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	03/12/2026

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2785066.Based on interview and record review the facility failed to thoroughly investigate an allegation of an injury of unknown origin for one (R603) of three residents reviewed for abuse. Findings include: The State Agency (SA) received a complaint that R603 had an injury of unknown origin to their lip. According to R603's Electronic Health Record (EHR) R603 admitted to the facility on [DATE] with multiple diagnoses that included history of a stroke with residual right-sided hemiparesis (partial paralysis) and aphasia (impaired ability to speak, understand, read, and write). The Minimum Data Set (MDS) dated [DATE] indicated R603 had a BIMS (brief interview for mental status) score of 00/15 due to R603 being rarely understood, declining to answer, or could not complete the BIMS. On 2/23/26 at 4:28 PM a progress note written by Social Worker (SW) I documented R603's family member called to report they were upset regarding care issues over the past weekend. The Nursing Home Administrator (NHA) was present and spoke with R603's family member over the phone regarding the care concerns. On 2/25/26 at 5:19 PM a progress note written by SW I documented the following: Wellness visit completed with resident. Asked how they were doing following the incident. (R603) constantly pointed at their mouth and nodded yes they would like to see someone regarding the incident. There were no additional progress notes regarding an incident with R603's lip injury. There was no skin assessment. There were no additional progress notes regarding a mouth, lip, or oral assessment for R603.On 3/11/26 at 2:55 PM during interview SW I stated, The resident's family called me on the phone and said she (R603) had something on her lip and the resident was upset about it. The family didn't know what happened and was upset. SW I said during this time the Nursing Home Administrator (NHA) walked into the Social Work office and overheard the conversation. At this time R603's family reported the concerns to the NHA over the phone. The NHA is the abuse coordinator. SW I said during their follow up visit with R603 there were no signs of injury on the outside of R603's mouth. SW I said they did not complete an assessment to the inside of R603's mouth because, That would be for the nurse to do.On 3/11/26 at approximately 3:10 PM during interview with the NHA and Nurse Unit Manager License Practical Nurse (LPN) F they said a soft investigation had been completed on 2/20/26 for R603 by the Director of Nursing (DON) and she had it. The DON was not present in the facility at this time. LPN F said they had looked at R603's mouth and saw a small, dried crack on their (R603's) bottom lip that looked chapped. LPN F confirmed there was no progress note or documentation regarding this assessment. LPN F said she did not conduct any type of interview or investigation into the allegation.On 3/11/26 at 3:20 PM during a phone interview with the DON they said they had completed an investigation for R603, and it was in a paper file. The DON said it was determined that during oral care the resident (R603) bit down on the toothbrush. There was no bruise only a small crack or split on bottom lip that looked like chapped lips and not an injury. The DON said she interviewed the CNA who performed the care on the R603. The DON said she did not interview anyone else and could not recall the name of the CNA. On 3/12/26 at 10:45 AM the DON provided a paper file of the investigation for R603's incident on 2/20/26. The investigation included a skin assessment dated [DATE] (untimed) that documented R603 had dry cracked lips. The DON said she interviewed CNA J who was assigned to care for R603 on 2/20/26. A (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	witness statement dated 2/20/26 (untimed) indicated CNA J reported the small slit on R603's bottom lip happened while providing oral care. The statement was unsigned by CNA J. The DON said that CNA J was from an agency and there was no contact information and that CNA J had not worked in the facility since that date. The DON confirmed there were no additional staff or resident interviews, assessments, or documentation regarding this allegation or the subsequent investigation. According to the facility's policy for Abuse last reviewed on 2/2/2026 in part reads: Key to investigating abuse allegations is an environment that facilitates the reporting of such allegations. Once reported, the center conducts a timely, thorough, and objective investigation of any allegation of abuse. It is the Center's policy to investigate all alleged violations involving Abuse, Neglect, Misappropriation of Resident Property, Exploitation or Mistreatment, including Injuries of Unknown Source to ensure that all individuals who report such; incidents amid allegations are free from retaliation or reprisal for reporting the incident. Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. Report the results of ail investigations to the administrator or designee and to the State Agency in accordance with State law. The investigation process includes: Identifying staff responsible for the investigation. Determining the purpose of the investigation and issue(s)to be investigated, whether or not the alleged violation has occurred, the extent, and cause.* Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegations (such as other residents, family members, staff who worked closely with the alleged perpetrator and/or alleged victim). Conducting observations of the alleged victim, including identification of any injuries as appropriate, the. location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between resident to other residents as applicable. Identifying and reviewing all relevant medical records and facility documentation as applicable.:. If the alleged perpetrator is a staff member, review their employment records. Exercising caution in handling evidence that could be used in a criminal investigation (e.g., not tampering or destroying evidence). 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 (or new policies and procedures) are needed to prevent similar Incidents or injuries from occurring in the future in accordance with its QAPI 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.Conclusion Reporting: The facility will ensure: The results of the investigation are reported to the Administrator and a final report will be submitted tothe State Survey Agency no later than five working days after the discovery of the incident. Any knowledge it has of any actions by a court of law which would indicate an employee is unfit forservice is reported to the state nurse aide registry or licensing authorities.Whether the incident/allegation is substantiated or unsubstantiated the Administrator and/or DON or designeewill:, Ensure involved patient/resident's plan of care is reviewed and revised, as appropriate, consistent with the results of the investigation. Review and analyze the results of the investigation with the QAPI committee to: Ensure a thorough investigation was completed, resident(s) are protected, root cause is determined. Determine if modifications to existing policies and procedures (or new policies and procedures)are needed to prevent similar events from occurring in the future, as applicable. Complete staff training, discipline, or termination, if appropriate, as determined by the results of the investigation. Implement any other measures as deemed necessary by the investigation including staff responsible f implementation of corrective actions and measures including the date of implementation and staff responsible for oversight.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2785066.Based on interview and record review the facility failed to follow physician orders for one (R603) of three residents reviewed for standards of practices resulting in R603 not having a urinalysis collected in a timely manner.Findings include:The State Agency received a complaint that the facility did not follow the physician's order to collect a urinalysis in a timely manner. According to the Electronic Health Record (EHR) R603 admitted to the facility on [DATE] with multiple diagnoses that included history of Urinary Tract Infection (UTI). On 2/5/26 the Nurse Practitioner (NP) B ordered R603 to have a urinalysis (UA) with culture and sensitivity (C&S) sent to the lab for complaints of abdominal pain and history of recurrent UTI. On 2/6/26, Licensed Practical Nurse (LPN) E documented that R603 had refused straight catheterization (tube inserted through urethra into the bladder to drain urine, then immediately removed) and a urine sample could not be obtained. There was no documentation to support additional attempts to obtain a UA and C&S had been made. On 2/24/26 (19 days later) NP B re-ordered for R603 to have a UA and C&S. There was no additional documentation to indicate a UA had been collected. On 3/1/26 (5 days later) NP B re-ordered R603 to have a UA and C&S. On 3/1/26, Registered Nurse (RN) G documented that a UA had been collected and sent to the lab. The Minimum Data Set (MDS) dated [DATE] indicated R603 had a BIMS (brief interview for mental status) score of 00/15 due to R603 being rarely understood, declining to answer, or could not complete the BIMS. The MDS documented R603 was usually continent of urine and able to use the toilet with 1 - 2 person assist. A care plan for Activities of Daily Living initiated on 1/30/26 indicated R603 was a 1-2 person assist to the toilet for urination. A care plan for dehydration related to UTI initiated on 2/6/2026 included the following interventions: Labs as ordered. Report abnormal results to physician promptly. Attempts to contact LPN E and NP B were unsuccessful during the time of the survey.On 3/11/26 at 2:30 PM, RN G stated, On 3/1/26 the family asked me about the UA results and there was none. I called the NP and got another order to collect the UA by doing a clean catch (method for collecting urine to detect infections, while minimizing skin bacteria contamination). I put a clean hat (disposable plastic container designed to fit over a standard toilet to collect urine sample) in the toilet and was able to collect the urine sample right away. RN G said R603 discharged from the facility the next day and was unaware of the results.On 3/11/26 at 1:30 PM during an interview with unit manager, Registered Nurse (RN) F they said there had been attempts to obtain R603's urine sample by straight catheterization method but R603 declined. RN F confirmed that there were progress notes to indicate R603 was able to urinate in a toilet with assistance. RN F could not explain why R603's urine sample was not collected as a 'clean catch' prior to 3/1/26.On 3/11/26 at 3:40 PM during an interview with the Nursing Home Administrator they stated, No we did not collect the urine sample in a timely manner. We should have done it earlier. We own that and will complete in-service educations on that.