STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235439	A. Building B. Wing	03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Allen Park	9150 Allen Rd Allen Park, MI 48101

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49103 This citation pertains to intake MI00143287 Based on observation, interview and record review, the facility failed to implement a comprehensive, person-centered care plan regarding vision impairment and chronic urinary tract infection for one resident (R202) of five residents reviewed, resulting in the potential for unmet care needs and the potential for injury. Findings include: On 3/19/24 at 10:20 PM R202 was observed sitting upright in bed. R202 was interviewed and described ongoing problems with a burning sensation within the bladder. R202 said there have been many falls and further explained the staff have instructed resident to await help. I can't wait that long. R202 was queried about vision and responded by putting on a pair of glasses explaining they are new having gotten them about a month ago. R202 explained prior to that she did not have glasses. With the new glasses resident said vision has improved. Record review revealed that R202 was admitted into the facility on [DATE] with diagnoses that included Chronic Kidney Disease 3. Record review revealed R202 had and a history of past urinary tract infections. According to the MDS dated [DATE] (Minimum Data Set), R202 had a BIMS (Brief Interview for Mental Status) score of 13 indicating intact cognition and required one person assist for ambulation. R202 was last treated for a urinary tract infection with Ceftin (antibiotic) on 2/29/24. Further record review revealed there was no mention of recurrent urinary tract infections in the care plan. An undated notation in the TASKS section of the electronic medical record (EMR) documenting vision deficit stated, resident is legally blind. Further review of the medical record revealed there was no mention of vision deficit in the care plan. According to record review, since 11/5/23, resident had fallen nine times. On 3/19/24 at 2:53 PM interview with Director of Nursing (DON) and Nursing Home Administrator (NHA) included discussion concerning lack of care planning concerning the vision deficit and recurrent urinary tract infections. The DON confirmed the care plans in the electronic medical record (EMR) did not include the stated concerns. (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: 235439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Allen Park	9150 Allen Rd Allen Park, MI 48101

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/19/24 at 3:35 PM, MDS Coordinator A reviewed the care plans and confirmed there was nothing entered in the care plan concerning the vision and chronic urinary tract infections. MDS Coordinator A said if someone is confirmed with a urinary tract infection there should be a care plan in place. MDS Coordinator A reviewed the vision assessment on the last MDS dated [DATE] which indicated R202's vision was noted to be impaired. This alone did not trigger a care plan entry. MDS Coordinator A explained there had been a lack of communication involved. During the interview and record review a vision exam form dated 1/11/24 was found in the chart revealing the following note made by a physician. The client. presents for evaluation of blurry vision in the right eye and left eye. It affects OU (both eyes). The symptom is constant. The condition is severe. On 3/20/24 at 12:45 PM, review of the facility's policy titled Care Plan - Comprehensive and Revision with a revision date of 8/25/23 stated in part, 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.

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NAME OF PROVIDER OR SUPPLIER Optalis Health and Rehabilitation of Allen Park		STREET ADDRESS, CITY, STATE, ZIP CODE 9150 Allen Rd Allen Park, MI 48101	

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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 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** 39465 Based on interview and record review, the facility failed to obtain a physician's order in a timely manner for one resident (R201) of three residents reviewed for an ostomy, resulting in unmet care needs. Findings include: According to the electronic medical record, R201 was initially admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis, ileostomy status (part of the small bowel, is brought through the abdominal wall via a surgically-created opening called a stoma, to evacuate stool from the body), and enterostomy malfunction (The frequent complications associated with enterostomy formation are prolapse, retraction, stenosis or necrosis of the stoma, parastomal hernia and breakdown of the skin). R201's admission Minimum Data Set (MDS) with a reference date of 2/21/24 indicated R201 had severe cognition impairment with a BIMS (brief interview for mental status) score of 0/15. Review of the medical record on 3/19/24 at 10:31 a.m. revealed, R201's Activity Daily Living (ADL) care plan with a review date of 3/7/2024, documented the following: - R201 has a self-care deficit as evidenced by weakness related to altered mobility. Interventions: Assist with daily hygiene, grooming, dressing, oral care, and eating as needed. There was no care plan noted for for ostomy care. Review of the Physician's Team-History and Physical documented, Small bowel resection times two, Ileostomy revision dated 10/10/2023. Review of the Physician's Order documented the care of the stoma as following: -Cleanse ostomy area with water only, pat dry, apply stoma powder, layer with no sting skin prep to form paste, allow to dry, apply small [NAME] seal (provides superior protection to help stop leaks and prevent sore skin around the stoma), apply adapt stoma [NAME] around [NAME] seal, cut to fit ostomy bag approximately 1 1/4 inch, place bag on ostomy, hold hand over site for five minutes to obtain seal every day and night shift for ostomy care and as needed dated 3/7/2024. -ostomy care every day and night shift and as needed dated 2/29/2024. -Change ostomy bag, report any redness around stoma to wound care dated 2/28/2024. -Document output from ostomy every shift for monitoring, administer PRN (as needed) Imodium (for loose stool) if greater than 500 ccs (Milliliters) per shift. Review of the Physician's orders did not reveal Ostomy care orders at the time of admission (2/15/2024). Review of the Treatment administration Record revealed ostomy care orders initiated on the date of 2/29/2024. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/20/2024 at 3:30 p.m., the Director of Nursing (DON) confirmed R201 was admitted into the facility with an ileostomy bag and there should have been a care plan for the care and monitoring initiated by the admitting nurse. The DON confirmed that there was no care plan for R201's ileostomy care and the physician's orders for ileostomy monitoring was not initated at admission. The DON said the orders was not started until 2/29/2024 and the resident was admitted [DATE] and the ileostomy went through February twenty ninth without any documentation and through February twenty-six without any output monitoring of the ileostomy. The DON explained the importance of monitoring an ileostomy bag and stoma was to assess for redness around the stoma, the amount, assess for bloody content and make sure the ileostomy bag is secure in place.