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	12/01/2025

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

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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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to 2663449 and 2668212. Based on interview and record review, the facility failed to ensure resident-to-resident verbal and physical abuse did not occur for two residents (R104 and R105), resulting in verbal and physical abuse. Findings include:Allegations of resident-to-resident abuse were reported to the State Agency. A review of the facility's investigation summary of a resident-to-resident incident between R104 and R105 documented in part the following: On October 11, 2025 at approximately 8:45 PM, R104 and R105 were involved in a physical altercation on the Cherry Hill unit. According to witness statements from staff and other resident, R104 was walking down the hallway returning to her room. R104 began using unprovoked profanity towards the nurse. At that time, R105 had just returned to her room from downstairs. R105 told R104 to be quiet and go back into her room. R104 said to R105, don't tell me what to do. R104 included profanity in her response. R105 said, what did you say? R104 replied again using profanity. R105 stood up quickly from her chair and ran towards R104. The nurse immediately intervened and attempted to de-escalate the situation. Despite efforts to separate them, R105 grabbed and forcefully pulled R104's and the nurse's hair causing both the nurse and R104 to fall to the floor. Staff immediately intervened and separated both residents. R105A review of the clinical record documented R105 was initially admitted on [DATE] and readmitted on [DATE]. R105's diagnoses included chronic obstructive pulmonary disease, adjustment disorder with mixed anxiety and depressed mood. A Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition. A review of R105's care plans documented in part: - Social with roommate, staff and peers. Can be argumentative and verbally aggressive, benefits from redirection. Date initiated 9/11/25.- Altered behavior in which resident acts characterized by ineffective coping verbal aggression toward other residents. Date initiated 9/16/25. Review of R105's progress notes documented in part the following:- Behavior note of 9/13/25: Writer summoned to room by resident's roommate due to resident yelling out, using profanity and making threats towards roommate. When writer asked resident what the conflict was about, she stated, I told her (profanity used) I like the door open, and she don't (profanity used) listen she can get the (profanity used) out. Writer de-escalated the situation and removed residents apart. Roommate stated she does not feel comfortable staying. Writer notified on call midnight supervisor and received order to move roommate into new room for safety.- Nurse note of 9/14/25: Writer was notified by unit manager and previous nurse about resident being transferred down to MedBridge on writer's set due to a problem with previous roommate. (R105) is okay and content with new room change. (R105) stated, she does not want a new roommate. She needs to be in the room by herself. Will continue to monitor for any new behavior changes. A review of room assignments for R105 documented the following:- Upon readmission to the facility on 9/10/25, R105 resided on the second-floor Cherry Hill South unit.- On 9/14/25, R105 was moved to the first-floor MedBridge unit.- On 9/15/25, R105 was moved to the second-floor Cherry Hill South unit.- R105 was discharged on 9/28/25 and upon return to the facility on [DATE], R105 returned to the second-floor [NAME] Hill South unit.- On 10/11/25, R105 was moved to the first-floor MedBridge unit. On 11/24/25 at 2:16 PM, R104's Concerned Family Member (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(CFM) F reported that R104 had been attacked by R105 on two separate occasions. R104A review of the clinical record documented R104 was admitted to the facility on [DATE]. R104's diagnoses included cerebral infarction, vascular dementia, and bipolar disorder. A MDS assessment dated [DATE] documented intact cognition. A review of R104's care plans documented in part: The resident has a behavior problem r/t (related to) patient continuously yells at staff and others. Date initiated 6/13/25. A 9/14/25 incident report for R104 documented in part the following: While doing the morning med pass, I saw (R105) and (R104) arguing and shouting to one another. Nurse L verbalized that he saw (R105) pushing (R104). (R104) verbalized that she was hit and pushed by another resident, and she is too old to fight other people. Denies pain and discomfort. A 10/11/25 incident report for R104 documented in part the following: A verbal and physical altercation occurred between (R105) and (R104) in the hallway. The incident began when (R104) directed profanity toward (R105). (R105) verbally confronted (R104) which escalated into (R105) physically assaulted (R104). (R104) said (R105) pulled her hair. A 10/12/25 progress/incident note for R104 documented in part the following: A verbal and physical altercation occurred between (R105) and (R104) in the hallway. The incident began when (R104) directed profanity toward (R105). (R105) verbally confronted (R104) which escalated into (R105) physically assaulted (R104) by grabbing her hair and slamming her on the floor. (R104) was assisted back to her room, assessment completed. Family, MD (Medical Doctor), DON (Director of Nursing) and Administrator were notified. (R104) was transferred to ER (emergency room) for evaluation per family request. During an interview on 12/1/25 at 11:42 AM, the Nursing Home Administrator (NHA) acknowledged that the resident-to-resident verbal and physical altercation between R104 and R105 on 10/11/25 could have been prevented had R105 remained on the first-floor MedBridge unit, rather than being moved back to the second-floor Cherry Hill South unit. The facility policy titled, Abuse, dated 5/24/23 was reviewed and documented in part the following:Residents have the right to be free from abuse.Prevention (of abuse) consists of facility systems designed to detect, identify, correct, and prevent the occurrence of abuse.Completing ongoing assessments and care planning for appropriate interventions, and monitoring of residents with behaviors, including but not limited to: verbally aggressive behaviors (screaming, cursing, demanding, insulting, etc, physically aggressive behaviors (hitting kicking, biting, spitting, throwing objects, threatening gestures, etc.)The facility will educate the staff in identifying abuse .Possible indicators of abuse include, but are not limited to: physical abuse of a resident observed.Any allegation of abuse must be immediately reported to the supervisor and the Abuse Prevention Coordinator. The Administrator initiates investigating any allegation of abuse against a patient.If a resident is the alleged perpetrator, the facility will ensure other residents are protected as determined by the circumstances, which may include but are not limited to resident room changes, increased supervision, or immediate transfer or discharge, if indicated. On 12/1/25 at 12:30 PM during the exit conference, the NHA and DON did not offer additional documentation or information when asked.

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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 intakes 2650924, 2663449, and 2668212.Based on interview and record review, the facility failed to implement policies and procedures for ensuring proper reporting of abuse to the State Agency for four residents (R102, R103, R104, R105) out of eight resident reviewed for abuse, resulting in the likelihood of further abuse and subsequent physical or psychological distress. Findings include:A review of a Facility Reported Incident (FRI) dated 10/6/2025 documented the following: R102 and R103. On 10/6/2025 at 3:00 p.m. the Administrator /Abuse Coordinator was notified by Licensed Practical Nurse (LPN) A that on October 2, 2025, R103 was heard swearing at the roommate R102. LPN A stated that the R103 was irritated and using abusive language with the roommate R102. The FRI continued and the Incident Summary documented: This was brought to the writer's (The Administrator/Abuse Coordinator) attention on today (10/6/2025) however the incident occurred on 10/2/1025. The (R103) as temporarily moved to another room due to verbiage from the (R102). Investigation initiated. Re-education started immediately on timely reporting adverse events to the Administrator/Director of Nursing (DON). The Investigation Conclusion documented: Following the facility's investigation, the incident between residents (R102) and (R103) was confirmed and that (R103's) room was changed to accommodate the comfortability of both residents. The facility will also do our due diligence in making sure that residents are appropriate to be in the same room to avoid any resident conflict in the future. R102 On 11/24/2025 at approximately 9:20 a.m. R102 was observed lying in bed with bilateral ear pods connected to a computer. During an interview R102 was asked to recall the incident that happened on October 2, 2025. R102 stated, I am alright, and I have not had any other altercation. R102 did not want to continue to elaborate on the incident, rolled over in bed, and continued to listen to the content on the computer. According to the electronic medical record (EHR), R102 was admitted to the facility on [DATE] with diagnoses of major depression, adjustment disorder with mixed anxiety and depressed mood, rheumatoid arthritis, and contracture of left and right hand. R102's quarterly Minimum Data Set (MDS) assessment, dated 10/29/2025, indicated R102 was cognitively intact with a BIMS (brief interview for mental status) score of 15/15. R102 was dependent with assistance with Activity Daily Living Care. R103. On 11/24/2025 at approximately 9:30 a.m. during an interview, R103 was asked to recall the incident that happened on October 2, 2025. R103 stated, I asked them (the staff) to move me after I had an altercation with my roommate because he kept the computer and the television on all night and I had to go to dialysis the next day early. I cussed him out because I was upset. According to the EHR, R103 was admitted to the facility on [DATE] with diagnoses of end stage renal (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease, immunodeficiency, type two diabetes mellitus, heart failure, and dependence on renal dialysis. R103's quarterly MDS, dated [DATE], indicated R103 was cognitively intact with a BIMS score of 15/15. R103 was dependent with assistance with Activity Daily Living Care. The facility's Nursing Home Administrator (NHA) was interviewed on 11/25/2025 at 4:45 p.m. regarding the verbal altercation between R102 and R103. The NHA was asked when the resident-to-resident verbal altercation happened. The NHA stated, The nurse did not notify me until October 6, 2025. I should have been notified of the day it happened on October 2, 2025. I already in-serviced my staff on reporting abuse timely. R104 and R105 A review of the clinical record documented R104 was admitted to the facility on [DATE]. R104's diagnoses included cerebral infarction, vascular dementia, and bipolar disorder. A Minimum Data Set assessment dated [DATE] documented intact cognition. A review of Incident/Accident reports for R104 documented in part the following: September 14, 2025: While doing the morning med pass, I saw (R105) and (R104) arguing and shouting to one another. Nurse L verbalized that he saw (R105) pushing (R104). (R104) verbalized that she was hit and pushed by another resident, and she is too old to fight other people. Denies pain and discomfort. A review of the clinical record documented R105 was initially admitted on [DATE] and readmitted on [DATE]. R105's diagnoses included chronic obstructive pulmonary disease, adjustment disorder with mixed anxiety and depressed mood. A MDS assessment dated [DATE] documented intact cognition. During an interview on 12/1/25 at 11:42 AM, the Nursing Home Administrator (NHA) confirmed that the 9/14/25 incident between R104 and R105 was reportable to the State Agency but was not reported due to an internal failure to notify her of the event. The facility policy titled, Abuse, dated 5/24/2023, was reviewed and documented in part the following: The facility will ensure that all allegations involving abuse .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 .or Reported to the State Survey Agency no later than 24 hours if the allegation does not involve abuse an does not result in serious bodily injury. On 12/1/25 at 12:30 PM during the exit conference, the NHA and Director of Nursing did not offer additional documentation or information when asked.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure showers for (R104) and grooming (R111) were provided per resident's preference resulting in unmet care needs and resident dissatisfaction. Findings include:R104A review of the clinical record documented R104 was admitted to the facility on [DATE]. R104's diagnoses included cerebral infarction, vascular dementia, and bipolar disorder. A Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition. A review of R104's care plans documented in part the following: ADL (activity of daily living) self-care deficit related to muscle weakness, unsteadiness on feet, behaviors. Date initiated: 5/19/25. Intervention: Assist to bathe/shower as preferred per shower schedule and as needed. Date initiated: 5/20/25. On 11/24/25 at 2:16 PM, Concerned Family Member (CFM) F said R104 had not been getting regular showers. On 11/25/25 at 12:15 PM, Licensed Practical Nurse/Unit Manager (LPN/UM) I said staff are to complete shower sheets when showers/bed baths were given or offered but refused. LPN/UM I said R104 was scheduled to receive showers on Tuesdays and Fridays on the afternoon shift. LPN/UM I added that showers were important because they help residents feel clean and better. If staff or family member gives the resident a shower, it should be documented. Certified Nurse Aide (CNA) documentation of baths for R104 during the past 30 days was reviewed with LPN/UM I and revealed the following:Bed bath given on 11/21/25Resident refusal documented on 11/11/25Not Applicable checked on 11/4/25, 11/7/25, 11/14/25, and 11/18/25.LPN/UM I was able to locate the following shower sheets:11/11/25 documented refusal11/18/25 documented refusalLPN/UM I said R104's refusals should have been reported to the nurse and documented in the medical record. A review of nursing documentation for the past 30 days did not reveal nursing documentation of shower refusals. On 12/1/25 at 10:59 AM, the Director of Nursing (DON) stated, showers and refusals should be documented. If it is not documented, it looks like it wasn't done. R111On 11/24/25 at 12:04 PM, R111 was observed alert and sitting in a wheelchair in his room. When asked about how he was doing, R111 responded that he was concerned because he had not been shaved since coming to the facility. R111 was observed to have a full, untrimmed, thick beard. On 11/24/25 at 12:18 PM, Certified Nurse Aide (CNA) O said R111's shower days were on Wednesdays and Saturdays. On 11/24/25 at 12:21 PM, R111 informed the State Surveyor and CNA O that the last time he was shaved was when he was in the hospital. A review of the clinical record documented R111 was admitted to the facility from the hospital on [DATE] with diagnoses that included left femur fracture, sarcoidosis of lung, Parkinsonism, and congestive heart failure. A MDS assessment dated [DATE] documented intact cognition. A review of R111's care plans documented in part the following: ADL self-care deficit related to impaired physical mobility due to left hip fracture, Parkinsonism, sarcoidosis. Date initiated: 11/13/25. Interventions included: Assist with daily hygiene, grooming, dressing, oral care and eating as needed. Date initiated: 11/14/25 CNA documentation of baths for R111 since admission on [DATE] revealed the following:Not applicable: 11/13/25, 11/14/25Bed bath: 11/15/25Shower: 11/19/25, 11/22/25 On 11/24/25, LPN P observed R111's facial hair and said it does not look like R111 was shaved Saturday, 11/22/25. On 11/25/25 at 11:35 AM, R111 was observed alert and sitting in his room. R111's full, untrimmed, thick beard remained. R111 said he still has not been shaved. On 11/25/25 at 11:53 AM, LPN/UM I said if the resident was alert and oriented and wanted to be shaved, we do shave them. We try to shave men more often than twice weekly, because less frequent shavings can be rough on their skin. LPN/UM I added, there was no reason why R111 should not have been shaved. On 11/25/25 at 1:02 PM, R111 was receiving care from CNA K. On 11/25/25 at 1:08 PM, CNA J said she showered R111 on 11/22/25 but did not offer to shave him. On 11/25/25 at 1:14 PM, R111 was interviewed in the presence of LPN/UM I. R111 said he wanted to be shaved on days he gets cleaned up. R111 was just shaved while receiving care and was smiling and grinning during the interview. On 11/25/25 at 1:17 PM, CNA K said R111 had a full beard, and it did not look like he had (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been shaved since admission. CNA K said R111's beard was thick, and it took five to six razors to shave him. A facility policy titled, Activities of Daily Living (ADL), dated 12/7/23 was reviewed and documented in part:- Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene.- Appropriate care and services will be provided for residents who are unable to carry out ADL independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).- The amount of assistance the resident needs to complete their ADL care will be documented in the resident's care plan. On 12/1/25 at 12:30 PM during the exit conference, the Nursing Home Administrator and DON did not offer additional documentation or information when asked.

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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 2598018. Based on observations interview, and record review, the facility failed to implement intervention to prevent falls in a timely manner for one resident (R101). Findings include: It was reported to the State Agency that the resident has fallen out of the bed and staff are not always ensuring the resident's bed was kept in a low position. On 11/24/25 at 2:51 PM, R101 was observed awake and lying in bed. The top of the mattress on R101's bed was approximately 24 inches from the floor. R101 said he fell out of bed a couple of months ago and that his left side, arms and legs got a little worse after the fall. On 11/25/25 at 3:37 PM, staff were observed putting R101 in bed. The bed was elevated. On 11/25/25 at 3:40 PM, R101 was observed in bed. The top of the mattress on R101's bed was approximately 20 inches from the floor. A review of the clinical record for R101 documented an admission date of 6/24/25 with diagnoses that included hemiplegia/hemiparesis following cerebral infarction, vascular dementia, aphasia, and gastrostomy status. A Minimum Data Set assessment dated [DATE] documented intact cognition. A review of R101's care plans documented the following interventions: - Bed in low position when resident is in bed. Initiated 6/24/25. - Bolsters to bed to define mattress edge. Initiated 7/14/25. - Always have two people to assist with changes and transfers. Initiated 9/22/25. Review of incident reports documented in part the following:1. 7/12/25: Fall during staff assist. Certified Nurse Aide (CNA) called my attention to resident, as staff doing care, resident was put on side lying position as stated by the staff and resident had a sudden movement and resident rolled out of bed. Resident was found on floor; head was up and lying on left side.2. 7/24/25: Un-witnessed fall. Patient was calling for help. Patient was observed on floor in room near bed. The writer has initiated more interventions in the care plan to help to minimize the risk of falls.3. 9/20/25: Fall during staff assist. Patient was being rolled onto his side during brief change when he fell out of bed landing on his left side. Patient's head struck the closet upon impact. Visible bump noted on left side of forehead and small laceration on left eyebrow. Bleeding controlled. Progress notes documented the following:- 7/14/25: CNA called my attention to resident, as staff doing care, resident was put on side lying position as stated by the staff and resident had a sudden movement and resident rolled out of bed. Resident was found on floor; head was up and lying on left side. IDT (Interdisciplinary Team) team reviewed & updated care plan the intervention is to add bolsters to the bed to define bed edges. - 7/29/25: Resident was found on floor by staff member, writer went to assess resident. took resident vital signs got resident into bed and notified doctor. no orders given. writer cleaned resident's face with normal saline and gauze and performed routinely neurochecks. VSS during neurochecks except heartrate was tachycardiac notified doctor no orders given. Ordered a wound consult due to resident face having a laceration on forehead and nosebleed due to fall. resident did not report pain in head area. notified brother-in-law of fall and doctor notified resident sister. Family did not want to send resident to hospital. Resident safe and stable in bed at end of shift. Interdisciplinary team reviewed & updated care plan. The intervention is to have reacher device at bedside. - 9/21/25: Patient was being rolled onto his side during brief change when he fell out of bed, landing on his left side. Patient's head struck the closet upon impact, visible bump noted on left side of forehead and small laceration on left eyebrow. Bleeding controlled. Patient was assessed for injury; neurochecks initiated. Physician and Family notified. Plavix and Aspirin to hold x 1 day. During an interview on 11/25/25 at 2:43 PM, Physical Therapist (PT) E said when R101 arrived he was totally dependent for bed mobility. This would include changing his briefs. Total dependence signified the need for two people to assist. At the time of R101's admission, he was recovering from an acute stroke. PT E added that R101 could not speak and had zero strength. He could not express himself or talk. His care plan should have reflected that he was dependent for bed mobility. On 11/25/25 at 4:12 PM, during a demonstration of the bed positions that R101 was observed in during (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the survey, the Director of Nursing (DON) said that neither position would be considered a low position but instead would be considered a transfer position. The DON said keeping R101's bed in a low position while in it was an intervention for someone that had a fall. The DON acknowledged that a two-person assist for bed mobility was not initiated for R101 until 9/22/25 and that dependence on bed mobility indicated he was a two-person assist. The DON indicated that had R101 been a two-person assist upon admission, his falls on 7/12/25 and 9/20/25 may have been prevented. A review of the facility policy titled, Fall Management Guidelines, dated 12/13/23, documented in part the following:- Fall management goals: Reduce the risk of falls by intervening in modifiable risk factors. Reduce the risk of injuries as a result of a fall.- The facility staff, with input of the attending physician, will implement a resident-centered comprehensive care plan that addresses the fall management program, the goal for fall management, individualized interventions to address the resident's modifiable fall risk factors, interventions to try to minimize the consequences of risk factors that are not modifiable, and the plan for reduction of risk and or risk for injury related to falls. On 12/1/25 at 12:30 PM during the exit conference, the NHA and DON did not offer additional documentation or information when asked.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to 2598018. Based on observation, interview, and record review, the facility failed to ensure nutritional supplement administration and hospital transfer documentation were accurately documented for two residents (R101and R104) and failed to ensure a complete medical record that documented a resident-to-resident altercation for one resident (R104), resulting in the potential for staff and providers lacking accurate information to care for residents. Findings include:R101A review of the clinical record for R101 documented an admission date of 6/24/25 with diagnoses that included hemiplegia/hemiparesis following cerebral infarction, vascular dementia, aphasia, and gastrostomy status. A Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition. R101's diet prescription included a regular diet, soft bite size pieces and a house supplement with meals. Physician orders included administering one can of high-calorie, fiber-fortified liquid supplement if R101 consumed less than 50% of his meal. A nutrition note dated 11/3/25 documented in part the following: Met with resident and his sister this morning to discuss progression of oral intake. Some weight loss anticipated with discontinuation of continuous enteral feedings. Continues with goal of weight maintenance and adequate oral intake as feasible. On 11/25/25 at 12:40 PM, R101's November 2025 Medication Administration Record (MAR) was obtained and documented the administration of the 11/25/25 12:00 PM can of high-calorie, fiber-fortified liquid supplement by Licensed Practical Nurse (LPN) C. On 11/25/25 at 12:47 PM, LPN C said that R101 only gets the one can of high-calorie, fiber-fortified liquid supplement when he consumes less than half of his meal. LPN C said that lately R101 has been cleaning his plate. When R101's November 2025 MAR was reviewed with LPN C, she acknowledged that the 11/25/25 noon administration of high-calorie, fiber-fortified liquid supplement was marked as given even though the liquid nutrition supplement had not been given. On 11/25/25 at 12:58 PM, R101 was observed still eating his lunch. LPN C acknowledged that the documentation of the liquid nutrition supplement administration was premature because R101 was still eating. On 11/25/25 at 1:31 PM, Registered Dietitian (RD) B was interviewed and said R101 was considered at high nutritional risk due to dysphagia, altered food texture, and current transition to oral meals from receiving nutrition via a feeding tube. After reviewing the circumstances regarding the 11/25/25 noon administration of the high-calorie, fiber-fortified liquid supplement, RD B stated, I need to talk with the unit manager and Director of Nursing (DON). It (the high-calorie, fiber-fortified liquid supplement) was checked but not given. RD B said the high-calorie, fiber-fortified liquid supplement was considered medication. RD B added, I want to trust that (nursing documentation) is true and accurate. On 11/25/25 at 4:26 PM, when the circumstances regarding the 11/25/25 noon administration of the high-calorie, fiber-fortified liquid supplement for R101 was reviewed with the DON, she said, She knows better. You don't sign administration of an order until it's done. R104A review of the clinical record documented R104 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, vascular dementia, and bipolar disorder. A MDS assessment dated [DATE] documented intact cognition. A review of a 10/11/25 incident report for R104 documented in part the following: A verbal and physical altercation occurred between (R105) and (R104) in the hallway. The incident began when (R104) directed profanity toward (R105). (R105) verbally confronted (R104) which escalated into (R105) physically assaulting (R104). (R104) said (R105) pulled her hair. A review of nursing notes documented in part the following:- 10/11/25 incident note: Patient to patient incident- resident is alert and oriented per baseline. Assessment completed. Denies pain, no new skin observations noted, no limitations of extremities noted. MD director notified of incident, family notified. - 10/12/25 incident note: A verbal and physical altercation occurred between (R105) and (R104) in the hallway. The incident began when (R104) directed profanity toward (R105). (R105) verbally confronted (R104) which escalated into (R105) physically assaulted (R104) by grabbing her (continued on next page)

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	12/01/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hair and slamming her on the floor. Patient was assisted back to her room, assessment completed. Family, doctor, DON and Administrator were notified. (R104) was transferred to ER (emergency room) for evaluation per family request. R104's eINTERACT Transfer Form dated 10/11/25, documented that a fall was the reason for R104's transfer to the hospital. On 11/25/25 at 12:15 PM, Licensed Practical Nurse (LPN)/Unit Manager (UM) I said the purpose of the eINTERACT form was to ensure that the hospital has accurate information regarding the transfer of a resident in order to provide correct treatment. LPN/UM I indicated the correct information on R104's eINTERACT form was not given to the hospital. LPN/UM I indicated R104 was transferred to the hospital following a resident-to-resident altercation. LPN/UM I added that a physical exam and assessment for a fall would be different than a physical exam and assessment following a physical altercation. A review of an incident report dated 9/14/25 involving R104 documented in part the following: While doing the morning med pass, I saw R105 and R104 arguing and shouting to one another. Nurse L verbalized that he saw R105 pushing R104. R104 verbalized that she was hit and pushed by another resident, and she is too old to fight other people. Denies pain and discomfort. Immediate action taken: Observed patient, conducted skin assessment to R104, no bruises nor injury noted. R104 denies pain and discomfort. The verbiage at the bottom of the incident report documented, Privileged and Confidential.Not part of the Medical Record. During an interview on 12/1/25 at 11:17 AM, the DON confirmed that the 9/14/25 incident, in which R104 was pushed by another resident, was not documented in the medical record. The DON indicated this was a necessary step to ensure a complete medical record and effective communication among staff. A review of the facility policy titled, Documentation in the Medical Record, dated 1/8/25 revealed the following:- The following information is to be documented in the resident medical record: Physicians, nurses, and other licensed professionals progress notes. Medication administration. Treatments or services performed.- Principles of documentation include, but are not limited to: Documentation should be factual, objective, and resident centered.- Documentation should be accurate, relevant, and complete.- Documentation should be completed at the time of service or by the end of the shift in which the evaluation, observation, or care service occurred. On 12/1/25 at 12:30 PM during the exit conference, the NHA and DON did not offer additional documentation or information when asked.