STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235217	A. Building B. Wing	12/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Bloomfield Hill	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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2662635.Based on observation, interview, and record review the facility failed to consistently notify and update R502's family of newly identified wounds for one (R502) of one resident reviewed for notification/plan of care. Findings include:A review of a complaint submitted to the State Agency (SA) noted concerns of the resident to have been identified with multiple wounds at the hospital that the family was unaware of. On 12/3/25 at 12:57 PM, R502 was observed in their room lying on their back in bed. The resident did not wake up with verbal stimuli. At approximately 1:15 PM, a skin observation was conducted with the Assistant Director of Nursing (ADON) C and Certified Nursing Assistant (CNA) D. A review of the medical record revealed that R502 was admitted to the facility on [DATE] with diagnoses that included: cerebral infarction and multiple myeloma. Further review of the medical record revealed R502 was dependent on staff for all Activities of Daily Living (ADLs). A review of the resident's electronic medical record profile noted R502's daughter as . Emergency Contact #1, Responsible Party (Bills).A review of a Skin Issues note dated 10/3/25 at 6:28 AM, documented in part . New skin Issue. Location: Rear left trochanter (Hip). Laterality <sic>. Wound acquired in-house. There was no documentation of the emergency contact #1 to have been notified of the findings. A review of a wound consultation dated 10/24/25, documented in part . Wound #1 - sacral 4 (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer), exudate is Moderate. Patient complains of pain level none. Infection or Inflammation is None. Residents wound is stable, please offload as there is bone in the wound bed. Above Multiple Medical Conditions can cause worsening of wounds, development of new wounds and delayed wound healing and infection. Therefore, patient needs to be seen every week.A review of the progress notes revealed the following:On 10/24/25 at 7:07 AM, a Skin Issues note documented in part . Sacrum. Exudate type: Purulent: indication of pus, typically thick, yellow, green ,tan or brown. Dressing appearance: Saturated. Dressing saturation: Moderate 26-75% . A review of multiple progress notes revealed documentation of R502's daughter participation in care discussions and modifications of plan of care with the facility staff, however there was no documentation found of the daughter to have been notified of the worsening of the wound. A nursing note dated 10/29/25 at 12:34 AM, documented . 911 arrived to facility stated daughter called for them to transport resident to hospital.A review of the hospital documentation for the 10/29/25 hospitalization documented in part, . 10/29/25 12:58 AM. Acceptance Note. Skin: Stage IV decubitus ulcer (Sacral/Sacrum) with erythema surrounding it and some pus drainage on the inferior portion palpate the bone, left hip pressure wound stage II right heel ulcer (Partial-thickness skin loss with exposed dermis).On 12/4/25 at 12:17 PM, the facility's Wound Nurse (WN) A and Director of Nursing (DON) was interviewed and asked if a new skin impairment or worsening of a wound was identified on a resident, who would be notified. WN A stated the family and Physician. WN A and the DON were both asked to provide documentation of R502's daughter to have been notified of the identification of the hip wound and the worsening of the sacral/sacrum wound, both stated they would look into it and follow back up. No further explanation or documentation was provided by the end of the survey.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2662635. Based on observation, interview and record review the facility failed to report a decline of a sacral/sacrum wound to the physician and implement treatment to an infected wound, for one (R502) of two residents reviewed for pressure wounds. Findings include: On 12/3/25 at 12:57 PM, R502 was observed lying on their back in bed. The resident did not awake with verbal stimuli. A review of the medical record revealed R502 was admitted to the facility on [DATE] with diagnoses that included: cerebral infarction and multiple myeloma. Further review of the medical record revealed R502 was dependent on staff for all Activities of Daily Living (ADLs). A review of a wound consultation dated 10/24/25, documented in part . Wound #1 - sacral 4 (full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer), exudate is Moderate. Patient complains of pain level none. Infection or Inflammation is None. Residents wound is stable, please offload as there is bone in the wound bed. Above Multiple Medical Conditions can cause worsening of wounds, development of new wounds and delayed wound healing and infection. Therefore, patient needs to be seen every week.A review of the progress notes revealed the following:On 10/24/25 at 7:07 AM, a Skin Issues note documented in part . Sacrum. Exudate type: Purulent: indication of pus, typically thick, yellow, green ,tan or brown. Dressing appearance: Saturated. Dressing saturation: Moderate 26-75% . A review of a care plan titled Actual Pressure Injury Formation initiated 10/9/25, documented the following intervention . Monitor wound for any significant changes (decline or improvement), alert physician of any changes. There was no documentation of the Physician or Wound Clinician to have been notified of the purulent drainage. Further review of the medical record revealed no additional documentation noted of the sacrum/sacral wound from 10/24/25 until 10/29/25.On 10/29/25 at 12:34 AM, the resident was transferred to the hospital. A review of the hospital record revealed the following: A Internal Medicine consult dated 10/29/25 at 11:57 AM, documented in part . Presents with PEG (Percutaneous Endoscopic Gastrostomy) Tube Clog. Skin shows stage IV decubitus ulcer (sacral/sacrum) with surrounding erythema and discharge suggestive of pus. Rocephin and Vanco (intravenous antibiotics). Await urine blood and wound culture results. Consult infectious disease.A culture report of the sacrum wound collected on 10/29/25 at 3:20 AM, documented the following . Abnormal. Methicillin-Sensitive Staphylococcus aureus (a type of staph bacteria). Pseudomonas aeruginosa (bacteria). Gram Stain Result. Neutrophils. Squamous epithelial cells. Gram positive cocci. Multiple Organisms Recovered. The resident was transferred back to the facility on [DATE]. The facility staff failed to identify and report to the physician the decline in the sacrum/sacral wound and failed to implement treatment. On 12/4/25 at 12:17 PM, the Wound Nurse (WN) A and Director of Nursing (DON) was interviewed together and asked about the staff failure to identify and report the decline in R502's sacrum wound. WN A stated they were off on medical leave during the time frame questioned, however stated any abnormal findings should have been reported to the Physician. The DON replied they were not informed of purulent drainage from R502's sacrum wound prior to their transfer to the hospital. WN A and the DON was asked to look into the concern and to provide any additional information for review. No further explanation or documentation was provided by the end of the survey.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2662635.Based on observation, interview and record review the facility failed to provide indwelling catheter care for one (R502) of one resident reviewed for catheter care. Findings include:On 12/3/25 at 12:57 PM, R502 was observed sleeping on their back in bed. Observed on the right side of the bed lower bed frame was a urinary foley bag with a privacy cover. Observed in the tubing was bright yellow cloudy urine. R502 did not wake with verbal stimuli. A review of the medical record revealed R502 was admitted to the facility on [DATE] with diagnoses that included: cerebral infarction and multiple myeloma. Further review of the medical record revealed R502 was dependent on staff for all Activities of Daily Living (ADLs). A review of the physician orders revealed the following: Start Date- 6/28/25 Catheter care has been provided every shift for management routine. Discontinued The medical record did not note the date the order was discontinued. The review of the medical record revealed no documentation of catheter care to have been consistently completed until 11/6/25. The review of the November 2025 Treatment Administration Record (TAR) revealed staff documented twice a day that catheter care was completed. A nursing note dated 10/29/25 at 12:34 AM, documented . 911 arrived to facility stated daughter called for them to transport resident to hospital.A review of the hospital record with the admission date of 10/29/25, documented the primary diagnosis for the hospitalization as Urinary tract infection. 10/29/2025.A hospital Internal Medicine consult dated 10/29/25 at 11:57 AM, documented in part . chronic indwelling Foley catheter. Patient seen and examined in ER (emergency room). In the ER Foley catheter was exchanged. UA (urinalysis) positive for nitrite leukocyte esterase and more than 50 white blood cells with 21-50 red blood cells. Rocephin and Vanco (intravenous antibiotics). Await urine blood and wound culture results. Consult infectious disease.After the hospitalization the resident was transferred back to the facility on [DATE]. On 12/3/25 at 2:21 PM, Unit Manager (UM) B was interviewed and asked about the catheter care order implemented on 6/28/25 that was discontinued. UM B stated they were unsure but would review the medical record and follow back up. UM B was asked to provide the date of the discontinuation of the 6/28/25 catheter care order, and to submit all documentation of catheter care to have been conducted for R502 from June to November 2025. On 12/4/25 at 12:31 PM, a follow up interview was conducted with UM B and the Director of Nursing (DON) together. UM B stated they were unable to find any documentation of catheter care to have been completed for R502. The DON stated they would look into it and follow back up. No further explanation or documentation was provided by the end of the survey.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2662635.Based on observation, interview, and record review the facility failed to ensure consistent Percutaneous Endoscopic Gastrostomy (PEG) care was completed for one (R502) of two residents reviewed for PEG maintenance/care. Findings include:Review of a complaint submitted to the State Agency (SA) documented concerns of the facility's failure to maintain R502's PEG care and noted the hospital found a . whole pill lodged in it (PEG). A review of the medical record revealed R502 was admitted to the facility on [DATE] with diagnoses that included: cerebral infarction and multiple myeloma. Further review of the medical record revealed R502 was dependent on staff for all Activities of Daily Living (ADLs). A review of the progress notes revealed the following: On 10/28/25 at 11:49 PM, a nurse's note documented in part . Residents peg-tube clogged, with several attempts to unclog writer unsuccessful. Physician notified and verbal orders to start hypodermoclysis with sodium chloride 0.9% at 50ml (milliters)/h (hour), until morning.On 10/29/25 at 12:34 AM, a nurse's note documented . 911 arrived to facility stated daughter called for them to transport resident to hospital.A review of a Internal Medicine consult dated 10/29/25 at 11:57 AM, documented in part . Chief Complaint Patient presents with PEG Tube Clog. PEG tube in place, suprapubic pain with palpation. General Surgery consulted for PEG tube malfunction. Avoid medication that can clog the PEG tube.On 12/3/25 at 1:12 PM, a skin observation of R502 was conducted with the assistance of the Assistant Director of Nursing (ADON) C and Certified Nursing Assistant (CNA) D. When requested to observe R502's PEG insertion site, the sheet was removed from R502's body, exposing a soiled white towel with large amounts of yellow and dark brown discharge. Observed under the resident was a second white towel with large amounts of yellow and brown drainage. The PEG site was covered with a white gauze. When asked about the soiled towels found left on and under the resident, ADON C and CNA D stated they were unsure of where the drainage was coming from and why the soiled towels were left on the resident. The ADON C stated they would follow up with the assigned nurse and provide one on one education.A review of the medical record revealed no documentation of any abnormal drainage or incidents that occurred with R502 that morning. On 12/3/25 at 2:44 PM, an agency Licensed Practical Nurse (LPN) E (the nurse assigned to R502 on 12/3/25) was interviewed and asked about the soiled towels and large amounts of drainage observed. LPN E stated they were informed by the night shift nurse that the residents PEG tube was leaking and the Physician was informed of it. LPN E stated the Nurse Practitioner (NP) examined R502 on 12/3/25, however their note had not been dictated to the chart yet. LPN E stated they were given orders by the NP to send R502 to the hospital. When asked about their lack of documentation in the medical record, LPN E stated they had not gotten around to documenting their note yet. LPN E stated they were on break when the surveyor conducted the skin observation with ADON C. A review of the Physician orders revealed the following: Cleanse peg tube site with NS (normal saline), pat dry, apply drain sponge every night for skin management. Report any increased redness, warmth, drainage, etc to medical provider. Start Date 6/28/25. This order was discontinued without a noted discontinued date documented. Review of the record revealed no documentation of the PEG care was consistently performed and revealed no current orders for PEG care. On 12/3/25 at 2:21 PM, Unit Manager (UM) B was interviewed and asked about the PEG care order implemented on 6/28/25 and when it was discontinued. UM B was also asked why R502 had no current orders implemented for PEG care and UM B stated they would look into it and follow back up. On 12/4/25 at 12:31 PM, a follow up interview was conducted with UM B and the Director of Nursing (DON). UM B stated they were unable to find any orders implemented for R502's PEG care. The DON stated they would look into it and follow back up. No further explanation or documentation was provided by the end of the survey.