STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235109	A. Building B. Wing	07/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Grosse Pointe	21401 Mack Avenue Grosse Pointe Woods, MI 48236

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Number of residents sampled: FacilityNumber of residents cited: PatternThis citation pertains to intakes 2560380, 2560402, 2560706, and 2560866.Based on observation, interview, and record review, the facility failed to ensure the safety and protection of six of six confidential female residents during a sexual abuse investigation. Findings include: Review of a Facility Reported Incident (FRI) submitted to the State Agency documented, On 07/10/2025, an unknown male patient (R66) talked (name of R45) into giving them oral sex while they were sitting in the wheelchair and (R66) was standing in the hallway. Two unidentified nurses' aides from the facility walked up on the two and reported the incident . On 07/22/25 at 12:16 PM, Assistant Director of Nursing (ADON) D was interviewed regarding the sexual abuse incident that was reported to the State Agency. R66 was identified as the alleged perpetrator and R45 as the alleged victim. ADON D indicated upon staff observation of the incident taking place, R66 was initially returned to their room after being separated from R45. ADON D said following completion of some initial resident and staff interviews, R66 was then moved to another room on the other side of the nurse's station further away from R45's room. Review of the facility record for R66 revealed an admission date of 12/02/23 with diagnoses including Diabetes Mellitus, Bipolar Disorder, and Vascular Dementia. The record further indicated R66 was able to ambulate in the facility using a cane and to mobilize further distances via wheelchair when needed. R66's Brief Interview for Mental Status (BIMS) score of 15/15 indicated intact cognition. On 07/22/25 at 2:47 PM, the facility Administrator (NHA) and the Director of Nursing (DON) were interviewed and reported R66 was initially returned to their room following the incident and was subsequently moved to another room which was on the same floor as R45 but around the corner of the T intersection where the nurse's station is located. The NHA indicated with this arrangement, R66 would be required to pass the nurse's station in order to access the end of the hallway which R45 resided in. When asked if they incorporated any additional protective measures, they reported they did not. They reported they felt there was limited risk of further abuse, as R45 was out of the facility being assessed at the hospital from 10:30 PM (7/10/25) until 7:30 AM the following day (7/11/25). They further reported the morning of (7/11/25), R66 was discharged to another facility at approximately 11:00 AM (3.5 hours after R45 returned to the facility). On 07/23/25 at 10:10 AM, the second-floor hallway, containing the room R66 was moved to, was observed to be directly accessible to approximately seven other rooms without being required to either pass or be within view of the nurse's station. Of these rooms, four were observed to be occupied by six female residents. During this observation there were intervals of time during which no staff were observed on the floor or at the nurse's station. On 07/23/25 at 2:29 PM, the NHA was interviewed and queried regarding the protection the six female residents on the unit between the hours of 6:00 PM on 7/10/25 to 11:00 AM on 7/11/25 from R66. The NHA indicated they felt appropriate precautions were taken due to the nurse's station being at the intersection of the hallway and stated, the nurse and the CENA's (Certified Nursing Assistants) are always on the floor, despite observations during the survey of staff not being present on unit. Review of the facility policy titled Abuse dated 05/24/23 revealed the Policy Overview statement Investigating allegations of abuse, neglect, misappropriation, mistreatment, and exploitation to include protecting residents during the investigation, and taking necessary actions as a result of the investigation. The Protection portion of the policy states The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: Providing a safe and secure environment for all patients .If a resident is the alleged perpetrator, the facility will ensure other residents are protected as determined by the circumstances, which may include but are not limited to resident room changes, increased supervision, or immediate transfer or discharge, if indicated.

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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. This citation pertains to Intake:1217345 Based on interview and record review, the facility failed to document and properly administer insulin for one resident (R105) of four reviewed for medication administration. Findings include:A review of a complaint received from the State Agency revealed concerns that the resident's diabetes was not managed appropriately while admitted in the facility. A review of R105's medical record revealed they were admitted into the facility on 6/14/25 with diagnoses that included Critical Illness Myopathy, and Diabetes Mellitus, Type II with Hyperglycemia. Further review revealed the resident was cognitively intact and needed supervision to limited assistance for Activities of Daily Living. Further review of the medical record revealed the following order placed on 6/14/25, Insulin Lispro 100 UNIT/ML (milliliters) Solution Inject as per sliding scale: if 151 - 200 = 2 units Give 2 units; 201 - 250 = 4 units. Give 4 unit; 251 - 300 = 6 units Give 6 units; 301 - 350 = 8 units Give 8 units; 351 - 400 = 10 units Give 10 units, subcutaneously before meals and at bedtime for Diabetes management Notify Physician if BS (blood sugar) is less than 70 and/or greater than 400. Further review of R105's medical record revealed that on 6/15/25, the resident had a blood sugar reading of 570. A review of the resident's Medication Administration Record (MAR) revealed the resident was provided with the insulin however, documentation of the amount administered was missing, as well as documentation that the physician was notified of a blood sugar reading over 400. A review of R105's progress notes revealed the following, 6/23/2025 10:15am Nursing Progress Note .Resident was admitted with noted irregular blood sugars (hyperglycemia). On 6/18/25, there was a medication error where the resident did not receive insulin from nursing staff for a 395 BS . A review of the Incident and Accident report dated 6/18/25 revealed the following, Informed on 6/19/25 by sister, residents blood sugar was not obtained 6/18/25 at lunch, upon investigation NA (not applicable) documented on MAR for 12pm blood sugar. spoke with nurses who states she got busy and forgot, states after resident asked, she went to take but therapy had taken resident downstairs, so it was not done. nurse education on importance of blood sugar/insulin along with how to proceed if not taken on time . On 7/23/2025 at 12:33 PM, an interview was completed with the Director of Nursing (DON) regarding 105's missed medication administration. The DON acknowledged that the nurse did not provide the medication, and when interviewed she stated, I forgot. The DON confirmed the nurse did not contact the doctor per order. A review of the Medication-Insulin Administration policy revealed the following, .The type of insulin, dosage, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order .Document the administration in the medication record .

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to post nurse staffing information daily affecting all 78 residents residing in facility. Findings include:On 7/21/2025 at 11:53 AM, a nurse staffing sheet was observed in the lobby. The nursing staff sheet was dated 7/9/2025 (12 days earlier). Receptionist B was asked if they posted the nurse staff information anywhere else in the facility. Receptionist B stated they only place it is posted is in the front lobby. At 11:57 AM, Admissions Director (AD) C was observed removing the nurse staffing sheet from the front lobby.On 7/23/2025 at 10:05 AM, an interview was conducted with Staffing Coordinator (SC) A. SC A reported they print out the nurse staffing sheets weekly, and they were in their office. SC A reported they forgot to put them out in the lobby daily.On 7/23/2025 at 12:31 PM, an interview was conducted with the Nursing Home Administrator (NHA). The NHA stated they were aware of the issue and working with the unit manager to ensure it does not get overlooked again.A review of a facility policy titled, Staffing noted the following, .Nursing direct care staffing data will be posted on a daily basis in a location accessible to residents and visitors in a clear and readable format.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to offer and provide the COVID-19 immunization vaccine and education to 11 (Staff E, Staff F, Staff G, Staff H, Staff I, Staff J, Staff K, Staff L, Staff M, Staff N, and Staff O) of 99 staff members. Findings include:On 7/23/2025 at 10:04 AM, the Infection Control Preventionist (ICP) was asked about the facility's process for offering the COVID-19 vaccine to residents and staff. The ICP explained they still offer the vaccine to residents; however, it is no longer offered to staff.A review of the facility staff vaccine documentation provided by the facility did not reveal that unvaccinated staff were provided education regarding the benefits and potential risks associated with the COVID-19 vaccine, or that staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine. On 7/23/2025 at 1:05 PM, the ICP explained the facility stopped offering vaccines to staff at the beginning of the year (2025) at the facility, and if a staff member would like the vaccine, they are referred to their local pharmacy. The ICP was asked if there was documentation that shows that staff are being offered or declining the vaccine or vaccine education, and stated, No.A review of the facility's COVID-19 policy revealed the following, .Staff will be offered the Covid-19 vaccine unless the immunization is medically contraindicated, or the staff has already been immunized. Staff will be educated regarding the risks, benefits, and potential side effects associated with the vaccine in a form and manner they understand and receive a copy of the CDC Covid-19 VIS Sheet before being offered the vaccine. CDC Vaccine Information Statements (VIS) can be found at the Center for Disease Control and Prevention (CDC) website. If the vaccination requires multiple doses of vaccine, the staff are again provided with education regarding the benefits and potential side effects of the vaccine and current information regarding those additional doses, including any changes in the benefits or potential side effects, before requesting consent for administration of any additional doses. The staff member must be provided the opportunity to refuse the vaccine and to change their decision about vaccination at any time. The facility maintains documentation related to staff Covid-19 vaccination that includes, Staff education regarding risks and benefits associated with the Covid-19 vaccine. Staff were offered the Covid-19 vaccine or information on obtaining the Covid-19 vaccine.