STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235580	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Ann Arbor	4701 E. Huron River Dr Ann Arbor, MI 48105

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 - Minimal harm or potential for actual harm 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** 49103 Pertaining to Intake MI00145739: Based on interview and record review the facility failed to administer medications as ordered for one (R2) of three reviewed, resulting in R2's strong dissatisfaction with care, final refusal of continued stay, and resident leaving the facility to obtain medical care. Findings include: On 8/2/24 record review of the electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE] with pertinent diagnoses of Infection following a Procedure, Presence of Aortocoronary Bypass Graft, and Presence of Prosthetic Heart Valve. According to an MDS dated [DATE] R2 had a Brief Interview for Mental Status (BIMS) of 15/15 indicating intact cognition. On 8/2/24 at 11:20 AM a telephone interview with R2 was held. R2 explained I had C Difficile. (Clostridioides Difficile is a bacterium which causes diarrhea and colon damage). R2 explained the medicine for C Difficile was supposed to be given every 6 hours and that throughout the stay at least 3 doses were missed. R2 expressed dissatisfaction with care because throughout his stay at the facility medications were frequently delayed and R2 considered care substandard. R2 reported he left the facility and went back to the hospital for treatment. Review of the Medication Administration Record (MAR) revealed R2 was ordered to receive Vancomycin (antibiotic) 125 milligrams by mouth every 6 hours for C-Diff for 14 days beginning on 6/25/24. The MAR revealed R2 missed doses on 7/4/24 at 12:00 AM, 6:00 AM, and 12:00 PM. Review of the progress note entered by Licensed Practical Nurse (LPN) C on 7/3/24 at 11:23 PM revealed Vancomycin was not administered because it was out of stock and an order was put in with pharmacy. Record review of the EMR further revealed a note entered by Licensed Practical Nurse (LPN) C 7/4/24 at 2:14 AM stating the following: patient expressed he was angry because he had to miss a dose of vancomycin due to it being out and not reordered. I did call the pharmacy to get the prescription refilled and explained the situation to the patient. Review of the progress note entered by Licensed Practical Nurse (LPN) C on 7/4/24 at 5:23 AM revealed Vancomycin was not administered because it was on order from the pharmacy. (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 - Minimal harm or potential for actual harm Residents Affected - Few	Record review of the EMR further revealed a note entered by Licensed Practical Nurse (LPN) D 7/4/24 at 1:42 PM which documented the following: resident's assigned nurse requested writer to speak to resident. resident is upset and would like to leave AMA. Record review of the EMR further revealed a note entered by LPN E at 1:43 PM which documented the following: Vancomycin HCl Oral Capsule 125 MG Give 1 capsule by mouth every 6 hours for c-diff for 14 Days. Patient refused medication. Record review of the EMR further revealed a note entered by LPN E at 1:47 PM which documented that resident had expressed upset. over missed medication the previous night and then early morning. LPN E attempted to talk with R2 about the situation and R2 responded by becoming . increasingly upset. R2 called a family member to pick him up. According to the note R2 refused to sign AMA paperwork. On 8/7/24 at 9:23 AM a telephone interview was held with LPN C who recalled the events documented 7/3/24 and 7/4/24. LPN C recalled that R2 got . really upset. because LPN C had found in the medication cart an empty box when the Vancomycin was due. When LPN C was asked about back up medication she explained it was later known to her back up medication (Vancomycin) had been available in the building. On 8/7/24 at approximately 11:45 AM during interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) the dissatisfaction of R2 was discussed and the particular concern that caused him to leave the facility on 7/4/24. The DON talked about the holiday weekend this occurred and explained the PYXIS (an automated medication dispensing system) had been the backup system for medication and DON stated, There was no available backup in the building, they had used it all referring to the Vancomycin. On 8/7/24 the pharmacy was contacted, and the representative said a copy of the medication record of type and amount of (Vancomycin) which was in the PYXIS on 7/4/24 was in the process of being emailed to administration. Review of the Transactions by Item/Procedure report from the pharmacy revealed the facility had eight capsules of Vancomycin 125 milligrams in stock at the time R2 was due to receive the medication on 7/4/24. On 8/7/24 at 1:46 PM a subsequent interview with the DON revealed there had been backup medication (Vancomycin) available in the PYXIS on 7/3/24 and 7/4/24 which could have been used and that fact had not been known until the pharmacy data sheet had been requested during survey and emailed during survey. The DON talked about having had a conversation with LPN C who confirmed the fact that there had been a lack of understanding concerning the PYXIS.