

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235439	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2025
NAME OF PROVIDER OR SUPPLIER Optalis Health and Rehabilitation of Allen Park		STREET ADDRESS, CITY, STATE, ZIP CODE 9150 Allen Rd Allen Park, MI 48101	

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1215649. Based on interview and record review the facility failed to prevent staff to resident abuse for one (R107) of four residents reviewed for abuse. Findings include: On 7/22/25 at 10:45 AM R107 was interviewed regarding an incident upon admission to the facility with Licensed Practical Nurse (LPN) C and said that LPN C did not want to admit her to the facility which caused a delay with her admission. R107 stated, The next day (5/27/25) LPN C came to my room and asked me if I reported her. I said that I didn't, but it was awkward, and I didn't appreciate that she accused me. Her tone was aggressive, and I was uneasy and fearful of her. Record review of the Electronic Health Record (EHR) revealed R107 was admitted to the facility on [DATE] with diagnosis of Right Tibia fracture, Lumbar Vertebra fracture, Injury in Motor Vehicle Accident. Review of the Minimum Data Set (MDS) dated [DATE] for R107 revealed a Brief Interview for Mental Status (BIMS) score of 14/15, which indicated intact cognition. Review of the facility's investigation report dated 5/28/25 conducted by the Nursing Home Administrator (NHA) and Director of Nursing (DON) revealed, Do you feel like the nurse (LPN C) was confrontational? -Yesterday she came in my room and accused me and my family of making a report on her. It was kind of intimidating and scary. On 7/22/25 at 12:55 PM, Registered Nurse (RN) A was interviewed and said LPN C confronted R107 after LPN C was suspended. RN A stated, The nurse should not have done that and that residents have the right to report concerns without the fear of retaliation. On 7/23/25 at 10:45 AM, the NHA and DON were interviewed and the DON said that on the morning of 5/27/25 she had a meeting with LPN C to notify her that LPN C was suspended pending an investigation regarding the incident with R107 and walked LPN C out of the building. The DON further said that after suspension LPN C reentered the building and talked to R107. The DON said the expectation was for employees to leave the building upon suspension and not to return until notified by a supervisor. The DON said LPN C was terminated. The NHA said that LPN C had abuse training upon hire and that she should not have gone back to talk to the resident after suspension. On 7/23/25 at 11:05 AM, LPN C was interviewed via phone and said that she spoke to R107 after the DON suspended her. When asked if LPN C accused R107 of reporting her LPN C did not provide an answer. Review of the facility policy titled Abuse, updated 5/24/25, revealed in part: Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property. This includes, but is not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint that is not required to treat the patient/resident's medical symptoms. The facility will educate its staff upon hire, annually, and as needed which will include, but not necessarily be limited to, the following topics: Prohibiting and preventing all forms of abuse, neglect, mistreatment, exploitation, and misappropriation of identifying what constitutes abuse, neglect, mistreatment, exploitation, and misappropriation of resident property. Reporting process for suspicions or allegations of abuse, injuries of unknown origin, neglect, exploitation, mistreatment, and misappropriation of resident property without fear of reprisal or retaliation. Providing residents, representatives, and staff information on how and to whom they report any allegations of abuse, neglect, mistreatment, exploitation, misappropriation of resident property, injuries of unknown origin, concerns, incidents, and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: Immediately removing the resident from contact with the alleged abuser. Providing a safe and secure environment for all patients. If a staff member is the alleged perpetrator, that staff member should be immediately removed from the facility and the schedule pending the outcome of the investigation.</p>		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2563789. Based on interview and record review the facility failed to report a fracture of unknown origin to the State Agency (SA) for one (R101) of four residents reviewed for abuse. Findings include: The State Agency (SA) received a complaint that R102 had a hip fracture of unknown origin. According to R102's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with diagnoses that included dementia and history of falls with left foot pain. On 11/26/24 the resident had a fall while in therapy. According to the Fall Report dated 11/26/24, R102 lost his balance during a self-transfer out of the wheelchair while in the therapy department. Therapy staff interfered with the fall and the resident was lowered to the floor by therapy staff. There was no injury or complaints of pain. Review of progress notes and pain assessments from 11/26/24 - 12/28/24 revealed that there were no changes in resident's pain levels. On 12/28/24 at 6:18 PM a progress note written by Registered Nurse (RN) D documented the family wanted an x-ray of the resident's right leg due to a recent fall and complaints of pain. X-rays were ordered for resident's right tibia and fibula (lower leg bones, shin/calve area). The X-rays were negative for any acute (recent) fracture or soft tissue injury. There was no documentation to indicate R102 had a fall after 11/26/24. On 12/30/24 at 4:30 PM a Therapy note written by Occupational Therapist (OT) E documented the resident's family reported the resident had a fall over the weekend and X-rays of the right leg were taken. On 1/1/25 R102 was sent out to the hospital for mental status changes. On 7/23/25 at 1:35 PM RN D said they had no recall of R102 falling. They reviewed R102's EHR and confirmed there was no documentation to indicate the resident had a fall after 11/26/24. RN D said they honored the family's request for the x-ray and did not ask when the resident fell. On 7/23/25 at approximately 1:50 PM the Director of Nursing (DON) provided a 'soft file' for R102 that included the hospital's x-ray results dated 1/1/25. The X-ray results indicated R102 had a right mildly displaced femoral neck/intertrochanteric (upper part of femur). The DON said an investigation was initiated by the former DON and was not reported to the SA. The DON said the fracture was of unknown origin and should have been reported to the SA within two hours of notification. On 7/23/25 at approximately 2:50 PM the Nursing Home Administrator (NHA) was queried about R102's right hip fracture on 1/1/25. The NHA said they were on a medical leave during this time and was unaware that R102 had a hip fracture of unknown origin until today. The NHA confirmed that this incident should have been reported to the SA. According to the facility's Abuse policy last updated on 5/24/2023 it reads in part. The facility will ensure that all allegations involving abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, and crimes are reported immediately to the Administrator and: Reported to the State Survey Agency immediately but not later than two hours after the allegation is made if the allegation involves abuse or results in serious bodily injury and to other officials (including adult protective services and/or law enforcement, when applicable) OR Reported to the State Survey Agency no later than 24 hours if the allegation does not involve abuse and does not result in serious bodily injury to the State Survey Agency and to other officials (including adult protective services and/or law enforcement, when applicable).		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>(continued on next page)</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2563789. Based on interview and record review the facility failed to complete a thorough investigation for fracture of unknown origin for one (R102) of four residents reviewed for abuse. Findings include: The State Agency (SA) received a complaint that R102 had a hip fracture of unknown origin. The complainant was attempted to be contacted on 7/23/25 at 10:32 AM and on 7/24/25 at 11:05 AM. According to R102's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with diagnoses that included dementia and history of falls with left foot pain. On 11/26/24 the resident had a fall while in therapy. According to the Fall Report dated 11/26/24, R102 lost his balance during a self-transfer out of the wheelchair while in the therapy department. Therapy staff interfered with the fall and the resident was lowered to the floor by therapy staff. There was no injury or complaints of pain. Review of progress notes and pain assessments from 11/26/24 - 12/28/24 revealed that there were no changes in resident's pain levels. On 12/28/24 at 6:18 PM a progress note written by Registered Nurse (RN) D documented the family wanted an x-ray of the resident's right leg due to a recent fall and complaints of pain. X-rays were ordered for resident's right tibia and fibula (lower leg bones, shin/calve area). The X-rays were negative for any acute (recent) fracture or soft tissue injury. There was no documentation to indicate R102 had a fall after 11/26/24. On 12/30/24 at 4:30 PM a Therapy note written by Occupational Therapist (OT) E documented the resident's family reported the resident had a fall over the weekend and X-rays of the right leg were taken. On 1/1/25 R102 was sent out to the hospital for mental status changes. On 7/23/25 at 1:35 PM RN D said they had no recall of R102 falling. They reviewed R102's EHR and confirmed there was no documentation to indicate the resident had a fall after 11/26/24. RN D said they honored the family's request for the x-ray and did not ask when the resident fell. RN D reported they had never been interviewed regarding why the X-ray was ordered or that the family had said the resident fell. On 7/23/25 at approximately 1:50 PM the Director of Nursing (DON) provided a 'soft file' for R102 that included the hospital's x-ray results dated 1/1/25. The X-ray results indicated R102 had a right mildly displaced femoral neck/intertrochanteric (upper part of femur). The DON said an investigation was initiated by the former DON on 1/1/25. A review of the investigation did not contain any interviews from staff, physician, residents, or R102's family. The investigation concluded that the fracture was the result of the fall on 11/26/24. On 7/23/25 at approximately 2:00 PM OT E was asked to review their note from 12/30/24 for R102. OT E said they were aware that R102 had been diagnosed with a hip fracture but did not know how it occurred. OT E confirmed they had never been interviewed by facility staff regarding R102. On 7/23/25 at approximately 2:50 PM the Nursing Home Administrator (NHA) was queried about R102's right hip fracture on 1/1/25. The NHA said they were on a medical leave during this time and was unaware that R102 had a hip fracture of unknown origin until today. The NHA reviewed the facility's investigation and confirmed that it was incomplete. According to the facility's Abuse policy last updated on 5/24/2023, it reads in part: The facility will develop and implement written policies and procedures that include: Investigating allegations of abuse, neglect, misappropriation, mistreatment, and exploitation to include protecting residents during the investigation, and taking necessary actions as a result of the investigation. The investigation process includes: Identifying staff responsible for the investigation. Determining the purpose of the investigation and issue(s) to be investigated, whether or not the alleged violation has occurred, the extent, and cause. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations (such as other residents, family members, staff who worked closely with the alleged perpetrator and/or alleged victim). Conducting observations of the alleged victim, including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between resident to other residents as applicable. Identifying and reviewing all relevant medical records and facility documentation as applicable. If the alleged perpetrator is a staff member, review their employment records. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence). Providing complete and thorough documentation of the investigation. After completion of the investigation, the evidence should be analyzed, and the Administrator or designee will make a determination regarding whether the allegation is substantiated or unsubstantiated. The Administrator will determine if modifications to existing policies and procedures (or new policies and procedures) are needed to prevent similar incidents.</p>		