STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235441	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Wyoming	625 36th Street SW Wyoming, MI 49509

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. This citation pertains to intake 2640739Based on observation, interview, and record review, the facility failed to thoroughly investigate an allegation of neglect for one resident (R1) out of four residents reviewed for abuse and neglect.Findings include:Review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) on 9/30/25 reflected, Incident Summary - Nurse reported to administrator that an outside door was alarming, and staff noticed resident (R1) was not in his room. Staff began searching and found him outside in facility parking lot. Resident was immediately brought back into the facility. No obvious injury observed. Resident was smiling. Head to toe assessment and 15-minute checks implemented. Investigation initiated.During an observation beginning at 9:29 AM on 10/21/2025 with Unit Manager/Licensed Practical Nurse (LPN) A it was discovered the list of residents at risk for elopement was not accurate as evidenced by a resident's room number for one resident who was at risk for elopement and wore a wander alert device was not correct on the audit sheet provided to the surveyor by the facility.Review of the Elopement Risk binders located at two nurse stations and with the receptionist at the front entrance of the facility reflected that the Resident Profile/Resident admission Records were not up to date with the residents' current and correct room number for 4 out of 9 residents identified by the facility as being at risk for elopement. During an observation of the facility's wander guard system and door alarms on 10/21/2025 at 10:13 AM, it was discovered that a wander guard alarmed door at the staff entrance was not routinely tested by the facility Maintenance Director N. Maintenance Director N reported he did not know that door was equipped with a wander guard sensor. Maintenance Director N also reported the facility had been having trouble with the laundry room door (the door R1 is suspected to have eloped from) alarming frequently prior to R1 eloping from the facility, contributing to alarm fatigue (when workers become desensitized to safety alerts and may ignore them) amongst staff.During a telephone interview on 10/21/2025 at 1:45 PM, CNA (Certified Nursing Assistant) F revealed she turned off the laundry room door alarm and looked outside but did not physically go outside to verify who had set the alarm off before returning to her regular duties. During a telephone interview on 10/22/2025 at 8:10 AM, LPN C reported that she was on duty when R1 eloped from the facility but was not assigned to care for R1. LPN C said she did not complete a face-to-face head count of the residents on the unit where she was assigned. LPN C reported that she had never participated in an elopement drill on the night shift and did not recall being educated about the facility elopement policy and procedure other than an email she reviewed a few days prior to this interview. Review of the facility investigation related to the FRI reported to the SA on 9/30/2025 reflected a Witness Statement indicating Certified Nursing Assistant (CNA) F reported, I came out of patient room when I heard door alarms going off. I checked the doors nearby. I found one alarming by the laundry room, looked outside but did not see anyone so turned alarm off. I came back in and came around the corner where another staff member, (CNA I) asked me if I had seen (R1) which I had not. At that time, I joined with the search. Shortly after, he was found. The witness statement did not capture the fact that CNA F failed to react to the door alarm according to established procedures in the facility Elopement policy. The completed FRI investigation did not reflect that a face-to-face head count of all the residents had been conducted at the time R1 eloped from the facility unbeknownst to staff. Further review of the completed facility (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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	investigation submitted to the SA reflected several other witness statements. The witness statements did not include pertinent details such as when and who had last observed R1 prior to R1 eloping from the facility. It was identified in the investigation that R1 may have been attempting to visit a friend who also resided at the facility, however, there was not a statement from this person included in the investigation. The investigation did not include a witness statement from the nurse assigned to care for R1 on the date of the incident. The investigation did not include a statement from the nurse who was parked outside and was the first person to make contact with R1 when he eloped from the facility. During an interview on 10/21/2025 at 2:35 PM, the Nursing Home Administrator (NHA) reported that she did not document which nurse was assigned to care for R1 on the date of the incident and did not obtain a statement from this nurse. The NHA said she did determine who had last seen R1, how R1 had been dressed when R1 was last observed, or what his behaviors had been prior to R1 eloping from the facility. The NHA said there was not a resident census printed to document a face-to-face head count of every resident at the facility at the time R1 eloped from the facility. The NHA reported she was not aware the laundry room door had been alarming frequently and that Maintenance Director N had been aware of the potential problem with the laundry room door R1 was suspected to have eloped from the facility through. The NHA reported that she had Maintenance Director N complete an audit of all the doors after R1 eloped from the facility but was unaware that Maintenance Director N was not checking all doors equipped with a wander alert sensor and alarm. When asked, the NHA said she was not aware the elopement risk binders kept at each nurse station and with the receptionist were not accurate. The NHA reported the facility did not have evidence Elopement drills were conducted with the night shift staff and was not aware staff had not been educated effectively regarding the facility elopement policies and procedures. After a review of additional residents at risk for elopement, the NHA reported it had not been discovered during the facility investigation that some residents at risk for elopement did not have care plans in place or orders that reflected the residents' need for a wander alert device. Review of a facility policy and procedure for Abuse last updated 5/24/2023, reflected residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property. 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 the result of the investigation. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. The policy describes key steps to take in order to conduct a thorough investigation which included: identifying and reviewing all relevant medical records and facility as applicable; .Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations; . 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 are needed to prevent similar incidents or injuries from occurring in the future in accordance with its QAPI (Quality Assurance Process Improvement) plan. The quality assurance investigative materials will be reviewed by the quality assurance committee in accordance with the facility QAPI plan. The quality assurance committee will take all actions deemed necessary based upon their review.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2640739Based on interview and record review, the facility failed to review and revise care plans for 3 residents (R1, R2, & R4) out of four residents reviewed for care planning. Findings Include:Resident #1 (R1)Review of a facility admission Record reflected R1 admitted to the facility on [DATE] with diagnosis that included hemiplegia and hemiparesis following cerebral infarction, vascular dementia, muscle weakness, lack of coordination, and unspecified abnormalities of gait and mobility.Review of a General Progress Note dated 6/8/2025 reflected R1 had a hospital LOA (leave of absence) in order to have a MRI magnetic resonance imaging, and the hospital called, . asking if it would be OK to remove the patient's wander guard (a wearable sensor device used to trigger an alarm when a resident attempts to elope/exits a door equipped with a wander alert system) nurse stated to unsnap wander guard's strap and when done doing MRI to place back on patient as patient will need this when he returns to the facility.Review of a psychiatry note dated 7/16/2025 reflected R1 was being evaluated for complaints of always trying to stand and walk. The Assessment and Plan documented in the progress note indicated R1 was diagnosed with Wandering in diseases classified elsewhere, Patient (R1) was referred for a complaint of always trying to stand and walk. This wandering behavior is likely related to his cognitive impairment. Will monitor for safety concerns related to wandering behavior and coordinate with nursing staff regarding appropriate supervision and safety measures.Review of Social Work notes dated 7/18/2025 and 7/21/2025 reflected the facility was sending referrals to get R1 admitted to a memory care unit (a specially designed space for individuals with dementia and/or cognitive impairments which provide 24-hour care and supervision to ensure residents' safety in a secure environment). Review of an IDT (interdisciplinary team) Note dated 8/11/2025 reflected IDT met regarding R1's removing his wander guard. R1 has settled into the facility and is much safer than he was initially he sits in the hallway near the nursing station and does not wander or pushing (sic) on doors any longer. IDT agrees that we will d/c (discontinue) the wander guard at this time and monitor for signs and symptoms of exit seeking.Review of a facility reported incident submitted to the state agency on 9/30/25 reflected, Incident Summary Nurse reported to administrator that an outside door was alarming, and staff noticed resident (R1) was not in his room. Staff began searching and found him outside in facility parking lot. Resident was immediately brought back into the facility. No obvious injury observed. Resident was smiling. Head to toe assessment and 15-minute checks implemented. Investigation initiated.Review of the Care Plan Report, including revision history reflected a care plan for Exit Seeking/elopement risk was not initiated until 9/30/2025, the day R1 successfully eloped from the facility unbeknownst to staff. Resident #2 (R2)Review of an admission record reflected R2 admitted to the facility on [DATE] with diagnosis that included severe major depressive disorder with psychotic symptoms.Review of two Elopement Risk Evaluation dated 8/15/2025 and 10/1/2025 reflected R2 was identified as being at risk for elopement.Review of an Order Recap Report for the date range 8/2025-10/31/2025 reflected R2 had an order in place for a wander alert device since 8/23/2025.Review of a care plan report that included revision history reflected R2 had not been care planned for their risk for wandering or elopement until 9/9/2025.Resident #4 (R4)Review of an admission record reflected R4 admitted to the facility on [DATE] with diagnosis that included dementia, bipolar disorder, insomnia, cognitive communication deficit, and altered mental status.Review of two Wandering Risk Scale assessments dated 12/17/2024 and 3/17/2025 reflected R4 was at risk to wander. 2 wandering risk scales were completed for R4 on 6/17/2025 and indicated in one that R4 was at high risk to wander and in the second assessment was deemed a low risk for wandering.Review of Elopement Risk Evaluation dated 8/1/2025 and 10/1/2025 reflected R4 was at risk for wandering and elopement.Review of a Care Plan Report including revision history, reflected a care plan had not been implemented for R4's exit seeking (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an elopement risk until 8/1/2025.During an interview on 10/22/2025 at 10:45 AM, the NHA and Regional Nurse Consultant reported they were not aware care plans were not in place for some residents who were identified as being at risk for elopement. Review of a facility policy Elopement - For Facilities with a Wander Alert Bracelet System revised 5/27/2024 reflected, The purpose of this policy is to provide guidelines to evaluate residents for risk of elopement, implement risk reduction strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission and a coordinated resident search in the event of a missing resident. The policy also specified that when a resident is at risk for elopement A care plan will be developed indicating the resident's exit seeking elopement risk which will include risk reduction interventions including diversion and/or redirection during periods of increased exit seeking. Review of a facility policy for Care Plan - Comprehensive and Revision revised 8/25/2023, reflected A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy specified Assessments of residents are ongoing, and care plans are revised as information about the resident's and the residents' conditions change.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2640739 Based on observation, interview, and record review, the facility failed to fully implement policy and procedure to prevent elopements and appropriately respond to an elopement incident for one resident (R1) out of four residents reviewed for elopement. Findings include:Review of a facility admission Record reflected R1 admitted to the facility on [DATE] with diagnosis that included hemiplegia and hemiparesis following cerebral infarction, vascular dementia, muscle weakness, lack of coordination, and unspecified abnormalities of gait and mobility.Review of a quarterly Minimum Data Set (MDS) assessment dated [DATE] reflected R1 was severely cognitively impaired as evidenced by a brief interview for mental status score of 6/15. The assessment indicated R1 was dependent on staff for lower body dressing and putting on and taking off footwear and required substantial to maximal assistance for upper body dressing. Review of a facility reported incident submitted to the state agency on 9/30/25 reflected, Incident Summary Nurse reported to administrator that an outside door was alarming, and staff noticed resident (R1) was not in his room. Staff began searching and found him outside in facility parking lot. Resident was immediately brought back into the facility. No obvious injury observed. Resident was smiling. Head to toe assessment and 15-minute checks implemented. Investigation initiated.During an observation beginning at 9:29 AM on 10/21/2025 with Unit Manager/Licensed Practical Nurse (LPN) A it was discovered the list of residents at risk for elopement was not accurate as evidenced by a resident's room number for one resident who was at risk for elopement and wore a wander alert device was not correct on the audit sheet provided to the surveyor by the facility.Review of the Elopement Risk binders located at two nurse stations and with the receptionist at the front entrance of the facility reflected that the Resident Profile/Resident admission Records were not up to date with the residents' current and correct room number for 4 out of 9 residents identified by the facility as being at risk for elopement. During an observation of the facility's wander guard system and door alarms on 10/21/2025 at 10:13 AM it was discovered that a wander guard alarmed door at the staff entrance was not routinely tested by the facility Maintenance Director N. Maintenance Director N reported he did not know that door was equipped with a wander guard sensor. Maintenance Director N also reported the facility had been having trouble with the laundry room door alarming frequently prior to R1 eloping from the facility, contributing to alarm fatigue (when workers become desensitized to safety alerts and may ignore them) amongst staff.Further review of the facility investigation reflected a Witness Statement indicating Certified Nursing Assistant (CNA) F reported, I came out of patient room when I heard door alarms going off. I checked the doors nearby. I found one alarming by the laundry room, looked outside but did not see anyone so turned alarm off. I came back in and came around the corner where another staff member, (CNA I) asked me if I had seen (R1) which I had not. At that time, I joined with the search. Shortly after, he was found. The completed Facility Reported Incident (FRI) did not reflect that a face-to-face head count of all the residents had been conducted at the time R1 eloped from the facility unbeknownst to staff. During a telephone interview at 1:45 PM on 10/21/25, CNA F reported she heard a door alarm and thought it was the front door alarm then realized it was the laundry room door. CNA F said she turned off the alarm and looked outside but did not physically go outside to verify who had set the alarm off. CNA F explained that after she was back from turning off the door alarm she returned to her duties and was getting ready to throw some garbage away and was going around a corner on the unit she was working on when another aide asked if I had seen R1. According to CNA F the laundry room door alarm goes off frequently and had been touchy when staff would go outside to throw trash away and sometimes you couldn't get the code from the outside to work to open the door to get back inside.During a telephone interview on 10/22/2025 at 8:10 AM LPN C reported she was working at the time R1 eloped out of the facility. LPN C said she was not assigned (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to care for R1 but did hear alarms going off and checked a few doors by walking around and while she was searching, LPN J was attempting to pass meds for R1 and discovered him missing from his room. LPN C said that everything happened really quickly and R1 was discovered outside of the building. LPN C reported she did not conduct a face-to-face count of all the residents and did not recall being provided with any specific education pertaining to elopement after the incident other than an email she had reviewed a few days prior to this interview. LPN C reported that she had never participated in an elopement drill on the night shift at the facility.Review of a facility policy Elopement - For Facilities with a Wander Alert Bracelet System revised 5/27/2024 reflected, The purpose of this policy is to provide guidelines to evaluate residents for risk of elopement, implement risk reduction strategies for those identified as an elopement risk, institute measures for resident identification at the time of admission and a coordinated resident search in the event of a missing resident. The policy specified the facility would maintain environmental risk reduction measures including but not limited to, Door alarms are routinely tested for proper functioning and documented by maintenance employee or designee; Wander alarm system will be tested/monitored per manufactured guidelines by the maintenance employee or designee. Guidelines for a missing resident indicate When an exit door alarm sounds it is the responsibility of all staff, regardless of the department they work in, to respond to an exit door alarm sounding. Staff should automatically assume it could be a resident elopement and check to see what triggered the alarm. If the reason for the alarm sounding is not immediately determined, staff will immediately conduct an initial internal and simultaneous external search of the facility perimeter to determine what triggered the alarm. During inclement weather conditions prioritize searching the surrounding outdoor areas first. A face-to-face headcount of all residents in the facility is conducted. A resident census should be printed from (name of Electronic Health Record (EHR)) and utilized to check off residents as they are physically seen face to face by the staff member. No resident should be checked off as accounted for by staff assuming they are with another staff member or department. The policy also indicated elopement drills are conducted on a regular basis on each shift, but semiannually at a minimum.