

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>734140</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>2/27/2025</b>
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NAME OF PROVIDER OR SUPPLIER  <b>OPTALIS HEALTH AND REHABILITATION ST FRANCIS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>915 N RIVER RD SAGINAW, MI 48609</b>
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F0000 SS=	INITIAL COMMENTS  Optalis Health and Rehabilitation St. Francis was surveyed for an Abbreviated Survey exiting on 02/27/2025.  Event ID: KOBM11  Intake Numbers: MI00149640, MI00149858, MI00150622  Census: 85	F0000		
F0692 SS= D	Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g) (2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by:  This Citation pertains to Intake Number MI00149640.	F0692	F692 Nutrition/Hydration Status Maintenance Element 1 Resident #701 currently do not reside within the facility.  Element 2 Like residents were identified as residents that reside within the facility. Like residents was audited to ensure they have accurate weight. A facility weight schedule was audited to ensure residents have been weighed and documented accurately. Element 3 The procedure to implement the plan of correction included: 1. IDT reviewed F692. 2. The weight schedule was reviewed and deemed appropriate. 3. The policy Weight was reviewed and deemed appropriate. 4. CNAs and Nurses were re-educated on the documentation of weight with emphasis on ensuring weights are documented accurately. 5. Dietician was re-educated on addressing fluctuations on residents' weights.  Element 4	3/14/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

03/14/2025

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

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	<p>Based on interview and record review the facility failed to address the disparities in one resident's (Resident #701) significant weight fluctuations over a short time period of one resident reviewed for weight loss. .</p> <p>Findings include:</p> <p>Resident #701:</p> <p>On 2/27/2025 at approximately 9:00 AM, a review was conducted of Resident #701's clinical record and it revealed that he initially admitted to the facility on 9/7/2024 with diagnoses that included, Lymphedema, Cellulitis, Congestive Heart Failure, Anxiety and Ulcer of left lower leg. Resident #701 was his own responsible party and able to make his needs known to staff. Further review of Resident #701's records yielded the following:</p> <p>Care Plan:</p> <p>The resident is at potential for nutrition risk r/t (related to) venous insufficiency, chronic le (lower extremity) wounds, lymphedema morbid obesity. anticipated significant weight changes r/t edema/diuretic ...weight per facility protocol as resident allows ..."</p> <p>Weights:</p> <p>Resident #701 was being monitored closely due to his disease process and being weighed almost daily. Many times, his weights from day to day differed by 20-80 pounds without meaningful intervention or investigation of possible inaccuracies from the facility. The weight history was as follows:</p> <p>09/08/2024: 374.4 Lbs (pounds)</p>		<p>The process to ensure that the specific citation remains corrected includes:</p> <ol style="list-style-type: none"> <li>1. The Director of Nursing / Designee will audit 10 residents weekly scheduled for weights to ensure they have been provided and documented accurately. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations.</li> <li>2. The Administrator will be responsible for sustained compliance.</li> </ol>		

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	09/20/2024: 374.0 Lbs			
	10/02/2024: 355.4 Lbs			
	10/04/2024: 356.0 Lbs			
	10/05/2024: 371.0 Lbs			
	10/08/2024: 370.0 Lbs			
	10/10/2024: 360.0 Lbs			
	10/11/2024: 341.0 Lbs			
	10/12/2024: 353.0 Lbs			
	10/18/2024: 346.0 Lbs			
	10/19/2024: 374.9 Lbs			
	10/23/2024: 374.1 Lbs			
	10/25/2024: 316.2 Lbs			
	10/28/2024: 305.8 Lbs			
	11/08/2024: 295.0 Lbs			
	11/18/2024: 292.6 Lbs			
	11/28/2024: 288.4 Lbs			
	12/03/2024: 276.8 Lbs			
	12/04/2024: 280.0 Lbs			
	12/11/2024: 274.7 Lbs			
	12/14/2024: 282.0 Lbs			

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	<p>12/24/2024: 282.4 Lbs</p> <p>12/30/2024: 283.0 Lbs</p> <p>01/02/2025: 201.2 Lbs</p> <p>On 2/27/2025 at 9: 45 AM, an interview was conducted with ADON (Assistant Director of Nursing) regarding Resident #701's weight that was entered into his record on 1/2/2024. The ADON explained they recalled the CNA (Certified Nursing Assistant) providing the weight and upon looking at it she thought it was inaccurate. They went back together and reweighed the resident to verify the weight, and it was correct. The ADON stated a progress note was inputted and follow up to be completed once the reweighs were completed over the course of the next few days as he was on daily weight.</p> <p>On 2/27/2025 at 10:40 AM, CNA "E" was asked about his involvement with weighing Resident #701 in early January 2025. He stated after weighing the resident he provided the value to the ADON, and she believed it was not accurate. They went back and reweighed the resident and received the same number. CNA "E" weighed the resident using the mechanical lift as the resident was unsure if he had the strength to transfer or not.</p> <p>On 2/27/2025 at 11:30 AM, Registered Dietitian "O" was queried regarding Resident #701's fluctuations in his weights throughout his stay at the facility. Dietitian "O" stated the resident had lymphedema in his bilateral lower extremities, heart failure and was on a diuretic. While they noticed the weight fluctuations (as he was on daily weights) they looked at the "big picture," to include food acceptance, wounds healing, laboratory work up, and medications and he was doing stable. Dietitian "O" was asked if there are</p>			

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	<p>consistent large weight disparities, why was it not addressed, and she stated the discrepancies were not expressed as a concern with his visits and she had multiple progress notes regarding his weight loss. When asked if the weight loss was intended, she reported this was not a discussion held with the resident as she was more concerned about his acute illness. Multiples weights were pointed out in Resident #701's clinical record and Dietitian "O" did not have a substantial answer as to what the facility did to investigate the accuracy of the weights provided. It can be noted Dietitian "O"s progress notes and interview were contradictory, as she stated the she did not speak to Resident #701 regarding "intended weight loss" but her progress notes state otherwise. It is unknown what is accurate, as Dietitian "O" verified she had access to her full documentation during the interview.</p> <p>Review was conducted of Registered Dietitian "O" progress notes for Resident #701. The notes detailed the substantial weight fluctuations, but stated it was due to his disease process. There were no other meaningful interventions put forth to determine why there were such extreme variations. The larger variations were as follows:</p> <p>12/30/2024: 283.0 Lbs; 1/2/2025: 201.1 Lbs - Difference of 82 pounds in three days</p> <p>10/27/2024: 316.0 Lbs; 10/28/2024: 305.6 Lbs - Difference of 10.4 pounds in one day</p> <p>10/23/2024: 374.1; 10/25/2025: 316.0 Lbs - Difference of 58.1 pounds in two days</p> <p>10/11/2024: 341.0 Lbs; 10/12/2024: 353.0 Lbs</p>			

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	<p>-Difference of 12 pounds in one day</p> <p>10/4/2024: 356.0 Lbs; 10/5/2024: 371.8 Lbs</p> <p>-Difference of 15.8 pounds in one day</p> <p>9/8/2024: 374.0 Lbs; 9/20/2024: 347.4 Lbs</p> <p>- Difference of 26.6 pounds in twelve days</p> <p>Dietitian Progress Notes:</p> <p>10/4/2024 at 19:46:" ... weight fluctuations r/t lymphedema, chf, diuretic therapy. currently 355#..."</p> <p>10/26/2024 at 08:11: " ...currently 316# bmi 42.9, on daily weight monitoring as resident allows</p> <p>weight loss desired/planned estimated needs with chronic le venous non pressure ulcers ...".</p> <p>11/22/2024 at 10:39: " ...weight loss planned/desired fluid coupled with likely gradual body mass loss-desired ...".</p> <p>12/6/2024 at 11:34: "274.6 12/5 ...weight history ...280 12/4, 276.8 12/3, 288.4 11/28; 11/6 305.7#; 356-371 10/4-10/5 ...".</p> <p>12/6/2024 at 11:51: "root cause analysis of weight loss and weight fluctuations due to planned fluid losses; diuretic therapy schedule ...".</p> <p>12/13/2024 at 12:12: "#274 ...-5.0% change [ 19.7% , 60.6 ] -7.5% change [ 28.9% , 100.4 ] -10.0% change [ 34.0% , 127.0 ]".</p> <p>12/20/2024 at 10:19: " ...weight stabilizing ...".</p>			

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F0760	<p>There was no documentation from Registered Dietitian "O" on or around 1/2/2025 when Resident #701's weight decreased by 83 pounds in three days.</p> <p>From the discussion it was evident Dietitian "O" did not address the fluctuations in Resident #701's documented weights.</p> <p>On 2/27/2025 at 12:40 PM, Resident #701's documented weights were reviewed with Unit Manager "B," to include the documented weight of 283 on 12/30/2024 to 201 on 1/2/2025. The manager reported the discrepancies are not just from fluid the resident retained due to his disease processes.</p> <p>On 2/27/2025 at 1:45 PM, phone contact was attempted with past Unit Manager "Q." A voicemail was left requesting a return phone call. There was no return phone call received by the time of exit.</p> <p>The facility was asked to provide any additional documentation related to his weight variations and none was received prior to or at exit.</p> <p>Review was completed of the facility policy entitled, "Weights," revised 2.1.2024. The policy stated, " ...Daily weights maybe ordered by the medical practitioner for a specific resident and my contain parameters ...Reweights will be completed when: the resident gains or loses 5 pounds if they weight 100 pounds or greater ...The Registered Dietitian or designee is responsible for the weight management program to include compliance with weights obtained, tracking and trending ...</p> <p>Residents are Free of Significant Med Errors The facility must ensure that its- \$483.45(f)</p>	F0760	F760 Residents are Free of Significant Med Errors	3/14/2025	

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SS= E	<p>(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by:</p> <p>This Citation pertains to Intake Number MI00150622.</p> <p>Based on observation, interview and record review, the facility failed to ensure that medications were administered to 4 residents (#702, #703, #704, #705) of 5 sampled residents, and 10 unsampled residents, resulting in multiple residents not receiving their 5:00 PM medications on 02/25/2025.</p> <p>Findings include:</p> <p>Observation on 2/27/2025 at 8:10 AM of the Madonna nursing unit revealed Licensed Practical Nurse (LPN) "H" was observed to be passing medications to residents on the 101-113 hallway.</p> <p>Record review of Resident #702's Medication Administration Record (MAR) for the month of February 2025 revealed that on 2/25/2025 at 5:00 PM that Xarelto (anticoagulant) 20 mg tablet by mouth for DVT/PE (Deep Ven Thrombosis/Pulmonary embolism) was not signed out as being completed. The medication Questran 4-gram packet was not signed out as being completed.</p> <p>Record review of Resident #703's Medication Administration Record (MAR) for the month of February 2025 revealed that on 2/25/2025 at 5:00 PM, Calcium Acetate 667 mg capsule was not signed out as being completed.</p> <p>Record review of Resident #704's Medication Administration Record (MAR) for the month of</p>		<p>Element 1 Residents #702 and #705 continue to reside within the facility. An audit was conducted to ensure both residents have been receiving their medications per physician orders. Resident #703 and #704 no longer resides in the facility.</p> <p>Element 2 Like residents were identified as residents who reside in the facility. Like residents have been audited to ensure their medications have been being administered per the physician orders.</p> <p>Element 3 The procedure to implement the plan of correction included: 1. IDT reviewed F760. 2. IDT reviewed the Medication Administration policy and deemed appropriate. 3. RN/LPN were re-educated on the Medication Administration policy on ensuring medications are always administered.</p> <p>Element 4 The process to ensure that the specific citation remains corrected includes: 1. The Director of Nursing / Designee will audit 10 residents weekly to ensure medication are signed out and administered. Audits will be conducted weekly for four weeks then monthly for two months. Any concerns will be immediately addressed. The results of the audits will be reviewed by the QAPI committee monthly for 3 months for further recommendations. 2. The Administrator will be responsible for sustained compliance.</p>	

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	<p>February 2025 revealed that on 2/25/2025 at 5:00 PM, that the chem for diabetes (blood sugar check) was not signed out as being completed.</p> <p>Record review of Resident #705's Medication Administration Record (MAR) for the month of February 2025 revealed that on 2/25/2025 at 5:00 PM, that the chem for diabetes (blood sugar check) was not signed out as being completed. Lispro insulin injection to scale was not signed out as being completed. Free water flush of 350 cc via peg tube was not signed out as being completed.</p> <p>Record review of the facility 'Medication Administration' policy, dated 08/07/2023 revealed that the policy was to safely and accurately prepare and administer medication according to physician's order, professional standards of practice, and resident needs ... Sign the MAR (Medication Administration Record) after administered. For those medications requiring vital signs, record vital signs on the MAR. Report and document any adverse side effects or refusals.</p> <p>In an interview on 2/27/2025 at 1:55 PM, Registered Nurse (RN) "B" (Unit manager on medication administration) stated that the process was to follow the resident 6 rights of medication administration, wash hands, compare the medication cards with resident name and dose, take the medications to the resident and ensure resident takes the medications, come back to document in the Medication Administration Record (MAR). Medications are clicked/checked off on the electronic MAR.</p> <p>A record review was conducted of Resident #702's February 2025 Medication Administration Record (MAR). An open/blank square in regard to Xarelto (anticoagulant) meant that the medication was not documented as being</p>			

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	<p>administered. If an open/blank square if not clicked/checked off, then the medication was not administered. The nurse should document medication refusal. Record review of Resident #702 Progress notes, dated 2/25/2025, revealed only documentation of refusal of shower/bath as authored by RN "B" Unit manager. The state surveyor asked for an audit of resident names for missed medications on 2/25/2025. RN "B" was asked if the facility audits or reviews medication administration records to monitor if medications are administered, and she stated "No".</p> <p>In an interview on 2/27/2025 at 2:30 PM, Registered Nurse (RN) "B" Unit manager revealed she did an investigation, and that on 2/25/2025 Licensed Practical Nurse (LPN) "H" left and counted off medications with the oncoming nurse at 4:00 PM which was Registered Nurse "P". Registered Nurse "P", did not give the 5:00 PM medications. LPN "H" left at 4:00 PM that day.</p> <p>An interview on 2/27/2025 at 2:35 PM with Licensed Practical Nurse (LPN) "H" revealed that it was her day off on the 2/25/2025 and she came in at 9:00 AM and left at 4:00 PM. LPN "H" stated that she gave all the resident medications up to 4:00 PM that day.</p> <p>Record review of the facility 'Missed Medication Administration on 2/25/25' form/audit revealed that there were 14 residents affected by the missed medication administration for that date on the Madonna nursing unit.</p>			