| 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 _____ | **6/6/2025** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **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 |
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| E0000<br>SS= | Initial Comments<br><br>On June 6, 2025, an Emergency Preparedness Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Optalis Health and Rehabilitation Of Allen Park was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73, Emergency Preparedness. | E0000 | | |
| E0006<br>SS= F | Plan Based on All Hazards Risk Assessment<br>§403.748(a)(1)-(2), §416.54(a)(1)-(2), §418.113(a)(1)-(2), §441.184(a)(1)-(2), §460.84(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a)(1)-(2), §483.475(a)(1)-(2), §484.102(a)(1)-(2), §485.68(a)(1)-(2), §485.542(a)(1)-(2), §485.625(a)(1)-(2), §485.727(a)(1)-(2), §485.920(a)(1)-(2), §486.360(a)(1)-(2), §491.12(a)(1)-(2), §494.62(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* (2) Include strategies for addressing emergency events identified by the risk assessment. * [For Hospices at §418.113(a):] Emergency Plan. The Hospice must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach. (2) Include | E0006 | E006<br>Element # 1<br>The facility emergency preparedness plan was updated using a geographically specific risk assessment.<br><br>Element # 2<br>Current residents have the potential to be affected by the deficient practice. The facility Emergency Preparedness plan was reviewed, necessary updates were made based on the geographically specific risk assessment.<br><br>Element # 3<br>The policy, Emergency Operations Plan was reviewed and deemed appropriate.<br>The maintenance department and IDT was re-educated on the policy, Emergency Operations Plan, with emphasis on a geographically specific risk assessment.<br><br>Element # 4<br>The Administrator and/or designee will conduct random audits of the emergency preparedness plan x1/week for 1 month, then weekly for 1 month and then monthly for 3 months to ensure substantial compliance with a geographically specific risk assessment. | 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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| | strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. (2) Include strategies for addressing emergency events identified by the risk assessment. *[For ICF/IIDs at §483.475(a):] Emergency Plan. The ICF/IID must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following: (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on record review and interview, the facility failed to maintain an Emergency Preparedness plan that must be reviewed and updated annually and be based on and include a documented, facility-based and community based risk assessment, utilizing an all-hazards approach, including missing residents, and include strategies for addressing emergency events identified by the risk assessment. This deficient practice | | Results of the audits will be brought to the QAPI committee.<br>The Administrator is responsible for sustained compliance.<br><br>Date of Compliance: 7/8/2025 | |

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| | could affect all 124 facility residents in the event of an emergency situation either man-made, natural, facility or community-based.<br><br>Findings Include:<br><br>On June 6, 2025, at 2:30 PM, record review revealed the facility failed to provide evidence of the required written geographically specific risk assessment for the hazards identified in their emergency plan. No compliance supporting documentation was presented to the surveyor by the time of exit.<br><br>These findings were confirmed in interview with the facility Maintenance Director and the Corporate Operations Director at the time of record review. | | | |

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| K0000<br><br>SS= | INITIAL COMMENTS<br><br>On June 6, 2025, a Life Safety Recertification Survey was conducted by the Michigan Department of Licensing and Regulatory Affairs, Bureau of Survey and Certification. At the survey, Optalis Health And Rehabilitation Of Allen Park was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.90(a), Life Safety from Fire and the applicable provisions of the 2012 Edition of the National Fire Protection Agency (NFPA) 101, Life Safety Code and the 2012 Edition of NFPA 99, Health Care Facilities Code.<br><br>The facility is a 1 story building of Type II (222) construction with a full walk-out basement built in 1950, with additions added in 1969 and 2007 of the same construction type. The building is fully sprinklered and has supervised smoke detection in the corridors and spaces open to the corridors.<br><br>The facility has 147 certified beds. At the time of the survey the census was 124. | K0000 | | |

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| K0345<br>SS= E | Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure the fire alarm system was tested and maintained in accordance with an approved program complying with NFPA 70 and NFPA 72. This deficient practice could affect 48 of 124 facility residents in the event of a fire.<br><br>Findings Include:<br><br>On June 6, 2025 at 3:45 PM, observation revealed the smoke detector in the north elevator room was disconnected from the ceiling mount and was hanging by the wires.<br><br>These findings were confirmed in interview with the facility Maintenance Director and the Corporate Operations Director at the time of observation. | K0345 | K 345<br>Element # 1<br>The smoke detector in the north elevator room was reconnected to the ceiling mount.<br><br>Element # 2<br>Current residents have the potential to be affected by the deficient practice. All smoke detectors in the facility were evaluated to ensure proper mounting to the ceiling.<br><br>Element # 3<br>The Maintenance Department was re-educated on proper mounting of smoke detectors.<br><br>Element # 4<br>The Administrator and/or designee will conduct random audits of the smoke detectors x1/week for 1 month, then weekly for 1 month and then monthly for 3 months to ensure substantial compliance with properly mounted smoke detectors. Results of the audits will be brought to the QAPI committee.<br>The Administrator is responsible for sustained compliance.<br><br>Date of Compliance: 7/8/2025 | 7/8/2025 |
| K0353<br>SS= F | Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of | K0353 | K 353<br>Element # 1<br>The sprinkler heads in the Med C Nurse Storage Room, Eagle Room, Med C Dining Room, Employee Lounge and Room 107 were cleaned. | 7/8/2025 |

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| | Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to provide sprinkler system maintenance and testing as required by NFPA 25. This deficient practice could affect of 124 facility residents in the event of a fire.<br><br>Findings Include:<br><br>1) On June 6, 2025 at 1:47 PM, observation revealed dirty sprinkler head in the Med "C" Nurse Storage Room.<br><br>2) June 6, 2025 at 1:50 PM, observation revealed dirty sprinkler heads in the Eagle Room.<br><br>3) On June 6, 2025 at 1:51 PM, observation revealed dirty sprinkler head in the Med "C" Dining Room.<br><br>4) On June 6, 2025 at 3:02 PM, observation revealed dirty sprinkler head in the Employee Lounge. | | The combustible stock on the Business/Activities Storage Cage and in the Kitchen Pantry was removed to be 18 from the ceiling and sprinkler heads.<br>The missing ceiling tile in the Janitor Room was replaced.<br>The escutcheon ring on the sprinkler in the Housekeeping Managers office was replaced.<br>The ceiling tile in the Housekeeping Managers Office was replaced.<br>The 3 recessed sprinkler heads in the corridor by the 1st floor elevator have been properly installed.<br><br>Element # 2<br>Current residents have the potential to be affected by the deficient practice. All sprinkler heads were evaluated to ensure cleanliness and proper installation. Any sprinklers found to be out of compliance will be corrected. All ceiling tiles were evaluated for compliance. Any ceiling tiles that were out of compliance are to be replaced.<br><br>Element # 3<br>The maintenance department was re-educated on sprinkler head cleanliness, proper installation of sprinkler heads and missing/broken ceiling tiles.<br><br>Element # 4<br>The Administrator and/or designee will conduct random audits of the sprinkler heads and ceiling tiles x1/week for 1 month, then weekly for 1 month and then monthly for 3 months to ensure substantial compliance. Results of the audits will be brought to the QAPI committee.<br>The Administrator is responsible for sustained compliance.<br><br>Date of Compliance: 7/8/2025 | |

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| | 5) On June 6, 2025 at 3:10 PM, observation revealed combustible stock stored within 18" of sprinkler head in Business/ Activities Office storage cage.<br><br>6) On June 6, 2025 at 3:44 PM, observation revealed missing ceiling tile in the Janitor Room (North Basement).<br><br>7) On June 6, 2025 at 3:53 PM, observation revealed dirty sprinkler head in Room 107.<br><br>8) On June 6, 2025 at 3:57 PM, observation revealed sprinkler missing an escutcheon ring in the Housekeeping Managers Office.<br><br>9) On June 6, 2025 at 4:00 PM, observation revealed ceiling tile with 5" x 8" annular space at the light fixture in the Housekeeping Managers Office.<br><br>10) On June 6, 2025 at 4:42 PM, observation revealed combustible stock items stored within 18" of the sprinkler head in kitchen pantry.<br><br>11) On June 6, 2025 at 4:53 PM, observation revealed (3) sprinkler heads in the corridor by the 1st floor elevator have recessed into the ceiling tile up to the deflector.<br><br>These findings were confirmed in interview with the facility Maintenance Director and the Corporate Operations Director at the time of observation. | | | |
| K0511<br><br>SS= F | Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric | K0511 | K 511<br>Element # 1<br>The (2) ceiling mounted light sockets in the Business/ activities Supply cage with broken light bulbs, were repaired. | 7/8/2025 |

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| | Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2<br>This REQUIREMENT is not met as evidenced by:<br><br>Based on observation and interview, the facility failed to ensure equipment using gas or gas-related piping complies with NFPA 54, and electrical wiring and equipment complies with NFPA 70. This deficient practice could affect all 124 facility residents in the event of a fire resulting from improperly maintained electrical equipment.<br><br>Findings Include:<br><br>1) On June 6, 2025 at 3:08 PM, observation revealed (2) ceiling mounted light sockets with the base of broken light bulbs still inside the sockets in the Business/ Activities Supply Cage.<br><br>2) On June 6, 2025 at 3:31 PM, observation revealed combustible stock items stored within 3' of electrical panel in the Laundry.<br><br>3) On June 6, 2025 at 3:42 PM, observation revealed Greenfield conduit displaced exposing inner wires at the plug to the relay in the back of a boiler in the North Boiler Room.<br><br>4) On June 6, 2025 at 3:54 PM, observation revealed combustibles stored within 3' of the electrical panel in the Sump Pump Room.<br><br>These findings were confirmed in interview with the facility Maintenance Director and the Corporate Operations Director at the time of | | The items stored in the Laundry Room within 3 of the electrical panel were removed.<br>The Greenfield Conduit in the North Boiler Room was repaired.<br>The combustible items within 3 of electrical panel in the sump pump room were removed.<br><br>Element # 2<br>Current residents have the potential to be affected by the deficient practice. The facilities electrical equipment was evaluated to ensure proper maintenance. Any deficiencies found were corrected.<br><br>Element # 3<br>The Maintenance Department was re-educated on properly maintained electrical equipment.<br><br>Element # 4<br>The Administrator and/or designee will conduct random audits of the emergency preparedness plan x1/week for 1 month, then weekly for 1 month and then monthly for 3 months to ensure substantial compliance with a geographically specific risk assessment. Results of the audits will be brought to the QAPI committee.<br>The Administrator is responsible for sustained compliance.<br><br>Date of Compliance: 7/8/2025 | |

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| | observation. | | | |
| K0923<br>SS= E | Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)<br>This REQUIREMENT is not met as | K0923 | K 923<br>Element # 1<br>A No Oxygen Allowed sign was placed on the Beauty Salon door.<br><br>Element # 2<br>Current residents have the potential to be affected by the deficient practice. A facility audit was conducted to ensure the proper storage of oxygen cylinders with proper signage related to oxygen are in place. Any found deficiencies were corrected.<br><br>Element # 3<br>The maintenance department was re-educated on proper storage of oxygen cylinders with proper signage in place.<br><br>Element # 4<br>The Administrator and/or designee will conduct random audits of oxygen storage and proper signage x1/week for 1 month, then weekly for 1 month and then monthly for 3 months to ensure substantial compliance with oxygen storage. Results of the audits will be brought to the QAPI committee.<br>The Administrator is responsible for sustained compliance.<br><br>Date of Compliance: 7/8/2025 | 7/8/2025 |

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| | evidenced by:<br><br>Based on observation and interview, the facility failed to ensure storage of nonflammable gasses meet all requirements of NFPA 99. This deficient practice could affect all 68 of 124 facility residents in the event of a fire intensified by the presence of an oxidizer.<br><br>Findings Include:<br><br>On June 6, 2025 at 4:53 PM, observation revealed the facility failed to display the required cautionary "NO OXYGEN ALLOWED" or similar signage prohibiting the use of oxygen in the hair salon.<br><br>These findings were confirmed in interview with the facility Maintenance Director and the Corporate Operations Director at the time of observation. | | | |