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	04/17/2026

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake #2962412.Based on observation, interview, and record review the facility failed to adequately address and resolve grievances in a timely manner for one (R504) of four residents reviewed for grievances, resulting in neglect related to care by nursing staff.Findings include:On 4/15/26 at 4:30 A.M. R504 was observed in bed sleeping. R504 was easily aroused and after introductions indicated the next day would be best for further discussions related to no response to call lights. The resident went on and stated you see that chair outside in the hall staff sit there and sleep and talk on their phones all night. Staff do not respond to our calls to the desk or nursing station.During an interview on 4/16/26 at 10:00 A.M. R504 reported on 3/15/26 lying in a soiled diaper for approximately four hours requesting assistance from staff around 20:30 hours (8:30 P.M.). At 22:55 hours (10:55 P.M) R504 called 911 for assistance in which the police department responded leading to no change in staff behavior as R504 diaper was still never changed. R504 was provided with a blanket. The Fire department left the facility at 23:38 hours (11:38 P.M.). R504 called 911 a second time at 0012 hours to report the same situation. This call was then reported to the police department. A written case report (#2604) was referenced and obtained for review.R504 was admitted to the facility on [DATE], with diagnoses which included: progressive multiple sclerosis, calculus in bladder, anxiety disorder, neuromuscular dysfunction of the bladder, gross hematuria, adjustment disorder, major depressive disorder, adjustment insomnia and protein calorie malnutrition.According to the Minimum Data Set (MDS) dated [DATE], R504 was moderately impaired in cognitive thinking with a BIMs of 10/15, was totally dependent on staff to provide all activities of daily living. According to the written case report #(2604), dated 3/15/26, noted, On the next day a follow-up from the local police/fire department was reported to the facility. Contact was made with the former Director of Nursing (DON) Q who initially advised she was not aware of the incident, and suspected staff to be turning the phones off at night and would be conducting an internal investigation and were provided with names for those staff interviewed by Police. Shortly after, voicemail was received from DON Q stating she was told about the incident but was half asleep when she was told and wanted to discuss further. Call was returned, email was sent, and no response was received.During the onsite investigation conducted 4/15/26 at 3:20 A.M., R504 was asked whether concerns related to delays or no response to call lights were presented to the facility administrator (Abuse Coordinator). R504 responded yes. The resident could not remember the exact dates but did indicate concerns were discussed with two previous administrators and another employee that later was reported to no longer be employed at the facility.On 4/16/26 at 11:50 A.M a request was made to review the concern forms submitted for R504 from 11/2025 to the present date. At 4:00 P.M. the Administrator presented one concern from dated 1/16/2026. Concerns from Resident: R504 On Friday, January 16,2026, R504 called me at approximately 12:28 P.M. and requested my presence to discuss his concerns. We spoke for over an hour, and he gave a multitude of grievances. They are as follows: (In the order written and submitted by staff). 1. On Midnight shift we must wait over two hours for his call lights to be answered.2. Both nurses and CENAs are constantly on their phones while performing patient care.4. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Agency CENA's are usually horrible and rude.5. R504 has gone two weeks without bed bath on Thursday, specifically when CNA M was assigned to the resident, never got cleaned up resident state when assigned to him tends to disappear.11. When staff get upset, they curse patients out.Review of the resolution to this grievance was reviewed and documented education will take place on his specific concern; The writer also assured the resident that his concerns are valid.On 4/17/26 at approximately 9:30 A.M. Administrator reported there was no evidence of the education of staff for the grievance and the individual who was assigned that job their last day of work was 3/27/26.On 4/17/2026 at 2:30 P.M. the facility's policy for grievances was requested and provided. Review of the facility policy titled : Concerns and (Grievances) Process, dated 2/4/2024 stated in part. The Administrator is the Grievance Officer of the facility. The Grievance Officer is responsible for overseeing the concern (grievance) process which includes receiving and tracking concerns through to their conclusion, maintaining the confidentiality of information associated with grievances, and issuing written grievance decisions to the residents upon their request. The grievance officer may choose to lead or delegate any necessary investigations and/or follow-up related to the concern. The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect, and misappropriation of property, as per state and federal law and facility policy, including taking immediate action to prevent further potential violations of resident's right while the alleged violation is being investigated.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 is related to intake #2962412.Based on observation, interview, and record review, the facility failed to protect the resident's right to be free from neglect for one resident (R504) of three residents reviewed for neglect, resulting in the resident calling three times to the local police/ fire departments for allegations of neglect of care by the nursing staff.Findings include: On 4/15/26 at 3:00 A.M. an onsite investigation was initiated concerning the allegations of neglect for R504.On 4/15/26 at 4:30 A.M. R504 was observed in bed sleeping. R504 was easily aroused and after introductions indicated the next day would be best for further discussions related to no response to call lights. The resident continued to talk and pointed to a chair in the hallway stating, you see that chair outside in the hall staff sit there and sleep and talk on their phones all night. Staff do not respond to our call lights at the front desk or at the nursing station. R504 continued to express his concern in an agitated manner repeating come back tomorrow, please.On 4/16/26 at approximately 9:00 A.M. R504 was interviewed. R504 initially declined to discuss the incident stating agency staff did not answer the call lights and after dialing the nursing station and the front desk R504 felt there was no other way to get help but to call 911. R504 indicated that the concern was ongoing and it did not matter who you reported the concern to it was not addressed. The care here is bad on the midnight shift. The nurses and aides just ignore you, it's like you do not exist in here.On 4/16/26 at 10:00 A.M. R504 admitted repeatedly calling 911 on (local police/Fire) department on 3/15/26 in the A.M leading into the next day. R504 stated putting his call light on . no one answered or responded after waiting two to three hours, My catheter was blocked I was in pain, I have had so many problems, and urinary tract infections. My roommate R79 can verify calling to the nursing station no one answers, we both began hollering out the door for help, no one came or responded. R504 stated agency staff were terrible, and the nursing staff did not see the urgency or the need to address concerns of neglect. The resident stated the same concerns were reported to two previous Administrator and nurse P who no longer was employed at the facility. Review of Police report case #2604 , dated 3/16/26 stated in part. on 3/15/26 time stamped 20:30 on 03/15/2026 R504 called 911 on two different occasions, hours apart after not being able to call or get assistance from facility staff to be changed when he soiled himself. The Fire department and dispatch called the facility multiple times, with no answers. The Fire department responded, upon arrival at the facility staff were unaware the patient needed assistance. When 911 was called the second time, The Fire Department called the facility within the building and did not hear any phones ringing. There were nurses located on their personal phones and afterwards they tended to R504 after being prompted by the Fire Department. Due to the suspected neglect Police were called to the scene by the fire department. During this onsite visit at the facility the police physically observed staff change the patient seeing a soiled diaper.R504 reported during the interview on 3/15/26 lying in a soiled diaper for approximately four hours requesting assistance from staff around 20:30 hours (8:30 P.M.) at 22:55 hours (10:55 P.M) R504 called 911 for assistance in which the police department responded leading to no change in staff behavior as R504 diaper was still never changed, Instead R504 was provided with a blanket. The Fire department left the facility at 23:38 hours (1:38 P.M.). R504 called 911 a second time at 0012 hours to report the same situation. This call was then reported to the police department.Further record review revealed case report #2602LOVE R504 made a service call to the local police department on 3/30/26 at 21:31 hours (9:31P.M.) stating staff not answering him. At 22:05 hours (10:05 P.M.) Nurse was in the resident's room prior to officer's arrival, no other issues notified.R504 was admitted to the facility on [DATE], with diagnoses which included: progressive multiple sclerosis, calculus in bladder, anxiety disorder, neuromuscular dysfunction of the bladder, gross hematuria, adjustment disorder, major depressive disorder, adjustment insomnia and protein calorie malnutrition.According to the Minimum Data Set (MDS) dated [DATE], R504 was (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	moderately impaired cognitively (ability to think) with a Brief Interview for Mental Status (BIMs of 10/15) and was totally dependent on staff to provide all activities of daily living.On 4/16/26 at 1:00 p.m. The Administrator denied knowledge of R504's concerns related to nursing and agency staff not responding to call lights. The Administrator reported residents should not be calling the Police/Fire department for assistance with care at the Nursing facility at any time.On 4/17/26 at 4:00 p.m. review of the facility's policy titled Abuse revised 2/2/2026 stated. Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of 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.Upon exiting the facility on 4/17/26 at 4:30 P.M no other additional information was provided regarding R504 calling local fire/police department on three separate occasions reporting that nursing staff were not answering or responding to his call light in a timely manner.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake #2962412.Based on interview and record review the facility failed to develop and revise a comprehensive Care plan for one resident (R504) of 14 residents reviewed for care plans, resulting in the potential for unmet care and services.Findings include:On 4/16/26 at 8:45 A.M. review of the Electronic Health Record indicated R504 was admitted to the facility on [DATE], with diagnoses which included: progressive multiple sclerosis, calculus in the bladder, anxiety disorder, neuromuscular dysfunction of the bladder, adjustment disorder, major depressive disorder, adjustment insomnia and protein calorie malnutrition.According to the Minimum Data Set (MDS) dated [DATE], R504 was moderately impaired in cognition (ability to think) and was totally dependent on staff to provide all Activities of Daily Living. (ADL's). On 4/16/26 at 8:50 A.M, review of the Care Plan Report initiated 8/4/2025 Titled: AT risk for changes in behavior and mood related to anxiety, MDD, with a Goal: R504 will accept care and medication as prescribed.Interventions documented to accomplish the goal included:Administer medications per physician ordersCalls police and Fire DepartmentMay attempt distraction intervention, music activities, relaxation techniques positioningOffer choices to enhance sense of controlPsy consult as orderedRedirect as needed.Record review on 4/16/26 at 9:30 A.M. revealed R504 had a history of calling the police and fire department requesting their assistance when the midnight shift failed to respond to the call light. The fire/police department reported R504 initiated three separate calls to their departments with the last call being made on 3/30/26 requesting a service call to the hospital. On each call officers and/ fire dispatch company responded to the resident.Further review of the Care Plan Report did not identify any interventions to prevent recurrences nor were there any revisions in the implemented care plans identifying R504 as receiving hospice care/services.According to the Nurses notes dated 3/17/26 through 4/17/26 by Director of Nursing (DON) Q, R504 was interviewed concerning one of the three incidents where the resident called the fire/police department. Per the nurses Note R504's only concern or complaint was he did not want agency staff caring for him. Safety measures were reported to be in place, however, there was no care plan or interventions addressing safety measures for R504.On 4/16/26 at 12:30 P.M Social Worker (SW) N was interviewed concerning the resident's behavior of calling the fire/police department. SW N reviewed the care plan but had no explanation how the intervention for calling the police/fire department was listed as a step to provide R504 assistance with agency or nursing staff. On 4/17/26 at 3:00 P.M. interview with the corporate consultant, the Administrator, Director of Nursing and Nurse K no additional information was provided. At this time a request was made of the facility's policy pertaining to care planning.Review of the facility's policy Titled: Care Plan-Comprehensive and Revision, dated 2/2/2026 indicated in part. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The interdisciplinary team reviews and updates the care plan: When there has been a significant change in the resident's condition.o When the desired outcome is not met.

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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** This citation pertains to 2980193, 2981179, 2966122, 2962412, 2962938, 2795382, 2794223, 2797203 and 2791414Based on observation, interview and record review, the facility failed to ensure appropriate urinary incontinence care for two residents (R519 and R520) of 14 residents reviewed, resulting in the potential to cause skin breakdown, discomfort and poor moisture management. Findings Include:On 4/15/2026 at 5:18 AM, a strong smell of urine was noted to come from the room of R519 and R520. At that time, Licensed Practical Nurse (LPN) C was interviewed regarding the smell of urine. LPN C said they did notice a smell and the room floor was sticky.At 5:43 AM Certified Nurse Aid (CNA) B took a white incontinence brief and towels in the room of R519 and R520. CNA B left the items and exited the room. At 5:58 AM (CNA) B returned to the room and asked R519 about performing incontinence care. CNA B exited the room.At 6:28 AM (CNA) B was observed to perform incontinence care on R519. While performing incontinence on R519 it was observed to have on two incontinence briefs. R519 had on a white incontinence brief with a green brief on the inside.4/15/2026 at 6:28 AM CNA B was interviewed about R519 having on two incontinence briefs. CNA B said they did not consider that double briefing because the brief that was placed on the inside was not closed.R512 was initially admitted on [DATE] diagnosed with the following: ACUTE RESPIRATORY FAILURE WITH HYPERCAPNIA, CHRONIC KIDNEY DISEASE, STAGE 3, ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD, HEART FAILURE and DIFFICULTY IN WALKING.Review of R519 Minimum Data Set (MDS) dated [DATE] revealed Brief Interview for Mental Status (BIMS) was 11 out of 15 moderately cognitively impaired.Review of R519 care plan focus indicated the following ADL self-care deficit related to muscle weakness, impaired physical mobility, COPD, CHF, low back pain. The goal was as follows: Will receive assistance necessary to meet ADL needs. Intervention for toileting was TOILETING USE: 1-2 person assist in bed.On 4/15/2026 at 6:37 AM, (CNA) B performed incontinence care on R520. While performing care CNA B was observed to remove multiple layers of clothing as well as two white incontinent briefs one brief inside of the other.On 4/15/2026 at 6:47 AM, LPN C was also queried about placing more than one incontinence briefs on residents at a time. LPN C said that staff are not allowed to double brief.On 4/16/2026 at 9:25 AM R520 was interviewed about staff applying multiple briefs. R520 said staff double brief residents at night.(R513) was initially admitted on [DATE] with diagnosis as follows: CEREBRAL INFARCTION, BIPOLAR DISORDER, GENERALIZED ANXIETY DISORDER, MILD COGNITIVE IMPAIRMENT, HEMIPLEGIA AND HEMIPARESIS, ACUTE RESPIRATORY FAILURE WITH HYPOXIA and DISORDER OF MUSCLE.Review of R520 Minimum Data Set (MDS) dated [DATE] Brief Interview for Mental Status (BIMS) was noted as 12 out of 15.On 4/16/2026 at 2:00 PM, interviewed the Director of Nursing (DON) said the staff should not double brief residents. The DON said they expect staff would check and change residents according to policy.Review of policy title, Incontinence Care-Urinary and Fecal with a review date of 2-3-2026 the policy did not address multiple briefs.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2980193 and 2962412Based on observation, interview and record review the facility failed to ensure that one resident (R519) with a stage III pressure injury received necessary treatment and services to promote healing of six reviewed for wound care.Findings include: At 5:43 AM Certified Nurse Aid (CNA) B took a white incontinence brief and towels in the room of R519. CNA B left the items and exited the room. At 5:58 AM (CNA) B returned to the room and asked R519 about performing incontinence care. CNA B exited the room.At 6:28 AM (CNA) B was observed to perform incontinence care on R519. While performing incontinence on R519 it was observed to have on two incontinence briefs. R519 had on a white incontinence brief with a green brief on the inside.4/15/2026 at 6:28 AM CNA B was interviewed about R519 having on two incontinence briefs. CNA B said they did not consider that double briefing because the brief that was placed on the inside was not closed.On 4/16/2026 at 9:14 AM, interviewed the Wound Care Nurse about R519. The Wound Care Nurse said R519 had a wound that was classified as stage III pressure ulcer. The wound was located to the sacral/coccyx area. The treatment was zinc oxide with alginate for stage III pressure ulcer. The Wound Care Nurse said residents with this type of wound should not have multiple incontinence briefs applied because additional moisture can impede healing. R519 was initially admitted on [DATE] diagnosed with the following: ACUTE RESPIRATORY FAILURE WITH HYPERCAPNIA, CHRONIC KIDNEY DISEASE, STAGE 3, ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD, HEART FAILURE and DIFFICULTY IN WALKING.Review of R519 Minimum Data Set (MDS) dated [DATE] revealed Brief Interview for Mental Status (BIMS) was 11 out of 15 moderately cognitively impaired.Review of R519 care plan focus indicated the following ADL self-care deficit related to muscle weakness, impaired physical mobility, COPD, CHF, low back pain. The goal was as follows: Will receive assistance necessary to meet ADL needs. Intervention for toileting was TOILETING USE: 1-2 person assist in bed.On 4/16/2026 at 2:00 PM, interviewed the Director of Nursing (DON) said the staff should not double brief residents. The DON said they expect staff would check and change residents according to policy.

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F 0689 Level of Harm - 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 intakes #2786224 and 2965279.Based on interview and record review, the facility failed to utilize a two-person assist and appropriate bed mobility techniques during a brief change of one resident (R511) of three residents reviewed for falls, resulting in the resident sustaining a closed head injury, abdominal hematoma, and a closed fracture of the femur requiring hospitalization.Findings include:On 4/15/2026 at 08:08 AM, the complainant, Family Member J was interviewed and queried about R511's fall. Family Member J said, On February 7th (2026), I receive a call from the facility that (R511) fell out of bed while staff were changing the (incontinence brief).(R511) was sent to the hospital with a broken leg. A review of R511's electronic medical record (EMR) revealed an admission to the facility on [DATE] with the diagnosis of Chronic Kidney Disease, Legally Blind, Atherosclerotic Heart Disease, Heart Failure, Spinal Stenosis (narrowing of spaces in the spine, causing nerve compression that leads to back/neck pain, numbness, and leg weakness), Muscle Weakness, Deep Vein Thrombosis (DVT), and Paraplegia (immobility causing loss of voluntary movement and sensation in the lower half of the body-typically both legs and sometimes torso). R511 was also on medication Eliquis (a blood thinner).A review of R511's Brief Interview for Mental Status (BIMS) dated 01/23/2026 disclosed a score of 10/15 (Moderately Impaired Cognition). A review of R511's care plan revealed the following: ADL (Activities of Daily Living) assist of 2 staff. Date Initiated: 01/22/Assist to bath / shower as preferred per shower schedule and as needed Date Initiated: 02/03/2026. Bed Mobility:2 person assists.dated 01/22/2026. Assist with daily hygiene, grooming, dressing, oral care and eating as needed Date Initiated: 02/03/2026.Bathing/Showering: 2 person assist. At risk for falls secondary to muscle weakness, paraplegia, encephalopathy, blindness.Dated 01/22/2026. A review of R511's Kardex (used to summarize essential patient information, medical orders, and nursing care needs) revealed the following: Bed Mobility: Two person assist.Toileting Use:2 person assist in bed. A review of R511 Emergency document Department (ED) Inpatient RN Handoff Note revealed the following: Patient presents with fall, leg pain Final Diagnoses:Acute Kidney InjuryFallClosed Head Injury, initial encounterAbdominal HematomaClosed fracture of femurED Intervention: Blood transfusion started HGB 6.8.Blood transfusionAcute right femoral distal metaphysical fracture due to witnessed fall-Presented after a rollover/fall from a bed.while changing clothes.-Imaging showed 5.1 CM left deep subcutaneous hematoma overlying the left hip.-Pain management. On 4/15/26 at 09:03 AM, Certified Nursing Assistant (CNA) A was interviewed by phone and queried about the care that was provided to R511's. CNA A stated, I was changing (R511's) brief I rolled (R511) to the other side of the bed.(R511) threw (their) leg over too hard and rolled off the bed as I walked to the other side of the bed. CNA A said she took her hands off R511while walking around to the other side of the bed. CNA A was asked if there was anyone assisting during the brief change. CNA A stated, I've changed (R511) alone several times.I did not have any help because I was the only aide down the [NAME] Hall. CNA A added that R511 was very sleepy during care. CNA A was asked the number of staff needed to assist R511during care according to the Kardex. CNA A said, The Kardex has (R511) two persons assisting. CNA A was asked if they were trained to roll residents toward or away. CNA A said that R511 should have been rolled towards her and not away. A review of the facility's daily assignment document revealed a census of 12 residents, one CNA and one Nurse for the [NAME] Hall. 4/16/2026 at 1:45 PM, the Director of Nursing (DON) and the Nursing Home Administrator (NHA) was interviewed and discussed R511falling out of bed after CNA A rolled the resident over, resulting in hospitalization and fracture. The DON said CNA A should have rolled the resident towards her and not away. A review of the facility's policy Bed Mobility-Safety Education dated 5/27/2025 revealed the following: Check Kardex and check for assist needed for bed mobility.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2786224 Based on observation, interview and record review, the facility failed to ensure training, evidence of skills performed, and confirmed Certified Nurse Assistants (CNAs) were capable of delivering safe care to vulnerable residents, resulting in one resident (R511) of three residents reviewed for falls, resulting in R511 sustaining a closed head injury, abdominal hematoma, and a closed fracture of the femur, requiring hospitalization. This has the potential to affect all residents Findings include: On 4/15/2026 at 08:08 AM, the complainant, Family Member J was interviewed and queried about R511's fall. Family Member J said, On February 7th (2026), I receive a call from the facility that (R511) fell out of bed while staff were changing the (incontinence brief).(R511) was sent to the hospital due to a broken leg. A review of R511's electronic medical record (EMR) revealed an admission to the facility on [DATE] with the diagnosis of Legally Blind, Atherosclerotic Heart Disease, Spinal Stenosis (narrowing of spaces in the spine, causing nerve compression that leads to back/neck pain, numbness, and leg weakness), Muscle Weakness, and Paraplegia. A review of R511's Brief Interview for Mental Status (BIMS) dated 01/23/2026 was a score of 10/15 (Moderately Impaired Cognition). A review of R511's care plan revealed the following: A review of R511's Kardex (used to summarize essential patient information, medical orders, and nursing care needs) revealed the following: Bed Mobility: Two person assist.Toileting Use:2 person assists in bed. A review of R511's progress note created by LPN L, dated 2/7/2026 at 07:21 AM revealed the following: Staff made nurse aware that the resident had a fall while changing brief. Upon entering the nurse observed resident on the floor, lying on Right side. On 4/15/2026 at 09:03 AM, Certified Nursing Assistant (CNA) A was interviewed by phone and queried about the care that was provided to R511's. CNA A stated, I was changing (R511's) brief I rolled (R511) to the other side (away from CNA A) of the bed.(R511) threw (their) leg over to hard and rolled off the bed while I walked to the other side of the bed. CNA A was asked if there was anyone assisting during the brief change. CNA A stated, I've changed (R511) alone several times.I did not have any help because I was the only aide down that hall. CNA A was asked how many persons were needed to assist during care according to the Kardex. CNA A said, The Kardex has (R511) two persons assisting. CNA A was asked if they were trained to roll residents toward or away. CNA A said that R511 should have been rolled towards her and not away. CNA A was asked if they received training or education following R511's fall from the bed. CNA A said, No one said anything to me about (R511's) fall.No one said I did anything wrong.I did not receive training at this facility about bed mobility.I don't know if we have a trainer here (at this facility). 4/16/2026 at 1:45 PM, the Director of Nursing (DON) and the Nursing Home Administrator (NHA) was interviewed and discussed R511falling out of bed after CNA A while receiving care and additional resident care training. The DON said CNA A should have rolled the resident towards her and not away. The DON said the Staff Educator/Trainer did not meet the expectations of the job. The DON said this position was not fully functioning since September 2025 (September 1, 2025 - April 1, 2026). The NHA said that preceptors were providing training to new staff. The NHA said a new Staff Educator/Trainer will start next week. A review of the facility's policy Skills Evaluations dated 02/09/2024 revealed the following: The skills evaluations checklist(s) is completed during job-specific orientation, re-validated annually, and completed as needed.The Human Resources Director is responsible for maintaining employee records involving performance appraisals, skills evaluation, and in-service records.

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	235618	A. Building B. Wing	04/17/2026

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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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on observation, interview and record review the facility failed to ensure operational, systemic systems were maintained to ensure the highest, practicable, physical, mental and psychosocial well-being of each resident, resulting in multiple complaints related to Quality of Care and Quality of Life in the facility. This deficient practice has the potential to affect all residents residing in the facility.Findings include:During the abbreviated survey conducted April 15, 2026, at approximately 3:30 A.M. multiple deficiencies were identified and are presented as follows:The facility failed to provide adequate supervision, transfer assistance and interventions to prevent a resident fall resulting in a fracture and hospitalization.There was no system or individual to consistently monitor, assess and coordinate the competency and skill level of Agency staff and nursing personnel of the facility from September 2025 through April 2026.There was no consistent Infection Control Program resulting in missed opportunities to prevent the spread of infections from September 2025 through April 2026.The staff turnover and the lack of utilization of effective resources was evident as the midnight shift on 4/15/26 could not identify what nurse was in charge and repeatedly identified each other. Nursing staff on the first floor reported they had been instructed to call the current Director of Nursing should any problem arise.There was an allegation of neglect reported to the Grievance Officer (The Administrator serves as the Grievance Officer) on 1/16/2026 by a resident. Subsequently, two more additional incidents were reported to Director of Nursing Q on 3/19/26 for the same resident after the resident called the local Fire/Police Department stating nursing staff failed to respond to the call light within a timely manner (more than a two-hour waiting period). There was no available evidence that the allegations were investigated or reported to state Agency after a 1:1 meeting with the Grievance Officer who interviewed the resident and documented resolution of the allegation.In addition, the standards of practices for incontinence care were not consistent with the most recent and latest Best Practices specified in PubMed: The effect of multiple layers of linens on surface interface pressure (2013): Evidence indicates that adding extra layers (like extra briefs or liners) increases pressure on the sacrum, directly contradicting pressure redistribution needs. Double briefing of two residents provided an unpleasant odor which permeated the halls on the second floor as well as the potential loss of the residents' dignity.There were multiple incidents reported by residents, local Fire/police and family members indicating the facility was called during the midnight shift and no one answered the telephone. This allegation was verified during the abbreviated survey. Calls were made to the facility on and off-site and no staff answered or responded to the calls. The Maintenance Director verified that the phones were on but not audible by staff.During the survey attempts were made to call the facility at 4:11 am and 4:48 am the facility phone-rang 6 times and went to voice mail without staff answering. One call was placed while present at the First-Floor nursing station, and no phone was heard to ring.Corporate Nurse K explained that during an internal facility audit on 4/6/2026 was unable to be completed and resulted in termination due to insufficient action and documentation of department leadership employed at that time.In an interview on 4/17/26 at 3:15 P.M. with Corporate Consultant P, the Administrator, Director of Nursing and RN K these issues were presented and reviewed. The facility staff explained that the previous Administrator and Director of Nursing Q were terminated the week of 3/29/26. The Administrator and the Director of Nursing explained that they were unable to address the concerns presented by the State Agency. At that time, additional information and explanations were requested in order to ascertain what concerns the facility was aware of.Upon existing the facility on 4/17/26 at approximately 4:30 P.M., no other information was provided or presented.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to (1) ensure the use of personal protective equipment when providing care for residents on Enhanced Barrier Precautions and (2) failed to continuously maintain, implement and operationalize a comprehensive infection control program, encompassing outcome and process surveillance, accurate data collection/documentation/analysis, resulting in missed opportunities to prevent the spread of infection.Findings include:On 4/15/2026, at 6:28 AM Certified Nurse Aid (CNA) B was observed changing R519 incontinent brief without wearing proper personal protective equipment (PPE) despite R519 being on Enhanced Barrier Precautions (EBP) for a stage III pressure ulcer to the sacrum/ coccyx area. CNA B did not wear a gown when performing hygiene care. CNA B was observed changing gloves after performing hygiene care. CNA B did not use sanitizer or soap and water to wash hands before applying new gloves. After performing hygiene care to R519 CNA B applied new gloves and moved to R520 and started hygiene care. On 4/15/2026 at 6:37 AM, observed (CNA) B perform incontinence care on R520. CNA B was observed providing incontinence care without wearing proper PPE despite R520 being on EBP for having a Percutaneous Endoscopic Gastrostomy tube (PEG tube), which is a feeding tube. CNA B did not wear a gown when performing hygiene care. On 4/15/2026 at 6:45 AM CNA B was interviewed and said they were in a hurry and did not see the EBP sign on the room door for residents R519 and R520. On 4/15/26 at 6:47 AM Licensed Practical Nurse (LPN) C was interviewed and acknowledged they observed CNA B perform hygiene on R519 and R520 without wearing proper PPE. LPN C was interviewed concerning EBP and said that CNA B should have had a gown on when performing hygiene care on EBP residents. On 4/16/2026 at 2:00 PM, interviewed the Director of Nursing (DON) who reported when a resident has (EBP) the staff are expected to wear the proper (PPE), which includes wearing a gown. The DON said staff should perform hand hygiene between residents. Review of facilities policy titled, Enhanced Barrier Precautions, revision date 2-6-2026. The policy was to serve as a guideline to prevent the transmission of multidrug resistant organisms. The EBP policy noted utilizing PPE a gown and gloves for certain residents which included residents with wounds R519 had a stage III wound and R520 had a feeding tube. On 4/16/26 at 09:55 AM, A review of the facility's infection control program was conducted with the Director of Nursing (DON) and the Corporate Nurse K. A review of the infection control binder provided by the facility revealed no documentation of an infection control program from September 1, 2025, through April 1, 2026. The DON stated, I was not employed here at that time. Corporate Nurse K said that the missing information was identified on 4/6/2026 during an internal facility audit. Corporate Nurse K said despite having several Infection Preventionist (IP)in the role, they did not perform IP core responsibilities of identifying, investigating, monitoring, and reporting infections. A review of the facility's Infection Control Binder revealed the following missing documentation: Antibiotic stewardship program (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff education and competency checks Environmental Audits Emergency preparedness for outbreaks Audit tools for hand hygiene, PPE, and cleaning McGeer Criteria (standardized infection classifications used for surveillance in long-term care (LTC) facilities to distinguish true infections from non-infectious symptoms) Outbreak Investigations On 4/16/2026 at 10:12 AM, requested the Infection Control Policy from the DON. This policy was not received upon exit.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on interview and record review the facility failed to maintain a continuous Antibiotic Stewardship Program that includes monitoring antibiotic usage, tracking resistance, prevent emergence of resistance, and following protocols for antibiotic use, which has the potential to affects all residents residing in the facility.Findings include:A review of the facility's policy Antibiotic Stewardship dated 02/04/2026, revealed the following: Facility staff and medical practitioners have a responsibility to assure that antibiotics are requested and provided only when the root cause is determined to be a bacterial infection and only for the length of time needed to adequately treat the infection.The overall goals of antibiotic stewardship is to:o Improve appropriate utilization of antibiotic therapy.o Reduce resistance to antibiotic therapy.o Reduce adverse drug events related to antibiotic therapy (including allergic rash, anaphylaxis, death, C. difficile, colonization, disruption of normal flora and the development of resistant organisms).o Reduce administration of unnecessary antibiotics.o Improve resident outcomes.The facility follows the CDC's core elements for antibiotic stewardship which includes:o Leadership commitment, including the Director of Nursing, Infection Preventionist, Medical Director, and Consultant Pharmacist, to the safe and appropriate use of antibiotics by ensuring that:Antibiotic stewardship prescribing protocols are followed: Utilization of McGeer's criteria in determining the presence of symptoms meets the definition of an infection. Diagnostic testing required to be completed per McGeer's criteria prior to initiation of antibiotic orders. Diagnostic test results received that do not meet criteria will be reported to the medical practitioner for further evaluation of need. Orders for antibiotics will include the name, dose, route, frequency of the antibiotic as well as indication for use and stop date. Pharmacy to assist with dosing recommendations especially for antibiotics that require peak and trough levels to determine therapeutic levels.racking is demonstrated by: Monitoring various measures of antibiotic use, which may include:o Adherence to clinical evaluation documentation including signs, symptoms, and other physical examination findings in the resident's electronic medical record.o Adherence to cultures obtained before antibiotics are initiated or changed after culture results are received.o Adherence to completeness of orders with name, dose, route, frequency, duration, and indication.On 4/16/26 at 09:55 AM, A review of the facility's Antibiotic Stewardship Program was conducted with the Director of Nursing (DON) and Corporate Nurse K. During the program review there was missing documentation in the Antibiotic Stewardship Program from September 1, 2025, through April 1, 2026. The DON was asked if they had an Infection Preventionist during September 1, 2025, through April 1, 2026. The DON stated, I was not employed here at that time and was unable to explain why the ABT stewardship program was not in affect during this time. Corporate Nurse K said they found inadequate documentation for the Antibiotic Stewardship Program during an audit conducted on April 6, 2026, indicating the program was not properly implemented.