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	02/12/2026

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 0600 Level of Harm - 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 intake 2723333.Based on observation, interview and record review, the facility failed to protect one resident (R905) from the right to be free from verbal abuse and neglect by Certified Nurse Assistant (CNA) A, out of five residents reviewed for abuse. This failure resulted in R905 experiencing degradation, humiliation, and episodes of tearfulness when retelling the incident.Findings include: An interview was conducted with R905 on 2/11/26 at 2:20 PM regarding an incident that occurred on 12/20/25 involving Certified Nursing Assistant (CNA) A. During the interview, R905 was observed and became tearful while describing the event. R905 said CNA A initially entered the room, placed a brief in the room, and was aware the resident was wet and required assistance but did not provide care until approximately one hour later. When CNA A returned, R905 requested a clean gown and flat sheet due to being wet with urine. R905 reported CNA A began yelling, stating the resident should have requested those items earlier and that she did not have time to obtain them, and indicated she would change the resident quickly and return later with the requested items. R905 reported CNA A yelled for approximately five minutes while providing care, which caused the resident to cry and feel degraded, humiliated, anxious, and uncomfortable. R905 said, CNA A returned approximately two hours later with a flat sheet and gown and behaved pleasantly in the presence of the nurse. R905 reported feeling anxious and uncomfortable while waiting approximately two hours for the requested items and sitting in urine.A follow-up interview was conducted with R905 on 2/12/26 at 9:30 AM for further information. R905 was observed and became tearful and stated, It just makes me sad that I was treated like that, I wish I could take care of myself.Record review of R905's electronic medical record revealed an original admission into the facility on [DATE] with a pertinent diagnosis of polyarthritis.Review of Minimum Data Set (MDS) dated [DATE], R905 had a Brief Interview for Mental Status (BIMS) score of 15/15, reflecting intact cognition, and required assistance with most Activities of Daily Living (ADL) care.Record review of R905's Care Plan Report dated 4/16/25, Assist with daily hygiene, grooming, dressing, oral care, etc.A phone interview with CNA A was attempted with no success on 2/12/26.Record review of Employee Counseling and Corrective Action Record dated 12/22/25, documented CNA A was terminated due to carelessness and negligence.An interview was conducted with the Director of Nursing (DON) on 2/12/26 at 1:30 PM. It was reported that an investigation was conducted and abuse was substantiated. It was reported that staff should not yell at residents and residents should receive incontinence care in a timely manner.An interview was conducted with Nursing Home Administrator on 2/12/26 at 2:55 PM, it was reported that an investigation was completed and abuse was substantiated. It was further reported that when staff yell at any resident it would be verbal abuse, and the CNA neglected the resident making her wait so long to be changed and causing her stress.Record review of facility's policy Abuse dated 2/2/26 documented the following: Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of (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: 235618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235618	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health and Rehabilitation of Canton		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2724140 and 2718825.Based on interview and record review the facility failed to adequately document, monitor and access one resident (R901) out of three residents reviewed for wound care, resulting in the potential for delayed treatment and worsening of R901's frost-bitten feet.Findings include:Record review revealed R901 was admitted into the facility on 1/9/26 with a pertinent diagnosis of pain in right and left foot and frost bite of feet.Record review of R901's Brief interview for Mental Status (BIMS) dated 1/10/26, R901 scored 15/15 reflecting intact cognition.A phone interview was conducted with Family Member (FM) B on 2/11/26 at 12:20 PM, it was reported the resident was admitted to the facility on [DATE] with bandages on both feet. It was further reported that during a visit on 1/10/26, R901's nurse was reminded by the FM B that the resident's bandages had not been changed. On a return visit on 1/11/26 in the morning, when R901's feet were inspected, both feet were still wrapped in the original bandage from hospital and had a bad stench to them. FM B said, the staff were reminded again: however, when staff did not come to the room in a timely manner emergency services were called, and R901 was transported to the hospital.Record review of admission Evaluation dated 1/9/26 at 12:17 PM, it was documented under Integumentary (skin)-both feet-frost bite.Record review of Physician Order Summary Report dated 2/12/26, revealed no orders to access, monitor or provide care for R901's bilateral feet.Record review of Progress Notes dated 1/9/26 - 1/11/26, revealed no documentation regarding a description of feet, assessment or monitoring of feet.Record review of Medication and Treatment Administration records revealed no physician orders.Record review of two Skilled Nursing Notes dated 1/10/26 documented no assessment or monitoring of resident's feet or dressings. Review of Skilled Nursing Notes dated 1/11/26 documented the resident had dressing on feet.Record review of R901's Skin Care Plan had no interventions to monitor, assess or treatment for the resident's feet.An interview was conducted on 2/11/26 at 1:50 PM with the Director of Nursing (DON), it was reported that the resident had no dressing applied to feet when resident was admitted on [DATE]. It was further reported that the resident's feet should have been assessed and monitored for any change in condition regardless of any bandage related to his diagnosis of frost bite.Record review of Emergency Department Admission paperwork dated 1/11/26. Pictures were reviewed of R901's feet that were taken on admission to the hospital and revealed the resident had the original dressings on both feet that were applied when discharged from the hospital on 1/9/26.A follow-up interview conducted with the DON on 2/12/26 at 1:45 PM, after reviewing paperwork for R905's admission to hospital, the DON reported that the nursing staff should do a thorough examination and should have documented the bandages in the resident's progress notes and informed the physician at the facility so orders could have been obtained and treatment orders implemented for the resident.Record review of facility's policy, Skin and Wound Guidelines dated 2/4/26, documented the following: Skin alterations and pressure injuries are evaluated and documented by the licensed nurse. Using the admission or readmission evaluation.