

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/21/2026
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. This citation relates to Intake 3054948. Based on observation, interview, and record review, the facility failed to ensure the proper preparation of purred food related to the kitchen tray prep line for one Resident (R701) of one resident reviewed resulting in a choking incident. Findings include: Review of a complaint received by the State Agency on 6/25/26 revealed Certified Nurse Aide (CNA O) was feeding resident R701 and was not familiar with their care needs. The report showed R701 was supposed to have a pureed diet but was given regular food and R701 began choking and had to call for help. The complainant reported this had happened more than once. The report alleged inadequate training for agency staff as well. On 7/20/26 at 11:00 a.m., R701 was observed in their room in their hospital bed with the covers over them. On 7/20/26 at 11:27 a.m., R701 agreed to be interviewed, and confirmed there was an incident recently when they choked on food. R701 said she was supposed to be on a pureed diet and staff hit them on the back which resolved the choking. R701 was unable to answer further questions as appeared fatigued. R701 was oriented to themselves, their surroundings, and situation. Review of R701's nursing progress note, dated 6/17/26 at 17:40 (5:40 p.m.) showed, Writer was notified by CNA (unnamed) that resident (R701) appeared to be choking while being fed meal tray. Writer immediately arrived to assess resident. Resident (R701) coughed and expelled the piece of food from throat without further intervention. No vomiting, respiratory distress, or signs of aspiration noted at this time. The note showed physician and family notification. On 7/20/26 at 3:49 p.m., LPN I was asked about R701's choking incident. LPN I described a new agency CNA (unnamed) not familiar with R701 came out of R701's room and said it looked like R701 was choking. LPN I said they observed R701 choking and coughing, and Registered Nurse (RN) H arrived patted R701 on the back and said the chicken came out of her airway. LPN I said R701's food looked like regular food, a chicken breast, and was not cut up or pureed. LPN I explained R701 was able to talk after the incident. LPN I said RN H told them this was not the first time this had occurred and said they had addressed with the dietary department prior to this incident. LPN I said they notified the physician and put in an order for speech therapy to see the resident. LPN I confirmed they were R701's nurse assigned when the incident occurred. On 7/20/26 at 4:13 p.m., RN H reported during a phone interview an aide (unnamed) came out of R701's room and they saw R701 was coughing and gave them a couple back blows, and the food came out, and then their airway was cleared. RN H said R701 was supposed to be on a pureed diet, and what they coughed up was dime sized meat chunks which appeared to be chicken. RN H said R701 was fine after the incident, and they came to assist with the incident however they were not R701's nurse. RN H said they could not recall R701's meal ticket or what it showed. On 7/20/26 at 4:56 p.m., Speech Language Pathologist (SLP) J was asked about R701, the choking incident and their follow-up. SLP J was accompanied by the Director of Therapy (DOT) K. SLP K reported R701 was on their caseload when the choking incident occurred, and R701 was on a (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pureed diet. SLP K said they left R701 on a pureed diet after the incident. SLP K said they were on the unit when the incident occurred, and it looked like the aide was feeding the resident a mechanical soft diet, not a pureed diet as ordered. SLP K said they were in R701's room with RN H after the incident occurred, and their tray ticket said a pureed diet. On 7/20/26 at 5:05 p.m., SLP K confirmed the diet was the wrong texture. SLP K clarified R701 needed a pureed diet due to dysphagia (difficulty swallowing). SLP K said this was a significant concern because R701 was on the lowest diet (consistency) already and she was a 1:1 (one person assist) feeding assistance because she was legally blind. SLP K described R701 seemed ok after the incident, caught her breath and was talking afterwards. SLP K said they acknowledged mistakes happened intermittently related to residents' food textures or liquid consistencies. SLP K said they followed up with the dietary department after the incident in person and the supervisor what happened via email. SLP K reported they educated the CNA involved when the incident occurred and educated staff on the spot when they found errors with consistencies and had not done an overall education for all staff. Review of SLP K's witness statement about the incident, dated 6/17/26, revealed they heard staff say someone was choking, and saw the nurse patting the resident on the back. The statement further showed SLP K observed the tray looked like mechanical soft in texture. On 7/20/26 at 5:52 p.m., Registered Dietician (RD) L was interviewed. RD L acknowledged they were made aware of R701's choking incident the following day and made sure the tray tickets were updated to the pureed texture as appropriate. RD L reported they believed R701's diet was changed and R701 was downgraded to pureed the next day and believed R701 was on a minced or mechanical soft diet per their recall without reviewing the record. R701's physician order was reviewed with RD L, which showed they could have a regular or mechanical soft cookie, with their pureed diet. RD L said that was sometimes ordered, and R701 was on a pureed diet after the incident. RD L reported their food services director completed the education after the incident. The Nursing Home Administrator (NHA) arrived during the interview. Review of R701's physician orders showed R701 was on a pureed diet on 6/16/26, and from 6/16/26 to present. It was noted soft or regular cookies had been removed from the orders on 6/16/26, with a new order written the same day for a pureed diet texture for all foods. On 7/20/26 at approximately 5:58 p.m., the NHA confirmed the Dietary manager completed education with staff, which included reading the tickets correctly, ensuring the correct diet was designated, the food on the ticket was correct, and the food that went out of the kitchen was correct. The NHA was made aware of the concerns related to SLP J reporting the discrepancies between the tray tickets and observed consistencies on the trays. The NHA said their expectation would have been they would have earlier been made aware of any concerns related to food consistencies. On 7/21/26 at 9:40 a.m., the Certified Dietary Manager (CDM) M confirmed the kitchen made a mistake, as a resident on a pureed diet (R701) was fed a mechanical diet. CDM M acknowledged the concern, as a resident (R701) choked, when dietary staff gave R701 the wrong diet texture on their dinner tray. CDM M explained Staff Q, and Staff R were educated the next day. CDM M clarified the staff who call the ticket was responsible as well as the last staff on the tray line to verify the correct diet texture was on the tray and all kitchen staff were trained in each position on the tray line. CDM M explained the process was to verify the tray (meal) with the ticket (a resident's meal ticket). CDM M said the ADON (Assistant Director of Nursing) also provided staff education. CDM M confirmed Staff M and Staff Q did not complete witness statements, as none by them were found in the investigation file provided electronically. Review of the facility investigation confirmed kitchen staff were educated regarding, Allergies /Meal Tickets on 6/17/26, without further clarification. A document was attached which showed staff education likely included on the policy, Mechanically Altered Diets. This document (reviewed 8/16/25) revealed, The facility (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will offer foods in a form that the resident is able to eat, such as a mechanically altered diet. The need for altered diet is determined by the SLP and or physician, ordered in the EMR. The diet change will automatically change the diet in the dietary software system. The SLP will notify the department of the diet texture change between meals. The dietary department will mechanically alter the food according to the guidelines within the IDDSI diet framework. Puree diets will receive all foods in smooth puree form. This education also showed Dietary Staff Q and Dietary Staff R received 1:1 education related to following dietary orders and ensuring the proper food consistency. The attachments included dietary staff education and review of residents to ensure pureed diets were being given appropriately. There was no nursing staff education included. On 7/21/26 at 10:03 a.m., Staff Q was interviewed about R701's tray via phone. Staff Q said they were not sure what happened and said they were at the end of the tray line and had not been made aware R701 choked. Staff Q clarified they had been made aware R701 was sent a mechanical tray when they were supposed to be sent a pureed tray. Staff Q said they called the ticket and were at the end of the tray line and had been educated about the incident. Staff Q denied completing a witness statement describing what had occurred. Staff Q acknowledged they should have double checked R701's ticket. An attempt was made to reach Staff R on 7/21/26, with no call returned. On 7/21/26 at 10:18 a.m., CNA O reported during a phone interview R701 was chewing their food for a minute and appeared uncomfortable. CNA O said they gave R701 some water, and was feeding them, and R701 began choking, patted their back, and described R701 started choking again. CNA O reported a male nurse arrived, smacked R701 on her back and said this was not the first time this had happened, and this time it was more severe. CNA O reported the diet was a normal consistency and was solid. CNA O said they were not sure what type of food but it was not bite sized and said they did not double check the meal check to the food. Review of R701's meal tickets, received on 7/21/26 at 18:51 p.m. (6:51 p.m.) revealed R701 was on a regular pureed diet with thin liquids on 6/16/26, and on 6/17/26. R701's meal ticket on 6/16/26 at dinner was shown and roasted pork pureed, mashed potatoes, a pureed salad, and a pureed crisp as well as thin liquids and a nutritional supplement. On 7/21/26 at 5:21 p.m., the NHA, with Regional Clinical Services Director P, confirmed their root cause of the incident was with the tray line process, and ensuring the proper process on the tray line, with staff ensuring the meal served had the right food (diet, texture, etc) with the right ticket. The NHA indicated they understood the concern with R701 being served the wrong food texture and said they had not received a pureed diet as prescribed when the incident occurred (6/16/26). The NHA explained education and audits were done with dietary staff. When asked about any concerns with tray delivery, the NHA then said education was done with their nursing staff as well. The NHA reported the cause of the incident was the kitchen error and did not speak to the concern regarding the resident being delivered the wrong tray on the unit as well. Survey team reviewed with the NHA and Regional Clinical Services Director P there were also concerns the nursing staff not matching the tray ticket to the meal upon delivery by the involved CNA as well, and there was no education received. This was also not included in a Past Non-Compliance (PNC) provided by the facility. The NHA reported they understood the concerns and then provided additional documentation of nursing staff education. Review of the facility investigation included a Past Non-Compliance Document, which read as follows: It is the content (sic) of (facility) to follow state and federal regulations. Deficiency Practice: 1. Staff failed to follow diet order and served a resident incorrect diet consistency. a. (R701) was supposed to be on a puree diet and believe (sic) it was mech (mechanical) soft. b. On 6/16/26, (R701) was served the incorrect diet and consistency which caused (R701) to have a choking/coughing incident. c. Kitchen staff served the incorrect diet receive (sic) a 1:1 education with emphasis on ensuring the diet is correct including (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	consistency. d. Kitchen staff will be 100% educated by 6/17/26 to ensure that diets are served according to diet, including consistency. The document showed the NHA was responsible, audits were completed, and there was no reference to nursing staff education, which was deemed part of the root cause of the incident. Review of IDDSI guidelines, utilized by the facility, described mechanical soft textured foods as moist, soft, tender, bite-sized food requiring minimal chewing; fork tender, solid pieces. Review of the policy, Food Preparation of Mechanically Altered Food, reviewed 7/14/26, revealed, .The facility will prepare mechanically altered foods per guidance according to IDDSI (food texture guidelines).The facility uses a food processor to break down food according to ground, minced and moist, pulsed, and smooth puree. Foods that are naturally pureed will be served according to manufacturer's directions, example instant pudding, mashed potato, gelatins, custard, souffles. The cook shall use nutrient dense liquids as a medium for puree, per facility recipe and guidance.Examples include olive oil, whole milk, cream, margarine, broth, and base. Review of the policy, Tray Accuracy Policy, reviewed 7/01/26, revealed, All residents shall receive diets that are exactly matched to physician-ordered medical needs, individualized care plans, and the updated federal dietary guidelines.Dietary staff will check each tray against the meal ticket prior to loading the cart. Dietary staff will be trained on the importance of tray accuracy upon hire. The nursing staff will take the meal into patient/ residents' rooms, using the name, room number, and picture if printed on the ticket as the tray identifier. The facility will do routine audits on tray accuracy. Review of the document, 4 (texture) Pureed Food, IDDSI, International Dysphagia Diet Standardization Initiative, was provided by the facility in the electronic data share document as their pureed texture guidance. The guidelines noted, Level 4 Pureed Food for Adults. What is this food texture? Level 4 - Pureed Foods: Are usually eaten with a spoon, do not require chewing, have a smooth texture with no lumps, hold shape of a spoon, fall off a spoon in a single spoonful when tilted, are not sticky, liquid (like sauces) must not separate from solids.Why is this food texture level used in adults? Level 4: Pureed food may be used if you are not able to bite or chew food or if your tongue control is reduced. Pureed foods only need the tongue to be able to move forward and back to bring the food to the back of the mouth for swallowing.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. This citation relates to Intake 3065617. Based on observation, interview, and record review, the facility failed to provide dignified care and privacy for one Resident (R704) of four residents reviewed for dignity. Findings include: On 7/20/26 at 10:51 a.m., R704 was observed in their hospital bed wearing a gown, undraped, with their brief and legs exposed. There was no sheet or blanket to cover them, and only a fitted sheet on their bed. Their call light was observed clipped over their dresser on their left side, out of reach. On 7/20/26 at 10:51 a.m., R704 reported they were cold and needed a blanket or covering, and said they were upset they had no blanket over them. On 7/20/26 at 10:53 a.m., floor staff were notified R704 needed a blanket, per their request. On 7/20/26 at 10:59 a.m., R704 remained uncovered. R704 said, I need a blanket and I am still uncovered here. Please put it on me; I am freezing to death. R704 appeared cold by shivering and grimacing, appearing uncomfortable. On 7/20/26 at 11:00 a.m., R704 received a blanket from staff, nine minutes after they were found exposed. On 7/20/26 at 11:03 a.m., Licensed Practical Nurse (LPN) C was asked if R704 was able to use their call light, to notify staff they needed their call light. LPN C reported R704 sometimes used their call light. LPN C said Certified Nurse Aide (CNA) D had been in R704's room and left to provide care for another resident and had planned to return to put a blanket on R704. LPN C confirmed R704's call light should have been in place. On 7/20/26 at 11:29 a.m., CNA D was asked about R704's care this morning. CNA D said, I am not sure what happened. Normally, I cover my residents. I had to hurry up and lay another resident down. CNA D acknowledged R704's call light should have been in place and said they were an agency nurse newer to these residents. CNA D was asked if there was any reason R704's call light was not in place. CNA D said they had 10 residents and it was difficult to get their care needs met timely, and said they might miss something, such as what occurred. Review of R704's Care Plan, accessed 7/21/26, revealed, (R704) has a ADL (activities of daily living) self-care deficit related to disease process, muscle wasting and atrophy, physical limitation. Date initiated; 8/15/2025. Bed mobility: 1 person assistance. Call light within reach. Review of the policy, Dignity, dated 9/21/23, revealed, It is the policy of this facility that each resident will be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with us, feeling of self-worth, and self-esteem. General Guidelines: Residents will be treated with dignity and respect. The facility culture supports dignity and respect for residents by honoring resident goals, choices, preferences, values, and beliefs. This begins with the initial admission and continues throughout the resident's stay at the facility. Resident's private space and property are always respected. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. This citation relates to Intake 3065617. Based on observation, interview, and record review, the facility failed to ensure call lights were in reach for two Residents (R701, R704) of four residents reviewed for accommodation of needs. Findings include: On 7/20/26 at 10:51 a.m., R704 was observed in their hospital bed wearing a gown, undraped, with their brief and legs exposed. There was no sheet or blanket to cover them, and only a fitted sheet on their bed. Their call light was observed clipped over their dresser on their left side, out of reach. It was noted that the light itself was a light with a grey plastic base and a red call button. On 7/20/26 at 10:51 a.m., R704 reported they were cold and needed a blanket or covering and said they were upset they had no blanket over them. R704 was alert and interviewable and was oriented to themselves and their surroundings. On 7/20/26 at 10:51 a.m., R704's roommate, R701, was observed laying in their bed with their covers over them. R701's call light was observed over their head on their right side, above the top of their pillow, out of reach. R701 attempted to reach their call light and said they could not reach it. R701 was aware of their name, situation, and surroundings. It was noted their call light was a grey soft touch pad. On 7/20/26 at 10:53 a.m., Licensed Practical Nurse (LPN) B was notified that R704 needed a blanket. On 7/20/26 at 10:59 a.m., R704 remained uncovered. R704 said, I need a blanket and I am still uncovered here. Please put it on me; I am freezing to death. R704 appeared cold by shivering and grimacing, appearing uncomfortable. On 7/29/26 at 11:00 a.m., R704 received a blanket from staff, nine minutes after they were found exposed and their call light was placed on them after Surveyors reported it was not accessible. Surveyors noted R701 and R704's call lights were out of reach. Staff placed R701's and R704's call lights in reach with a clip. It was noted the R704's call light was slipping from R704's hands, and they could only access it with extra effort and time. On 7/20/26 at 11:03 a.m., Licensed Practical Nurse (LPN) C was asked if R704 was able to use their call light, to notify staff they needed their call light. LPN C reported R704 sometimes used their call light. LPN C said Certified Nurse Aide (CNA) D had been in R704's room and left to provide care for another resident and had planned to return to put a blanket on R704. LPN C confirmed R704's call light should have been in place. On 7/20/26 at 11:29 a.m., CNA D was asked about R704's care this morning, as they were their assigned aide. CNA D said, I am not sure what happened. Normally, I cover my residents. I had to hurry up and lay another resident down. CNA D acknowledged R704's call light should have been in place and said they were an agency nurse newer to these residents. CNA D was asked if there was any reason R704's call light was not in place. CNA D said they had 10 residents and it was difficult to get their care needs met timely, and said they might miss something, such as what occurred. It was confirmed R701 used their call light most of the time as they were able to let staff know what they needed. On 7/21/26 at 11:43 a.m., R704 was observed in their bed, in their gown, with a blanket over them. Their call light was clipped to the left side of their sheet however the call light itself was hanging to the left almost touching the floor, out of reach. On 7/21/26 at 11:46 a.m, Registered Nurse (RN) G was asked to observe R704's call light. RN G concurred R704 could not reach their call light and placed their call light in reach. RN G said the call light needed to be in a reachable position on the middle of the bed. RN G reported R704 used their call light at times to call for assistance. Review of R704's Care Plan, accessed 7/21/26, revealed, (R704) has a ADL (activities of daily living) self-care deficit related to disease process, muscle wasting and atrophy, physical limitation. Date initiated; 8/15/2025. Bed mobility: 1 person assistance. Call light within reach. Review of R701's Care Plan, accessed 7/21/26, revealed (R701) is at risk for falls, decreased mobility, medication side effects, requires assist with adls. Date initiated: 11/19/2025. Call light in reach. Date initiated: 11/19/2025. Review of the policy, (continued on next page)		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Call light Accessibility and Timely Response, issued 8/16/23, revealed, The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside and bathing facility (area) to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Each resident will be reviewed for unique needs and preferences to determine any special accommodation that may be needed for the resident to utilize the call system. Special accommodation will be identified on the resident's person-centered plan of care and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.). Staff will ensure the call light is plugged in, functioning, within reach of residents, and secured, as needed. The call system will be accessible to residents while in their room at bedside as well as in the bathroom and shower room.		

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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 relates to Intake 3065617. Based on observation, interview, and record review, the facility failed to ensure documentation of a physician order for wound treatment for one Resident (R703) of three residents reviewed for skin and wound care, resulting in the delayed documentation of a physician order for an unstageable pressure injury and the potential for missed treatments. Findings include: Review of the clinical record including wound care documentation showed R703 was readmitted to the facility after a hospital stay on 7/16/26, with a right heel pressure injury, which they had prior to their admission. Review of R703's census showed they were hospitalized [DATE] and readmitted to the facility on [DATE]. Review of R703's TAR (Treatment Administration Record) on 7/20/26 showed no right heel pressure injury treatment orders. On 7/20/26 at 11:56 a.m., R703 was observed in their room laying in their bed. R703 agreed to be interviewed initially, then declined to answer questions about wound treatment or for surveyors to observe their right heel pressure injury, with Licensed Practical Nurse (LPN) B. R703 was alert and oriented to themselves, time, situation, and surroundings. On 7/20/26 at 12:04 p.m., LPN B was asked about R703's right heel pressure injury, as no treatment orders were not found in the Electronic Medical Record (EMR). LPN B noted R703 had just returned from the hospital a few days prior, with the right heel pressure injury from prior admissions. LPN B confirmed R703 had the pressure ulcer prior to their hospitalization. LPN B said they used (Name brand) two wound care products to treat R703's right heel pressure injury on 7/17/26, despite no physician order in place, which would have been entered by them. LPN B reported they treated facility wounds about four times a week, and the nursing staff completed facility wound care about three times a week. LPN B confirmed R703 was designated to receive daily treatment for their right heel pressure injury. Review of R703's readmission wound care note, dated 7/17/26, showed R703 had an unstageable right heel pressure injury, which measured 2.25 (length) by 1.0 (width) by 0.2 (depth) by 1.78 (area) (centimeters squared). Review of R703's EMR on 7/20/26 with LPN B revealed R703 had no admission orders, and no way to determine if they received wound treatments on 7/18/26 or 7/19/26. LPN B said R703 refused wound care over the weekend, however this was not documented. R703 reported they completed R703's wound treatment on 7/17/26 and said they missed writing the order for R703's pressure injury, not the completion of the treatment. LPN B said they would add the wound care treatment order after the interview and ensure the physician was made aware. LPN B confirmed they were the wound care coordinator, and putting the wound in the EMR was typically their responsibility. LPN B reported they understood the concern. On 7/21/26 at 11:11 a.m., LPN B was about to complete R703's wound care. R703 was observed in their bed and declined the wound care and for their right heel to be observed at that time. It was noted they had a Kerlix wrap from their foot / heel and up to their knee. There was a tape securing the Kerlix at the top over their knee, with a date of 7/20/26. Review of the EMR showed R703 had a history of declining some wound care or other treatments. On 7/21/26 at 11:15 a.m., the Assistant Director of Nursing (ADON) was interviewed with LPN B present. The ADON acknowledged the concerns and reported they had been addressed. On 7/21/26 at 11:26 a.m., LPN B was asked for follow-up regarding R703's wound dressings and treatment. LPN B reported they had received a 1:1 education regarding the missing wound orders, and they were ensuring this did not happen again going forward. LPN B said they understood the concern treatment could not have been provided without orders for R703's right heel pressure injury, and the other nurses would not have had a treatment designated. LPN B confirmed they provided the treatments to R703's right heel pressure injury on 7/17/26 and 7/20/26. (continued on next page)		

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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	
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN B noted they could not clarify whether R703's pressure injury wound treatments on 7/18/26 and 7/19/26 were missed or refused from R703's TAR, as there was no physician order, and they had not made those attempts. Review of R703's TAR, showed they had a right heel pressure injury treatment for their right heel, dated 7/20/26, which was blank, to be provided once daily. Review of the policy, Physician and Practitioner Orders, revised 11/09/23, reviewed 2/03/26, revealed, The purpose of this policy is to provide guidelines for the proper and consistent provision of physician ordered services according to professional standards of quality.admission orders will be obtained for the residents' immediate care and needs. The orders should allow facility staff to provide essential care to the resident consistent with the resident's mental and physical status on admission.For consulting physician / practitioner orders received in writing, verbally (including via telephone), or via fax, the nurse will: Contact the attending physician to verify the order. Transcribe the order into the EMR (Electronic Medical Record) in accordance with attending physician approval. Review of the policy, Skin and Wound Guidelines, revised 3/20/24, revealed, To describe the process steps required for identification of residents at risk for the development of pressure injuries, identify prevention techniques and interventions to assist with the management of pressure injuries and skin alterations.Treatment options are based on the type of wound, the need for protection of the wound bed, the goal of treatment, and manufacturer's recommendation for product utilization. Treatments ordered by the medical practitioner. A complete treatment order consists of the following: Site of application, type of skin alteration or treatment needed, cleansing agent, if indicated, frequency, including end date orders if applicable, directions for use, if applicable, primary and secondary dressing, if applicable, type of securement, if applicable.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. This citation relates to Intake 3054948. Based on observation, interview, and record review, the facility failed to prevent an avoidable choking incident for one Resident (R701) of four residents reviewed for accidents and incidents. Findings include: Review of a complaint received by the State Agency on 6/25/26 revealed Certified Nurse Aide (CNA O) was feeding resident R701 and was not familiar with their care needs. The report showed R701 was supposed to have a pureed diet but was given regular food and R701 began choking and had to call for help. The complainant reported this had happened more than once. The report alleged inadequate training of agency staff as well. On 7/20/26 at 11:00 a.m., R701 was observed in their room in their hospital bed with the covers over them. On 7/20/26 at 11:27 a.m., R701 agreed to be interviewed, and confirmed there was an incident recently when they choked on food. R701 said she was supposed to be on a pureed diet and staff hit them on the back which resolved the choking. R701 was unable to answer further questions due to being sleepy. R701 was oriented to themselves, their surroundings, and situation. Review of R701's Care Plan, accessed 7/20/26, revealed an admission date of 5/11/18, and showed R701 was legally blind, and had diagnoses including stroke, heart failure, contractures, and were bed bound (bed dependent). The Care Plan showed R701 received total assistance for care including feeding. Their nutritional care plan further revealed R701 was at risk for aspiration and needed 1:1 assistance for feeding due to dysphagia (swallowing impairment) and to monitor for signs of choking or coughing with a puree diet and thin liquids, with the interventions dated 6/03/26. An updated intervention dated 6/16/26 designated R701 sit upright 30 to 60 minutes after meals. On 7/20/26 at 1:24 p.m., nursing staff were observed leaving R701's room and heard to say R701 choked; R701 was asked by staff if it was hard for them to swallow. Licensed Practical Nurse (LPN) C was outside R701's room and said R701 began coughing while eating their pureed lunch with staff assistance, and they were getting speech therapy to see R701. LPN C said R701's head was upright and she was eating in bed, and CNA D was the aide working with R701 when the incident occurred. On 7/20/26 at 1:26 p.m., R701's lunch tray was observed, which showed their ticket designated pureed food including baked chicken puree, mashed potatoes, and pureed sweet potatoes, which was observed. On 7/20/26 at approximately 1:27 p.m., R701 was briefly asked how they were doing. R701 said they were ok, and said, Sometimes I get like that. R701 did not elaborate further. On 7/20/26 at 1:34 p.m., CNA D was asked what happened. CNA D said they had to stop feeding R701 when they started coughing during the lunch meal and denied choking. CNA D confirmed R701 received a pureed diet and said R701 was fine afterwards. Review of R701's physician provider note, dated 6/22/26, revealed R701 was seen for an episode of choking on 6/16/26, with no signs or symptoms of distress or discomfort, with chest x-ray completed and no respiratory symptoms, and not convincing for aspiration. Aspiration precautions were continued and speech therapy was ordered. Review of R701's nursing progress note, dated 6/17/26 at 17:40 (5:40 p.m.), showed, Writer was notified by CNA that resident (R701) appeared to be choking while being fed meal tray. Writer immediately arrived to assess resident. Resident (R701) coughed and expelled the piece of food from throat without further intervention. No vomiting, respiratory distress, or signs of aspiration noted at this time. The note showed physician and family notification. On 7/20/26 at 3:49 p.m., LPN I was asked about R701's choking incident. LPN I described a new agency CNA (unnamed) who was not familiar with R701 came out of R701's room and said it looked like R701 was choking. LPN I said they observed R701 choking and coughing, and Registered Nurse (RN) H arrived patted R701 on the back and said the chicken came out of their airway. LPN I said R701's food looked like (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	regular food, a chicken breast, and was not cut up or pureed. LPN I explained R701 was able to talk after the incident. LPN I said RN H told them this was not the first time this had occurred and said they had addressed with the dietary department prior to this incident. LPN I said they notified the physician and put in an order for speech therapy to see the resident. LPN I confirmed they were R701's nurse assigned when the incident occurred. On 7/20/26 at 4:13 p.m., RN H reported during a phone interview an aide (unnamed) came out of R701's room and they saw R701 was coughing and gave them a couple back blows, and the food came out, and then their airway was cleared. RN H said R701 was supposed to be on a pureed diet, and what they coughed up was dime sized meat chunks which appeared to be chicken. RN H said R701 was fine after the incident, and they came to assist with the incident however they were not R701's nurse. RN H said they could not recall R701's meal ticket or what it showed. On 7/20/26 at 4:56 p.m., Speech Language Pathologist (SLP) J was asked about R701, the choking incident and their follow-up. SLP J was accompanied by the Director of Therapy (DOT) K. SLP K reported R701 was on their caseload when the choking incident occurred, and R701 was on a pureed diet, and said they left them on a pureed diet after the incident. SLP K said they were on the hallway when the incident occurred, and it looked like the aide was feeding the resident a mechanical soft diet, not a pureed diet as ordered. SLP K said they were in R701's room with RN H after the incident occurred, and their tray ticket said a pureed diet. On 7/20/26 at 5:05 p.m. SLP K confirmed the diet was the wrong texture and said little mistakes happened sometimes. SLP K clarified R701 needed a pureed diet due to dysphagia (difficulty swallowing). SLP K said this was a significant concern because R701 was on the lowest diet (consistency) already and she was a 1:1 (one person assist) feeding assistance because she was legally blind. SLP K described R701 seemed ok after the incident, caught her breath and was talking afterwards. SLP K said they acknowledged mistakes happened intermittently related to residents' food textures or liquid consistencies. SLP K said they followed up with the dietary department after the incident in person and informed the dietary department what happened via email. SLP K reported they educated the CNA involved when the incident occurred and educated staff on the spot when they found errors with consistencies and had not done an overall education for all staff. SLP K had been made aware of the other choking incident on this date and planned to follow up but said they had not seen R701 yet on this date (7/20/26) to reassess them, as they were not currently on their caseload. Review of SLP K's witness statement about the incident, dated 6/17/26, revealed they heard staff say someone was choking, and saw the nurse patting the resident on the back. The statement further showed SLP K observed the tray looked like mechanical soft in texture. On 7/20/26 at 5:52 p.m., Registered Dietician (RD) L was interviewed. RD L acknowledged they were made aware of R701's choking incident the following day and made sure the tray tickets were updated to the pureed texture. RD L reported they believed R701's diet was changed and R701 was downgraded to pureed the next day and believed R701 was on a minced or mechanical soft diet per their recall without reviewing the record. R701's physician order was reviewed with RD L, which showed they could have a regular or mechanical soft cookie, with the puree diet. RD L said that was sometimes ordered, and R701 was on a puree diet after the incident. RD L reported their food services director completed the education after the incident. The Nursing Home Administrator (NHA) arrived during the interview. Review of R701's physician orders showed R701 was pureed diet on 6/16/26. On 7/20/26 at approximately 5:58 p.m., the NHA confirmed the Dietary manager completed education with staff, which included reading the tickets correctly, ensuring the correct diet was designated, the food on the ticket was correct, and the food that went out of the kitchen was correct. The NHA was made aware of the concerns related to SLP J reporting the discrepancies between the tray tickets and observed consistencies on the trays. The NHA was (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	aware of the incident on this date at lunch with R701 choking / coughing. The NHA said their expectation would have been they would have earlier been made aware of any concerns related to food consistencies. On 7/21/26 at 9:40 a.m., the Certified Dietary Manager (CDM) M confirmed the kitchen made a mistake, as a resident on a pureed diet (R701) was fed a mechanical diet. CDM M acknowledged the concern, as a resident (R701) choked, when dietary staff gave R701 the wrong diet texture on their dinner tray. CDM M explained the process was to verify the tray (meal) with the ticket (a resident's meal ticket). CDM M said the ADON (Assistant Director of Nursing) also provided education. Review of the facility investigation confirmed kitchen staff were educated regarding, Allergies /Meal Tickets on 6/17/26, without further clarification. A document was attached which showed staff education likely included on the policy, Mechanically Altered Diets. This document reviewed 8/16/25 revealed, The facility will offer foods in a form that the resident is able to eat, such as a mechanically altered diet. The need for altered diet is determined by the SLP and or physician, ordered in the EMR. The diet change will automatically change the diet in the dietary software system. The SLP will notify the department of the diet texture change between meals. The dietary department will mechanically alter the food according to the guidelines within the IDDSI diet framework. Puree diets will receive all foods in smooth puree form. This education also showed Dietary Staff Q and Dietary Staff R received 1:1 education related to following dietary orders and ensuring the proper food consistency. This included dietary staff education and review of residents to ensure pureed diets were being given appropriately. The document did not show nursing staff including aides were educated. On 7/21/26 at 10:03 a.m., Staff Q was interviewed about R701's tray via phone. Staff Q said they were not sure what happened and said they were at the end of the tray line and had not been made aware R701 choked. Staff Q clarified they had been made aware R701 was sent a mechanical tray when they were supposed to be sent a pureed tray. Staff Q said they called the ticket and were at the end of the tray line and had been educated about the incident. Staff Q denied completing a witness statement describing what had occurred. Staff Q acknowledged they should have double checked R701's ticket. On 7/21/26 at 10:18 a.m., CNA O reported during a phone interview R701 was chewing their food for a minute and appeared uncomfortable. CNA O said they gave R701 some water, and was feeding them, and R701 began choking. CNA O stated they patted their back and described R701 started choking again. CNA O reported a male nurse arrived, smacked R701 on her back and said this was not the first time this had happened, and this time it was more severe. CNA O reported the diet was a normal consistency and was solid. CNA O said they were not sure what type of food but it was not bite sized and said they did not double check the ticket to the food. CNA O said they were an agency nurse aide and said denied receiving education, then said, No, not really. CNA O said they came from agency and assumed the nurses were checking the trays. CNA O reported they saw no other concerns for R701 during their shift. CNA O stated there were not enough nursing (CNA) staff to fully meet the care needs of the residents, however it was unclear whether this impacted what occurred. On 7/21/26 at 12:05 p.m., RN H was asked to clarify the tray delivery and ticket review process on the units at mealtimes. RN H reported it was the CNA's responsibility, not the nurses, to match the tray ticket to the diet, and ensure they matched. RN H explained they had not worked with R701 in a few months, since they relocated halls where they were typically assigned. RN H explained the CNA working with R701 when they choked should have ensured the tray ticket matched R701's meal on the tray. RN H acknowledged sometimes residents had been served with the wrong dietary texture prior, however denied this being R701, or other choking incidents or any outcomes when this had occurred. On 7/21/26 at 12:47 p.m., SLP J followed up with the survey team, with DOT K present. SLP J indicated they followed up with R701, and they had no (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exactly matched to physician-ordered medical needs, individualized care plans, and the updated federal dietary guidelines. Dietary staff will check each tray against the meal ticket prior to loading the cart. Dietary staff will be trained on the importance of tray accuracy upon hire. The nursing staff will take the meal into patient/ residents' rooms, using the name, room number, and picture if printed on the ticket as the tray identifier. The facility will do routine audits on tray accuracy. Review of the policy, Accidents and Incidents, reviewed 2/02/26, revealed, It is the policy of this facility for staff to utilized (EMR) risk management to report, investigate, and review any accidents or incidents that may involve or allegedly involve a resident. Types of incidents: Choking. Review of the document, 4 (texture) Pureed Food, IDDSI, International Dysphagia Diet Standardization Initiative, was provided by the facility in the electronic data share document as their pureed texture guidance. The guidelines noted, Level 4 Pureed Food for Adults. What is this food texture? Level 4 - Pureed Foods: Are usually eaten with a spoon, do not require chewing, have a smooth texture with no lumps, hold shape of a spoon, fall off a spoon in a single spoonful when tilted, are not sticky, liquid (like sauces) must not separate from solids. Why is this food texture level used in adults? Level 4: Pureed food may be used if you are not able to bite or chew food or if your tongue control is reduced. Pureed foods only need the tongue to be able to move forward and back to bring the food to the back of the mouth for swallowing.		