

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  10/24/2024
NAME OF PROVIDER OR SUPPLIER  Optalis Health and Rehabilitation of Three Rivers		STREET ADDRESS, CITY, STATE, ZIP CODE  517 S Erie St Three Rivers, MI 49093	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>41982</p> <p>Based on interview and record review, the facility failed to ensure the identification and timely reporting of an injury of unknown origin in one Resident (#100) of three residents reviewed for reporting, resulting in the potential for unidentified abuse or neglect and further exposure to abusive situations.</p> <p>Findings include:</p> <p>Resident #100</p> <p>Review of an Admission Record revealed Resident #100 was a female, with pertinent diagnoses which included: age-related osteoporosis with current pathological fracture, left femur, initial encounter for fracture (Onset Date 10/15/24) and vascular dementia.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 9/10/24 revealed a Brief Interview for Mental Status (BIMS) score of 4, out of a total possible score of 15, which indicated Resident #100 was severely cognitively impaired.</p> <p>Review of a Facility Reported Incident (FRI) document for Resident #100 revealed, Type of Alleged Incident: Injury of Unknown Source .Date/Time Incident Discovered: 10/15/2024 07:30 PM Date/Time Incident Occurred: 10/15/2024 07:30 PM Incident Summary: Resident complained of pain during transfer to bed. X-ray taken showed fracture of L (left) femur (thigh bone). Physician notified. Family notified. Hospice notified. Pain management intervention initiated immediately. Non-weight bearing until further notice. Full investigation to follow .Incident Submission Submitted By: Registered Dietitian and Nursing Home Administrator in Training (NHAT) J .Submitted Date/Time: 10/16/2024 10:11 AM .</p> <p>Review of Resident #100's Radiology Results Report with an Examination Date of 10/15/24 at 9:21 PM and a Reported Date of 10/15/24 at 9:56 PM revealed, PROCEDURE: FEMUR 1 VIEW INTERPRETATION . There is diffuse bone demineralization. There is a fracture deformity of the distal femur supracondylar region (thigh bone just above the knee joint) with minimal displacement. Disease suboptimally evaluated . CONCLUSION: Distal femur fracture .</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #100's Nursing Progress Note dated 10/16/24 at 1:12 AM revealed, Note Text: During Med pass, nurses aide requested writer to observed (sic) resident. Upon entering residents room, supine (on back with face and torso facing up) with both legs bilaterally (both sides) together in a upwards position. When assessed writer noticed that during palpation (using hands to examine) resident made nonverbal gestures grabbing and tugging on writers forearm, when palpated residents left lower leg area. When asked if resident was in any pain in the area resident stated yes. Writer obtained order for Xray STAT (without delay). During Xray, Pelvis and lateral (away from the middle or to the side) femur examined. Xray employee not able to obtain full femur Xray due to residents contractions. Radiology reports Distal femur (the lower part of the thigh bone forming the top of the knee joint) Fracture .</p> <p>Review of Resident #100's Nursing Progress Note dated 10/16/24 at 2:11 PM revealed, Note Text: DON (Director of Nursing) contacted last night at approximately 730pm by floor nurse regarding suspicion of injury to L (left) leg. Nurse was instructed to call abuse coordinator and report possible injury. Floor nurse notified DON that she was unable to reach abuse coordinator at that time. DON called abuse coordinator and spoke with him regarding possible injury. Administrator in training was also notified by DON of situation. (Medical Doctor (MD) M) was called by DON and aware of situation and all updates. Floor was instructed to contact hospice as well as residents POA (power of attorney).</p> <p>Review of the facility Policy &amp; Procedure Policy Title: Abuse last updated 5/24/2023 revealed, .INITIAL REPORTING: The facility will ensure that all allegations involving . injuries of unknown source .are reported immediately to the Administrator and: * Reported to the State Survey Agency immediately but not later than two hours after the allegation is made if the allegation involves abuse or results in serious bodily injury and to other officials (including adult protective services and/or law enforcement, when applicable) .DEFINITIONS . Injury of Unknown Source When all of the following conditions are met: The source of the injury was not observed by any person; AND The source of the injury could not be explained by the patient/resident; AND The injury is suspicious because of the extent of the injury, the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma), the number of injuries observed at one particular point in time, or the incidence of injuries over time .</p> <p>In an interview on 10/24/24 at 9:49 AM, NHAT J and Regional Clinical Services Director (RCSD) G were queried on the reporting requirement for Resident #100's injury of unknown origin, a distal femur fracture. RCSD G reported the timeline for reporting in this case was immediately but no more than 2 hours. RCSD G reported that Former Interim Nursing Home Administrator (FINHA) Q had been the administrator in charge for 2 days at the time that Resident #100's injury was discovered but that he had called off work on his second day, 10/15/24. NHAT J reported he had submitted the FRI, the Injury of Unknown Source, to the State Agency the next day, 10/16/24.</p> <p>In an interview on 10/24/24 at 10:39 AM, Director of Nursing (DON) B reported in the evening on 10/15/24, she had received a call from Licensed Practical Nurse (LPN) O who reported they believed Resident #100 had fractured her leg because it appeared visibly deformed when they had gotten her in bed. DON B reported she then contacted MD M and relayed what had been reported to her by LPN O. DON B reported at that point MD M had ordered the STAT Xray. DON B reported had spoken to MD M throughout the evening of 10/15/24 and that MD M thought the fracture may be pathological (weakness of the bone structure) but that the facility was reassured the next morning when the team went over everything together and did a timeline.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 10/24/24 at 2:27 PM, Current Interim Nursing Home Administrator (CINHA) A reported the expectation to report a FRI, an Injury of Unknown Source, to the State Agency was within 2 hours of discovery and to start an investigation immediately. CINHA A reported Resident #100's fracture had not been reported within the 2-hour timeframe because the physician had thought the fracture was pathological and not abuse and that there was a note or something from the doctor to that effect in the resident's medical record. This writer requested the physician's note from the facility at this time.</p> <p>In an interview on 10/24/24, DON B reported there was no documentation in Resident #100's medical record that it had been determined that Resident #100's fracture was pathological and not because of abuse but showed this surveyor a record on her cellular phone that showed that she spoke with MD M on 10/15/24 at 10:45 PM for 7 minutes. DON B reported it was during this call that it was determined by the physician that the fracture was pathological. A handwritten statement was provided to this surveyor at that time by DON B which read, 10/15/24 at 10:45 PM, (DON B) called (MD M) and spoke with her about probability of Fx (fracture) being pathological. (MD M) determined she believed it was pathological and abuse was not suspected over disease process.</p> <p>On 10/24/24 at 4:24 PM, DON B sent electronic correspondence to this surveyor with an attached statement from MD M which read, Witness statement from 10/15 fracture It is my medical opinion, that after being aware of the patient's past medical history and being aware of her risk factors that the fracture she suffered could be considered a pathological fracture after receiving the results of the X-ray and discussing the case with the DON at 10:45pm on 10/15 (MD M). There was no indication that a full investigation as to whether the resident was mistreated or transferred inappropriately had been discussed by MD M, DON B, or any other member of the management team to determine full cause of Resident #100's fracture.</p>		