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	05/16/2024

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

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44750 Based on observation, interview, and record review, the facility failed to label/date and remove a peripheral intravenous line (PIV) for one resident (R95) out of one reviewed for PIV's. Findings include: On 5/14/2024 at 9:00 AM, R95 was observed laying in bed and eating breakfast. R95 was noted to have an PIV inserted in their left wrist, the dressing was not dated or labeled. An IV pump was also noted to be in the room. R95 stated they were not receiving anything through the PIV and did not know why they still had it in. R95 stated they would like it removed because it was uncomfortable. A review of the medical record revealed that R95 admitted into the facility on [DATE] with the following diagnoses, Parkinson's Disease and Dementia. A review of the Minimum Data Set assessment revealed a Brief Interview for Mental Status score of 14/15 indicating an intact cognition. R95 also required assistance with bed mobility and transfers. Further review of the medical record revealed the following progress notes, 5/7/2024 17:24 (5:24 PM) General Progress Note. Note Text: IV to left hand placed by unit manager, line patent, 0.9 Sodium chloride started as prescribed, PT(patient) tolerating well . 5/8/2024 17:03 (5:03 PM) General Progress Note. Note Text: Sodium chloride IV completed, line patent and flushed, dressing clean dry and intact. On 05/14/24 at 11:12 AM, an interview was conducted with Infection Control Preventionist (ICP) A. ICP A was shown the PIV and queried as to why it was still in since R95 finished their fluids on 5/8/2024. ICP A stated R95 was hypotensive and that may be why the PIV was still in. ICP A stated the dressing should have a label and date and they would see why the PIV was still inserted. A review of the facility policy titled, Catheter Insertion and Care noted the following Catheter Removal: 2. Remove the peripheral catheter if: a. It has not been used for 24 hours .therapy is discontinued. Additional review of a facility policy titled, Catheter Insertion and Care noted the following, Procedure .8. Label dressing with date, time, and initials.

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

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40384 Based on observation, interview, and record review, the facility failed to identify and document targeted behaviors, non-pharmacological interventions for behaviors, and monitor side effects of a prescribed psychotropic for one resident (R9) of six residents reviewed for unnecessary medications. Findings include: On 05/14/24 at 8:45 AM, R9 was observed lying on their back in bed asleep. A review of R9's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Cerebral Infarction, Adjustment Disorder with mixed disturbance of emotions and conduct, Diabetes Type II, and Hypertension. Further review revealed the resident was severely cognitively impaired and required one person assistance for bed mobility and transfers. On 5/15/24 at 9:05 AM, R9 was observed in bed asleep. On 5/15/24 at 10:06 AM, R9 was observed in bed asleep. Their breakfast food tray was observed on their overhead table untouched. On 5/15/24 at 12:15 PM, R9 was observed still in bed asleep. Their lunch tray at the bedside. On 5/15/24 at 1:55 PM, R9 was observed still in bed asleep. Their lunch tray remained at the bedside untouched. A review of R9's food acceptance record revealed that the resident did not consume breakfast or lunch on this 5/15/24. On 5/15/24 at 3:32 PM, R9 remained in bed still asleep. On 5/15/24 at 3:38 PM, Certified Nursing Assistant (CNA D) was asked about R9's excessive sleeping, and they explained that R9 sleeps quite often, and has been observed to be up for no more than an hour before they request to go back to bed where they stay asleep. They further explained that the resident has appeared drowsy since they were admitted . A review of R9's medical record revealed that a Medication Regimen Review was completed on 4/28/24 indicating the following, The resident is taking antipsychotic drug therapy quetiapine 25 mg (milligrams) PO (by mouth) at bedtime. There does not appear to be an appropriate diagnosis listed in [medical record] that indicates this type of drug therapy. Appropriate diagnosis to support antipsychotic use include schizophrenia, schizo-affective disorder, psychotic mood disorders .Please consider discontinuation of antipsychotic therapy at this time or adding a supporting diagnosis. The document for the physician to response had three options to respond to which were Agree, Disagree. and Other. The Other box had a check mark by it with the following written next to it stating, Still awaiting eval. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R9's medical record revealed that upon discharge from the hospital on 4/27/24, they were prescribed the following antipsychotic, Quetiapine (Seroquel) 25 mg (milligrams) 1 tablet by mouth every night at bedtime. Further review of R9's April Medication Administration Record revealed that the resident was administered this medication twice, until the physician's order was changed on 4/30/24 increasing the resident's dose to the following: Quetiapine Fumarate Oral Tablet 25 MG (Quetiapine Fumarate). Give 3 tablet by mouth two times a day for dementia with behavioral disturbances. This order was in place until 5/7/24. Further review of R9's physician's orders revealed another increase in the resident's antipsychotic on 5/7/24, Quetiapine Fumarate Oral Tablet 100 MG (Quetiapine Fumarate). Give 1 tablet by mouth two times a day for psychosis and agitation. A review of R9's medical record revealed the following progress notes: Effective Date: 05/01/2024 14:39 (2:39pm) Type: Nutrition PN (progress note) Note .RD (registered dietician) attempted visits patient few times today, pt (patient) was sleeping, RD tried waking her up, dd not wake up . RD observed pt did not touch her lunch today. Effective Date: 05/09/2024 15:58 (3:58pm) Type: Assessment Note : Patient A&Ox1 (alert and oriented). All medications given and taken as prescribed. Vital signs stable .Patient has been sleeping on and off all day and may be related to Seroquel. In MD (medical doctor) book to follow up in this regard . A review of R9's care plan revealed the following, Focus: The resident is on psychotropic medications r/t (related to depression). Date Initiated: 04/28/2024 .Interventions: Provide non-pharmacological interventions for symptom management such as (Specify: provide quiet environment, decrease stimuli, monitor for thirst/hunger & provide fluids/snacks of resident's preference ,redirection, monitor for resident being cold/hot). Date Initiated: 04/28/2024 .Monitor for signs/symptoms of adverse side effects r/t psychotropic medication use and report to physician as indicated .excessive sedation, falls, constipation, shortness of breath, weight gain. Date Initiated: 04/28/2024 . Further review of R9's medical record did not reveal targeted or documented non-pharmacological attempts for behavior management for the resident prior to the increase in the resident's medication. On 5/16/24 at 8:20 AM and 11:54am, R9 was observed in bed asleep. On 5/16/24 at 11:55 AM, an interview was completed with Nurse Practitioner (NP E) regarding R9's prescription for Seroquel and their excessive sleeping. NP E explained that since the resident has been on the medication, their mentation has been better and that she sometimes sleeps extra during the day. She further explained that the resident has been participating and completing therapy well. Regarding non-pharmacological interventions being used prior to medication, NP E explained that interventions should be attempted prior to placing a resident on medications. A review of R9's Physical Therapy and Occupational Therapy notes were reviewed and revealed the following: (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/12/24: Additional Skill Additional Skilled Services: Patient needed Max encouragement to participate in therapy for exercises in bed. Patient Reports Patient Remarks/Goals: Patient states 'she wants to do nothing today.' 5/13/24: Response to Tx (treatment) Response to Treatment: Poor. Pt lethargic, crying out at times and becoming agitated with encouragement for participation. 5/14/24: Response to Tx Response to Treatment: Pt very lethargic scratched fell ow therapist nurse manager aware as she was the third person to assist with transfers. 5/14/24: Worked on getting patient to the toilet however she was not as responsive and cooperative which then she needed 3 people assist. So we needed the nurse manager to assist because patient was dead weight today. 5/15/24: Education and encouragement for participation on 3rd attempt/third refusal Response to Tx Response to Treatment: Pt became irritated with encouragement tx ended. 5/16/24: Response to Tx Response to Treatment: Patient needs max encouragement to participate in therapy. Patient easily gets agitated and screams during therapy. Patient put back to bed due to low BP. Nursing informed. On 5/16/24 at 1:31 PM, an interview was completed with the Director of Nursing (DON) regarding observations of R9 and concerns for oversedation. The DON explained they are in the process of having the resident assessed by the NP and reviewing pharmacy recommendations. The DON further explained that non-pharmacological interventions are utilized prior to placing a resident on a psychotropic medication. On 5/16/24 at 10:18am, a policy for unnecessary medications was made however, it was not received by the end of survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 34851 This citation has two deficient practice statements. Deficient Practice Statement #1 Based on observation, interview, and record review, the facility failed to store medication in a safe and secure manner for two of the nine medication/treatment carts. Findings include: On 5/14/24 at 9:14 AM, during a tour of the facility a treatment cart was observed unlocked that was station near 152 room. On 5/15/24 at 9:20 AM, a medication on the second floor was observed to be unlocked. During this time residents and staff were observed to walk pass the unlocked medication cart. On 5/15/24 at 9:25 AM, a medication was observed to remain unlock. At that time the unit manager, Licensed Practical Nurse (LPN C) was asked about the unlocked medication cart. The Cart was observed to have the overflow of medication for the residents that lived on the unit. LPN C was observed to ask the assigned Nurse about the cart and if they had the keys. LPN C explained to the nurse that she had to ensure the cart was locked. On 5/17/24 at 11:10 AM, the Nursing Home Administrator (NHA) was asked the facility's expectation for securing resident medication. The NHA stated, if the medication cart is not in use hit the button to lock it. A review of the policy titled, Medication and Treatment Storage, dated, 8/7/23 revealed, POLICY OVERVIEW: It is the policy of this facility to ensure accurate labeling and dating of medications and treatments for safe administration and safe and secure storage (including proper temperature controls, appropriate humidity and light controls, limited access, and mechanisms to minimize loss or diversion) of all medication and treatments. GENERAL GUIDELINES: All medications and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls . 40384 Deficient Practice Statement #2 Based on observation, interview, and record review, the facility failed to monitor the temperatures of one of one medication refrigerator that stored drugs and biologicals. Findings include: (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 8:12 AM, the One [NAME] Unit medication refrigerator located in the medication storage unit was viewed with Licensed Practical Nurse (LPN B), and was asked about the process for checking and documenting refrigerator temperatures. LPN B explained that the day shift nurse is responsible for completing the temperature log on the day shift, and the afternoon nurse is responsible for its completion on the afternoon shift. A review of the Medication/Vaccine Refrigerator Temperature Log revealed the following, .Store medications in accordance with manufacturer's specifications, state requirements and standards of practice . A review of the February 2024 temperature log revealed incomplete documentation for the following dates on both shifts: 2/7/24, 2/11/24 , 2/12/24, 2/13/24, 2/14/24, 2/15/24, and 2/24/24. A review of the March 2024 temperature log revealed incomplete documentation for the following dates on both shifts: 3/29/24, 3/30/24, and 3/31/24. A review of the April 2024 temperature log revealed incomplete documentation for the following dates on both shifts: 4/1/24 and 4/2/24. A review of the May 2024 temperature log revealed incomplete documentation on 5/1/24 on both shifts. On 5/17/24 at 11:09 AM, the Nursing Home Administrator was asked about their expectations for the monitoring of refrigerators storing medications, and he explained that they should be monitored daily. On 5/17/24 at 1:28 PM, the Director of Nursing (DON) was informed of the surveyor's observation in the One [NAME] medication room, and explained that the expectation is that the temperature logs be completed. The facility's Medication and Treatment Storage was reviewed and revealed the following, .Logs are kept on each refrigerator and temperature levels are recorded daily by the charge nurse or other designee .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 Based on observation, interview, and record review, the facility failed to ensure food was safely stored and failed to maintain sanitary conditions in the kitchen. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 5/14/24 between 8:35 AM-9:25 AM, during an initial tour of the kitchen with Certified Dietary Manager (CDM) H, the following observations were made: In the walk-in cooler, there were 2 foil covered pans with cooked whole pork roasts dated 5/13. When queried about the pork roasts, CDM H stated they had been cooked sometime last evening and were to be served for dinner on 5/14. The internal temperature of the pork roasts was measured to be between 56-58 degrees Fahrenheit. When queried if staff utilized cooling logs, CDM H stated they do use cooling logs, but was unsure of where the cook had put the log. When asked to see a blank copy of the cooling log utilized by kitchen staff, CDM H looked in the office and on the computer, but stated she couldn't find one. According to the 2017 FDA Food Code section 3-501.14 Cooling, 1. (A) Cooked POTENTIALLY HAZARDOUS FOOD (TIME/TEMPERATURE CONTROL FOR SAFETY FOOD) shall be cooled: 1. (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); P and 2. (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. According to the 2017 FDA Food Code section 3-501.15 Cooling Methods, (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3) Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. In addition in the walk-in cooler, there was a tube of raw ground beef stored on a tray next to a pan of cooked beef patties and a pan of cooked chopped beef. There was a box of raw bacon stored directly above the 2 pans of cooked beef. When queried, CDM H confirmed the raw meat should not be stored next to and above the cooked meat. According to the 2017 FDA Food Code section 3-302.11 Packaged and Unpackaged Food - Separation, Packaging, and Segregation, (A) Food shall be protected from cross contamination by: .(2) Except when combined as ingredients, separating types of raw animal foods from each other such as beef, fish, lamb, pork, and poultry during storage, preparation, holding, and display by: .(b) Arranging each type of food in equipment so that cross contamination of one type with another is prevented,. In the second floor kitchenette, the interior top surface of the microwave was soiled with dried, encrusted food debris. CDM H confirmed the soiled microwave. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In the second floor nourishment room refrigerator, there was 2 food containers with unknown food items dated 5/7, 1 food container with an unknown substance that was undated, and 2 undated salad dressing cups. In the 1 [NAME] nourishment room refrigerator, there was a bag of food items dated 4/7. Inside the bag, there was a container of diced chicken, a container of potato salad with a use by date of 4/17, and a container of coleslaw with a use by date of 4/15. In the 1 East nourishment room refrigerator, there was an undated container of soup. Review of the Outside Food Policy dated 10/2/23 noted: Leftover food will be stored in covered containers or wrapped carefully and securely. All refrigerated food is to be used within 72 hours or discarded. Once daily, Housekeeping is responsible for cleaning of the refrigerator and for review of dated items stored in the refrigerator.