STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235249	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation at St. Francis	915 North River Road Saginaw, MI 48609

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 3027112.Based on interview and record review, the facility failed to ensure physician orders were followed for the timely testing and reporting results of residents' blood tests for three residents (#s 101, 106 and 107) of four residents reviewed for anticoagulant therapy (prevents blood from clotting) resulting in delays in evaluation and treatment for R101, R106 and R107 and the death of R101.Findings Include: A record review revealed Resident #101 who was receiving anticoagulant therapy did not receive the ordered timely testing and reporting of test results since admission into the facility. Additional record review indicated that Resident #101 was subsequently hospitalized and died due to a large brain bleed from decreased blood clotting. The Immediate Jeopardy (IJ) began on [DATE]. The Immediate Jeopardy (IJ) was identified on [DATE]. The Administrator was notified of the Immediate Jeopardy on [DATE] at 3:45 pm. A plan to remove the immediacy was requested. The Immediate Jeopardy was removed on [DATE], based on the facility's implementation of the removal plan. Resident #101: Review of the Face Sheet, Laboratory reports dated 2/26, Physician and Nurse Practitioner progress notes dated 2/26, and nurse's note's dated [DATE] through [DATE], revealed Resident #101 was 74 years-old, admitted to the facility on [DATE], was alert, her own person, full Code status, and required extensive assist with all Activities of Daily Living/ADL's. The resident's diagnosis included metabolic encephalopathy, Atrial Fibrillation (Afib), Factor 5 Leiden Deficiency (bleeding disorder, risk for pulmonary embolism and DVT-Deep Vein Thrombosis-blood clot), with a history of pulmonary embolism. The resident had a critical INR lab of 11.9 (normal: 2.0-3.0) reported by lab on [DATE], became unresponsive, was transferred to the hospital on [DATE], and deceased on [DATE] due to a large brain bleed related to a critical INR level (decreased blood clotting). Review of the facility Brief Interview for Mental Status/BIMS dated [DATE], revealed the resident was scored as a 14, intact cognitively. Hospital Discharge to facility Record: Review of the hospital Discharge summary dated [DATE] at 12:40 PM, revealed Resident #101 was admitted to the hospital on [DATE], with Factor 5 Laden Deficiency and on Coumadin 1 MG daily, a history of PE (Pulmonary Embolism), obesity, Acute metabolic encephalopathy, cellulitis of the right leg, UTI (Urinary Tract Infection) with hypokalemia and hypomagnesemia. The resident was given antibiotic vancomycin and ceftriaxone, wound care, hydration and discharged to the facility on (continued on next page)

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

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]. Hospital admission Paperwork: Review of the hospital Impression Plan dated [DATE], revealed Factor 5 Leiden Deficiency-Resident was on Coumadin, INR lab ordered, and a history of pulmonary embolism with IVC filter and on Coumadin. The residents ordered Coumadin 1 mg daily (had been on prior to hospitalization due to risk factors). Review of Hospital Lab dated [DATE] through [DATE] (prior to facility admission), revealed on [DATE], the residents' INR was 5.2 (abnormally high, normal range: 2.0-3.0), Coumadin was held and dosed according to INR labs. Upon discharge to the facility the residents INR level dated [DATE], was 2.4. Review of the facility electronic medical record dated [DATE] through [DATE], revealed Resident #101 was admitted from the hospital on [DATE] with a INR lab within the normal range (2.4). At the time of admission to the facility, the resident was receiving 1 mg oral daily of Coumadin. Drugs.com [DATE] Precautions: Blood tests, such as INR, are needed to check for proper dosage and unwanted side effects. Facility admission Orders and Assessment: Review of facility physician admission orders dated [DATE], stated Warfarin (Coumadin) Oral Tablet 1 MG, Give 1 tablet by mouth one time a day for Factor 5 Laden deficiency, Afib. Review of facility physician admission orders dated [DATE], revealed no order for PT/INR labs to be placed. Review of the facility Standing Orders/S.O. found at the nursing station in the nursing information book on [DATE], stated Warfarin (Coumadin, Jantoven) PT/INR on admit-yes (lab to be drawn upon admission to facility), Routine-Q (every) week until stable then q month. Per facility SO, the resident was to receive PT/INR blood draw upon admission due to being on Coumadin when admitted . Review of the facility admission Nursing Assessment and nursing progress notes dated [DATE], revealed no documentation of the resident being on an anticoagulant, nor an INR lab to be drawn. Review of the admission MDS (assessment tool) and residents admission care plans dated [DATE] through [DATE], revealed there was no care plan developed for anticoagulant therapy, Factor 5 Leiden Deficiency, history of pulmonary embolism, nor monitoring for side effects of Coumadin (bleeding, excessive bruising, may cause skin necrosis, assess for purple or dark color of toes, calcium uremic (with or without kidney disease), increased temperature and a color change to any part of body). Facility Progress Notes and Delayed INR lab draw: Review of facility physician orders dated [DATE] stated PT (Prothrombin Time)/INR , one time only related to Paroxysmal atrial fibrillation; an order for a PT/INR lab to be drawn dated [DATE], and per facility Standing Orders (if on Coumadin, admission INR draw), from admission ([DATE]) to the INR (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	lab draw done on [DATE], was a delay of 11 days. From physician order ([DATE]) for a INR lab to be drawn on [DATE], to the lab actually being drawn at the facility on [DATE], was a delay of 8 days. Review of the residents' facility electronic medication administration record (EMAR) dated 2/26, revealed the resident had received Coumadin 1 MG does a total of 8 times (8 doses=8 mg) while at facility with the last dose given on [DATE] (oral Coumadin 1 mg given at facility on [DATE], [DATE], [DATE], [DATE], [DATE], [DATE], [DATE] and on [DATE]). Reviewed facility nursing progress notes dated [DATE] through [DATE], no documentation was found regarding assessment for side effects of Coumadin (bleeding, excessive bruising, may cause skin necrosis, assessment for purple or dark color of toes, increased temperature and a color change to any part of body). Review of Physician and Nurse Practitioner/NP, I progress notes dated [DATE] through [DATE], revealed no documentation of INR lab draw needed or follow-up with the [DATE] INR lab order. Review of the resident's facility PT/INR lab result dated [DATE], revealed lab was ordered by physician on [DATE] and was drawn on [DATE], resulting in a PT of 90.1 (normal: 12.5-13.7), and INR of 11.9 (HH/critically high, normal: 2.0-3.0). The residents had a critically high level for PT/INR (increased blood clotting time) which lead to a brain bleed and death. Review of facility nursing progress notes and physician orders dated [DATE], revealed lab had called the facility with a critically high INR (11.9) on [DATE]; the nurse called Physician K and orders were given for a one-time dose of vitamin K to be given. Review of the EMAR (electronic medication administration record) dated 2/26, revealed documentation the one-time dose of vitamin K was given on [DATE]. Review of physician order dated [DATE] stated, Vitamin K Oral Give 5 mg by mouth-phone (phone order) one time only. During a phone interview done on [DATE] at 11:38 a.m., Lab staff F said the PT/INR lab was not in the facility lab book (facility lab binder kept at nursing station) for the lab technician to get to draw the lab on [DATE]. Lab staff F said it was drawn on [DATE], and called as a critical lab to the facility on [DATE] (a 2-day time frame, not put in as a Stat lab-immediately to be drawn by facility). Review of the facility Licensed Nurse LPN H Medication Management Skills Checklist dated [DATE] (after the INR lab draw on [DATE]), revealed on [DATE], nurse Hwas checked off for PT/INR completed as ordered; called to physician; validated prior to administration of medication; recorded on eMAR (EMAR) and/or tracking log (in lab book at nursing station)-Warfarin (Coumadin) administered as ordered; resident monitored for S/S (signs/Symptoms) of bleeding-Dosage change orders documented correctly. Review of the facility Medication Administration policy dated [DATE], stated Medications are administered in accordance with the following rights of medication administration: Right resident, Right medication, Right dose, Right route, Right time and frequency, Right documentation, Right of resident to refuse, Right clinical indication. Transfer to Hospital: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of facility nurse's progress note's dated [DATE], stated Resident non-responsive to verbal and pain stimuli with shallow breathing, writer alert emergency MMR (Medical Mobil Resecure) patient transferred to hospital at around 7:00 a.m., physician, DON notified of status. No documentation of facility informing Family was found. During a phone interview done on [DATE] at 4:42 pm, Family Member #1 stated The ER call me (on [DATE]) and said to get here asap, because they did not know if (Resident #101) would live. Review of the hospital ED INR lab dated [DATE], had the INR lab result as 10.7 (critical lab). Review of hospital Emergency Department/ED records dated [DATE], revealed the resident was unresponsive upon arrival to ED, and stated her eyes: deviated upward, pupils nonreactive, General: Unresponsive. Review of the hospital CT done on [DATE] at 0759 (7:59 am), stated Large left intraparenchymal hemorrhage (Lg. brain bleed) and significant midline shift towards the right. Altered mental status. There is a large left intraparenchymal hemorrhage measuring at least 7.6 x 7.3 cm with extension into the lateral ventricles bilaterally. There is marked midline shift towards the right of at least 2.6 cm. The resident was admitted to the critical care unit on [DATE]. Review of the hospital ED note addendum dated [DATE], listed main diagnosis as Left intraparenchymal hemorrhage with shift and supratherapeutic INR (critical INR lab value)-Comfort measures only. Cause of Death: Review of Certificate of Death dated [DATE], revealed Resident #101 expired on [DATE] at 4:48 pm, at the hospital. The cause listed for death was Nontraumatic Intracerebral Hemorrhage within 24 hours, (and) Warfarin (Coumadin)-related Coagulopathy (condition where blood's ability to clot is impaired, leading to prolonged or excessive bleeding) within 1 to 2 weeks (time resided in the facility). Review of the facility Abuse policy dated [DATE], stated Neglect: Failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of the facility Laboratory Services Agreement dated [DATE], stated Client Facility shall provide Lab with a copy of all physician orders related to requested treatment (in facility lab binder) and each such patient's consent for treatment prior to Lab's provision of any clinical care related Services. Review of the facility Laboratory Results policy dated [DATE], stated The facility will assist the resident in making transportation arrangements to and from the laboratory if necessary. STAT lab results are received according to timeframes established in the contract. The laboratory will notify the facility of critical or panic laboratory results. Statements: Nurse Manager/MDS Coordinator G: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview conducted on [DATE] at 11:00 am, Prior Nurse Manager/MDS Coordinator G stated: (Prior MDS Nurse) did the care plans (upon admission for Resident #101). I cannot find a care plan for anticoagulant, Factor 5 blood clotting disorder, PT/INR. You need for her coumadin, INR and Factor 5 blood disorder. I agree that her (resident #101) not having those care plans is a problem. Orders for PT/INR, they typically draw the same day and will get the results in the afternoon. They should have followed up on [DATE] (the INR lab results). Nothing was charted about the lab; I could not find anything. Looks like the lab (PT/INR) was ordered on [DATE], and no result until [DATE]. No one from facility followed up with the lab. I don't remember hearing about this; I believe this was a mess-up a follow-up by the Doctor, Nurse Practitioner and Manager. There is a nursing note on [DATE] for a chest x-ray and labs and hold coumadin to INR 11.9 and PT 90.1 (hold coumadin medication until next lab draw with results) and give vitamin K one time dose. I was the manager, we are to come in and go through morning report, it was not on that, and I went through her chart on [DATE] and saw it wasn't addressed. I then told (Nurse H) she needed to call the doctor. We (Manager G and DON) did go into the hospital records (ED records and hospital discharge records) and saw it (the resident had decreased). The DON and I looked at her labs and looked to see what happened to her. The DON did nothing that I am aware of; no one did and Inservice on PT/INR that I am aware of. During an interview done on [DATE] at 11:16 am, Nurse Manager/MDS Coordinator G stated You get an order from the doctor, place order in PCC, print Face Sheet and order and place in lab binder (for lab tech to get when they come in facility to draw). You put it under the date to be drawn. The lab only comes here twice a week, there are no stat labs, we don't have stat labs. We have been having trouble with our lab; we never know when they are coming. We can't get a phlebotomist and (hospital) won't do labs anymore (lab draws) because of reimbursement issues. We don't have copies of the orders in the book (lab binder). I came in on [DATE] and wanted to know if they drew it then. The lab called us on [DATE] and reported a critical lab, During an interview done on [DATE] at 12:13 pm, Nurse Manager G stated I put the lab slip under [DATE] to be drawn on [DATE]. Unless I have another lab order placed, I don't check the book (lab binder). Labs are done on Tuesdays and Thursdays, we don't have a policy for this. Director of Nursing/DON: During an interview conducted on [DATE] at 12:45 am, the DON stated It usually takes 24 hours to get the results (lab results), it would be on [DATE] (get the residents INR lab results). The lab should call the critical lab to the nurse on the floor, it should be put in the notes or the assessment. When they (lab tech) come to draw, they pull out the orders for the day and draw them (from the facility lab book). It should of been done, I don't know why it wasn't, I don't remember. The nurses are educated upon hire and it's on their yearly competency. I did look up (Hospital) site and found out she (Resident #101) died, the family called and let us know, I did not look back and find the lab concerns (at the facility), I should have. The nurses are to review after visit/discharge summary (from the hospital upon admission), the med's, the order's, the admitting nurse. No education or discipline was done for this. My thought is the lab was not drawn on [DATE] or [DATE], it was not reported until [DATE]. We should follow up on (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	our morning meetings on the board. I didn't follow-up on this because of the annual (DON said the State of Michigan/SOM was in for 3 days during this time doing an annual survey and that's why she did not follow-up). Review of the SOM 2/26 calendar revealed the team was in the facility doing an annual survey a week prior to this event. During an interview done on [DATE] at 11:36 am, the DON stated yes, it should have been followed up on, it was collected on [DATE], and on [DATE] at 3:38 am, the lab called us with the INR of 11.9. During an interview done on [DATE] at 8:45 am, the DON stated We don't have a PT/INR policy. Our driver was busy he could not take residents and that (hospital) and (local lab) would not take their resident's. Transport Driver N: During an interview done on [DATE] at 11:35 am, Transport Driver N stated I do (local lab) and (hospital). I have a part time driver too; I have never refused to take anyone (including for lab draws). If they had asked me, I would have. During an interview done on [DATE] at 8:55 am, the DON stated They (nursing staff) are not going to check it (lab binder) every day because labs are drawn on Tuesdays and Thursdays only. We don't have a procedure for this. When asked if staff nurses are able to draw blood themselves, the DON stated, The nurses have been trained, but some are not comfortable doing it. The DON said the facility does have their own INR machine (small handheld machine that gives PT/INR clotting times), however the strips were recalled some time ago and no one has ordered any more. Review of the facility calendar done on [DATE], with the DON for 2/26, revealed lab was in the facility for blood draws on [DATE] and on [DATE]. Facility Laboratory Services: During a phone interview done on [DATE] at 11:38 am, lab staff F stated The only sample (blood draw from the facility) was on [DATE], this was the first time it was in the lab book. At our SNF's (Skilled Nursing Facilities) there is a binder with the ordered slips in it. The tech (no longer for the lab) takes the orders out and draws (draws blood per each resident's orders). If it was ordered on [DATE], they might not have put it in the binder. On the 10th our tech found it and drew it. We called the facility with the results on [DATE], we must send it out to be processed. The INR was 11.9, the normal is 2.0 to 3.0 and the PT was 90.1, the normal is 12.5 to 14.7. Nurse, LPN M: During a phone interview done on [DATE] at 12:40 pm, nurse, LPN M stated I have never read a policy to check the lab book daily or on Tuesdays and Thursdays. Definitions: INR: International Normalized Ratio lab. PT: Prothrombin Time lab. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Factor 5 Laden Deficiency: A change of one of the clotting factors in the blood. A clotting factor is a protein that helps blood to clot. This change in clotting can raise the risk of getting harmful blood clots, mostly in the lungs (Pulmonary Embolism) or legs. This condition can lead to hemorrhage (excessive bleed) and can be fatal. Intraparenchymal Hemorrhage: A serious brain issue; it happens when blood bleeds into the brain tissue. It can lead to severe disability or death. The Immediate Jeopardy that began on [DATE] was removed on [DATE] when the facility took the following actions to remove the immediacy: -On [DATE], an audit for all active lab services was reviewed to ensure labs testing was scheduled to be completed. Resulted labs were received and reviewed with the physician. -Standing Orders dated 2016, have been removed from Nursing Binders at every nursing station. -When a physician orders Coumadin therapy, nursing staff will immediately clarify INR monitoring frequency and parameters with the physician. -The Director of Nursing (DON) or designee will: *Monitor all lab requisitions daily. *Ensure labs are completed as ordered. *Ensure results are reviewed with the physician upon receipt. -The facility has created a lab tracking log that will assist with identifying when labs are to be drawn. The nursing administration team will audit these logs daily to ensure completion, monitoring for results and ensure MD notification has been completed. -The DON or designee will review all new admission orders and lab orders during the daily morning clinical meeting. -Nursing (RN & LPN) were reeducated on [DATE] * Lab Services policy with emphasis on ensuring labs were being completed by physician orders and resulted in timely and reviewed with the Medical Director/MD. *The emphasis on monitoring lab values while residents receiving coumadin therapy. -Any staff not present on [DATE], will receive this education prior to their next scheduled shift. Resident 106 (R106): A review of Resident 106's medical record revealed an admission into the facility on [DATE] and readmission on [DATE] with diagnoses that included venous insufficiency, anemia, and ulcerative colitis. A review of the Minimum Data Set assessment revealed a Brief Interview of Mental Status score of 15/15 that indicated intact cognition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of R106's lab results in the medical record revealed a collection date on [DATE] and reported [DATE] at 00:25 (12:25 AM). The laboratory order was put in on [DATE]. The results included a low Hemoglobin of 7.82 g/dL (with normal levels of 12.00 -16.75) with other abnormal laboratory results. A review of the progress notes revealed no documentation that the physician had been contacted regarding the results of the abnormal labs. On [DATE] at 1:22 PM, an interview was conducted with Nurse P who was assigned to Resident 106. The Nurse was asked if she was aware of the Resident's abnormal laboratory results and the Nurse indicated she was not aware and that no information of labs pending or resulting were passed on in morning report. The Nurse indicated that results or pending labs should be passed on in report. The Nurse was asked where she could find the results but was unsure being that she was still orientating at the facility. At 1:24 PM, the Director of Nursing (DON) was at the nurses' station and reported that she had reviewed the results in the morning and that the Doctor was in and went through the labs with no orders received. The DON reported the Hgb (hemoglobin) was low but everything else was ok for her. When asked if the Doctor will chart, the DON indicated he will put a note in later. On [DATE] at 1:31 PM, an interview was conducted with the DON. The DON was asked how the Nurse was aware of lab results and reported the results show up on the dashboard and the lab tab on the EMR (electronic medical record). When asked when the physician gets notified of abnormal results, the DON reported that the lab would call with any critical and then we notify the doctor. When asked when the Doctor was notified of abnormal lab results, the DON reported they review them in the morning in the clinical meetings. During the interview with the DON at 1:46 PM, Doctor O returned a request for a call back and was interviewed regarding Resident 106's abnormal laboratory results. When asked about the labs, the Physician reported he was not aware of any abnormal results and that the facility had not notified him of the labs and was unaware they were reported to the facility. The DON talked with the Physician on the phone, reported the results and obtained further orders from the Physician for follow-up assessment, further lab testing and consultation to a GI specialist. When asked when he expected to receive abnormal results, the physician reported they should call immediately with critical labs and call with abnormal as well and indicated they should have let him know when he was there in the morning and that he would want to know the abnormal labs as soon as possible, they could have put them in the physicians book or call and leave a message. The physician reported that if the Hgb was under 8 and hypotensive or symptomatic, then it needs to be addressed immediately. It was reviewed with the DON of the concern that the Nurse was unaware that labs were pending/completed and the Physician was not made aware of the abnormal results when at the facility in the morning, the DON indicated earlier that the physician was aware of the results but after the phone interview, he was not aware. The DON reported that she had assumed he reviewed them in the morning, had texted him to review the labs at approximately 12:20 PM and that he had access to the chart. When asked what the facility policy was and the nurses' responsibility for conveying abnormal results to the physician, the DON stated, If they get the lab results, they need to put it in the Dr. book to be reviewed, call the Dr. with high or low abnormals. Resident 107 (R107): A review of Resident 107's medical record revealed an admission into the facility on [DATE] and readmission on [DATE] with diagnoses that included diabetes, resistance to multiple antimicrobial drugs, urinary tract infection, gastro-esophageal reflux disease, intestinal obstruction, and pseudomonas. A review of the Resident's MDS revealed a BIMS score of 13/15 that indicated intact (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	cognition and the Resident was dependent on a helper for toileting hygiene, bathing, dressing and transfer into a chair. A review of R107's laboratory orders revealed an order dated [DATE] for a Basic Metabolic Panel (BMP) and a CBC (complete blood count). A review of the Progress Note dated [DATE] at 5:58 PM, revealed, Call placed to (doctors name), the resident has tea-colored urine. Current vitals: Bp 68/56 HR 89 O2 sats 95% 2L(liters) NC (nasal canula), denies pain or discomfort at this time. (Doctors name) responded with recheck vitals and the 98/63 manual. Check UA (urinalysis), CBC, and BMP. Review of the orders revealed the CBC and BMP were ordered but the UA had not been ordered. A review of the medical record revealed no labs results or urinalysis completed. A review of R107's progress notes revealed an eInteract SBAR Summary for Providers, dated [DATE] at 8:56 AM, Situation: The change in condition/s reported on this CIC Evaluation are/were: Altered mental status tired, Weak, Confused, or Drowsy. BP(blood pressure) 75/40, P (pulse)101. Pulse Oximetry: O2 80% .Positive findings reported on the resident/patient evaluation for this change in condition were: Mental Status Evaluation: Altered level of consciousness, increased confusion; -Functional Status Evaluation: Needs more assistance with ADLs General weakness, Swallowing difficulty. -Respiratory Status Evaluation: Labored or rapid breathing Abnormal lung sounds (rales, rhonchi, wheezing) Other respiratory changes; -Cardiovascular Status Evaluation: Resident pulse greater than 100 or less than 50 .-Neurological Status Evaluation: Altered level of consciousness. Primary Care Provider Feedback:. A. Recommendations: send to ER (emergency room) for eval and treat. Resident 107 readmitted into the facility on [DATE] from the hospital. A review of R107's medical record of the hospital Discharge Summary revealed, .Acute hospital diagnosis: Orthostatic hypotension, Sepsis POA (present on arrival), Complicated catheter associated UTI (MRSA, E faecalis, Pseudomonas), Acute and chronic hypoxic respiratory failure, possible aspiration pneumonia, Acute metabolic encephalopathy, Acute on chronic blood loss anemia, acute GI bleed, AKI (acute kidney injury) resolved, likely metastatic prostate cancer, acute thrombocytopenia, resolved. the discharge summary included, Issues to be addressed at follow-up with PCP/Consultant: Things to be followed up with PCP: CBC and BMP in 3-4 days. Further review of the discharge summary revealed, Hospital course: .brought to ED (emergency department) on 04/23 2026 due to hypotension with blood pressure reading of 60/80 and hypoxia with oxygen saturation in 80s on home 2L O2. Patient reported shortness of breath, cough, abdominal discomfort and multiple episodes of emesis. Recent Labs: HGB 8.5 (low) on [DATE], K+ 3.2 (low). On [DATE] at 1:50 PM, an interview was conducted with the DON regarding Resident 107's lack of labs completed after ordered on [DATE]. A review of the medical record with the DON revealed an order for the BMP and CBC on [DATE], no results in the medical record with the DON stating, I'm not seeing it (lab results). When asked if they were put in to be drawn, the DON reported there was a requisition done for the lab work to be drawn but the DON confirmed there was no lab results and indicated they must not have drawn it. A review of the progress note revealed a UA was also to be completed but the DON was unable to find an order for the UA. The DON was asked about the progression of the Resident's illness and the DON reviewed the medical record and reported that on 4/22 there was a change in condition of hypotension (low blood pressure), medication Midodrine was started and then on 4/23 another change in condition was completed and the Resident was sent to ER with change in mental status. It was reviewed with the DON of the Resident presenting with signs and (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235249	A. Building B. Wing	06/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation at St. Francis	915 North River Road Saginaw, MI 48609

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	symptoms to warrant the Physician to order labs on [DATE] for BMP, CBC and UA, the labs were not completed and the Resident transferred to the emergency room and hospitalized with diagnoses that included sepsis, UTI, possible aspiration pneumonia, anemia, GI bleed and acute metabolic encephalopathy and the potential for a different outcome had the labs been completed when ordered. The discharge recommendations from the hospital discharge summary of Things to be followed up with PCP: CBC and BMP in 3-4 days. was reviewed with the DON. The DON reported that the next day the resident would be back for two weeks and indicated the labs had not been done or ordered. When asked why this had not been ordered. The DON replied, that is there jargon they put on everyone that comes back. When queried, the DON reported there was no risk versus benefit documented to not follow the discharge recommendations. On [DATE] at 1:13 PM, an observation was made of Resident 107 lying in bed with the head of the bed elevated and the Resident was watching TV. The Resident was interviewed, answered questions and engaged in conversation. The Resident was asked about his recent hospital stay. The Resident indicated he had been sick and went to the hospital with his blood pressure low, not breathing good and had vomited multiple times, had a fever, was hot, and had pain in his stomach. The Resident reported he was really sick and stayed there a while at the hospital and then came back here.