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	06/25/2025

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 0684 Level of Harm - 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** R303 Review of the medical record revealed R303 was admitted to the facility on [DATE], with a primary diagnosis of displaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture, pulmonary hypertension and heart failure. A Minimum Data Set (MDS) assessment dated [DATE], noted a Brief Interview for Mental Status (BIMS) score of 15 (which indicated intact cognition). A review of a Nursing note dated 1/8/25 at 9:00 PM, documented in part . Patient observed sleeping in chair when writer attempted wake patient, she had a delayed response which was different from our morning interactions. Writer checked her BP (blood pressure) it was 90/44, writer then checked her blood sugar it was 49 (normal is above 70). Writer assisted CNA (certified nursing assistant) to help patient into bed and elevated her feet. Writer gave the patient orange juice and chocolate candies she had in her room. Her blood sugar went up to 70. Writer attempted to get the patient to eat dinner she ate a small portion and but was still slightly lethargic . Unit manager notified. Monitoring ongoing . There was no documentation of the Physician to have been notified. Review of a Nursing note dated 1/11/25 at 6:53 PM, documented in part . Patients family requested to take pt (patient) out AMA (against medical advice) rt (related to) cardiac issues. After speaking to DON (Director of Nursing) family agreed to have labs ordered and EKG (electrocardiography) in house. Labs drawn, urine sample collected and EKG ordered. Review of the Physician orders revealed an EKG order was not implemented until the next day on 1/12/25 at 7:43 AM, that documented . EKG Symptom(s): CABG (coronary artery bypass grafting) Condition of patient that requires the exam to be performed portably . STAT (immediate) . The order was created by the DON. A review of the record revealed the STAT EKG was not completed and the resident was transferred to the hospital on 1/12/25 at 6:40 PM, for respiratory distress. A review of the record revealed no documentation from the clinical staff regarding the cardiac concerns documented in the 1/11/25 Nursing note. A review of the Pulse Summary noted the following: On 1/10/25 at 10:12 PM- 53 bpm (beats per minute) (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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 1/9/25 at 1:18 PM- 58 bpm (normal is above 60) A review of the Blood Pressure Summary noted the following: On 1/6/25 at 5:02 PM- 120/48 mmHg (millimeters of mercury) On 1/7/25 at 9:26 AM- 107/55 mmHg On 1/7/25 at 1:37 PM- 92/43 mmHg On 1/7/25 at 5:49 PM & 7:26 PM- 112/60 mmHg On 1/8/25 at 5:27 PM- 90/44 mmHg On 1/9/25 at 12:06 PM- 94/52 mmHg On 1/10/25 at 12:55 PM- 89/55 mmHg On 1/10/25 at 2:27 PM- 90/62 mmHg On 1/10/25 at 7:15 PM- 84/57 mmHg On 1/10/25 at 10:22 PM- 101/50 mmHg These are all noted deviations from R303's baseline. The record revealed no documentation of the Physician to have been notified. Review of a facility policy titled Change in Condition policy dated 10.2022 documented in part . It is the policy of this facility that residents will be routinely monitored and evaluated by all staff members to determine the need for additional heal services monitoring of chronic, unstable, or changes in condition. Results of additional monitoring will be routinely evaluated for appropriateness and effectiveness . Observations or Changes of Condition could indicate the need for additional health services or monitoring . Seems different than usual . Tired, weak, confused, or drowsy . When a change in condition has been identified, the physician team will be called for direction . A Nursing note dated 1/12/25 at 7:39 PM, documented in part . Patient transferred to hospital via ambulance at 18:40 for respiratory distress . A review of the hospital records revealed the following: A Emergency Medicine consult dated 1/12/25 at 8:07 PM, documented in part . presents to the Emergency Center today with a chief complaint of SOB (shortness of breath). Patient has had worsened SOB and fatigue over the last one week, with some confusion over the last week . She does not wear home oxygen and is on 4 L (liters) NC (nasal cannula) here . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	A General Medicine consult dated 1/13/25 at 4:33 PM, documented in part . She came to the ER due to shortness of breath and hypoxia. Does not wear home oxygen. The patient reports having shortness of breath and fatigue for the past week. There has been some confusion over the past week as well per family . She has significant swelling in her legs and abdomen. There is abdominal discomfort. Patient also stated that she had difficulty making urine for the past week and had little urine output . None of the above signs and symptoms were identified or documented by the facility staff. On 6/25/25 an interview was conducted with the DON. The DON was asked what cardiac issues R303 was experiencing as noted in the Nursing note on 1/11/25. The DON stated they were not sure but would look into it and follow back up. The DON was asked why the STAT EKG was ordered on 1/12/25 and asked if it was completed. The DON stated they would look into it. At 2:20 PM, the DON returned with a radiology requisition dated 1/11/25 for an EKG to be completed due to shortness of breath. The DON was asked again what signs and symptoms R303 was experiencing at that time. The DON was also asked about the indication of having shortness of breath identified by the staff on 1/11/25 considering the resident had to be transferred to the hospital on 1/12/25 due to respiratory distress. The DON stated they were unsure of the signs and symptoms R303 exhibited. The DON did not provide documentation of the EKG to have been completed or the results. No further explanation or documentation was provided by the end of the survey. This citation pertains to intake(s): MI00153566. Based on interview and record reviews, the facility failed to identify a change of condition, notify the Physician, ensure the appropriateness of antibiotics and ensure continuous monitoring, assessment and follow-up for two (R's 302 & 303) of three residents reviewed for a change of condition, resulting in an untreated urinary tract infection (UTI) that developed into septic shock secondary to UTI and Pneumonia and resulted in death (R302) and delayed treatment and transfer to a higher level of care (R303). Findings include: Clinical record review revealed R302 was admitted to the facility on [DATE] for further rehabilitation to improve strength and balance related to an unwitnessed fall at home resulting in lower spinal fractures, rib fractures and rhabdomyolysis (serious condition when lying in a position too long results in skeletal muscle break down and releases toxins into the blood and kidneys). R302 required a Foley catheter (indwelling catheter to drain urine from the bladder) while hospitalized related to their history of aggressive infusion of intravenous fluids related to their dehydration and history of urinary retention. R302 arrived to the facility with a condom catheter (external urine catheters applied like a condom) placed by the hospital. The Brief Interview of Mental Status (BIMS) assessed from 3/28/25 and 5/10/25 scored 15/15 indicating R302 was cognitively intact. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/27/25 at 9:39 AM, an interview was conducted with the sibling who filed the allegation (the complainant) and confirmed on Sunday morning 5/25/25 they called the facility concerned they had not heard from R302 in two days which was not normal. Per the sibling complainant, there is a five-hour drive distance between them, but were very close and would text and or converse daily. Unable to contact R302 the day prior, the sibling proceeded to contact the Facility's main number on the morning of 5/25/25 and spoke with a Nurse (unable to recall name) who commented R302 had not eaten in the last two days. While on the phone with the Nurse, it was found R302 had the phone turned off. The Nurse asked what the pass code was, accessed the phone, and instructed to call R302 back and left the room. The sibling said once on the phone with R302, I knew something was not right R302 .sounded weak, had slurred speech, could not understand what they were saying and could hardly speak . I knew R302 was in bad shape and immediately called the facility back and informed the Nurse that R302 sounds very bad, they cannot talk, sounds very weak. The Nurse replied they were in the middle of passing morning medications for 14 Residents and did not have time to send R302 out. The sibling complainant said they would call 911 themselves if the facility would not. The interview proceeded to reveal there was concern when R302 was to follow up with a Urologist back in April and was informed the appointment was not scheduled until May 29, 2025, and recent days prior to the 5/25/25 of having throat pain. A Medical Progress Note dated 4/1/25, authored by Medical Director (MD) F documented R302 was assessed for urinary retention greater than 600 milliliter (ml) and required straight catheter (insertion of tube into the bladder to drain urine, then removed after bladder emptying). Further record review revealed R302 had informed MD F urinary retention happens frequently, especially when after being hospitalized , and MD F ordered to consult with Urology. The Medical Progress note dated 4/2/25 authored by MD F documented R302 was calm, alert and orientated, in no distress but insisted on being evaluated for a Urinary Tract Infection (UTI) related to complaints of .was up peeing all night . and had bladder disease. R302 was adamant going to the hospital to be evaluated for Intravenous (IV) Antibiotics and seen by their Urologist. R302 was sent to the Emergency Department (ED) on 4/2/25 for further evaluation per their request. Record review from the ED discharge from 4/2/25 documented R302 was seen for urinary retention and was to follow up with Urology within three to five days. Record review of the 4/4/25 Progress Note from the Facility Provider documented R302 was to consult with Urology for urinary retention within three-seven days. Further record review revealed not until 4/24/25 was a Urology Consult scheduled and would not be seen until May 29, 2025. On 6/25/25 at 2:23 PM, an interview with Unit Manager LPN C was queried about the process for assuring Resident consultations are scheduled. LPN C replied once a Provider enters the order, Nursing must confirm, print the order, then forward to the unit clerk to schedule. On 6/25/25, the Director of Nursing (DON) was informed the original order from the Facility identified on 4/4/25, R302 was to follow up with Urology within three-five business days, and the first attempt of the follow up was not acknowledged until 4/14/25. Furthermore, the DON was informed that not until 4/24/25 was an appointment confirmed and scheduled for R302 to see a Urologist, which was not until 5/29/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	The DON proceeded to provide an email dated 4/14/2025 at 11:08 AM, the facility was waiting on the doctor's office to call back with a date and time for Urology appointment and had no further comment why this appointment had such a delay in scheduling. Record review of a Nursing Progress note dated 5/6/25 at 2:00 PM documented Nursing observed hematuria (blood in urine) in the resident's brief, and they expressed concerns of pain while urinating and Nurse Practitioner (NP) B was made aware of the situation. Progress notes from 5/8/25 authored by NP B documented .Urinalysis came back positive for infection. Patient started on Keflex . (brand name for Cephalexin an antibiotic). On 5/8/25 a 11:43 AM .Note Text: The system has identified a possible drug allergy for the following order: Cephalexin 500 milligram (mg) give one capsule my mouth three times a day for a UTI for 7 Days . Review of the Medication Administration Record (MAR) documented on 5/8/25 start Cephalexin 500 milligram (mg) give one capsule my mouth three times a day for a UTI. The MAR documented administration of the medication on 5/9/25 at 9:00 AM and 5/9/25 at 1:00 PM. Review of the MAR revealed Macrobid (generic for Nitrofurantoin an antibiotic) 100 mg give one capsule by mouth two times a day for UTI for 5 days. The MAR confirmed full administration of the antibiotic was started on 5/8/25 and completed on 5/13/25. Record review of the Urine Culture and Sensitivity reported on 5/9/25 at 11:05 AM, identified the organism present in R302's urine was Proteus Mirabilis which was resistant to the antibiotic Macrobid (Nitrofurantoin) which indicated this treatment was ineffective in treating R302's UTI. On 6/25/25 at 3:54 PM, an interview by telephone was conducted with NP B and when inquired about overseeing R302's medical care, NP B remarked they were not in front of their computer but recalled R302 had a complicated urinary history and mentioned retention and hematuria. NP B was queried about R302's antibiotic regimen and was unable to recall the specific details. When informed that R302 was started on the antibiotic Macrobid (Nitrofurantoin) on 5/8/25 and the urine culture and sensitivity reported on 5/9/25 confirmed Macrobid (Nitrofurantoin) was resistant to the infection, no comment was made by NP B. When questioned why an ineffective antibiotic for this specific infection remained ordered and administered, NP B had no comment. The DON was interviewed and confirmed laboratory results are posted daily from a dashboard and that themselves, the Infection Control Nurse and Nurse Unit Managers are responsible for reviewing. When inquired how review of R302 culture and sensitivity from 5/9/25 was missed, the DON requested to look into the concern. The DON returned moments later and acknowledged they personally signed off on this. When questioned what signed off meant, they replied this was discussed with NP B and because R302 and was no longer having signs and symptoms of infection, they felt it was appropriate to keep them on the antibiotic Macrobid (Nitrofurantoin). Record Review from Progress note from 5/22/25 at 3:47 PM by Social Worker (SW) G documented during a wellness visit for R302, .He stated he has a sore throat right now. Nurse notified . further record review did not reveal Nursing addressed the sore throat. Record review from an Alert Progress note from 5/23/25 at 9:12 AM by LPN C documented R302 .pt <sic> is so sad. HE <sic> said he wants to home. --NURSING WILL HAVE PSYCH F/U <sic> . (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 6/25/25 at 2:23 PM, an interview with Unit Manager LPN C was queried about why there are Progress Notes and additional notes titled Alert Note. LPN C replied any staff member can make an Alert Note if they feel there is something very important and needs to be addressed. When asked why the Alert Note identifies them (LPN C) as the creator of the note, LPN C replied they were not, they just reviewed the Alert Note and the entered the follow up portion . --NURSING WILL HAVE PSYCH F/U <sic> . When asked who originated the Alert note, LPN C said there is no documentation available who was the original creator. When asked if there was an urgency that warranted the staff to create an Alert Note and they are unable to know who found it be an alert, how do you follow up to triage the urgency, LPN C abruptly replied they have 45 residents to oversee on a daily basis and cannot remember specifics on all Residents and Alert Progress Notes don't necessarily stand out. Record review of the CNA (Certified Nurse Assistant) Nutrition Task revealed on 5/23/25 and 5/24/25, R302 was not eating as reported by the sibling complainant on 5/25/25 when they spoke with a Nurse (unable to recall name) who commented R302 had not eaten in the last two days. On 6/25/25 at 3:30 PM, a telephone interview was completed with LPN A who acknowledged they were familiar with R302 since admission to the rehabilitation unit. LPN A recalled the events of that morning of 5/25/25 and confirmed they were the Nurse assigned to R302. When asked why they sent R302 to the hospital, they replied because the sibling was yelling so loud over the phone about sending them, I recruited all the staff to help me transfer. When asked what the sibling was saying they mentioned something about him not eating for two days. When asked if a there was assessment done on R302, they recalled they took the vitals, but no further assessment was completed. LPN A said another nurse called EMS (Emergency Medical Service), a third nurse printed off paperwork, EMS arrived, and they notified the DON and Medical Provider. When asked what the specific change in condition was, LPN A commented nothing was abnormal about R302, they just sent them because the sibling was concerned, they had not eaten in two days and if I didn't send them, they would call 911. LPN A remarked nothing was abnormal with R302. Nursing Progress Note from 5/25/25 at 10:41 AM by Licensed Practical Nurse (LPN) A documented the Resident's family requested R302 be sent out to hospital for change of a condition. The Resident was sent out to hospital at 10:20AM . Hospital Records were reviewed and documented on 5/25/25 at 11:04 AM, R302 arrived with Emergency Medical Service (EMS) and reported R302 had right sided weakness, facial droop, slurred speech, throat pain, and difficulty swallowing. Per EMS, the staff at the Extended Care Facility (ECF) reported last seeing R302 well two days ago .and the ECF staff reportedly seemed unconcerned about patient mental status, but patient is known to ED nurse at bedside who states patient is normally alert and orientated . Per EMS, upon arrival to the facility, R302's Blood Pressure (BP) was 90/40 (below normal), Oxygen level on room air was 82% (normal is 90-100%) and EMS had to apply to Six Liters (6L) of oxygen. Patient is confused. Arousable to voice. Follows basic commands. After evaluation in the Emergency Department, R302 was diagnosed with a UTI and Pneumonia (infection in the lungs) with sepsis (devastating response to an infection leading to organ damage) required admission to the Intensive Care Unit (ICU) for intubation (insertion of an artificial airway). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 5/29/25 at 2:29 AM, R302 was pronounced dead. Record review of the Death Certificate documented the primary cause of death was Septic Shock secondary to UTI and Pneumonia (PNA) with the approximate onset of death within days.