

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2025
NAME OF PROVIDER OR SUPPLIER Optalis Health and Rehabilitation of Canton		STREET ADDRESS, CITY, STATE, ZIP CODE 7025 Lilley Road Canton, MI 48187	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901</p> <p>This citation pertains to intakes MI00149008 and MI00148990.</p> <p>Based on interview and record review, the facility failed to ensure proper transfer assistance for two residents (R102 and R103) out of four residents reviewed for accidents.</p> <p>Findings include:</p> <p>R102 -</p> <p>It was reported to the State Agency that the facility failed to ensure proper transfer assistance. The complainant indicated that the resident fell to the floor while being transferred back into the bed and a nurse assistant and nurse were rough with the resident during the transfer from the floor into the bed.</p> <p>A review of the clinical record for R102 documented an admission into the facility on [DATE] and discharge on 12/8/24. R102's diagnoses included ovarian cancer and severe protein-calorie malnutrition. A Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition. Record review of R102's ADL (activity of daily living) self care deficit as evidence by weakness related to metastatic CA (cancer) care plan documented transfer with one-person assistance using two wheeled-walker and gait belt, initiated 12/6/24. R102's care plan also indicated R102 was at risk for falls due to weakness.</p> <p>A review of an incident report dated 12/7/24 and corresponding investigation for R102 revealed the following:</p> <p>CNA G documented that she previously assisted R102 out the bed to take her to the bathroom and R102 transferred easy. CNA G reported that when she was transferring R102 back into her bed, R102's knees buckled and R102 dropped to the floor and R102 landed on both of her knees. CNA G indicated it was hard to get R102 in the bed. R102 appeared light, but R102 was heavy. R102 was positioned on her knees facing the bed. CNA G called RN F who was right outside the door. RN F grabbed R102's upper body as if she was hugging R102 from the left side. CNA G indicated she grabbed R102's legs near her thighs. CNA G and RN F maneuvered R102 onto the bed where she was lying crossway. CNA G and RN F were able to get R102 in the bed. R102 was lying on her stomach with her face towards the head of the bed.</p> <p>(continued on next page)</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 235618	If continuation sheet Page 1 of 6

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Registered Nurse (RN) F reported Certified Nurse Aide (CNA) G called her into R102's room. Upon arrival to the room, RN F observed R102 on the floor in what appeared to be a knee position. CNA G informed RN F that she didn't know that R102 was heavy. CNA G asked RN F to assist with getting R102 up. RN F assisted R102 by her left armpit and the back of her brief with the CNA's help. They were able to get R102 halfway on the bed and at that time, R102 was lying on her left arm. When RN F and CNA F tried to rearrange R102, she rolled on to her stomach.</p> <p>A review of education provided to the facility clinical staff, dated 12/8/24, on falls and appropriate transfer when getting resident from the floor documented in part the following:</p> <ol style="list-style-type: none"> 1. Employees are to utilize mechanical lifts when transferring residents from the floor to ensure no injuries are sustained. 2. Employees should never lift residents by their arms or legs when transferring them. 3. Employees should always ensure the safest transfers possible when assisting residents. <p>R103 -</p> <p>It was reported to the State Agency that the facility failed to prevent a fall.</p> <p>A review of the clinical record for R103 documented an admission into the facility on [DATE] and discharge on 9/23/24. R103's diagnoses included brain cancer and repeated falls. A MDS assessment dated [DATE] documented moderate cognitive impairment. Record review of R103's ADL self-care and mobility deficit related to COVID, weakness, recurrent falls, brain cancer, documented to transfer with full mechanical lift, initiated 9/20/24. R103's care plan also indicated R103 was at risk for falls due to generalized weakness, status post hospitalization for COVID.</p> <p>A review of a facility document titled, Functional Abilities and Goals, for R103 dated 9/19/24 documented the following:</p> <ul style="list-style-type: none"> - Lower extremity: impairment on one side - Toileting hygiene: substantial/maximal assistance - Sit to stand: dependent <p>Review of incident note of 9/23/24 regarding R103 revealed, IDT (interdisciplinary team) met to review resident's recent incident accident. Resident was attempting to use the bathroom with staff and fell to the floor. Intervention: Staff to refer to Kardex when transferring patient.</p> <p>On 1/2/25 beginning at 2:00 PM, the Director of Nursing (DON) was interviewed regarding the falls for R102 and R103. The DON confirmed that staff should have used a mechanical lift when transferring R102 from the floor to the bed. The DON confirmed that staff attempted to walk R103 to the bathroom. R103 was not a one-person assist. R103 was interviewed and said he told staff that he needed more assistance. R103 should have been transferred with two-persons and a mechanical lift.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy titled, Fall Management Guidelines, dated 12/13/23, documented in part that a post-fall evaluation included: If after evaluation it is deemed safe, use the full mechanical lift to assist the resident off the floor.</p> <p>On 1/2/25 at 5:45 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information regarding this citation when asked.</p>

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901</p> <p>Based on interview and record review, the facility failed to ensure the correct amount of TPN (total parenteral nutrition used to provide complete nutrition directly into the bloodstream) was administered for one resident (R102), out of three residents reviewed for altered methods of receiving required nutrients.</p> <p>Findings include:</p> <p>A review of the clinical record for R102 documented an admission into the facility on [DATE]. R102's diagnoses included ovarian cancer and severe protein-calorie malnutrition. A Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition. Record review of R102's care plans documented resident was at nutritional risk related to diet restrictions, recent hospitalization , unplanned/unexpected weight loss, recurrent ovarian cancer, abdominopelvic abscess with blockage, history of nausea/vomiting, abnormal labs, history of multiple transfusions, gastrointestinal bleed, depression, severe protein-calorie malnutrition, fragile skin with drains, pedal edema, requires TPN, history of enteral support, anemia, and history of breast cancer. Interventions included to administer TPN as ordered. Date initiated: 12/8/24.</p> <p>Further chart review of R102's clinical record revealed an incident note of 12/8/24 that documented R102 and family member indicated that R102's TPN was not being correctly administered. R102 and family member voiced what R102 had been receiving. They stated that R102 had not received the correct dosing of the TPN since 12/6/24. R102 and husband voiced that R102 should have been receiving two bags of TPN daily to achieve the total calories but had only been receiving one a day and missed the entire dose on 12/5/24.</p> <p>During an interview on 1/2/25 at 2:13 PM, Registered Dietitian (RD) H said R102's TPN order was on paper, and the order had been faxed to the pharmacy. RD H indicated the order was not in the electronic health record. A review of R102's December 2024 Medication Administration Record (MAR) and Treatment Administration Record (TAR) did not reveal documentation of the administration of R102's TPN. RD H was unsure of how nursing documented TPN administration.</p> <p>During an interview on 1/2/25 at 2:19 PM, the Director of Nursing (DON) said the administration of R102's was never put on the MAR. R102 received TPN but nursing never transcribed the order. Nursing should have documented the administration of R102's TPN in the progress notes. The DON said when the pharmacy was contacted to clarify R102's TPN order, the facility was informed that R102 should be receiving two bags of TPN per day. The DON also indicated that lipids were included in the TPN order twice weekly on Tuesday and Thursday. Staff were hanging the TPN bag containing lipids (which appears milky white in color) but not the clear TPN bags. The DON indicated that R102 did not receive the prescribed amount of TPN. During a review of R102's clinical record, the DON could not provide documentation of TPN administration.</p> <p>A review of nursing education initiated on 12/8/24 regarding the accurate prescribing of ordered medications: TPN, documented the following content:</p> <p>- Pharmacy to dose medication</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Reading and understanding prescribed TPN orders - Clarifications of orders when orders are not clear (Pharmacy, MD) - Notification to MD and families of medication errors - Completing the risk management assessment when medication errors are observed <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included:</p> <ul style="list-style-type: none"> - Identification of affected and like residents to ensure pharmacy is notified promptly and verified TPN orders are transcribed in medication record timely. - Coordinate with pharmacy to clarify process in verifying TPN orders received from the hospital. - One to one education conducted with involved nurses and in-service conducted with all other nurses regarding: 1. Process in obtaining verified TPN order; 2. Transcribing TPN order from pharmacy promptly and accurately; and 3. Verifying physician order prior to administering TPN. - Nurse managers to conduct audits on all residents receiving TPN to ensure hospital TPN orders are verified by pharmacy, order transcribed timely, and TPN order verified before administering formula. - The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34901</p> <p>Based on interview and record review, the facility failed to consistently change the PICC (peripherally inserted central catheter) line tubing according to physician's order for one resident (R102) out of three residents reviewed for altered methods of feeding. (The parenteral method delivers nutrition intravenously which increases the risk of infection).</p> <p>Findings include:</p> <p>A review of the clinical record for R102 documented an admission into the facility on [DATE]. R102's diagnoses included ovarian cancer and severe protein-calorie malnutrition. A Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition. Record review of R102's potential for complications at IV (intravenous line) insertion site. PICC inserted at upper right arm, care plan indicated to change IV tubing per physician orders, initiated 12/5/24. Physician's order documented to Change IV PICC line tubing daily every day shift for safety monitoring. Start date of 12/6/24.</p> <p>A review of R102's Skin assessment dated [DATE] documented in part the following: Skin assessment done. Resident has a PICC line at left arm with dressing dry and intact.</p> <p>On 1/2/25 at 4:33 PM, a review of R102's clinical record was conducted with the Director of Nursing (DON). According to R102's December 2024 Treatment Administration Record, nursing staff failed to document that R102's IV PICC line tubing was changed on 12/7/24 and 12/8/24. A review of progress notes from 12/7/24 and 12/8/24 did not provide documentation to support the tubing had been changed. The DON stated, It doesn't look like it got done. The protocol is to change the tubing daily. It's supposed to be done daily to monitor the site and for infection prevention.</p> <p>On 1/2/25 at 5:45 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information regarding this citation when asked.</p>