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	08/07/2024

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00146135. Based on interview and record reviews the facility failed to develop and implement a comprehensive person-centered care plan to address the urinary diagnoses for one (R303) of four residents reviewed for quality of care. Findings include: Review of the preadmission documents provided to the facility by the transferring hospital at R303's admission documented the following: A History and Physical dated 7/14/24, documented in part . Chief Complaint- Dysuria (painful urination) . past medical history of recurrent UTI's (Urinary Tract Infections) with resistant bacteria . right ureteric stent (a thin tube inserted into the ureter to prevent or treat obstruction of the urine flow from the kidneys) for hydronephrosis (a condition characterized by excess fluid in a kidney due to a backup of urine) exchanged every 3 months . Patient has been admitted multiple times for recurrent complicated UTIs with multidrug-resistant (MDR) bacteria as Pseudomonas (bacteria), ESBL (extended spectrum beta-lactamase-bacteria), MRSA (methicillin-resistant staphylococcus- bacteria), and for ureteric stent exchange every 3 months for right hydronephrosis . Past Medical History- Ongoing . Hydronephrosis, right . Renal insufficiency- CKD (chronic kidney disease) stage 3 . Acute complicated UTI with MDR . Sepsis on admission . Further review of the hospital documentation revealed R303 was transferred to the facility on [DATE], with antibiotics to be administered for an additional four days to treat their UTI infection. A review of the medical record revealed R303 was readmitted to the facility on [DATE], with diagnoses that included urinary tract infection, hydronephrosis with ureteral stricture (narrowing), resistance to vancomycin, pseudomonas, methicillin resistant staphylococcus, extended spectrum beta lactamase resistance, sepsis, obstructive and reflux uropathy, and chronic kidney disease stage 3. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status score of 14 (which indicated intact cognition). R303 required staff assistance for all Activities of Daily Living (ADLs). A review of the care plans revealed no care plan ever implemented for the resident's urinary tract infection or complicated history of, ureteric stent, hydronephrosis or chronic kidney disease. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a facility policy titled Care Plan - Comprehensive and Revision revised 8/25/23, documented in part . A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident . Care plan interventions are chosen only after gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making . On 8/7/24 at 11:02 AM, the Director of Nursing (DON) was interviewed and the hospital documentation, medical diagnoses and care plans were reviewed. The DON was asked if care plans should have been implemented for the resident's UTI upon admission, complications/history of UTIs, chronic kidney disease, ureteric stent and hydronephrosis. The DON stated a care plan should have been in place and stated they would follow up on the concern. No further explanation or documentation was provided by the end of the survey.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34275 This citation pertains to Intake #MI00145683 and MI00145247 Based on interview and record review, the facility failed to ensure timely showers were provided for one (R302) of two residents reviewed for Activities of Daily Living (ADL). Findings include: Complaints were filed with the State Agency (SA) that alleged residents were not adequately groomed and told by staff that they did not have time to provide showers. R302 A review of R302's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: sciatica right side, dementia, leukemia of B-cell and hearing loss. A review of the resident's Minimum Data Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 15/15 (cognitively intact cognition) and required assistance with all transfers. The resident's care plan documented, in part: Focus: ADL Self care deficit as related to back pain with sciatica Interventions: Assist to bathe/shower as needed .Bed mobility x1 .Toilet x2 at bed level for safety . The facility was asked to provide documentation pertaining to showers provided to R302 from admit 6/5/24 through 7/3/24 as the shower TASK could not be reviewed electronically. A paper printout of R302's Task was provided and reviewed. The documents complete by facility staff noted R302 did not receive a shower during their stay at the facility and received their first bed bath on 6/24/24 (over three weeks past admission). On 8/7/24 at approximately 2:55 PM, the Director of Nursing (DON) was interviewed as to the protocol for providing showers. The DON noted that showers and/or bed baths were usually provided twice per week and as needed. Nursing staff should document that the shower was provided or refused. Following the interview, the DON noted that there may be additional paperwork that showed that showers/and or bed baths were provided. On 8/7/24 at approximately 3:30 PM, paper shower sheets were provided and indicated that R302 received only bed baths on 6/13/24, 6/17/24, 6/20/24 and 6/24/24. There was no documentation in the residents notes that they either requested only bed baths and/or refused showers. Review of the provided facility policy titled, Select Facility (2/1/2003) documented, in part: Policy: To cleanse and refresh the resident .escort the resident to the shower .

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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** 41415 This citation pertains to intake: MI00146135. Based on interview and record reviews the facility failed to obtain an adequate assessment, notify the physician of the change in condition and ensure the timely transfer to a higher level of care, for one (R303) of four residents reviewed for quality of care. Findings include: Review of a complaint submitted to the State Agency (SA) documented concerns of R303's care and the delay in transferring the resident to a higher level of care. A review of the medical record revealed R303 was readmitted to the facility on [DATE], with diagnoses that included acute respiratory failure with hypoxia, urinary tract infection, hydronephrosis with ureteral stricture, sepsis, obstructive and reflux uropathy, and chronic kidney disease stage 3. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status score of 14 (which indicated intact cognition). R303 required staff assistance for all Activities of Daily Living (ADLs). Review of a change of condition note dated 8/4/24 at 5:57 PM by Registered Nurse (RN) D, documented in part, . Change In Condition . Blood Pressure 116/58 - 8/4/2024 17:58 (5:58 PM) . Pulse: P 119 - 8/4/2024 17:59 (5:59 PM) Pulse Type: Regular . R (respirations) 18.0 - 8/4/2024 11:44 (AM) Temp (temperature): T 98. 4 - 8/4/2024 11:44 (AM) Route: Forehead . Pulse Oximetry: 02 (oxygen) 100.0% - 8/4/2024 11:44 (AM) Method: Oxygen via Nasal Cannula . Review of a Nursing note by RN D at 6:11 PM on 8/4/24, documented in part . Pt (patient) alert and oriented x3, able to make needs known. Pt informed writer that she was having [NAME] (difficulty in breathing), pt's daughter is at the bedside, pt is showing no s/s (signs/symptoms) of distress. Writer left to go obtain VS (vital signs) from this resident, daughter informed writer that pt wants to go to the hospital. VSS (vital signs stable) charted in (electronic record), writer offer <sic> a prn (as needed) breathing treatment per physicians' orders, which pt and her daughter decline <sic>. Pt's daughter call <sic> 911, 911 transferred pt to (hospital name) for further evaluation. DON (director of nursing) notified of situation; paperwork send with EMS (emergency medical services). A review of the medical record revealed RN D had obtained the blood pressure and pulse of R303, however failed to obtain the current respirations, temperature and pulse oximetry levels for a resident verbalizing difficulty breathing. Further review of the medical record revealed no documentation of the physician to have been notified. On 8/7/24 at 9:35 AM, an interview was conducted with R303's Family Member (FM B). FM B was asked about the incident on 8/4/24 and why they called 911 to have R303 transferred to the hospital. FM B stated they had asked RN D several times to send R303 to the hospital. FM B stated R303 had informed them that they had difficulty breathing throughout the night and had asked the nurse to send them to the hospital and they would not. FM B stated they told R303's nurse (RN D) to send the resident to the hospital. FM B stated they ended up having to call 911 themselves to have the resident transferred out. FM B stated R303 was currently admitted to the intensive care unit for sepsis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 10:02 AM, the room mate of R303, was interviewed. When asked if they remembered R303, they stated they did. The room mate stated how R303 kept saying they couldn't breathe in the middle of the night and they tried their best to keep R303 calm until the nurse got in the room. The room mate stated the nurse eventually came and administered R303 a breathing treatment and medications. The room mate stated R303 was sweating and kept saying that they couldn't breathe and the next day R303's daughter took R303 out of the facility to the hospital. Review of the hospital records documented the following: An Emergency Medicine physician consult dated 8/4/24 at 6:35 PM, documented in part . comes from ECF (extended care facility) with fever chills tachycardia borderline blood pressure. Patient's temperature is 38.8 (101.8 degrees Fahrenheit) tachycardic at 131 . blood pressure 109/47 . will start IV (intravenous) antibiotics as concern for sepsis with fever and tachycardia . Patient will be started on fluid hydration Tylenol antibiotics and will be admitted to intensive care unit . The failure to initiate these interventions on an urgent basis would likely (high probability) result in sudden, clinically significant or life-threatening deterioration in the patient's condition . A Urology consult dated 8/5/24, documented in part . Primary Problem: Sepsis 1. UTI, sepsis 2. Right ureteral stricture managed with chronic right ureteral stent 3. Mild right hydronephrosis 4. AKI (acute kidney injury) . Continue antibiotics per ID (infectious disease) . On Rocephin and vanco (vancomycin- antibiotics) . A Infectious Disease consultation dated 8/5/24, documented in part . Patient's family was seeing her at the extended care facility when her blood pressure went low, became tachycardic. Family was concerned so called 911. On presentation she was complaining of chest pain, shortness of breath, chills. On presentation she was febrile up to 38.8 . She was started on IV meropenem and vancomycin (antibiotics) and ID has been consulted for sepsis . At the time of the survey R303 was still hospitalized in the intensive care unit. Review of the care plans revealed no implementation of a care plan for any of R303's urinary diagnoses. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 10:29 AM, RN D was interviewed via telephone, when asked about R303 on the date they transferred to the hospital, RN D stated they were informed that R303 was having difficulty breathing. RN D stated they offered to complete a breathing treatment and check their vitals. RN D stated R303's daughter wanted R303 to be transferred to the hospital. RN D was asked about their note documented on 8/4/24 regarding the resident's vitals to have been stable. RN D confirmed the vitals were stable. RN D was asked how they considered the value of the respirations, temperature and pulse oximetry that was obtained earlier that day on 11:44 AM as a full accurate stable assessment. RN D stated at the time they were more concerned about the resident's blood pressure and pulse. When asked why, considering the resident was already dependent on 3 L (liters) of supplemental oxygen continuously, and had the chief complaint of difficulty breathing. RN D was asked why the respirations, pulse oximetry and temperature wouldn't be just as important. RN D stated they know they took the complete vitals, which were normal per RN D but they could not recall where they documented. RN D then stated they must have forgot to document the respirations, pulse oximetry and temperature. RN D was asked if they were concerned about the heart rate of 119 that they had obtained, considering there was no documentation of the physician to have been notified or any interventions/treatment provided. RN D stated 911 was already on their way to the facility and the 119 heart rate was R303's normal baseline. RN D was informed that R303's blood pressures were reviewed for their whole duration of inpatient care and R303 heart rate had never reached into the 100's until 8/4/24 the day that R303 was transferred to the hospital. RN D then stated the off going nurse that gave them report stated R303 was tachycardic and that was the residents normal baseline. RN D was asked if they reviewed R303's record themselves and RN D stated it was the first time they were assigned to R303. RN D was asked if they contacted the physician regarding the change of condition for R303 and RN D stated they were unable to get in touch with the physician so they notified the DON who they believed contacted the physician. RN D stated they informed the DON of the resident's daughter to have called 911 for EMS to transfer the resident to the hospital despite them offering the breathing treatment. Review of a facility policy titled Change in Condition Notification dated 8/9/23, documented in part . It is the policy of the facility to notify the resident, his or her attending physician/practitioner . A significant change in the resident's physical, mental, or psychosocial status, such as deterioration which includes life-threatening conditions or clinical complications . On 8/7/24 at 10:52 AM, the DON was interviewed and asked if the nurses were expected to do a full assessment with a complete set of current vitals for a resident with a change of condition. The DON replied a full assessment with current vitals should be conducted and reported to the physician. The DON was then asked if the resident and resident family reports a change of condition and informs the staff of their wishes to be sent to the hospital, what is the facility's protocol. The DON replied they are supposed to do interventions based off of the nurses assessment before sending them out. R303's record was reviewed with the DON. The DON stated the nurse should have completed a full assessment and contacted the physician. The DON stated care plans should have been implemented for R303's urinary diagnoses. The DON stated they would look and see if they can find any additional information. No further explanation or documentation was provided by the end of the survey.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41415 This citation pertains to intake: MI00146135. Based on interview and record reviews, the facility failed to ensure an order for oxygen was continuously administered as prescribed by the physician, for one (R303) of two residents reviewed for oxygen administration. Findings include: Review of a complaint submitted to the State Agency (SA) documented the facility failed to ensure the resident was receiving their supplemental oxygen continuously as ordered. A review of the medical record revealed R303 was readmitted to the facility on [DATE], with diagnoses that included acute respiratory failure with hypoxia. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status score of 14 (which indicated intact cognition). R303 required staff assistance for all Activities of Daily Living (ADLs). A review of the physician orders documented the following: Oxygen delivery via NC (nasal cannula) 3 L (liters) continuous every shift for breathing. Start date 7/19/24 & reordered on 7/30/24. On 8/7/24 at 9:35 AM, the Family Member (FM B) of R303 was interviewed and when asked about R303's care at the facility, recalled an incident when they visited R303 at the facility and went into their room and observed R303's oxygen concentrator shut off. FM B stated they went to inform R303's nurse (later identified as Registered Nurse- RN A) to see what was going on and RN A asked FM B if they had turned the oxygen concentrator back on for the resident. FM B stated No, but I will. I wanted to make you aware. FM B continued to verbalized their concerns regarding the care that R303 received while at the facility. On 8/7/24 at 11:53 AM, a telephone interview was conducted with RN A. RN A was asked if they recalled the incident with FM B approaching them and informing them that R303's oxygen concentrator was completely off with no oxygen being provided to R303. RN A stated they did remember the incident regarding (FM B) being upset that R303's oxygen was off. RN A stated they believed R303 went with the beautician that day. RN A stated they were unaware of R303 being up in their chair without oxygen being administered until notified by FM B. RN A stated that FM B was upset, understandably. RN A stated they were unsure of which staff member assisted R303 that day and denied being informed by any staff member that R303 was not being provided their ordered supplemental oxygen. RN A stated they informed the Therapy Director- TD C of the incident, because they believed it was a therapy staff member that transported the R303 back to their room and failed to inform the nurse that R303 was not receiving their oxygen. On 8/7/24 at 12:12 PM, TD C was interviewed and asked about the incident with R303 and stated they were made aware of the incident by RN A. TD C stated they investigated the incident with their staff and identified that none of the therapy staff members were involved in the incident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/7/24 at 2:05 PM, the Director of Nursing (DON) was interviewed and asked if there was any exception to not provide continuous oxygen to a resident that is prescribed continuous supplemental oxygen and the DON stated, No, the oxygen should be on at all times. The DON was then asked about the incident with R303 and RN A and the DON stated they were made aware of the situation today by RN A and would start an investigation and education immediately. Review of a facility policy titled Administration of Oxygen Policy dated 8/2/10, documented in part . It is the Center's Policy to manage patient/residents utilizing Oxygen per physician orders and clinical best practices . It is the responsibility of the RN/LPN (Licensed Practical Nurse) to ensure compliance . No further explanation or documentation was provided by the end of the survey.