

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation of Bloomfield Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 2975 N Adams Road Bloomfield Hills, MI 48304	

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 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. (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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<p>F 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #1191844. Based on interview and record review, the facility failed to provide access or copies of the resident's medical records to the resident representative within the required timeframe for one (R705) of two residents reviewed for access to medical records. Findings include: A review of a complaint submitted to the State Agency in May 2025, revealed an allegation that the resident representative had been waiting to receive R705's medical records for two months. It was documented the resident representative requested the most recent care plan, physical therapy and occupational therapy notes, medication lists, and the last three Kardex (the resident's care guide). It was alleged the resident representative was verbally told by the Administrator that he would follow up regarding the medical records, but there was no follow-up. A review of a Grievance and Satisfaction Form dated 5/20/25 revealed the former Administrator (Administrator 'H') received a grievance regarding R705 from R705's resident representative (RR 'J'). The grievance included an attached email sent to Administrator 'H' by RR 'J' on 5/20/25, that documented, 'We have additionally been waiting two months for requested medical records to review. We will not schedule another care conference until we are provided the medical records requested. We are still waiting on a medical records request including previous care plans/Kardex, medication list, and OT (occupational therapy)/PT (physical therapy) notes for over two months, because at this time the wait time with no follow up is ridiculous. There was a handwritten note by the facility on that page that documented, 'Refused care conference until med records released. has not signed a release of med records. The following was documented in the Investigation section of the grievance form, Spoke with resident daughter (RR 'J') on 5/20 she refused to come in and sign medical records request form. Form was scanned over by assistant administrator. Resident daughter to complete and scan back to Administrator. A review of R705's clinical record revealed R705 was admitted into the facility on 6/2/20 and readmitted on [DATE] with diagnoses that included: dementia. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R705 had severely impaired cognition. It was documented RR 'J' was designated as R705's medical decision maker. A review of a Social Work progress note dated 5/18/25 revealed, 'Family member expressed that she will not agree to schedule a care conference until she receives certain documents from (facility name) staff; administrator notified of this concern. A review of a COMMUNICATION progress note dated 5/20/25, written by the current Administrator (Administrator 'I') who was the Assistant Administrator at the time of the progress note, revealed, Spoke with (RR 'J') on phone regarding concerns - med records, offered to have a form at the front desk for her available to sign release of medical records but she declined for today says she prefers only scanned but will try to be available to pick it up. On 9/17/25 at 8:22 AM, a facility policy regarding obtaining medical records was requested from Administrator 'I'. A review of a facility policy titled, Release of Health Information, dated 5/1/22, revealed, in part, the following, 'a patient or his or her authorized representative has the right to examine or obtain the patient's Health Record. Health Information Management/Medical Record Department will .Make the Health Record available for inspection or copying, or both, at the facility's business location during regular business hours or provide a copy of all or part of the Health Record, as requested by the resident or his or her authorized representative. Per Federal regulations, residents will have access to their Health Records within 24 hours of request, during normal business hours. On 9/17/25 at 9:10 AM, an interview was conducted with Administrator 'I'. When queried about what was going on with R705's medical records being provided to RR 'J', Administrator 'I' reported she was required to sign a form and refused to do so, per the grievance form from 5/20/25. Administrator 'I' reported RR 'J' did eventually receive the medical records she requested. When queried about the time frame between when RR 'J' first requested the medical records and when she actually received them, Administrator 'I' did not know. On 9/17/25 at 9:49 AM, an interview was conducted with Medical Records Staff (MR 'E'). MR 'E' reported she had not received any requests to provide medical records to RR 'J' regarding R705. On 9/17/25 at 10:59 AM, it was confirmed via email with RR 'J' that the facility provided on 6/5/25. RR 'J' reported they asked for R705's medication list on 3/7/25. RR 'J' was told by Administrator 'H' that MR 'E' was out on 3/7/25 but would be back that Monday (3/10/25) and would ensure they received a copy of the most recent medication list. RR 'J' said that did not happen. Nothing was received until 6/5/25. On 9/17/25 at 3:03 PM, Administrator 'I' reported she spoke with RR 'J' on that day and was informed she received R705's medical records in June 2025.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>(continued on next page)</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2564545Based on observation and interview, the facility failed to provide a sanitary homelike environment among the first and second floor residential common areas including the second-floor dining rooms, first floor community room, and first floor residential community shower room, resulting in an unkempt environment and potential for resident dissatisfaction with their living conditions and failure to maintain a clean healthcare environment.Findings include: On 7/14/25, the State Agency received a complaint alleging the facility is not maintaining a clean environment.During an initial environmental tour of the facility on 9/16/25 at 12:30 PM, the Two-West dining room was observed and revealed areas of beige colored dried substances spillage incorporated into the carpeting entering the room and near two front resident dining tables. Food crumbs and debris were noted amongst the entire dining room including the entire perimeter of floor, under dining tables and chairs, windows, and cabinets.The front corner of room was observed storing a Vacuum cleaner, two dirty dust pans, and two brooms. Next to these items, on the floor, was a camouflage baseball cap, one blue colored seat cushion pad, food wrappers, and lifted unglued blue pieces of carpet.An unlocked beige colored cabinet on the wall next to the entry revealed an unzipped larger sized black purse imprinted with G's, next to a pink rubber handle tote bag containing what appeared to be personal items. The shelf above the purses revealed a white Tupperware container with a green colored see through lid containing French fries and another unrecognizable food substance along with a half full bottled of juice in the back corner.A large dark colored credenza on the back wall was opened and revealed a half open can of Celsius (energy drink), pillowcases, used napkins, straw wrappers, blue medical mask, and moderate amounts dust and debris were observed throughout.On 9/16/25 at 12:43 PM, the Nursing Home Administrator (NHA) was requested and observed the findings in the Two-West dining room and recognized the concerns and confirmed the cabinets with locks should be locked. Purses, totes and backpacks should not be stored in the cabinets, and old food, partially consumed, should not be stored in the cabinets.On 9/16/25 at 1:00 PM, the Two-East dining room was observed and revealed an unlocked beige colored cabinet on the wall containing an empty aquarium revealed storage of a black backpack, balled up linen, and a plastic fork with an unknown black substance on the tings, and a used Styrofoam cup with a lid and a straw. The bases of all the cabinets were unkempt and observed with moderate amounts of dried spillage. The cabinet faces and handles of the kitchen area with stove was also observed having liquid spillage and dried food matter, and countertops appeared unkempt.The entire dining room was observed and revealed areas of beige colored dried substances spillage incorporated into the carpeting entering the room amongst resident dining tables. Food crumbs and debris were noted amongst the entire dining room including the entire perimeter of floor, under dining tables and chairs, windows, and cabinets. Noted insect webs were observed in the corners of the room and spiders were observed crawling amongst webs in the back right corner.Second floor common hallways were observed throughout the morning and afternoon and moderate amounts of debris, spills and the overall appearance of the flooring were unkempt. The common hallway in front of room [ROOM NUMBER] was observed with moderate dark colored sticky appearance smudging noted in front of a portable Personal Protective Equipment (PPE) cabinet. The common area windowsill next to room [ROOM NUMBER] revealed a used napkin/tissue and food wrapper on sill.On 9/17/25 at 9:40 AM, the first-floor community shower room was accessed by Certified Nurse Assistant (CNA) C and confirmed is operational and used by the residents. Upon entering, a blue and white shower bed was observed with two bags of white colored linens, a crumbled Hoyer lift tarp, and package of opened disposable bathing wipes. When asked, CNA C could not confirm whether the bagged linen was clean or dirty and was observed removing from the room. The entire floor of the shower room was observed with dark soiled matter throughout. The drain located under the shower bed was observed with two large piles of human hair, broken plastic razor caps, and small antlike insects actively crawling under shower bed. The shower bed middle wheel was observed tangled with large amounts of human hair. The pink and white shower chair was observed storing 6 bottles of half used shower gels. The pink bathing seat was observed with black film discoloration in the creases and seams of the seat.On 9/17/25 around 9:45 AM, the community room on the first floor where the vending machines are stored, was confirmed by the NHA as a room open to the residents, staff, and visitors, revealed unlocked cabinets storing Personal Protective Equipment (PPE), including boxes of facemasks and gowns. A full box of opened 3-millimeter (ml) hundredmic syringes were</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** This citation pertains to intake #'s 1191435 and 1191855. Based on observation, interview and record review, the facility failed to ensure medications were available for administration and arrange a dermatology consultation per the Physician's order for two residents (R701 and R703) of two residents reviewed for Physican orders/Medications. Findings include:R701</p> <p>Clinical record review revealed R701 had a medical diagnosis including diabetes, morbid obesity, heart disease, seborrheic dermatitis (chronic inflammatory skin condition), and schizoaffective disorder, bipolar type (bouts of hypomania, mania, and depression)</p> <p>On 9/16/25 at 9:30 AM, during an interview, R701 confirmed they had chronic dermatology concerns and had informed the Providers and Nurses at the facility for the last few months requests to be seen by a Dermatologist (doctor that specializes in the treatment of skin disorders).</p> <p>Clinical record review revealed on 7/22/2025 at 11:16 AM, Nurse Practitioner (NP) &ldquo;G&rdquo; ordered R701 to be consulted by a specific named Doctor of Dermatology to address abdominal folds, groin, and scalp. The order was confirmed by Nursing on 7/22/25 at 11:37 AM.</p> <p>On 9/17/25 at 1:53 PM, the facility Medical Records/Unit Clerk Scheduler &ldquo;E&rdquo; was interviewed and asked to provide a list of scheduled consults for R701. After reviewing the medical record calendar, MR &ldquo;E&rdquo; was unable to retrieve confirmation of the ordered 7/22/25 Dermatology consult being entered. MR &ldquo;E&rdquo; replied it was not scheduled yet because they wanted R701 to be seen by Urology first. When asked if they were instructed not to schedule the Dermatology from July, and who made that decision, MR &ldquo;E&rdquo; replied no one instructed them.</p> <p>MR &ldquo;E&rdquo; was then observed retrieving a stack of papers off their desk. After filtering through the pile, the Dermatology order was printed off and highlighted in orange marker. MR &ldquo;E&rdquo; openly admitted &ldquo;I just didn't do it&rdquo;</p> <p>On 9/17/25 at 2:24 PM, NP &ldquo;G&rdquo; was contacted and when asked if they were aware of R701 being consulted by Dermatology from their orders on 7/22/25, NP &ldquo;G&rdquo; could not recall if they were scheduled. Per NP &ldquo;G&rdquo; they send an email to the Medical Records scheduler confirming appointments. NP &ldquo;G&rdquo; then took a moment to retrieve their emails and confirmed they did not see R701 on their follow list up list.</p> <p>On 9/17/25 around 3:30 PM, The NHA and Regional Clinical Director &ldquo;M&rdquo; were informed of the orders for R701 from July 2025 to see a Dermatologist were never scheduled and R701 is still having skin concerns.</p> <p>R703</p> <p>On 9/16/25 a complaint submitted to the State Agency was reviewed which alleged R703 was not administered multiple medications for multiple days after they had been readmitted to the facility from the hospital.</p> <p>(continued on next page)</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>On 9/16/25 at approximately 10:51 a.m., R703 was observed in their room, laying in their bed. R703 was queried regarding their care and they reported they had issues with medications being available when they got back from the hospital in June. R703 reported they went days without getting their medications.</p> <p>On 9/16/25 the medical record for R703 was reviewed and revealed the following: R703 was initially admitted to the facility on [DATE] and had diagnoses including Protein-Calorie Malnutrition and Autistic disorder. A review of R703's MDS (minimum data set) with an ARD (assessment reference date) of 8/21/25 revealed R703 needed supervision from facility staff with their activities of daily living. R703's BIMS score (brief interview of mental status) was 15 indicating intact cognition.</p> <p>A progress note dated 6/23/25 revealed the following: pt (patient) alert, vs (vital signs) stable, came from hospital via emt (Emergency Medical Technician) at 6.20 pm. Dr (Doctor) notified. Per her request pharmacy was notified to call the dr for narcotics verbal orders at 8pm Night shift nurse notified to follow up in 30minutes with the pharm (pharmacy). admission endorsed to night shift; meds (medications), assessments, CarePlan etc .</p> <p>A review of R703's EMAR (electronic medication administration record) progress notes revealed the following medications that were not available to be administered:</p> <p>6/24/2025 at 08:02 (military time)-Dicyclomine HCl Oral Solution 10 MG/5ML(milligrams/milliliters) .related to Gastroparesis-awaiting meds from pharmacy. 6/24/2025at 08:03-Zinc Oxide External Paste 40 % .for Rash-awaiting meds from pharmacy. 6/24/2025 at 08:03- cloBAZam Oral Suspension 2.5 MG/ML .for Seizure-awaiting meds from pharmacy. 6/24/2025 at 08:03-Lacosamide Oral Solution 10 MG/ML for Seizure-awaiting meds from pharmacy. 6/24/2025 at 08:04-Neomy-Bacit-Polymyx-Pramoxine External Ointment 1 % for Rash-awaiting meds from pharmacy. 6/24/2025 at 08:04-Gabapentin Oral Solution 250 MG/5ML for Pain-awaiting meds from pharmacy. 6/24/2025 at 08:04-LaMICtal Tablet 100 MG related to Conversion disorder with seizures or convulsions-awaiting meds from pharmacy. 6/24/2025 at 10:15-Lovenox Injection Solution Prefilled Syringe 120 MG/0.8ML related to Personal history of pulmonary embolism-on order. 6/24/2025 at 12:16-Neomy-Bacit-Polymyx-Pramoxine External Ointment 1 %-for Rash. 6/24/2025 at 12:20-Zinc Oxide External Paste 40 % for Rash-On order. 6/24/2025 at 21:48-Propranolol HCl Oral Tablet 20 MG for Htn (Hypertension)-On order. 6/24/2025 at 21:49-busPIRone HCl Oral Tablet 10 MG related to Attention-Deficit hyperactivity disorder-On order, no access to pyxis (backup supply). 6/24/2025 at 21:49-Dantrolene Sodium Oral Capsule 25 MG related to Epilepsy-On order.</p> <p>6/25/2025 at 06:27-busPIRone HCl Oral Tablet 10 MG-On order. 6/25/2025 at 06:28-Dantrolene Sodium Oral Capsule 25 MG-On order. 6/25/2025 at 06:32-Neomy-Bacit-Polymyx-Pramoxine External Ointment 1 %-On order. 6/25/2025 at 10:50-Propranolol HCl Oral Tablet 20 MG-Med not available, NP (Nurse Practitioner) notified, pharm notified to deliver the meds. 6/25/2025 at 15:12-busPIRone HCl Oral Tablet 10 MG-n/a (not available) at this time. 6/25/2025 at 15:13-Dantrolene Sodium Oral Capsule 25 MG-n/a at this time, pharm aware, NP aware. 6/25/2025 at 18:07-PriLOSEC OTC Oral Tablet Delayed Release 20 MG-n/a reordered. 6/25/2025 at 18:07-Neomy-Bacit-Polymyx-Pramoxine External Ointment 1%-n/a. 6/25/2025 at 18:08-Zinc Oxide External Paste 40 %-n/a reordered. 6/25/2025 at 21:53-busPIRone HCl Oral Tablet 10 MG-awaiting supply. 6/25/2025 at 21:53-Dantrolene Sodium Oral Capsule 25 MG-awaiting supply.</p> <p>6/26/2025 at 07:55-Neomy-Bacit-Polymyx-Pramoxine External Ointment 1 %-Awaiting supply.</p> <p>6/28/2025 at 06:29-Neomy-Bacit-Polymyx-Pramoxine External Ointment 1 %-Awaiting pharmacy.</p> <p>(continued on next page)</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>7/20/2025 at 23:35-Change PICC (Peripherally Inserted Central Catheter) Line Dressing (location):Left arm-Not a PICC changing drsg (dressing) available from pharmacy during shift</p> <p>7/29/2025 at 23:07-Gabapentin Oral Solution 250 MG/5ML-Awaiting pharmacy.</p> <p>7/30/20250 at 6:51-Gabapentin Oral Solution 250 MG/5ML-Awaiting pharmacy.</p> <p>8/16/20250 at 6:40-Dicyclomine HCl Oral Solution 20 MG/10ML-Awaiting Pharmacy. 8/16/2025 at 12:20-Dicyclomine HCl Oral Solution 20 MG/10ML-On order.</p> <p>8/22/2025 at 06:56-Gabapentin Oral Solution 250 MG/5ML-medication not available, Pharmacy stated medication is not due for refill until tomorrow. Will notify MD (medical doctor). 8/22/2025 at 13:19-on order.</p> <p>A review of R703's June 2025 MAR (Medication Administration Record) revealed the following medications that were not administered: Lovenox Injection Solution Prefilled Syringe 120 MG/0.8ML (Enoxaparin Sodium)-Inject 0.74 ml subcutaneously one time a day related to PERSONAL HISTORY OFPULMONARY EMBOLISM-6/24 (1000) dose, cloBAZam Oral Suspension 2.5 MG/ML (Clobazam) Give 8 ml via J-Tube every 12 hours for seizure-6/23 (2100) dose. Lacosamide Oral Solution 10 MG/ML (Lacosamide) Give 5 ml by mouth every 12 hours for seizure-6/23 (2100) dose. LaMICtal Tablet 100 MG (LamoTRlgine) Give 1 tablet by mouth two times a day related to CONVERSION DISORDER WITH SEIZURES OR CONVULSIONS-6/24 (0600) dose. PriLOSEC OTC Oral Tablet Delayed Release 20 MG (Omeprazole Magnesium) Give 1 tablet via PEG-Tube two times a day related to GASTRO ESOPHAGEAL REFLUX DISEASE WITHOUT ESOPHAGITIS-6/25 (1700) dose. busPIRone HCl Oral Tablet 10 MG (Buspirone HCl) Give 1 tablet via J-Tube every 8 hours related to ATTENTION-DEFICIT HYPERACTIVITY DISORDER, UNSPECIFIED TYPE-6/24 (2200) dose, 6/25 (0600) dose, (1400) dose, (2200) dose. Dantrolene Sodium Oral Capsule 25 MG (Dantrolene Sodium) Give 1 capsule via J-Tube every 8 hours related to EPILEPSY, UNSPECIFIED, NOT INTRACTABLE, WITHOUT STATUS EPILEPTICUS-6/24 (2200) dose, 6/25 (0600) dose, (1400) dose, (2200) dose. Gabapentin Oral Solution 250 MG/5ML (Gabapentin) Give 2 ml via PEG-Tube every 8 hours for pain-6/24 (0600) dose. Neomy-Bacit-Polymyx-Praxoxine External Ointment 1 % (Neomycin-Bacitracin-Polymyxin-Praxoxine) Apply to peg site topically three times a day for rash-6/24 (0600) dose, (1300) dose, (1700) dose, 6/25 (0600) dose, (1700) dose, 6/26 (0600) dose, (1300) dose, (1700) dose, 6/28 (0600) dose, (1300) dose, (1700) dose, 6/29 (0600) dose, (1300) dose, Dicyclomine HCl Oral Solution 10MG/5ML (Dicyclomine HCl) Give 10 ml via PEG-Tube every 6 hours related to GASTROPARESIS-6/24 (0600) dose. Zinc Oxide External Paste 40 % (ZincOxide (Topical)) Apply to peg site topically four times a day for rash-6/24 (0600) dose, (1300) dose, 6/25 (1700) dose.</p> <p>On 9/17/25 at approximately 10:13 a.m., during a conversation with the Director of Nursing (DON), The DON was queried regarding R703's not receiving their medications for multiple days after they were readmitted from the hospital on 6/23/25. The DON reported the Nursing staff have a process that should be followed to ensure medications are available for the next ordered administration times including utilizing the backup supply, and the drop ship method (a faster option to get medications delivered). The DON was queried regarding regular supply reordering of medications and they reported that the Nursing staff should be reordering medications two-three days before a resident runs out to ensure an uninterrupted supply is maintained. The DON was queried if residents should have their medications administered as ordered and they indicated that they should. The DON reported the facility had recently switched to a new pharmacy to try to ensure medications were available to be administered.</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>(continued on next page)</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #1191844. Based on interview and record review, the facility failed to provide medically related social services related to obtaining consent for psychotropic medication use and coordination of psychiatric services for one (R705) of four residents reviewed for medications. Findings include: A review of a complaint submitted to State Agency revealed allegations that the resident representative requested multiple times that Physician 'K' not be assigned to evaluate or change medications orders for R705 due to changing the resident's antipsychotic medication (Seroquel) order without consent of the resident representative (RR 'J'). It was alleged on 8/17/25, nursing staff contacted R705's resident representative and notified them that he was more verbally combative and attempted to hit staff. On 8/20/25, the Director of Nursing (DON) called to report a change in condition with exacerbated behaviors. A behavioral health evaluation and medication review was requested due to R705 missing dialysis on 8/17/25. The DON notified the resident representative that Physician 'K' changed R705's Seroquel order without consent of the resident representative on 8/7/25 which caused the change in condition (behaviors). A review of R705's clinical record revealed R705 was admitted into the facility on 6/2/20 and readmitted on [DATE] with diagnoses that included: dementia, paranoid schizophrenia, and anxiety disorder. A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R705 had severely impaired cognition, behaviors, and took antipsychotic medications. It was documented RR 'J' was designated as R705's medical decision maker. A review of R705's Physician's Orders for Seroquel revealed the following: From 3/25/25 until 8/7/25, R705 was prescribed 25 milligrams (MG) of Seroquel every 12 hours for paranoid schizophrenia. On 8/7/25, the Seroquel order was changed to 12.5 MG (25 MG tablet give 0.5 tablet) at bedtime (QHS) and 25 MG in the morning. On 8/22/25, the 12.5 MG dose was discontinued, and 25 MG of Seroquel was ordered to be given at bedtime. A review of R705's progress notes revealed no notes that documented any reason for the reduction in the bedtime dose of Seroquel to 12.5 MG or that R705's resident representative was contacted regarding the dosage change. A review of a Nursing progress note dated 8/18/25 revealed, R705 was agitated during dialysis, and they could not start dialysis, and resident was sent back to facility. A review of a Nursing progress note dated 8/20/25, written by the DON, revealed, Writer spoke with resident's daughter regarding recent increased behavioral issues during transportation to and from dialysis. Discussed potential interventions to help keep the resident calm during these times. Medications were also reviewed with the daughter, including the current regimen and any recent changes. Daughter verbalized a misunderstanding psych to review meds and contact daughter for medication review; psychiatric evaluation was ordered. Behavior monitoring has been initiated for 7 days. A review of a Nursing progress note dated 8/21/25 at 7:41 AM revealed, Resident heard yelling intermittently on and off during the night. Stating that writer should leave him alone and he does not need anything. A review of a Nursing progress note dated 8/22/25 revealed, (RR 'J') arrived on pm shift stated that she requested for Seroquel dose for HS to be changed from 12.5 mg to 25 mg qhs per her discussion with nursing leadership team 2 days ago. Writer called on call NP (Nurse Practitioner), order received. To change seroquel order from 12.5 mg to 25 mg. A review of a Social Work progress note dated 8/25/25 revealed, (Physician 'K') notified pt (patient) is no longer on her caseload, per family request. A review of a Social Work progress note dated 8/25/25 revealed the social worker contacted RR 'J' following a medication change without her consent. Further review of R705's progress notes revealed no psychiatry visits since 12/5/24. R705 was admitted to the hospital on [DATE] until 3/24/25 and was readmitted on Seroquel 25 MG twice times a day. There were no documented medication reviews by a psychiatry practitioner after readmission. A review of a Physician progress note dated 8/27/25 revealed, Spoke with the patient's daughter yesterday considering his agitation while being on Seroquel 12.5 (MG). Currently his Seroquel is 25 MG, psychiatry not on the case anymore. Today I discussed with social worker as well as nursing manager concerning patient's behaviors. We will continue 25 MG. On 9/17/25 at approximately 12:40 PM, an interview was conducted with the DON and the Administrator. When queried about the process for monitoring residents on psychotropic medications, the DON reported residents on psychotropic medications were referred to the psychiatrist. The DON reported the resident, or the resident representative gave consent for the mental health services and the behavioral health team or nursing was required to update and obtain consent from the resident representatives if changes were made or behaviors increased. When queried about why R705 was not seen by a psychiatry practitioner since 12/5/24 the DON reported RR 'J' refused</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235217	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2025
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation of Bloomfield Hill		STREET ADDRESS, CITY, STATE, ZIP CODE 2975 N Adams Road Bloomfield Hills, MI 48304	
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 0791</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide or obtain dental services for each resident.</p> <p>This citation pertains to Intake 1191435Based on interview and record review the facility failed to obtain requested and ordered services to be seen by an Oral Surgeon for two surgical teeth extractions to meet a needed escalation of dental care for one resident (R701) of one reviewed for dental services. Findings include:Clinical record review revealed R701 had a medical diagnosis including diabetes, morbid obesity, heart disease, seborrhic dermatitis (chronic inflammatory skin condition), and schizoaffective disorder, bipolar type (bouts of hypomania, mania, and depression)On 9/16/25 at 9:30 AM, during an interview , R701 stated they had two molars that need to be removed but the facility never followed through setting up an appointment.Requested medical records for R701 from March 2025 were reviewed and revealed on 3/5/2025 R701 was seen at bedside by a Dentist related to tooth pain in their lower right side. Treatment notes documented R701 had severely decayed teeth #30, #31 (Tooth number 30 is the lower right first molar; Tooth number 31 is the lower right second molar.) and R701 would need surgical extractions with sedation due to their agitation.Action Required by Nursing Home Staff.Refer to oral surgeon for extraction #30, #31. The Dental Provider further documented rewrote orders today (3/5/2025), spoke to the floor Nurse, and gave prescription for Clindamycin (antibiotic).Further record review revealed the Nurse who ordered the Clindamycin on 3/5/25 was the current Director of Nursing (DON) and on 9/17/25 around 3:00 PM was questioned why R701 was not referred to an Oral Surgeon as ordered. The DON recalled R701 being sent to the hospital on 3/6/25 and could not confirm nor deny why the orders were not followed through or documentation of not being sent upon his readmission to the facility on 3/20/2025.Review of the facility policy titled Dental Services dated 4/2019 documented.Referrals to dietician, speech therapist, physician, or dental provider shall be made as appropriate.The facility will, if necessary or requested, assist the resident with making dental appointments and arranging transportation to and from the dental services location.All actions and information regarding dental services, including any delays related to obtaining dental services, will be documented in the resident's medical record.</p>		