

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 06/25/2024
NAME OF PROVIDER OR SUPPLIER Optalis Health and Rehabilitation of Troy		STREET ADDRESS, CITY, STATE, ZIP CODE 925 W South Blvd Troy, MI 48085	

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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415</p> <p>This citation pertains to Intake: MI00145107.</p> <p>Based on interview and record reviews the facility failed to implement an effective baseline care plan to ensure the necessary care was provided to one R402 of three residents (including R405) reviewed for a change of condition. Findings include:</p> <p>R402 was admitted to the facility on [DATE], with diagnoses that included: chronic respiratory failure with hypoxia, gastrostomy status, paralysis of vocal cords and larynx and tracheostomy status. R402 required staff assistance for all Activities of Daily Living (ADLs).</p> <p>Review of the physician orders revealed R402 was receiving enteral feeding 24 hours continuously.</p> <p>Review of the progress notes revealed the following:</p> <p>On [DATE] at 10:11 PM, a Nursing note documented . upon arriving on shift at 1900 writer walked into (R402's name) room to do rounds and pt (patient) appeared to be lying in bed in <sic> feed tube running. At 2120 Writer later went into pts room to get vitals and given medications to pts and pt appeared unresponsive. Writer tried to obtain pts vitals but was unsuccessful with any. Writer noticed a brown substance around pts tracheotomy area. Writer called a code cpr (cardiopulmonary resuscitation) chest compressions performed and ambu bag attached to tracheotomy. 911, DON (director of nursing) and emergency contact #1 called and made aware of (R402's name) passing.</p> <p>On [DATE] at 10:27 AM, the DON documented a following up note . found unresponsive at 2120. She was wearing a DNR (do not resuscitate) bracelet from the hospital but code status was confirmed to be full code in the facility at time of code. CPR was initiated. The kangaroo pump was stopped, and tube feeding was suctioned from her mouth and trach as it started to come out, resident had foam at mouth. Resident's extremities were cold to touch. EMS (emergency medical services) arrived and took over code at 2132, continuing compressions and pushing epi pens. TOD (time of death) called by (physician name) .</p> <p>Review of the care plans included the following:</p> <p>A care plan titled The resident has altered respiratory status/Difficulty Breathing r/t (related to) trach, chronic resp (respiratory) failure.</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 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A care plan titled The resident is at nutritional risk r/t PCM (protein calorie malnutrition), malnourished, dysphagia (difficulty swallowing), dependence on enteral feed, alcoholic cirrhosis.</p> <p>Review of a facility policy titled Tube Feeding - Overview dated [DATE], documented in part . The resident's plan of care will address the use of feeding tube, including strategies to prevent complications, proper positioning of the resident consistent with the resident's needs .</p> <p>Review of the 22 pages of R402's care plans failed to implement an intervention on the proper positioning of the resident.</p> <p>Review of a sampled resident R405, the only resident in the facility at the time of the survey with a tracheostomy and who also received enteral feedings was completed.</p> <p>Review of R405's medical record revealed they were admitted to the facility on [DATE]. A physician order implemented the day of admission documented in part, . Elevate HOB (head of bed) 30 to 45 degrees at all times during feeding and for at least 30 to 40 minutes after the feeding is stopped . every shift for Nutrition and hydration needs Elevate HOB 30 to 45 degrees at all times during feeding .</p> <p>The facility staff failed to implement an intervention or physicians order for R402 for proper positioning while receiving enteral feeding.</p> <p>On [DATE] at 4:57 PM, the Administrator and Assistant Director of Nursing (ADON) D who served as the representative of the DON (the DON was on vacation at the time of this survey), was interviewed. The Administrator and ADON D were both asked why R402 did not have an intervention implemented for proper body positioning considering they had continuous enteral feeding and a tracheostomy, the same as R405 who had the intervention/physician order implemented the same day as admission. The Administrator and ADON D stated they would look into it and follow back up. At 5:49 PM, the Administrator and ADON D returned and stated it was the facility's standard of practice to have the proper positioning implemented and physician order put in place on admission, both acknowledged the concern.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415</p> <p>This citation pertains to intake: MI00144714.</p> <p>Based on interview and record review the facility failed to ensure a change of condition was timely addressed and accurately reported for one (R403) of three residents reviewed for a change of condition. Findings include:</p> <p>Review of a complaint submitted to the State Agency (SA) documented concerns of the facility staff failure to address a change of condition for R403 timely.</p> <p>Review of the medical record revealed R403 was admitted to the facility on [DATE] with diagnoses that included syncope and collapse.</p> <p>Review of the Nursing progress notes documented the following:</p> <p>On 5/25/24 at 8:26 PM, . Resident has excessive menorrhagia (abnormally heavy menstrual bleeding), family insisted on sending pt (patient) to ER (emergency room). Family contact <sic> (local police department name) and pt was sent by request of pt and family to (hospital name).</p> <p>On 5/25/24 at 9:59 PM, . Pt passing blood clots. Writer informed MD (Medical Doctor). BP (blood pressure) 107/57, P (pulse) 75, SPO2 (oxygen saturation)=93% T (temperature)=100.5 R (respiration)18. Denies pain at this time. Writer informed that surgeon was contacted. Order for HgB (hemoglobin) on Monday. Will continue to monitor.</p> <p>On 5/26/24 at 12:59 AM, . Pt request to be sent to hospital for excessive bouts of menorrhagia. Family member contacted (local police department) to have patient transported to hospital. ER contacted with report. Pt transferred to (hospital name) at 11:18pm at family and pt request.</p> <p>The above notes were documented by Licensed Practical Nurse (LPN) A.</p> <p>Review of the medical record revealed no documentation or explanation on why it took close to three hours to transfer R403 to the hospital after the identification of R403's change of condition and per R403/family request. Further review of the medical record revealed no notification to the physician of R403's 100.5-degree temperature and no treatment administered for R403's elevated temperature.</p> <p>On 6/25/24 at 4:33 PM, LPN A was interviewed via telephone and asked if they reported the temperature of 100.5 when the physician was notified of R403's blood clots and LPN A stated they did not. When asked why they had not reported to the physician or administered medications/interventions to help bring R403's temperature down, LPN A replied they did not treat the resident because they were sending them to the hospital. LPN A was then asked why it took almost three hours to transfer the resident to the hospital after the initial identification of the change of condition and per R403/family request, and LPN A stated they monitored R403 for a little bit and they believed R403 stated they did not want to go to the hospital, so LPN A monitored R403. LPN A stated R403's daughter came to the facility and maybe an hour later the police came to the facility at the family's request to transfer the resident to the hospital.</p> <p>(continued on next page)</p>		

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