STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehab of Dearborn Heights	26001 Ford Rd Dearborn Heights, MI 48127

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 40330 Based on observation, interview, and record review, the facility failed to update one Resident's Care Plan (R132) of 19 residents reviewed for Care Plans, after a burn injury. This deficient practice resulted in limited interventions to prevent another burn injury. Findings include: On 10/23/24 at approximately 12:00 p.m., R132 sustained a second-degree burn on their abdomen after spilling a cup of hot water on themselves during the lunch meal, which leaked through their blanket, shirt, and onto their skin. On 11/20/24 at 11:59 a.m., an observation revealed R132's hot water was served in a foam cup and was temped on their lunch tray at 164 degrees Fahrenheit, which placed R132 at risk for additional burns due to above scalding temperature. On 11/20/24 at 1:00 p.m., an observation revealed the hot water was temped at 184.6 degrees from the kitchen hot water dispenser for beverages, which was above scalding temperature. On 11/19/24 at 11:05 a.m., R132 reported they were burned when they spilled hot tea on themselves. R132 stated, It was in a (name of) foam cup and was not very stable. Sometimes they serve it in a mug. R132 explained the incident happened a few weeks ago at the facility. R132 stated, I keep the cup away from me, and make sure I pick it up with both hands. R132 clarified they were afraid of spilling hot water on themselves, because 90% of the time it is (served in) a foam cup and lid. On 11/19/24 at approximately 12:25 p.m., Surveyors observed R132 in their room seated in a manual wheelchair with their cup of hot water for tea in front of them, in a foam cup with no lid. Surveyors observed the tray was not set up for R132, and the hot water temped at 124.4 degrees Fahrenheit. On 11/20/24 at 11:59 a.m., R132 was observed seated in their wheelchair in their room. Their lunch tray was delivered and set on R132's bedside table by the Activity Director, Staff G. R132's hot water for their tea was observed in a foam lidded cup. Surveyor requested permission to temp R132's hot water, which was granted by R132, with Staff G present. R132's hot water temped at 164 degrees using a digital food thermometer, above scalding temperature, with Staff G confirming they observed the same temperature. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/20/24 at approximately 12:29 p.m., the Unit manager, Licensed Practical Nurse (LPN) O, was asked about any changes they had implemented since R132's abdominal burn from hot water on 10/23/24. LPN O responded, .Staff deliver (R132's) tray and do the set-up and the tea bag. Surveyor asked about R132 being observed with foam cup with hot water. LPN O stated, They (kitchen staff) typically use the brown (thermal) cups with lids for (hot) liquids .They (kitchen staff) are supposed to temp it before it leaves the kitchen, and it (the cup) sits there (in the kitchen). Review of R132's Care Plan, accessed on 11/21/24, after the burn incident, revealed, The resident (R132) has actual impairment to skin integrity of the lower mid abdomen r/t (related to) burn . Date initiated: 10/23/2024 . The Care Plan revealed no new interventions respective to the wound treatments or the prevention of additional burns, including set-up of R132's meal tray, increased monitoring/supervision, the provision of proper adaptive equipment (cup), or ensuring the temperature of the hot water was in a safe range to prevent scalding burn injuries. Review of the policy, Care Plan - Comprehensive and Revision, revised 8/25/2023, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident . Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. The IDT (Interdisciplinary Team) reviews and updates the care plan when there has been a significant change in the resident's condition .

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to provide and document showers per resident preference for one Resident (R132) of four residents reviewed for showers. This deficient practice resulted in feelings of frustration and uncleanliness for R132. Findings include: On 11/19/24 at 11:33 a.m., R132 was observed in their room, dressed and seated in their manual wheelchair. On 11/19/24 at 11:35 a.m., R132 reported they felt frustrated and unclean as they only had received one shower since they had been in the facility. R132 stated they had not refused any showers, and expressed they did not feel bed baths were an adequate substitute for showers. R132 stated they had been on infection precautions earlier in their stay, however since they had come off isolation precautions, they had still not received a shower. Review of R132's shower logs, accessed 11/19/24, showed R132 received one shower and four bed baths in the last 30 days, with one refusal. The log showed R132 was dependent for showers. Review of R132's Minimum Data Set (MDS) assessment, dated 10/17/24, revealed R132 was admitted to the facility on [DATE], with diagnoses including coronary artery/heart disease, kidney disease, muscle wasting and atrophy, and repeated falls. R132 required maximal assistance with bed mobility, transfers, and showers. The Brief Interview for Mental Status (MDS) assessment score was 13/15, which showed R132 was cognitively intact. On 11/20/24 at 11:08 a.m., R132 reported they had not received a shower on 11/19/24, or thus far on 11/20/24, which they reported bothered them. They confirmed they had asked staff and let their family member know. On 11/21/24 at approximately 12:30 p.m., R132's Family Member, FM V, approached Surveyor regarding R132's care. FM V reported R132 had only received one shower since they had been at the facility, which was frustrating to both. FM V clarified they had asked staff for several days if R132 could have a shower on their scheduled days. They were concerned about R132's cleanliness, as R132 had accidents on themselves when they had an infection, and needed a shower, as bed baths were not adequately cleaning R132. FM V reported they felt frustrated it had taken so long for R132 to receive a shower, as this was R132's wishes as well. Review of the policy, Activities of Daily Living, revised 12/07/2023, revealed, Residents will be provided care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADLs independently .including appropriate support and assistance with Hygiene (bathing)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to ensure one Resident (R132) of one resident reviewed for accidents was served hot beverages in a stable, handled, thermal cup and provided proper meal set-up. This deficient practice resulted in an Immediate Jeopardy, when R132 sustained a second-degree burn (a burn affecting the skin layers, causing redness, pain, swelling, and blisters), and developed increased pain. Findings include: The Immediate Jeopardy was identified on 10/23/24, at 12:00 p.m., when R132 spilled hot scalding water for tea on themself, resulting in a second-degree burn and the likelihood of other residents affected due to lack of assessment and monitoring practices which could lead to serious harm, injury, impairment, or death. The Administrator was notified of the Immediate Jeopardy (IJ) on 11/21/24 at 11:30 a.m The Immediate Jeopardy began on 10/23/24. A plan to remove the immediacy was requested. The IJ was removed on 11/21/24, based on the facility's implementation of the plan of removal as verified by the Survey team on site. Although the IJ was removed, the facility's deficient practice was not corrected and remained isolated with actual harm. On 10/23/24 at approximately 12:00 p.m., R132 sustained a second-degree burn on their abdomen after spilling a cup of hot water on themselves during the lunch meal, which leaked through their blanket, shirt, and onto their skin. On 11/20/24 at 11:59 a.m., an observation revealed R132's hot water was served in a foam cup and was temped on their lunch tray at 164 degrees Fahrenheit, which placed R132 at risk for additional burns due to above scalding temperature. On 11/20/24 at 1:00 p.m., an observation revealed the hot water was temped at 184.6 degrees from the kitchen hot water dispenser for beverages. On 11/19/24 at 11:05 a.m., R132 reported they were burned when they spilled hot tea on themselves. R132 stated, It was in a (name of) foam cup and was not very stable. Sometimes they serve it in a mug. R132 reported they had pain 7/10 on their abdomen during the interview, and stated it was painful when the nurses changed their bandage. R132 explained the incident happened a few weeks ago at the facility. R132 stated, I keep the cup away from me, and make sure I pick it up with both hands. R132 confirmed they were afraid of spilling hot water on themselves, because 90% of the time it is (served in) a foam cup and lid. On 11/19/24 at approximately 12:25 p.m., the surveyors observed R132 in their room seated in a manual wheelchair with their cup of hot water for tea in front of them, in a foam cup with no lid. The surveyors observed the tray was not set up for R132, and the hot water temped at 124.4 degrees Fahrenheit. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R132's, Skin and Wound Evaluation, dated 10/23/24 at 1:15 p.m., revealed a new second-degree burn injury on the left lower quadrant of the abdomen, which was designated as in-house acquired. The measurements were 56.7 cm (centimeters) squared (area), 7.7 cm length, 10.7 cm width, and 0.2 cm depth. The wound was observed as a large pink wound, with slight blistering along the wound edges. Review of R132's, Skin and Wound Evaluation, dated 11/19/24, showed the burn wound measurements were 17.2 area in cm squared, 3.2 cm length, 6.4 cm width, and .3 cm depth. The wound was designated as slow to heal. The wound was observed as a medium-size healing blister, with scabbing and yellow blistering in the center of the wound. Review of R132's progress note, dated 10/23/24 at 12:30 p.m., by Licensed Practical Nurse (LPN) K, confirmed the description of the wound. The note revealed R132 reported they were attempting to place their tea bag after removing the cup lid and spilled hot water onto their blanket, shirt, and onto their skin .The noted further described petroleum jelly and burn cream were ordered to treat the wound. Review of R132's progress note, dated 10/23/24, by the wound care nurse, LPN L, revealed R132 spilled hot liquid on their abdomen when in bed, sustaining a burn injury which they described as on the mid-lower abdomen, pink in color with minimal serous (clear yellow) drainage. The note revealed they applied one layer of petroleum jelly and covered the wound with an ABD (wound protective) pad. Review of R132's facility investigation report, dated 10/23/24, revealed the facility interviewed Certified Nurse Assistant (CNA) U, who stated they were passing lunch meal trays and gave R132 their tray and hot tea. When CNA U returned to pick up R132's tray, R132 stated, Oh my G**, the hot water spilled on my belly . Review of R132's pain log revealed increased pain after the burn injury as follows: 10/23/24 at 12:00 p.m.: 5/10 pain (with 10 the highest possible pain) 10/23/24 at 12:40 p.m.: 7/10 10/23/24 at 6:25 p.m.: 0/10 10/23/24 at 8:00 p.m.: 2/10 Review of R132's Minimum Data Set (MDS) assessment, dated 10/17/24, revealed R132 was admitted to the facility on [DATE], with diagnoses including coronary artery disease, kidney disease, muscle wasting and atrophy, and repeated falls. R132 required set-up with eating, and maximal assistance with bed mobility and transfers. The Brief Interview for Mental Status (MDS) assessment score was 13/15, which showed R132 was cognitively intact. Review of the 10/23/24 food and beverage temperature log, showed the coffee temperature at breakfast was 191 degrees. There was no temperature designation on the log for a hot beverage at lunch or dinner. The log showed no category for hot beverages, only for coffee at breakfast. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	On 11/20/24 at 11:59 a.m., R132 was observed seated in their wheelchair in their room. Their lunch tray was delivered and set on R132's bedside table by the Activity Director, Staff G. R132's hot water for their tea was observed in a foam lidded cup. R132's hot water temped at 164 degrees using a digital food thermometer with Staff G confirmed they observed the same temperature. On 11/20/24 beginning at 12:00 p.m., LPN K, LPN O, and Registered Dietician (RD) J were asked to observe R132's hot water in the foam cup, and the temperatures, as follows: 12:03 p.m.: 158.5 degrees 12:05 p.m.: 152 degrees 12:08 p.m.: 148 degrees On 11/20/24 at 12:08 p.m., RD J was asked about R132's hot water being served at 164 degrees. RD J responded the safe temperature for hot liquids was 130 to 160 degrees, which they reported was their facility policy/process. On 11/20/24 at approximately 12:29 p.m., the Unit manager, Licensed Practical Nurse (LPN) O, was asked about any changes they had implemented since R132's abdominal burn from hot water on 10/23/24. LPN O responded, .Staff deliver (R132's) tray and do the set-up and the tea bag. Surveyor asked about R132 being observed with Styrofoam cup with hot water. LPN O stated, They (kitchen staff) typically use the brown (thermal) cups with lids for (hot) liquids .They (kitchen staff) are supposed to temp it before it leaves the kitchen, and it (the cup) sits there (in the kitchen). On 11/20/24 at approximately 12:35 p.m., LPN K confirmed they were the nurse assigned to R132 when the burn injury occurred on 10/23/24. LPN K stated, When it was reported, it was like three different areas and now it is one large area. The doctor was here when it happened and ordered Petroleum jelly. (R132) was in 6-7/10 pain. They reported they administered Over-the-Counter pain medication, which relieved R132's pain. On 11/20/24 at 12:55 p.m., RD J was interviewed with the Assistant Dietary Manager, DM B. DM B explained the hot beverages were obtained from the hot water dispenser in the kitchen, and cooled down for 15 minutes before being served, which RD J confirmed. RD J reported residents were typically assessed for hot liquid safety by Occupational Therapy staff. Both were asked why R132's hot liquid for tea was temped at 164 degrees on their tray, and neither could explain how this occurred. There was nothing about this process in writing upon Surveyor request. On 11/20/24 at approximately 1:00 p.m , RD J stated R132's Occupational Therapist indicated R132 was safe to handle hot liquids prior and after the burn injury. RD J and DM B both reported they were not instructed to do anything different in terms of providing hot beverage service to R132 after the incident. Both conveyed they usually served hot beverages in plastic, thermal mugs with handles, however stated they had been running out of the stable thermal mugs. When asked why, DM B explained, We order them, and they just run out. Both indicated all the residents were supposed to receive thermal mugs with lids unless otherwise designated. RD J and DM B were asked how R132's hot water had temped at 164 degrees in their room on their tray in a foam lidded cup at lunch on 11/20/24. Neither could not explain how this occurred, as their process was for kitchen staff to cool down the hot water before it left the kitchen. (continued on next page)

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F 0689

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Few

Note: The nursing home is disputing this citation.

On 11/20/24 at 1:05 p.m., Surveyor and DM B jointly temped the hot water in a foam cup coming out of the hot water dispenser in the kitchen. Surveyor obtained the temperature at 184.6 degrees with a food and beverage digital thermometer, and DM B obtained the temperature at 186 degrees, with their kitchen digital thermometer.

On 11/20/24 at 1:10 p.m., Staff I, the day shift cook, was asked about serving hot liquids to facility residents. Staff I indicated they obtained the hot water from the hot water dispenser and then cooled it down. Staff I stated, We (kitchen staff) give it to them (residents) at 140 to 150 degrees. Surveyor asked about the temperature of 164 degrees taken in R132's room at lunch on their tray, and how this occurred. Staff I stated, It's too hot, that's a risk for a burn.

On 11/20/24 at 1:23 p.m., DM B was asked about the temperature logs not showing a hot liquids temperature column prior to the incident. DM B explained they did not have the hot temperatures recorded on the old logs, as they only temped the coffee at breakfast prior to R132's burn incident. DM B stated, Our protocol wasn't tempting hot tea. DM B clarified the maximal temperature for serving hot liquids was 160 degrees. DM B was asked about the 191-degree temperature of the coffee logged on 10/23/24, the date R132 received their burn injury. DM B responded, That would have been pretty hot if we took this out (of the kitchen). That's scalding (temperature) hot right there. We should have never put it out (given to residents) at 191 degrees.

Review of R132's tray ticket from 10/23/24 and 11/20/24 revealed no designation of a container for beverages, such as a thermal lidded cup with a handle.

On 11/20/24 at 3:44 p.m., the Rehabilitation Director, Occupational Therapist (OT) R, was asked if R132 was determined to be safe with hot liquids, and for a copy of any assessments. OT R reported R132 was assessed to be safe with hot liquids during the initial OT evaluation by OT F on 10/08/24, and after the incident by Certified Occupational Therapist Assistant (COTA) H on 10/24/24. OT R reported the hot liquid assessment was a part of the therapy evaluations, and documentation.

On 11/20/24 at 3:53 p.m., Certified Occupational Therapist Assistant, (COTA) H, was asked how R132 was determined to be safe with hot liquids after the burn injury on 10/23/24. COTA H reported they assessed R132 by having them set-up and drink their hot tea from a foam cup at their bedside. When asked about R132's functional status, COTA H reported although R132 set-up the tea adequately, they had postural concerns, as they slid down, or sometimes slumped forward, as they tired easily, had mild coordination problems, and fair safety. COTA H stated, .I prefer the mugs because of the handle and because the handle is good security (to prevent spillage). COTA H was asked if they reviewed the results of R132's hot liquid assessment with a supervising occupational therapist, and COTA H responded, No.

Review of R132's progress note, dated 10/24/24, by COTA H, revealed they passed R132 on the second hot liquid assessment in a narrative notation and worked on sitting balance exercises and seating and positioning during self-feeding, showing postural concerns which may have impacted R132's safety and performance with self-feeding.

Review of R132's physician note, dated 10/21/24 at 8:25 a.m. (prior to the burn incident), revealed R132 had muscle weakness, with 3/5 strength (fair muscle strength) in both arms and legs, and debility.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of R132's physician note, dated 10/23/24 at 12:56 p.m. (after the burn incident), revealed R132 continued to have muscle weakness, with 3/5 strength in their arms and legs, and debility. Review of R132's Occupational Therapy and Physical Therapy records showed R132 was receiving therapy services from 10/08/24 through 11/20/24, prior, during, and after the burn incident. Review of R132's Occupational Therapy evaluation, dated 10/08/24, revealed R132 had decreased muscle strength in their arms, fair sitting balance, and muscle atrophy. On 11/21/24 at 9:53 a.m., R132's OT, OT F, was asked about the hot liquid evaluation process. OT F reported they simulated the task with residents as the assessment was documented in their evaluations. OT F confirmed they cleared R132 as safe with hot liquids on the OT evaluation on 10/08/24. OT F was asked if COTA H reviewed the assessment results with them or supervising therapists from 10/24/24. OT F responded, No. OT F reported R132 had some coordination problems. OT F explained R132 may have had limitations in reaching and grasping due to frequent infections, which caused slightly decreased coordination, increased weakness and decreased energy (activity tolerance). OT F acknowledged they or another OT did not reassess R132's feeding ability after the spill and burn from hot liquids on 10/23/24. OT F confirmed R132 would be safer with a stable mug with a handle and lid. OT F explained when a resident had breakfast in bed, they were concerned about safe positioning, and reported decreased postural control in bed could have played a role in R132's burn injury. On 11/21/24 at 12:22 p.m., R132's Power of Attorney, (POA) J, was asked about R132's care. POA J stated R132 was burned because the water (for tea) was so hot, and it was just in a foam cup instead of a mug. Maybe they (staff) can't control how hot the water comes out, and it should have been (served) in a mug. POA J explained R132 had neuropathy in their hands, which caused weakness. On 11/24/24 at 2:18 p.m., the NHA was asked about the concerns related to the Immediate Jeopardy. The NHA explained their former certified dietary manager had been on a leave since June 2024, and there had been a gap in kitchen supervisory staffing and training challenges due to limited availability of managerial oversight, as they had only recently moved DM B into the kitchen manager position. The NHA acknowledged a system failure, reporting they had become aware there was a breakdown in the temperature logging process, as this was a newer process, serving hot liquids in the kitchen. The NHA clarified until recently the kitchen had only made and served coffee and hot water for tea or cocoa per resident request from carafes and had only recently began providing coffee or hot water from the coffee and hot water dispenser. The NHA confirmed they were not aware of the shortage of mugs, although they understood the concern was missing lids. Review of the policy, Hot Beverages Temperature Limits, issued 11/03/24, revealed, Policy: Coffee machines will be set at 180 - 190 degrees Fahrenheit. This is industry standards for palatability. Goals for test trays will be to have coffee above 140 during tray line. There are no current regulations that specify temperatures appropriate for the consumption of hot beverages. Procedure: 1. Hot beverage temperatures will be monitored daily with tray line temperatures . There was no reference regarding above 140 degrees (or even as low as 120 degrees) may be scalding temperature for vulnerable adults in the facility. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the policy, Hot Liquid Assessment, issued 11/19/2018, revealed, It is the policy of the facility to assess residents for safe consumption of hot liquids .The Registered Dietician will observe all residents for safe handling of hot liquids upon admission and quarterly thereafter. Criteria for the Registered Dietician to consider include: Tremors, weakness .The Occupational Therapist (OT) will be responsible for determining if the resident continues to require a supervised dining setting due to hot liquid risk and if any additional interventions should be used to minimize risk of burns. Dietary will provide cups with sipping lids for all hot liquids during meal times .Activities will provide cups with sipping lids for all hot liquids served . Review of the State of (State Name) Department of Community Health Alert, titled, Scalding Injuries Caused by Excessive Hot Water: Food and Hot Beverage Temperatures, Revised August 5, 2008, revealed, Background: In all age groups, tap water scald injuries have been cited as the second most cause of serious burns. A scald is a burn caused by spills, immersion, splash, or contact with hot water, food and beverages, or steam. The elderly are particularly at increased risk because their skin tends to be less sensitive and reaction times are reduced, causing a tendency to not pull away from hot water quickly enough to avoid scalding. Their thinner skin also burns full depth (through the skin layers and into tissue) more quickly . Although Federal and State agencies do not specify temperatures appropriate to the consumption of hot beverages, facilities should be aware of the risk for harm to a resident from contact or consumption of hot beverages.Scalds can commonly occur from hot food, beverages, or steam . The estimated time for a person to receive second-degree burns was noted as follows: 120 degrees. Time to receive second-degree burn: 8 minutes. 124 degrees. Time to receive second-degree burn: 2 minutes. 131 degrees. Time to receive second-degree burn: 17 seconds 140 degrees. Time to receive second-degree burn: 3 seconds. 150 degrees. Time to receive second-degree burn: Less than one second. The Immediate Jeopardy that began on 10/23/24 was removed on 11/21/24, when the facility took the following actions to remove the immediacy: 1. Resident #132 remains a resident of the facility and as of 11/21/24 is being served their hot liquids in a stable thermal cup with a handle and is being offered assistance with hot liquids. 2. Like residents are residents that reside in the facility and receive hot liquids. On 11/21/24 at 12:15 p.m., like residents have been audited to ensure their liquids are being served in a stable, handled, thermal cup and staff are offering and/or providing assistance with set-up as needed. 3. Dietary staff have been re-educated on 11/21/24 to ensure hot liquids are being served in a stable, handled, thermal cup. Dietary staff has also been re-educated on ensuring hot liquids are being serviced at a temperature less than 160 degrees Fahrenheit. Any staff member who is currently not working will be reeducated prior to the start of their next shift of duty. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235428	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehab of Dearborn Heights	26001 Ford Rd Dearborn Heights, MI 48127

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	4. LPN/RN/CENA has been re-educated on 11/21/24 to ensure when meals are served resident with hot liquids are in a stable, handled, thermal cup and they are offering and/or providing assistance when serving hot liquids as needed. Any staff member who is currently not working will be reeducated prior to the start of their next shift of duty. 5. An Ad Hoc QA Committee meeting was held on 11/21/24 with the Medical Director and IDT (Interdisciplinary Team) to discuss the deficient practice and plan to ensure compliance. The NHA/Designee will conduct audits to ensure that hot liquids are served in a stable, handled, thermal cup. The NHA/Designee will audit to hot liquid temperature logs to ensure temperatures are less than 160 degrees Fahrenheit prior to leaving the kitchen. Audits will be completed weekly x 4 weeks and monthly x 2 months. Results of the audits will be taken to the QA committee for review and recommendation. Any areas of non-compliance will be addressed immediately. The Administrator is responsible for maintaining compliance. 6. The Administrator is responsible for sustained compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: Optalis Health and Rehab of Dearborn Heights		STREET ADDRESS, CITY, STATE, ZIP CODE: 26001 Ford Rd Dearborn Heights, MI 48127	

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to provide a meal tray per physician's order for one resident (R36) out of two reviewed for nutrition. Findings include: A review of the medical record revealed that R36 admitted into the facility on [DATE] with the following diagnoses, Unspecified Protein-Calorie Malnutrition and Cerebral Infarction. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 0/15 indicating an impaired cognition. R36 was also dependent on staff for bed mobility and transfers. A review of the physician's orders revealed the following, Ordered:11/18/2024. Order: Regular Diet, Puree Texture, Thin Consistency .Status: Active. On 11/19/2024 at 12:47 PM, R36 was observed in their bed during lunch time. R36 had no lunch tray. Certified Nursing Assistant (CNA) T was asked if R36 should have a lunch tray to which they responded, [R36] used to get a pleasure try, but for the last couple of days they have not gotten one. I will have to check on that. On 11/20/2024 at 9:00 AM and 12:34 PM, No tray was observed on the cart or in the room for R36. On 11/20/2024 at 2:08 PM, an interview was conducted with the Registered Dietitian (RD) J. The RD stated R46 does get a tray, but it is mostly for pleasure because R36 gets their nutrition from their tube feeding. RD J stated R36 should be getting 1:1 assistance with meals and it should be documented how much R36 is eating. RD J stated R36 should still be receiving their tray and assistance eating and thy would have to check and see why they were not receiving a tray. On 11/21/2024 at 1:00PM, a Quality Assurance meeting was completed with the Nursing Home Administrator (NHA). The NHA stated that it was brought to their attention. The NHA stated the diet was not changed in the computer, but the tickets stopped printing for the pleasure tray. It has since been corrected and an audit has been created so that doesn't happen again. A review of a facility policy titled, Nutritional Management did not address the delivery of pleasure trays.

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 Based on observation, interview, and record review, the facility failed to provide a lunch and/or snack for one Resident (R6) of three residents reviewed for dialysis care. Findings include: On 11/19/24 at 12:08 p.m., R6 was observed in their room seated in their manual wheelchair. R6 appeared thin and gaunt, with bony prominences observed. Their hands were clenched into fists, and they could open them partly. On 11/19/24 at 12:10 p.m., R6 reported the facility staff did not give them a lunch to take to dialysis on their dialysis days, and stated, I would like a lunch. R6 explained they attended dialysis from 10:30 a.m. to 1:00 p. m., three days a week, and said, It is lunch time, so I miss lunch. I get hungry. I sit here 'til dinner time. When asked if they received a snack to take with them, R6 responded, No. R6 stated they requested lunches or at least a snack each time they went to dialysis and had not received either. R6 explained they could open their hands enough to feed themselves with regular utensils. Review of R6's Minimum Data Set (MDS) assessment, dated 11/06/24, revealed they were admitted to the facility on [DATE], with diagnoses including kidney failure, heart failure, and malnutrition. The sensory assessment revealed R6 had normal vision and hearing and was able to be understood and understand others with clear comprehension. R6 was independent with eating, was 66 tall, and weighed 97# on the assessment. Their customary preferences showed it was important for them to have snacks available. R6 was dependent for bed mobility, transfers, and wheelchair mobility. Review of R6's profile revealed R6 was their own responsible party. On 11/20/24 at 10:23 a.m., R6's assigned Certified Nurse Aide, (CNA) W, confirmed R6 had left for dialysis. CNA W said they had not provided R6 with a lunch, as they were doing care with another resident when R6 left for dialysis. On 11/20/24 at approximately 10:28 a.m., LPN X indicated they had not provided R6 with a lunch or snack before they left for dialysis. On 11/21/24 at approximately 10:00 a.m., R6 reported they had not received their lunch or a snack for their dialysis appointment on 11/20/24. R6 stated, They (staff) did not give me lunch when I came back. When I went to OT (Occupational Therapy), I told the therapist I was hungry, and they went to the kitchen and got me a sandwich. Review of R6's Physician Orders, accessed 11/21/24, revealed an order for dialysis on Monday, Wednesday, and Friday at 10:30 a.m., leaving the facility at 9:30 a.m. by transport. There were no orders for a lunch or snack in this order, or found in the orders. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Optalis Health and Rehab of Dearborn Heights		STREET ADDRESS, CITY, STATE, ZIP CODE: 26001 Ford Rd Dearborn Heights, MI 48127	

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of R6's Physician Orders revealed a new diagnosis on 11/06/24 of Protein Calorie Malnutrition: Severe as evidenced by severe global muscle and fat wasting, 46% weight loss from UBW (usual body weight), ESRD (End Stage Renal Disease) on HD (hemodialysis), lupus (an autoimmune disorder) . The orders revealed R6 was on a renal (kidney) diet, with soft bite texture and thin liquid consistency. Review of R6's dialysis notes, from visits on 11/02/24, 11/06/24, 11/08/24, 11/11/24, 11/13/24, 11/15/24, 11/18/24 and 11/20/24 revealed no documentation of a lunch or snack provided by the dialysis provider. Review of R6's Dialysis Care Plan, accessed 11/21/24, revealed, .Send meal/snack with resident to dialysis. Date initiated: 11/01/2024 . On 11/21/24 at approximately 1:15 p.m, the Nursing Home Administrator (NHA) was asked about R6 missing their lunch and or snacks on their dialysis days. The NHA responded they had prepacked lunches in the dietary department that were supposed to go with a resident to dialysis, after being picked up by their CNA or nurse. The NHA clarified when a resident returned from dialysis, the dietary department was in the facility until 8:00 p.m., so they did not know why R6 was missing their lunch and snacks on dialysis days, or not receiving a meal later. On 11/21/24 at 1:40 p.m., the Assistant Dietary Manager, DM B, was asked about R6 not getting their lunch on dialysis days, and if they were aware. DM B reported they had not been made aware. DM B clarified they had lunches for dialysis residents premade in the kitchen, placed in the unit refrigerators, so the Certified Nurse Aides (CNA's) were likely not delivering the lunches, as they made them available. DM B clarified there were always extra sandwiches in the unit refrigerators as well, available for residents at anytime. Review of the policy, Hemodialysis, revised 11/15/2023, revealed, This facility will provide necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving hemodialysis .The facility dietician or designee will monitor and document the resident's nutrition/hydration needs, including the provision of meals on days that dialysis treatments are provided which may include: Early meal service provided by the kitchen before dialysis transportation times, meal or snack sent with the resident to the dialysis facility, (or) late meal service provided by the kitchen after resident returns from dialysis .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 50223 Based on interview and record review, the facility failed to implement an effective water management plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in water borne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all of the 86 residents in the facility. Findings include: On 11/20/24 at approximately 1:00 PM, the building water management plan was requested from the Maintenance Director MD C. On 11/20/24 at approximately 2:00 PM, MD C provided a binder including a policy titled Safe Water Temperature, and a document titled Water Management Program Plan that included weekly temperature logs for the following: toilets in two resident rooms in each of the buildings four halls; dish machine; laundry; and the kitchen hand sink. The water management program plan also included a monthly log of eyewash station flushes which was not signed. On 11/20/24 at 2:08 PM, during an interview, MD C explained that the facility's water is tested yearly for legionella by an outside company and that they do not have the results for this years test yet. MD C also confirmed that they do not have documentation of prior tests. MD C confirmed that the only prevention measures or surveillance that is performed in between the yearly water testing by the outside agency is a check of the water temps. MD C confirmed they do not have a flow mapping of the facility's plumbing included in the water management plan. On 11/20/24 at 12:47 PM, during an interview, the Nursing Home Administrator (NHA) explained that MD C is responsible for doing audits for water temps daily, checking for legionella twice per month including checking fixtures and running water, checking fixtures that are not utilized as much as others and checking for smells or abnormalities. During the interview the facility's water management plan was reviewed with the NHA. The NHA confirmed that the water management plan did not include all of the necessary components as outlined in the facility's water management program plan instructions. The NHA stated I don't have any additional information other than what is in here. If the water plan says that it should be done then it should be done.