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	06/25/2025

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

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** A review of the record for R152 revealed R152 was admitted into the facility on [DATE]. Diagnoses included Non traumatic Brain Dysfunction, Stroke and High Blood Pressure. The Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition, impaired range of motion of the extremities, and R152 was dependent on staff for all activities of daily living including bed mobility, bathing and personal hygiene. A review of the policy, Care Plan - Comprehensive and Revision, revised 8/25/2023, revealed, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident . Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. The IDT (Interdisciplinary Team) reviews and updates the care plan when there has been a significant change in the resident's condition . Based on observation, interview, and record review, the facility failed to update a care plan for one (R152) of four residents reviewed for plans of care. Findings include: On 6/23/25 at 8:53AM, the room door of R152 was observed with an Enhanced Barrier Precautions (EBP) signage on it. The sign identified what personal protective equipment was to be used when entering the room and remained in place for the duration of the survey which ended on 6/25/25. A review of medical records revealed R152 was admitted into the facility on 5/22/25 and was placed on Contact Isolation Precautions (to prevent the spread of infections through direct and indirect contact) on 5/23/25 for C. Difficile (C-Diff, a contagious infection in the bowel). A review of the active Physician's order dated 6/23/25, (R152) was placed on EBP every shift related to their tube feeding. A review of R152's care plan (revised 5/23/25) revealed the resident was currently on Contact Isolation Precautions. R152's care plan did not reflect the current Physican's order for EBP. On 6/24/25 at 1:33 PM, the Infection Preventionist (IP) was interviewed regarding care plans and explained the care plans should be updated immediately (when the resident was placed on EBP precautions). The IP continued to explained the resident was supposed to be on EBP only and the C-Diff precautions were discontinued. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 1:40 PM, the Director of Nursing (DON) was interviewed regarding the revision of care plans and explained the care plans should be updated immediately to reflect the changes of care and also reflect on the Kardex (the care plan for the nurse aides).

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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 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** A review of the record for R152 revealed R152 was admitted into the facility on [DATE]. Diagnoses included Non traumatic Brain Dysfunction, Stroke and High Blood Pressure. The Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition, impaired range of motion of the extremities, and R152 was dependent on staff for all activities of daily living including bed mobility, bathing and personal hygiene. Resident #57 On 06/23/25 at 9:01 AM, R57 was observed to be supine in bed, with their heels on the bed, and and dressed in a hospital style gown. R57's breakfast tray was observed on the over bed table which was over the waist area of R57. R57 had not eaten or drank any items. The mighty shake (for calorie/nutrition assistance) was not opened. The call light was in the top drawer of the night stand away from R57. On 06/23/25 R57 was not observed to be out of bed during the hours of the survey. On 06/24/25 at 8:16 AM, R57 was observed to be laying on their back (supine) in bed. The head of the bed was flat. The arm for trapeze (device to assist bed mobility) extended over the upper portion of the bed with the handle hooked over the end of the arm. The call light button was observed to be in the top and mostly closed, drawer of the night stand at the right side of the bed. The bed control was at the foot of the bed. R57 wore a hospital style gown. R57 confirmed they would like to be out of bed at times during the day. On 06/24/25 at 12:59 PM, CNA N was asked about R57 and reported they had care for R57 three times in the last month and R57 will answer when asked directly but will not ask for care needs to be met such as to get out of bed, or use the call light. CNA N further noted R57 required a Hoyer lift (two persons) for transfers. On 06/24/25 at 4:19 PM, R57 appeared as before but with the head of the bed up around 30-45 degrees. R57 was not observed to have been out of bed or repositioned. No devices for for repositioning such as an extra pillow or a foam wedge were observed. On 06/25/25 at 9:51 AM, R57 was observed to be in bed, supine, feet/heels on bed, and dressed in a hospital style gown. The call light was in the slightly open top drawer of the night stand. On 06/25/25 at 10:17 AM and 12:05 PM, R57 was on their back in bed, slumped down slightly, with the head of bed around 30-45 degrees. The call light in the top drawer of the night stand. R57 reported on query that they had not been out of bed the day before but does like to be out of bed at times. R57 was not sure if staff had checked on them. The TV was off and their roommate was dressed and out of bed. On 06/25/25 at 12:08 PM, Licensed Practical Nurse (LPN) T was asked to observed R57 and the location of the call light in the top drawer of the night set and reported it should be in reach of R57. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/25 at 12:14 PM, CNA U reported they offer to get residents out of bed and noted they had noted worked with R57 since they moved from the second floor and reported R57 was more aware now and no longer had an indwelling urinary catheter. On 06/25/25 at 1:40 PM, the Director of Nursing (DON) was asked what is the expectations of repositioning, brief change, and call light use. DON replied repositioning, brief change every two hours and as needed, and the call lights are to be within reach. A review of the record for R57 revealed R57 was admitted into the facility 03/19/2025. Diagnoses included Alzheimer's Anxiety and Depression. The Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognition and the need for assistance with all activities of daily living and was dependent or required maximal assistance for all except eating. A review of the facility policy titled Call light accessibility and Timely Response issued 08/16/23, revealed, . Staff will ensure the call light is plugged in, functioning, within reach of resident and secured as needed . Staff members who see or hear and activated call light are responsible for responding regardless of assignment . Turn off call light when resident's request's is met . This citation pertains to Intakes: MI00152680, MI00152773, MI00153364, and MI00153659. Based on observation, interview, and record review, the facility failed to ensure that brief changes and repositioning were provided in a timely manner for three dependent residents (R57, R152, and R271) of eight reviewed for activities of daily living (ADL) care. Findings include: R271 On 6/24/25 at 9:15 AM, R271's call light was observed to be activated and R271 was heard to say, I need a brief change. At 9:21 AM, Certified Nursing Assistant (CNA) C entered R271's room, deactivated their call light and exited the room. At 9:25 AM, R271 reactivated their call light. At 9:33 AM, CNA F who was observed walking down R271's hallway, entered R271's room, deactivated their call light, exited, and proceeded to enter another resident's room. On 6/24/25 at 9:38 AM, CNA C was interviewed regarding the policy regarding responding to activated call lights for residents and was asked if a residents' call light should be deactivated prior to the residents' care need being met. CNA C indicated they were, agency staff and admitted they didn't know the call light policy. On 6/24/25 at 3:30 PM, R271 was interviewed about their care and call light response at the facility. R271 was unable to respond coherently to any questions. A review of R271's electronic medical record (EMR) revealed that they were admitted to the facility on [DATE] with diagnoses that included Fracture of right side of pelvis and Dementia. R271's most recent minimum data set assessment (MDS) dated [DATE] revealed R271 had a severely impaired cognition and was frequently incontinent of bowel. A review of R271's Kardex (guide to care for CNA) revealed R271 required two person assistance for all ADL care other than eating. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of resident council meeting minutes for the months of January 2025-June 2025 revealed the following, Call lights not being answered in a timely manner. Staff not being present or responding in a timely manner. Why is there a lack of care? On 6/25/25 at 10:35 AM, the Assistant Director of Nursing (ADON) A was interviewed and asked about their expectations for resident care and call light response to which they responded staff should respond to call lights in a timely manner and the call light should remain on until the care need has been met. On 6/25/25 at 10:42 AM, the Director of Nursing (DON) was interviewed and asked about their expectations for resident care and call light and indicated call lights should be answered as quickly as possible and the care need should be met prior to the call light being turned off. R152 On 6/23/25 at 8:53 AM, 11:50 AM, and 1:40 PM, R152 was observed in supine position in bed with of the bed elevated around 30-45 degrees. The call light was in the top drawer of the nightstand and two briefs were stacked on the over bed table on the left side of the bed. R152's fingernails were long appeared to have dirt under the nails and extended an eigth to a quarter inch beyond the tip of the fingers. On 06/23/25 at 1:40 PM, R152 was asked if they had been changed or repositioned recently and R152 nodded their head no. On 06/23/25 at 1:43 PM, Certified Nursing Assistant (CNA) M and another CNA N were observed to give R152's a bath and a brief change. R152's brief was observed to be saturated with urine and slightly soiled with stool. On 06/23/25 at 3:19 PM, CNA M interviewed and asked if they knew the facility policy for brief change, repositioning, and call lights. CNA M stated, every two hours and call lights need to be within reach. On 06/23/25 at 3:45 PM, R152 was observed to be supine in bed with the head of the bed elevated 30-45 degrees and dressed in hospital style gown. On 06/24/25 at 8:33 AM, and 11:00 AM and 12:10 PM, R152 was observed supine in bed with the head of the bed around 30-45 degrees. The call light was in the top draw of the nightstand. A single brief was observed on their dresser. At 12:10 PM a vague odor of bowel movement (BM) was noted.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide appropriate and meaningful activities for two (R57 and R152) of three residents reviewed for activites. Findings include: R57 On 06/23/25, 06/24/25, and 06/25/25 during the hours of 9:00 am and 4:00 PM, R57 was observed to be in bed in their room. The TV was not on nor was there any device observed to play music. A review of the record for R57 revealed R57 was admitted into the facility 03/19/2025. Diagnoses included Alzheimer's Anxiety and Depression. The Minimum Data Set (MDS) assessment dated [DATE] documented severely impaired cognition and the need for assistance with all activities of daily living and was dependent or required maximal assistance for all except eating. Section F: Preference for Customary Routine and Activities documented it was very important or somewhat important for R57 to choose what to wear, listen to music, keep up on the news, do things with groups of people, go outside, do favorite activities . A review of the At risk for changes in behavior and mood related to Alzheimer's care plan dated 03/20/2025, revealed, Encourage resident to attend activities of choice . A review of the Activities/Recreation care plan initiated 03/29/2025 revealed, assist resident off the unit for strolls, special events or entertainers . A review of the Activities Task documentation from 6/9/25 to 6/22/25, revealed no Independent, Intellectual, Physical, Social, and Spiritual activities had been provided to R57. R152 On 06/23/25, 06/24/25, and 06/25/25 during the hours of 9:00 am and 4:00 PM, R152 was observed to be in bed in their room the TV was not on nor was there any device observed to play music. A review of the record for R152 revealed R152 was admitted into the facility on [DATE]. Diagnoses included Non traumatic Brain Dysfunction, Stroke and High Blood Pressure. The Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition, impaired range of motion of the extremities, and R152 was dependent on staff for all activities of daily living including bed mobility, bathing and personal hygiene. Section F: Preference for Customary Routine and Activities documented it was very important or somewhat important for R57 to .listen to music, be around animals, keep up on the news, do things with groups of people, do favorite activities . The primary respondent was documented as R152. A review of the Activities Task documentation from 6/9/25 to 6/22/25, revealed no Independent, Intellectual, Physical, Social, and Spiritual activities had been provided to R152. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/25/25 at 11:49 AM, the identified concerns were reviewed with the Activity/Recreation Director. The Activities Director reported they were responsible for completion of the Recreational Therapy assessment and section F in the MDS. The Activities Director was asked about room visits and reported room visits are for resident who are bed bound or do not come out of their rooms. The activity documentation for R57 and R152 was reviewed with the Activities Director who confirmed there was no documentation of any activities provided for R57 nor R152. On 06/25/25 at 1:42 PM, the Director of Nursing (DON) was interviewed and confirmed care activities should be provided and documented. A review of the facility policy titled, Activities dated 04/01/22 revealed, It is the policy of this facility to provide an ongoing program of activities designed to meet the interest, choice and preferences as well as to meet the interest of and support the physical, mental, and psychosocial well being of each resident . A review of the facility policy titled Resident Rights issued 11/12/24 revealed, .Right to Self Determination to: Participate in activities programs of their choice .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide gynecological care in a timely manner for one resident (R25) of one reviewed for a delay in treatment. Findings include: On 6/23/25 at 10:39 AM, R25 explained since June 2024, they had been having post-menopause vaginal bleeding and was unable to be seen by a gynecologist until May 2025, in which they were ultimately diagnosed with uterine and cervical cancer. R25 explained the facility nurse practitioner initially thought they had a urinary tract infection however, after the results came back negative, nothing more was done to further investigate the cause of the bleeding. R25 explained the vaginal bleeding would become heavy and at times become painful. R25 explained they were provided with menstrual pads. R25 also explained there had also been issues related to transportation resulting in missed appointments. A review of R25's medical record revealed they were admitted into the facility on 7/7/2017 with diagnoses which included Paraplegia, Adjustment Disorder, and Hypertension. Further review revealed the resident was cognitively intact and required extensive assistance for transfers and bed mobility. Further review of R25's medical record revealed the resident underwent a pap smear, Hysteroscopy and D&C (dilation and curettage, a procedure that surgically removes tissue from the lining of the uterus to diagnose abnormal uterine bleeding) on 5/2/25. A pathology report dated 5/9/25 revealed the following, Mixed high-grade endometrial carcinoma (cancer). Further review of R25's medical record revealed the following progress notes: Encounter Date: 06-11-2024. Chief Complaint: Vaginal bleeding. Patient seen today resting in bed. (resident) reports intermittent vaginal bleeding . (Resident) does have a history of abnormal intrauterine bleeding in several years ago underwent D&C for this. It has been a long time since (resident) has followed up with GYN (gynecologist). (Resident) denies any cramping. Bleeding is not heavy and is essentially spotting and is intermittent. Blood pressure has been stable, patient is afebrile. Bleeding is not suspected to be related to (residents) urine. (Resident) denies any dysuria .Assessments/Plans: Abnormal uterine bleeding Patient reports intermittent pink spotting, denies any pain complaints or cramping History of previous abnormal uterine bleeding several years ago status post D&C with hormone regulation. Recommend follow-up with GYN (gynecologist). Will check CBC (complete blood count) . Date of Service: 07/02/2024, Visit Type: 1. Acute/Follow-Up Plan: Abnormal uterine and vaginal bleeding, unspecified: Intermittent, spotting. Stable. CBC (complete blood count) is stable. Recommended follow-up with GYN per PCP (primary care physician). [insurance]care [NAME] assisting in finding GYN for resident and setting up apt.(appointment) . 7/26/2024 16:47 (4:47pm) Note Text: Resident is A&Ox3 (alert and oriented to person, place and time) and able to make needs known. Resident had small vaginal bleeding, MD (medical doctor) and Nurse manager aware, waiting for gynecologist follow up. No complain of pain and discomfort . 8/21/2024 00:00 (12:00am) Date of Service: 08/21/2024. Visit Type: 1. Acute/Follow-Up (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan: Abnormal uterine and vaginal bleeding, unspecified: Intermittent, spotting. Stable. CBC is stable. Recommended follow-up with GYN per PCP. [Insurance] care [NAME] assisting in finding GYN for resident and setting up apt. 9/3/2024 16:20 (4:20pm) Physician Team - Progress Note Assessments/Plans: Abnormal uterine bleeding Patient reports intermittent pink spotting, denies any pain complaints or cramping. History of previous abnormal uterine bleeding several years ago status post D&C with hormone regulation. Recommend follow-up with GYN. 9/14/2024 19:06 (7:06 PM). Note Text: Patient is paraplegia, alertx4 and able to makes needs known . Patient c/o (complains of) bleeding of the vagina with menstruation symptoms. Patients mention it happens often. Management aware and NP (nurse practitioner), but patient says they are waiting for follow up of gynecologist . 9/17/2024 00:00 (12:00am) Date of Service: 09/17/2024. Visit Type: 1. Acute/Follow-Up History of Present Illness: .(Resident) has a history of abnormal intrauterine bleeding, underwent D & C several years ago. The bleeding has unchanged since visit from PCP. It is spotting, not heavy, intermittent. Patient requests follow-up with GYN and [insurance] care [NAME] is assisting building to find a local GYN- the problem is that resident prefers in house GYN eval which has been difficult to find. (Resident) is aware of the difficulty in finding a traveling GYN to come to building. [Physician] was also notified of resident request. GYN appt requested by resident, PCP and [insurance] care [NAME] is assisting to find GYN to accommodate resident. 9/19/2024 20:31 (8:31pm) Social Work. Note Text: Resident has been bleeding from Vagina, (resident) has also pain associated with the bleeding, [physician] and Regeistered Nurses (RNs) were both informed. SW (social work) is working on setting up an appointment so resident can be eaminate (examined). 11/5/2024 00:00 Plan: Abnormal uterine and vaginal bleeding, unspecified: Intermittent, spotting. Stable. CBC is stable. Resident requesting follow-up with GYN and PCP aware: difficulty finding GYN to accommodate resident weight and bedbound status-app rescheduled. Date is undetermined. 12/2/2024 13:33 (1:33pm) Physician Team - Progress Note Assessments/Plans: Abnormal uterine bleeding Hemoglobin has been stable. No gross bleeding at this time. Continue to monitor. Did consult GYN. Patient will benefit from evaluation but not having any emergency needs. 12/3/2024 00:00. Plan: Abnormal uterine and vaginal bleeding, unspecified: Intermittent, spotting. Stable. CBC is stable. Resident requesting follow-up with GYN and PCP aware: difficulty finding GYN to accommodate resident weight and bedbound status-app rescheduled. Date is rescheduled for 12/19/2024 at 10:45 at [local hospital]. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/7/2025 00:00 (12:00am) Chief Complaint / Nature of Presenting Problem: Routine folllow-up for multiple chronic conditions. History Of Present Illness: Patient has a history of abnormal intrauterine bleeding, underwent D&C in 2016. The bleeding has unchanged since visit from PCP. It is spotting, not heavy, intermittent, none today. Patient was scheduled for appointment with GYN on 12/19/2024 at 10:45 at [local hospital]. Discussed care with unit clerk, [unit clerk H]. The appointment was canceled, rescheduled for 01/16/2025 at 2:00 at [local hospital]. There are no changes since last visit. Discussed care with nursing staff, there are no concerns at this time. Effective Date: 02/10/2025 15:01 (3:01pm). Chief Complaint: Vaginal bleeding .Patient was seen and examined today in room, (resident) is sitting comfortably up in bed in no acute distress. Was called to evaluate patient today because of nursing concern of recurrent vaginal bleeding. Patient reports history of D&C in 2017 because of recurrent bleeding. (Resident) was prescribed hormones which (they) took for 3 months. Bleeding did resolve but recurred recently in the last 3 to 5 months. According to patient, they have a scheduled follow-up appointment with gynecology on Friday, 2/14/2025 for a vaginal ultrasound . Date of Service: 2025-02-19 .Details: Chief Complaint: monthly follow-up, chronic deconditioning, intermittent vaginal bleeding. Review Of Systems: Patient was seen and examined today in room; (Resident) is sitting comfortably up in bed in no acute distress. Patient had a couple appointments and both fell through. Patient has not had ultrasound or lab work done recently. Patient requires stretcher transport for outpatient labs tests, visit. Has had a lot of complications with arranging all the steps necessary for this. Patient is frustrated specially (especially) since (resident) is still having significant decline. Has been stable and vital signs obtaining lab draw in our facility. Assessments/Plans: Abnormal uterine bleeding-Check CBC. Patient has a scheduled follow-up appointment with GYN at the end of this week but unable to be attended (attend) due to requiring stretcher transportation. Patient continues to have periodic bleeding and spotting. Has not had GYN follow-up yet scheduling constraints . On 6/25/25 at 8:55 AM, R25 was asked additional information about the missed appointments, and denies they ever asked for a traveling gynecologist, and the vaginal bleeding started off as light spotting that progressed to heavy bleeding.The resident further reported when they had their first appointment on 3/4/25 with the gynecologist and was unable to get on the exam table and bend their leg, so they attempted an ultrasound which was unsuccessful. As a result, they had an exam on 5/2/25 in which they were placed under anesthesia and a D&C was performed. R25 also explained they spoke to NP J about going to emergency room for an exam, and was advised they did not have emergent needs. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 10:54 AM, an interview was completed with Unit Clerk H regarding R25's appointments, and they explained the resident had to be transported to outside appointments via stretcher, so they must contact two local Emergency Medical Services for transportation. Unit Clerk H explained after an appointment is made, they provide a window of time to the transportation company however, due to priority calls being made for emergencies, the resident would miss their appointments. Unit Clerk H was asked how many appointments had been missed, and said, two. Unit Clerk H was asked when they started working on gynecology appointments for R25 and explained they were not aware of the need for the resident to be scheduled for gynecology appointments until March 2025. Unit Clerk H was asked if there was a care [NAME] that worked in the building and they explained that a care [NAME] would assist with appointments and insurance. The process includes sending a form to the care [NAME] regarding a resident when an appointment is being made, they then in turn approve and return the form within 2 days. On 6/25/25 at 11:58 AM, an interview was completed with CNA I, who cares for R25 regularly, and was asked about the vaginal bleeding. The CNA explained they have been working with the resident for about 8 months, and during time has observed vaginal bleeding which ranged from spotting to blood clots. CNA I explained they informed the nurses and the bleeding persisted. On 6/25/25 at 12:19 PM, an interview was completed with Social Worker K who was asked about R25's gynecology appointments, and they explained the social work department informed the resident's physician of the resident's concerns however, their department only sets up ancillary services (dental, vision, and podiatry, and all other medical appointments are set up by nursing and the unit clerk. On 6/25/25 at 12:48 PM, Nurse Practitioner J (NP J) was interviewed about the treatment provided to R25 regarding vaginal bleeding. NP J explained they no longer work with the resident, and hasn't done so since the end of January (2025), but did explain the resident had some bleeding which they ruled out as a urinary tract infection (UTI). NP J explained the facility had some difficulty locating a gynecologist that could accommodate the resident and acknowledged delays as a result however, in the meantime the resident's hemoglobin was monitored. NP J was asked what would have made circumstances emergent for the resident's vaginal bleeding and explained that if the resident was steadily bleeding with a heavy flow and lasting more than a day. On 6/25/25 at 2:13 PM, a phone interview was completed with the resident's current NP, NP L regarding the delay in R25 being seen for gynecological care. NP L referred the surveyor to a progress note dated 2/12/25 and explained it was not easy to locate a gynecologist for a bedbound resident who needs appropriate transportation. On 6/25/25 at 3:44 PM, the Director of Nursing (DON) was asked about the delay in R25's gynecological care and explained they were not familiar with the concern and was unable to speak to the topic at that time. A review of the facility's Change in Condition policy revealed the following, It is the policy of this facility that residents will be routinely monitored and evaluated by all staff members to determine the need for additional health services monitoring of chronic, unstable, or changes in condition. Results of additional monitoring will be routinely evaluated for appropriateness and effectiveness.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review the facility failed to prevent a fall for one resident (R143) of four residents reviewed for falls resulting in pain. Findings include: On 6/23/25 at 9:28 AM, R143 was observed in bed, unable to move their right arm. R143 was asked about their care in the facility and explained they've had concerns regarding transfers and bed mobility as they recently sustained a fall. A review of R143's medical record revealed they were admitted into the facility on 4/18/25 with diagnoses which included, nontraumatic intracerebral hemorrhage in brain stem, Diabetes, and Heart Failure. Further review revealed the resident was cognitively intact and required 1-2 person assist with transfers, bed mobility, and grooming. Further review of the medical record revealed the following progress notes: 6/11/2025 21:21 (9:21pm) . Note Text: Resident is A&Ox3-4. (alert and oriented to person, place, and time) Assist x1-2 (persons) with adl's (activities of daily living), bed mobility, and transfers. Incont (incontinent) of bowel and bladder with incontinence care given as needed during shift. Hard of hearing. In bed with call light and personals within reach. 6/12/2025 05:47 (5:47am) Note Text: While charting at nursing station loud noise was heard where staff entered room to observe pt (patient) on the floor .Pt transferred back to bed via (name of mechainical lift) with assist x3-4. C/o (complain of) pain to RUE/RLE (right upper extremity/right lower extremity) In bed at this time with call light and personals within reach. 6/12/2025 07:30 (7:30am) Note Text: Spoke to [physician] X-rays ordered to RUE and RLE. Logged to be seen today. 6/13/2025 13:47 (1:47pm) .Details: Chief Complaint: Fall incident 6/12/2025 .Review of Systems: patient was seen and examined today in [their] room, [they are] laying comfortably in bed in no acute distress. Was called to evaluate patient today because of nurse report of a fall incident yesterday. Per patient, chart review and staff, patient fell off the bed in the early morning of 6/12/2025 when [they were] receiving care; patient reports continued pain to right shoulder A review of Incident and Accident report dated for 6/12/25 revealed, heard loud noise from pts room with aide noted in room. Pt notes on floor lying on right side near window against wall. Resident states [they] fell out of bed and complains of pain to RUE and RLE. Pt. states [they] may of hit [their] head. [R143] states that the impact was to [their] R (right) side which broke the fall .Description: Staff reports that during care pt was getting clean and pt rolled out of bed to the floor .Level of pain: 8 . On 6/25/25 at 1:33 PM, the Assistance Director of Nursing (ADON) was asked about the incident and said she thought the CNA had rolled the resident the wrong way during care. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/25/25 at 1:50 PM, R143 was interviewed further regarding their fall, and explained at approximately 5am, a CNA came into their room to change them, and at that time expressed concern because they were working by themselves and appeared small in stature. R143 explained while providing incontinence care, the CNA was standing behind them, and in the process of rolling them over, pushed them away and onto the floor saying they remained on the floor for approximately 30-45 minutes naked while staff went to locate a mechanical lift to lift them off the floor. R143 explained many x-rays were completed due to pain, and explained they had bruising to their right kneecap, and right elbow. On 6/25/25 at 3:09 PM, an attempt to contact CNA E was to no avail. On 6/25/25 at 3:44 PM, the Director of Nursing (DON) was asked about R143's fall and acknowledged CNA E rolled the resident the wrong way, away from her and not toward her causing the fall. On 6/25/25 at 4:01 PM, a request for the facility's fall policy was made, and a policy titled Accident and Incident Report was provided, however, it did not address fall interventions and/or prevention.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to label, date, and provide tube feeding (nutrition infused directly into the stomach via a tube) as ordered for one resident (R152) of three residents reviewed for tube feeding. Findings include: A review of the record for R152 revealed R152 was admitted into the facility on [DATE]. Diagnoses which included Non traumatic Brain Dysfunction, Stroke and High Blood Pressure. The Minimum Data Set (MDS) assessment dated [DATE], indicated severely inmpaired cognition, impaired range of motion of the extremities, and R152 was dependent on staff for all activities of daily living including eating, bed mobility, bathing and personal hygiene. On 06/23/25 at 8:53 AM, 3:45 PM and on 06/24/25 at 8:33 AM, R152's was observed to be in bed with the tube feeding actively running at 40 milliliters(ml) per hour (ml/hr), with the formula bag dated 6/22 5:30 PM. A review of the active Physician's order R152's tube feeding rate revealed the feeding should have been set at 45 ml per hour. No indication for the rate to be at 40 ml/hr was noted in the progress notes or discontinued tube feeding orders. On 06/24/25 at 11:36 AM, Registered Nurse (RN) D was interviewed regarding the tube feeding orders, the labeling and dating of the tube feeding bags. RN D stated the policy is to change the bag every 24 hours. On 06/25/25 at 1:40 PM , the Director of Nursing (DON) was interviewed regarding tube feeding policy for orders, label and dating. The DON explained the policy was to change the bag every 24 hours, date it the day they hang it and follow the physician orders. A review of the facility policy titled, Tube Feeding-Overview dated issued 08/09/23 revealed, .A resident will be fed via feeding tubes when their clinical condition demonstrates that enteral feeding is clinically indicated . Feeding tubes (nasogastric, gastrostomy, jejunostomy) will be utilized in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible . Feeding tubes will be utilized according to physician orders, which typically include: the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush .

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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 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. Based on observation, interview, and record review, the facility failed to ensure resident medications were not left at the bedside for one resident (R74) of one resident reviewed for medication storage. Findings include: On 6/23/25 at 3:32 PM, R74 was observed lying in their bed. A medication cup with 2 pills were observed sitting on the resident's overbed table. The resident was asked about the medications and explained they didn't realize they were there, and didn't know how long they had been sitting there. On 6/23/25 at 3:34 PM, during an interview with Licensed Practical Nurse (LPN) G, assigned nurse to R74, who explained they had gone into the room to provide services to R74's roommate and in doing so provided the medications to the R74. LPN G confirmed they didn't know why the resident hadn't taken them. LPN G then entered R74's room and watched the resident take the medication. LPN G indicated the medications in the medication cup were, Robaxin (muscle relaxer) and (R74's) blood pressure medication because their blood pressure runs high.' A review of R74's medical record revealed they were admitted into the facility on 5/17/25 with diagnoses that included Cerebral Infarction, Hypertension, and Muscle Weakness. Further review revealed the resident was cognitively intact and required minimal assistance for activities of daily living. Further review of the medical record did not reveal an assessment for the self-administration of medications. On 6/25/25 at 3:44 PM, the Director of Nursing (DON) was asked for the expectations regarding medications left at the bedside, and explained medications should not be left at the bedside, and the nurse should have watched the resident take them. A review of the facility's Storing Drugs and Biologicals-Storage and Maintenance of Medication did not address medications being left at the bedside.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On 6/24/25 at 2:12 PM, five of the 14 residents that attended the group reported the food did not taste good. They went on to say the food is sometimes cold when it reaches them. A review of the facility's policy titled Food Palatability dated 4/4/25 noted, Food is prepared by methods that conserve nutritive values, flavor, and appearance. Food and drink should be palatable, attractive, and at a safe and appetizing temperature for the general population This citation pertains to Intake: MI00153364 Based on observation, interview, and record review, the facility failed to ensure that food was served in a palatable manner and at the preferred temperature for four residents (R31, R33, R51, R95) and five confidential group residents of twenty reviewed for food palatability. Findings include: R31 On 6/23/25 at 10:26 AM, R31 was interviewed regarding the care and services they were receiving at the facility. R31 indicated the food didn't taste good and was frequently cold when served to them. A review of R31's electronic medical record revealed that R31 was admitted to the facility on [DATE] with diagnoses that included Cellulitis (bacterial skin infection) and Heart disease. A review of R31's most recent minimum data set assessment (MDS) dated [DATE] revealed that R31 had an intact cognition. R51 On 6/23/25 at 10:56 AM, R51 was interviewed regarding the care and services they were receiving at the facility. R51 indicated the food was frequently cold when served to them. A review of R51's electronic medical record revealed that R51 was admitted to the facility on [DATE] with diagnoses that included Fracture of right lower leg and Muscle weakness. A review of R51's most recent minimum data set assessment (MDS) dated [DATE] revealed that R51 had an intact cognition. R95 On 6/23/25 at 1:20 PM, R95 was interviewed regarding the care and services they were receiving at the facility. R95 indicated the food was frequently cold and didn't taste good. A review of R95's electronic medicate record revealed that R95 was admitted to the facility on [DATE] with diagnoses that included Spondylolisthesis lumbar region (spinal condition) and Heart failure. A review of R95's most recent minimum data set assessment (MDS) dated [DATE] revealed that R95 had an intact cognition. R33 (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/23/25 at 1:23 PM, R33 was interviewed regarding the care and services that they were receiving at the facility. R95 indicated the food was frequently cold and didn't taste good. A review of R33's electronic medical record revealed R33 was admitted to the facility on [DATE] with diagnoses that included Heart failure and Depressive disorder. A review of R33's most recent minimum data set assessment (MDS) dated [DATE] revealed that R33 had an intact cognition. On 6/25/25 at 8:52 AM, a breakfast tray was pulled from a food cart on the one hundred unit of the facility and temperature tested by Dietary manager (DM) B. The food was observed to be contained in white foam containers. DM B was asked about the containers and indicated the facility dishwasher was currently broken. The results of the food temperature test was; Pancakes: 105 degrees Fahrenheit; Turkey sausage: 103 degrees Fahrenheit. DM B was asked what the preferred temperature was for the pancakes and sausage and indicated they liked to see the temperature at 130 degrees Fahrenheit or greater. DM A acknowledged the white foam containers did not maintain the temperature of the food very well. On 6/25/25 at 8:58 AM, the food was taste tested by members of the survey team and revealed the pancakes and sausage tasted cold, which negatively impacted the palatability of the food. A review of resident council meeting minutes for the months of January 2025-June 2025 revealed the following, Food is horrible. Meals are cold. Overall food needs improving. On 6/25/25 at 2:00 PM, the Administrator (NHA) was interviewed regarding their expectations for food palatability and temperature at the facility. The NHA indicated the food should meet all standards of temperature. Hot food should be hot and cold food should be cold.

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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. Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: On 6/23/25 between 8:30 AM-9:15 AM, during an initial observation of the kitchen with Dietary Manager (DM) B, the following observations were made: There was a buildup of a black, mold-like substance on the backsplash located on the soiled side of the dish machine, and the faucet assembly for the hose sprayer was continuously leaking water. According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions, (A) Physical facilities shall be cleaned as often as necessary to keep them clean. According to the 2022 FDA Food Code section 5-205.15 System Maintained in Good Repair, A plumbing system shall be: (A) Repaired according to law; P and (B) Maintained in good repair. In the walk-in cooler, there was an opened, undated 1 gallon container of ranch dressing and Greek dressing, and a container of cut carrots and celery dated 6/16-6/18, which appeared to be dried out. DM B confirmed the dressings should have been dated when opened, and stated the carrots and celery needed to be discarded. According to the 2022 FDA Food Code section 3-501.17: Ready-to-eat, potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded when held at a temperature of 41 degrees Fahrenheit or less for a maximum of 7 days. Refrigerated, ready-to- eat, potentially hazardous food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and: (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on food safety. Dietary Staff was observed washing soiled dishware at the dish machine. The dish machine was tested by this surveyor with a paper thermometer test strip, and the strip did not change color to denote the surface temperature of the dishware was reaching 160 degrees Fahrenheit, to ensure adequate sanitization. A plate simulating dishwasher tester was sent through the dish machine, and noted a maximum temperature of 150 degrees Fahrenheit. DM B stated there have been issues with the dish machine, and that they have purchased a new dish machine, but are waiting for it to be installed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 FDA Food Code section 4-501.110 Mechanical Warewashing Equipment, Wash Solution Temperature. (A) The temperature of the wash solution in spray type warewashers that use hot water to SANITIZE may not be less than: (1) For a stationary rack, single temperature machine, 74°C (165°F); Pf (2) For a stationary rack, dual temperature machine, 66°C (150°F); Pf (3) For a single tank, conveyor, dual temperature machine, 71°C (160°F); Pf or (4) For a multitank, conveyor, multitemperature machine, 66°C (150°F). Pf (B) The temperature of the wash solution in spray-type warewashers that use chemicals to SANITIZE may not be less than 49°C (120°F) On 6/23/25 at 9:15 AM, the filter for the ice machine in the main kitchen was observed with a handwritten date of 1/23/24. DM B stated that Maintenance was responsible for changing the filters, and stated she was unaware if the date written on the filter was the date it was changed, or the date it expired. On 6/23/25 at 9:20 AM, the filter for the ice machine on the 1 [NAME] unit was observed with a handwritten date of 9/20/23. On 6/23/25 at 9:25 AM, the filter for the ice machine on the 1 East unit was observed with a handwritten date of 1/23/24. On 6/23/25 at 2:30 PM, Maintenance Supervisor S was queried about the ice machine filters, and confirmed that they should be replaced annually. Maintenance Supervisor S further stated, They're expired. On 6/23/25 at approximately 12:10 PM, Dietary Staff R was observed entering the kitchen to begin working. Dietary Staff R did not perform handwashing after entering the kitchen. Dietary Staff R went immediately to the lunch trayline, and began handling the resident lunch tray items. When queried at that time, DM B stated Dietary Staff R should have performed handwashing after entering the kitchen. According to the 2022 FDA Food Code section 2-301.14 When to Wash, Food employees shall clean their hands and exposed portions of their arms as specified under § 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles P.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to maintain the exterior trash refuse area in a clean manner. This deficient practice had the potential to affect all residents, staff, and visitors. Findings include: On 6/23/25 at 9:10 AM, the exterior dumpster area was observed. The ground surrounding both dumpsters was observed to be soiled with grease and sludge, and there was a milky liquid pooled on the ground. In addition, there was a foul, sour odor in the dumpster vicinity. Dietary Manager B stated Maintenance was responsible for cleaning the dumpster area. On 6/23/25 at 1:30 PM, Maintenance Supervisor S was queried about the dumpster area, and stated that they try to clean it monthly. Maintenance Supervisor S stated, It's probably due for cleaning again. According to the 2022 FDA Food Code section 5-501.115 Maintaining Refuse Areas and Enclosures, A storage area and enclosure for refuse, recyclables, or returnables shall be maintained free of unnecessary items, as specified under § 6-501.114, and clean.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation has two deficient practice statements. Deficient Practice #1 Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility. Findings include: Review of the facility's Water Management Program Plan (WMPP) updated 4/29/23 noted: Each facility must establish a Water Management Team. The Team is responsible for implementing policies and procedures presented in this WMPP including: .Implement water management policies and procedures .monitor and document performance improvement .review elements of the water management program at least annually . The team consists of the following: Facility Administrator, Maintenance Director, Infection Preventionist . In addition, the plan notes that Point of Use Residual Disinfectant will be monitored monthly, and Fixture Flushing Log will be done twice per week. On 6/23/25 at 3:10 PM, the facility Infection Preventionist was queried regarding their involvement on the facility's water management team, and stated that Maintenance does it all. On 6/23/25 at 3:15 PM, the Administrator was queried regarding his involvement in the facility's water management program and stated that the Maintenance Supervisor is responsible for their water management program. When queried about the components of the plan that were not being completed, and that the plan had not been updated since 4/29/23, the Administrator apologized but provided no further explanation. On 6/23/25 at 3:20 PM, Maintenance Supervisor S was queried about the facility's water management plan. When queried about why the plan had not been updated since 4/29/23, Maintenance Supervisor S provided no explanation. When queried about any Point of Use Residual Disinfectant logs or fixture flushing logs, Maintenance Supervisor S stated, Am I supposed to be doing that? This citation pertains to MI00153659. Deficient practice statement number two: Based on observation, interview and record review the facility failed to ensure, the appropriate Personal Protective equipment (PPE) was worn for isolation precautions during patient care activities for one resident (R152) of four reviewed for isolation and failed to complete departmental infection control surveillance. Findings include: (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/23/25 at 1:43 PM, R152 was observed to have a sign on their door which indicated, Enhanced Barrier Precautions (EBP) and that a gown and gloves were required for high contact resident care activities. Certified Nursing Assistant (CNA) M and CNA N were observed to give R152 a bath and a brief change. R152's brief was observed to be saturated with urine and slightly soiled with stool. The CNAs were observed to only wear gloves and not the gown as indicated by the EBP sign on the door. On 06/24/25 at 11:36 AM, Registered Nurse (RN) D was observed to change the tube feeding formula bag, flush the PEG (Percutaneous Endoscopic Gastrostomy tube-through which feeding, water and medications are administered) with 30 mililiters (ML) of water, and connect to R152's PEG tube while wearing only gloves and not the gown as indicated by the EBP sign on the door. A review of the record for R152 revealed R152 was admitted into the facility on [DATE]. Diagnoses included Non traumatic Brain Dysfunction, Stroke and High Blood Pressure. The Minimum Data Set (MDS) assessment dated [DATE], indicated severely impaired cognition, impaired range of motion of the extremities, and R152 was dependent on staff for all activities of daily living including eating, bed mobility, bathing and personal hygiene. A review of physician order dated 06/23/25 revealed Enhanced Barrier Precautions: PEG Tube every shift. On 06/24/25 at 11:37 AM, during a medication pass observation for insulin administration, Licensed Practical Nurse (LPN) W, was observed to don and doff gloves without hand hygiene. On 06/24/25 at 1:30 PM, the infection control program was reviewed with the Infection Control Preventionist. The ICP reported Enhanced Barrier precautions (EBP) are used for any resident with tube feeding via a PEG (tube inserted into stomach), an indwelling urinary catheter, Peripherally Inserted Central Catheters and any stage three and stage four wounds. Resident R152 was noted by the ICP to have entered the facility on contact precautions for a stool borne pathogen and was switched to EBP. It was noted the order indicated both types of isolation and subsequently the ICP discontinued the order for contact isolation. The EBP remained for the residents PEG tube feeding. The ICP confirmed on query that the two staff who gave R152 a bath and the nurse who connected the tube feeding should be wearing a gown and gloves. A review of the monthly documentation for the infection control program revealed no documentation of departmental surveillance for appropriate infection control practices. On 06/24/25 at 4:05 PM, the Infection Control Preventionist was asked if they had any documentation of monthly departmental infection control surveillance and reported they did not have any documentation and was provided prior to survey exit. On 06/25/24 at 1:42 PM, the identified concerns were reviewed with the Director of Nursing (DON) who reported precautions should be followed as per the signage on the door for all care activities listed on the signage. The DON further noted the current isolation precautions for the resident should be reflected in the care plan and physician orders. A review of the facility policy titled, Infection Surveillance revised 09/25/24 revealed, .The Infection Control Preventionist or designee will analyze the monthly data to identify trends and present to the QAPI (Quality Assurance) committee for review and potential recommendations to minimize risk and control to spread of infection and multidrug resistant organisms, and improve outcomes through education, skills validation or other initiatives as warranted.

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	06/25/2025

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

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure the completion of 12-hours of annual in-service trainings of two Certified Nursing Assistants (CNA O and CNA P), of five reviewed for the completion of 12-hours of annual in-service training. Findings include: On 6/25/25 at 8:43 AM, 12-hours of annual in-service training was requested from the facility for CNA O and CNA P. On 6/25/25 at 11:44 AM, the facility provided documentation the 12-hours of annual training was requested from the vendor the facility uses for CNAs that work on an as needed basis and are not hired directly through the facility. A review of a document titled, CNA skills competency checklist was provided for CNA P however, it did not reveal the number of training hours, nor did it reveal that dementia management training and resident abuse prevention was provided. Training documentation for CNA O was not received by the end of the survey. On 6/25/25 at 4:18 PM, In-service Director Q was interviewed regarding training for agency CNAs, and explained the facility has a contract with a vendor that is to provide trainings through an app. In addition, huddles and education is on-going while they are working in the facility. A review of the facility's Staffing policy did not address the required 12-hours of in-service training for CNAs.