing, oral care and eating as needed . During an observation and an interview on 10/01/24 at 09:30 AM, Resident #28 was lying in her bed which was not low to the ground. Resident #28 reported she did not get bathed or showered during the entire time she was on isolation precautions. She reported she did not remember the last time she had received a shower and that it had been a long time. Resident #28 reported she was unsure when the last time was she had her hair washed was. She reported she finally received a bed bath the previous night but when she asked staff to use the shower cap to wash her hair, they informed her the facility did not have any of those. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 10/01/24 at 10:47 AM, CNA M reported when the residents would refuse a shower, they would report it to the nurse and document it in the medical record. The nurse would also document in the medical record of the resident's refusal. In an interview on 09/27/24 at 06:26PM, Anonymous LLL reported the residents were not receiving their showers. The CNAs were to do their own showers and if there was one CNA, the CNA couldn't leave the hallway unsupervised, so the residents weren't getting their showers. For example, on C Hallway, there were quite a few falls, so the facility needed to have someone in the halls to keep an eye on them. 36221 Resident #5 Review of an Admission Record revealed Resident #5 was a female, with pertinent diagnoses which included chronic respiratory failure, muscle weakness, anemia, morbid obesity, peripheral vascular disease (PVD), high blood pressure, diabetes, seizure disorder, neuropathy (weakness, numbness, and pain from nerve damage), and major depression. Review of a Minimum Data Set (MDS) assessment for Resident #5, with a reference date of 8/21/24, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. Review of a current Care Plan for Resident #5 revealed the focus .(Resident #5) has an ADL (Activities of Daily Living) Self care deficit as evidenced by weakness r/t (related to) morbid obesity, Chronic respiratory failure, PVD, Idiopathic neuropathy . initiated 4/2/24, with interventions which included .Assist to bathe/shower as needed . initiated 6/7/24, and .assist x 1 with bathing, dressing and grooming needs . initiated 4/5/24. In an observation and interview on 9/25/24 at 1:19 PM, Resident #5 was in bed in her room. Resident #5 reported she preferred to get washed up in bed due to concerns with the shower room. Resident #5 reported the aides assist her with bed baths .once in a while . and at times use a hair-washing cap to clean her hair. Resident #5 stated .but my hair is still really ooey and gooey after that . Resident #5 became tearful and stated .I wash my hair in the sink. This last year I have been so sick that I don't have the strength to stand up by the sink. I just take a washcloth and wet it down, and go through my hair . In an observation and interview on 10/1/24 at 2:32 PM, Resident #5 was in bed in her room. Resident #5 reported in regard to frequency of bed baths, staff assist her with a bed bath .at least halfway once a week . Resident #5 clarified and reported that she gets cleaned up in different areas throughout the week. Resident #5 reported her legs are washed when dressing changes are completed, her armpits in the mornings, and her private area with brief changes. Resident #5 stated staff have not washed her hair .in a long time . Noted Resident #5's hair appeared greasy, with visible flakes of dry skin noted along her hairline. Review of the Master (Unit Name) Shower Schedule, updated 8/1/24, revealed Resident #5 was scheduled for showers/baths on Wednesdays and Saturdays, first shift. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #5's Task: Type of Bathing/ GG Shower Bath documentation for the past 30 days revealed refusals documented on Wednesday 9/4/24, Saturday 9/7/24, Wednesday 9/11/24, Saturday 9/14/24, Saturday 9/21/24, and Wednesday 9/25/24. This task was documented as Not Applicable on Wednesday 9/18/24. Noted no documentation of a completed shower or bed bath for Resident #5 in the past 30 days. Review of the Progress Notes for Resident #5, from 9/1/24 to 9/27/24, revealed no documentation related to showers/bed baths completed, or refusals of scheduled showers/bed baths. Personal hygiene affects patients' comfort, safety, and well-being. Hygiene care includes cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities such as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation, foster a positive self-image, promote healthy skin, and help prevent infection and disease. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition. 47955 Resident #57 Review of an Admission Record revealed Resident #57 had pertinent diagnoses which included: cerebral infarction (stroke) and hemiplegia and hemiparesis affecting right dominant side (lack of use of the right side of the body). Review of a Minimum Data Set (MDS) assessment for Resident #57, with a reference date of 6/11/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #57 was cognitively intact. In an interview on 9/25/24 at 1:25 PM., Resident #57 reported she had not had a shower in the last week, nor was she getting a bed bath. Resident #57 reported she was told no showers were being given due to an outbreak in the facility. On 9/25/24 at 1:30 PM., there was no noted indication that Resident #57 was on isolation precautions. In an interview on 9/25/24 at 3:10 PM., Licensed Practical Nurse (LPN) H reported residents who were in isolation due to the outbreak were not to be transported to the shower room, but residents who were not in isolation should be getting showers. In an interview on 9/26/24 at 3:08 PM., Nursing Schedule Coordinator (NSC) QQ reported showers did not get done when staffing was short. In an interview on 9/27/24 at 2:28 PM., Resident #57 reported she still had not had a shower in two weeks. Resident #57 reported her shower days were Monday, Wednesday, and Friday. Resident #57 reported the last shower she received was September 11, 2024. Resident #57 reported she had been told by staff that not enough staff working was a reason she did not get her showers on her assigned days. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Master B Hall Shower Scheduled provided by the facility with a revision date of 8/1/24 revealed showers were assigned by room numbers and were to be given on two days each week on either Monday and Thursday, or Tuesday and Friday or Wednesday and Saturday. Resident #57 room number (omitted) was listed to have a shower on .Monday and Thursday, Tuesday and Friday, and Wednesday and Saturday, 1st shift . Review of Bathing/GGShower Bath for 30 days beginning on 9/2/24 revealed .documentation on 9/2/24 at 13:59 (1:59 PM), 9/4/24 at 13:33 (1:33 PM) and 9/11/24 at 10:54, indicated Resident #57 received a shower. Documentation noted on 9/23/24 at 7:53 and 9/25/24 at 13:59 (1:59 PM), indicated that Resident #57 did not receive a shower as the task was documented as not applicable . In an interview on 9/27/24 at 3:00 PM., Certified Nursing Assistant (CNA) W reported when the facility was short staffed, resident showers did not get completed during a shift. In an interview on 9/27/24 at 4:09 PM., CNA U reported some of the things that were not completed when the facility was short staffed included resident showers. In an interview on 10/1/24 at 9:24 AM., Infection Preventionist (IP) C reported her expectations were residents who were not on isolation should still be getting showers in the shower room. IP C confirmed that Resident #57 was not on isolation.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 This citation pertains to intake MI00146657 Based on observation, interview, and record review the facility failed to ensure sufficient staffing, resulting in the potential for unmet care needs of the residents who resided in the facility. Findings include: Review of (Name Omitted) Daily Schedule dated 9/25/24 revealed . shift times for nurses was 6 am to 6 pm, scheduled were 3 nurses for 12 hours, and one nurse for a 6-2 shift .7 Certified Nurse Assistants (CNA) scheduled for day shift 6 am to 2 pm with no shower aides scheduled . Review of (Name Omitted) Daily Schedule dated 9/26/24 revealed .RN/LPN (registered nurse/licensed practical nurse) 6 pm to 6 am scheduled were one on A hall and one on C hall . In an interview on 9/25/24 at 1:15 PM., LPN/Agency BBB reported it was her first day, her first shift and she had had no training or orientation. In an interview on 9/25/24 at 1:52 PM., Resident #57 reported she had not had a shower in a week and two days because there was not enough staff to give showers. In an interview on 9/25/24 at 3:10 PM., LPN H reported staffing should be one nurse, and two to three CNAs on each of the four halls. LPN H reported call ins were a problem, and when a call in happens, staff was moved to split a hall making staffing one and a half on each of the halls. LPN H reported the facility started using agency within the last couple of weeks, and that management did have to cover open shifts on the floor. In an interview on 9/26/24 at 8:30 AM., Resident #42 reported when the facility was short staffed she did not get her shower or fresh water at the bedside. Resident #42 reported the staff will tell the resident they were short staffed and they did not have time to give showers. In an interview on 9/26/2024 at 2:27 PM., Nursing Staff Coordinator (NSC) PP stated Staffing is challenged. NSC PP reported staffing had been short on the weekends for several months and the facility started using agency staff on September 14, 2024, to cover open shifts. NSC PP reported call ins or staff not showing up to scheduled shifts was a problem, and if another staff member or agency staff picked up the last-minute shift, it would take time to get to the facility. NSC PP reported when CNAs had to be reassigned due to call ins, CNAs from halls C and D were the first ones moved to other halls for coverage. NSC PP reported she and other management staff have had to work the floor to cover for the staffing shortage. In an interview on 9/26/24 at 3:08 PM., NSC QQ reported staffing was not great on the weekends and there was not enough staff to meet the needs of the residents. NSC QQ reported that showers did not get done when staffing was short. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 9/26/24 at 3:10 PM., NSC PP reported ideal staffing on day shift was three on each of the four halls. NSC PP reported there had been day shifts with only one CNA on each hall, and another CNA to split A and B hall and a CNA to split C and D hall for a total of 6 CNAs. NSC PP reported there had been shifts with only one CNA on each of the four halls. In an interview on 9/26/24 at 3:34 PM., NSC PP reported when there were 3 CNAs between C and D hall, showers did not get done. In an interview on 9/26/24 at 4:40 PM., Clinical Coordinator (CC) UU reported the facility had consistent call ins and staff who worked only part of a shift or staff who did not complete their scheduled shifts which caused a disruption in the schedule. CC UU reported CNAs are scheduled both 8- and 12-hour shifts which caused a gap in coverage where only one CNA was working on a hall for several hours. CC UU reported halls that have higher acuity (level of care or assistance a resident may require) or more dependent (relying on others for care) residents should have at least two CNAs assigned to those halls. In an interview on 9/26/24 at 4:45 PM., Nursing Home Administrator (NHA) A reported resident of the facility had complained the facility was short staffed and he had completed a past noncompliance report. Review of Facility assessment dated [DATE] revealed .A hall staffing requirements (based on numbers, not acuity) were 1 nurse 6 am to 6 pm and 1 nurse 6 pm to 6 am; 1-3 CNAs 6 am to 2 pm, 1-2 CNAs 2 pm to 10 pm, and 1 CNA 10 pm to 6 am; B hall staffing requirements were 1 nurse 6 am to 6 pm and 1 nurse 6 pm to 6 am; 1-3 CNAs 6 am to 2 pm, 2 CNAs 2 pm to 10 pm, and 1 CNA 10 pm to 6 am; C hall staffing requirements were 1 nurse 6 am to 6 pm and 1 nurse 6 pm to 6 am; 2 CNAs 6 am to 2 pm, 2 CNAs 2 pm to 10 pm, and 1 CNA 10 pm to 6 am; D hall staffing requirements were 1 nurse 6 am to 6 pm and 1 nurse 6 pm to 6 am; 3 CNAs 6 am to 2 pm, 2 CNAs 2 pm to 10 pm, and 1 CNA 10 pm to 6 am . In an interview on 9/27/24 at 3:00 PM., CNA W reported when the facility was short staffed, resident showers and passing of fresh ice water were some of the tasks that did not get completed during a shift. In an interview on 9/27/24 at 4:09 PM., CNA U reported staff that consistently showed up was being burnt out by having to do all the work with no additional help. CNA U reported some of the things that were not completed when the facility was short staffed included resident showers and bedside water for residents. In an interview on 10/1/24 at 9:24 AM., Resident #19 reported she had been told in August she could not get a shower due to the facility being short staffed. See F677 for additional information. 41424 In an interview on 09/25/24 at 10:29 AM, Licensed Practical Nurse (LPN) I reported the agency had been brought in the last few weeks, the Director of Nursing and the Administrator left, and a bunch of nurses left after they did. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235395	A. Building B. Wing	10/01/2024

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/27/24 09:41 AM, review of the resident listing revealed C Hallway had 18 residents with one CNA to provide care for them. The schedule indicated it was a split assignment but this writer did not observed the split CNA on the hallway throughout the observations the whole day. In an interivew on 09/27/24 at 09:45 AM, Anonymous LLL when queried reported the C Hallway always had one CNA. The CNAs never got breaks because there was not enough staff to cover. In an interview on 09/27/24 06:26PM, Anonymous LLL reported the administration staff would never come to the hallway to assist the nursing staff unless the surveyors were in the building. The situation in the facility was so bad many of the CNAs had quit or went as needed, and the facility couldn't get anyone to work. The residents were not taken care of and not getting the showers even before the COVID outbreak. Anonymous LLL reported the residents were not receiving their showers. The CNAs were to do their own showers and if there was one CNA, the CNA couldn't leave the hallway unsupervised so the residents weren't getting their showers. For example on C Hallway, there were quite a few falls, so the facility needed to have someone in the halls to keep an eye on them. Anonymous LLL reported when new staff start they were not getting fully trained or acclimated to the facility and the residents. The CNAs were to be mentored for three days and that was not happening and they were left on their own most of the time. 48637 During an interview on 9/26/2024 at 2:30 PM, Infection Preventionist (IP) C stated that it depends on the circumstances, but she works the floor as a nurse one to two times a week and it is 12-hour shifts. IP C said that patient care is first so her job duties have to be put aside when she works the floor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 This citation pertains to intake: MI00147064 Based on interview, observation, and record review, the facility failed to:1.) implement effective infection control to prevent the spread of COVID-19 and, 2.) maintain effective Enhanced Barrier Precautions (EBP) for 3 of 21 residents (Resident #23, #17, and #51) reviewed for infection control, resulting in the potential for the continued spread of COVID-19 with negative resident outcomes and the increased risk for the transmission/transfer of pathogenic organisms and cross contamination between residents. Findings include: Review of the COVID Positive list of residents received on 9/27/24, revealed, there were 50 COVID positive residents out of a census of 82 at entry. During an observation on 09/25/24 at 09:21 AM, There were yellow Stop Signs posted on the wall for Rooms D-106 and D-109 with no other signage which indicated the appropriate PPE (personal protective equipment) to wear or to see a nurse prior to entering a room. There were no PPE carts/bins outside of the door. In an interview on 09/25/24 at 09:21 AM, Medical Records (MR) RR reported she was still a certified nursing assistant (CNA). She reported the yellow Stop signs indicated the residents for the room were under COVID precautions. MR RR reported the majority of the residents were coming off of COVID precautions soon, when they come off, housekeepers come in the room and clean it while they were in the shower room getting a shower. MR RR reported the residents were taken out of their rooms during isolation and provided a shower. MR RR reported she was central supply and normally the third shift CNAs were stocking the PPE bins and she would also walk around during her shift, 7 AM - 3 PM to make sure the PPE bins were stocked. In an interview on 09/25/24 at 10:46 AM, CNA N reported the residents only had bed baths done in the rooms during the Covid outbreak. For those residents who were capable of washing themselves, she would bring them a basin so they were able to wash themselves up. In an interview on 09/25/24 at 09:53 AM, Nursing Staff Coordinator (NSC) PP reported she had been a CNA for years before becoming the scheduler. NSC PP reported when the COVID outbreak happened the infection preventionist (IFP) came around and re-educated the staff on the use of PPE. During an observation on 09/25/24 at 11:01 AM, Social Services Coordinator (SSC) OO was observed at the PPE cart grabbed a gown, had gloves in his hands, and a surgical mask on his face. He went into Covid positive room, and the CNA gave him an N95 when she entered the room. SSC OO did not don a face shield prior to entering the room as well. During an observation on 09/25/24 at 11:06 AM, SSC OO exited the room removed his glasses and placed them on the top of the PPE bin and did not sanitize them. He was observed heading down the hallway to his office to throw away his N95 mask as there was not waste basket in the hallway. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 09/26/24 at 09:34 AM, Resident #58 had a yellow Stop Sign on the wall out side of her room. Licensed Practical Nurse (LPN) XX was entering a Covid positive room and she donned gown, gloves, left her surgical mask on, and did not don a face shield. At 09:46 AM, LPN XX exited the room wearing the surgical mask and continued down the hallway to the medication cart and then proceeded towards the nurse's station. In an interview on 09/26/24 at 09:49 AM, LPN XX reported the stop sign was posted for those residents who were COVID positive, and the other sign was for Enhanced barrier precautions. This writer requested LPN XX review the back of the stop sign and she reported for a resident who was diagnosed with COVID, she was to wear an N95, wear a face shield, and replace her mask when finished. During an observation on 09/26/24 at 09:39 AM, SSC OO was entering Resident #23's room to assist her. He asked CNA J to bring the sit to stand into the room. SSC OO entered the resident's room with no face shield on. During an observation on 09/26/24 at 03:01 PM, Resident #28 was lying in her bed. The PPE waste basket was overflowing onto the floor. The contaminated PPE was touching the privacy curtain and the wall where the waste basket was placed. During an observation on 09/27/24 at 03:16 PM, CNA Z entered Room D-109 who was on COVID precautions, without donning any PPE and then she exited out and down the hallway. Resident #23 Review of an Admission Record revealed Resident #23 was a female with pertinent diagnoses which included heart failure, thyrotoxicosis (too much thyroid hormone in your body), lupus (disease that occurs when your body's immune system attacks your own tissues and organs, sarcopenia (muscle loss that occurs with aging and/or immobility, and high blood pressure. Review of Progress Notes dated 9/16/2024 at 00:00 AM, revealed, .CHIEF COMPLAINT: COVID f/u . HISTORY OF PRESENT ILLNESSES: General: Patient is a [AGE] year old female .who is being seen today for an acute visit. Patient was recently diagnosed with COVID 19. She is requesting assistance to ambulate to the toilet. She mainly ambulates with use of her wheelchair but is able to take a few steps with her walker. She complains of having diarrhea, and reports that it is chronic. She reports feeling a little poor today, reports a cough with phlegm, and denies shortness of breath or other respiratory symptoms. She denies any pain or discomfort at this time. Her vitals are reviewed and noted to be stable. She is afebrile . Review of Nursing - Progress Note dated 9/18/2024 at 08:28 AM, revealed, .Resident not responding to voice or physical touch. resp shallow. O2 on at 2L. skin warm and dry. NP visited. orders received to send to (Local Hospital) ER for eval. 911 called and report called to (Local Hospital) ER . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Medical ICU Attending Physician Note dated 9/18/24 at 1:28 PM, revealed, .EMS was called for hypoxia and altered mentation. The patient had been diagnosed with COVID on 9/15. She was found to be hypoxic with oxygen saturation in the 60% range on room air. She was administered DuoNeb(bronchodilator sued to open the airways to the lungs) and seemed to improve some but her oxygenation remained low. She then reportedly had an episode of posturing and there was concern for seizure so she was administered 5 mg of IV Versed. She became somnolent (drowsiness) with minimal respiratory effort after this. She arrived to the emergency department with a GCS of 3 (Glasgow Coma Scale, used to measure a patient's level of consciousness. A score of 3 very low.) and was intubated for airway protection .She received a total of 1 L of IV fluids per ED nursing (500 mL by EMS and 500 mL in the emergency department. She was febrile and had atrial fibrillation with rapid ventricular rate up to the 140s. However, her blood pressure was stable. The patient was more alert during my evaluation in the emergency department was purposefully moving her hands towards the endotracheal tube. She required additional propofol (anesthetic used for sedation) for comfort and heart rate control .Pertinent physical exam findings: Chronically ill, critically ill, obese female who is intubated, sedated and mechanically ventilated (tube was inserted into a patient's airway with a machine to assist with the work of breathing) .Lungs demonstrate scattered coarse rhonchi (low-pitched, continuous rattling lungs sounds often described as snoring or gurgling) with diminished breath sounds at bilateral bases. Irregularly irregular with atrial fibrillation on telemetry with rates in the 120s on telemetry .Pertinent Laboratory data: ABG (arterial blood gas) demonstrates respiratory acidosis (decreased ventilation increases the concentration of carbon dioxide in the blood) with poor oxygenation on 50% FiO2 (% of oxygen in a gas mixture, The FiO2 for room air is 21%) .Positive COVID .Assessment: Acute hypoxemic (low level of oxygen in the blood) and hypercapnic (CO2 retention) respiratory failure .Sepsis secondary to COVID-19 pneumonia with possible bacterial coinfection .Plan: Continue full ventilatory support with weaning when appropriate . Initiate remdesivir (antiviral medication to treat a range of viruses) and Decadron (injectable steroid); continue cefepime and vancomycin; (antibiotic injection used to treat serious infections) .Sepsis due to COVID-19 from Pneumonia with SIRS criteria, Acute hypoxic respiratory failure, Acute hypercapnic respiratory failure, Respiratory acidosis, and Acute toxic metabolic encephalopathy .note possible seizure activity by EMS was likely secondary to hypoxia and hypercapnia .Due to a high probability of clinically significant, life threatening deterioration, this patient required my highest level of preparedness to intervene emergently . Review of Progress Note dated 9/25/2024 at 00:00 AM, revealed, .Follow up after re-admission. HISTORY OF PRESENT ILLNESSES: General: Patient is a [AGE] year old female .who is being seen today for follow up after hospital admission. Patient was intubated with ET tube and orogastric tube. A fib with rapid ventricular rate has been observed in the ER. Respiratory acidosis, elevated bicarbonate level . Antibiotic treatment provided for possible bacterial infection along with Covid. Chest x-ray on 09/18/24 has shown suspected right plural effusion with adjusted patchy atelectasis (complete or partial collapse of a lung), and or consolidation within the right lung base, mild pulmonary, vascular congestion. patient has been discharged with the instructions of continuous 2 L per minute oxygen as tolerated. Patient states that she is feeling good. Breathing is better. Working on breathing exercise. States that speaking has been improved. No other concerns at this time . In an interview on 09/26/24 11:24 AM, Resident #23 reported she had requested the COVID booster shot for the last few months and she did not get it. She reported she did not know why she was sent to the hospital as she was so out of it and had no idea. Resident #23 reported she had been intubated for 3 days, and she never wants that to happen again as it was so scary for her, not knowing what was going to happen to her. When queried in regards to her oxygen use, Resident #23 reported she guessed the oxygen was here to stay. (continued on next page)

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	235395	A. Building B. Wing	10/01/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview 10/01/24 09:11 AM, Licensed Practical Nurse (LPN) FFF reported when she went to check on her early in the day, the resident was not super responsive, very lethargic, and that was not like her at all. LPN FFF reported the resident's respirations were shallow, she seemed to be struggling to breath, and she had oxygen on. Resident #23's oxygen saturation was not very high. LPN FFF reported at this time, the resident was only using oxygen overnight. When she was diagnosed with COVID she started wearing it all the time. She was not breathing right, used a lot of muscles to breath. LPN FFF reported she was not normally lethargic and not as responsive, normally the resident would engage in conversation and would respond right a way. 48637 Resident #17 (R17) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R17 readmitted to the facility on [DATE] with diagnoses of tracheostomy and traumatic brain injury. Brief Interview for Mental Status (BIMS) reflected a score of 5 out of 15 which indicated R17 was severely cognitively impaired (00 to 07 is severe cognitive impairment). Review of R17's physician orders revealed Enhanced Barrier Precautions: Indwelling Medical Device, Trach (Tracheostomy tube) : Care every shift and prn (as needed). Surgical chest wound Enteral (Tube) Feed . On 9/25/2024 at 10:35 AM, it was observed that R17 did not have an Enhanced Barrier Precautions (EBP) sign on his door. During an interview on 9/25/2024 at 10:28 AM, Licensed Practical Nurse (LPN) BBB stated it was her first day working as an agency nurse in the facility. When asked what EBP means, LPN BBB said she didn't know. She also stated that she didn't know R17 should be on EBP with his trach and said when performing trach care on him she wears gloves and a mask and no gown. On 9/26/2024 at 8:00 AM, an EBP sign was observed outside of R17's door. During another interview on 9/26/2024 at 8:13 AM, LPN BBB stated that she understands EBP now since she spoke to someone for clarification and knows it's for any residents with an indwelling device or wounds. She said that anyone that talks to a resident who is under EBP must wear a gown, mask and gloves even if care isn't being provided. During an interview on 9/26/2024 at 8:24 AM, Certified Nursing Assistant (CNA) L stated that she didn't know what the EBP sign meant outside R17's room and it must be a mistake. CNA L said that she wasn't sure if gowns should be used in an EBP room. Review of Centers for Disease Control and Prevention (CDC) dated March 20,2024 revealed .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities Effective Date: April 1, 2024 . (continued on next page)

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	235395	A. Building B. Wing	10/01/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #51 (R51) Review of the Face Sheet and Minimum Data Set (MDS) dated [DATE] revealed R51 admitted to the facility on [DATE] with diagnoses of type 1 diabetes, anxiety and depression. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R51 was cognitively intact (13 to 15 cognitively intact). On 9/25/2024 at 11:46 AM, there was a STOP sign outside of R51's room which indicated she had COVID and precautions that needed to be taken were listed on the back of the sign. Review of the COVID positive list provided by the facility revealed she tested positive for COVID on 9/19/2024. Review of R51's chart revealed no order for COVID precautions. During an interview on 9/25/2024 at 11:46 AM, R51 stated that she was finally feeling better and was looking forward to moving back to her previous room. Review of R51's chart revealed she had a room change on 9/20/2024 after she tested positive for COVID. During an interview on 9/25/2024 at 10:28 AM, when discussing the COVID residents on her hall, LPN BBB said that staff were wearing N95 masks, gown and gloves when going into COVID positive resident rooms but they weren't wearing face shields. During an interview on 9/25/2024 at 1:22 PM, Director of Nursing (DON) B stated that face shields are not optional and must be worn in COVID positive rooms. During an interview on 9/25/2024 at 2:46 PM, Infection Preventionist (IP) C stated if a resident tested positive for COVID then the roommate was tested and if he/she was negative then they were moved to another room if the resident agreed. During another interview on 9/26/2024 at 2:30 PM, Infection Preventionist (IP) C stated that any resident with an indwelling device such as a wound, trach, tube feeding and/or foley needs to be under EBP and staff must wear gloves, gown and a mask when providing care. When asked if staff know the differences between EBP and COVID precautions, IP C stated that staff should be aware of the difference and signs are posted for them to read and know what to do. IP C stated she has a discussion with staff if she sees something wrong when rounding. IP C' said that when someone is on EBP or TBP (COVID) a physician order is put in the chart and care plans are put in place. When discussing why room changes were done with COVID positive and negative residents, IP C said that was the best way to contain it and they tried to keep them on same hallways and not mix them up but it was hard to do. She stated that they would move the exposed but negative residents in with other residents that were found already exposed as close as possible to the same timeline or moved a positive resident with another positive resident. IP C' stated their policy says to not continue with exposure, move the resident out that was negative but she didn't ask the health department if that was recommended. During an interview on 10/1/2024 at 8:46 AM, IP C' stated that they tried to move COVID negative residents together but sometimes to cohort better they moved 2 COVID positives together. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	36221 In an observation on 9/25/24 at 12:39 PM, the lunch tray cart was delivered to the D Hall. Observed Licensed Practical Nurse (LPN) I don a gown, gloves, N95 mask, and face shield prior to entering a COVID-19 positive resident room (marked with a yellow STOP sign) to deliver the lunch meal. Prior to exiting the room, LPN I removed and discarded her gown and gloves, and performed hand hygiene. Noted LPN I did not remove or discard her N95 mask or eye protection upon exiting the COVID-19 positive resident room. LPN I then continued down the D Hall, delivering lunch trays to residents on the unit, while wearing the same N95 mask and face shield. In an observation on 9/25/24 at 12:51 PM, LPN I continued to deliver lunch trays to residents on the D Hall. Noted LPN I still wore the same N95 mask and face shield initially donned prior to entering a COVID-19 positive resident's room. In an observation and interview on 9/25/24 at 12:59 PM, LPN I finished passing lunch trays on the D Hall, removed her N95 mask and face shield, and placed the used PPE on the top of the D Hall medication cart before donning a surgical mask. LPN I reported when entering multiple COVID-19 positive resident rooms, she changes her gown and gloves between residents but wears the same N95 mask and face shield. In an observation and interview on 9/26/24 at 8:57 AM, Certified Nursing Assistant (CNA) O donned a gown, gloves, and face shield, in addition to a surgical mask already worn, prior to entering a COVID-19 positive resident room (marked with a yellow STOP sign) on the B Hall. When care was completed, CNA O exited the room, removed her PPE (Personal Protective Equipment) in the open doorway, placed the soiled PPE in a clear plastic trash bag, and discarded the trash in the soiled utility room. CNA O reported a N95 mask was not required in the room. Noted the back of the yellow STOP sign listed the required PPE to be worn in the room, which included a gown, gloves, eye protection, and a N95 mask. In an interview on 9/26/24 at 11:33 AM, Infection Preventionist C reported for COVID-19 positive resident rooms, staff are required to don a gown, gloves, N95 mask, and face shield (eye protection) prior to entering the room. Infection Preventionist C reported staff should place a surgical mask over the N95. Infection Preventionist C reported prior to exiting the COVID-19 positive resident room, staff should remove and discard the gown, gloves, face shield, and surgical mask, and exit wearing the N95 mask. Staff should then dispose of the used N95 and switch to a new surgical mask. Review of the Centers for Disease Control (CDC) Infection Control Guidance: SARS-CoV-2 (June, 2024) Nursing Homes .Placement of residents with suspected or confirmed SARS-CoV-2 infection: Ideally, residents should be placed in a single-person room as described in Section 2. If limited single rooms are available, or if numerous residents are simultaneously identified to have known SARS-CoV-2 exposures or symptoms concerning for COVID-19, residents should remain in their current location. Source control options for HCP include: A NIOSH Approved(R) particulate respirator with N95(R) filters or higher; A respirator approved under standards used in other countries that are similar to NIOSH Approved N95 filtering facepiece respirators (Note: These should not be used instead of a NIOSH Approved respirator when respiratory protection is indicated); (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A barrier face covering that meets ASTM F3502-21 requirements including Workplace Performance and Workplace Performance Plus masks; OR A well-fitting facemask. When used solely for source control, any of the options listed above could be used for an entire shift unless they become soiled, damaged, or hard to breathe through. If they are used during the care of patient for which a NIOSH Approved respirator or facemask is indicated for personal protective equipment (PPE) (e.g., NIOSH Approved particulate respirators with N95 filters or higher during the care of a patient with SARS-CoV-2 infection), they should be removed and discarded after the patient care encounter and a new one should be donned.