STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235618	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Canton	7025 Lilley Road Canton, MI 48187

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 1221139 Based on interview and record review the facility failed to ensure security and accountability for 30 oxycodone-acetaminophen 10-325 mg (milligram) tablets for one resident (R1) of three reviewed for drug diversion of controlled substances, resulting in 30 missing oxycodone-acetaminophen without resolution and a delay in pain relief.A review of the facility's incident report was received by the State Agency via online submission on: 6/23/25 revealed the following: Incident Summary On 6/22/25, the facility's routine narcotic count revealed a discrepancy involving (drug name, Oxycodone 10-325mg prescribed to resident R1. A total of 30 tablets were unaccounted for during the beginning of the day shift count.Upon further review of the narcotic sign-out sheet along with the blister pack of medication noted missing. Investigation initiated immediately by the Director of Nursing.Misappropriation of Controlled Substance (Narcotics) Time of Incident: 11:00a.m.The nurse notified the pharmacy to get a refill the pharmacy notified the nurse that the resident received a quantity of 60 pills on 6/16/25 which was too soon for a refill. The facility's routine narcotic count revealed a discrepancy involving (Drug name Oxycodone 10-325mg) prescribed to resident (R1). A total of (30) tablets were unaccounted for during the narcotic count.along with the controlled drug receipt record disposition form for the resident (R1). The alleged misappropriation involves Nurse V (Agency Nurse), a licensed nurse who had access to the medication cart during the shift prior to the discovery.On 08/11/2025 at 10:57 AM, R1 was observed in bed, wearing a hospital gown. R1 had a Tracheostomy (a surgical procedure where an incision is made in the neck to create an opening into the trachea/windpipe, allowing for a tube to be inserted to assist with breathing) that was clean and intact. A tracheostomy supply cart was next to R1's bed. R1 was interviewed and asked about the delay on June 22, 2025 of their prescribed Oxycodone 10-325mg. R1 stated after placing a speaking valve over their tracheostomy (used to help a person with a tracheostomy speak) in a soft voice , I was told that someone took my pain medication and the nurse had to call the pharmacy for more medication.my pain medication was due at 10 (A.M.).I call the DON (Director of Nursing) because I have her phone number and told her that my pain medication was missing.I had to wait a long time for my medication.my pain was horrible because I have cancer.It (pain) was horrible.I was in so much pain.A review of R1's electronic medical record revealed an admission to the facility on [DATE] with the diagnoses of Malignant Neoplasm of the Hypopharynx (a type of cancer that develops in the lower throat), Chronic Obstructive Pulmonary Disease, Respiratory Failure, Tracheostomy, and Chronic Pain related to Cancer. A review of R1's Minimum Data Set (MDS) dated [DATE] revealed a score of 15/15 (cognitively intact). A review of R1's care plan revealed the following: Focus-At risk for pain and has pain related to Cancer, Malnutrition, radiation Dated Initiated 12/20/2024. Intervention/Task-Administer pain medication per physician orders.A review of R1's medication order dated 4/25/25, revealed the following: Oxycodone-Acetaminophen tablet 10-325 Give one tablet via pet-tube six times a day for pain.On 08/12/2025 at 11:18 AM, the DON was interviewed about the missing Oxycodone. The DON stated that the medication was initially received from the pharmacy on 6/16/2025. The DON was unable to determine the time that the medication was delivered by pharmacy. The DON added that Nurse Manager E signed the Controlled Substance document from the pharmacy for a total of three controlled substances cards: one card had 30 Clonazepam tablets and two cards with 30 tablets of Oxycodone that totaled 60 tablets on 6/16/2025. The DON was asked when the one card containing 30 Oxycodone tablets went missing. The DON said, I'm not sure when the Oxycodone went missing.I'm not sure who took the narcotic (Oxycodone). The DON was then asked about her documentation on the investigative report revealed that Agency Nurse V was the alleged nurse staff who had access to the medication cart during the shift and removed the Oxycodone. The DON said, I'm not sure who took the Oxycodone.It could be anyone at this point.I don't know, I don't know, I don't know. The DON stated that the narcotic sheet was also removed from the narcotic book. The DON added that Nurse AA called around 10A.M. on 6/21/2025 and stated that they called pharmacy due to R1 was out of Oxycodone. The DON said that pharmacy indicated that they delivered 60 Oxycodone on 6/16/2025 and R1 should have enough Oxycodone in the cart. The DON then said she called the pharmacy and ordered Oxycodone to be taken from the Pyxis machine (an automated medication dispensing system used to streamline medication management and enhance patient safety.) At this time the DON revealed a report showing Oxycodone 10-325mg was removed from the Pyxis timed stamped at 12:02PM on 6/22/2025 and administered to R1.A review of R1's Medication Administration

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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 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. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 1221139 Based on interview and record review the facility failed to report to law enforcement drug diversion of 30 Oxycodone tablets (controlled substances) for one resident (R1) of three residents reviewed for missing medications. Findings include: A review of the facility's incident report was received by the State Agency via online submission on: 6/23/25 revealed the following: Incident Summary On 6/22/25, the facility's routine narcotic count revealed a discrepancy involving (drug name, Oxycodone 10-325mg (milligram) prescribed to resident R1. A total of 30 tablets were unaccounted for during the beginning of the day shift count.Upon further review of the narcotic sign-out sheet along with the blister pack of medication noted missing. Investigation initiated immediately by the Director of Nursing (DON). Misappropriation of Controlled Substance (Narcotics) Time of Incident: 11:00a.m.The nurse notified the pharmacy to get a refill the pharmacy notified the nurse that the resident received a quantity of 60 pills on 6/16/25 which was too soon for a refill. The facility's routine narcotic count revealed a discrepancy involving (Drug name Oxycodone 10-325mg) prescribed to resident (R1). A total of (30) tablets were unaccounted for during the narcotic count.along with the controlled drug receipt record disposition form for the resident (R1). The alleged misappropriation involves Nurse V (Agency Nurse), a licensed nurse who had access to the medication cart during the shift prior to the discovery.On 08/11/2025 at 10:57 AM, R1 was observed in bed, wearing a hospital gown. R1 had a Tracheostomy (a surgical procedure where an incision is made in the neck to create an opening into the trachea/windpipe, allowing for a tube to be inserted to assist with breathing) that was clean and intact. A tracheostomy supply cart was next to R1's bed. R1 was interviewed and asked about the delay on June 22, 2025 of their prescribed Oxycodone 10-325mg. R1 stated after placing a speaking valve over their tracheostomy (used to help a person with a tracheostomy speak) in a soft voice , I was told that someone took my pain medication and the nurse had to call the pharmacy for more medication.my pain medication was due at 10 (A.M.).I call the Director of Nursing because I have her phone number and told her that my pain medication was missing.I had to wait a long time for my medication.my pain was horrible because I have cancer.It (pain) was horrible.I was in so much pain.A review of R1's electronic medical record revealed an admission to the facility on [DATE] with the diagnoses of Malignant Neoplasm of the Hypopharynx (a type of cancer that develops in the lower throat), Chronic Obstructive Pulmonary Disease, Respiratory Failure, Tracheostomy, and Chronic Pain related to Cancer. A review of R1's Minimum Data Set (MDS) dated [DATE] revealed a score of 15/15 (cognitively intact). A review of R1's care plan revealed the following: Focus-At risk for pain and has pain related to Cancer, Malnutrition, radiation Dated Initiated 12/20/2024.Intervention/Task-Administer pain medication per physician orders. A review of R1's medication order dated 4/25/25, revealed the following: Oxycodone-Acetaminophen tablet 10-325 Give one tablet via pet-tube six times a day for pain.On 08/12/2025 at 11:18 AM, the DON was interviewed about the missing Oxycodone. The DON stated that the medication was initially received from the pharmacy on 6/16/2025. The DON was unable to determine the time that the medication was delivered by pharmacy. The DON added that Nurse Manager E signed the Controlled Substance document from the pharmacy for a total of three controlled substances cards: one card had 30 Clonazepam tablets and two cards with 30 tablets of Oxycodone that totaled 60 tablets on 6/16/2025. The DON was asked when the one card containing 30 Oxycodone tablets went missing. The DON said, I'm not sure when the Oxycodone went missing.I'm not sure who took the narcotic (Oxycodone). The DON was then asked about her documentation on the investigative report revealed that Agency Nurse V was the alleged nurse staff who had access to the medication cart during the shift and removed the Oxycodone. The DON said, I'm not sure who took the Oxycodone.It could be anyone at this point.I don't know I don't know I don't know. The DON stated that the narcotic sheet was also removed from the narcotic book. The DON added that Nurse AA called around 10A.M. on 6/21/2025 and stated that they called pharmacy due to R1 was out of Oxycodone. The DON said that pharmacy indicated that they delivered 60 Oxycodone on 6/16/2025 and R1 should have enough Oxycodone in the cart. The DON then said she called the pharmacy and ordered Oxycodone to be taken from the Pyxis machine (an automated medication dispensing system used to streamline medication management and enhance patient safety). At this time the DON revealed a report showing Oxycodone 10-325mg was removed from the Pyxis timed stamped at 12:02PM on 6/22/2025 and administered to R1.A review of R1's Medication Administration Record noted documentation on 6/22/2025 that the Oxycodone 10-325mg was administered

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

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 1221139 Based on interview and record review the facility failed to ensure the misappropriation of 30 oxycodone-acetaminophen 10-325 mg (milligram) tablets was thoroughly investigated for one resident (R1) of three reviewed for drug diversion of controlled substances, resulting in 30 missing oxycodone-acetaminophen without resolution and a delay in pain relief. The review of the incident report revealed the following: Incident Summary On 6/22/25, the facility's routine narcotic count revealed a discrepancy involving (drug name, Oxycodone 10-325mg prescribed) to resident (R1). A total of 30 tablets were unaccounted for during the beginning of the day shift count.Upon further review of the narcotic sign-out sheet along with the blister pack of medication noted missing. Investigation initiated immediately by the Director of Nursing.Misappropriation of Controlled Substance (Narcotics) Time of Incident: 11:00a.m.The nurse notified the pharmacy to get a refill the pharmacy notified the nurse that the resident received a quantity of 60 pills on 6/16/25 which was too soon for a refill. The facility's routine narcotic count revealed a discrepancy involving (Drug name Oxycodone 10-325mg) prescribed to resident (R1). A total of (30) tablets were unaccounted for during the narcotic count.along with the controlled drug receipt record disposition form for the resident (R1). The alleged misappropriation involves Nurse V (Agency Nurse), a licensed nurse who had access to the medication cart during the shift prior to the discovery.On 08/11/2025 at 10:57 AM, R1 was observed in bed, wearing a hospital gown. R1 had a Tracheostomy (a surgical procedure where an incision is made in the neck to create an opening into the trachea/windpipe, allowing for a tube to be inserted to assist with breathing) that was clean and intact. A tracheostomy supply cart was next to R1's bed. R1 was interviewed and asked about the delay on June 22, 2025 of their prescribed Oxycodone 10-325mg. R1 stated after placing a speaking valve over their tracheostomy (used to help a person with a tracheostomy speak) in a soft voice , I was told that someone took my pain medication and the nurse had to call the pharmacy for more medication.my pain medication was due at 10 (A.M.).I call the Director of Nursing (DON) because I have her phone number and told her that my pain medication was missing.I had to wait a long time for my medication.my pain was horrible because I have cancer.It (pain) was horrible.I was in so much pain.A review of R1's electronic medical record revealed an admission to the facility on [DATE] with the diagnoses of Malignant Neoplasm of the Hypopharynx (a type of cancer that develops in the lower throat), Chronic Obstructive Pulmonary Disease, Respiratory Failure, Tracheostomy, and Chronic Pain related to Cancer. A review of R1's Minimum Data Set (MDS) dated [DATE] revealed a score of 15/15 (cognitively intact). A review of R1's care plan revealed the following: Focus-At risk for pain and has pain related to Cancer, Malnutrition, radiation Dated Initiated 12/20/2024.Intervention/Task-Administer pain medication per physician orders. A review of R1's medication order dated 4/25/25, revealed the following: Oxycodone-Acetaminophen tablet 10-325 Give one tablet via pet-tube six times a day for pain.On 08/12/2025 at 11:18 AM, the DON was interviewed about the missing Oxycodone. The DON stated that the medication was initially received from the pharmacy on 6/16/2025. The DON was unable to determine the time that the medication was delivered by pharmacy. The DON added that Nurse Manager E signed the Controlled Substance document from the pharmacy for a total of three controlled substances cards: one card had 30 Clonazepam tablets and two cards with 30 tablets of Oxycodone that totaled 60 tablets on 6/16/2025. The DON was asked if nurses count narcotics at the beginning of each shift. The DON said, They are supposed to check the narcotics at the beginning of each shift. The DON was asked about the time and date the medication card containing 30 Oxycodone tablets went missing. The DON said, I'm not sure when the Oxycodone went missing.I'm not sure who took the narcotic (Oxycodone). The DON was then asked about her documentation on the investigative report revealed that Agency Nurse V was the alleged nurse staff who had access to the medication cart during the shift and removed the Oxycodone. The DON said, I'm not sure who took the Oxycodone.It could be anyone at this point.I don't know I don't know I don't know. The DON stated that the narcotic sheet was also removed from the narcotic book. The DON added that Nurse AA called around 10A.M. on 6/21/2025 and stated that they called pharmacy due to R1 was out of Oxycodone. The DON said that pharmacy indicated that they delivered 60 Oxycodone on 6/16/2025 and R1 should have enough Oxycodone in the cart. The DON then said she called the pharmacy and ordered Oxycodone to be taken from the Pyxis machine (an automated medication dispensing system used to streamline medication management and enhance patient safety.) At this time the DON revealed a report showing Oxycodone 10-325mg was removed