

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2025
NAME OF PROVIDER OR SUPPLIER  Optalis Health and Rehabilitation of Ann Arbor		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0557</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45135</p> <p>Based on observation, interview and record review the facility failed to exercise reasonable care for the protection of one of two resident's, Resident #117 (R117) personal property from loss, resulting in loss of personal clothing and potentially affecting resident's psychological wellbeing.</p> <p>Findings include:</p> <p>Resident #117 (R117)</p> <p>Review of the medical record reflected R117 was an initial admission to the facility on [DATE] and readmitted on [DATE]. Diagnoses of Parkinsons Disease with Dyskinesia, Heart Disease, Bi-Polar, Multiple Sclerosis, Chronic Pain, Depression and Anxiety.</p> <p>The most recent Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/19/2025 revealed R117 had a Brief Interview of Mental Status (BIMS) of 15 (Cognitively Intact) out of 15. Under section G0100, Activities of Daily Living (ADL) Assistance reveals R117 required moderate assistance with care.</p> <p>Record review revealed the concern/grievance logs did not contain a complaint form or grievance form that was completed for R117 on any of his missing clothing items.</p> <p>During an interview and observation on 04/10/25 at 10:05 AM, R117 was dressed in a light green Carhartt shirt, the residents name was boldly written on his front t shirt pocket. R117 pulled out an acrylic pen from his front pocket and stated that his son wrote his name on my shirt so he would stop losing items. R117 stated that he had to buy the marker himself. R117 stated he was tired of replacing clothes, so he started marking stuff on the front and inside with his name. R117 stated he didn't know what they did with his clothes they lose. R117 was observed in a hospital gown yesterday because he didn't have any clothes to wear.</p> <p>(continued on next page)</p>

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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<p>F 0557</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>During an interview on 04/10/25 at 1:20 PM, Director of Nursing (DON) B stated R117 did not tell her that he was missing multiple clothing items, he told her that he lost a pair of grey pants, which he was wearing. Writer asked why he was wearing a hospital gown yesterday? DON B stated he only told her about the grey pants. DON B stated, if he had told her about missing clothes, she would have filled out a concern form or grievance form and turned it in to the administrator A. DON B also stated that she talked with this resident all the time and he never told her about having clothes missing other than the pants.</p> <p>During an interview on 04/10/25 at 1:38 PM, R117 stated he did tell the DON B several times that he has had clothes missing. R117 stated he had to buy some more clothes because he didn't have anything left to wear and he only had \$50-\$60 left a month after paying the cost of this facility.</p> <p>R117 also stated he still had multiple clothing items missing. Writer asked R117 if he had ever filled out a concern or complaint form reporting the missing items and he stated no, he didn't know he had to. R117 shared frustration of not having his own clothes to wear. R117 also stated that it was embarrassing to not have clothes to wear.</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46954</p> <p>Based on observation, interview and record review, the facility failed to consistently honor a resident's choices regarding his daily routine and failed to facilitate the ability to go outside when requested, in one of two residents reviewed for choices (Resident #117). Findings include:</p> <p>Resident #117 (R117)</p> <p>Review of the medical record reflected R117 was admitted to the facility on [DATE], with diagnoses that included multiple sclerosis, depression, bipolar disorder, and anxiety. The Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 4/3/25, reflected R117 scored 13 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool).</p> <p>On 04/08/25 at 10:45 AM, R117 was observed dressed and seated in a motorized wheelchair. During the observation, R117 shared that he had always been a busy body and, for many years, was up and at work by 7:00 AM. He expressed that having to wait until after lunch for staff assistance to get out of bed kills something in my soul. R117 reported that this delay in receiving morning assistance has been a recurring issue and stated he recently brought it to the attention of staff. R117 stated that he required the sit to stand and staff assistance to transfer out of bed and into his chair.</p> <p>He further expressed feeling incredibly depressed lately. R117 shared that he greatly missed being outdoors. He stated he had been an avid outdoorsman his entire life and strongly desires sunshine and fresh air. Despite being his own responsible party, R117 stated that the facility does not allow him to go outside on his own. He reported making multiple requests for assistance to go outdoors but was consistently told by staff that he is not allowed to do so when he attempts to sign himself out. R117 emphasized that being kept in bed through the morning hours and being restricted from going outside are really messing with my mood.</p> <p>R117 stated that he recently reported to staff that he wanted to drive his chair in front of a bus but explained that he made the comment out of frustration after being left in bed until after 2:00 PM and had no desire to act on any plan. R117 stated it was a statement made out of frustration. R117 stated that he was being told he is now permitted from leaving the building and denied staff offering to supervise him outside.</p> <p>Review of a Progress Note dated 4/8/25 at 7:57 AM stated, writer spoke with resident regarding concerns-resident [R117] voiced that he would like to be an early morning get up, writer will adjust midnight get up list.</p> <p>Review of the Care Plan and Kardax revealed an absence of preference instructions regarding R117's desired morning routine.</p> <p>On 4/09/25 at 11:04 AM, R117 was observed in bed, dressed in a hospital gown. R117 expressed that he is very disappointed and anxious because he was still in bed, despite the facility promising to ensure he would be assisted out of bed in the morning at his desired time.</p> <p>(continued on next page)</p>		

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<p>F 0561</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R117's Physician Ordered dated 3/24/25 revealed an active order which stated, may go loa (leave of absence).</p> <p>Review of the Kardax revealed a care instruction which stated monitor location while up in motorized wheelchair. Do not allow to exit facility while in motorized wheelchair.</p> <p>In an interview on 04/10/25 at 12:51 PM, Director of Nursing (DON) B stated that residents should be allowed up at their requested time and that staff should offer to take R117 outside when he desires.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 38383</p> <p>Based on observation, interview and record review, the facility failed to ensure oral care was provided to one (R81) of two reviewed.</p> <p>Findings include:</p> <p>Review of the medical record reflected R81 admitted to the facility on [DATE], with diagnoses that included atherosclerotic heart disease and essential tremor. The admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 3/20/25, reflected R81 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool), had impairment on one upper extremity and one lower extremity and required setup or clean-up assistance for oral hygiene.</p> <p>On 04/08/25 at 11:18 AM, R81 was observed lying in bed. R81 stated their teeth had not been brushed since admitting to the facility, and staff did not provide supplies for them to be able to brush their teeth. R81 reported they would have been able to brush their own teeth, if they had the supplies.</p> <p>On 04/09/25 at 2:06 PM, R81 was observed in bed, watching TV. R81 denied brushing their teeth that day and stated they had not been offered set-up assistance by staff to do so. R81 reported their teeth had not been brushed throughout their admission at the facility.</p> <p>On 04/09/25 at 2:15 PM, Certified Nurse Aide (CNA) N reported their shift started at 7:00 AM and would end at 3:00 PM that day. CNA N reported R81 transferred via hooyer lift and had heavy care needs. CNA N reported R81 mostly required set-up assistance to brush their teeth, unless staff noticed R81 struggling. CNA N reported they had not asked R81 if they wanted to brush their teeth that day, reporting R81 did not feel well that morning. Upon observation of R81's personal care items, with CNA N, it was noted that R81's toothbrush was located in a basin, in their room. The toothbrush was in a sealed, clear, plastic package. R81 did not have toothpaste in their room, upon observation with CNA N.</p> <p>Review of R81's oral hygiene task for the prior 30 days reflected that on 4/9/25 at 12:50 PM, CNA N documented R81 performed oral hygiene with Partial/moderate assistance - Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort.</p> <p>On 04/10/25 at 1:08 PM, R81 was observed lying in bed. R81 reported they had been provided with assistance to brush their teeth the prior afternoon, after the State Agency had been in their room with staff, as well as that morning (4/10/25). R81 reported staff set them up with supplies, and they brushed their own teeth, while in bed. An open toothbrush (no longer in a sealed plastic package) and a tube of toothpaste were observed in a basin in R81's room. R81 reported their mouth had felt dirty due to not having their teeth brushed until the day prior.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R81's medical record reflected an order dated, 3/17/25, for the nurse to prepare a toothbrush for oral care after medication pass in the morning and at bedtime. The March 2025 and April 2025 Medication Administration Record (MAR) reflected the order was being documented as completed.</p> <p>In an interview on 04/10/25 at 1:19 PM, Director of Nursing (DON) B reported residents should have been provided oral care at least once a day but could receive oral care as often as they requested. DON B reported the order for the nurse to prepare a toothbrush for oral care in the morning and at bedtime was verification that the resident had supplies for oral care to be done and that the CNA was asked to do oral care.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 22050</p> <p>Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment effecting 134 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, reduced air quality, and inadequate sanitization of dishware and utensils.</p> <p>Findings include:</p> <p>On 04/07/25 at 09:20 A.M., An initial tour of the food service was conducted with Dietary Manager G. The following items were noted:</p> <p>The ceiling mounted return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust/dirt deposits. The soiled ventilation grill plate measured approximately 3-feet-wide by 4-feet-long.</p> <p>6 of 25 food production kitchen overhead light assembly plastic lens covers were observed soiled with accumulated (dust/dirt/dead insect carcasses). Dietary Manager G indicated he would contact maintenance for necessary repairs as soon as possible.</p> <p>The 2022 FDA Model Food Code section 6-501.12 states: (A) PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of FOOD is exposed such as after closing.</p> <p>One-half gallon of [NAME] Lactose Free Reduced Fat 2% Milk was observed within the Hoshizaki 2-door reach-in cooler, without an effective open or discard date. The manufacturer's use-by-date was also observed to read 4-24-25. Dietary Manager G indicated the facilities date marking procedure was currently day of opening plus 6 days for a total of 7 calendar days.</p> <p>The 2022 FDA Model Food Code section 3-501.17 states: (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1.</p> <p>The can opener assembly was observed soiled with accumulated and encrusted food residue. Dietary Manager G stated: I will have staff clean the opener immediately.</p> <p>The 2022 FDA Model Food Code section 4-601.11 states: (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>The atmospheric vacuum breaker was observed broken and missing the cover plate on the dish machine room hand sink faucet assembly.</p> <p>The 2022 FDA Model Food Code section 5-205.15 states: A plumbing system shall be: (A) Repaired according to LAW; and (B) Maintained in good repair.</p> <p>The mechanical dish machine pounds-per-square-inch (psi) gauge was observed to read 45 (psi), during the final rinse cycle.</p> <p>The 2022 FDA Model Food Code section 4-501.113 states: The flow pressure of the fresh hot water SANITIZING rinse in a WAREWASHING machine, as measured in the water line immediately downstream or upstream from the fresh hot water SANITIZING rinse control valve, shall be within the range specified on the machine manufacturer's data plate and may not be less than 35 kilopascals (5 pounds per square inch) or more than 200 kilopascals (30 pounds per square inch).</p> <p>On 04/07/25 at 10:45 A.M., An initial tour of the facility food service pantries was conducted with Dietary Manager G. The following items were noted:</p> <p>Pantry (100-200 Hall): The Vissani microwave oven face plate surface was observed (etched, scored, corroded, particulate). The damaged face plate surface measured approximately 1-inch-wide by 2-inches-long. Dietary Manager G indicated he would have maintenance replace the damaged microwave oven as soon as possible.</p> <p>Pantry (300-400 Hall): The ice machine dispensing spout was observed mineralized with accumulated and encrusted calcium/lime deposits. Dietary Manager G indicated he would have staff thoroughly clean and sanitize the ice machine dispensing spout assembly as soon as possible.</p> <p>Pantry (500 Hall): The return-air-exhaust ventilation grill was observed soiled with accumulated and encrusted dust/dirt deposits. The soiled ventilation grill plate measured approximately 12-inches-wide by 24-inches-long. Dietary Manager G indicated he would have maintenance thoroughly clean and sanitize the soiled ventilation grill plate as soon as possible.</p> <p>Pantry (600-700 Hall): The Sharp Carousel microwave oven was observed soiled with accumulated and encrusted food residue. Dietary Manager G indicated he would have housekeeping staff thoroughly clean and sanitize the microwave oven interior as soon as possible. The window ledge laminate surface was also observed (etched, scored, missing). The damaged laminate surface measured approximately 1-inch-wide by 10-inches-long. Dietary Manager G indicated he would have maintenance perform necessary repairs as soon as possible.</p> <p>Pantry (600-700 Hall): The Scotsman ice machine dispensing spout was observed mineralized with accumulated and encrusted calcium/lime deposits. Dietary Manager G indicated he would have staff thoroughly clean and sanitize the ice machine dispensing spout assembly as soon as possible.</p> <p>On 04/09/25 at 09:00 A.M., Record review of the Policy/Procedure entitled: General Kitchen Sanitation Policy dated 03/28/2025 revealed under Policy Overview: The facilities Department of Food and Nutrition Services shall maintain kitchen sanitation through compliance with a written cleaning schedule, Food Service Department (FSD) sanitation daily rounds, and monthly sanitation audits.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/09/25 at 09:15 A.M., Record review of the Policy/Procedure entitled: Preventative Maintenance Program dated 11/01/2020 revealed under Policy: A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Record review of the Policy/Procedure entitled: Preventative Maintenance Program dated 11/01/2020 further revealed under Procedure: (1) The Maintenance Director is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 22050</p> <p>Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant effecting 138 residents, resulting in the increased likelihood for cross-contamination, bacterial harborage, and reduced air quality.</p> <p>Findings include:</p> <p>On 04/07/25 at 03:50 P.M., An environmental tour of the facility Laundry Service was conducted with Director of Maintenance H and Director of Housekeeping and Laundry Services I. The following items were noted:</p> <p>Two 4-foot-wide by 6-foot-long padded floor mats were observed (etched, scored, particulate), adjacent to the three commercial dryers. The worn padded floor mats were also observed attached to the flooring surface with maroon colored duct tape. Director of Maintenance H indicated he would have staff remove and replace the worn floor mats as soon as possible.</p> <p>The flooring surface was observed (etched, scored, particulate), adjacent to the three commercial washers. The damaged flooring surface measured approximately 7-foot-wide by 10-foot-long. Director of Maintenance H indicated he would have staff replace the worn flooring surface as soon as possible.</p> <p>On 04/07/25 at 04:05 P.M., The corridor carpeted surface was observed stained and soiled, adjacent to resident rooms [ROOM NUMBERS]. The stained and soiled carpet surface measured approximately 2-foot-wide by 4-foot-wide.</p> <p>On 04/08/25 at 10:15 A.M., A common area environmental tour was conducted with Director of Maintenance H and Director of Housekeeping and Laundry Services I. The following items were noted:</p> <p>200 Hall</p> <p>One clean linen cart cover (pink) was observed (etched, scored, threadbare). Director of Housekeeping and Laundry Services I stated: We need to replace that cover.</p> <p>300 Hall - 400 Hall</p> <p>Nursing Station: 2 of 6 chairs were observed (etched, scored, threadbare, particulate), exposing the inner Styrofoam padding.</p> <p>Activity Room: 1 of 3 office chairs were observed (etched, scored, particulate), exposing the inner Styrofoam padding.</p> <p>Main Dining Room: The chair railing was observed missing. The missing chair railing measured approximately 12-14 feet-long. Director of Housekeeping and Laundry Services I stated: We have vending machines coming soon to fill the space.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Physical Therapy: The hand sink basin faucet assembly was observed loose-to-mount. Director of Housekeeping and Laundry Services I indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>500 Hall</p> <p>Meadows Room: 2 of 9 clear plastic overhead light lens covers were observed soiled with dust and dirt deposits.</p> <p>Shower Room: The shower wand assembly was observed missing an atmospheric vacuum breaker. Director of Housekeeping and Laundry Services I indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>600 Hall</p> <p>Shower Room Restroom: The hand sink faucet assembly was observed loose-to-mount. Director of Housekeeping and Laundry Services I indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>Nursing Station: The small black oscillating desk fan was observed soiled with accumulated and encrusted dust/dirt deposits. Director of Housekeeping and Laundry Services I indicated she would have staff thoroughly clean and sanitize the soiled fan as soon as possible.</p> <p>Dining Room Kitchenette: The lower base cabinetry exterior/interior surfaces were observed soiled with accumulated and encrusted food residue. 2 of 4 base cabinet drawers were also observed broken and enlarged from moisture exposure. Director of Housekeeping and Laundry Services I indicated she would have staff thoroughly clean and sanitize the soiled cabinetry as soon as possible. Director of Housekeeping and Laundry Services I also indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>On 04/08/25 at 02:05 P.M., An environmental tour of sampled resident rooms was conducted with Director of Maintenance H and Director of Housekeeping and Laundry Services I. The following items were noted:</p> <p>103: The Bed-D overbed light assembly upper 48-inch-long fluorescent light bulb was observed non-functional.</p> <p>202: The restroom commode base caulking was observed (etched, scored, particulate).</p> <p>209: The Portable Terminal Air Conditioning (PTAC) Unit filters were observed soiled with accumulated and encrusted dust/dirt deposits. The drywall surface was also observed (etched, scored, particulate), adjacent to the Bed-W headboard. The damaged drywall surface measured approximately 5-feet-wide by 5-feet-long.</p> <p>304: The Portable Terminal Air Conditioning (PTAC) Unit filters were observed soiled with accumulated and encrusted dust/dirt deposits. The restroom vanity countertop laminate edge was also observed missing. The damaged laminate surface measured approximately 2-inches-wide by 26-inches-long.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  04/10/2025
NAME OF PROVIDER OR SUPPLIER  Optalis Health and Rehabilitation of Ann Arbor		STREET ADDRESS, CITY, STATE, ZIP CODE  4701 E. Huron River Dr Ann Arbor, MI 48105	

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>305: The restroom commode base caulking was observed (etched, scored, particulate). The Portable Terminal Air Conditioning (PTAC) Unit filters were observed soiled with accumulated and encrusted dust/dirt deposits.</p> <p>307: The restroom vanity countertop was observed (etched, scored, chipped). The damaged laminate surface measured approximately 3-inches-wide by 6-inches-long. The Portable Terminal Air Conditioning (PTAC) Unit filters were observed soiled with accumulated and encrusted dust/dirt deposits.</p> <p>308: The restroom vanity countertop was observed (etched, scored, chipped), adjacent to the corner edge. The damaged laminate surface measured approximately 2-inches-wide by 12-inches-long. The Portable Terminal Air Conditioning (PTAC) Unit filters were also observed soiled with accumulated and encrusted dust/dirt deposits.</p> <p>403: The restroom over sink light assembly was observed non-functional. The Portable Terminal Air Conditioning (PTAC) Unit filters (2) were also observed missing from the cabinet housing.</p> <p>408: The Portable Terminal Air Conditioning (PTAC) Unit filters were observed soiled with accumulated and encrusted dust/dirt deposits.</p> <p>409: 1 of 2 restroom light assemblies were observed non-functional. Director of Housekeeping and Laundry Services I indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>503: The restroom commode base caulking was observed (etched, scored, particulate). The Bed-D (pillow, pillowcase, bed sheets, bedspread) were also observed soiled with accumulated and encrusted bodily fluids and food residue. Director of Housekeeping and Laundry Services I indicated she would have Certified Nursing Assistant (CNA) staff remove the soiled Bed-D bedding as soon as possible.</p> <p>504: The restroom hand sink basin was observed draining very slow. Director of Housekeeping and Laundry Services I indicated she would contact maintenance for necessary repairs as soon as possible.</p> <p>507: The restroom commode base caulking was observed (etched, scored, particulate). The Portable Terminal Air Conditioning (PTAC) Unit filters were also observed soiled with accumulated and encrusted dust/dirt deposits. The restroom vanity countertop laminate surface was further observed (etched, scored, particulate). The damaged laminate surface measured approximately 2-inches-wide by 12-inches-long.</p> <p>508: The restroom commode base caulking was observed (etched, scored, particulate).</p> <p>516: The restroom vanity countertop edge was observed (etched, scored, particulate). The damaged laminate surface measured approximately 2-inches-wide by 40-inches-long. The Portable Terminal Air Conditioning (PTAC) Unit filters were also observed soiled with accumulated and encrusted dust/dirt deposits.</p> <p>702: The vanity countertop laminate surface was observed (etched, scored, particulate). The damaged laminate surface measured approximately 2-inches-wide by 30-inches-long.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Optalis Health and Rehabilitation of Ann Arbor		STREET ADDRESS, CITY, STATE, ZIP CODE  4701 E. Huron River Dr Ann Arbor, MI 48105	
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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>704: The restroom commode base caulking was observed (etched, scored, particulate). The vanity countertop laminate surface edge was also observed (etched, scored, particulate). The damaged laminate surface measured approximately 2-inches-wide by 12-inches-long.</p> <p>706: The restroom vanity countertop laminate edge strip was observed loose-to-mount. The damaged laminate surface measured approximately 2-inches-wide by 24-inches-long. 1 of 2 overhead light assemblies were also observed non-functional. The Bed-D overbed upper 48-inch-long fluorescent light bulb was further observed non-functional.</p> <p>708: The Portable Terminal Air Conditioning (PTAC) Unit filters were observed soiled with accumulated and encrusted dust/dirt deposits. The restroom commode base caulking was also observed (etched, scored, particulate).</p> <p>711: The restroom vanity countertop was observed (etched, scored, particulate), adjacent to the hand sink basin. The damaged countertop surface measured approximately 2-inches-wide by 4-inches-long. The Portable Terminal Air Conditioning (PTAC) Unit filters were also observed soiled with accumulated and encrusted dust/dirt deposits. The Bed-W drywall surface was further observed (etched, scored, particulate), adjacent to the headboard. The damaged drywall surface measured approximately 3-feet-wide by 5-feet-long.</p> <p>On 04/08/25 at 04:40 P.M., An interview was conducted with Director of Maintenance H regarding the facility maintenance work order system. Director of Maintenance H stated: We have manual work order forms that staff fill out for maintenance and housekeeping requests.</p> <p>On 04/09/25 at 10:00 A.M., Record review of the Manual Work Order form dated 11/2021 revealed the following information: (1) Facility Name, (2) Department/Wing/Room, (3) Date, (4) I.D. No, (5) Work Requested, (6) Justification, (7) Material Cost, (8) Labor Cost, (9) Signature of Department Head, (10) Date Received, (11) Date Work Completed, and (12) Disposition.</p> <p>On 04/09/25 at 10:15 A.M., Record review of the Policy/Procedure entitled: Cycle Cleaning dated 11/01/2020 revealed under Policy: It is the policy of this facility to identify the functional areas in the facility that require cleaning and to use cycle cleaning schedules to outline the frequencies and maintain regularly scheduled environmental service tasks. Record review of the Policy/Procedure entitled: Cycle Cleaning dated 11/01/2020 further revealed under Procedure: (1) Routine cleaning of environmental surfaces and non-critical resident care items shall be performed according to a predetermined schedule and shall be sufficient enough to keep surfaces clean and dust free.</p> <p>On 04/09/25 at 10:30 A.M., Record review of the Policy/Procedure entitled: Maintenance Inspection dated 11/01/2020 revealed under Policy: It is the policy of this facility to utilize a maintenance inspection checklist in order to assure a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.</p> <p>On 04/09/25 at 10:45 A.M., Record review of the Policy/Procedure entitled: Routine Cleaning and Disinfection dated 08/2022 revealed under Policy: It is the policy of this facility to ensure the provision of routine cleaning and disinfection in order to provide a safe, sanitary environment and to prevent the development and transmission of infections to the extent possible.</p> <p>(continued on next page)</p>		

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

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On 04/09/25 at 11:00 A.M., Record review of the Manual Work Order forms for the last 30 days revealed no specific entries related to the aforementioned maintenance concerns.</p>