STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235580	A. Building B. Wing	12/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Ann Arbor	4701 East Huron River Drive Ann Arbor, MI 48105

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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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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(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 - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to protect the resident's (R4) right to be free from neglect resulting in resident experiencing blunt force trauma and contributing to the resident's death. This citation pertains to intake number 2642837.Per the facility face sheet Resident #4 (R40 was an [AGE] year-old who resided at the facility since [DATE]. Diagnoses included muscle weakness, age related physical disability, and morbid severe) obesity due to excess calories. Review of an incident report dated [DATE] revealed Certified Nurse Aid (CNA) C informed a nurse that while providing a brief change R4 rolled out of bed onto the floor. The report further revealed R4 was assessed to have a skin tear to the left elbow, a hematoma (bruising) to the left knee, and left side of the head. Per the report R4 was transferred back to his bed with a mechanical lift, Neuro checks (checking id there is any possible brain injury) were started, and education was provided to CNA C. The incident report revealed that R4's Physician was notified at 2:40 AM. Review of the facility's investigation revealed that it was documented on an EMPLOYEE COUNSELING & CORRECTIVE ACTION RECORD dated [DATE], CNA C was suspended and given a Final Written Warning for a work rule violation, CENA (CNA C) Failed to Follow plan of care as written. The form revealed CNA C was suspended from 10/29 through [DATE]. Review of progress notes dated [DATE] and timed at 2:59 AM revealed, CNA (C) informed nurse that while providing brief change to resident (R4) he rolled out of bed onto the floor. Nurse entered room to find patient (R4) sitting on the floor, head against small refrigerator and legs bent at the knees, folded to the right side. Resident (R4) assessed and noted to have skin tear to left elbow, hematoma to left knee and left side of forehead, Resident transferred back to bed via Hoyer (mechanical lift) and two Staff members. The note also revealed that R4's Physician was notified and an X-ray was ordered for both of R4's legs. Review of R4's progress notes dated [DATE] and timed at 4:28 AM, revealed CNA informed nurse that while providing brief change to resident he rolled out bed onto the floor. Nurse entered room to find patient (R4) sitting on the floor, head against small refrigerator and legs bent at knees, folded to the right side. Resident (R4) assessed and noted to have skin tear to left elbow, hematoma to left knee and left side of forehead, Resident transferred back to bed via Hoyer (mechanical lift) and two Staff members. The note also revealed that R4's Physician was notified and an X-ray was ordered for both of R4's legs. Review of Physician's orders dated [DATE] revealed an order for bilateral (both sides) STAT (immediately) X-rays of both lower extremities. The order was not written until 8:20 AM. Review of an X-ray result dated 10:29/24 revealed R4 had a fracture of both his left and right femur bone. The X-ray report revealed that the X-ray was taken on [DATE], but not until 8:36 AM and was reported to the facility on [DATE] at 9:41 AM. Review of a progress note dated [DATE] at 10:00 AM revealed, IDT (Interdisciplinary Team) met to review the fall that (R4) had during staff assist on [DATE] at approximately 02:10hrs (2:10 AM). While CNA (C) was performing incontinence care (R4) rolled out of bed onto the floor, Nurse immediately assessed resident and noted that (R4) had a skin tear to left elbow. (sic) hematoma to left side of forehead, hematoma to left knee. Neuro checks were initiated and noted no immediate changes from baseline. The physician was notified and ordered x-rays, (sic) of both legs .Per POC (plan of care) pt (patient) (R4) is a 2 person assist with bed mobility immediate intervention: Assigned CNA (C) received education on following plan of care .Xray resulted in fracture of left femur. (Physician) made aware and ordered to be sent to the hospital . The facility did not identify that R4 also had a fracture of the right femur as revealed from the X-ray results. Review of an SBAR (Situation, Background, Assessment, and Recommendation) dated [DATE], revealed R4 had new pain that R4 scored at a 10 out of 10 in the left knee. The SBAR revealed that it was not until 10:00 AM that R4's Physician was notified of the X-ray results, and then an order was received to send R4 to the hospital. Review of another progress note dated [DATE] and timed at 11:22 AM, revealed it wasn't until 11:15 AM that R4 was transferred to the hospital due to abnormal X-ray results. There were no other progress notes regarding the incident, there were no further notes regarding the complaints of pain R4 had, there were no notes of any updates of R4's status from the time of the fall at 2:10 AM until R4 went to the hospital at around 11:15 AM on [DATE].Review of a Brief Interview for Mental Status (BIMS) dated [DATE] revealed R4 had a BIMS score of 10 out of 15 which indicated R4 had a moderate cognitive impairment, Review of R4's care plans that were in place and active at the time of R4's fall out of bed revealed a care plan with a Focus of At risk for falls due to functional deficits, reduced mobility .prefers to keep his bed in high position . The care plan had an intervention, Staff educated on reading Kardex (document with a resident's plan of care for