STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	824020	A. BUILDING _____ B. WING _____	6/4/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTALIS HEALTH AND REHABILITATION OF ALLEN PARK	9150 ALLEN RD ALLEN PARK, MI 48101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Optalis Health and Rehabilitation of Allen Park was surveyed for a Recertification survey on 6/4/2025. Intakes: MI00151192, MI00151582, MI00151634, MI00152151, MI00152688, MI00153077 and MI00153256. Census: 124.	F0000		
F0656 SS= D	Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F0656	F 656 Comprehensive Care Plan ELEMENT #1 Resident #19 care plan was updated with a dental care plan. ELEMENT #2 Current residents followed by Health Drive for dental services have the potential to be affected by the deficient practice. Current residents followed by Health Drive were assessed for dental health problems. Any resident identified with dental health problems had a dental care plan reviewed, updated or created. ELEMENT #3 The policy, Care Plan-Comprehensive Revision, was reviewed and deemed appropriate. The policy, Care Plan-Comprehensive Revision remains in place. The IDT was re-educated on the policy, Care Plan-Comprehensive Revision, with emphasis on dental care plans. ELEMENT #4 The Director of Nursing and/or designee will conduct random audits on 5 residents weekly to ensure substantial compliance with dental	7/8/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/27/2025

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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	resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement a dental care plan for one resident (R19) out of three residents reviewed for dental services. Findings include: On 6/2/25 at 10:44 AM, R19 was observed with crooked and uneven teeth. An interview was conducted with R19, the resident reported having broken teeth and had seen a dentist but had never heard anything about another appointment. Review of R19's care plans revealed no dental care plan had been implemented. Review of electronic medical record (EMR) revealed resident was admitted into the facility on 3/6/23 with a diagnosis of Parkinson's Disease (disorder that affects central nervous system). According the R19's Brief interview for Mental Status (BIMS) dated 3/12/25, R19 scored 14 out		care plans. 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. Any area of non-compliance will be addressed. The Administrator is responsible for sustained compliance. Date of Compliance: 7/8/2025	

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	of 15 (intact cognition). Further review revealed resident required substantial/Maximal assistance with Activities of Daily Living (ADLs). Review of "Dental Referral Memo" dated 6/17/24, It was documented that R19 was planned for a full mouth extraction in the dentist's office. Review of "Dental Group" form dated 3/13/25, it documented that resident would "like teeth removed and dentures fabricated." Review of "Appointment Sheets" dated 12/26/24 and 3/25/25 documented resident had appointments for "Oral Surgery". An interview was conducted on 6/3/25 at 2:15 PM with the Director of Nursing (DON), after reviewing R19's EMR, it was reported that the facility should have been aware that R19 poor dental health, and the resident did not have a dental care plan implemented. It was further reported residents should have care plans implemented to meet their individual needs. Review of facility's policy "Care Plan-Comprehensive and Revision" dated 8/25/23 it was documented, "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."			
F0677 SS= D	ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F0677	F 677 ADL Element #1 Resident #41 was provided nail care. Element # 2 Current residents have the potential to be affected by the deficient practice. Current residents were assessed for the need of nail care. Any residents without nail care completed were provided nail care and documented in the electronic medical record.	7/8/2025

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	Based on observation, interview and record review the facility failed to provide nail care for one resident (R45) out of 27 sampled residents, resulting in unmet resident personal hygiene needs. Findings include: R45 On 6/02/25 at 11:13 AM, R45 was interviewed about care in the facility and stated, "I need my nails cut." R45's fingernails appeared long, jagged with debris. R45 said he had a bed bath over the weekend. On 6/03/25 at 8:30 AM, R45 was observed with long, jagged fingernails. On 6/04/25 at 9:26 AM, R45's fingernails were observed with Licensed Practical Nurse (LPN) "C". LPN "C" said R45 had long, dirty nails. When LPN "C" asked R45 if he would like his nails trimmed R45 agreed. LPN "C" said R45 has had some refusal for care before but not for bed baths or nail care. Record review of R45's Electronic medical record (EMR) revealed he was admitted to the facility on 10/20/2024 with diagnoses that included venous insufficiency (obstruction of blood flow), and chronic ulcers to right and left calves. Review of the MDS dated 5/5/2025 for R45 revealed a "Brief interview for Mental Status"		Refusals and/preferences were documented in the electronic medical record and care plan was updated accordingly. Element # 3 The policy, Nail Care Policy has been reviewed and deemed appropriate. The policy, Nail Care Policy remains in place. CNA□s, Licensed Practical Nurses & Registered Nurses were re-educated on the policy for Nail Care Policy with emphasis on routine cleaning and inspection. Element #4 The Director of Nursing and/or designee will conduct random audits of 5 residents to ensure substantial compliance with nail care. 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. Any area of non-compliance will be addressed. The Administrator is responsible for sustained compliance. Date of Compliance: 7/8/2025	

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	(BIMS) of 12/15 which indicated moderate cognitive impairment and dependent assistance for personal hygiene. Review of the EMR for May and June 2025 did not reveal refusals of bed baths, showers or refusals of nail care. Review of R45's care plan date initiated 10/21/2024 revealed "Nail care to be provided twice a week on shower days, and as needed." On 6/5/25 at 11:30 AM the Director of Nursing (DON) was interviewed and said the expectation is for the Certified Nursing Assistants to complete nail care on bed bath/shower days or as needed and to document refusals of care.			
F0684 SS= D	Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: This Citation Has Two Deficient Practice Statement. Deficient Practice Statement #1	F0684	F 684 Deficient Practice #1 ELEMENT # 1 Resident #30 pregabalin was ordered and received from the pharmacy. ELEMENT # 2 Current residents admitted within the last 7 days, electronic medication administration records were reviewed for medications that were held due to medication unavailability. Any medications identified as unavailable; the pharmacy was contacted to resolve the unavailability. ELEMENT #3 The policy, Ordering and Receiving Drugs and Biologicals- Emergency Pharmacy Delivery and Emergency Kits, was reviewed and	7/8/2025

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	Based on observation, interview, and record review the facility failed to remove medications from the back-up medication supply for administration to one resident (R30) of one resident reviewed for missed medications, resulting in R30 missing 18 of 21 scheduled doses of their their neuropathy medication. Findings include: On 6/2/25 at 12:00 PM, a review of R30's clinical record revealed they admitted to the facility on 5/21/25 with diagnoses that included hereditary and idiopathic neuropathy (nerve pain). R30's physician's orders were reviewed and revealed an order for pregabalin (neuropathic pain medication) 75 mg (milligrams) twice daily scheduled for 9 AM and 9 PM. A review of R30's medication administration record (MAR) for May 2025 was reviewed and revealed the pregabalin medication documented as "7" (meaning the medication was held with an accompanying progress note documenting the reason) for the 9 AM doses on 5/22/25, and from 5/24/25 thru 5/30/25. The MAR further revealed the medication documented as a "7" for the 9 PM doses from 5/21/25 thru 5/29/25. The accompanying progress notes for why the medication was held were documented as:, "Awaiting pharmacy delivery, dosage not available in backup", "On order", "Not in cart", and "awaiting new script". On 6/3/25 at 11:00 AM, R30 was up in their wheelchair in the hallway. They were asked if they missed any medications and said when they first admitted to the facility they either ran out of or didn't have their Lyrica (pregabalin) medication. On 6/3/25 at 11:20 AM, the facility's Director of		deemed appropriate. The policy, Ordering and Receiving Drugs and Biologicals- Emergency Pharmacy Delivery and Emergency Kits, remains in place. Licensed Practical Nurses & Registered Nurses were re-educated on the policy, Ordering and Receiving Drugs and Biologicals- Emergency Pharmacy Delivery and Emergency Kits, with emphasis on obtaining medications from the emergency back-up supply. ELEMENT #4 The Director of Nursing and/or designee will conduct random audits of 5 newly admitted residents electronic medication administration records to ensure unavailable medications are being pulled from back up and or reviewed by the physician. 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. Any area of non-compliance will be addressed. The Administrator is responsible for sustained compliance. Date of Compliance: 7/8/2025 F 684 Deficient Practice #2 Element # 1 Resident #30 & #233 PICC line dressings were changed. Element # 2 Current residents with PICC lines have the potential to be affected by the deficient practice. Current residents with PICC lines electronic medical records were reviewed to identify residents for PICC line dressing	

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	Nursing (DON) provided a list of medications kept on-site in the back-up medication supply. It was noted the facility had 25 and 50 mg tabs of pregabalin in the back-up supply. On 6/3/25 at 12:34 PM, an interview was conducted with the facility's DON regarding R30's missed pregabalin. They said the nurses should have checked the supply and pulled the medication if available. They also said given the duration of time (10 and a half days) and the amount of doses missed (18 of 21) someone should have followed up with the physician and the pharmacy to obtain the medication. A review of a facility provided document titled, "ORDERING AND RECEIVING DRUGS AND BIOLOGICALS-EMERGENCY PHARMACY DELIVERY AND EMERGENCY KITS" was reviewed and read, "Emergency pharmacy service is available on a 24-hour basis. Emergency needs for medication are met by using the facility's approved medication supply or by special order from the pharmacy..." Deficient Practice Statement #2 Based on observation, interview, and record review, the facility failed to ensure PICC (peripherally inserted central catheter) line care and maintenance were provided for two residents (R30 and R233) of two residents reviewed for PICC line care resulting in the potential for malfunction of the line and or the development of infection. Findings include: R233 On 6/2/25 at 10:36 AM, R233 was observed in their room with a PICC line to their right upper arm. An interview was conducted at that time and they said they admitted to the facility with the		changes. Any residents without dressing changes, were changed and documented in the electronic medical record. Element # 3 The policy, Catheter Insertion and Care, was reviewed and deemed appropriate. The policy, Catheter Insertion and Care, remains in place. Licensed Practical Nurses and Registered Nurses were re-educated on the policy, Catheter Insertion and Care with emphasis on PICC line dressing changes. Element #4 The Director of Nursing and/or designee will conduct random audits of 5 residents with PICC lines to ensure substantial compliance with PICC line dressing changes. 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. Any area of non-compliance will be addressed. The Administrator is responsible for sustained compliance. Date of Compliance: 7/8/2025	

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	line for the delivery of intravenous antibiotics. They were asked if they would lift their sleeve so the dressing covering the line could be observed and they did. At that time, a transparent dressing covering the line insertion site was observed with multiple layers of tape securing the dressing to their arm. It further appeared a date had been written on one of the multiple layers of tape; however it could not be determined what date was written. R233 was asked about the last time the dressing had been changed and they said they didn't know but they were told when they discharged from the hospital it was supposed to be changed every seven days or sooner if needed. A review of R 233's clinical record revealed they admitted to the facility on 5/22/25 with diagnoses that included: aftercare following joint replacement surgery and infection following a surgical procedure. R233's admission assessment indicated they admitted to the facility with a PICC line. A review of R233's physician's orders, medication administration records (MAR) and treatment administration records (TAR) for May 2025 and June 2025 was conducted and revealed an order to flush the line with 10 milliliters of normal saline before and after medication administration, however; the boxes on the MAR where staff would sign off they performed the flushes all contained an "X" in them, not allowing staff to sign off they performed the flushes. Further review of the June 2025 TAR revealed Nurse 'B' signed off as changing the dressing for the PICC line on 6/1/25; however, that date was not observed on the dressing during the observation on 6/2/25 at 10:36 AM. R30 On 6/2/25 at 10:27 AM, R30 was observed in their room seated in their wheelchair. At that time, it was observed R30 had a PICC line to			

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	their right upper arm. R30 was asked if the dressing covering the line insertion site could be observed and they consented. R30 lifted the sleeve of their shirt and it was observed the transparent dressing covering the line was dated 5/20/25. They were asked the last time it was changed and they said they did not know and further queried how often the dressing should be changed. R30 in room up to wheelchair. Few months. On 6/2/25 at 11:30 AM, a review of R30's clinical record revealed they admitted to the facility on 5/21/25 with a PICC line placed upon discharge from the hospital for the delivery of intravenous antibiotics in the facility. R30's physician's orders and MAR and TAR for May and June 2025 were reviewed and revealed Nurse 'D' signed off on 5/25/25 they changed the dressing and Nurse 'B' signed off on 6/1/25 they changed the dressing despite the date on the dressing observed as 5/20/25. On 6/2/25 at 12:19 PM, R30's PICC line dressing was observed with Unit Manager 'C' and they confirmed the dressing to be dated 5/20/25. They were asked how often the dressings should be changed and said they were done every 7 days. At that time, it was shared with them two nurses documented they changed the dressing and signed off on the TAR. Unit Manager 'C' said they would look into what happened. A review of a facility provided document titled, "Catheter Insertion and Care" was conducted, however; the document did not address how often the PICC line dressings should be changed. According to the, "National Institutes of Health" guidelines at https://www.ncbi.nlm.nih.gov/books/NBK573064 / PICC dressings should be changed at least once a week, or more frequently if the dressing			

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	becomes loose, wet, or soiled.			
F0693 SS= D	Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to perform tube feed (a tube providing nutrients and medications directly to the stomach) insertion site care and dressing changes per physician order for one (R69) of two resident's reviewed for tube feeding, resulting in the potential for infection. Findings include:	F0693	F 693 Tube Feeding Element #1 Resident #69 dressing was changed. Element #2 Current residents with gastrostomy tubes have to potential to be affected. Current residents with gastrostomy tubes were assessed to ensure that dressings were changed. Any dressing not in place or in need of change was completed. Current residents with gastrostomy tubes electronic medical records were reviewed to ensure that dressing change orders were in place. Any resident without orders for dressing change orders were entered into the electronic medical record. Element #3 The policy, Tube Feeding- Formula Administration, Flushing, and Unclogging and the policy Tube Feeding- Formula Administration, Flushing, and Unclogging has been reviewed and deemed appropriate. The policy, Tube Feeding- Formula Administration, Flushing, and Unclogging remains in place. Registered Nurses & Licensed Practical Nurses were re-educated on the policy for Tube Feeding- Formula Administration, Flushing, and Unclogging with emphasis on gastrostomy tube dressings. Element #4 The Director of Nursing and/or designee will conduct random audits of 5 residents to ensure substantial compliance tube feeding dressing changes. Audits will be conducted	7/8/2025

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	On 6/03/25 at 2:45 PM, R69 was observed in bed and stated, "The staff are not changing my tube feed dressing." The tube feed dressing was observed with a date of 5/24/25. On 6/03/25 at 2:55 PM, R69's tube feed dressing was observed with Licensed Practical Nurse/Unit Manager LPN "C". LPN "C" said the dressing was dated 5/24/25 and explained that was the date that the dressing was last changed. LPN "C" said the dressing should be changed daily on the night shift and there is a risk for infection if the site is not kept clean. Review of R69's Electronic Medical Record (EMR) revealed, R69 admitted to the facility on 3/29/25 with pertinent diagnoses which included dysphagia and gastrostomy status (presence of artificial opening to the stomach). Review of a "Minimum Data Set" (MDS) assessment dated 5/31/25 revealed R69 had intact cognition and required a feeding tube. Review of Physician orders 5/2/25 revealed, "Enteral Tube Site Care: Cleanse site with soap and water, rinse with water and allow to air dry, apply split gauze date and initial every night shift for site care notify physician for any signs or symptoms of infection." On 6/4/25 at 11:30 AM the Director of Nursing (DON) was interviewed and said the		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. Any area of non-compliance will be addressed. The Administrator is responsible for sustained compliance. Date of Compliance: 7/8/2025	

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	expectation is for the nurses to follow physician orders and that R69's dressing should have been changed daily. Review of the facility policy titled "Tube Feeding -Overview" dated 8/9/2025 revealed in part: 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.			
F0698 SS= D	Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure appropriate coordination of care between the facility and the contracted dialysis center for one resident (R15) out of one resident reviewed for dialysis services, resulting in the potential for resident to experience fluid overload. Findings include: On 6/2/25 at 1:03 PM, R15 was observed asleep in bed. A 20 oz. sized cup was observed on R15's overbed table.	F0698	F 698 Dialysis Fluid Restrictions ELEMENT #1 A fluid restriction order was entered into the electronic medical record for Resident #15. ELEMENT #2 Like residents that receive dialysis treatment; electronic medical records were reviewed to ensure that residents needing fluid restrictions had orders entered into the electronic medical record. Any resident identified to need fluid restrictions had orders entered into the electronic medical record. ELEMENT #3 The policy, Fluid Restrictions was reviewed and deemed appropriate. The policy, Fluid Restrictions remains in place. Registered Nurses, Licensed Practical Nurses and Registered dietician were re-educated on the policy, Fluid Restrictions, with emphasis on residents receiving dialysis treatment and fluid restrictions.	7/8/2025

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	On 6/3/25 at 10:55 AM, R15 was observed awake in bed. A 20 oz. sized cup was observed on R15's overbed table. R15 was able to reach and shake the cup which appeared to be half full. R15 said that she enjoys drinking water. On 6/4/25 at 10:31 AM, an observation of R15 was conducted with Registered Dietitian (RD) "F". R15 was observed awake in bed. RD "F" indicated R15 had a 20 oz. cup on the overbed table. R15 was able to reach and shake the cup which appeared to be full of ice. A review of the clinical record for R15 documented an admission date of 1/27/25 with diagnoses that included end stage renal disease (ESRD), hypertension, and atrial fibrillation. A Minimum Data Set assessment dated 5/5/25 documented intact cognition. Physician order dated 3/26/25 documented, "No bedside water and one beverage per meal tray. Per HD (hemodialysis) clinic." Documents for R15 titled, "Hemodialysis Communication Form", used to facilitate communication between the facility and the hemodialysis center, were reviewed. Section 2, completed by the dialysis center revealed the following: - 5/5/25: Nutrition concerns: "Too much fluid - gaining more than we can take (off)." - 5/16/25: Nutrition concerns: "Pt. (patient) gaining more (sic) too much fluid than we can take off. Less fluid please. Cut portions. Watch liquidly foods/snacks." - 5/19/25: Nutrition concerns: "Too much fluid intake - Swollen arm - High BP (blood pressure) - SOB (shortness of breath) - hospitalization." Post dialysis instructions: Hard candies, ice cubes,		ELEMENT # 4 The Director of Nursing and/or designee will conduct random audits of 5 residents receiving Dialysis treatments to ensure substantial compliance with fluid restrictions if ordered. 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. Any area of non-compliance will be addressed. The Administrator is responsible for sustained compliance. Date of Compliance: 7/8/2025	

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	bubble gum (if able) will help with thirst." Review of R15's care plans documented in part the following: 1. Focus: The resident needs dialysis hemo r/t (related to) (sic). Initiated 1/28/25. Interventions: Coordinate dialysis care with dialysis center. Initiated 1/28/25. 2. Focus: Bowel Elimination Alteration; Constipation related to (sic). Initiated 1/28/25: Interventions: Encourage and assist as needed to consume fluids offered at and between meals. Initiated: 1/28/25 3. Risk for alteration in hydration related to (sic). Initiated 1/28/25. 4. Resident is at nutritional risk r/t ESRD with Hemodialysis Resident has increased nutrient needs and increased nutrient loss. Initiated 2/3/25. Interventions included: Encourage resident to maintain dietary restrictions and provide diet education as requested. Initiated 2/3/25. During an interview and review of R15's clinical record on 6/4/25 at 11:18 AM, Licensed Practical Nurse (LPN)/Unit Manager "A" said R15 should not have water or (20 oz. cup of) ice at her bedside. She should not be getting that much fluid. LPN "A" added, R15 should receive fluid as ordered because she was on "dialysis and fluid overload was a problem because she cannot void on her own." A fluid restriction was not indicated and addressed on R15's Kardex (a guide Certified Nurse Aides used for patient care) or R15's care plan. LPN "A" said R15's fluid restriction should have been on the Kardex and care plan because they "determine how we care for the resident. It's the order given by the dialysis center to ensure (R15) gets proper care."			

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	During an interview on 6/4/25 at 1:19 PM, the Director of Nursing (DON) said R15's has had urinary tract infection(s) and the physician wants to push fluids but R15 was on a fluid restriction because of dialysis. The DON stated, "We should consult with the facility RD and hemodialysis." The DON acknowledged that this was not done. On 6/4/25 at 3:30 PM during the exit conference, the Nursing Home Administrator and Director of Nursing did not offer additional documentation or information pertaining to this citation when asked.			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F0761	F 761 Medication Storage ELEMENT #1 Medication was removed and properly disposed of from Resident # 21 room. ELEMENT #2 Current residents have the potential to be affected by the deficient practice. Current resident□s rooms were evaluated for proper medication storage. Any medications not properly stored, were properly stored and/ or disposed of. ELEMENT #3 The policy, Medication and Treatment Cart Storage policy was reviewed and deemed appropriate. The policy, Medication and Treatment Cart Storage remains in place. Licensed Practical Nurses & Registered Nurses were re-educated on the policy, Medication and Treatment Cart Storage with emphasis on proper medication storage. ELEMENT #4 The Director of Nursing and/or designee will conduct random audits of 5 residents□ rooms	7/8/2025

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	Based observation, interview and record review the facility failed to ensure prescription medication was properly stored for one resident (R21) of 27 residents reviewed for medication administration, resulting in unsecured medication and the potential for access to unauthorized persons to the medication. Findings include: On 6/3/2025 at 8:40 a.m. during a morning medication administration (Med Pass) on the "Mackinaw" unit with Licensed Practical Nurse (LPN) "M" a cup with two pills was observed on R21's bedside table. LPN "M" was interviewed regarding the medication at bedside. LPN "M" stated, "I have no idea who put the pills on the resident's table near her breakfast tray. I just pulled my medications." LPN "M" verified the two pills as (Faxiga and Levothyroxine) and the R21 does not self-administer medication. LPN "M" stated, "This was 6 a.m. scheduled meds and medication should not be left at bedside." On 6/3/2025 at 8:50 a.m. R21 was interviewed regarding the medications left at bedside. R21 stated, "I don't know who sat the pills on my table (while reaching for the medication to take them). They do that all the time. They claim they can't wake me up." Record review revealed that R21 was initially admitted into the facility on 3/9/2023 and most recently readmitted on 9/3/2024 with diagnoses which included, chronic obstructive pulmonary disease (COPD), dementia, psychotic disorder, schizoaffective disorder, major depressive disorder, type two diabetes mellitus, and generalized anxiety. R21's Quarterly Minimum Data Set Assessment (MDS) with a reference date of 5/8/2025 indicated R21 had moderately cognition impairment with a BIMS (brief		to ensure substantial compliance with medication storage. 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. Any area of non-compliance will be addressed. The Administrator is responsible for sustained compliance. Date of Compliance: 7/8/2025	

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	interview for mental status) score of 10/15. A care plan initiated on 5/5/2025 for "Activity of Daily Living (ADLs)" had the following: Bed mobility modified independent. Transfer modified independent. The Electronic health record did not reveal a self-administration assessment form completed for R21. Review of the physician's orders revealed "Faxiga oral tablet 2 milligrams give one tablet by mouth one time a day for diabetes give on empty stomach. Levothyroxine sodium 59 microgram tablet take one tablet by mouth every morning for hypothyroidism." On 6/4/2025 at 2:35 p.m. the Director of Nursing (DON) was interviewed regarding the medication left at bedside. The DON said it was not safe to leave medication at bedside because a resident could wheel into the room and take the medication. The DON stated, "No nurse should leave them there. It's a hazard to leave medication at bedside. The medication should be storage in locked med cart." According to the facility's 5/4/2022 "Medication & Treatment Cart Storage" policy: "It is the policy of this facility to ensure all supplies for treatments and medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendation and sufficient to ensure proper sanitation ... Security. Compliance Guidelines as following: a. All drugs and biologicals will be stored in locked compartment (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms). c. During a medication pass, medications must be			

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	under the direct observation of the person administering medications or locked in the medication storage area/cart."			
F0791 SS= D	Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(f) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by:	F0791	F 791 Dental Services ELEMENT #1 Resident # 19 had a dental appointment made for 6/24/25. ELEMENT #2 Current residents followed by Health Drive have the potential to be affected by the deficient practice. Current residents followed by Health Drive were assessed for additional dental service needs. Any resident in need of dental services was referred to Health Drive. Any resident needing additional dental care, an appointment was made for. ELEMENT #3 The policy, Dental Services has been reviewed and deemed appropriate. The policy, Dental Services remains in place. The social work department and ward clerks were re-educated on the policy, Dental Services with emphasis on follow-up dental appointments. ELEMENT #4 The Director of Nursing and/or designee will conduct random audits of 5 residents to ensure substantial compliance with dental services being scheduled. 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. Any area of non-compliance will be addressed. The Administrator is responsible for sustained	7/8/2025

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	Based on observation, interview and record review the facility failed to ensure dental services were provided in a timely manner for one resident (R19) out of three residents reviewed for dental services. Findings include: On 6/2/25 at 10:44 AM, R19 was observed with crooked and uneven teeth. An interview was conducted with R19, the resident reported having broken teeth. R19 reported past dentist appointments, but had not heard anything else since last appointment. R19 stated, "I have been waiting a long time to get dentures." Review of electronic medical record (EMR) revealed resident was admitted into the facility on 3/6/23 with a diagnosis of Parkinson's Disease (disorder that affects central nervous system). According the R19's Brief interview for Mental Status (BIMS) dated 3/12/25, R19 scored 14 out of 15 (intact cognition). Further review revealed resident required substantial/Maximal assistance with Activities of Daily Living (ADLs). Record review of "Dentist Consultation" dated 6/17/24 revealed R19 had a referral to have all teeth extracted. Further review of electronic medical record revealed resident had an appointment for oral surgery on 12/26/24 and 2/18/25 the procedure was not performed. Review of "Dental Group" dated 3/13/25, a new referral was written for resident to have all teeth extracted. R19 had appointment for oral surgery on 3/25/25, and procedure was not performed. Further review revealed a new appointment had not been scheduled. An interview conducted on 6/3/25 at 1:15 PM		compliance. Date of Compliance: 7/8/2025	

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	with Unit Clerk (UC) "L", it was reported that each time resident went to appointment family had not shown for procedure and it was canceled. It was further reported that no future appointments had been scheduled after 3/25/25. An interview conducted on 6/3/25 at 2:16 PM with the Director of Nursing (DON), it was reported that staff should have followed up and scheduled another appointment for R19 to have teeth extracted. It was further reported that staff could have accompanied the resident to the appointment for assistance. Lastly, it was reported that the resident had not received dental care in a timely manner. Review of facility's policy "Dental Services" dated 3/10/25 it was documented, "It is the policy of the facility to assist residents in obtaining routine and emergency dental care."			
F0842 SS= D	Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To	F0842	F 842 Accurate Medical Record ELEMENT #1 Resident #69 dressing was changed and properly documented in the electronic medical record. ELEMENT #2 Current residents with enteral tubes have the potential to be affected by the deficient practice. Current residents with enteral tubes dressings were evaluated to determine if they were changed timely. Any dressing not changed was changed and appropriately documented in the electronic medical records. ELEMENT #3 The policy, Tube Feeding- Formula Administration, Flushing, and Unclogging and the policy Tube Feeding- Formula Administration, Flushing, and Unclogging has been reviewed and deemed appropriate.	7/8/2025

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	the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain complete and accurate medical records for one		The policy, Tube Feeding- Formula Administration, Flushing, and Unclogging remains in place. Registered Nurses & Licensed Practical Nurses were re-educated on the policy for Tube Feeding- Formula Administration, Flushing, and Unclogging with emphasis on enteral tube dressing changes and documentation. ELEMENT #4 The Director of Nursing and/or designee will conduct random audits of 5 residents to ensure substantial compliance with enteral tube dressing changes and documentation. 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. Any area of non-compliance will be addressed. The Administrator is responsible for sustained compliance. Date of Compliance: 7/8/2025	

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	resident (R45) out of 27 sampled residents resulting in unmet resident care. Findings include: On 6/03/25 at 2:45 PM, R69 was observed in bed and stated, "The staff are not changing my tube feed dressing." The tube feed dressing was observed with a date of 5/24/25. On 6/03/25 at 2:55 PM, R69's tube feed dressing was observed with Licensed Practical Nurse/Unit Manager LPN "C". LPN "C" said the dressing was dated 5/24/25 and explained that was the date that the dressing was last changed. LPN "C" said the dressing should be changed daily on the night shift and there is a risk for infection if the site is not kept clean. On 6/04/25 at 8:57 AM, R69's May and June of 2025 Medication Administration Record (MAR) and Treatment Administration Records (TAR) were reviewed with LPN "C". LPN "C" said R69's MAR/TAR was incorrect from 5/25/25 to 6/2/25 since the wound care and bandage change last occurred on 5/24/25. LPN "C" stated the last two entries were recorded by Registered Nurse (RN) "E". LPN "C" stated, "I spoke to RN "E" and informed her that that it is falsification of records for R69's chart and that treatment should only be documented after care has occurred. " Review of R69's Electronic Medical Record			

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	(EMR) revealed, R69 admitted to the facility on 3/29/25 with pertinent diagnoses which included dysphagia and gastrostomy status (presence of artificial opening to the stomach). Review of a "Minimum Data Set" (MDS) assessment dated 5/31/25 revealed R69 had intact cognition and required a feeding tube. Review of Physician orders 5/2/25 revealed, "Enteral Tube Site Care: Cleanse site with soap and water, rinse with water and allow to air dry, apply split gauze date and initial every night shift for site care notify physician for any signs or symptoms of infection." On 6/4/25 at 11:30 AM the Director of Nursing (DON) was interviewed and said the expectation is that medical records are correct and that patients get the treatments ordered.			
F0880 SS= F	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all	F0880	F 880 Infection Control Deficient Practice #1 ELEMENT #1 Infection control program data for April & May 2025 was completed. ELEMENT #2 Current residents have the potential to be affected by the deficient practice. An infection control program that includes preventing, identifying, reporting investigating, and monitoring and surveillance infections was put into place for June 2025. ELEMENT # 3 The policy, “Infection Control Surveillance,”	7/8/2025

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	residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:		was reviewed and deemed appropriate. The policy, “infection Control Surveillance,” remains in place. The Infection Preventionist was re-educated on the policy, “Infection Control Surveillance” with emphasis on data collection and tracking. ELEMENT #4 The Director of Nursing and/or designee will conduct random audits of 5 residents with identified and/or potential infections to ensure substantial compliance infection control data tracking. 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. Any area of non-compliance will be addressed. The Administrator is responsible for sustained compliance. Date of Compliance: 7/8/2025 F 880 Infection Control Deficient Practice #2 ELEMENT #1 Enhanced Barrier Precautions were put into place for residents #126, 233,235, 4, 234, 85 and 30. ELEMENT #2 Current residents requiring Enhanced Barrier Precautions have the potential to be affected by the deficient practice. Current residents requiring Enhanced Barrier Precautions were evaluated to ensure Enhanced Barrier Precaution signage was in place and orders were entered into the electronic medical record. Any resident identified as needing	

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	This Citation Has Two Deficient Practice Statements. Deficient Practice Statement #1 Based on interview and record review the facility failed to maintain an infection control program that included a system for preventing, identifying, reporting, investigating and controlling infections. This deficient practice had the potential to affect all 124 residents residing in the facility. Findings include: On 6/3/25 at 2:20 PM, an interview was conducted with the facility's Infection Control Preventionist (ICP), Nurse 'A'. Nurse 'A' said they assumed the role as the ICP effective May 18, 2025. They further reported the previous ICP Nurse did not compile April 2025's data and May 2025's data was not finished. On 6/3/25 at 3:13 PM, a review of the facility's monthly infection control program data was reviewed and revealed no data, including: a monthly summary, a calculated infection rate, a list of facility infections, facility mapping for trends/outbreaks, line listings for appropriate antibiotic usage, pharmacy reports, laboratory reports, departmental surveillance, or any staff education provided regarding infection		Enhanced Barrier Precautions had proper signage placed and orders entered into the electronic medical record. ELEMENT #3 The policy, “Enhanced Barrier Precautions” was reviewed and deemed appropriate. The policy, “Enhanced Barrier Precautions” remains in place. Licensed Practical Nurses and Registered Nurses were re-educated on the policy, “Enhanced Barrier Precautions” with emphasis on proper signage and orders. ELEMENT #4 The Director of Nursing and/or designee will conduct random audits of 5 residents needing enhanced barrier precautions (EBP) to ensure substantial compliance with enhanced barrier precautions including signage and MD orders. 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. Any area of non-compliance will be addressed. The Administrator is responsible for sustained compliance. Date of Compliance: 7/8/2025	

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	control for October, November, or December 2024. A review of the documents for January, February, and March 2025 included line listings, however; the line listings did not demonstrate prescribed antibiotics meeting McGeer's Criteria (a set of definitions to identify and track healthcare-associated infections). The monthly data was also noted to be missing mapping for trends/outbreaks, pharmacy reports, lab reports, departmental surveillance, and education. On 6/3/25 at 4:05 PM, an interview with the facility's Director of Nursing (DON) was conducted regarding the facility's monthly infection control program data. They admitted their knowledge the program was not comprehensively kept by the previous ICP Nurse and said they would be working with Nurse 'A' to improve the program. A review of a facility provided policy titled, "Infection Control Surveillance" dated 4/1/20 was conducted and read, "The infection preventionist will conduct ongoing surveillance for Healthcare Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission-based precautions and other preventative interventions...Information about infections is gathered, monitored, and tracked throughout the month by the infection preventionist or			

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	designee. The QAPI Committee may be involved in the interpretation of the data. The infection preventionist or designee will utilize surveillance tools to recognize the occurrence of infections, record their number and frequency, detect outbreaks and epidemics, monitor employee infection, monitor adherence to infection prevention and control practices, and detect unusual pathogens with infection control implications. The Infection Preventionist or designee will enter the resident infections into the line listing report throughout the month. The surveillance should include a review of the following information to help identify possible indicators of infection: Laboratory reports...Infection documentation records, pharmacy records, Antibiotic review...For residents with infections that meet the criteria for definition of infection for surveillance, the following information will be collected: Resident identifying information. Infection diagnosis and/or pathogen. Admission date. Date of onset of infection (signs & symptoms, if known or positive test). Infection Site. Treatment measures and precautions...Calculating Infection rates...Outbreak Management...The Infection Preventionist or designee will analyze the monthly data to identify trends and present to the QAPI committee for review and potential recommendations to minimize the risk and control the spread of infection and multidrug resistant organisms, and improve outcomes through education, skills validation, or other initiatives as warranted.			

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	Deficient Practice Statement #2 Based on observation, interview, and record review the facility failed to ensure proper identification for enhanced barrier precautions (an infection control strategy that uses targeted use of gowns and gloves to reduce the transmission of multidrug-resistant organisms) for seven residents, (R#'s 126, 233, 235, 4, 234, 85, and 30) of seven residents reviewed for enhanced barrier precautions, resulting in the potential for the spread of infection. Findings include: On 6/2/25 at 10:27 AM, R30 was observed in their room; at that time it was noted they had a PICC (peripherally inserted central catheter) line to their right upper arm. They were asked about the line and said they were receiving intravenous antibiotics for a post-operative infection. An observation of the outside of the room did not reveal any signs to indicate they were on EBP. On 6/2/25 at 10:32 AM, R63 was observed lying in bed with a urinary catheter drainage bag hanging on the side of the bed. An observation of the outside of the room did not reveal any signs to indicate they were on EBP. On 6/2/25 at 10:36 AM, R233 was observed in their room. At that time, it was observed they had a PICC line to their right upper extremity. When asked, R233 said they line had been			

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	placed prior to discharge from the hospital so they could receive intravenous antibiotics through the course of their stay at the the facility. An observation of the outside of their room did not reveal any signs to indicate they were on EBP. On 6/2/25 at 11:07 AM, R126 was observed seated in their wheelchair at the nurses station. It was observed R126 had a urinary catheter drainage bag hanging under the seat of the wheelchair. An observation of R126's room did not reveal any signage to indicate they were on enhanced barrier precautions (EBP). On 6/2/25 at 11:14 AM, R234 was observed in their bed asleep. It was noted a urinary catheter drainage bag was attached to the side of the bed. The outside of R234's room did not reveal any signage to indicate they were on EBP. On 6/2/25 at 2:12 PM, a review of R30's clinical record revealed they admitted to the facility on 5/21/24 with a PICC line, however; order for EBP were not placed until 6/2/15. On 6/2/25 at 2:15 PM, a review of R63's clinical record revealed they re-admitted to the facility on 5/19/25 with a urinary catheter and had a physician's order for EBP dated 5/20/25. On 6/2/25 at 2:17 PM, a review of R233's clinical record revealed they admitted to the			

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	facility on 5/22/25 with a PICC line and had an order dated 5/22/25 for EBP. On 6/2/25 at 2:17 PM a review of R126's clinical record revealed they admitted to the facility on 5/1/25 with an indwelling urinary catheter. R126's orders did not include an order EBP. On 6/2/25 at 2:19 PM a review of R234's clinical record revealed they admitted to the facility on 5/22/25 with an indwelling urinary catheter, however; orders for EBP were not placed until 6/2/25. On 6/2/25 at 3:42 PM, R126's room was observed with no signage to indicate they were on EBP, despite R126 having an indwelling urinary catheter. On 6/2/25 at 3:49 PM, an observation of R234 and R85's room was observed to have a sign to indicate EBP, however; the sign did not specify whether R235, R85, or both residents were on EBP. An observation of R63 and R235's room revealed a sign to indicate EBP, however; the sign did not indicate if EBP was in place for R63, R235, or both residents. An observation of R233 and R4's room revealed a sign to indicate EBP were in place and the sign further indicated the EBP was only for bed A, R4's bed despite R233 having a PICC line. A review of R4's clinical record did not reveal any orders for EBP. On 6/3/25 at 8:15 AM and 2:30 PM, an			

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	observation of R234 and R85's room was again observed to have a sign to indicate EBP, however; the sign did not specify whether R235, R85, or both residents were on EBP. An observation of R63 and R235's room continued to reveal a sign to indicate EBP, however; the sign did not indicate if EBP was in place for R63, R235, or both residents. An observation of R233 and R4's room still revealed a sign to indicate EBP were in place for bed A (R4), despite R233 having a PICC line. R234's room was still without signage to indicate they were on EBP. On 6/3/25 at 2:40 PM, an interview was conducted with the facility's Infection Control Preventionist, Nurse 'A' regarding enhanced barrier precautions. They indicated residents with PICC lines, wounds, catheters, and tube feeding should be placed on EBP upon admission, signs should be placed outside the room, and the sign should indicate which resident (bed A, bed B, or both) was on EBP. A review of a facility provided policy titled, "Enhanced Barrier Precautions" issued 3/2024 was conducted and read, "...Enhanced barrier precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms...Procedure: Residents admitted to the facility with or during their stay at the facility acquire a wound and/or an indwelling medical device will be placed in enhanced barrier precautions. A physician order is obtained...Enhanced Barrier Precautions			

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	signage will be posted on the door or wall outside of the resident's room..."			
F0883 SS= E	Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the	F0883	F 883 Influenza & Pneumococcal Immunizations ELEMENT #1 Residents # 28, 24, 26, 19 and 12 continue to resident within the facility and Influenza vaccinations were administered on 3/25/25 with no negative outcomes. Facility infection control was reviewed and there has not been any confirmed cases of Influenza from March through June 2025. ELEMENT #2 Residents residing within the facility will be educated, offered, and vaccinated with the Influenza vaccine for 2025/2026 when made available and dispensed by pharmacy. ELEMENT #3 The policy, Influenza Vaccine was reviewed and deemed appropriate. The policy, Influenza Vaccine remains in place. The Infection Control Nurse was re-educated on the policy, Influenza Vaccine with emphasis on offering vaccinations in a timely manner. ELEMENT #4 The Director of Nursing and/or designee will conduct random audits of 5 residents to ensure substantial compliance with offering vaccinations. 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. Any area of non-compliance will be addressed.	7/8/2025

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	opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure seasonal influenza (flu) vaccines were offered and administered in a timely manner for five residents, (R28, R24, R26, R19, and R12) of five residents reviewed for influenza vaccines, resulting in the increased potential for contracting influenza. Findings include: A review of a facility provided policy titled, "Vaccination-Influenza" dated 10/2023 was reviewed and read, "...Influenza vaccinations will be offered annually between September 1st (or when influenza vaccines become available) and March 31st..." On 6/3/25 at 12:46 PM, R28's clinical record was reviewed and revealed their most recent re-admission to the facility occurred on 1/7/22. A review of R28's vaccination		The Administrator is responsible for sustained compliance. Date of Compliance: 7/8/2025	

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	documentation in the clinical record revealed they were administered the 2024-2025 influenza vaccine on 3/25/25. 6/3/25 at 12:53 PM, R24's clinical record was reviewed and revealed they admitted to the facility on 1/30/19. A review of R24's vaccination documentation in the clinical record revealed they were administered the 2024-2025 influenza vaccine on 3/25/25. On 6/3/25 at 1:00 PM, R26's clinical record was reviewed and revealed they admitted to the facility on 9/12/12 and most recently re-admitted on 1/24/25. A review of R26's vaccination documentation in the clinical record revealed they were administered the 2024-2025 influenza vaccine on 3/25/25. On 6/3/25 at 1:07 PM, R19's clinical record revealed their most recent re-admission to the facility occurred on 7/26/23. A review of R19's vaccination documentation in the clinical record revealed they were administered the 2024-2025 influenza vaccine on 3/25/25. On 6/3/25 at 1:10 PM, R12's clinical record revealed they most recently re-admitted to the facility on 2/13/24. A review of R12's vaccination documentation in the clinical record revealed they were administered the 2024-2025 influenza vaccine on 3/25/25. On 6/3/25 at 4:05 PM, an interview was conducted with the facility's Director of			

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	824020	A. BUILDING _____ B. WING _____	**6/4/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OPTALIS HEALTH AND REHABILITATION OF ALLEN PARK	**9150 ALLEN RD ALLEN PARK, MI 48101**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Nursing (DON) regarding the timing of the administration of the 2024-2025 influenza vaccine. The DON reported they were aware the former Infection Control Preventionist (ICP) did not offer the vaccine at the beginning of the 2024-2025 influenza season. They said the administrations were done in March when they (the DON) found out and told the former ICP to offer and administer the immunizations.			