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	05/14/2026

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

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2801978.Based on observation, interview and record review, the facility failed to prevent missing controlled substance medication for one (R2) and maintain accurate controlled substance records for five (R6, R7, R8, R9, R10) in two of seven medication carts reviewed.Findings include:R2:Review of the medical record reflected R2 admitted to the facility on [DATE], with diagnoses that included low back pain, chronic pain and systemic lupus erythematosus. On 5/12/26 at 12:13 PM, R2 was observed in bed, watching TV, and declined to be interviewed. The January 2026 Medication Administration Record (MAR) included a Physician Order for 10 milligrams (mg) of oxycodone by mouth, every six hours, as needed, for ANALGESICS [pain relief]. A Facility Reported Incident investigation file reflected a blister pack of R2's oxycodone 10 mg went missing between the 7:00 AM and 7:00 PM nursing shift on 1/30/26. A Controlled Drug Receipt/Record/Disposition Form reflected 30 tablets of oxycodone 10 mg were received from the pharmacy, for R2, on 1/18/26. The last dose of oxycodone from that prescription pack was administered on 1/28/26 at 10:27 PM. A packing slip, dated 1/28/26, reflected the pharmacy delivered 30 tablets of oxycodone 10 mg for R2.The January 2026 MAR reflected oxycodone doses were signed out as being administered on 1/29/26 at 9:37 AM, 4:00 PM and 10:43 PM. On 1/30/26, doses were signed out as being administered at 5:02 AM and 12:18 PM. According to the facility's investigation, on 1/30/26 at 10:10 PM, a nurse (Registered Nurse (RN) H) attempted to administer a dose of oxycodone to R2 but discovered none was available on the medication cart. RN H attempted to reorder the medication through the pharmacy and was told it was too soon to provide more of the medication to the facility, as the medication had been delivered on 1/28/26. RN H notified the supervisor, who then called Director of Nursing (DON) B. According to the investigation, all nurses who had been in possession of the keys to the medication cart's controlled medication between 7:00 AM on 1/30/26 and 12:00 AM on 1/31/26 were suspended, pending investigation. The Controlled Substance Shift Inventory form for the medication cart reflected the out-going and on-coming nurses signed for the total number of controlled medications in the cart on 1/30/26 at 7:00 AM. The documentation for the total number of controlled medications at the start of the shift was unclear. One controlled medication was documented as being received from the pharmacy. The documentation for the total number of controlled medications at the end of the shift was unclear.The next entry on the Controlled Substance Shift Inventory form for the medication cart reflected the out-going nurse signed for the total number of controlled medications in the cart at 7:00 PM. The date was not completed. The documentation for the total number of controlled medications at the start of the shift was unclear. One controlled medication was documented as being received from the pharmacy. The documentation for the total number of controlled medications at the end of the shift was 9. The on-coming nurse did not sign the log for that entry.In an interview on 5/13/26 at 2:37 PM, DON B reported receiving a phone call around 12:00 AM or 1:00 AM that a package of oxycodone was missing. DON B reported the pharmacy had been called for a drop ship delivery of the medication, which was how the nurse (RN H) found out the medication was gone. It was reported the medication (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had just recently been delivered. RN H called the nurse manager, and they discovered a discrepancy with the total number of controlled medications in the medication cart. DON B reported RN H arrived for her shift around 7:00 PM (on 1/30/26), and the day shift nurse (Licensed Practical Nurse (LPN) G) was still charting. RN H then went to obtain vital signs. When LPN G was ready to leave, LPN F counted the controlled medications in the cart with LPN G. DON B described that there was a discrepancy with the total number of controlled medications in the cart when RN H took the medication cart over. DON B reported the oxycodone that was delivered for R2 on 1/28/26 was missing, and they were unable to find the count sheet (Controlled Drug Receipt/Record/Disposition Form) for the medication. On 5/14/26 at 11:55 AM, Registered Nurse (RN) L reported she was training Licensed Practical Nurse (LPN) M and they were responsible for Cypress Cart 1. RN L and LPN M were asked to demonstrate a controlled substance count. The following discrepancies were noted during their count:R6's oxycodone 5 milligrams (5mg) had 10 tablets documented in stock on the Controlled Drug Receipt/Record/Disposition Form, but only nine tablets were available in the medication cartR7's pregabalin 25 mg had 24 capsules documented in stock on the Controlled Drug Receipt/Record/Disposition Form, but only 23 capsules were available in the medication cartR8's morphine sulfate 15 mg had 22 tablets documented in stock on the Controlled Drug Receipt/Record/Disposition Form but only 21 tablets were available in the medication cartR8's methadone 10 mg had 20 tablets documented in stock on the Controlled Drug Receipt/Record/Disposition Form, but only 18 tablets were available in the medication cartR9's oxycodone 5 mg had 20 tablets documented in stock on the Controlled Drug Receipt/Record/Disposition Form, but only 19 tablets were available in the medication cart. RN L and LPN M reported all the medications were administered and signed out on the Medication Administration Record (MAR) and that they forgot to sign the medications out on the Controlled Drug Receipt/Record/Disposition Form. Review of the MARs revealed the above medications were administered at 10:06 AM, 9:00 AM, 10:36 AM, 6:00 AM, and 7:30 AM. On 5/14/26 at 12:12 PM, LPN N reported she was training LPN O and they were responsible for Cypress Cart 2. LPN N and LPN O were asked to demonstrate a controlled substance count. During the count, it was noted that R10's pregabalin 75 mg had 15 capsules documented in stock on the Controlled Drug Receipt/Record/Disposition Form, but only 14 capsules were available in the medication cart. LPN N reported the medication was administered at 8:52 AM, but she forgot to sign it out on the Controlled Drug Receipt/Record/Disposition Form. In an interview on 5/15/26 at 1:03 PM, Director of Nursing (DON) B reported nurses should sign controlled medications on the Controlled Drug Receipt/Record Disposition Form right away when the medication is removed from the medication cart. Review of the facility's Controlled Medication Guidelines dated 10/2019 revealed When the licensed nurse removes the controlled medication from the package, they will document the quantity removed and the quantity left on the Controlled Drug Receipt/Record/Disposition Form.