| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | **824519** | A. BUILDING _____ B. WING _____ | **7/31/2023** |

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| **OPTALIS HEALTH AND REHABILITATION OF CANTON** | **7025 LILLEY ROAD CANTON, MI 48187** |

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| F0000 SS= | INITIAL COMMENTS<br><br>Optalis Health and Rehabilitation of Canton was surveyed for an Abbreviated survey on 7/26/23.<br><br>Intakes: MI00138406<br><br>Census= 108 | F0000 | | |
| F0622 SS= D | Transfer and Discharge Requirements<br>§483.15(c) Transfer and discharge-<br>§483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, | F0622 | Element 1<br><br>Resident R# 401 no longer resides in the Center. R# 401 change in health status did not result from the identified practice. Appropriate individuals, providers and entities were notified immediately upon learning of failure to provide accurate resident identifying documents and medical records upon emergent transfer to the hospital. The center has identified that the profile record sent included a photo identification and that the information in the medical record sent had no impact on the care received at the hospital. Residents residing at the center had their medical records immediately audited to ensure each profile record included a photo identification. The Agency Nurse assigned to R#401 was reported to the agency company for appropriate counseling and training. Nurse will no longer return to center.<br><br>Element 2<br><br>All residents who currently reside in the Center have the potential to be impacted by the identified practice. The Center will continue to identify and audit all admitted residents to ensure their photo identification is attached to their profile record promptly. Residents with unplanned transfer to an acute care setting will be verified by at least 2 | 8/21/2023 |

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

Electronically Signed | 08/15/2023

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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| | pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need (s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c) (1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. | | nursing staff prior to transport as the Acute Care Transfer checklist is completed.<br><br>Element 3<br><br>All licensed nurses will receive education to evaluate their understanding of the Acute Care Transfer process. To improve our systems and processes related to compliance with Standards of practice related providing correct medical records, the Center will review during morning meeting the daily report on missing photos and will ensure completion of task during stand down meeting. The Center will also obtain all Acute Care Transfer checklist to ensure 2 nursing staff signatures are attached indicating that the resident's identity has been verified before transport to hospital.<br><br>Element 4<br><br>As part of the Quality Assurance process the Campus will conduct audits during morning meeting (1) to identify residents recently admitted has their photos attached to their profile record; and (2) to identify residents with unplanned transfer to the hospital has the correct medical records sent with them. The Administrator or designee will take immediate corrective action if photos are not uploaded in a timely manner. The DON or designee will take immediate corrective action if Acute Care Transfer checklist indicating proper identification was not completed. The audits will continue x 4 weeks and the findings will be submitted to the Quality Assurance Committee for review and recommendation for ongoing monitoring if indicated. | |

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| | (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.<br>This REQUIREMENT is not met as evidenced by:<br><br>This citation pertains to intake MI00138406.<br><br>Based on interview and record review, the facility failed to provide accurate resident identifying documents and medical records upon emergent transfer to the hospital for one resident (R401) of four residents reviewed for emergency transfer resulting in incorrect resident identification and medical information being sent with EMS (Emergency Medical Service) personnel to the hospital, incorrect family involvement with R401's hospitalization, and the potential for unmet care needs upon transfer.<br><br>Findings include:<br><br>On 7/16/23 at 9:19 PM R401 was transferred to the hospital by EMS, at which time an inaccurate face sheet (document that give a patient's information that includes contact details and brief medical history) and medical information was passed on to the EMS personnel. The facility became aware of the incorrect medical information being sent to the hospital on 7/17/23 at 7:15 PM when R401's Family Member "A" called the facility.<br><br>A review of the facility investigation report revealed R401 was transferred to the hospital by EMS on 7/16/23 at 9:19 PM for pain and shortness of breath. During the transfer, Licensed | | | |

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| | Practical Nurse (LPN) "B" gave EMS the wrong resident's face sheet. A review of the EMS run sheet (form that includes resident's demographics, vital signs, assessments, and medical information) revealed R404's name and date of birth. The face sheet and medication list of R404 was given to EMS.<br><br>A review of R401's Electronic Medical Record (EMR) revealed R401 was admitted to the facility 7/11/23 and discharged on 7/16/23. R401 had medical diagnoses of acute and chronic respiratory failure with hypercapnia (increased carbon dioxide in the blood). R401 was their own responsible party but had an emergency contact (Family Member "C"). A review of R401's EMR revealed she had 'full code' status (all resuscitation procedures will be provided).<br><br>A review of R404's EMR revealed R404 was admitted to the facility 9/7/21. R404 had medical diagnoses of Dementia, Hypothyroidism, and Parkinson's Disease. R404 had a Legal Guardian, who was their responsible party and first emergency contact. A review of R404's EMR revealed she had 'full code' status.<br><br>On 7/31/23 at 9:44 AM in an interview with LPN "B", she said on the evening of 7/16/23 at 9:30 PM Certified Nurse Assistant (CNA) "E" told her R401 was complaining of pain. She said when she went to check on R401 she noticed immediately R401 was having difficulty breathing. R401's Sp02 (oxygen saturation in the blood) and found out it was 45% (normal range is 90% or above). When rechecked the Sp02 went up to 73%. LPN "B" said Nurse Manager "D" told her to send R401 to the hospital right away. She said she called 911 and EMS said she need to collect the admission sheet (face sheet) and medication list for R401. When asked about giving the wrong paperwork to EMS she stated, "I | | | |

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pulled up the wrong paperwork. I gave EMS the wrong face sheet and medication list."

On 7/16/23 at 9:15 PM R401 was transferred to the hospital for emergency care. At the time of transfer when LPN "B" giving report and documents to EMS she gave R404's medical documents (medication list and face sheet) with R401. The documents sent with R401 would reveal to the hospital that she had a Legal Guardian, no known allergies, and a medication list that contained R404's medications. Whereas R401's face sheet and medication list would have provided the hospital with accurate information to inform them she was her own responsible party and prompted them to call her emergency contact (Family Member "C"), and made them aware of her allergies to certain antibiotics.

On 7/31/23 at 10:21 AM, Family Member "F" (R404's family member) was queried regarding the incident. Family Member "F" recalled he received a call on the night of 7/16/23 by the local hospital saying R404 was in the Intensive Care Unit (ICU). Family Member "F" said on 7/17/23 he came to the local hospital to check on R404, at which time he realized the patient in the hospital room was not R404. That evening he saw R401's family member and discovered that it was R401 who was in the hospital, not R404.

On 7/26/23 at 2:12 PM, during an interview with the Director of Nursing (DON) she was asked about the wrong information being sent with R40. The DON said there was no check list regarding the documents needed to be sent out during transfer to the hospital. The DON added there was no policy that outlined what to do or to ensure that accurate documents are being given to EMS during a transfer of a resident to the hospital.

On 7/26/23 at 3:07 PM, the DON was asked

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| | about the possible harm that could have occurred to R401 when inaccurate medical documents were sent to the hospital with R401, the DON said R401 could have had a possible allergic reaction to medication and had the wrong medical care (code status action in an emergency). The DON said R401 was transferred to the hospital on a Sunday and the facility did not become aware of the incorrect medical information being sent with R401 until the next day, Monday. | | | |