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	03/19/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act in one (R102) of four residents reviewed for abuse. Review of the medical record reflected R102 was admitted to the facility on [DATE], with diagnoses that included anxiety disorder, vascular dementia, and dementia with behavior disturbances. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/20/25, reflected R102 scored 11 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of a Nursing-Progress Note dated 3/8/25 at 4:26 PM revealed Resident [R102] verbally abusing resident. Resident stated he would smack another resident. The note author was identified as Licensed Practical Nurse (LPN) T. In an interview on 3/19/25 at 1:14 PM, LPN T stated that she was familiar with R102. LPN T stated that she did write the Progress Note on 3/8/25, however, could not recall details of the verbal abuse allegation and that R102 gets into arguments with other residents often. LPN T did not report the allegation. In an interview on 3/19/25 at 1:50 PM, Nursing Home Administrator (NHA) A reported that she was unaware of the Progress Note on 3/8/25 and that the expectation would be to maintain safety of both residents and report any abuse allegations immediately.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to, investigate allegations of abuse for one out of four residents (Residents #102). Findings Include: Review of the medical record reflected R102 was admitted to the facility on [DATE], with diagnoses that included anxiety disorder, vascular dementia, and dementia with behavior disturbances. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/20/25, reflected R102 scored 11 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of a Nursing-Progress Note dated 3/8/25 at 4:26 PM revealed Resident [R102] verbally abusing resident. Resident stated he would smack another resident. The note author was identified as Licensed Practical Nurse (LPN) T. In an interview on 3/19/25 at 1:14 PM, LPN T stated that she was familiar with R102. LPN T stated that she did write the Progress Note on 3/8/25, however, could not recall details of the verbal abuse allegation and that R102 gets into arguments with other residents often. LPN T did not report the allegation. In an interview on 3/19/25 at 1:50 PM, Nursing Home Administrator (NHA) A reported that she was unaware of the Progress Note on 3/8/25 and that the expectation would be to maintain safety of both residents and report any abuse allegations immediately.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans for two (Resident #102 and #103) of three reviewed. Review of the medical record reflected R102 was admitted to the facility on [DATE], with diagnoses that included anxiety disorder, vascular dementia, and dementia with behavior disturbances. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 1/20/25, reflected R102 scored 11 out of 15 (cognitively impaired) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R102's Care Plan revealed R102 ambulated independently with the use of a walker. Review of the medical record reflected R103 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included aphasia. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/9/25, reflected R103 was rarely understood. On 3/17/25 at 10:47 AM, R102 was observed in his room sleeping. In an interview on 3/19/25 at 10:09 AM, Certified Nursing Assistant (CNA) O stated that one evening, she overheard R103 make a noise and overheard another male resident state, no hey, get out of here! CNA O approached the residents and observed R102 in the room R103. CNA O removed R102 from the room. CNA O stated that R102 is a wanderer, especially in the evening hours and she often hears other residents complaining about R102 going into their rooms. CNA O stated that the staff do their bets to manage R102 and is behaviors, however, lack of staff make it difficult to keep up with R102 going in and out of rooms. On 3/19/25 at 10:48 AM, Resident #106 (R106) was observed seated outside of his room. R106 resided across the hall from R102. R106 states that he sits out in the hallway often and reported that he observed the incident when R102 entered a female residents room. R106 stated [R102] goes in and out of rooms all the time, it drives me dam* nuts! In an interview on 3/20/25 at 8:51 AM, LPN Y reported that R102 is confused and can be aggressive at times. LPN Y stated that R102 tends to wander more during the evening hours and has observed R102 wandering into other residents rooms. Review of a Behavior Note dated 10/18/24 at 1:29 AM revealed R102 redirected two times out of other patient's (resident's) rooms . confusion appears to increase with the lateness of the hour . Review of a Nursing-Progress Note dated 11/7/24 at 6:34 PM revealed R102 wanders in and out of other residents rooms and bathrooms . Review of a Behavior Note dated 11/7/24 at 2:51 AM revealed R102 up many times during the night wandering in hallway. Redirected out of patient's rooms . Review of a Behavior Note dated 2/17/25 at 5:06 PM revealed R102 observed self-ambulating throughout unit with walker .wandering in other patients' rooms often . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Behavior Note dated 2/18/25 at 3:57 PM revealed R102 observed attempting to enter other patient rooms . Review of R102's Care Plan revealed an absence of a Care Plan to address an effort to minimize or restrict 102 from wandering into other resident's room. Review of R103's Care Plan revealed an absence of interventions to ensure R102 does not wander back into her room again. In an interview on 3/20/25 at 12:38 PM, Director of Nursing (DON) B confirmed an absence of a Care Plan for the wandering into other rooms behavior.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide showers per care plan for two (Resident #104, #105) of three reviewed for activities of daily living. Findings include: Resident #104 (R104) Review of the medical record reflected R104 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included muscle weakness and dislocation of internal left hip prothesis. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/28/25, reflected R104 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 3/17/25, at 11:26 a.m., R104 was observed in bed watching television. R104 was wearing a hospital gown and appeared ungroomed. R104 stated that she was unimpressed with the care she was receiving at the facility. She expressed concerns about not receiving showers consistently and call lights not being answered in a timely manner, sometimes waiting over an hour for assistance. R104 reported that she often resorts to using her telephone to contact the front desk to alert staff that her call light is on and she required assistance. According to R104, certified nursing assistants frequently tell her that they are understaffed and have many other residents to care for. She also stated that, particularly in the afternoon and at night, staff will intentionally leave her call light activated, preventing her from reactivating it when she needs assistance. To work around this, she contacts the front desk to request help. R104 expressed frustration regarding her scheduled shower day on Saturday. When she requested a shower, staff informed her that they did not have time, and she was instead given the option of a bed bath. She was dissatisfied with this alternative, as she wanted an actual shower and to have her hair washed. R104 stated that she requested a shower again on Sunday, which was designated as a shower make-up day, but was once more told that staff did not have time to assist her. As a result, she had not received a shower. R104 stated that if she declines a bed bath over a shower, the staff will report that R104 refused a shower. R104 stated that she does not refuse a shower, but does not accept being provided a bed bath instead of a shower for time saving purposes. R104 emphasized that this was not the first time she had experienced these issues. Review of R104's medical record revealed that the scheduled shower days were Wednesdays and Saturdays. Review of R104's Care Plan revealed R104 was a transfer assist of two staff members. Review of the Activities for Daily Living Care Plan reflected, assist to bathe/shower as needed, implemented on 8/15/24. Review of the shower task list for R104 revealed the following: 2/19/25: Marked as not applicable. 2/22/25: Marked as refused. 2/26/25: Marked as not applicable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/1/25: Marked as bed bath. 3/5/25: Marked as not applicable. 3/8/25: Marked for receiving a shower 3/12/25: Marked for receiving a shower 3/15/25: Marked as refused. During the week of 3/17/25, A confidential staff member (SM D) confirmed that they are a direct care staff member and stated that staffing at the facility is inadequate. SM D reported that most residents in the [NAME] and Meadows units are fully dependent on staff for care and that the facility does not take acuity into consideration when assigning staff to the units. SM D also stated that she is unable to complete her tasks as outlined in the [NAME] and Care Plan. During the week of 3/17/25, a confidential staff member (SM E) reported that they are a direct care staff member and expressed concerns about staffing levels. SM E stated that one of the Certified Nursing Assistants (CNAs) has to wrap to the adjacent unit, and due to the double doors, it is impossible to be notified of call lights from the other unit. SM E further reported that teamwork is an issue, often resulting in call lights remaining activated for extended periods without notification to the assigned CNA or nurse, especially the residents in the wrapped rooms. Additionally, SM E noted that the [NAME] and Meadows units have residents with higher acuity and behavioral needs. According to SM E, essential care tasks such as oral care, checking for brief changes, and providing showers are not being completed due to insufficient staffing. As a result, SM E has offered bed baths in place of showers. In an interview on 3/19/25 at 8:45 AM, CNA G, who primarily works second shift, stated that there is room for improvement regarding staffing levels. CNA G reported that she regularly works in the [NAME] and Meadows units and, due to the lack of staffing, there is no guarantee for the safety and care of the residents. CNA G expressed the same concern about wrapping to the adjacent unit, noting that there is no way to be notified if a call light is activated in the other unit. When asked whether she is able to complete her assigned duties, CNA G stated that it is unrealistic to complete all required care as outlined in the [NAME] and Care Plan. She further explained that the [NAME] and Meadows units house residents with higher acuity and behavioral concerns, such as wandering. Additionally, she reported that a large percentage of residents require a mechanical Hoyer lift, and finding a second staff member to assist is often very difficult. In an interview on 3/18/25 at 1:41 PM, CNA H reported that she commonly works day and afternoon shifts in the [NAME] and Meadows units. She described staffing levels as terrible and stated that she frequently observes residents who are saturated or soiled in their beds, requiring complete bed linen changes. CNA H also raised concerns about wrapping to the adjacent unit, noting that there is no way to know if a call light is activated there. She stated that call lights often remain activated for a long time. Additionally, CNA H reported that she is unable to complete all required care as outlined in the [NAME] and, to save time, she offers bed baths instead of showers. She also stated that due to staffing shortages, she is unable to take her entitled breaks. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/19/25 at 8:57 AM, CNA I reported that staffing is terrible. CNA I explained that most of the time, there are 80 residents that reside on the Meadows and [NAME] units and confirmed that the residents on those units are higher acuity and have behaviors. CNA I stated that the staffing is unrealistic and she has had to handle complaints from family about long call light response times. CNA I stated that she is unable to complete the tasks per the Kardax, including showers and turning and repositioning. CNA I stated it takes all the effort to ensure that the residents brief and dry which does not leave time for much else. CNA I stated that often she will discover residents wet and soiled at the beginning of her shift. In an interview on 3/20/25 at 9:43 AM, Registered Nurse (RN) C stated that the process for showers is to offer the scheduled shower and if the resident refuses, offer a bed bath. RN C stated that it was not acceptable to provide a bed bath instead of a shower if the resident is requesting a shower. In an interview on 3/20/25 at 12:38 PM, Director of Nursing (DON) B stated that the expectation would be to provide a shower to a resident that wanted a shower. Resident #105 (R105) Review of the medical record reflected R105 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included muscle weakness, need for assistance with personal care, and reduced mobility. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/21/24, reflected R105 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R105's care plan reflected that R105 required one person assist for transfers and staff assistance with personal hygiene. On 3/19/25 at 11:43 AM, R105 was observed in bed, wearing a hospital gown and unkempt. R105 expressed frustration because on her scheduled shower days, Tuesdays and Saturdays, she is being told staff is too busy to give her a shower, therefore R105 has no other choice but to accept a bed bath. R105 stated she wants a shower. R105 denied being offered a shower on an as needed basis or on the shower makeup day. R105 stated that she refuses to sign the shower sheet indicating that she refused a shower because she isn't refusing the shower, she's refusing the bed bath that's offered. R105 stated that this is a reoccurring problem and most recently, that on 3/18/25, she was told she had to have a bed bath instead of a shower. Review of R105's medical record shows instruction for shower days Tuesday and Saturday evening shift. Review of R105's Shower Task documentation revealed the following: 2/25/25: Marked as bed bath 3/1/25: Marked as bed bath 3/4/25: Shower given 3/8/25: Marked as bed bath (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/11/25: Resident refused 3/15/25: No documentation for scheduled shower day 3/18/25: Bed bath During the week of 3/17/25, A confidential staff member (SM D) confirmed that they are a direct care staff member and stated that staffing at the facility is inadequate. SM D reported that most residents in the [NAME] and Meadows units are fully dependent on staff for care and that the facility does not take acuity into consideration when assigning staff to the units. SM D also stated that she is unable to complete her tasks as outlined in the [NAME]. During the week of 3/17/25, a confidential staff member (SM E) reported that they are a direct care staff member and expressed concerns about staffing levels. SM E stated that one of the Certified Nursing Assistants (CNAs) has to wrap to the adjacent unit, and due to the double doors, it is impossible to be notified of call lights from the other unit. SM E further reported that teamwork is an issue, often resulting in call lights remaining activated for extended periods without notification to the assigned CNA or nurse, especially the residents in the wrapped rooms. Additionally, SM E noted that the [NAME] and Meadows units have residents with higher acuity and behavioral needs. According to SM E, essential care tasks such as oral care, checking for brief changes, and providing showers are not being completed due to insufficient staffing. As a result, SM E has offered bed baths in place of showers. In an interview on 3/19/25 at 8:45 AM, CNA G, who primarily works second shift, stated that there is room for improvement regarding staffing levels. CNA G reported that she regularly works in the [NAME] and Meadows units and, due to the lack of staffing, there is no guarantee for the safety and care of the residents. CNA G expressed the same concern about wrapping to the adjacent unit, noting that there is no way to be notified if a call light is activated in the other unit. When asked whether she is able to complete her assigned duties, CNA G stated that it is unrealistic to complete all required care as outlined in the [NAME]. She further explained that the [NAME] and Meadows units house residents with higher acuity and behavioral concerns, such as wandering. Additionally, she reported that a large percentage of residents require a mechanical Hoyer lift, and finding a second staff member to assist is often very difficult. In an interview on 3/18/25 at 1:41 PM, CNA H reported that she commonly works day and afternoon shifts in the [NAME] and Meadows units. She described staffing levels as terrible and stated that she frequently observes residents who are saturated or soiled in their beds, requiring complete bed linen changes. CNA H also raised concerns about wrapping to the adjacent unit, noting that there is no way to know if a call light is activated there. She stated that call lights often remain activated for a long time. Additionally, CNA H reported that she is unable to complete all required care as outlined in the [NAME] and, to save time, she offers bed baths instead of showers. She also stated that due to staffing shortages, she is unable to take her entitled breaks. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 3/19/25 at 8:57 AM, CNA I reported that staffing is terrible. CNA I explained that most of the time, there are 80 residents that reside on the Meadows and [NAME] units and confirmed that the residents on those units are higher acuity and have behaviors. CNA I stated that the staffing is unrealistic and she has had to handle complaints from family about long call light response times. CNA I stated that she is unable to complete the tasks per the Kardax, including showers and turning and repositioning. CNA I stated it takes all the effort to ensure that the residents brief and dry which does not leave time for much else. CNA I stated that often she will discover residents wet and soiled at the beginning of her shift. In an interview on 3/20/25 at 9:43 AM, Registered Nurse (RN) C stated that the process for showers is to offer the scheduled shower and if the resident refuses, offer a bed bath. RN C stated that it was not acceptable to provide a bed bath instead of a shower if the resident is requesting a shower. In an interview on 3/20/25 at 12:38 PM, Director of Nursing (DON) B stated that the expectation would be to provide a shower to a resident that wanted a shower.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake numbers MI00150030 and MI00150146. Based on observation, interview, and record review the facility failed to maintain sufficient staff to meet residents' needs timely and provide scheduled showers for three (Resident #101, #104, #105) of seven reviewed for staffing. Resident #101 (R101) Review of the medical record reflected R101 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included muscle weakness and contractures of the left and right hand. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/9/25, reflected R101 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R101's Care Plan reflected she required assistance of two staff members via mechanical lift for transferring. On 3/17/25 at 11:09 AM, R101 was observed in bed watching television. R101 reported that staffing sucks and often experience call light responses that are up to an hour. R101 also reported that staff will come in, ask R101 what she needs, turn off the call light without providing the requested service, and not return. R101 stated that CNAs come in and complain to R101 about being short staffed or report to R101 how many residents that they are assigned to and tell R101 she will have to just wait. R101 stated that she has sat in her own urine and feces for extended periods of time due to her call light not being answered in an acceptable time frame. Resident #104 (R104) Review of the medical record reflected R104 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included muscle weakness and dislocation of internal left hip prothesis. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 2/28/25, reflected R104 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/25, at 11:26 a.m., R104 was observed in bed watching television. R104 was wearing a hospital gown and appeared ungroomed. R104 stated that she was unimpressed with the care she was receiving at the facility. She expressed concerns about not receiving showers consistently and call lights not being answered in a timely manner, sometimes waiting over an hour for assistance. R104 reported that she often resorts to using her telephone to contact the front desk to alert staff that her call light is on and she required assistance. According to R104, certified nursing assistants frequently tell her that they are understaffed and have many other residents to care for. She also stated that, particularly in the afternoon and at night, staff will intentionally leave her call light activated, preventing her from reactivating it when she needs assistance. To work around this, she contacts the front desk to request help. R104 expressed frustration regarding her scheduled shower day on Saturday. When she requested a shower, staff informed her that they did not have time, and she was instead given the option of a bed bath. She was dissatisfied with this alternative, as she wanted an actual shower and to have her hair washed. R104 stated that she requested a shower again on Sunday, which was designated as a shower make-up day, but was once more told that staff did not have time to assist her. As a result, she had not received a shower. R104 stated that if she declines a bed bath over a shower, the staff will report that R104 refused a shower. R104 stated that she does not refuse a shower but does not accept being provided a bed bath instead of a shower for time saving purposes. R104 emphasized that this was not the first time she had experienced these issues. Resident #105 (R105) Review of the medical record reflected R105 was admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included muscle weakness, need for assistance with personal care, and reduced mobility. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/21/24, reflected R105 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R105's care plan reflected that R105 required one person assist for transfers and staff assistance with personal hygiene. On 3/19/25 at 11:43 AM, R105 was observed in bed, wearing a hospital gown and unkempt. R105 expressed frustration because on her scheduled shower days, Tuesdays and Saturdays, she is being told staff is too busy to give her a shower, therefore R105 has no other choice but to accept a bed bath. R105 stated she wants a shower. R105 denied being offered a shower on an as needed basis or on the shower makeup day. R105 stated that she refuses to sign the shower sheet indicating that she refused a shower because she isn't refusing the shower, she's refusing the bed bath that's offered. R105 stated that this is a reoccurring problem and most recently, that on 3/18/25, she was told she had to have a bed bath instead of a shower. During the week of 3/17/25, A confidential staff member (SM D) confirmed that they are a direct care staff member and stated that staffing at the facility is inadequate. SM D reported that most residents in the [NAME] and Meadows units are fully dependent on staff for care and that the facility does not take acuity into consideration when assigning staff to the units. SM D also stated that she is unable to complete her tasks as outlined in the [NAME]. (continued on next page)

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	03/19/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the week of 3/17/25, a confidential staff member (SM E) reported that they are a direct care staff member and expressed concerns about staffing levels. SM E stated that one of the Certified Nursing Assistants (CNAs) has to wrap to the adjacent unit, and due to the double doors, it is impossible to be notified of call lights from the other unit. SM E further reported that teamwork is an issue, often resulting in call lights remaining activated for extended periods without notification to the assigned CNA or nurse, especially the residents in the wrapped rooms. Additionally, SM E noted that the [NAME] and Meadows units have residents with higher acuity and behavioral needs. According to SM E, essential care tasks such as oral care, checking for brief changes, and providing showers are not being completed due to insufficient staffing. As a result, SM E has offered bed baths in place of showers. In an interview on 3/19/25 at 8:45 AM, CNA G, who primarily works second shift, stated that there is room for improvement regarding staffing levels. CNA G reported that she regularly works in the [NAME] and Meadows units and, due to the lack of staffing, there is no guarantee for the safety and care of the residents. CNA G expressed the same concern about wrapping to the adjacent unit, noting that there is no way to be notified if a call light is activated in the other unit. When asked whether she is able to complete her assigned duties, CNA G stated that it is unrealistic to complete all required care as outlined in the [NAME]. She further explained that the [NAME] and Meadows units house residents with higher acuity and behavioral concerns, such as wandering. Additionally, she reported that a large percentage of residents require a mechanical Hoyer lift, and finding a second staff member to assist is often very difficult. In an interview on 3/18/25 at 1:41 PM, CNA H reported that she commonly works day and afternoon shifts in the [NAME] and Meadows units. She described staffing levels as terrible and stated that she frequently observes residents who are saturated or soiled in their beds, requiring complete bed linen changes. CNA H also raised concerns about wrapping to the adjacent unit, noting that there is no way to know if a call light is activated there. She stated that call lights often remain activated for a long time. Additionally, CNA H reported that she is unable to complete all required care as outlined in the [NAME] and, to save time, she offers bed baths instead of showers. She also stated that due to staffing shortages, she is unable to take her entitled breaks. In an interview on 3/19/25 at 8:57 AM, CNA I reported that staffing is terrible. CNA I explained that most of the time, there are 80 residents that reside on the Meadows and [NAME] units and confirmed that the residents on those units are higher acuity and have behaviors. CNA I stated that the staffing is unrealistic and she has had to handle complaints from family about long call light response times. CNA I stated that she is unable to complete the tasks per the Kardax, including showers and turning and repositioning. CNA I stated it takes all the effort to ensure that the residents brief and dry which does not leave time for much else. CNA I stated that often she will discover residents wet and soiled at the beginning of her shift. In an interview on 3/19/25 at 10:25 AM, Licensed Practical Nurse (LPN) EE reported that staffing is troubling at times, especially for the CNAS. LPN EE stated that the nurses have to wrap to the adjacent unit that's that it is difficult to care for people on another unit behind double doors, which can result in delay of being notified and/or providing care. (continued on next page)

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	235580	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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