STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235626	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Troy	925 W South Blvd Troy, MI 48085

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 0585

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

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 41415

This citation pertains to intake: MI00144428.

Based on interviews and record reviews the facility failed to accurately document and address the concerns verbalized for one (R402) of two residents reviewed for quality of care. Findings include:

Review of a complaint submitted to the State Agency (SA) documented in part, . On more than one occasion (R402's) bed was wet, and she was left sitting in her own urine. (R402 name) told staff that it is burning her when she went to pee. A strong urine smell was in her room . Staff advised they would take a urine sample . Staff never took her sample to see if she had a UTI (urinary tract infection) . On 5/6/24 she was sitting on soaked bedsheets . (complainants name) pulled (R402 name) out of (facility name) on 5/7/24 due to them not providing her with proper care .

Review of the medical record revealed R402 was admitted to the facility on [DATE], with diagnoses that included: Rhabdomyolysis (condition where your muscles break down and release toxins into your blood and kidneys) and a urinary tract infection. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition and required staff assistance for all Activities of Daily Living (ADLs).

Review of a Social Work note dated 5/6/24 at 4:56 PM, documented in part . Discharge note: Writer spoke with resident's son (son name), son stated that he would like resident to d/c (discharge) tomorrow, 5/7/24 on insistency . No further questions or concerns at this time. SW (Social Worker) will continue to follow . this note was documented by SW B.

On 5/20/24 at 10:21 AM, SW B was interviewed and asked why R402's son requested that R402 be discharged from the facility earlier than planned and SW B stated the son had nursing concerns and they could not remember the exact concerns but knew it had something to do with nursing.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
NAME OF PROVIDER OR SUPPLIER: Optalis Health and Rehabilitation of Troy		STREET ADDRESS, CITY, STATE, ZIP CODE: 925 W South Blvd Troy, MI 48085	

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 12:30 PM, Licensed Practical Nurse (LPN) G (the nurse assigned to R402 on 5/6/24 when R402 was allegedly observed sitting on urine-soaked bed sheets) was interviewed and asked about 5/6/24 and the concerns that R402's son had that prompted their request to have R402 discharged the next day and LPN G stated in part, . when he came in she was wet . I calmed him down . she was wet because I changed the bed myself, so the bedding was wet. I cleaned her up and changed the complete bedding . LPN G explained that she informed the Nurse Practitioner (NP) that was on the unit at the time of R402's son's concerns and that he wanted R402 discharged , and the NP stated they would go and talk to R402's son. LPN G stated they did not hear anything more about the situation for the rest of their shift. LPN G stated the last time they saw R402's son they were talking to the Social Worker. When asked, LPN G stated they did not complete a concern form regarding R402's concern. Review of a facility policy titled Investigations of Grievances 10/1/22, documented in part . This Facility has a formal grievance format for the resident to voice a grievance to the facility . The resident and/or residents' representative may voice any grievance or concern by speaking with a staff member . The grievance whether given verbally or written to a staff member will be given to the Director of Nursing or Designee on duty . The Director of Nurses is responsible to ensure the proper investigation and follow-up is conducted . On 5/20/24 the Director of Nursing (DON) who was also serving as the Administrator in the absence of the facility's Administrator during this survey was asked to provide all of the grievances/concern forms filed for R402. Review of a concern form dated 5/6/24, completed by SW B, documented in part . son has concern about resident's blood pressure dropping . The Documentation of facility follow-up documented in part . resident's son refused to speak w (with)/me, he spoke with resident's nurse (LPN G) . Further review of the section Resolution of Concern documented Was complainant satisfied with the resolution? No . refusal to speak w/writer . This concern form did not document the actual concern of R402's son, regarding the resident to have been found soaked in urine and urine-soaked sheets. The follow up documentation noted on this form was completed by the Unit Manager. Review of the progress notes revealed R402 was discharged the next day on 5/7/24. On 5/20/24 at 1:11 PM, the DON was interviewed and asked if they knew why R402's son requested for R402 to be discharged from the facility earlier than their anticipated discharge date of (5/16/24 per SW B) and if they knew the concerns that R402's son had regarding R402's care and the DON stated they were not really sure of R402's son concerns, however when asked, acknowledged his concerns should have been documented on a grievance form. The DON stated they would look into it further and follow back up with any additional information. No further information or documentation was provided before the end of the survey.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00144428. Based on interviews and record reviews the facility failed to ensure consistent physician monitoring and follow-up of vaginal/urinary concerns for one R402 of two residents reviewed for quality of care. Findings include: Review of a complaint submitted to the State Agency (SA) documented urinary concerns to have not been address and followed up on by the facility nurses and physician, which resulted in R402 to have been admitted to the hospital with a diagnosis of a Urinary Tract Infection (UTI). Review of the medical record revealed R402 was admitted to the facility on [DATE], with diagnoses that included: Rhabdomyolysis (condition where your muscles break down and release toxins into your blood and kidneys) and a urinary tract infection. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition and required staff assistance for all Activities of Daily Living (ADLs). Review of the hospital documents provided to the facility staff upon R402's admission documented in part . Patient's rehab course was complicated by dysuria, U/A (urinalysis) positive for bacteria and leukocyte esterase, pt (patient) started on Macrobid (antibiotic) 100 mg (milligram) bid (twice a day) x5days. Suggest urine culture at receiving facility to assess sensitivity . Review of R402's medical record revealed no results of a urine culture to have been completed. Further review of the medical record revealed no documentation of the nurses or physician to have identified or acknowledged the hospital recommendation of the urine culture to be completed once at the facility. Review of a Nursing note dated 4/30/24 at 3:08 PM, documented in part . Charge nurse informed to notify attending if vaginal odor persist . Review of a Nursing note dated 5/1/24 at 11:06 AM, documented in part . (Physician F name) notified. New order to collect urine for UA (urinalysis). Assigned nurse notified. Resident notified. Plan of on-going care . Review of the physician orders documented in part . 5/1/24 . Collect urine for UA and C&S (culture and sensitivity), and call lab for pick up . one time only until 05/01/2024 . Status . Completed . Review of the medical record revealed no results of a UA or C&S to have been completed or followed up on. Review of the physician notes, including the physician note dated 5/7/24, documented on the day of R402's discharge, revealed no documentation of the physician to have followed up with the ordered UA and C&S, nor assess or address the documented concerns of R402's vaginal odor before R402's discharge. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 1:11 PM, the Director of Nursing (DON) was interviewed and asked about the urinalysis and C&S follow up for R402 and the DON stated the Assistant Director of Nursing (ADON) E was on the phone with the laboratory trying to figure out what happened and will follow up once they were done. The DON was then asked if the physician should have followed up with the concern of the vaginal odor and UA and C&S results before R402 was discharged and the DON stated the physician should have reviewed and addressed the concerns before R402 was discharged . On 5/20/24 at 2:59 PM, a telephone interview was conducted with Physician F, when asked, Physician F confirmed they were aware of R402 to have had a vaginal odor, however stated the urinalysis and C&S was pending at the time they consulted with R402. Physician F asked if it was the normal procedure to discharge residents without the monitoring and assessment of these concerns and Physician F stated they would have to review their notes, because they did not remember the resident telling them any concerns. Physician F was then read the recommendation of the hospital to culture R402's urine once at the facility to review the sensitivity and/or the resistance of the prescribed antibiotic and Physician F sated they were not aware of the hospital note. Physician F did not have access to their notes for this telephone interview. On 5/20/24 at 3:46 PM, the DON forwarded an email to the surveyor for the alleged laboratory supervisor, that documented in part . We received the sample for the above patient in the subject line on 05/02/2024. However, We were unable to proceed with testing due to no accompanying order for the test specimen. We tried to contact your facility the same day before rejecting the specimen, which is our standard protocol for all the specimens we receive in the sample. When our laboratory does reject specimens, if there is an order created for the patient, a notification is generated automatically informing the facility to recollect the specimen with a new order. In this case this did not happen due to absence of the original order . This indicated the ordered UA and C&S was not processed and/or followed up on and R402's vaginal concerns were not addressed prior to their discharge from the facility.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00144428. Based on interviews and record reviews the facility failed to ensure laboratory services for a urinalysis and culture/sensitivity test were completed as ordered and ensured the timeliness of a urinalysis results were processed, obtained, and reported to the physician for follow-up for one (R402) of two residents reviewed for quality of care. Findings include: Review of a complaint submitted to the State Agency (SA) documented concerns of the facility staff failing to have obtained a urine sample, ensure it was processed and the results were reported to the physician, which resulted in R402 to have been admitted to the hospital with a diagnosis of a Urinary Tract Infection (UTI). Review of the medical record revealed R402 was admitted to the facility on [DATE], with diagnoses that included: Rhabdomyolysis (condition where your muscles break down and release toxins into your blood and kidneys) and a urinary tract infection. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition and required staff assistance for all Activities of Daily Living (ADLs). Review of a Nursing note dated 4/30/24 at 3:08 PM, documented in part . Charge nurse informed to notify attending if vaginal odor persist . This note was written by an Assistant Director Of Nursing (ADON) P who was no longer employed with the facility, was documented to be a Registered Nurse (RN). There was no further documentation on why ADON P had not notified the physician of the vaginal odor. Review of a Nursing note dated 5/1/24 at 11:06 AM, documented in part . (physician name) notified. New order to collect urine for UA (urinalysis). Assigned nurse notified. Resident notified. Plan of on-going care . Review of the physician orders documented in part . 5/1/24 . Collect urine for UA and C&S (culture and sensitivity), and call lab for pick up . one time only until 05/01/2024 . Status . Completed . Review of the medical record revealed no results of a UA or C&S to have been completed or followed up on. On 5/20/24 at 11:25 AM, ADON E (the current ADON, who also serves as the facility Infection Control nurse) was interviewed and asked the facilities protocol on ADON P to have initially identified a change of condition with R402 on 4/30/24, with no documented follow up and ADON E stated it should be the nurse that identified it notifying the physician, especially if they documented on it. ADON E was informed that another facility nurse did notify the physician the next day on 5/1/24, in which a UA and C&S was ordered, however the results were unable to be located in the medical record. ADON E stated they would look into it and follow back up. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/24 at 1:11 PM, the Director of Nursing (DON) was interviewed and asked about the UA and C&S results that was ordered by the physician on 5/1/24, the DON stated that ADON E was on the phone with the laboratory trying to figure out what happened and would follow back up once they were done. On 5/20/24 at 3:46 PM, the DON forward an email to the surveyor for the alleged laboratory supervisor, that documented in part . We received the sample for the above patient in the subject line on 05/02/2024. However, We were unable to proceed with testing due to no accompanying order for the test specimen. We tried to contact your facility the same day before rejecting the specimen, which is our standard protocol for all the specimens we receive in the sample. When our laboratory does reject specimens, if there is an order created for the patient, a notification is generated automatically informing the facility to recollect the specimen with a new order. In this case this did not happen due to absence of the original order . No further explanation or documentation was provided before the end of the survey.