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	05/27/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number(s): 2786159 and 2732494. Based on interview and record review, the facility failed to allow readmission into the facility after hospitalization and failed to document the reason for discharge in the medical record for one (R904) of three residents reviewed for inappropriate discharge, resulting in the resident remaining in the hospital for 45 days after they were determined to be stable for discharge. Findings include:A review of two complaints submitted to the State Agency revealed allegations that the facility refused to allow R904 to return to the facility after hospitalization. On 5/27/26 at 11:07 AM, an interview was conducted with long term care (LTC) Ombudsman 'B' via the telephone. When queried about R904's discharge to the hospital, Ombudsman 'B' reported R904 went to the hospital with suicidal ideations, and the facility would not allow her to return. R904 was in the hospital for a very long time. Ombudsman 'B' reported R904 was very easily triggered due to her developmental and behavioral diagnoses, and the facility placed a roommate with R904 and it went horribly. On 5/27/26 at 12:12 PM, an interview was conducted with one of R904's legal guardians who reported the facility would not take R904 back after a hospitalization. The guardian explained R904's room was changed to the second floor and said she would not have a roommate due to her mental and physical conditions, but a roommate was placed in R904's room. R904 became very vocal about not wanting to live after a roommate was moved in and she was sent to the hospital with suicidal ideations. The guardian said when R904 was ready to be discharged from the hospital, the facility would not allow her to return, and she stayed in the hospital for approximately six more weeks. The family and the hospital had to coordinate a discharge plan. A review of R904's clinical record revealed R904 was admitted into the facility on 3/26/24, readmitted on [DATE], and discharged on 1/7/26 with diagnoses that included: autism spectrum disorder, attention deficit hyperactivity disorder (ADHD), obsessive compulsive disorder (OCD), generalized anxiety disorder, gastroparesis, seizures, and postural orthostatic tachycardia syndrome (POTS). A review of a Minimum Data Set (MDS) assessment dated [DATE] revealed R904 had intact cognition and no behaviors. A review of R904's progress notes revealed the following documentation: On 1/6/26, a Social Work progress note documented, Resident called SW (social work) and spoke about how resident is upset that she is getting a roommate. Resident reported that she will leave and go to the hospital if she has to have a roommate. SW attempted to redirect resident and calm her down. Resident was still upset and not easily redirectable . On 1/7/26, a PROGRESS NOTE documented, Administrator spoke to resident with Social work Director and DON (Director of Nursing) present. Resident says she said she did not want a roommate. Resident was informed by Administrator that she was not promised a private room when she agreed to move upstairs .Resident attempted to remove her roommate's items and was immediately redirected. Resident says she would be calling her mom and sending herself to the hospital due to not wanting a roommate. On 1/7/26, a Nursing-Progress Note documented, Resident returned from appointment. While writer was in room, resident was on the phone with a 911 operator stating she wanted to leave and that she did not feel safe due to having a new roommate .resident was taken to (hospital) . On 1/7/26, a Social Work (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress note documented, Resident came back from appt (appointment) and was upset about getting a roommate .Resident reported that she was going to go to the hospital and wanted to die due to hating her life. Resident reported 'I wish they just pulled the plug when I had sepsis. I do not want to be here and I do not want to live anymore. Social work had directive to petition for resident to be sent out for psych eval. However, resident called 911 on her own and willingly wanted to go to the hospital .Resident reported she does not like that idea of having a roommate and said she would go to the hospital if she got a roommate . On 5/27/26 at 1:03 PM, an interview was conducted with the Administrator and Regional Clinical Service Director (RCSD 'A') . When queried about why R904 was not allowed to return to the facility after the last hospital stay, the Administrator reported because R904 went to the hospital with suicidal ideations and while in the hospital she reported she overdosed on pills without the nursing home staff's knowledge in the past and that she would attempt to kill herself if she was sent back to the nursing home. RCSD 'A' reported R904's room was changed from the first floor where she had a private room to the second floor after the facility had to make some room changes to accommodate staffing needs. The room on the second floor was not a private room, but the Administrator and RCSD 'A' reported R904 was notified that she could get a roommate at any time. The Administrator reported R904 was fine with having a roommate. A review of R904's hospital records revealed the following: An ED (emergency department) Provider Note dated 1/7/26 documented, .history of autism spectrum disorder .functional paraplegia presenting for suicidal ideations .She does not believe that they (the nursing home) are flushing her ports correctly. States that this is causing her stress and that she 'no longer wants to be here'. States that she 'wishes she has [sic] never taken off the ventilator' and has been asking staff if they have against [sic] that they can 'shoot her' .Suicidal ideation without active plan .The mental health team did evaluate the patient and given her multiple medical conditions they do recommended [sic] Medicine admission with the psych on consult while they try and arrange additional treatment and placement . An H&P (History and Physical) dated 1/8/26 documented, .Patient stated that she did not like the facility she was staying at, hence she called EMS (Emergency Medical Services) and was transported to the ER (Emergency Room), patient refusing to go back to the same facility, stating that if she is sent back to same facility she will kill herself .case manager consulted for finding placement at new nursing/psychiatric facility .We will need inpatient psychiatry . A review of a Discharge Summary from the hospital revealed R904 remained inpatient in the hospital from [DATE] until 3/24/26 with a primary diagnosis of suicidal ideation. A Psychiatry Consult dated 1/8/26 documented, .On my evaluation today the patient reports she came to the hospital to get help as she does not like she current nursing home and if we release her back to that nursing home she is going to kill herself. Patient reports suicidal ideations but does not disclose a plan to me though she reports having a plan .She should be transferred to an inpatient psych unit once cleared medically . A Psychiatry Progress Note dated 1/20/26 documented, .Writer discusses with patient that noinpatient psychiatric facility can accept her due to medical admission criteria. Patient understandably is frustrated.When writer asks what accommodations can be made for her to feel more safe at nursing home, she begins yelling atwriter and telling him that nothing will make her feel safe. She continues to report suicidal ideation with plan tooverdose on medication if she does return to nursing home, however, denies any suicidal ideation or plan while in thisfacility .Recommendations .Per virtual social work, all inpatient psych options have been exhausted by the placement team, and no facility options remain. At this point, will need to coordinate safe discharge plan back to nursing home. Social work at our facility has been in contact with social work at (facility) in helping to coordinate increased frequency of psychiatric services for patient once she returns to nursing home. Importantly, our social work team did speak with administrator at (facility) who reported that they can accommodate 1:1 safety sitter for suicide, however they do not want to force a resident where they do not want to be and with her SI (suicidal ideations), 'it is a liability'. Appears administrator asked social work if our social work team can find alternative LTC placement for patient, but our social worker explained to them that they cannot find (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alternative LTC placement since she already has LTC and the SW at (facility) would have to work on alternative placement . A Psychiatry Progress Note dated 1/28/26 documented, .Patient more understanding of the reality of having to return to nursing home with (disability and mental health agency) working on finding patient alternative placement. She reports she would feel much more comfortable if she could have a private room at her nursing facility .she continues to deny suicidal ideation or plan while here in the hospital. She reports that in the case she returns to nursing home and has suicidal ideation with plan, she will call 911 for her safety .Meeting completed 01/28/2026 between 3 p.m. to 4 p.m. with our social work team, patient's mother (guardian), patient's grandmother, (disability and mental health agency) staff, myself, supervising psychiatrist and primary attending to discuss next steps. At this point, we clinically recommend increased frequency of psychiatric services. Specifically, patient would significantly benefit intensive dialectical behavioral therapy in the outpatient setting. It would help her symptoms improve, if patient did have a private room at her nursing home as she reports that having a roommate is one of the largest stressors for her. She reports that in the case she returns to nursing home and has suicidal ideation with plan, she will call 911 for her safety as she had prior to this admission. She was also made aware that (disability and mental health agency) will continue helping to assist with eventual transition to a semi-private residence although this will take time. She remains hopeful for this .When asked about thinking of hurting herself in the nursing home the patient reports she would not hurt herself as she feels now she is being heard by the team's and people are trying to help her. She tells me that she was talking about wanting to kill herself in the nursing home because she felt nobody was listening to her. Now she feels hurt [sic] and would not attempt to hurt herself. Patient does request however her needs and some accommodations be made known to the nursing home. Patient tells me that because of being on the spectrum she gets very stimulated and overwhelmed inthe presence of a roommate and is therefore requesting to be in a private room. I support and also recommend that patient be accommodated in the nursing home to a private room as the environment would be less stimulating for her that way with better chances of successfully working towards the goal of eventual independent living. When asked if the patient is willing to return to her nursing home she replied she is ready with the support that she has been requesting for. When asked about the possibility of recurrence of suicidal thoughts once the patient is at the nursing home she replied she would not hurt herself but would instead ask for help. She tells me that she is the 1 who called 911 last time from the nursing home and if she gets to a point that she has those thoughts of wanting to hurt herself she will once again seek help and call 911 or make sure she comes back to the hospital. Patient is very pleasant today, very motivated and looking forward to work with the team to be able to eventually live independently with support and is willing to work closely with the staff at the nursing home as well in order to achieve her goal. However the patient continues to request a private room at the nursing home which I strongly support . On 5/27/26 at approximately 2:30 PM, the Administrator and RCSD 'A' reported the [NAME] President (VP) of Clinical Services (VPCS) 'C' was the person who made the final decision not to allow R904 to readmit into the facility. On 5/27/26 at 2:57 PM, an interview was conducted with VPCS 'C' via the telephone. When queried about why the facility did not accept R904 back into the facility after the hospital developed a safe discharge plan for the resident, VPCS 'C' reported he talked with the hospital physician and asked if he could give a 100 percent guarantee that R904 would not kill herself if she came back to the facility and the physician said he could not guarantee it. When queried about what interventions could have been put in place by the facility, including a private room and the resources set up by the hospital, to ensure R904's safety to the best of their ability, VPCS 'C' reported they could not accept the resident back due to the suicidal ideations she expressed related to the facility. VPCS 'C' said R905 was alert and oriented and said she would kill herself so that was a risk. When queried about the safety plan coordinated by the hospital and the documentation of R904 no longer being suicidal and willing to work with the staff at the nursing home to achieve her discharge goal, VPCS 'C' said R904 was 'manipulative' and therefore they could not (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	take a chance that she was just saying that to get back into the facility. Further review of R904's clinical record revealed no documentation of why R904's needs could no longer be met at the facility and the basis of the discharge. A review of a facility policy titled, Transfers and Discharges, revised 4/18/26, revealed, in part, the following, .Transfer to Acute Care Facility .Transfers to an acute care facility such as a hospital are initiated for medical reasons for the immediate safety and welfare of a resident .The resident will be assessed at the time of the proposed return to the facility and permitted to return as long as the facility can meet the resident's needs and that the safety or health the resident and individuals at the facility would not be endangered. The ability of the facility to meet the resident's needs and the risk of endangerment to the health and safety of individuals at the facility will not be based on the resident's status/condition at the time of transfer to the acute care facility .

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2983214 Based on interview and record review the facility failed to issue a notice of discharge and discharge summary for one resident (R901) of two residents reviewed for discharges. Findings include:On 5/27/26 a concern submitted to the State Agency was reviewed which alleged the facility did not let R901 come back to the facility after they were transferred to the hospital. On 5/27/26 at approximately 9:55 a.m., R901 was contacted via phone to discuss their hospital transfer. R901 reported the facility did not allow him to return to their room after they were stabilized at the hospital. R901 indicated they had no chance of stating their case to return and indicated they felt the facility was not allowing them to return due to making previous complaints to the State Agency. R901 was queried if the facility had provided them or their responsible party with a notification of discharge and their discharge summary when they did not allow them to return and they indicated the facility did not send anything to them and their new facility does not have any records from them. On 5/27/26 the medical record for R901 was reviewed and revealed the following: R901 was initially admitted on [DATE] and discharged on 5/3/26 with diagnoses including Schizoaffective disorder and Chronic obstructive pulmonary disease and was not readmitted . A review of R901's MDS (minimum data set) with an ARD (assessment reference date) of 4/7/26 revealed R901 needed assistance from facility staff with most of their activities of daily living. R901's BIMS score (brief interview of mental status) was 15 indicating intact cognition.A progress note dated 5/3/2026 at 11:42 revealed the following: Nursing - Progress Note-Note Text: Ems (Emergency Medical System) arrived at 11:35. Resident left facility via stretcher at 11:40 he is being transported to [Name of local hospital]. Bed hold policy given.Further review of the medical record did not reveal any documentation that R901 or their responsible party had been provided a notice of transfer/discharge or a discharge summary when the facility made the decision not to permit R901's readmission to the facility. On 5/27/26 a review of the facility's communication with the local hospital regarding R901's readmission revealed the following: Facility message at 5/8/26 at 3:47 p.m.,-Facility says they can not accept back with cecostomy tube, it would need to be dc'd (discontinued) prior to return .Hospital message at 5/11/26 at 11:06 a.m.,-Good morning, GI (gastroenterologist) is stating that cecostomy tube is need to be in long term, is there reasoning as to why they are unable to accommodate? .Hospital message on 5/11/26 at 1:39 p.m.,-Okay, patient is medically cleared. Trying to find out if I need to start looking for alternative placement for him .Hospital message on 5/11/26 at 2:49 p.m.,-Sending over GI note from Friday that explains the plan of care regarding cecostomy .Hospital message at 5/12/26 at 1:34 p.m.,-Here are the instructions given to Nursing from GI specialist .Hospital message on 5/12/26 at 4:07 p.m.,-Please let me know if this is something that can be taught/educated to staff members or if I need to work with family to find different placement. The patient would prefer to return to you ASAP (as soon as possible) .Hospital message on 5/13/26 at 10:53 a.m.,-Physican is wanting to discharge, wanting to know if you can take him .Facility message to hospital on 5/13/26 at 10:56 a.m.,-Ok i'm sorry we cannot .On 5/27/26 at approximately 2:27 p.m., during an interview with Regional Clinical Service Director A (RCSD A), RCSD A was queried regarding the information that the hospital sent over instructions on how to care for R901's cecostomy tube. RCSD A indicated that the facility does not have a policy on that particular tube and would not be able to accommodate the return of the resident. RCSD A was queried regarding the information provided by the hospital in the readmission referral on how to care for the cecostomy tube and they indicated that the decision not to permit readmission was made by the [NAME] President of Clinical Services C (VPCS C).On 5/27/26 at approximately 2:30 p.m., during a conversation with the facility Administrator, the Administrator was queried for documentation that R901 was provided a notice of transfer/discharge from the facility indicating their appeal rights and the reasons why they were (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being discharged and not permitted to return. On 5/27/26 at approximately 2:56 p.m., during a conversation with VPCS C, VPCS C reported that the facility could not accommodate the new device/tube that R901 had which was a cecostomy tube. VPCS D reported the facility has no plan of care for that specific device and does not have a policy /procedure to care for that device so as long a R901 had the tube they would not be permitted to return to the facility and would need to be discharged . On 5/27/26 at approximately 4:07 p.m., during a follow up conversation with the facility Administrator, the Administrator was queried if they were able to provide any documentation that R901 or their responsible party was provided a notice of transfer/discharge, and they indicated they did not. On 5/27/26 a facility document pertaining to the policies and procedures of notifications of discharge was reviewed and revealed the following: Policy Title: Transfers and Discharges-The purpose of this policy is to provide guidelines for the safe transfer and discharge of a resident across the continuums of care Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility. The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident. The health of individuals in the facility would otherwise be endangered. The resident has failed, after reasonable and appropriate notice, to pay or have paid under Medicare or Medicaid for their stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for their stay. The facility ceases to operate. When a resident exercises their right to appeal a transfer or discharge, the facility will not transfer or discharge the resident while the appeal is pending, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility The facility's transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in which they can understand. The notice will include the following at the time it is provided: The specific reason and basis for transfer or discharge. o The effective date of transfer or discharge. The specific location (such as the name of the new provider or description and/or address if the location is a residence) to which the resident is to be transferred or discharged . An explanation of the right to appeal the transfer or discharge to the State.The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests.Information on how to obtain an appeal form. information on obtaining assistance in completing and submitting the appeal hearing request.The name, address (mailing and email), and phone number of the representative of the Office of the State Long-Term Care Ombudsman. For nursing facility residents with intellectual and developmental disabilities (or related disabilities) or with mental illness (or related disabilities), the notice will include the name, mailing and e-mail addresses and phone number of the state agency responsible for the protection and advocacy of these populations. Generally, the notice must be provided at least 30 days prior to a transfer or discharge of the resident. Exceptions to the 30-day requirement apply when the transfer or discharge is affected because: The health and/or safety of individuals in the facility would be endangered due to the clinical or behavioral status of the resident. The resident's health improves sufficiently to allow a more immediate transfer or discharge, o An immediate transfer or discharge is required by the resident's urgent medical needs, or o A resident has not resided in the facility for 30 days. The facility will maintain evidence that the notice was sent to the Ombudsman.If the information in the notice changes prior to affecting the transfer or discharge, the Social Services Director or designee must update the recipients of the notice as soon as practicable once the updated information becomes available. For significant changes, such as a change in the transfer or discharge destination, a new notice will be given that clearly describes the change(s) and resets the transfer or discharge date in order to provide 30-day advance notification. For circumstances where the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discharge or transfer is necessary for the resident's welfare and the facility cannot meet the resident's needs or the resident's health has improved sufficiently so that the resident no longer needs the care of the facility, the resident's physician must document information about the basis for the transfer or discharge. Additionally, if the facility determines it cannot meet the resident's needs the documentation made by the resident's physician (or nurse practitioner or physician's assistant) will include: o The specific resident needs the facility could not meet o The facility efforts to meet those needs and o The specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility. In situations where the facility determines a resident's clinical or behavioral status endangers the safety or health of individuals in the facility, documentation regarding the reason for transfer or discharge will be provided by a physician, nurse practitioner, or physician assistant. For residents who are transferred to an acute care facility or psychiatric facility for the health and safety of others at the facility, those residents will be assessed at the time of the proposed return to the facility and permitted to return as long as the facility can meet the resident's needs and that the safety or health of individuals at the facility would not be endangered. The ability of the facility to meet the resident's needs and the risk of endangerment to the health or safety of individuals at the facility will not be based on the resident's status/condition at the time of transfer or discharge to the acute care facility. If the facility determines that they are unable to meet the needs of the resident at the facility at the proposed time of return, the facility will follow the steps outlined under the above section Discharge When Needs Cannot Be Met or When Safety and Health of Individuals is Endangered .