STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Wyoming	625 36th Street SW Wyoming, MI 49509

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake # 3045819 Based on interview and record review, the facility failed to complete physician ordered care and treatments for one of three residents (R101) reviewed for wound care. Findings:Resident #101 (R101) Review of a Face Sheet revealed R101 was a [AGE] year-old male, admitted to the facility on [DATE], with a pertinent diagnoses of sepsis. Review of a nursing admission Evaluation date 06/08/26 reflected R101 was admitted with the following skin concerns: open areas on the right and left buttock and open areas to the front and back side of the right thigh. During an interview on 06/23/26 at 7:50 AM, R101 indicated that staff have not completed wound care and dressing changes per physician orders. Review of a Electronic Treatment Administration Record (E-tar) for R101, dated June 2026, reflected a wound care order for the right leg twice daily was not documented as completed on 06/11/26 second shift, 06/13/26 second shift, 06/15/26 second shift, and 06/21/26 first shift. Review of an Etar for R101, dated June 2026, reflected a wound care order twice daily for the right buttock was not documented as completed on 06/11/26 second shift, 06/13/26 second shift, 06/15/26 second shift, and 06/16/26 second shift. During an interview on 06/23/26 at 8:50 AM, the Director of Nursing indicated that she was aware that there were missed ordered wound care and treatments for R101 and the issue had been addressed with nursing staff.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 3034407 Based on observation, interview, and record review, the facility failed to monitor and assess one of three resident's (Resident #102) reviewed for ostomy care. Findings:Resident #102 (R102) Review of Face Sheet revealed R102 was a [AGE] year-old Spanish speaking male, originally admitted to the facility on [DATE], with pertinent diagnoses of a small bowel obstruction that was surgically repaired and a colostomy was placed, and an abdominal abscess that developed after surgery and required IV (intravenous) antibiotics. Other pertinent diagnoses include a history of a brain bleed that required a craniotomy and resulted in aphasia (difficulty speaking) and weakness to one side of his body. During a telephone interview on 06/22/26 at 10:29 AM, Registered Nurse (RN) A, from a local Infectious Disease clinic, stated that on 05/21/26, R102 had an appointment in their office and R102 arrived with a colostomy that was leaking stool onto his lap and clothes. During an observation on 06/23/26 at 10:12 AM, R102's call light was on and R102 pointed to his colostomy bag that was full of stool. During an interview on 06/23/26 at 10:20AM, Family Member 'K indicated that frequently when he visits, he has to tell staff that R102's colostomy is full or it is leaking. Review of a physician Progress Note dated 06/03/26, revealed R102 reported to the infectious disease physician that he (R102) had concerns about the wound care and the ostomy bag leaking over the surgical site. Review of Electronic Treatment Administration Record's (E-tar's) for R102, dated May and June 2026, revealed no colostomy orders, (i.e how frequently to check the bag, when to burp the bag, when to change to the appliance/wafer, monitoring of the stoma for skin changes or breakdown, monitoring stool amount, color and consistency for changes). Review of a Care Plan for R102 reflected that the only staff intervention/task regarding the colostomy was .change ostomy appliance as needed. Wears ileostomy product. Review of the facility policy/procedure Ostomy Care revealed .the purpose of this policy is to provide guidelines for the colostomy and ileostomy care, to maintain cleanliness and good skin condition, and to monitor the amount of fecal drainage .Ostomy care includes: the release of flatulence that has accumulated in the ostomy bag or pouch as needed, evaluating the ostomy site and visible surrounding skin for any signs of skin breakdown, evaluating the amount, consistency, and color of stool for any changes, and emptying the ostomy bag of feces.

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake # 3034407 Based on interview and record review, the facility failed to provide standard professional care to one of one resident's (Resident #102) reviewed for Intravenous (IV) access and fluids. Findings:Resident #102 (R102) Review of Face Sheet revealed R102 was a [AGE] year-old Spanish speaking male, originally admitted to the facility on [DATE], with pertinent diagnoses of a small bowel obstruction that was surgically repaired and a colostomy was placed, and an abdominal abscess that developed after surgery and required IV (intravenous) antibiotics. Other pertinent diagnoses include a history of a brain bleed that required a craniotomy and resulted in aphasia (difficulty speaking) and weakness to one side of his body. Review of a hospital Transfer Summary revealed that on 05/13/26 R102 had a PICC (peripherally inserted central catheter) inserted prior to discharge from the hospital. The PICC was placed for IV (intravenous) antibiotic use once R102 arrived at the skilled nursing facility on 05/14/26. Detailed information regarding the PICC was documented on the hospital transfer summary. Review of a nursing admission Evaluation for R102, dated 05/15/26, reflected that (a) an IV was present and (b) the location was midline left upper arm. Not documented on the nursing admission evaluation were the following: (1) venous access type, (a PICC), (2) size and length of the access, (3) circumference of the arm (or other insertion location if applicable) at the access site, and (4) an observation and description of the IV access site. During a telephone interview on 06/21/26 at 1:45 PM, a Registered Nurse from a local infectious disease clinic, (RN) A, reported the following concerns that were observed in the clinic on 05/21/26 regarding R102's PICC: (a) the dressing was peeling off at the corners, (b) the PICC was not clamped off, (c) there was no legible date on the dressing, and (d) the stat lock was not in use. Review of a facility physician order reflected: (a) change needless connector during a routine flush every 7 days for infection prevention. The due date for this order was 05/20/26, and (b) change midline dressing every 7 days for safety monitoring. The due date for this order was also 05/20/26. Review of an Electronic Medication and Treatment Record (Emar and Etar) for R102, dated May 2026, revealed (a) that the needless connector was not changed on 05/20/26. It was changed when the PICC was replaced on 05/22/26 due to pain in the left arm and possible SVT (superficial venous thrombosis-a blood clot), and (b) the dressing change was not completed on 05/20/26. It was changed when the PICC was replaced on 05/22/26. The needless connector for R102's PICC would next be replaced on 05/29/26 (7 days after previous change). No documentation in the Electronic Health Record (EHR) could be located to show the connector was changed on 05/29/26. The dressing change for R102's PICC would next be completed on 05/29/26 (7 days after previous change). No documentation in the EHR could be located to show the dressing was changed on 05/29/26. Review of an the E-mar and E-tar for R102, dated May and June 2026 revealed that when the IV antibiotics were stopped on 05/25/26, there were no maintenance flushes of the PICC completed every 12 hours. Unused catheters that do not at least receive twice daily maintenance flushes are at high risk for infection. During an interview on 06/23/26 at 3:08 PM, the Director of Nursing stated that on 03/20/26 all nurse had been re-educated on PICC and IV therapy, including required orders, documentation, dressing care, and proper use of connectors.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 3034407 Based on interview and record review, the facility failed to administer antibiotics and monitor labs per physician orders for one of three residents (Resident #102) reviewed for antibiotic stewardship. Findings:Resident #102 (R102) Review of Face Sheet revealed R102 was a [AGE] year-old Spanish speaking male, originally admitted to the facility on [DATE], with pertinent diagnoses of a small bowel obstruction that was surgically repaired and a colostomy was placed, and an abdominal abscess that developed after surgery and required IV (intravenous) antibiotics. Other pertinent diagnoses include a history of a brain bleed that required a craniotomy and resulted in aphasia (difficulty speaking) and weakness to one side of his body. Review of a hospital Transfer Summary For R102, revealed the following orders: meropenem (an antibiotic) 1 gram IVPB (Intravenous piggy back) every 8 hours for 42 doses. Final duration to be determined at outpatient infectious disease follow-up appointment. (05/21/26) Review of a Infectious Disease physician progress note for R102, dated 05/21/26, reflected the following orders: (a) continue Meropenem 1 gram IV every 8 hours, (b) CT (cat scan) ordered, final antibiotic duration will depend on results, (c) continue weekly labs CBC (complete blood count) with differential, CMP (Comprehensive Metabolic Profile), and CRP (C-reactive protein) while on IV antibiotics and fax results to our office (last labs reviewed were from the hospital on [DATE]), and (d) Infectious Disease clinic follow up in 2 weeks (06/03/26). Review of the Electronic Health Record (EHR) for R102 revealed no lab results. During an interview on 06/23/26 at 3:08 PM, the Director of Nursing (DON) indicted that lab work had not been completed for R102 until she received a telephone call from the Infectious Disease (ID) office on 06/03/26. ID called to make the facility aware that weekly labs were not being completed as ordered. The DON then produced lab results for R102 from 06/05/25 and weekly thereafter. The DON could not explain why the weekly labs had not been completed as ordered. Review of an Electronic Medication Administration Record (E-mar) for R102 dated May 2026 revealed the order for Meropenem 1 gram IV every 8 hours was stopped on 05/25/25. During an interview on 06/23/26 at 3:15 PM, the DON stated she did not know why the IV antibiotic for R102 was discontinued on 05/25/26, and after receiving the telephone call from the Infectious Disease office on 06/03/26, the IV antibiotic Meropenem was re-started. R102 had missed 27 ordered doses of antibiotics.