STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235665	A. Building B. Wing	11/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehab of Sterling Heights	38200 Schoenherr Road Sterling Heights, MI 48312

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 This citation pertains to Intake: MI00147942. Based on interview and record review, the facility failed to provide timely incontinence care for one resident (R702) of two residents reviewed for Activities of Daily Living (ADL) care. Findings include: A review of a complaint submitted to the State Agency (SA) documented concerns of the facility's failure to timely change the soiled brief of R702. On 11/13/24 at 1:10 PM, R702 was interviewed in bed and was asked about concerns related to not being changed timely. R702 opened a notepad of written notes that contained dates, and assigned staff for the day, in addition to wait times for care. They explained on 11/10/24, day shift, they had a soiled brief, and was told by their assigned certified nursing assistant (CNA C) they would return to change them however, the resident waited for approximately one hour before they were eventually changed by the CNA. R702 further explained they have experienced issues like this before, and has tried to plan when to have a bowel movement based on the shift, as they have struggled with getting changed due to long call light wait times. A review of R702's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Polyarthritis, Dysphagia and Muscle Weakness. Further review revealed the resident was cognitively intact, and required the extensive assistance of two persons for incontinence care. A review of grievances filed on behalf of R702 revealed the resident's representative had concerns regarding timely incontinence care on 11/10/24. A review of an Employee Counseling and Corrective Action dated 11/10/24 for CNA C revealed they received a Written Warning for the following, Failure to complete assigned task. Carelessness is the performance of the job assignment. Failure to provide care to [R702] prior to leaving shift after telling a family you were going on break . On 11/13/24 at 3:15 PM, the Director of Nursing (DON) was asked about R702's incontinence concerns, they acknowledged the employee counseling form, and had no additional comments about the incident. (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facilities Incontinence Care-Urinary and Fecal revealed the following, Residents that are incontinent of bowel and/ or bladder will provide incontinent care assistance as needed based on resident request and/or check and change, or as per resident preference or need .

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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 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** 40384 This citation pertains to Intake: MI00147856. Based on interview and record review the facility failed to timely implement preventative and effective interventions to prevent the development of a pressure ulcer (wound caused by pressure) for one resident (R701) of two residents reviewed for pressure ulcers. Findings include: A review of a complaint submitted to the State Agency (SA) documented concerns of the facility's failure to prevent the development of a pressure ulcer for R701. A review of R701's medical record revealed the resident was initially admitted into the facility on [DATE] without skin integrity issues, and had diagnoses that included Vascular Dementia, Cerebral Infarction, Dysphagia, and Acute Kidney Disorder. Further review revealed the resident was severely cognitively impaired, and required extensive assistance of two persons for bed mobility, transfers, and toileting. Further review of the medical record revealed R701 was transferred to the hospital on 3/22/24, returning to the facility on [DATE] with a Stage II pressure ulcer (partial thickness tissue loss pressure ulcer with exposed dermis) to their coccyx. R701 was again transferred to the hospital on 4/11/24, returning to the facility on [DATE] with the pressure ulcer to their coccyx healed. A review of R701's progress notes revealed the following: 4/29/2024 12:37 (22:37pm) Skin .skin assessment. Heels pink and intact, Buttocks pink and intact healed stag2 (Stage 2) on sacrum will provide preventative care .feeding tube to LUG (left upper groin) no s/s (signs or symptoms) of infection noted TF (tube feeding) running without difficulty. There are no open areas or areas of concern. Resident has decreased mobility. Discussed need to turn side to side while in bed and sit up in chair to decrease pressure on boney prominences. A review of R701's Braden Scale for Predicting Pressure Ulcer Risk dated 4/26/24 revealed the resident scored Very High Risk for the development of pressure ulcers. Further review of R701's physician's orders revealed the following order dated for 4/29/24: Order Summary: Bilateral buttocks and sacrum: cleanse with soap and water every shift and PRN (as needed) for periods of incontinence pat dry and apply barrier paste for protection/prevention every day and night shift for Skin care AND as needed. A review of the May (2024) Treatment Administration Record (TAR) revealed those treatments were not completed on morning shifts on 5/1/24, 5/11/24, and 5/15/24. Further review of R701's weekly total body evaluations dated for 4/30/24, 5/7/24, and 5/14/24 were reviewed and revealed for Question F, Does the resident have any skin abnormalities? The question was answered, No. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R701's progress notes revealed the following: 5/14/2024 14:09 (2:09pm) Skin Note Text: . in to see resident at Unit managers request, Sacral wound presenting as stg3(Stage III- full thickness loss of skin, in which subcutaneous fat may be visible in the ulcer and granulation tissue and rolled wound edges are often present) possible due to friction/shearing/pressure. area cleaned with wound cleanser and medihoney applied to wound bed and covered with sacral foam dressing, care plan and orders updated. Foam dressing also applied to boney prominences between shoulder blades for protection at this time to be changed every 3 days. 5/16/2024 09:37 (9:37am) Skin .Encounter Date: 05-16-2024 .Chief Complaint: Wound consultation .Sacrum stage III pressure ulcer (previously presented as stage II but now reopened/deteriorated post readmission), 3. 7 x 3.3 x UTD (unable to determine), 90% slough, 10% granular, periwound epithelial/fragile, scant serosanguineous drainage, no infection. Assessments/Plans: Sacrum stage III pressure ulcer Cleanse area, pat dry, apply Medihoney to wound base, and cover with dry dressing daily and as needed. Alternating pressure mattress . 5/21/2024 14:18 (2:18pm) Physician Team - Progress Note .Encounter Date: 05-21-2024 Chief Complaint: Wounds, need for low-air-loss mattress for discharge .Sacral stage III pressure ulcer None necrotic, irregular borders of slough tissue, moderate drainage, clinically noninfected .Recommend low-air-loss mattress for offloading. Hospital bed required on discharge as patient requires positioning of the body in ways not feasible with an ordinary bed, requires the head of bed to be elevated more than 30 degrees most of the time secondary to tube feeds and aspiration precautions. Patient requires frequent changes in body position for pressure relief and ulcer prevention. Patient also requires a lift device in order to transfer him between bed and a chair, wheelchair, or commode. Without the lift the patient would be bed confined completely . 5/23/2024 09:18 (9:18am) Skin Encounter Date: 05-23-2024 .Chief Complaint: Wound reevaluation .Skin: Sacrum stage II pressure ulcer, 7.5 x 7.6x UTD (unable to determine), 90% slough, 10% granular, periwound fragile, scant serosanguineous drainage, no infection. Assessments/Plans: Sacrum stage III pressure ulcer Cleanse area, pat dry, apply nickel thick layer of Medihoney, cover with foam daily and as needed . On 11/13/14 at 12:00 PM, an interview was completed with Wound Care Nurse (WCN A) regarding pressure ulcer interventions put into place for R701, and he explained they were provided with orders related to barrier cream for incontinence issues and were to be turned and repositioned regularly. WCN A explained the resident did not have a low air loss mattress at the time of admission or any other interventions. On 11/13/24 at 3:15 PM, an interview was completed with the Director of Nursing (DON) regarding R701's interventions for pressure ulcer development, and explained that upon admission to the facility the resident was provided with a custom care mattress (a brand of mattresses that can be converted to address complex and/or multiple pressure ulcers), and provided an algorithm document outlining the type of mattress a resident would receive based on their skin integrity. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R701's physician orders and care plan were reviewed, and did not address pressure reducing support surfaces such as a low air loss mattress until after the resident's Stage III pressure ulcer was identified. On 11/13/24 at 4:10 PM, an interview was held via phone with Nurse Practitioner (NP B) regarding R701's pressure ulcer, and explained that R701 did have a lot of comorbidities which place them at risk for pressure ulcer development. Regarding interventions, NP B explained the resident had a custom care mattress, and later an alternating pressure mattress. A review of the Algorithm document provided by the facility revealed the following, This algorithm is meant as a guide, not a substitute for clinical judgement . A review of the facility's Skin and Wound Guidelines did not address the implementation of preventative interventions for the prevention of pressure ulcers.