

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health and Rehabilitation of Ann Arbor		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to address and resolve grievances reported in Resident Council Meetings as stated during a confidential Resident Council meeting resulting in unresolved concerns, unmet resident needs and frustration. Findings include: During a Confidential Resident Council Meeting on 7/8/2026 at 3:00 PM there were 11 residents present with 10 residents who actively participated and appeared to be alert and oriented. In discussing staff response to call lights, 5 of 10 resident reported ongoing issue with slow response to call lights including greater than 1 hour on night shift. Residents reported this has been discussed at every Resident Council Meeting for months with no improvements and management staff say they are working on it. Residents gave examples of call light response times greater than one hour on night shift including residents who required two people assist to get back to bed. Three residents reported waiting at least 2 hours to be assisted to bed for evening shift. During the meeting the residents, including Resident [NAME] President, verified had discussed long call light response times at prior meetings and with Director of Nursing (DON) B several times with no improvements and continue to be greater than 1 hour call light wait times three times weekly on night shift. Ten of ten confidential residents were not aware where to locate or how to complete a grievance form or how the process worked. Review of six months of Resident Council Meeting minutes, dated 1/28/26 through 6/25/26, provided by Nursing Home Administrator (NHA) A reflected no mention on call light response times. Continued review of requested minutes and follow up revealed no concern forms. During an interview on 7/09/2026 at 2:00 PM confidential Resident X was observed in bed, able to answer questions without difficulty and confirmed routine attendance at Resident [NAME] Group meetings. Confidential Resident X verified every month residents report concern with long call light response times on night shift mostly on night shift at least three times weekly with no improvements noticed. During an interview on 7/09/2026 about 11:10 AM Nursing Home Administrator (NHA) A reported being in position for about 2.5 years. NHA A reported often attends Resident [NAME] meetings and reported residents are routinely asked about call light response times and residents have not reported concerns. NHA A reported would expect Resident [NAME] minutes to be accurate including resident reported concerns about call light response times. NHA A verified several, nursing concerns on grievance log including call light response times.		

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to notify residents of where to find grievance forms and how to file a grievance as stated during a confidential Resident Council meeting and one sampled residents (R169), resulting in unresolved concerns, unmet resident needs and frustration. Findings include: Resident #169 (R169) Review of the Face Sheet and Minimum Data Set (MDS) with assessment reference date of 7/7/26, reflected R169 was a [AGE] year-old male with diagnoses that included hypertension (high blood pressure), heart disease, radiculopathy (nerve pain), chronic pain and anxiety. The MDS reflected R169 had a BIM (assessment tool) score of 15 which indicated his ability to make daily decisions was cognitively intact. During an observation and interview on 7/07/2026 at 3:45 PM, R169 was observed in room, appeared to be able to answer questions without difficulty. R169 reported ongoing concerns with long call light response times greater than two hours after requesting pain medications mostly on nights. R169 reported 7/6/26 was administered pain medications four times and usually received they five to six times daily to manage pain. R169 reported was unable to sleep last night and unable to go to therapy that morning related to uncontrolled pain and that is why he is at facility for rehab. R169 reported same situation had happened prior to last night but R169 reported getting frustrated and reported to unit manager that morning and was informed facility planned to change medication timing with no mention of addressing concern related to long call light response times. During a Confidential Resident Council Meeting on 7/8/2026 at 3:00 PM there were 11 residents present with 10 residents who actively participated and appeared to be alert and oriented. When asked if staff respond to call light timely, 5 of 10 resident reported ongoing issue with slow response to call lights including greater than 1 hour on night shift. Residents reported call lights response time are discussed at every Resident Council Meeting for months with no improvements and management staff say they are working on it. Residents gave examples of call light response times greater than one hour on night shift including residents who required two person assist to get back to bed with three residents who reported waiting at least 2 hours to be assisted to bed for evening shift. Residents verified they had discussed concerns at prior meetings and with Director of Nursing (DON) B several times with no improvements and continue to be greater than 1 hour call light wait times three times weekly on night shift. Ten of ten confidential residents were not aware where to locate or how to complete a grievance form or how the process worked. During an observation on 7/8/26 at about 4:15 p.m. this surveyor toured the entire facility and was unable to locate easily accessible facility grievance/concern forms. During an observation and interview on 7/09/2026 at about 11:05 AM Unit Manager (UM) Y reported grievance forms were located at the nurse station and UM Y was observed attempting to locate at Cyprus Nurse Station and reported was unable to locate and reported admissions coordinator had them in her office. UM Y reported Grievance forms were not available to residents and or family without asking. UM Y reported had completed grievance form for R169 on 7/7/26 related to pain medications. During an observation and interview on 7/09/2026 at 11:10 AM, Nursing Home Administrator (NHA) A reported had been in position for about 2.5 years. NHA A reported grievance forms were available at facility Nurse Stations including Cyprus. Observed NHA A attempting to located forms at Cyprus Nurse Station and reported was unable to locate and reported forms were not available without asking. NHA A reported would expect to be informed of reported concerns within 24 hours and completed within 7 days depending on issue. During an interview on 7/09/2026 at 1:06 PM, Director of Nursing (DON) B reported became (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aware of R169 medication concerns today upon questioning with UM Y. During an interview two days later, on 7/09/2026, at about 3:50 PM Nursing Home Administrator (NHA) A reported had not seen R169's concern form dated 7/7/26.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain the physical plant affecting 143 residents, resulting in the increased likelihood for cross-contamination and bacterial harborage. Findings include: On 07/07/2026 at 12:48 P.M., an environmental assessment of resident room [ROOM NUMBER] was completed. The following items were noted: The 503-W drywall surface, located directly behind the bed headboard, was observed scraped, scored, and fragmented from the bed being raised and lowered numerous times. The damaged drywall surface measured approximately 3 feet-long by 2 feet-wide. The 503-W bed overhead light assembly lower bulb was also observed non-functional. On 07/07/2026 at 1:02 P.M., an environmental assessment of resident room [ROOM NUMBER] was completed. The following items were noted: The 510-D drywall corner and plastic protective edge guard assembly were observed heavily soiled and stained with a dark brown substance, adjacent to the restroom entrance door. Three pieces of transparent tape were also observed adhered to the plastic protective edge guard assembly. The soiled and stained surface measured approximately 2 feet-wide by 4 feet-long. The wall/floor juncture surfaces, located adjacent to the restroom entrance door, were further observed heavily soiled with accumulated and encrusted dust/dirt/grime. The wall/floor juncture surfaces were also observed to be extremely dark (black) in color. On 07/08/2026 at 8:25 A.M., an environmental tour of the facility Laundry Service was conducted with Director of Housekeeping and Laundry (DHL) Q. The following items were noted: Clean Laundry Room: 4 of 4 overhead clear plastic overhead light lens covers were observed soiled with accumulated and encrusted dust/dirt/dead insect carcasses. (DHL) Q indicated she would contact maintenance for necessary cleaning as soon as possible. Laundry Room: 12 of 12 overhead clear plastic overhead light lens covers were observed soiled with accumulated and encrusted dust/dirt/dead insect carcasses. (DHL) Q indicated she would contact maintenance for necessary cleaning as soon as possible. On 07/08/2026 at 8:45 A.M., an environmental tour of the facility was conducted with Director of Housekeeping and Laundry (DHL) Q. The following items were noted: Meadows (900 500-519): Central Bath: 1 of 3 shower stall grab bars were observed loose-to-mount. (DHL) Q indicated she would contact maintenance for necessary repairs as soon as possible. On 07/08/2026 at 9:40 A.M., (DHL) Q was interviewed regarding the facility maintenance work order system. (DHL) Q stated: We have written work orders and the (name of electronic maintenance monitoring) software system. On 07/09/2026 at 10:00 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. On 07/09/2026 at 10:15 A.M., record review of the Policy/Procedure entitled: Environmental Services Inspection dated 10/01/2022 revealed under Policy: It is the policy of this facility to regularly monitor environmental services to ensure the facility is maintained in a safe and sanitary manner and assessed on a regular basis. On 07/09/2026 at 10:30 A.M., record review of the Manual Maintenance Work Orders for the last 90 days revealed no specific entries related to the aforementioned maintenance concerns.		

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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** This Citation Pertains to Intake 3073823. Based on interview and record review, the facility failed to ensure an injury of unknown source was thoroughly investigated for one (Resident #98) of one reviewed for abuse. Findings include: Review of the clinical record revealed R98 was a [AGE] year-old female admitted to the facility on [DATE] with diagnosis that included polyosteo arthritis and age-related cognitive decline. R98 was transferred to the hospital on 7/4/2026 for unrelated reasons and not in the facility at the time of the survey. Further review of the clinical record reflected English was not R98's primary language. Review of the facility reported incident dated 6/27/26 reflected after Certified Nursing Assistant (CNA) S gave R98 a shower, R98 had begun to hold her left elbow and cry out in pain, R98 was unable to give description of pain. A stat x-ray was ordered on 6/26/26 and revealed an acute transverse supracondylar fracture of the humerus with partial comminution at the medial epicondyle. Mild impaction of fracture fragments. R98 was transferred to the hospital and returned in the early morning hours of 6/27/26. The facility reported incident included one interview. The interview was dated 6/30/26 and conducted by Nursing Home Administrator (NHA) A and CNA S the interviewee. CNA S statement reflected I took resident to the shower room and gave her a shower without incident. After her shower she grabbed the bar in the shower with both hands and cried out in pain. I sat her down on her walker and got her dressed with 3 layers of clothes and she didn't cry out in pain when I dressed her. When I took her back to her room, I told the nurse of her pain. The facility reported incident did not include any interviews with R98, other residents, R98's nurse, or any staff from the current shift or previous shifts. On 07/09/2026 at 2:09 PM, during an interview with NHA A she reported she was the facility's Abuse Coordinator and did the investigation regarding R98's fracture. NHA A stated she received a phone call on Saturday 6/27 from License Practical Nurse (LPN) T who reported R98 had an elbow fracture and they didn't know how it occurred. When queried why there was no written statement/interview with LPN T included in the investigation, NHA A stated because she called her and told her what happened, and she read LPN T nurses note and felt there was no need to interview her or obtain a statement. When queried why R98 wasn't interviewed, NHA A stated she contacted a translation service and attempted to interview R98, but the translator reported R98 was too confused and was not able to be interviewed. Upon asking for documentation of the attempted interview of R98 with a translator, NHA A stated it was not documented. When queried why additional staff from that shift and the prior shift along with other residents on R98's unit were interviewed, NHA A stated she reviewed R98's record and didn't find any concerns and thought additional interviews were not necessary. NHA A elaborated that R98's family visits often and they would know if there was a problem and would report it and hadn't. Thus, NHA A had no concerns. On 07/09/2026 at 3:03 PM, during an interview with CNA S, she reported R98 was not assigned to her on 6/26/26, but she was told to give R98 a shower and she did what she was told. CNA S reported working the afternoon shift and gave R98 at shower at 4:00 PM on 6/26/26. CNA S reported R98 routinely would make noises and cry out during care particularly showers. CNA S elaborated the shower on 6/26/26 was just like previous showers she had given R98, but R98 stood grabbed the bar and yelled a different type of yell but then was ok. CNA S stated she dressed R98 in 3 layers of shirts (R98 preference) and R98 never cried out or winced in pain. CNA S stated she and R98 speak the same native language and R98 was not able to articulate when/why/how the pain started.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Level I pre-admission screening was completed and referred for a Level II evaluation and determination for one (R14) of three reviewed. Findings include: Review of the medical record revealed R14 was admitted to the facility on [DATE] with diagnoses that included adjustment disorder with mixed anxiety and depressed mood and post-traumatic stress disorder (PTSD). The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/12/26 revealed R14 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R14's medical record revealed no Level I or Level II Preadmission Screening/Annual Resident Review (PASARR). In an interview on 07/08/2026 at 2:20 PM, Social Worker (SW) N reported they could not locate R14's Level I or Level II PASARR. SW N reported it was possible the admissions staff had a copy. R14's PASARR documents were requested from SW N. SW N reported the OBRA website did not indicate R14 had been referred for a Level II evaluation. On 07/09/26 at 9:19 AM, R14's Level I and Level II PASARR was requested from Nursing Home Administrator (NHA) A. In a telephone interview on 07/09/26 at 9:22 AM, Social Work Director (SWD) M reported R14 should have had a Level I PASARR in their medical record. On 07/09/26 at 12:27 PM, NHA A reported the facility had to call Veteran's Affairs (VA) to obtain R14's PASARR documents because they did not have the documents in the facility. NHA A provided the documents received from the VA on 7/9/26. Review of the DCH-3877 PASARR revealed R14's Level I screening was completed on 3/3/26. R14 was marked Yes to the following screening criteria:1. The person has a current diagnosis of mental illness.2. the person has received treatment for mental illness.3. The person has taken or been prescribed psychotropic medications within the last 14 days. The DCH-3877 revealed the person screened will require a comprehensive Level II OBRA evaluation if any of the above items are Yes UNLESS a physician, nurse practitioner or physician's assistant certifies on form DCH-3878 that the person meets at least one of the exemption criteria, or the CMHSP Coordinator determines a Level II is not needed.Review of R14's DCH-3878 revealed the form was signed by a physician on 3/4/26, however none of the exemption criteria were checked as selected. R14 was not referred to OBRA for a comprehensive Level II evaluation.		

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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** Based on observation, interview and record review, the facility failed to provide medications timely and as prescribed for 2 residents (R33, R38) and failed to ensure physician orders for 1 resident (R26) of 27 residents reviewed. Findings include: Resident 26 (R26) A review of the clinical record revealed R26 was admitted into the facility on 1/20/23 with diagnoses that included: optic atrophy (right eye), muscle weakness, major depressive disorder and anxiety disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R26 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). On 7/7/26 at 10:52 AM, R26 was observed lying in bed on his back. He reported that when he wakes up in the morning his eyes burn, sometimes they are dry and irritated throughout the day, and that a provider had told him that they would order eye drops to help but he had not received any yet. R26 reported this had been ongoing for weeks. A review of R26's progress notes revealed the following: 7/3/26 .Examination of the eyes revealed PERRLA (pupils equal, round, reactive to light and accommodation).looks slightly irritated.Diagnosis: 1. Debility. 2. Dry eye syndrome.Medications were reviewed and approved for renewal.Continue artificial tears for dry eye syndrome. and 6/5/26 Patient is seen for monthly evaluation.He reports that his eyes are bothering him burning and itching. There is no discharge. Examination of the eyes revealed PERRLA.looks slightly irritated.Diagnosis: 1. Dry eye syndrome. 2. Hayfever.I advised the patient to use artificial tears for the dry eye syndrome. On 7/9/26 at 1:11 PM, during an interview with Unit Manager (UM) U, she reported not being aware of R26 experiencing dry eyes. UM U confirmed seeing progress notes indicating R26 had reported having dry eyes and that the notes indicated that the provider would order artificial tears to help. UM U further confirmed that a review of R26's physician orders revealed no active or discontinued order for artificial tears. Resident 38 (R38)On 7/7/26 at 10:05 AM, R38 was observed sitting up in a manual wheelchair at his bedside. R38 reported that he had not received his morning medications yet including his blood pressure medications. He added that they are frequently given late. R38 reported getting them late made him nervous because his blood pressure had been running high and that the staff are just not serious. A review of the clinical record revealed R38 was admitted into the facility on 3/15/24 with diagnoses that included: schizoaffective disorder, major depressive disorder and generalized anxiety disorder. According to the Minimum Data Set (MDS) assessment dated [DATE], R38 scored 15/15 on the Brief Interview for Mental Status exam (which indicated intact cognition). A review of R38's physician orders revealed active orders for amlodipine 5mg Give 1 tablet by mouth one time a day for HTN (hypertension-high blood pressure) to be given at 9 AM and Metoprolol Succinate ER (extended release) Give 1 tablet by mouth one time a day for HTN to be given at 9 AM. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Medication Admin (administration) Audit Report provided by the facility revealed for the last 30 days the resident received his amlodipine late (outside of the facilities one hour grace period) 7 times, 6/9 at 10:59 AM, 6/13 at 10:25 AM, 6/17 at 10:04 AM, 6/24 at 10:25 AM, 7/4 at 10:22 AM, 7/7 at 10:26 AM, 7/8 at 10:37 AM and received his Metoprolol late 3 times, 7/4 at 10:22 AM, 7/7 at 10:26 AM, 7/8 at 10:37 AM. On 7/9/26 at 12:40 PM, during an interview with Director of Nursing (DON), when asked what the expectation was for timeliness of medication administration, she replied that she expected her staff to administer medications as soon as they can, they can administer 1 hour before the scheduled administration time and 1 hour after and that staff tried to adhere to that. DON added that they do their best on that unit and that the nurses have to assist the certified nursing aides due to the workload. Resident 33 (R33) Review of the medical record revealed R33 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/19/26 revealed R33 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 07/07/2026 at 2:38 PM, R33 was observed sitting in a wheelchair in his room. R33 expressed frustration due to missed doses of Trulicity (weekly injection to help lower blood sugar) because the medication was not always available. R33 reported he was prescribed Trulicity in an attempt to lower his A1C (average blood sugar level over the past three months) so that he could have knee and oral surgery. Review of R33's Physician's Orders revealed weekly Trulicity injections were first ordered on 4/2/26 and continued as an active order. Review of R33's Medication Administration Records (MARS) and Progress Notes revealed the following: On 4/4/26 at 4/11/26, R33 refused the Trulicity. On 4/14/26 and 4/21/26, R33's Trulicity was documented as administered. On 4/28/26, Trulicity was not available. Trulicity was given the next day, on 4/29/26. On 5/6/26, R33's Trulicity was documented as administered. On 5/13/26, R33's Trulicity was not documented as administered and there was not an explanation in the progress notes. On 5/20/26, R33's Trulicity was documented as administered. On 5/27/26, R33's Trulicity was marked as 02 which indicated LOA (Leave of Absence) without medications. There was no documentation that R33 received his Trulicity after his LOA or a progress note explaining the situation. On 6/3/26, R33's Trulicity was not signed out as administered and there was not an explanation in the progress notes. On 6/10/26, R33's Trulicity was marked as 3 which indicated absent from home with medications. There was no progress note or anything that indicated R33 self-administered his Trulicity. On 6/17/26 and 6/24/26, R33's Trulicity injections were documented as administered. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/1/26, R33's Trulicity was marked as 07 which indicated Other/See Progress Note. The Progress Note revealed Medication currently unavailable. Pharmacy was called and medication was reordered. On 7/8/26, R33's Trulicity was documented as administered. Review of the pharmacy Packing Slips revealed R33's Trulicity was delivered on 5/13/26, 5/18/26, 6/3/26, 6/5/26, 6/17/26, 6/24/26, and 7/1/26. There was no delivery of Trulicity on 5/27/26 On 07/09/2026 at 8:48 AM, R33 was observed in bed and reported he did not receive his Trulicity dose the previous day as ordered on 7/8/26 because it was not in stock. Review of the MAR at that time, revealed R33's Trulicity was signed out as administered by Licensed Practical Nurse (LPN) J. In an interview on 07/09/2026 at 8:52 AM, LPN J reported she did not administer R33's Trulicity on 7/8/26 because it was not in stock and she had to reorder it. In an interview on 07/09/2026 at 8:55 AM, Assistant Director of Nursing (ADON) L reported there were times R33 refused Trulicity and then would complain it was not in stock at the facility. ADON L reported they were not aware R33's Trulicity was not administered on 7/8/26 and reported another injection was received from the pharmacy on 7/8/26. ADON L reported they would look into the missed documentations and administrations. On 07/09/2026 at 10:44 AM, ADON L reported on 5/13/26 R33 refused his insulin, however there was no documentation that he refused Trulicity. ADON L reported on 5/27/26, R33 was LOA and it was his pattern that he usually refused everything when he came back from LOA. ADON L reported there was no documentation that he refused Trulicity on 5/27/26. ADON L reported on 6/3/26 R33 went LOA and refused his insulin, however there was no documentation that he refused his Trulicity. ADON L reported on 7/1/26 the Trulicity was not available, pharmacy was contacted, and the Trulicity was delivered on 7/1/26. ADON L agreed there was no documentation that the Trulicity was administered but reported she would assume so since there were not any extra doses in the refrigerator. On 07/09/2026 at 11:45 AM, R33 was observed in his wheelchair in the common area. R33 reported the nurse attempted to administer his Trulicity that morning, however, was unsuccessful because the medication went all over the outside of his skin. R33 reported he occasionally refused insulin but had not refused Trulicity. Review of the eMAR Administration Note dated 7/9/26 revealed R33's Trulicity was not administered because pen injector did not break seal on skin .new pen has to be ordered. In an interview on 07/09/2026 at 12:29 PM, Director of Nursing (DON) B reported the facility reported R33 refused his Trulicity all the time. DON B reported her and ADON L have discovered the Trulicity needs to be ordered every week and that pharmacy would not automatically refill.		

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NAME OF PROVIDER OR SUPPLIER Optalis Health and Rehabilitation of Ann Arbor		STREET ADDRESS, CITY, STATE, ZIP CODE 4701 East Huron River Drive Ann Arbor, MI 48105	
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pain management was provided for a resident with severe pain in 1 resident (Resident #169) of 2 residents reviewed for pain management resulting in unrelieved pain that can impact the resident's functional status, quality of life, and increased their mental anguish. Findings include: Resident #169 (R169) Review of the Face Sheet and Minimum Data Set (MDS) with assessment reference date of 7/7/26, reflected R169 was a [AGE] year-old male with diagnoses that included hypertension (high blood pressure), heart disease, radiculopathy (nerve pain), chronic pain and anxiety. The MDS reflected R169 had a BIM (assessment tool) score of 15 which indicated his ability to make daily decisions was cognitively intact. During an observation and interview on 7/07/2026 at 3:45 PM, R169 was observed in room, appeared to be able to answer questions without difficulty. R169 reported ongoing concerns with long call light response times greater than two hours after requesting pain medications mostly on nights. R169 reported 7/6/26 was administered pain medications four times and usually received they five to six times daily to manage pain. R169 reported was unable to sleep last night and unable to go to therapy that morning related to uncontrolled pain and that is why he is at facility for rehab. R169 reported when staff answer call light he would reported need for as needed pain medication and return to inform R169 that nurse said R169 would get medications with scheduled medication during medication pass. R169 reported same situation had happened prior to last night but R169 reported getting frustrated and reported to unit manager that morning and was informed facility planned to change medication timing with no mention of addressing concern related to long call light response times. Review of R169 Medication Administration Record, dated 7/1/26 through 7/7/26, reflected several as needed pain medications had been administered with scheduled medication pass. Continued review reflected several occasions of pain assessments had been completed up to 12 hours after ordered. Review of R169 Care Plans, dated 7/1/26, reflected, At risk for pain and/or has pain related to: Syncope, Chronic Back Pain .Goal-Will express that pain management is within acceptable limits .Interventions/Tasks-Administer pain medication as ordered .Notify physician if pain frequency/intensity is worsening or if current analgesia regimen has become ineffective . During an observation and interview on 7/09/2026 at about 11:05 AM Unit Manager (UM) Y had completed grievance form for R169 on 7/7/26 related to pain medications. UM Y reported R169 complained of not receiving pain medications timely to her on 7/7/26 morning. UM Y reported physician was contacted and pain medications were changed to scheduled and resident was satisfied with response.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain complete and accurate medical records for 3 of 27 residents reviewed (Resident #10, #14 and #33). Findings include: Resident 14 (R14) Review of the medical record revealed R14 was admitted to the facility on [DATE] with diagnoses that included adjustment disorder with mixed anxiety and depressed mood, post traumatic stress disorder (PTSD), and anxiety disorder. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 6/12/26 revealed R14 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R14's medical record revealed no Level I or Level II Preadmission Screening/Annual Resident Review (PASARR). In an interview on 07/08/2026 at 2:20 PM, Social Worker (SW) N reported they could not locate R14's Level I or Level II PASARR. SW N reported it was possible the admissions staff had a copy. R14's PASARR documents were requested from SW N. On 07/09/26 at 9:19 AM, R14's Level I and Level II PASARR was requested from Nursing Home Administrator (NHA) A. In a telephone interview on 07/09/26 at 9:22 AM, Social Work Director (SWD) M reported R14 should have had a Level I PASARR in their medical record. On 07/09/26 at 12:27 PM, NHA A reported the facility had to call Veteran's Affairs (VA) to obtain R14's PASARR documents because they did not have the documents in the facility or in R14's medical record. Resident 33 (R33) Review of the medical record revealed R33 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 4/19/26 revealed R33 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). Review of R33's Physician's Orders revealed weekly Trulicity injections were first ordered on 4/2/26 and continued as an active order. On 07/09/2026 at 8:48 AM, R33 was observed in bed and reported he did not receive his Trulicity dose as ordered the previous day on 7/8/26 because it was not in stock. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R33's Medication Administration Record (MAR) revealed on 7/8/26, R33's Trulicity was documented as administered by Licensed Practical Nurse (LPN) J. In an interview on 07/09/2026 at 8:52 AM, LPN J reported she did not administer R33's Trulicity on 7/8/26 because it was not in stock and she had to reorder it. In an interview on 07/09/2026 at 8:55 AM, Assistant Director of Nursing (ADON) L reported they were not aware R33's Trulicity was not administered on 7/8/26 and reported another injection was received from the pharmacy on 7/8/26. Resident 10 (R10) Review of the clinical record, including the Minimum Data Set (MDS) dated [DATE] reflected Resident 10 (R10) was a [AGE] year old female admitted to the facility on [DATE] with diagnosis that included end stage renal disease and R10 received hemodialysis 3 times a week. Further review of R10's clinical record reflected R10 scored 14 out of 15 (cognitively intact) on the Brief Interview for Mental Status with diagnosis of end stage renal disease. Review of R10's medical record for 2026 contained communication sheets with dialysis center for the following dates: 1/1, 1/15, 1/27, 2/10, 2/26, 3/10, 6/16 and 6/16. During an interview with Medical Records staff V on 07/09/2026 9:55 AM she reported R10 goes out to dialysis 3 times a week, facility nursing staff fill out the top portion of the form (type of access, medications given, medications sent with resident, code status), the dialysis center completes the middle section of the form, which was to include post dialysis vital signs, total fluid removal, medications that were given and any complications. The bottom of the form was to be signed off by facility nursing staff and placed into Licensed Practical Nurse/ Unit Manager (LPN/UM) U filing basket which gets picked up by Medical Records staff V and then gets and scans into the electronic medical record. Medical record staff V offered no explanation as to why R10's medical record had 8 dialysis communication forms when there should be roughly 85 dialysis communication forms. On 07/09/2026 at 10:50 AM during an interview with LPN/UM U she reported she had some of R10's dialysis sheets in her office and were there because she needed to review and sign off on them. It was queried how floor staff know what occurred or if there was a problem at dialysis with the dialysis communication sheets for R10 in her office. On 07/09/2026 at 12:43 PM, during an interview with Director of Nursing (DON) B she was not aware there was a total of 8 dialysis communication sheets in R10's medical record and the remaining forms may be located in an office. DON B reported she had no knowledge of R10's medical record being incomplete but would look into it. On 7/09/2026 1:07 PM DON B presented 43 pages of R10's dialysis communication forms that were not part of the medical record. When queried why the documents were not in R10's medical record, DON B offered no explanation.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to coordinate care with hospice to ensure the accuracy of advance directives for one (R14) of two reviewed. Findings include: Review of the medical record revealed R14 was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of the pancreas, adjustment disorder with mixed anxiety and depressed mood, and post-traumatic stress disorder (PTSD). The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of [DATE] revealed R14 scored 11 out of 15 (moderate cognitive impairment) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). R14 received hospice services. Review of R14's electronic medical record main profile page revealed R14 wanted full cardiopulmonary resuscitation (CPR). Review of a scanned in written Physician's Order dated [DATE] revealed R14's code status was DNR (Do Not Resuscitate). Review of the electronic Physician's Order dated [DATE] revealed R14's code status was Full Code. Review of the Social Work progress note dated [DATE] revealed Resident is a full code at this time pending a valid DNR signed by the DPOA [Durable Power of Attorney]. Review of the Physician Team-H&P (History and Physical) note dated [DATE] revealed Patient is DNR. Review of the Care Conference dated [DATE] revealed no indication that hospice staff were invited or attended. The Care Conference revealed R14 was a full code. Review of the hospice IDG Comprehensive Assessment and Plan of Care Update Report for benefit period dates of [DATE] through [DATE] revealed R14's code status was DNR as of [DATE]. The Social Work portion of the hospice documents also revealed R14's code status was DNR. The hospice binder located at the nurse's station had a DNR order signed by R14's DPOA and one witness (hospice staff) on [DATE]. A second witness and the physician did not sign the DNR order. In an interview on [DATE] at 2:20 PM, Social Worker (SW) N reported R14's code status was CPR-full code. SW N reported during the last care conference, R14's DPOA did not wish to change his code status to DNR. In a telephone interview on [DATE] at 3:18 PM, R14's DPOA W reported it was their understanding that R14's code status was going to be changed to DNR after the last care conference on [DATE]. DPOA W reported she was told she would have to sign something indicating the change, but the facility never followed through with her. DPOA W reported she had visited the facility since but had not been asked to sign anything. In an interview on [DATE] at 9:04 AM, Assistant Director of Nursing (ADON) L reported R14's code status was a full code. When asked why all of R14's hospice paperwork indicated his code status was DNR, ADON L reported they were not aware of that and would have to check with Social Work. ADON L reported hospice staff were not in the building for care conferences. When asked if they ever participated via telephone, ADON L reported hospice staff usually communicated with her when they were in the building. In a telephone interview on [DATE] at 10:33 AM, Hospice Social Worker (HSW) O reported R14's code status was DNR which was signed by R14's DPOA upon admission. HSW O reported their hospice company had requested to be included in care conferences; however, they were not directly contacted to participate.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain infection control standards during eye drop administration for one (R170) of seven reviewed. Findings include: Review of the medical record revealed R170 was admitted to the facility on [DATE] with a diagnosis of glaucoma. Review of the Physician's Order dated 7/6/26 revealed an order for Cosopt ophthalmic solution 2-0.5% (Dorzolamide HCl-Timolol Maleate) instill one drop in right eye two times a day for glaucoma. On 07/08/2026 at 8:49 AM, Licensed Practical Nurse (LPN) J was observed administering dorzolamide 2% eye drops to R170's right eye. LPN J did not wear gloves, pulled down R170's right lower eye lid and placed one drop in R170's right eye. Review of the facility's Medication-Eye Drop or Ointment Administration dated 9/14/23 revealed Perform hand hygiene and don clean gloves. Use a barrier if you place the medication cap or bottle on a surface. Steady the hand holding the medication cap or bottle on a surface. With the other hand, pull down the lower eyelid to form a pouch of the conjunctival sac, instructing resident to look up. For eye drops: squeeze the prescribed number of drops into the conjunctival sac, avoiding placement of the drops directly on the eyeball. Remove gloves and perform hand hygiene. In an interview on 07/09/2026 at 12:29 PM, Director of Nursing (DON) B reported staff were expected to wear gloves while administering eye drops.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview, and record review the facility failed to post the actual daily Nursing Staffing Data resulting in the potential for all 143 Residents and/or family and/or visitors to be well informed of the facility's staffing information. Findings Included: During observation on 07/09/2026 at 09:24 a.m. the facility document entitled 8(SP)Resident Care & Complaint Intake Staff was observed to be posted in a glass case across from the Nursing Home Administrators office. The document demonstrated a date of 07/08/2026 and a Resident Census of 146. The document revealed two columns that were listed by shift (Day shift, Afternoon Shift, and Midnight Shift). Below each shift was listed job classification and listed total and total Hours. The same facility document listed the following: Day Shift Total Total Hours Total Total Hours RN 0 0 Agency-RN 0 0 LPN 9 72 Agency-LPN 0 0 CENA 13 97.5 Agency-CENA 0 0 MDS-RN 3 24 Restorative -LPN 0 0 MDS-LPN (blank) (blank) Restorative -CENA (blank) (blank) Afternoon Shift Total Total Hours Total Total Hours RN 0.5 4 Agency-RN 0 0 LPN 9 72 Agency-LPN 0 0 CENA 11.5 86.25 Agency-CENA 0 0 MDS-RN (blank) (blank) MDS-LPN (blank) (blank) Midnight Shift Total Total Hours Total Total Hours RN 1 8 Agency-RN 0 0 LPN 9 72 Agency-LPN 0 0 CENA 10 75.0 Agency-CENA 0 0 MDS-RN (blank) (blank) MDS-LPN (blank) (blank) In an interview on 07/09/2026 at 10:08 a.m. Staffing Coordinator D explained that she was responsible for posting the 8(SP)Resident Care & Complaint Intake Staff document each day. Staffing Coordinator D explained that the hours record are scheduled hours to be worked and not actual hours worked for each shift. She explained that she had not been educated to post the actual hours worked at the end of the shift. In an interview on 07/09/2026 at 10:22 a.m. Director of Nursing (DON) B confirmed that the posted document entitled 8(SP)Resident Care & Complaint Intake Staff, dated 07/08/2026, had not included actual hours worked for each shift. DON D explained that she did not have knowledge that federal statute 483.35(iii) had the requirement that the facility must post information that included actual hours worked.		