STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235626	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Troy	925 W South Blvd Troy, MI 48085

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to provide an environment that promoted and enhanced resident's dignity for multiple residents, including two (R50 and R259) of two residents reviewed for dignity and anonymous residents attending resident council. Findings include: Review of a facility policy titled Dignity dated 9/21/23 read in part, .It is the policy of this facility that each resident will be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem .Demeaning practices and standards of care that compromise dignity are prohibited . R259 On 12/9/24 at 9:20 AM, R259 was observed lying in bed with a sling on their right arm. R259 was asked about the care at the facility. R259 explained one night they pushed their call light because they had to go to the bathroom, but when a staff member came in they told them just to go in their brief, and they would change them later. R259 was asked if they had told anyone about what had happened. R259 explained they had told several people at the facility. Review of the clinical record revealed R259 was admitted into the facility on [DATE] with diagnoses that included: displaced fracture of right arm, depression and acute pain due to trauma. According to the Minimum Data Set (MDS) assessment dated [DATE], R259 was cognitively intact and required substantial/maximal assistance of staff to use the toilet. Review of R259's ADL (activities of daily living) care plan initiated 11/22/24 read in part, .Toileting & toilet transfers: x1 .Transfer with X1 person physical assist with gait belt WITH Pyramid cane . On 12/10/24 at 1:01 PM, Unit Manager (UM) BB was interviewed and asked if R259 had ever told her someone had told them to use their brief instead of taking them to the bathroom. UM BB explained she did remember R259 telling her that, but as R259 was not able to give her the exact time it happened, so she could not determine who had told them that. UM BB was asked why R259 had to give her the exact time it happened. UM BB explained she needed to know if it happened on the afternoon or midnight shift. When asked if she had asked other residents if they had been told the same thing, UM BB had no answer. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 1:32 PM, the Director of Nursing (DON) was interviewed and asked if she had been notified of a staff member telling R259 to urinate in their brief instead of taking them to the bathroom. The DON explained she had not heard about that, and explained that should never happen. R50 On 12/9/24 at 9:10 AM, R50 was observed lying in bed from the hallway. R50 would yell out whenever they saw someone in the hall. The door was open, the curtain was pushed back against the wall. R50 was not wearing clothes or a gown, only in a brief. Upon entering the room, R50 kept saying a specific word. When asked questions, R50 would answer with the same word. On 12/9/24 at 9:45 AM, R50 was observed sitting in a wheelchair in the hall near the nurse station. R50 was wearing a facility provided gown. Review of the clinical record revealed R50 was admitted into the facility on [DATE] with diagnoses that included: stroke, aphasia (language disorder) and anxiety disorder. According to the MDS assessment, R50 had severely impaired cognition and was dependent on staff for all ADL's. Review of R50's ADL care plan revealed an intervention initiated 1/22/24 that read, Resident prefers to not wear clothing/gowns. Staff to ensure curtain pulled for privacy and offer blanket. Review of a Resident Inventory List dated 11/20/24 read, No Inventory As of 11/21/24. On 12/10/24 at 10:28 AM, R50 was observed sitting in a wheelchair wearing a gown in the hall by the nurse station. On 12/10/24 at 10:32 AM, Social Worker (SW) H was interviewed and asked if R50 had any clothing at the facility. SW H explained R50 had been admitted without any clothes, and they had reached out to R50's family to bring in some clothes, but had not brought in any yet. When asked if there was any documentation R50's family had been asked to bring in clothing, SW H explained there was no documentation. When asked what would happen if R50's family did not bring any clothes, SW H explained the facility did have donated clothes that they give to residents, but was not sure any would fit R50. On 12/10/24 at 11:05 AM, Certified Nursing Assistant (CNA) EE was asked if R50 had any clothes at the facility. CNA EE explained no, R50 did not have any clothes at the facility. On 12/10/24 at 3:01 PM, an observation of R50's closet with Registered Nurse I revealed R50 had no clothes. On 12/10/24 at 3:05 PM, SW H was interviewed and told of the observation that R50 had no clothes and asked why R50 still did not have any clothes after being at the facility for three weeks. SW H explained R50 did not like to wear clothes, they kept taking them off. SW H was asked since R50 had never had clothes while at the facility, how did she know they would not wear them. SW H had no answer. On 12/10/24 at 3:45 PM, the DON was interviewed and asked about R50 not having clothes at the facility and only wearing a gown in the hall. The DON explained R50 did not like to wear clothes. When asked how did she know R50 did not like to wear clothes when they had never worn clothes at the facility, the DON had no answer. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at 4:00 PM, Unit Manager (UM) BB brought a paper copy of R50's ADL care plan that documented R50 did not like to wear clothes. UM BB was asked how she knew R50 would not wear clothes when they had not had any clothes while at the facility. UM BB explained she did not think R50 would wear them, as they kept taking off their gown. On 12/11/24 at 11:40 AM, R50 was observed from the hall lying in their bed. R50 would yell out when they saw someone in the hall. The door was open, the curtain pushed back against the wall, a gown was laid over R50 like a blanket. R50 was not wearing any other clothing, gown, sheet or blanket. 38271 On 12/10/24 at approximately 10:49 a.m., during the group meeting, the residents were asked if the facility staff were treating them with dignity and respect and three residents (who preferred to be anonymous) reported the staff do not treat them with respect and indicated they felt like they were just numbers.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 38271 Based on interview and record review, the facility failed to ensure that grievances were promptly documented, investigated, tracked and resolved for four residents (R24, R30, R37, R40) of five residents that participate in the resident council (RC) meetings. Findings include: On 12/10/24 at approximately 10:41 a.m., during the group meeting, the residents were asked if their concerns that were brought up in the monthly resident council meetings were addressed and resolved and four residents (R24, R30, R37 and R40) all indicated that their concerns were not addressed and resolved in a timely manner. R40 reported that concerns are brought up, but no resolution is provided. On 12/10/24 the resident council meeting minutes were reviewed for September, October and November 2024. Further review of September's meeting minutes revealed the RC had concerns with Nursing services. On 12/11/24 at 8:32 a.m., the Administrator was asked for grievance/concern forms that showed resident council concerns were addressed and resolved for the previous four months. On 12/11/24 at 9:43 a.m., the Administrator reported they did not have any documentation that the concerns noted in the resident council minutes had been address/resolved with the council. On 12/11/24 at approximately 11:35 a.m., Activities aide GG (AA GG) was asked if they kept documentation of the concerns that were noted in the resident council meetings and they indicated that they did. AA GG reported that the Activities Director had recently resigned but that they had kept the grievance forms in a binder. AA GG was asked for the grievance resolution form for Nursing Services noted in the September 2024 meeting minutes and they indicated they did not have any documentation for the concerns for Nursing services documented in the meeting minutes for September.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview and record review the facility failed to ensure resident's right to personal privacy during treatment (lab draw) for one (R6) of one resident reviewed for privacy. Findings include: On 12/11/24 at 9:18 AM, from the hallway outside R6's room, the resident was observed laying in bed and another person was observed at their bedside performing a blood draw. The privacy curtain and/or door was not closed and the entire procedure was observed from the hallway. On 12/11/24 at 9:20 AM, Unit Manager 'FF' was observed just outside R6's room and confirmed the lack of privacy. On 12/11/24 at 9:22 AM, upon exiting the resident's room, Phlebotomist (Lab Staff 'K') was asked about why they didn't close the door, or pull the curtain to provide privacy during a lab draw and they offered no response. Review of the clinical record revealed R6 was admitted into the facility on [DATE] with diagnoses that included: MSSA (Methicillin-susceptible Staphylococcus aureus - a type of bacterial infection). On 12/11/24 at 1:01 PM, the facility was requested to provide a policy regarding privacy during care, however there was no further documentation provided by the end of the survey.

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on interview and record review, the facility failed to ensure necessary documentation was completed, provide evidence of communication to the receiving facility, and completing the discharge process for one (R2) of one resident reviewed for hospitalization . Findings include: On 12/9/24 upon entrance into the facility, a Daily Census report dated 12/9/24 at 8:35 AM was provided. R2 was listed as Active. On 12/9/24 at approximately 9:35 AM, the door to R2's room was closed, upon knocking and entering, the room was observed fully cleaned, and no belongings were observed. Registered Nurse (RN) Y was asked about R2. RN Y explained R2 had been discharged to the hospital. Review of the clinical record revealed R2 was admitted into the facility on [DATE] with diagnoses that included: diabetes, depression and dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R2 was cognitively intact. The record also indicated R2 was still a resident at the facility. Review of R2's assessments revealed no documentation of transfer form to provide to the receiving hospital. Review of a SBAR (situation-background-assessment-recommendation) Change of Condition form dated 12/6/24 at 4:16 PM revealed an order to send R2 to the hospital. Review of R2's progress notes revealed two nursing progress notes by Licensed Practical Nurse (LPN) Z one a late entry created 12/9/24 at 12:24 AM with an effective date of 12/7/24 at 11:23 PM, and one dated 12/8/24 at 11:24 PM that documented R2 was in the facility. On 12/9/24 at 11:58 AM, RN Y was again asked about R2. RN Y explained she had been told in report R2 was sent to the hospital on 12/6/24. RN Y was informed R2 was still on the census, the lack of transfer form, and progress notes documenting R2 was at the facility. RN Y explained R2 should have been discharged , and a transfer form should have been completed. On 12/9/24 at 12:08 PM, the Director of Nursing (DON) was interviewed and informed that R2 had been sent to the hospital on 12/6/24, but was still active in the medical record, there was no transfer form and there were progress notes from after R2 was sent to the hospital that documented the resident was in the facility. The DON explained she had been there when R2 was transferred to the hospital, R2 should have been discharged from the census when they left, and a a transfer form should have been completed, as to the progress notes, she would look into the matter. (continued on next page)

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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled, Transfers and Discharges revised 3/20/24 read in part, .Initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident .Complete the hospital transfer form assessment in (medical record), print and send a copy with the resident, which includes but may not be limited to: Contact information of the practitioner who was responsible for the care of the resident; Resident representative information including contact information; Advance directive information; Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer recent vital signs; Diagnoses and allergies; Most recent relevant labs, other diagnostic tests, and recent immunizations .

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on record review and interview, the facility failed to ensure an admission medication order was followed for one (R38) of one resident reviewed for admission orders. Findings include: Record review revealed R38 was admitted to the facility on [DATE] requiring nursing care and rehabilitation after a fall resulting in spinal and elbow fractures. Medical history included hypertension, anxiety, asthma, and muscle weakness. R38's BIMS (Brief Interview Mental Status) documented on admission was 14/15 indicating R38 was cognitively intact. On 12/10/24, A record review revealed on 10/25/24 pharmacy recommendations to nursing documented . Resident has orders .Per hospital records, the resident should not continue on Trelegy Ellipta (an inhaled medication to control and prevent wheezing and shortness of breath) .Please clarify with the provider and update the medical record accordingly . On 12/10/24 at 11:38 AM, the Director of Nursing (DON) was interviewed and confirmed the signature on the document was theirs and they would have been responsible for clarifying the admission order with the physician. The DON further acknowledged after review of Medication Records for October and November 2024; the resident was receiving Trelegy Ellipta. When asked if the physician was informed regarding the medication, the DON was observed looking into the residents' electronic medical record, and a To Do List notebook and was unable to confirm if they communicated the recommendation from pharmacy. Review of the facility's policy titled; Medication, Treatment, and Physician Order Transcription dated 11/3/2023 documented: .Orders for medications and treatments will be consistent with principles of safe and effective order writing . New admission orders will be reviewed with the resident's physician for any changes or clarifications .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview, and record review the facility failed to ensure services provided met professional standards of practice for four (R2, R45, R13, and R308) of four residents reviewed for professional standards. Findings include: R2 On 12/9/24 upon entrance into the facility, a Daily Census report dated 12/9/24 at 8:35 AM was provided. R2 was listed as Active. On 12/9/24 at approximately 9:35 AM, the door to R2's room was closed, upon knocking and entering, the room was observed fully cleaned, and no belongings were observed. Registered Nurse (RN) Y was asked about R2. RN Y explained R2 had been discharged to the hospital. Review of the clinical record revealed R2 was admitted into the facility on [DATE] with diagnoses that included: diabetes, depression and dementia. According to the Minimum Data Set (MDS) assessment dated [DATE], R2 was cognitively intact. The record also indicated R2 was still a resident at the facility. Review of R2's progress notes revealed: A nursing note dated 12/6/24 at 4:26 PM by RN C that read in part, .New orders given to petition resident out and send to local hospital . Two nursing notes by Licensed Practical Nurse (LPN) Z one a late entry created 12/9/24 at 12:24 AM with an effective date of 12/7/24 at 11:23 PM, and one dated 12/8/24 at 11:24 PM that were exactly the same, Resident alert and oriented <sic> x3, able to make needs known. Resident takes medication whole, diet regular texture and thin liquids. Resident is continent of bowel and bladder Resident has left knee immobilize, no complications noted. resident is 1PA (one person assist) per therapy careplan <sic>. Resident denies any pain or discomfort at this time. Resident resting in bed, respiratory rate even and unlabored, call light and personal belongings in reach. On 12/9/24 at 11:58 AM, RN Y was again asked about R2. RN Y explained she had been told in report R2 was sent to the hospital on 12/6/24. On 12/9/24 at 12:08 PM, the Director of Nursing (DON) was interviewed and informed that R2 had been sent to the hospital on 12/6/24, but there were progress notes from after R2 was sent to the hospital that documented the resident was in the facility. The DON explained she had been there when R2 was transferred to the hospital and she would look into the matter of the progress notes. On 12/9/23 at 12:23 PM, the DON explained she had talked to LPN Z, who had stated she charted on the wrong residents when she wrote those progress notes. The DON also explained LPN Z had been assigned to an entirely different unit at the facility and she did not even know how LPN Z was able to chart in R2's chart. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 7:52 AM, a call was place to LPN Z. No return call was made before the end of the survey. R45 On 12/9/24 at 10:22 AM, R45 was observed sleeping in bed. A medical measuring cup was observed on R13's over-bed table that contained 240 milliliters (ml) of an orange liquid that had a deep layer of sediment at the bottom of the cup. Several individual ointment packets were also observed on the over-bed table. On 12/9/24 at 11:01 AM, R45 was observed lying in bed. The cup of orange liquid and the ointment packets were still on the over-bed table. R45 was asked about the liquid. R45 explained they thought it was medicine for their bowels. On 12/9/24 at 1:10 PM, R45 was observed lying in bed. The cup of orange liquid and the ointment packets were still on the over-bed table. Review of the medical record revealed R45 was admitted into the facility on [DATE] with diagnoses that included: compression fracture of vertebra, diabetes and depression. According to the MDS assessment dated [DATE], R45 was cognitively intact. Review of R45's medications revealed an order for Questran for diarrhea. On 12/10/24 at 4:23 PM, Licensed Practical Nurse (LPN) T was asked what was the color of Questran powder when mixed with water. LPN T explained the mixture was an orange color. On 12/11/24 at 12:22 PM, the DON was interviewed and asked if a resident does not want to take a medication, can it be left at the bedside. The DON explained the medication should be removed and re-offered again at a later time, it should not be left at the beside. 49083 R13 Record review revealed R13 is a long-term resident admitted to the facility on [DATE] with a medical history of colon and liver cancer, COPD (chronic obstructive pulmonary disease), diabetes, atrial fibrillation (abnormal heart rhythm) and Clostridium difficile bacteria (C-Diff) (highly contagious infection of the colon). The BIMS (Brief Interview Mental Status) last recorded was 15/15 indicating R13 was cognitively intact. On 12/9/24 at 1:53 PM, R13 voiced concern when being to be tested for C-diff Licensed Practical Nurse R (LPN R) communicated the stool sample provided was mishandled, and/or not labeled correct. R13 voiced frustration because they were placed in isolation longer than need be and had to provide additional samples. Record review of R13's lab orders revealed on 11/26/24 an order was placed to test for C-Diff X1. On 11/27/24, R13's Stool sample was collected. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/11/24 at 11:10 AM, an interview was conducted with LPN R and the Director of Nursing (DON). LPN R was questioned why the results (on 12/3/24) were for a stool culture and not C-Diff. LPN R contacted the lab. The lab confirmed the label was sent documented by the nurse to test for a stool culture, not C-Diff. At the conclusion of the interview, LPN R and the DON acknowledged the stool sample for R13 was labeled incorrectly and not tested per the physician orders causing a delay in treatment and interventions. R308 R308 was randomly selected and reviewed for the facility's Infection Control Program, Antibiotic Stewardship survey. On 12/11/24, a record review revealed R308 was admitted to the facility on [DATE] for wound care to the left toe. R308 had a history leukemia, kidney cancer, bone cancer, and atrial fibrillation (abnormal heart rhythm). R308 was admitted with a urine catheter and was assessed for a possible urinary tract infection. Record review revealed a physician order to obtain a urine sample prior to the first dose of an antibiotic. On 8/7/24 the facility's lab results report revealed the urinalysis specimen was unable to be processed due to the following reason(s): Unverifiable Patient Info <sic> Comments: No Patient Identifiers on urine cup. On 12/11/24 at 10:30 AM, a record review and interview were conducted with the facilities Infection Preventionist E (IP E) and DON. Both acknowledged the urine specimen sent was labeled incorrectly and unable to be tested per the physicians' orders. Further record revealed there was no documentation of communication between nursing and the physician that the sample was invalid.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on observation, interview and record review, the facility failed to assess and implement treatment orders, and identify skin changes and/or the worsening of pressure ulcers for two (R38 and R39) of three residents reviewed for pressure ulcers. Findings include: This citation pertains to intake: MI00148681. Resident #38 Review of a complaint submitted to the State Agency on 11/29/24 documented an allegation the facility failed to provide adequate and appropriate interventions to prevent and care for pressure ulcers. Record review revealed R38 was admitted to the facility on [DATE] requiring nursing care and rehabilitation after a fall resulting in spinal and elbow fractures. Medical history included hypertension, anxiety, asthma, and muscle weakness. R38's BIMS (Brief Interview Mental Status) documented on admission was 14/15 indicating R38 was cognitively intact. Record review revealed on 10/25/24 an order to consult wound care was placed for R38. On 11/25/24 a skin assessment was performed for R38 and identified bilateral heel skin breakdown. On 12/11/24 at 2:33 PM, an interview was conducted with the facility Wound Care Nurse B (WC B). During a record review WC B acknowledged meeting with the resident's husband on 12/3/24. Per WC B they were informed the husband requested a meeting to assess R38's heels for concerns of skin breakdown. WC B documented on 12/3/24 .writer assessed resident heels per husband stated 'I am applying my own cream and moist bandages to heels' which is causing callus to open and soften. Tx (treatment) order in place, educated husband on the importance of wound care and healing. Husband was understanding of education . During the interview, WC B confirmed the wound care consult ordered, and the skin assessment performed on 11/25/24 which identified heel breakdown was not communicated to them and R38 was not seen until 12/3/24. 38271 R39 On 12/09/24 at approximately 10:12 a.m., R39 was observed in their room, laying in their bed. R39 appeared fragile/vulnerable and was asked if they had any wounds and they reported that they did on their leg and backside. R39 was asked if their wound dressings were being changed regularly and they reported they thought they were but were unsure. At that time, no positioning wedges or pillows were observed to relive pressure and R39 was observed to be laying flat in supine position in their bed. (continued on next page)

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	235626	A. Building B. Wing	12/11/2024

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/9/24 the medical record for R39 was reviewed and revealed the following: R39 was last admitted to the facility on [DATE] and had diagnoses including Congestive heart failure and Pressure ulcer of sacral region stage three. A review of R39's MDS (minimum data set) with an ARD (assessment reference date) of 10/30/24 revealed R39 was dependant on facility staff for most of their activities of daily living. A Physician's order with a start date of 10/24/24 and an end date of 10/28/24 revealed the following: SITE: SACRUM Clean area with NS (normal saline), pat dry apply ,Medi-honey (a wound treatment) to wound bed and cover with Foam dressing. Notify MD (Medical Doctor)/NP (Nurse Practitioner) or WCC (Wound Care Coordinator) for any complications or concerns A NP Wound Consult dated 10/28/24 revealed the following-Exam .Wound #2: Sacrum stage III pressure ulcer (Full-thickness skin loss with damage to subcutaneous tissue), 6.2 x 1.7 x 0.1, 2 areas skin bridged, 10% purple, 20% granular, 70% slough (devitalized tissue that forms on the wound bed of chronic wounds and hinders healing), periwound dry/flaky/pink/epithelial/fragile, minimal serosanguineous drainage (wound drainage secreted by an open wound in response to tissue damage), no infection .Assessments/Plans Sacrum stage III pressure ulcer .Cleanse area with normal saline, pat dry, apply Medihoney to open areas, apply Calmoseptine to periwound, cover with ABD (abdominal pad), and secure with tape daily . A Physician order with a start date of 10/28/24 and an end date of 11/4/24 revealed the following: SITE: SACRUM Clean area with NS, pat dry apply calmoseptine to surrounding areas then apply, Medi-honey to wound bed and cover with dry dressing. Notify MD/NP or WCC for any complications or concerns Start date 10/28/24 end date 11/4/24. A NP Wound Consult dated 11/4/24 revealed the following: Exam .Wound #2: Sacrum stage III pressure ulcer, 6.2 x 1.7 x 0.1, 7 areas skin bridged, 30% granular, 70% slough, periwound dry/flaky/pink/epithelial/fragile, minimal serosanguineous drainage, no infection .Assessments/Plans: Sacrum stage III pressure ulcer .Cleanse area with normal saline, pat dry, apply Triad every shift . A Physician's order with a start date of 11/5/24 and an end date of 11/26/24 revealed the following: SITE: SACRUM Clean area with NS, pat dry apply Triad to affected areas. Notify MD/NP or WCC for any complications or concerns . A review of R39's November 2024 treatment administration record (TAR) revealed R39 was not provided their triad sacrum wound treatment on 11/7, 11/9, 11/10, and 11/16. A NP Wound Consult dated 11/11/24 revealed the following: Exam .Wound #2: Sacrum stage III pressure ulcer, 12.1 x 11.9 x 0.2, 8 areas skin bridged, 50% granular, 50% slough, periwound dry/flaky/pink/epithelial/fragile, minimal serosanguineous drainage, no infection. Sacrum stage III pressure ulcer .Assessment/Plans: Cleanse area with normal saline, pat dry, apply Triad daily and as needed . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A NP Wound Consult dated 11/18/24 revealed the following: Exam .Wound #2: Sacrum stage III pressure ulcer, 18.6x 5.3x UTD (unable to determine), 12 areas skin bridged, 20% eschar, 60% granular, 20% slough, periwound dry/flaky/pink/epithelial/fragile, minimal serosanguineous drainage, no infection . Assessment/Plans: Sacrum stage III pressure ulcer .Cleanse area with normal saline, pat dry, apply Medihoney to open areas, apply Calmoseptine to periwound, cover with ABD, and secure with tape daily Downloading interventions implemented On protein/supplement DON (Director of Nursing) aware of wound status . A NP Wound Consult dated 11/25/24 revealed the following: Exam .Wound #2: Sacrum stage III pressure ulcer, 17.8 x 5.7 x 0.1, 6 areas skin bridged, 30% eschar, 20% granular, 50% slough, periwound dry/flaky/pink/epithelial/fragile, minimal serosanguineous drainage, no infection .Assessment/Plans-Sacrum stage III pressure ulcer .Cleanse area with normal saline, pat dry, apply Medihoney to open areas, apply Calmoseptine to periwound, cover with ABD, and secure with tape daily .UltraMist therapy once weekly . A Physicians order with a Order Start date of 11/27/24 and an end date of 11/29/24 revealed the following: SITE: SACRUM Clean area with NS, pat dry Santyl ointment to affected areas and cover with ABD. Notify MD/NP or WCC for any complications or concerns . A review of R39's November 2024 treatment administration record (TAR) revealed R39 was not provided their santyl sacrum wound treatment on 11/27 and 11/29. A Physician's order with a start date of 11/29/24 and an end date of 12/2/24 revealed the following: SITE: SACRUM Clean area with NS, pat dry Santyl ointment to affected areas and cover with ABD. Notify MD/NP or WCC for any complications or concerns . A review of A review of R39's November 2024 treatment administration record (TAR) revealed R39 was not provided their santyl sacrum wound treatment on 11/30/24 (second application). On 12/11/24 at approximately 12:50 p.m., during a discussion of R39's sacral pressure ulcer with the DON, WCC (B) and NP HH, NP HH was asked if their treatment plan was for R39 to be treated with medihoney then triad, then medihoney and ending with santyl and they indicated that was the correct treatment course that they ordered. WCC B was asked why the triad treatment had extended from 11/5 until 11/26 when NP HH's consultation indicated that the orders were to be switched to medihoney again and they indicated they did not know why the consultation indicated medihoney and that they thought the NP still wanted the triad in place. WCC B was asked why R39's treatment was changed to the Santyl tx that started on 11/29 when the NP wound consult indicated medihoney was to be continued and they indicated that they did not know why that was documented on the consult and that they believed santyl should have been started at that time. WCC B was asked if they do the wound treatments and they reported sometimes but the floor Nurses were responsible for them and documenting that it was done in the TAR. WCC B was asked to clarify why the NP's consultation indicated different treatments than what were ordered and they indicated they would have to reform the process to ensure all the treatments matched the documentation on the consults.

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	235626	A. Building B. Wing	12/11/2024

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 30675 Based on interview and record review, the facility failed to ensure two (Certified Nurse Aides - CNA 'L' and CNA 'P') of five CNAs reviewed for competency was evaluated for skills and techniques necessary to care for the needs of the residents. Findings include: On 12/10/24 at 2:11 PM, the Administrator was requested to provide documentation for review which included skills/competency evaluations for five CNAs. Review of the documentation provided revealed concerns with the lack of annual skills/competency evaluations not completed timely with two of the five CNAs reviewed. These concerns included: 1) For CNA 'L', their date of hire was 4/22/11, and the most recent skills/competency evaluation was completed on 7/6/23. 2) For CNA 'P', their date of hire was 5/14/12 and the most recent skills/competency evaluation was completed on 7/6/23. On 12/11/24 at 11:24 AM, an interview was conducted with the In-Service Director (Staff 'I'). They reported they took over the role for in-service education in October 2024 and had been working to try to complete many things that had not been completed when they took on that role. They reported they were starting from scratch. When asked how often the CNA skills/competency evaluations should be done, Staff 'I' reported that should be done annually. They confirmed the last skills/competency evaluations for CNA 'L' and CNA 'P' was 7/6/23. Review of the documentation provided for a facility policy request for skills/competencies revealed a blank copy of the CENA New Hire and Annual Skills Checklist.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 30675 Based on observation, interview and record review, the facility failed to ensure nurse staffing information was readily accessible for all 79 residents and/or families/visitors in the facility, resulting in necessary staffing information not being available. Findings include: On 12/10/24 at 12:02 PM, the Administrator was requested to provide the daily staff postings for the past three months. Review of the binder provided by the facility of the actual daily staff postings for the past three months revealed the following dates had no daily staff postings available for review: December: 12/1 (Sun), 12/2 (Mon), 12/3 (Tues), 12/6 (Fri), 12/7 (Sat), 12/8 (Sun). November: 11/2 (Sat), 11/3 (Sun), 11/9 (Sat), 11/10 (Sun), 11/14 (Thu), 11/15 (Fri), 11/16 (Sat), 11/17 (Sun), 11/18 (Sat), 11/23 (Sat), 11/24 (Sun), 11/28 (Thu), 11/29 (Fri), 11/30 (Sat), and 11/31 (Sun). October: 10/5 (Sat), 10/6 (Sun), 10/7 (Mon), 10/11 (Fri), 10/12 (Sat), 10/13 (Sun), 10/19 (Sat), 10/20 (Sun), 10/21 (Sat), 10/26 (Sat), 10/27 (Sun), 10/28 (Mon), 10/30 (Wed), and 10/31 (Thu). On 12/10/24 at 12:40 PM, an interview was conducted with the Administrator. When asked who was responsible for posting the daily staff postings, the Administrator reported that was their scheduler. When asked who posted on the weekends when the scheduler was not working, they reported that was usually the receptionist. The Administrator was informed of the concern with posting observed on 12/9/24, as well as the multiple missing documentation of posting in the binder provided for review.

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	235626	A. Building B. Wing	12/11/2024

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39592 Based on observation, interview and record review, the facility failed to ensure accurate documentation of controlled substances for one (R258) of one resident reviewed for controlled medications. Findings include: Review of the closed record revealed R258 was admitted into the facility on [DATE] with diagnoses that included: intraspinal abscess, meningitis and rheumatoid arthritis. According to a Brief Interview for Mental Status (BIMS) assessment dated [DATE], R258 scored 15/15 indicating cognitively intact. Review of medications revealed a physician order for Hydromorphone 2 milligrams (mg), give 2 tablets every 4 hours as needed for pain. Comparing the Controlled Drug Receipt/Record/Disposition Form for Hydromorphone 2 mg with R258's November 2024 Medication Administration Record (MAR) revealed the following discrepancies: On 11/16/24 at 6:00 PM two tablets were documented as being removed from R258's supply. There was no documentation on the MAR that R258 was given the two tables of Hydromorphone. On 11/16/24 the time appeared to be written over another time. It appeared 2041 (8:41 PM) had been originally written, then a 2 appeared to be written over the 0 making it look like 2241 (10:41 PM). The MAR documented R258 was given the Hydromorphone at 2241. *It should be noted 8:41 PM is only two hours after the 6:00 PM dose give, not the ordered four hours* On 11/17/24 the time appeared to be written over another time. It appeared 4 p had been originally written, then a 5 appeared to be written over the 4. There was no documentation on the MAR that R258 was given the two tablets of Hydromorphone. On 11/18/24 at 7:45 AM two tablets were documented as being removed from R258's supply. There was no documentation on the MAR that R258 was given the two tables of Hydromorphone. On 11/18/24 at 12:24 PM two tablets were documented as being removed from R258's supply. There was no documentation on the MAR that R258 was given the two tables of Hydromorphone. No medications were documented as having been wasted on the Controlled Drug Receipt/Record/Disposition Form. On 12/10/24 at 12:23 PM, the Director of Nursing (DON) was informed of the discrepancies between R258's Controlled Drug Receipt/Record/Disposition Form and MAR for Hydromorphone, and that there were eight 2 mg tables of Hydromorphone that were documented removed from R258's supply, but not documented as having been given to R258. The DON explained she would look into the matter and start education. No additional information was received prior to the end of the survey. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a facility policy titled, Controlled Medication Guidelines revised 3/20/24 read in part, .Administering Controlled Medications: .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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 39592 Based on observation, interview and record review, the facility failed to ensure medications were appropriately stored and in a safe/sanitary manner in three of four medication carts and one treatment cart reviewed. Findings include: Review of a facility policy titled, Storing Drugs and Biologicals-Storage and Maintenance of Medication dated 3/1/18 read in part, .Only drugs (and supplies necessary for their administration) are to be kept in medicine cabinets and carts . Medication must be checked regularly for expiration dates and deterioration On 12/10/24 at 9:41 AM, observation of the 1st floor Cart 2 medication cart was made with Licensed Practical Nurse (LPN) T. In the third drawer from the top on the left, a large, clear plastic coffle cup with a coffee colored liquid and straw was on the left side of the drawer. When asked what it was, LPN T explained it was her coffee, and she needed to move it. Also in the same drawer was a vial of Lispro Insulin that had no open date written on it. A bottle of Brimonidine Tartrate 0.2% eye drops had no open date. Both items were confirmed with LPN T to have been opened and used. On 12/11/24 at 10:01 AM, observation of the 1st floor Cart 3 medication cart was made with LPN V. In the top drawer on the left, the right back corner had a large amount of what appeared to be crushed pill debris. On 12/11/24 at 10:39 AM, observation of the 2nd floor Cart 2 medication cart was made with LPN W. A Lantus SoloStar Insulin Pen for was undated. A Fluticasone Salmeterol inhaler for was undated. A Spiriva for was undated. All three medications were confirmed with LPN W to have been opened and used. On 12/11/24 at 12:20 PM, the Director of Nursing (DON) was informed of finding coffee and open undated Insulin's and inhalers in the medication carts. The DON explained coffee was not to be in a medication cart, and all medications should be dated when opened. 38271 On 12/11/24 at approximately 10:26 a.m., an unlocked and unattended treatment cart containing various wound care creams and medication was observed by room [ROOM NUMBER]. On 12/11/24 at approximately 10:28 a.m., The DON (Director of Nursing) was observed coming down the hall and was asked if the cart should be unlocked without any Nurses attending it and they indicated it should not be and was observed locking it.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38271 Based on interview and record review the facility failed to ensure a Physician ordered laboratory (lab) diagnostic was completed for two residents (R47 and R52) of two residents reviewed for diagnostics. Findings include: R47 On 12/9/24 the medical record for R47 was reviewed and revealed the following: R47 was initially admitted to the facility on [DATE] and had diagnoses including Tracheostomy, End stage renal disease and Cerebral infarction. A review of R47's MDS (minimum data set) with an ARD (assessment reference date) of 11/20/24 revealed R47 needed assistance from facility staff with all their activities of daily living. A Physician's order dated 11/18/24 revealed the following: Weekly cbc (complete blood count), cmp (comprehensive metabolic panel) A review of R47's weekly lab results only revealed one set of the cbc/cmp results with a collection date of 12/2/24. R52 On 12/9/24 the medical record for R52 was reviewed and revealed the following: R52 was initially admitted to the facility on [DATE] and had diagnoses including Hemiplegia and Hemiparesis following cerebral infarction affecting left-non dominant side. A review of R52's MDS (minimum data set) with an ARD (assessment reference date) of 11/12/24 revealed R52 needed assistance from staff with most of their activities of daily living. R52's cognition was documented as severely impaired. A Physician ordered lab dated 11/25/24 revealed the following: CBC with diff (differential) dx (diagnosis) leukocytosis Further review of the medical record did not reveal any results of the CBC lab ordered on 11/25/24. On 12/10/24 at approximately 3:46 p.m., during a conversation with the Director of Nursing (DON), the DON was asked if they were aware of Physician ordered laboratory diagnostics not being completed in their building. They reported that they were and that they were doing a PNC (past non-compliance). At that time, the DON was asked if R52's lab results from the CBC lab that was ordered on 11/25/24 and R47's weekly labs had been completed and reported to the Physician and the DON reported they would look for them. (continued on next page)

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	235626	A. Building B. Wing	12/11/2024

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/10/24 at approximately 3:59 p.m., during a follow-up conversation with the DON, the DON reported they were unaware of R52's CBC lab order on 11/25/24 and it was not completed and not identified on their lab audit because the order was entered into the EMR (electronic medical record) incorrectly and was categorized as other verses the laboratory category. The DON also reported that they only had the results from 12/2/24 weekly lab for R47 and that the other weekly labs were not done and that was why they implemented action plan for the labs to be completed and the process reformed. No lab results were provided for R52's lab order on 11/25/24 or the other weekly lab draws for R47 were provided by the end of the survey.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49083 Based on interview and record review, the facility failed to ensure collaboration with hospice representatives with one (R32) of one resident reviewed for hospice services, resulting in hospice not informed of clinical and intervention changes. Findings include: Clinical record review revealed R32 was admitted to the facility on [DATE] under the care of hospice services for medical diagnoses of cerebral infarct, hypertension, atrial fibrillation (abnormal heart rhythm) right sided hemiplegia, contractures, sepsis, and urinary retention. The BIMS (Brief Interview Mental Status) recorded on admission was 14/15 indicating R32 was cognitively intact. Review of a Nursing progress note dated 12/7/24 documented .Resident observed moaning in discomfort, stated (It burns/hurts when I pee), discharge noted from penile area . Nursing obtained orders to collect a urine sample and remove the catheter. Review of the Physician progress note dated 12/10/24 detailed R32 was seen for a urinary tract infection, had an abnormal urinalysis, was complaining of dysuria. Further review revealed antibiotics were started. A record review of the Hospice communication binder revealed no communication to Hospice of the plan of care, treatment, and interventions for the urinary tract infection. On 12/10/24 at 4:02 PM, a telephone interview was conducted with R32's assigned Registered Nurse from Hospice II (RN II) was not aware of concerns of R32's Foley catheter. RN II further revealed they are new to this facility and typically communication to Hospice was from the Physicians and Nursing, they ave a communication binder or can call them directly. When asked if the concerns with urine pain, foley removed, abnormal lab results, and developing a new infection should have been communicated, RN II acknowledged they should have been notified and they had no knowledge of R32's new clinical concerns and interventions. RN II concurred no collaboration or communication has been initiated between the facility and hospice services for the plan of care for R32. Review of the facility's policy titled; Hospice dated 3/20/2024 documented: .Notifying the hospice about the following: A significant change in the resident's physical status .Clinical complications that suggest a need to alter the plan of care .Communicating with the hospice provider and documenting such communication .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30675 Based on observation, interview, and record review the facility failed to ensure appropriate infection control practices related to transmission-based precautions (TBP) for two (R159 and R6) of three residents reviewed for infection control, resulting in the potential for the spread of infection. Findings include: According to the facility's policy titled, Infection Control - Standard and Transmission-Based Precautions dated 3/4/2024: .Transmission-based precautions are used for residents who are known or suspected to be infected with infectious agents that require additional control measures above standard precautions to effectively prevent transmission which included: Contact Precautions .Each route of transmission will dictate the necessary personal protective equipment (PPE) and precaution may be used. When used singly or in combination, they are always used in addition to standard precautions .Residents on transmission-based precautions should have a sign outside of the resident's room with Stop See Nurse for Instructions, the specific transmission-based precautions, or similar sign .INITIATION OF PRECAUTIONS: A nurse may initiate transmission-based precautions .An isolation cart should be placed outside of the resident's room to store personal protective equipment .Contact precautions include: Hand hygiene (hand washing with soap and water or use of an alcohol-based sanitizer) Personal protective equipment (PPE): Gloves - apply before entering and remove before leaving the resident's room and perform hand hygiene. Gown - Apply gown upon entering and before leaving the resident's room and perform hand hygiene .Resident care equipment - Dedicate non-disposable items when possible .and clean and disinfect any non-dedicated multi-use equipment between residents with EPA-registered disinfectant designed to kill the pathogen the resident has . On 12/11/24 at 10:45 AM, the facility was requested to provide their policy regarding Enhanced Barrier Precautions, however there was no further documentation provided by the end of the survey. R159 On 12/09/24 at 10:05 AM, R159's door was observed to have signage that indicated they were on CONTACT PRECAUTIONS and directed everyone to don/doff PPE including gown, gloves and hand hygiene before entering and upon leaving the room. At that time, Certified Nursing Assistant (CNA 'D') was observed exiting the resident's room while carrying two clear garbage bags which contained soiled briefs and linens. CNA 'D' was not observed to utilize any hand hygiene upon exiting the room and proceeded to go to the soiled linen rooms down the hallway to dispose of the items. On 12/9/24 at 10:08 AM, CNA 'D' was then observed taking a water cup and entering R159's room without hand hygiene, or donning any PPE. Upon exit from the resident's room, no hand hygiene was performed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235626	A. Building B. Wing	12/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Troy	925 W South Blvd Troy, MI 48085

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/9/24 at 10:10 AM, an interview was conducted with CNA 'D'. They reported they began working at the facility for about a month. When asked if they could explain what precautions the resident was on and the reason why, CNA 'D' reported they thought they only needed to wear PPE if they were providing care. When asked if they had inquired about the medical reason for their own knowledge, they reported they had asked a nurse last week but that nurse didn't follow up with them. CNA 'D' was asked if they had ever followed up and they reported they did not. When asked to explain what they had been educated on in regard to the differences regarding TBP and Enhanced Barrier Precautions, CNA 'D' reported they were not aware of any difference. Review of the clinical record revealed R159 was admitted into the facility on [DATE] with diagnoses that included Candadia Auris (According to the Centers for Disease Control (CDC) a type of yeast that can cause severe illness, spreads among patients in healthcare facilities and is often resistant to antifungal medication). Review of the physician orders included: Ordered 12/4/24, Contact Precautions for: candadia auris. Review of the care plans included: Initiated on : 12/4/24 The resident has candida auris. Interventions included: CONTACT ISOLATION: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry. On 12/09/24 at 1:10 PM, an interview was conducted with the Director of Nursing (DON). The DON was asked about who handled the infection control and they reported that would be Infection Preventionist (IP 'E') who had only been doing that for a few weeks. When asked about how direct care staff such were educated on the different transmission-based precautions (TBP) including contact precautions and non-TBP such as enhanced barrier precautions, the DON reported they were educated during orientation and they had also done several in-services since they had identified concerns since they started working at facility in October 2024. The DON was informed of the concerns with earlier observations and interviews with staff and reported that should not have occurred and would have to follow-up. R6 On 12/09/24 at 10:20 AM, R6's room was observed to have signage on the door that indicated they were on Enhanced Barrier precautions and directed staff to don/doff PPE when providing care. The resident was observed laying in bed and an intravenous (IV) pole was next to the bed. R6 reported they were on IV antibiotics for a while now, almost two months for an infection. When asked if staff utilized PPE when providing care, R6 reported most of the staff did, but there were times they didn't. Review of the clinical record revealed R6 was admitted into the facility on [DATE] with diagnoses that included: arthritis due to other bacteria left knee, and MSSA (Methicillin-susceptible Staphylococcus aureus - a type of bacterial infection). (continued on next page)

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