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	02/21/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 This citation pertains to intake MI00150000. Based on interview and record review the facility failed to prevent the misappropriation of scheduled narcotic medication for 2 (R111 and R103) of 3 residents reviewed for misappropriation of property, resulting in the potential for ongoing misappropriation of narcotic medications. Findings include: R110 & R111 Review of R111's medical record Census revealed STOP BILLING on 12/31/24. Review of R111's Controlled Drug Receipt/Record/Disposition Form dated 1/12/25 revealed at 9:00 AM, RN T had removed 1 Morphine Sulfate 30 mg ER tablet from the card and indicated Medication Error. It was noted R111 had been discharged from the facility on 12/31/24, 13-days prior to the misappropriation. Review of the Medication Error Report dated 1/12/2025 at 10:00 AM revealed, In resident's (R#110) room . Resident due for Morphine 15 mg. Nurse pulled 30 mg dose from wrong card (#R111's) and gave to resident. Residents unable to follow conversation with nurse explaining what error occurred. Resident now requesting more pain medication following dressing change .Level of Pain was an 8 out of 10 . Review of R110's Order Summary revealed: -12/27/24 Morphine Sulfate oral tablet 30 mg. Give 30 mg by mouth three times a day for moderate to severe pain. Discontinue date 1/15/25. -12/31/24 Morphine Sulfate ER (extended release) 15 mg .give 15 mg by mouth (PO) three times a day (TID) for pain. Give with 30 mg tablet to equal 45 mg total TID. Discontinue date 1/7/25. -1/8/2025 Morphine Sulfate ER oral tablet extended release 15 mg. Give 15 mg by mouth three times a day for pain. Give with 30 mg for a total of 45 mg TID. Discontinue date 1/15/2025. Review of R110's Controlled Drug Receipt/Record/Disposition Form dated 1/12/25, revealed Registered Nurse (RN) T had signed out 1-Morphine Sulfate 30 mg IR (immediate release) tablet. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R110's Controlled Drug Receipt/Record/Disposition Form dated 1/12/25 revealed at 8:00 PM 9-Morphine Sulfate ER (extended release) 15 mg tablets were dispensed from the pharmacy and recorded by the facility. Review of R110's MAR/TAR (Medication/Treatment Administration Record) dated 1/1/2025-1/31/2025, revealed on 1/12/2025, RN T documented as administering one Morphine sulfate 30 mg tablet and one Morphine sulfate ER 15 mg tablet at 9:00 AM for a total of 45 mg. During an interview and record review on 2/20/25 at 9:00 AM, RN T stated while reviewing R110's Medication Error Report dated 1/12/25, I think what happened was, (R110) gets 2 pills, a 30 mg and 15 mg (Morphine sulfate). I pulled a Morphine pill from another resident's card. I administered two pills to (R110) but I do not know what dose of Morphine it was or whose it was. I notified my supervisor, (RN CC), the doctor, and the resident's son. (RN CC) counted the narcotic drawer with me and we found out whose morphine it was and the dose, but I do not remember. RN T read the IR, discovering 2-Morphine 30 mg tablets were given to (R110) and not 45 mg as ordered. RN T then stated, She (R110) got an extra 15 mg of Morphine. The doctor told me to continue monitoring (R110). The card of morphine belonging to the other resident was pulled so it would not happen again because that resident was not in the building any longer. During an interview on 2/20/25 at 10:53 AM Director of Nursing (DON) B stated, Registered Nurse (RN) T realized she had given (R110) 2-30 mg Morphine Sulfate tablet. I did not know she took 1 of the 30 mgs from another resident and I did not realize (R110) was also missing 1-15 mg Morphine Sulfate table from that specific med pass. So that means (R110) got 60 mg of morphine sulfate instead of 45 mg and 1-15 mg morphine sulfate table was missing. I do not know what happened to the Controlled Drug Receipt/Record/Disposition Forms for (R110's) 15 mg Morphine Sulfate ER. The DON stated she had not done further investigations into the medication misappropriation. Requested from facility on 2/20/25 R110's Controlled Drug Receipt/Record/Disposition Form dated 1/12/25 with the 8:00 AM and 12:00 PM administration record and did not receive by end of survey 2/21/25 at 5:30 PM. R103 Review of R103's Controlled Drug Receipt/Record/Disposition Form Lorazepam 0.5 mg tablet twice daily (8:00 AM and 8:00 PM) revealed: -1/11/25 at 9:30 PM 1-tablet was administered -It was noted that no Lorazepam was administered on 1/12/25 at 8:00 AM -1/12/25 at 8:00 PM, LPN U had administered 1-tablet and wrote Actual Count documented, along with the morning nurse supervisor documenting. -A note was added, One tab missing, notified DON Locked box key with manager, oncoming nurse no access to narcotic medication. -1/12/25 at 7:00 AM, 1-Lorazepam table was administered by the oncoming nurse (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of DON's investigation dated 1/12/25 indicated, On the morning of 1/12/2025, DON was contacted by weekend manager, RN CC, with reports of a possible missing Lorazepam. It was found that two night nurses who had access to the narcotic drawer (D Hall med cart) with suspected missing Lorazepam did not appropriately verify narcotic count previously to administering medication from the narcotic drawer. (LPN U) signed onto the narcotic drawer and (LPN S) administered medication from the drawer including a Lorazepam from the card in question. Upon investigation, DON found a small white pill under the narcotic drawer that was unidentified by DON and floor nurse, but looked as though it could be a Lorazepam. This was put in a drug buster but not signed as destroyed because the facility could not confirm or deny that it was in fact the Lorazepam in question. Review of R103's MAR/TAR 1/1/25-1/31/25 revealed -1/12/25 at 8:00 AM, documentation of 1-Lorazepam 0.5 mg tablet had been administered. It was noted, this was not indicated on the resident's Controlled Drug Receipt/Record/Disposition Form Lorazepam 0.5 mg tablet twice daily (8:00 AM and 8:00 PM) -1/12/25 at 8:00 PM, LPN U documented administration of 1-Lorazepam 0.5 mg tablet. During an interview and record review on 2/20/25 at 12:52 PM, DON B stated, (LPN EE), no longer works here. On 1/11/25 at 6-630 PM was the start of night shift. (LPN EE) the off -going nurse with oncoming nurses (LPN U and LPN S) splitting D hall med cart. (LPN S) did not want to count narcotics on D hall because she felt it was inconvenient. (LPN U) was responsible for the narcotic box key and counted the D Hall narcotics with the off-going nurse. (LPN U) was solely responsible for the narcotic key. That night on 1/11/25 at 21:30 PM, (LPN S) she signed out Lorazepam 0.5 mg for (R103). (LPN S) got the key from (LPN U) without prior counting of the narcotics. It shows on (R103's) Lorazepam control sheet that (LPN EE) gave him 1-Lorazepam at 9:00 AM then another nurse gave that resident 1-Lorazepam on 1/11/25 at 9:00 PM. (LPN EE) counted off the narcotics with (LPN U) when he came on 1/12/25 night shift. The count should have been correct because I didn't get a phone call. It was noted on R103's MAR/TAR dated 1/11/25 at 8:00 AM, R103 was administered 1-Lorazepam by LPN EE who did not document this on the Controlled Drug Receipt/Record/Disposition Form Lorazepam 0.5 mg. Staff did not follow rules. Attempted to contact LPN S on 2/20/25 at 1:38 PM leaving a message to call surveyor back. No call back was received by end of survey 2/21/25 at 5:30 PM. During an interview on 2/21/25 at 7:32 AM, LPN U stated I split D Hall and the med cart with narcotics on 1/11/25 night shift with (LPN S). Normally (LPN S) would count her narcotics in the med cart but I don't believe she did that night. When using D Hall med cart that night for narcotics, I would give (LPN S) the narcotic key and she would take the narcotics she needed from the D Hall med cart. She would sign it out on the controlled substance sheet and the MAR then give me back the key. When our shift was over, she did not count the narcotics with the oncoming nurse. I will say, it was unusual for (LPN S) not to count narcotics. The med error was me. I probably wrote it down wrong, so that was human error. It would have affected the count. I don't remember what happened that night. Other times, when working nights and splitting the D Hall med cart and narcotics, when I had not counted narcotics when starting my shift, I would go ask for the keys from the other nurse(s) but would sign the narcotic out on the controlled substance sheet and MAR to prove I had taken and administered the medication. But I did not have to count narcotics with the oncoming nurse, the other nurse from that night would. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/20/25 at 9:17 AM Licensed Practical Nurse (LPN) V stated, Up until a week or two ago, night nurses shared D Hall med cart (medication cart) because that hall would be split among the night nurses. There normally were three nurses, sometimes two, that shared the narcotic drawer for all residents on D Hall. The nurses would share one key for the one narc (narcotic) drawer. This had gone on for years. Narcotic count (Controlled Substance) is done by each nurse making sure their meds are signed but only one nurse assigned to the D Hall med cart would count in and out. If there was a missing narc and the other nurses said it was not them that took it, then it was a he said/she said and no nurse took the blame. Review of facility policy, Controlled Medication Guidelines revised date: 3/20/2024, revealed, Policy overview-the purpose of this policy is to provide guidelines for controlled medications .Schedule II, III, IV, and IV controlled medications are stored under double lock. The access key to the controlled medications is not the same key that allows access to other medications. The medication nurse on duty maintains possession of a key to controlled medications .Administering Controlled Medications: The licensed nurse will validate the physician's order on the medication administration record matches the controlled medication package and the Controlled Drug Receipt/Record/Disposition Form. When the licensed nurse removes the controlled medication from the package, they will document the quantity removed and the quantity left on the Controlled Drug receipt/Record/Disposition Form. After administration of the controlled medication the licensed nurse will document the administration on the medication administration record .A physical inventory of all controlled medications is completed by two licensed nurses and is documented on the Shift-to-Shift form: At shift change, whenever one nurse relinquishes their keys to another nurse (i.e. anytime they leave the premises for lunch or break, etc.), The on-coming nurse will open the locked medication cart and the double-locked controlled medication box and initiate the count as follows .Complete an incident report detailing the discrepancy, steps taken to resolve it, and the names of all licensed staff working when the discrepancy was noted .The DON, charge nurse, or designee must also report any loss of controlled medications where theft is suspected to the appropriate authorities such as local law enforcement, Drug Enforcement Agency, State Board of Nursing, State Board of Pharmacy, and possibly the State Licensure Board for Nursing Home Administrators .Michigan Licensing and Regulatory Affairs ([NAME]) .Controlled medications should be wasted when: The medication is contaminated (i.e. the medication is dropped .) .

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 This citation pertains to intake MI00150239. Based on interview and record review, the facility failed to prevent the use of physical restraint/confinement for 1 (Resident #100) of 3 residents reviewed for abuse, resulting in Resident #100 being confined by a locked wheelchair placed against the nurse's station and restrained into a seated position. Findings include: Review of an Admission Record revealed Resident #100 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified psychosis (a mental disorder characterized by a disconnection from reality), vascular dementia (progressive disease resulting in loss of cognitive abilities), and generalized anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #100 with a reference date of 11/29/24, revealed a Brief Interview for Mental Status (BIMS) score of 5/15 which indicated Resident #100 was severely cognitively impaired. Section GG of the MDS revealed Resident #100 could walk 50' independently, and did not regularly use a wheelchair. Review of a Care Plan for Resident #100 with a reference date of 9/30/24, revealed a focus/goal/interventions of: At risk for falls due to lack of safety awareness .unsteadiness. Goal: Minimize risk of falls. Interventions: Bed at transfer height .nonskid tape to bedside floor .staff to offer and assist to toilet during nighttime hours . In an interview on 1/18/25 at 1:38pm, Licensed Practical Nurse (LPN) S reported at approximately 2:30am on 2/12/25 she walked by Resident #100 who was seated in a wheelchair, facing the cut out window of the nurse's station. LPN S reported the brakes on the wheelchair were locked, the armrests were against the half wall of the nurse's station and the resident was saying she wanted to get up. LPN S reported she heard the resident saying can you help me get up, can you help me, I can't get up!. LPN S reported she initially told the resident that getting up would not be a good idea because the resident's legs had not been working as well lately. Resident #100 then replied No, I can't get this belt off of me. LPN S looked at Resident #100 who then lifted her shirt and revealed a black gait belt across her ribs, fastened around the back of the wheelchair. LPN S reported Resident #100 appeared emotionally upset about the situation. LPN S reported she immediately went to LPN Z and asked if Resident #100 was supposed to be restrained. LPN Z confirmed the resident was not supposed to be restrained. LPN S stated she felt shocked seeing Resident #100 in that situation and left the floor to call Director of Nursing (DON) B. LPN S reported DON B instructed her to return to the floor immediately and release Resident #100, then complete a skin and pain assessment for the resident. LPN S reported when she returned, Resident #100 was in bed with no restraint. LPN S reported Resident #100 had no injuries and no complaints of pain following the incident. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/18/25 at 2:20pm, Certified Nursing Assistant (CNA) E reported she cared for Resident #100 on the overnight shift of 2/11/25. CNA E reported she assisted LPN Z with getting the resident into a wheelchair after she was found standing by her room door at approximately midnight on 2/12/25. CNA E reported she recalled seeing Resident #100 seated at the cutout window area with her wheelchair against the half wall of the nurse's station. CNA E reported it was difficult to provide the amount of supervision Resident #100 needed while also caring for other residents. CNA E reported at that time, Resident #103 was transferring from sitting to standing about every 5 seconds. CNA E denied placing or seeing a gait belt around Resident #100 and her wheelchair. In an interview on 1/19/25 at 8:06am, LPN Z reported he transferred Resident #100 to a wheelchair after she was found standing by her room door at approximately midnight on 2/12/25. LPN Z reported he positioned Resident #100 at the cutout window of the nurse's station, with her wheelchair against the half wall of the nurse's station. LPN Z reported Resident #100 could not unlock the wheelchair breaks on her own. LPN Z reported he confined Resident #100 to that area by using her wheelchair in this manner in effort to reduce her likelihood of falling. LPN Z reported Resident #100 did not have a gait belt restraining her to her chair at that time and that she stood and sat back down repeatedly. LPN Z reported Resident #100 was upset that night and thought she needed to find her family. LPN Z reported he had difficulty supervising Resident #100 because of the number of residents in his assignment that night. LPN Z reported at approximately 2am, 2 CNA's left the floor for their break, leaving even fewer staff to supervise the residents, including Resident #100 who remained at the nurse's station. In an interview on 1/19/25 at 10:12am, CNA H reported she worked overnight on 2/11-2/12/25. CNA H reported Resident #100 was restless that night and had recently had several falls. CNA H reported it was difficult to help her remain safe and that sometimes we gotta hold down residents to keep them safe. CNA H explained that we had her (Resident #100) pushed all the way up against the desk and locked the brakes so she could not attempt to walk. CNA H reported Resident #100 appeared anxious, verbalized a desire to move away from the nurse's station, that the resident was looking for her loved ones and stated, I have to find them, referring to her family. CNA H denied any knowledge of Resident #100 having a gait belt wrapped around her and the wheelchair. Review of an Investigation Summary with a reference date of 2/11/25, revealed at 3:15am: (Resident #100) when shown a picture of LPN Z, she confirmed emphatically that he was the one who placed the gait belt around her. In an interview on 2/19/24 at 12:41pm, Resident #100 did not appear to recall the event that took place on 2/12/25. In an interview on 2/20/25 at 10:53am, DON B reported she came to the facility at approximately 3am on 2/12/25 to initiate an investigation after Resident #100 was found physically restrained. DON B reported at that time, Resident #100 reported a man tied her to a wheelchair and voiced that she didn't like it. In an interview on 2/20/25 at 2:01pm, Guardian Y reported the facility had informed her Resident #100 had been found physically restrained in the early morning hours of 2/12/25. Guardian Y reported she would expect that any reasonable person would be significantly emotionally distressed by the act of being physically restrained. (continued on next page)

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F 0604 Level of Harm - Actual harm Residents Affected - Few	Using the reasonable person concept, though Resident #100 and Resident had decreased ability to verbally express their own thoughts due to medical diagnoses, any reasonable person would likely feel frustration, a decreased sense of autonomy and decreased sense of psychological wellbeing because of being physically restrained.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview and record review, the facility failed to adhere to nursing professional standards related to documentation of medication administration for 2 of 3 (Resident #206 and Resident #110) residents reviewed for medication administration documentation, resulting in a potential for missing controlled substances and inaccurate medication administration. Findings include: Resident #206 Review of an Admission Record revealed Resident #206 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: anxiety disorder (mental health condition characterized by excessive and persistent worry, feat and unease that can significantly interfere with daily life. Review of a Minimum Data Set (MDS) assessment for Resident #206 with a reference date of 3/26/25, revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #206 was cognitively intact. Section D of the MDS revealed Resident #206 had thoughts of harming himself during 2-6 days of the 14-day assessment period. Review of a Care Plan for Resident #206 with a reference date of 5/20/24, revealed a focus/goal/interventions of: Focus: Resident has a mood problem r/t (related to) admission. Goal: The resident will have improved mood state happier (sic), calmer appearance, no s/sx (signs or symptoms) of . anxiety or sadness through next review date. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness . Review of a Medication Administration Record for Resident #206, with a reference date of April 2025, revealed the resident received ALPRAzolam Oral Tablet 0.5MG (milligrams) at 1200 on 4/2/25. During an observation on 4/2/25 at 12:40pm, Assistant Director of Nursing (ADON) L began a controlled substance audit at the medication cart assigned to Licensed Practical Nurse (LPN) I. LPN I stated Wait a minute! I may not be caught up on signing out my medications. LPN I picked up the Medication Disposition Binder, flipped through the pages and filled out a form labeled for Resident #206 and his prescribed medication, Alprazolam. In an interview on 4/2/25 at 12:41pm, LPN I reported she had administered Resident #206's Alprazolam around 12:00 but had not signed the medication out on the disposition form. In an interview on 4/2/25 at 12:47pm, ADON L confirmed it was a standard of practice that a nurse would sign out a medication on the disposition form, document the amount of medication removed, and the amount of medication that remained at the time of the medication removal. Resident #110 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Controlled Drug Disposition Form for Resident #110's Morphine Sulfate Oral Solution revealed the medication was signed out for administration by Agency Registered Nurse (RN) U on 3/27/25 at 6:00pm, 3/28/25 at 8:00am and 3/28/25 at 10:00am. In an interview on 4/3/25 at 2:21pm, RN U confirmed she signed out the doses of Resident #110's morphine on 3/27/25 at 6:00pm, 3/28/25 at 8:00am and 3/28/25 at 10:00am.RN U reported the medications should be documented as administered on Resident #110's Medication Administration Record. RN U confirmed the medications were not documented on Resident #110's Medication Administration Record. When further queried, RN U reported the facility had not approached her about the lack of documentation regarding this controlled substance, and although she thought she'd given the medication to Resident #110, there was no way to confirm this. In an interview on 4/3/25 at 3:04pm, Director of Nursing (DON) B reported the nurse should sign out a controlled medication on the disposition form, administer the medication and document the administration in the Medication Administration Record at the time it was administered. DON B a medication must be documented in the Medication Administration Record to confirm it was given to the resident. Review of the policy/procedure Controlled Medication Guidelines, dated 3/20/24, revealed .When the licensed nurse removes the controlled medication from the package, they will document the quantity removed and the quantity left on the Controlled Drug Receipt/Record/Disposition Form .After administration of the controlled medication the licensed nurse will document the administration on the medication administration record .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 This citation pertains to intake # MI00149896 Based on interview, and record review, the facility failed to comprehensively assess and prescribe appropriate treatment for 1 (Resident #103) of 3 residents reviewed for change of condition, resulting in Resident #103 being hospitalized with aspiration pneumonia. Findings include: Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: major depressive disorder, recurrent, severe with psychotic symptoms (serious mental health condition characterized by persistent low mood and other symptoms that significantly interfere with daily life). Review of a Minimum Data Set (MDS) assessment for Resident #103 with a reference date of 11/8/24, revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #103 was moderately cognitively impaired. Review of a Behavior Health Progress Note for Resident #103, with a reference date of 1/21/25 revealed He (Resident #103) reports that lately has felt like he is having vertigo (sudden spinning or swaying sensation). Review of a Behavior Note for Resident #103, with a reference date of 1/25/25 revealed: Resident has been tearful and displayed unhappiness throughout shift .has mad multiple statements that his care needs are not being met . Review of a Nursing Progress Note for Resident #103 with a reference date of 1/27/25, revealed Resident in bed .appetite poor .dry heaving .c/o (complains off) vertigo. In an interview on 2/18/25 at 10:21am Family Member (FM) BB reported Resident #103 was taken to the hospital on 1/27/25 for a psychiatric evaluation but was admitted to a medical floor rather than a psychiatric unit, because the Resident was found to have pneumonia and was deemed psychologically stable. FM BB reported Resident #103 had complained of dizziness, fatigue and shortness of breath in the days leading up to his hospitalization but had not received any treatment for the symptoms. In an interview on 2/19/25 at 8:03am Resident #103 reported prior to his hospitalization on [DATE], he had complained to several staff members that he did not feel well and felt something was wrong with his body. Resident #103 reported he felt dizzy, tired, achy and had no appetite. Resident #103 reported on 1/27/25 he was told the facility was sending him to a local hospital for a psychiatric evaluation which only increased his anxiety because of an experience he had while on a psychiatric unit. In an interview on 2/20/25 at 8:22am, Certified Nursing Assistant (CNA) G reported Resident #103 vomited several times during the last week of January 2025 and she observed him coughing, producing a lot of phlegm and vomiting in the dining room one day during that week. (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	02/21/2025

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/20/25 at 1:41pm, Unit Manager (UM) EE confirmed Resident #103 had no physician notes/record of medical evaluation by Medical Director (MD) AA from 1/15-1/27/25. In an interview on 2/21/25 at 10:23am, Medical Director (MD) AA reported she evaluated Resident #103 several times throughout the week of 1/21/25 and found no evidence of any new medical issues for the resident. When asked to review the documentation of her evaluations on or around 1/21/25 for Resident #103, MD AA reported she was really behind on entering documentation and had not entered any progress notes/record of medical evaluations for Resident #103 since 1/15/25. When further queried, MD AA reported staff had not told her Resident #103 had recent episodes of coughing while eating prior to 1/27/25. MD AA confirmed coughing during meals could indicate a risk of aspiration pneumonia (lung infection that occurs when a person inhales something other than air into their lungs, such as food, liquid or saliva). MD AA reported a resident who aspirates food or liquid can develop aspiration within hours of the initial inhalation of food or liquid into the lungs. MD AA reported it was difficult to determine Resident #103's medical needs because he had several behavioral issues, and the facility thought Resident #103 was having psychiatric issues, rather than a physical illness. MD AA reported when Resident #103 was evaluated at a local emergency department it was determined that he had an acute physiological illnesses that required admission to the acute care unit. Resident #103 was later assessed for psychiatric treatment and deemed not in need of hospital based psychiatric treatment. In an interview on 2/21/25 at 10:53am, Ombudsman DD reported she visited Resident #103 on 1/24/25 and described the resident as appearing unwell and that he reported fatigue, dizziness, and an inability to tolerate getting out of bed for the past 4 days. Ombudsman DD reported Director of Nursing (DON) B was present during her visit with Resident #103 and reported she would assess the resident's medical condition. Ombudsman DD reported Resident #103 voiced a desire to go to a hospital for medical evaluation at that time. Review of Resident #103's vital signs upon admission to the local emergency department revealed Resident #103's SpO2 level (oxygen saturation of peripheal oxygen) was 82%. The normal range is between 95-100%. Review of a Chest Xray completed in a local emergency department on 1/27/25 revealed: Findings: .bilateral (both sides) dependent consolidative airspace disease concerning for multifocal pneumonia/aspiration pneumonia . Review of an After Visit Summary from a local acute hospital revealed Resident #103 was admitted on [DATE] with the following diagnoses: acute CHF (congestive heart failure) (fluid buildup around the heart causing poor circulation of blood throughout the body), aspiration pneumonia, community acquired pneumonia .hypoxia (low oxygenation in the blood characterized by shortness of breath, elevated heart rate, dizziness .). Review of Resident #103's medical record from the skilled nursing facility revealed no laboratory orders between 1/21-1/27/25. Review of Resident #103's medical record from the skilled nursing facility revealed no nursing assessments between 1/21/-1/27/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's medical record from the skilled nursing facility revealed no documentation of vital signs between 1/21/-1/27/25. Review of a facility Change of Condition policy with a reference date of 12/13/23 revealed: An acute change in condition is a clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional status. Any facility staff that notices a change in the resident's condition should notify the licensed nurse .some examples of changes of condition that staff may notice and should report . ate less than usual . tired, weak .overall needs more help than usual .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to remove and safely dispose of discharged resident controlled substance medication in 1 of 3 residents (R111) reviewed for medication storage and disposal, resulting in diversion and/or misappropriation. Findings include: Review of facility policy, Medication Disposal, Destruction, and Sending Home with Resident, date approved 4/1/2022, revealed, Policy: The medications of residents who are .discharged , or medication that has been discontinued will be removed from the facility in accordance with local, State, and Federal regulations .the medication should be removed from the medication storage area(s) .This includes .medication carts .When a resident is discharged .The controlled medications being destroyed by the facility will be destroyed by two or more licensed personnel as designated by the Director of Nursing (DON) .When a resident is transferred out to the hospital. All medications prescribed for the resident will be placed in a medication room up to 14 days after transfer . R110 Review of R110's Medication Error Report dated 1/12/2025 at 10:00 AM revealed, In resident's room . Resident due for Morphine 15 mg. Nurse pulled 30 mg dose from wrong card and gave to resident. Resident unable to follow conversation with nurse explaining what error occurred. Resident now requesting more pain medication following dressing change .Level of Pain was an 8 out of 10 . During an interview and record review on 2/20/25 at 9:00 AM, Registered Nurse (RN) T stated while observing R110's Medication Error Report dated 1/12/25, I think what happened was (R110) gets two pills of Morphine sulfate; 1- 30 mg and 1-15 mg. I pulled a 30 mg Morphine from another resident's card (Resident #111's). RN T read the Medication Error Report and stated, Two-30 mg tablets were given to (Resident #110) and not 45 mg. She got an extra 15 mg. So, a total of 60 mg of Morphine. (R110) was to get 1-30 mg of Morphine sulfate IR (immediate release) and 1-15 mg Morphine sulfate ER (extended release). The resident was complaining of pain because she a pressure ulcer on her bottom. She got 2 pills of Morphine and was still complaining. During an observation, interview, and record review on 2/20/25 at 12:05 PM, LPN V observed A Hall med cart narcotic drawer Controlled Medication Sheets and reviewed the January 2025 MAR for R110. R110's MAR documented on 1/12/25, the resident received one 30 mg Morphine sulfate IR tablet and one 15 mg Morphine sulfate ER tablet. When LPN V was asked what residents morphine with a card next to R110 it was discovered R111 was on Morphine sulfate ER 30 mg at the same time. Upon reviewing R111's MAR, it was discovered he was discharged on [DATE]. R111's card of Morphine sulfate ER 30 mg tablets was still in the cart. LPN V stated, (R111's) should not have been in the med cart. Narcotics are left in the med cart until the facility knows discharged resident (Residen #111) is not coming back or admitted to the hospital. The narcotics then are placed in the safe in the medication room. There is a slot to put the meds in. The DON is to dispose of them from there. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R110's MAR/TAR (Medication/Treatment Administration Record) dated 1/1/2025-1/31/2025, revealed on 1/12/2025, Registered Nurse (RN) T documented as administering one Morphine sulfate 30 mg tablet and one Morphine sulfate ER 15 mg tablet at 9:00 AM for a total of 45 mg. During an observation and interview on 2/20/25 at 12:26 PM, DON B retrieved R110's card of Morphine sulfate IR 30 mg from the medication safe, stating They are a round white tablet. (R110's) Morphine order was changed on 1/15/25. This med card was placed in the safe 36 days ago. I do not know what the facility's policy says on when to destroy a discontinued narcotic. I was a floor nurse before I became the DON, and I know narcotics should be destroyed by the DON and one other nurse after the resident is known not to return or the narcotic is discontinued. DON B continued stating while observing R111's Morphine 30 mg ER Controlled Medication sheet, I found on 1/12/25 that (RN T) and (LPN CC) had signed out one of (R111's) Morphine ER 30 mg tablets and they are purple. The difference between IR and ER is that IR is immediate release and ER is extended release. That is the reason (R110) asked for pain meds during her wound treatment, because the ER Morphine she was given by (RN T) had not taken affect. Review of R111's Order Summary revealed, Morphine Sulfate ER Oral Table Extended Release 30 mg (Morphine Sulfate) Give 30 mg by mouth three times a day for moderate to severe pain. Start date 12/27/2024. Discontinue date: 1/1/2025. During an interview on 2/20/25 at 10:53 AM, Director of Nursing (DON) B stated, (RN T) realized she had given (R110) two 30 mg Morphine sulfate tablets. I didn't know she gave one of the 30 mgs from another resident and I didn't realize (R110) was also missing one 15 mg Morphine sulfate from that med pass as well. So that means (R110) got 60 mg of morphine instead of 45 mg and 1-15 mg Morphine sulfate tablet was missing. The DON stated she had not done further investigations into the medication error.