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

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| Optalis Health and Rehabilitation of Canton | 7025 Lilley Road<br>Canton, MI 48187 |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to initiate Cardiopulmonary Resuscitation (CPR) for one resident (R108-with full code status by default on [DATE]) of one resident reviewed for CPR. R108 was found unresponsive with absent vital signs and CPR was not initiated.Findings include: On [DATE], when (R108) was found unresponsive without vital signs, the facility called a code and called 911. However, the facility did not initiate CPR because they executed an invalid Do Not Resuscitate (DNR) order. This deficient practice may result in the likelihood of other residents not receiving CPR according to code status resulting in serious harm, serious impairment, or death.The Immediate Jeopardy (IJ) began on [DATE] and the immediacy was removed [DATE] per review of the facility's responding interventions as verified on [DATE]. The IJ was identified on [DATE] during a recertification survey. The facility was notified of the IJ on [DATE] at 4:50 PM and was asked for a removal plan. The surveyor confirmed that the IJ was removed on [DATE], based on the facility's implementation of the removal plan as verified onsite on [DATE]. The facility executed a Do Not Resuscitate order without valid Durable Power of Attorney documentation of authority to make life sustaining decisions. The facility also entered two code status changes after R108 became unresponsive.Record review of the Electronic Health Record (EHR), revealed R108 entered the facility on [DATE] with a diagnosis of failure to thrive, paroxysmal A-fib with recurrent falls, ischemic cardiomyopathy with reduced ejection fraction, hypertension, hyperlipidemia, and pulmonary hypertension. R108 was hospitalized on [DATE] and re-admitted to the facility on [DATE]. Record review revealed R108 was deemed incompetent on [DATE]. According to the Minimum Data Set (MDS), R108 was severely cognitively impaired. On [DATE], record review of progress note from Social Worker (SW) J dated [DATE] at 14:11 PM documented, Message left for (Family Member, ( FM U)) to contact writer regarding Durable Power of Attorney (DPOA) paperwork.On [DATE], record review of progress note from SW J dated [DATE] documented, FM U reported he will bring (Power of Attorney) POA paperwork this evening. On [DATE], record review of progress note from (SW) P dated [DATE] documented, Care Conference held today with IDT (interdisciplinary team) and (FM U) via phone. SW reviewed the uploaded healthcare representation paperwork, however it only states HIPPA representative and financial. SW explained that the current paperwork does not state anything about being able to consent/withdraw care or any other medical treatment authority. (FM U) is going to bring in another copy to see if it is any different than what is uploaded. SW briefly explained that if the paperwork that (FM U) has does not allow authorization for care then Legal Guardianship will need to be started but we can review once SW reviews the paperwork.This note also denoted: SW will continue to monitor and assist as needed. (FM U) is open to changing R108 code status to (DNR, Durable Power of Attorney) however current paperwork does not provide (FM U) with the authority to complete DNR form which (FM U) appears to understand.Record review of progress note from SW P dated [DATE] documented, Emergent care conference held, yesterday [DATE]. (FM U) expressed wanting (R108) to be DNR and not full code. Current uploaded documentation did not show accurate DPOA, however (FM U), did provide DPOA paperwork today, per social work. Social work following<br>(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 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | regarding updated CODE STATUS. Record review of progress note dated [DATE] at 11:31 AM by SW N, documented, SW notified (FM U) that the DPOA is now activated. SW will continue to follow up as needed.Record review of progress note dated [DATE] documented, Discussed with (FM U), plan to sign onto hospice on [DATE]. Social work following on updating CODE STATUS. Record review of progress note dated [DATE] from Social Services Social Worker O, (FM U), brought in (DNR) order form on [DATE]. On [DATE], record review of document entitled (DNR) dated [DATE] was uploaded into the electronic medical record (EMR) on [DATE]. On [DATE], record review revealed two orders were placed into the EMR on [DATE]. Both orders were uploaded after R108 became unresponsive. R108 passed at the facility at 10:45 PM. On [DATE] at 22:45/10:45 PM- Do Not Resuscitate order initiated by Nurse Q. On [DATE] at 23:59/11:59 PM- Full Code order initiated by Director of Nursing (DON). A nursing progress note dated [DATE] revealed: Date and time vital signs absence. [DATE] 10:45 PM.Date and time physician notified. [DATE] 11:50 PM. A physician was contacted.Date and time family notified. [DATE] 11:00 PM. (FM U) was contacted. Date and time body released to mortuary. [DATE] 12:15 AM.Name & Phone number of the mortuary body is released to funeral home. On [DATE] at 2:08 PM, SW N was interviewed regarding the progress note entered by SW N on [DATE] that documented DPOA is now in effect. SW N was asked if additional DPOA paperwork was received, authorizing FM U to make life sustaining decisions for R108. SW N stated, I don't have any additional DPOA paperwork, and I don't see it in the system. R108's current documentation, which gave authority pursuant to (HIPPA) Health Insurance Portability and Accountability Act and Specific Power of Attorney to execute financial decisions, was reviewed with SW N. SW N explained that she thought this document gave FM U authority to change R108's code status to DNR. On [DATE], SW N at 10:55 AM queried whether the facility received documentation of Durable Power of Attorney over medical authority to make life sustaining decisions. (SW) N stated, I thought we did. I thought the current healthcare representative form for HIPPA covered the authority to sign a DNR.Record Review of Progress Note dated [DATE] at 17:48, SW O documented, (FM U) brought in Do-Not-Resuscitate order form. On [DATE] at 3:30 PM, Nurse BB was contacted and reported that R108 was a DNR and that Nurse S called 911.On [DATE] at 4:07 PM, FM U was contacted and confirmed submitting a signed DNR form to the facility on [DATE] prior to R108's death. FM U also reported that he had DPOA and provided the facility with a copy of the document on three different occasions, the last time being in mid-July. On [DATE] at 11:07 AM, SW P was interviewed and acknowledged her progress note regarding invalid medical DPOA papers. SW P reported having no recollection of receiving the appropriate DPOA paperwork from FM U to declare a change R108 code status from full code to DNR. On [DATE] at 10:15 AM, Nursing Health Administrator (NHA) was interviewed and acknowledged that the current Nomination of Agent as Healthcare Personal Representative form dated [DATE], provided by FM U, did not cover medical decisions. The NHA was queried about the orders regarding R108's code status that was documented after R108's time of death. The NHA reported being unaware of a physician order for DNR followed by a physician order for full code. When the NHA was asked, Why was 911 called if a DNR order was implemented? The NHA stated, I don't know, we don't usually tie up those resources like that. On [DATE] at 10:37 AM, The DON was interviewed and reported receiving a call from the midnight nursing supervisor Nurse R on [DATE]. According to the DON, Nurse R contacted the DON because the order in place at the time R108 was found unresponsive was a full code but Nurse R thought R108 was a DNR. The DON acknowledged that she wrote an order to change the code status back to Full Code after receiving the call from Nurse R. The DON also reported not knowing that R108 was deceased at the time of the code change. When asked why 911 was called if a DNR order was in place, she stated that's not normally the process.On [DATE] at 11:50 AM, Nurse Q was interviewed and confirmed confusion over code status at the time of R108's death on [DATE]. Nurse Q was asked, was CPR performed on R108? Nurse Q stated, No, I understood the code status was a DNR. On [DATE] at 12:54 PM Nurse R was contacted and reported that she knew the facility had a conflicting code status, so she called the DON. Nurse R reported that a Full Code was in the<br>(continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | system, but DNR paperwork for R108 was produced. Nurse R also stated, I knew the facility did not have the correct DNR paperwork. According to Nurse R, the EMR noted Full Code status while the paperwork noted DNR. On [DATE] at 1:13 PM, Nurse Q requested to meet with the surveyors. Nurse Q stated, I put the DNR (physician's order) in. I did not know it needed signatures.On [DATE] at 10:10 AM, Medical Director T was interviewed and stated, I had a discussion last week with the facility about code status. We (the facility) were working with (FM U) for an extended period of time. (FM U) wanted a no code no CPR. We were working on that process. A DNR code status was placed in my book. I signed a code status DNR for (R108). The DNR was signed and done prior to the resident actually coding. On day (R108)'s death, (R108) coded and EMS was called. I was called by a nurse about a patient that coded, and EMS was called - I had no other conversation. Medical Director T was queried regarding the meaning of coded and stated, I interpretated that to mean that CPR was initiated because EMS was called. When asked if he was made aware of the physician orders changing R108's code status, Medical Director T said he was not aware of anything about changing the resident's code status after R108 was found unresponsive. Medical Director T was asked if a physician order for a DNR was written for R108 and stated, At no time did I give a verbal order for a DNR. That is not how it works. When there is a full code, CPR is initiated!Medical Director T stated, It is standard procedure that if the resident is a DNR that we would not call 911. If someone is DNR there is no need to call EMS. On [DATE] at 10 AM requested a copy of the Cardiac Arrest Emergency Management Policy and the Advanced Directive Code Status Policy. Review of facility policy titled, Social Services, revised [DATE], documented in part: The social Worker, or social service designee tasks include but are not limited to assisting residents with advanced care planning, which includes formulating an advanced directive and educating residents on code status choices.Review of facility policy titled, Cardiac Arrest Emergency Management (Michigan), issued [DATE] and reviewed on [DATE], documented in part: General Guidelines- CPR is to be initiated on residents in the event of a cardiac arrest unless the resident has a Do Not Resuscitate order and this is properly documented in the medical record. Guidelines for a Resident with a Full Code Order- First licensed nurse to arrive directs additional staff to review the resident's medical record for the resident's code status and whether there is a Do Not Resuscitate Order in place. If the resident has a Full Code order and is without a pulse/respiration: Direct designated staff to call 911 requesting emergency assistance. The licensed nurse should verify the resident's code status. Michigan Guidelines for a resident with a Do; Not Resuscitate Order- First licensed nurse to arrive directs additional staff to review the resident's medical record for the resident's code status and whether there is a Do Not Resuscitate Order in place. If the resident does have a DNR order and is without a pulse/respiration: Police or Medical Examiner notification as appropriate per county rules.Review of facility policy titled, Advanced Directives- Code Status, issued [DATE], revised [DATE] and reviewed on [DATE], documented in part: Code Status: In accordance with the Michigan Do-Not-Resuscitate Procedure Act a DNR must be documented on the Do-Not-Resuscitate (DNR) form for the DNR to be valid. Until the form is fully filled out and signed by the resident or the resident's legal representative, two witnesses and a physician, the resident will be a Full Code by default. If the resident and/or their legal representative has chosen for the resident's code status to be Do-Not Resuscitate: The attending physician writes an order for the resident's DNR code status. The Michigan Do-Not-Resuscitate form will be uploaded into the resident's electronic health record in Point Click Care under the documents tab. Until the form is fully filled out and signed by the resident or the resident's legal representative, two witnesses and a physician, the resident will be a Full Code by default. From the physician order the resident's DNR code status will auto populate and prominently displayed on the resident's chart header in PCC and will also populate to the resident's face sheet. The Immediate Jeopardy that began on [DATE] was removed and the deficient practice corrected on [DATE] when the facility took the following actions to remove the Immediacy and correct the noncompliance. 1. Residents that are currently reside in the facility were audited by licensed Social Worker on [DATE] to ensure that residents with a current Do-Not-Resuscitate (DNR) (continued on next page) |

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| F 0678<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | code status have the DNR form filled out fully and executed by the person who has authority to sign the form. Residents that currently reside in the facility has the appropriate Advanced Directives/Code Status in place, the appropriately signed DNR form, appropriate DPOA, Guardian, or Patient Advocate documentation, and the appropriate capacity documentation as applicable.2. Licensed nursing staff (including agency licensed nurses) and Social Workers were immediately re-educated on the Advanced Directive Code Status Policy. Licensed Nurses were also educated on the Cardiac Arrest Emergency Management Policy to include locating and confirming code status in the medical record-Once the code status order is entered into PCC, it is instantly transferred and displayed in the resident's banner, allowing for immediate identification. Education was started on [DATE] with 13 licensed nurses were educated including 7 agency licensed nurse and all (2) social workers were educated on [DATE]. Licensed nurses including and Social workers will be educated prior to working their next scheduled shift. 3. Audits will be conducted by Social Services/designee on 8 residents per week for 8 weeks to ensure the resident's Advanced Directives code status for DNR has the DNR form filled out fully and executed by the person who has authority to sign the form, and when applicable DPOA, Guardian, or Patient Advocate documentation and the appropriate capacity documentation.The facility alleges the immediacy of these discrepancies have been removed on [DATE]. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review, the facility failed to ensure food contact and non-food contact surfaces were adequately cleaned and sanitized. This deficient practice had the potential to affect all residents who consumed food from the kitchen, resulting in the increased potential for food borne illness. Findings include: The following was observed during the initial tour of the kitchen on 8/11/25 at 8:15 AM with Dietary Manager A- The rubber bumper at the base of the reach-in juice cooler was visibly soiled with dust and food stains.- The front drip tray of the commercial ice dispenser was stained with food debris. DM A said the ice machine was not clean. Food debris (collard greens) observed on the inside base of the drip tray was easily removed by DM A. - A full fruit cup, an empty plastic cup, a plastic cup lid, loose paper, and food debris was observed on the floor behind the ice dispenser and reach-in cooler.- Four ladles, hanging from a rack, were stored bowl side up. Each ladle was stained with dried food debris. DM A indicated they needed to be cleaned. On 8/14/25 at 12:33 PM the Nursing Home Administrator (NHA) said the kitchen should be clean and sanitary.On 8/18/25 at 12:50 PM, the NHA and Director of Nursing were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey and they reported there was none.A review of the 2013 FDA (Food and Drug Administration) Food Code revealed the following:Section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) Equipment food-contact surfaces and utensils shall be clean to sight and touch. (B) The food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.Section 4-602.11. Equipment Food-Contact Surfaces and Utensils. Equipment food-contact surfaces and utensils shall be cleaned (5) at any time during the operation when contamination may have occurred.Section 4-602.13, Nonfood-Contact Surfaces, Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>Based on observation, interview, and record review, the facility failed to properly dispose of rubbish and maintain cleanliness of the outside garbage area, resulting in a visually unappealing property and the potential for harborage of pests. Findings include: Based on observation, interview, and record review, the facility failed to properly dispose of rubbish and maintain cleanliness of the outside garbage area, resulting in a visually unappealing property and the potential for harborage of pests.Findings include:On 8/13/25 at 11:16 AM, the outside dumpster area was observed with Dietary Manager (DM) A. Three dumpsters were in this area. The half lid on dumpster one was flipped open. Dumpster two was pushed up against dumpster three which prevented the lid on dumpster three from closing. Trash and debris of various types and mounds of decaying leaves were piled up behind the dumpsters. A lid from a 55-gallon trash can was wedged underneath dumpster three. The lid of a 55-gallon trash was not fully closed. A pool of standing water was observed on the lid of a large gray square plastic trash container positioned on a dolly. A small cream-colored trash can was positioned on the lid of the square gray container. DM A stated, This area needs to be clean up.On 8/14/25 at 12:33 PM, the Nursing Home Administrator (NHA) said staff were to make sure the lids to the garbage containers were closed and nothing was on the ground around the garbage cans.On 8/14/25 at 2:28 PM, the NHA indicated the facility did not have a policy for maintenance of the outside grounds specifically the outside garbage area.On 8/18/25 at 12:50 PM, the NHA and Director of Nursing were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey and they reported there was none.A review of the 2013 FDA (Food and Drug Administration) Food Code revealed the following:Section 5-501.110 Storing Refuse, Recyclables, and Returnables: Refuse, recyclables, and returnables shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents.Section 6-501.114 Maintaining Premises, Unnecessary Items and Litter: The premises shall be free of: (B) Litter. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Keep all essential equipment working safely.<br><br>Based on observation, interview, and record review, the facility failed to ensure consistent proper working order of the handwashing sink faucet, commercial ice dispenser, and walk-in freezer which had the potential to affect all residents that eat from the kitchen. Findings include:During the initial tour of the kitchen on 8/11/25 at 8:15 AM with Dietary Manager (DM) A the following was observed, the faucet for the handwashing sink did not shut off completely, dripping water was observed coming from the commercial ice dispenser drainage pipe, and the internal temperature of the walk-in freezer was observed to be 12 F (Fahrenheit). A four-ounce cup of ice cream stored in the freezer was observed soft, not frozen solid. The AM recorded temperature on the freezer temperature log for 8/11/25 was 8 F. DM A said he will contact maintenance.During an interview on 8/11/25 at 10:23 AM, Maintenance Director (MD) B said he was unaware of any current leaks in the kitchen. MD B said he fixed a leaky drainpipe on the handwashing sink in the kitchen a while ago but did not know the handwashing sink faucet did not fully shut off or that the pipe behind the ice machine was leaking.On 8/14/25 at 12:33 PM the Nursing Home Administrator (NHA) said she expects the kitchen to be fully functioning.A review of the 2013 FDA (Food and Drug Administration) Food Code revealed the following:Section 3-501.11. Stored frozen foods shall be maintained frozen.Section 4-501.11. Good repair and proper adjustment. (A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2On 8/18/25 at 12:50 PM, the NHA and Director of Nursing were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey and they reported there was none. |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain consent for psychotropic medications (drugs that affect behavior, mood, thoughts, or perception) use for two residents (R2, R4) out of five residents sampled for unnecessary medications. Findings include:<br><br>R2<br><br>Record review of R2's Electronic Health Record (EHR) revealed admission to the facility on 6/11/25 with diagnoses which included aftercare following Joint Replacement Surgery, Major Depressive Disorder, and Neurocognitive Disorder with Lewy Bodies (dementia).<br><br>Review of R2's Brief interview for Mental Status (BIMS) assessment performed on 7/7/25 revealed a BIMS of 12/15 moderately impaired cognition. R2 had guardianship appointed on 12/13/24.<br><br>Review of the physician orders revealed Trazadone and Citalopram Hydrobromide (antidepressants/psychotropic medications) were ordered on 6/12/25.<br><br>Review of R2's care plan revealed At risk for adverse effects related to use of antidepressant medication. Date initiated 6/12/25.<br><br>Review of the Psychiatric Consultation form dated 6/17/25 revealed a declination of services signed by R2's guardian.<br><br>Review of the Psychotropic Medication Consent form dated 6/17/25 revealed, R2 was provided education and consented to the psychotropics. There was no record of consent from the guardian.<br><br>On 8/14/2025 at 11:51 AM, Social Worker (SW) J was interviewed and stated, I didn't get the psychotropic medication consent signed by the guardian. I should have.<br><br>R4<br><br>A review of the clinical record for R4 documented an original admission date of 10/18/23 and readmission date of 4/23/24. R4's diagnoses included vascular dementia, delusional disorders, major depressive disorder, and psychotic disorder with delusions. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment. R4 was prescribed Depakote on 2/19/25 by Psychiatric Nurse Practitioner DD. The chart review revealed the psych medication consent form dated 3/19/25 did not include Depakote. Record review of R4's care plans documented the following: Behavior management new repetitive behavior related to history of vascular dementia with severe agitation and psychotic disorder with delusions due to known physiological condition, and The resident has a mood problem related to major depressive disorder, psychotic disorder, cognitive, social and emotional deficit following cerebrovascular accident, adjustment disorder with anxiety adjustment insomnia.<br><br>Current orders documented the administration of Depakote sprinkles oral capsule delayed release sprinkle 125 mg (milligrams). Give 1 capsule by mouth two times a day for Mood disorder. Dated 4/24/25.<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/13/25 at 1:51 PM, the clinical record for R4 was reviewed with Social Worker (SW) J. SW J indicated R4 was put on Depakote for behaviors and should a medication be used for behaviors there needs to be a consent. SW J said a consent for Depakote signed by R4's resident representative was not obtained until 8/7/25.<br><br>On 8/13/25 at 3:07 PM, SW J reported that a review of psych notes confirmed that there were no notes that the psych practitioner discussed the use of Depakote with the resident representative.<br><br>On 8/14/25 at 2:12 PM, the Nursing Home Administrator (NHA) stated that the social worker should have made sure a consent for psychotropic medication use was signed. It is their responsibility to get consent. The social worker and prescribing medical provider are responsible for reviewing the risks and benefits with the resident if able or their resident representative.<br><br>A review of the facility policy titled, Psychotropic Medication Use, dated 4/18/25 documented in part the following, The facility will identify when a resident is prescribed a psychotropic medication and will obtain informed consent from the resident or authorized representative for each psychotropic medication ordered.<br><br>On 8/18/25 at 12:50 PM, the NHA and Director of Nursing were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey and they reported there was not. |

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

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

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

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| Optalis Health and Rehabilitation of Canton | 7025 Lilley Road<br>Canton, MI 48187 |

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|---|---|
| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | narcotic book. The DON added that Nurse AA called around 10A.M. on 6/21/2025 and stated that they called pharmacy due to R1 was out of Oxycodone. The DON said that pharmacy indicated that they delivered 60 Oxycodone on 6/16/2025 and R1 should have enough Oxycodone in the cart. The DON then said she called the pharmacy and ordered Oxycodone to be taken from the Pyxis machine (an automated medication dispensing system used to streamline medication management and enhance patient safety.) At this time the DON revealed a report showing Oxycodone 10-325mg was removed from the Pyxis timed stamped at 12:02PM on 6/22/2025 and administered to R1.A review of R1's Medication Administration Record noted documentation on 6/22/2025 that the Oxycodone 10-325mg was administered at 10am; however, the Oxycodone 10-325mg was not available at that time according to Nurse AA and the DON.On 08/12/2025 at 1:45 PM, the Nursing Home Administrator (NHA) was interviewed and queried about their expectation of Controlled Substance compliance. The NHA said, The Nurse staff must adhere to policies and procedures around controlled substance.A review of the facility's Abuse policy updated 5/24/2023 revealed the following: Residents have the right to be free from abuse, neglect, exportation, mistreatment, and misappropriation of resident property.The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written. |

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

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| | 235618 | A. Building<br>B. Wing | 08/18/2025 |

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| Optalis Health and Rehabilitation of Canton | 7025 Lilley Road<br>Canton, MI 48187 |

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|---|---|
| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | narcotic book. The DON added that Nurse AA called around 10A.M. on 6/21/2025 and stated that they called pharmacy due to R1 was out of Oxycodone. The DON said that pharmacy indicated that they delivered 60 Oxycodone on 6/16/2025 and R1 should have enough Oxycodone in the cart. The DON then said she called the pharmacy and ordered Oxycodone to be taken from the Pyxis machine (an automated medication dispensing system used to streamline medication management and enhance patient safety). At this time the DON revealed a report showing Oxycodone 10-325mg was removed from the Pyxis timed stamped at 12:02PM on 6/22/2025 and administered to R1.A review of R1's Medication Administration Record noted documentation on 6/22/2025 that the Oxycodone 10-325mg was administered at 10am; however, the Oxycodone 10-325mg was not available at that time according to Nurse AA and the DON.On 08/12/2025 at 1:45 PM, the Nursing Home Administrator (NHA) was interviewed and queried about their expectation of Controlled Substance compliance. The NHA said, The Nurse staff must adhere to policies and procedures around controlled substance.A review of the facility's Abuse policy updated 5/24/2023 revealed the following: Residents have the right to be free from abuse, neglect, exportation, mistreatment, and misappropriation of resident property.The facility will attempt to coordinate with State and Local law enforcement annually and as needed to determine which crimes are reportable. The facility will ensure that all allegations involving abuse, neglect, exportation, mistreatment, injuries of unknown source, misappropriation of resident property, and crimes are reported immediately to the Administrator and: Report to State Survey Agency immediately .and law enforcement . |

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

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| | 235618 | A. Building<br>B. Wing | 08/18/2025 |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Oxycodone. The DON said, I'm not sure who took the Oxycodone.It could be anyone at this point.I don't know I don't know I don't know. The DON stated that the narcotic sheet was also removed from the narcotic book. The DON added that Nurse AA called around 10A.M. on 6/21/2025 and stated that they called pharmacy due to R1 was out of Oxycodone. The DON said that pharmacy indicated that they delivered 60 Oxycodone on 6/16/2025 and R1 should have enough Oxycodone in the cart. The DON then said she called the pharmacy and ordered Oxycodone to be taken from the Pyxis machine (an automated medication dispensing system used to streamline medication management and enhance patient safety.) At this time the DON revealed a report showing Oxycodone 10-325mg was removed from the Pyxis timed stamped at 12:02PM on 6/22/2025 and administered to R1. The DON was asked if Agency Nurse V was interviewed and the DON stated she could not reach the nurse. The DON was asked if they notified the staffing agency that Agency Nurse V was being investigated for 30 tablets of Oxycodone 10-325mg. the DON said, No, we told (the staffing agency) that (Agency Nurse V) could not work at their facility anymore.A review of R1's Medication Administration Record noted documentation on 6/22/2025 that the Oxycodone 10-325mg was administered at 10am; however, the Oxycodone 10-325mg was not available at that time according to Nurse AA and the DON.On 08/12/2025 at 2:31 PM, the DON, Nurse Manager Q, and Nurse Manager E were interviewed and queried about the process of receiving medication from their pharmacy and signing narcotics into medication carts once received. The DON stated that on June 16, 2025, Nurse Manager E received three controlled substances cards: one card had 30 Clonazepam tablets and two cards with 30 tablets of Oxycodone that totaled 60 tablets on 6/16/2025 for resident R1. Nurse Manager E stated that two cards with 30 tablets of Oxycodone that totaled 60 tablets and one card had 30 Clonazepam tablets was received from pharmacy and she checked the medication and gave it to Nurse Manager Q. Nurse Manager Q stated that she received one card of 30 Clonazepam tablets and two cards with 30 tablets of Oxycodone that totaled 60 tablets and signed the medication into the medication cart. A review of the medication sheet did not indicate the medication name. Nurse Manager E stated that she did not verify the medication count sign-in on the narcotic sheet because it was not her cart. The DON stated that Nurse Manager E should have counted the controlled substance with Nurse Manager Q. A review of the narcotic medication sheet revealed illegible signatures. Nurse Manager Q was asked if the signature on the narcotic medication sheet was her signature. Nurse Manager Q stated several times that she was unsure if the signature was hers. Then Nurse Manager Q said after questioning, Well, yes it's my signature. The DON was asked when they identified that the medication was missing. The DON stated they were unsure. The DON stated that she did not notify law enforcement. A request for documentation of all staff investigated for the missing Oxycodone 10-325mg tablets was requested on 08/12/2025 at 2:31 PM. During the exit of this survey, the DON had not submit any requested additional information.On 08/13/2025 at 10:50 AM, Staffing Agency CC was interviewed by phone and asked if they were aware of the allegation against Agency Nurse V for 30 missing Oxycodone 10-325mg tablets. Staffing Agency CC said, No. We were only told that they (the facility) did not want (Agency Nurse V) working at their facility. Staffing Agency CC said they did not know anything about allegations of missing medications. Staffing Agency CC was asked when the last date Agency Nurse V worked at the facility. Staffing Agency CC indicated that that Agency Nurse V last date worked at the facility was on 6/16/25 on the midnight shift 7PM-7AM.On 08/13/2025 at 12:38 AM, Nurse AA was called and asked about when they became aware of the missing Oxycodone 10-325mg tablets. Nurse AA stated that R1 asked for their pain medication at 10AM and after checking the medication cart, there was not any Oxycodone 10-325mg available. Nurse AA said they called the pharmacy for a refill. The pharmacy told Nurse AA that the resident received a quantity of 60 Oxycodone 10-325mg tablets on 6/16/25, which was too soon for a refill. Nurse AA stated they called the DON related to the missing Oxycodone. Nurse AA was asked if 30 Oxycodone 10-325mg tablets was counted at the beginning of their shift on 6/22/25. Nurse AA stated that they counted the cart, it was accurate according to the narcotic sheet, and it did not appear to be missing Oxycodone.On 08/13/2025 at 1:45<br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PM, the Nursing Home Administrator (NHA) was interviewed and queried about their expectation of Controlled Substance compliance. The NHA said, The Nurse staff must adhere to policies and procedures around controlled substances.Sometimes nurses will leave before counting the cart if the incoming nurse is late.that is not how it should beA review of the facility's Abuse policy updated 5/24/2023 revealed the following: Residents have the right to be free from abuse, neglect, exportation, mistreatment, and misappropriation of resident property.Key to investigations 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.Identify and interview all involved persons, including the alleged victim, alleged perpetrator, witness an others who might have knowledge of the allegations. |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate transfer documentation was in place for one resident (R6) out of one resident reviewed for hospital transfer, resulting in the lack of information regarding resident's health status, safety, and transfer arrangements upon transfer from the facility. Findings include: A review of the admission Record for R6 documented an initial admission date of 6/18/25 and readmission on [DATE]. R6 was discharged from the facility on 8/5/25. R6's diagnoses included hemiplegia and hemiparesis following cerebral infarction, surgical aftercare following surgery on the nervous system, heart failure, aphasia following cerebral infarction, and adult failure to thrive. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment.On 8/12/25 at 9:52 AM, Unit Manager/Licensed Practical Nurse (UM/LPN) F said R6 was not in the facility (at the time of this interview) because he went out for a procedure on 8/5/25. A review of a physician's note dated 8/4/25 documented that R6 was scheduled for a cranioplasty on 8/5/25. UM/LPN F reviewed R6's clinical record and confirmed there was no transfer form, progress note, or physician's order regarding R6's transfer from the facility. UM/LPN F was unable to provide information on where R6 was transferred to on 8/5/25, the mode of his transfer, or his health status upon leaving the facility. UM/LPN F said nursing should have documented when he transferred out for a scheduled surgery.On 8/12/25 at 11:52 AM, the Director of Nursing (DON) said the nurse on shift was supposed to document when a resident transfers. This documentation was important for effective communication. The DON added that documentation provides a record of the resident's departure time and condition upon leaving. The DON said there should have been an order from the physician for the resident to go because the facility was responsible.A review of the facility policy titled, Transfers and Discharges, dated 3/20/24 documented in part the following:- Definition of transfer: refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility.- Initiated by the facility for medical reasons to an acute care setting such as a hospital, for the immediate safety and welfare of a resident.- Prepare the resident for physician ordered transfer to acute care facility to minimize anxiety and to ensure safe and orderly transfer.- Complete the hospital transfer form assessment in (the electronic health record).- Document assessment findings and other relevant information regarding the transfer in the medical record.On 8/18/25 at 12:50 PM, the Nursing Home Administration and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey and they reported there was none. |

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

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

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Pre-admission Screening and Annual Resident Review (PASARR - determines whether or not an individual who has a diagnosis of Mental Illness or Intellectual/Developmental Disability meets the criteria for a nursing home and their needs are met) Level I (3877) was completed for one resident (R4) out of two residents reviewed for PASARR screening. Findings include:A review of the clinical record for R4 documented an original admission date of 10/18/23 and readmission date of 4/23/24. R4's diagnoses included vascular dementia, delusional disorders, major depressive disorder, and psychotic disorder with delusions. A Minimum Data Set assessment dated [DATE] documented severe cognitive impairment. The PASARR document available in R4's clinical record was dated 7/19/24. This PASARR document indicated in part the following, The recipient may be admitted to or remain in the nursing facility and receive mental health services. Further PASARR Level II Evaluation are not required unless a significant change has been reported by the nursing facility. This does not alter the nursing facility's requirement for completing the Annual Level I (DCH-3877) or reporting significant changes to the CMHSP (Community Mental Health Services Program). On 8/12/25 at approximately 2:00 PM, the facility was requested to provide a current PASARR for R4. On 8/13/25 at 1:44 PM, Social Worker (SW) J provided a PASARR for R4 with a date/time stamp of 8/12/25 at 2:23 PM. SW J indicated the facility reached out to the corporate social worker regarding R4's PASARR because of the State Agency's inquiry made on 8/12/25. SW J said the PASARR was used to screen out mental illness in the resident, to determine if the resident needs specialized services, and to determine if a nursing home placement was appropriate. The PASARR was to be completed annually or if there was a significant change with the resident. SW J said R4's annual PASARR should have been completed by 7/19/25. On 8/14/25 at 1:42 PM the Director of Nursing (DON) said the social services department was responsible for completing the PASARR. On 8/14/25 at 2:09 PM the Nursing Home Administrator (NHA) said that R4's annual PASARR should have been done timely. The facility policy titled, Social Services, dated 3/10/25 was reviewed and revealed in part, The social worker, or social service designee, will evaluate and determine a resident's needs upon admission, quarterly, and as needed to promote a culture of respect, dignity, autonomy, and choice.On 8/18/25 at 12:50 PM, the NHA and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey and they reported there was none. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely pain management for one resident (R120) out of five residents reviewed for pain management, resulting in a shortened therapy session and resident pain and discomfort. Findings include:On 8/12/25 at 10:25 AM R120 was observed sitting in her wheelchair in her room. R120 said earlier in the morning a physical therapist came and took her to therapy before she was able to receive her pain medication. R120 said she was in therapy for only about 10 minutes because she was in severe pain.On 8/12/25 at 10:30 AM Licensed Practical Nurse (LPN) W said a therapist took R120 to therapy before pain medications could be administered. The therapist said they would bring her back in 40 minutes. LPN W said she prefers for R120 to get her meds before going to therapy.On 8/12/25 at 12:01 PM, the Director of Nursing (DON) said that it was not okay that R120 received therapy before she received her pain medications. The DON said both parties, therapy and nursing, should have had a conversation with each other to determine if the resident needed anything before receiving therapy. Nursing should practice time management and proper prioritization to make sure residents receive their pain medications timely.On 8/14/25 at 9:36 AM, the Director of Therapy (DT) G said therapist should ask residents if they are in pain and have they had their pain medicine. DT G said we proceed with therapy if the resident's pain is under control. If the resident's pain is not under control, we are to check with the nurse to see if they can have something for pain.On 8/14/25 at 9:43 AM, Physical Therapy Assistant (PTA) H said she started R120's therapy in the morning on 8/12/25. PTA H said she took R120 back to the resident's room after about 15 minutes because she (R120) was in pain. PTA H stated, I might have spoken with the nurse that morning then added that the nurse said she had not been able to give R120 her pain medications yet. PTA H said she completed R120's therapy in the afternoon.On 8/14/25 at 9:46 AM, a review of the R120's physical therapy note from PTA H dated 8/12/25 was conducted with DT G and revealed the Response to Treatment: Limited with activity by pain. DT G said there should have been separate notes if R120 was seen twice on 8/12/25 as indicated by PTA H. DT G indicated there are times when a resident has not been medicated prior to therapy and we offer conservative measures that might assist with pain, but this approach to pain management was not reflected in PTA H's note. DT G said there should have been two encounter notes, one for the first encounter and a second note that documented what happened in the afternoon when the PTA went back to the resident. DT G said the therapist should have checked with the nurse about pain medication and indicated she would come back to get the resident after R120 received her pain medicines. DT G said the therapist could have acknowledged that the resident had not received pain medications and then had a discussion about the resident receiving conservative pain measures if she was interested. DT G acknowledged that this was not documented.A review of the clinical record for R120 documented an admission date of 8/6/25 with diagnoses that included cancer of the lung and intrahepatic bile duct, pathological fracture, anxiety disorder, and neoplasm related pain. A Minimum Data Set (MDS) assessment dated [DATE] documented intact cognition. Record review of R120's care plans documented in part the following: At risk for pain and/or has pain related to chronic neoplasm pain, pathological fracture. Interventions included: Administer pain medication as ordered and assess for verbal and non-verbal signs of pain and treat accordingly. Initiated 8/7/25.A review of R120's Medication Administration Record for August 2025 documented the following for 9:00 AM medication administration: Lidocaine Maximum Strength 24 Hours external patch 4 %. Apply to lower back topically two times a day for pain. Start Date: 8/8/25 and Lyrica oral capsule 50 mg (Pregabalin). Give 50 mg by mouth three times a day for nerve pain. Start Date: 8/7/25. R120 was also prescribed Hydromorphone (Dilaudid) 4 mg. Give one tablet by mouth every four hours as needed for pain. Start date 8/8/25.On 8/14/25 at 1:45 PM, the Director of Nursing (DON) said therapy should have assessed R120 for pain before taking her to therapy.A review of the facility policy titled, Pain Management, dated 4/18/24, documented in part<br>(continued on next page) |

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| Optalis Health and Rehabilitation of Canton | 7025 Lilley Road<br>Canton, MI 48187 |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the following:- The individualized comprehensive care plan addresses the pain management program, the goal for pain management, individualized interventions to address the resident's pain and the plan for reduction or elimination of the resident's pain.- Licensed nurses will routinely evaluate the resident's pain using the appropriate standardized pain scale.On 8/18/25 at 12:50 PM, the Nursing Home Administrator and DON were asked if there was any additional documentation or information that the facility would like to provide prior to the end of the survey and they reported there was none. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>Based on interview and record review, the facility failed to provide morning meals for two residents (R62, R91) who attended dialysis out of three residents sampled for dialysis services. Findings include:R62On 8/11/2025 at 11:17 AM R62 and R62's spouse were interviewed regarding dialysis services and R62 said she wasn't given breakfast before or after dialysis nor a snack to take with her this morning. R62's spouse said he usually brings in something for his wife to eat since the facility doesn't provide anything in the morning for her.Record review of R62's Electronic Health Record (EHR) revealed admission to the facility on 7/17/25 with diagnoses which included End Stage Renal Disease, and Dependence on Renal Dialysis.Review of R62's Brief interview for Mental Status (BIMS) assessment performed on 8/1/25 revealed a BIMS of 11/15 moderately impaired cognition. Review of R62's physician orders revealed, Dialysis Treatment .Treatment days Mon, Wed, Fri pick up at 5:45 AM Ensure packed food if needed.Review of R62's care plan revealed, Focus The resident needs hemodialysis related to renal failure. Date initiated 7/18/25. Tasks Send meal/snack with resident to dialysis date initiated 7/18/25.R91On 8/11/25 at 11:06 AM, R91 was interviewed about dialysis services and stated, I'm not getting breakfast before or after dialysis. They don't send a snack with me. I'm tired and hungry and shouldn't have to wait for lunch.Record review of R91's Electronic Health Record (EHR) revealed admission to the facility on 7/7/25 with diagnoses which included End Stage Renal Disease, Severe Protein -Calorie Malnutrition and Dependence on Renal Dialysis.Review of R91's Brief interview for Mental Status (BIMS) assessment performed on 8/5/25 revealed intact cognition. Review of R91's physician orders revealed, R91 M-W-F (Monday, Wednesday and Friday) at 6AM pick up time 5AM dialysis.Review of R91's care plan revealed, Focus: The resident is at nutritional risk related to underweight BMI (body mass index) = 18.1, ESRD (end stage renal disease) on HD (hemodialysis), not wearing dentures. Date initiated 7/8/25. Goal: The resident will maintain adequate nutritional status. Date initiated 7/8/25. Tasks: Offer food and beverage selections. Date initiated 7/10/25.On 8/12/25 at 9:15 AM, Registered Nurse (RN) Y was interviewed and said the nurses' aides and nurses are responsible to provide a snack for the residents who go to dialysis. RN Y further said there are always premade sandwiches available in the kitchen and that it is the responsibility of nursing staff to ask residents if they would like a snack for dialysis. On 8/12/25 at 3:19 PM Registered Dietician (RD) Z was interviewed and said her recommendation is for residents who go to dialysis to get offered and sandwich/snack to take to dialysis.On 8/14/25 at 2:00 PM the Director of Nursing (DON) was interviewed and said the expectation is for the nursing staff to offer residents who go to dialysis a snack or meal prior to dialysis to take along to dialysis or upon return from dialysis.Review of the facility policy titled Hemodialysis reviewed date 10/1/24 revealed in part: The facility dietician or designee will monitor and document the resident's nutrition/hydration needs, including the provision of meals on days that dialysis treatments are provided which may include:Early meal service provided by the kitchen before dialysis transportation time.Meal or snack sent with resident to the dialysis facility.Late meal service provided by the kitchen after the resident returns from dialysis. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>Based on observation, interview and record review, the facility failed to ensure proper cleaning and disposal of loose medications were conducted per professional standards of practice for one medication cart (Cherry Hall Cart) of three medication carts observed for medication storage and cleanliness. Findings include On 08/12/2025 at 11:47AM, an observation and interview were conducted with Nurse M's Cherry Hall medication cart. Upon inspection of the medication cart, a total of 12 loose pills were scattered on the bottom of the second drawers. The loose pills varied in shapes, colors and sizes. In addition, the second drawer of the medication cart had a pack of cigarettes and dust.On 08/12/2025 at 11:55 AM, an interview was conducted with Nurse M regarding the loose pills, cigarettes and dust found in their medication cart (Cherry Hall). Nurse G said that the cart should be clean by dayshift and midnight nurses. On 08/12/2025 at 12:18 PM, an interview was conducted with the Director of Nursing (DON) regarding the 12 loose pills, cigarettes and dust found in Cherry Hall medication cart. The DON said that the nurse and nurse managers were expected to check and clean the medication carts on their units. A review of the facility's policy Medication and Treatment Storage in the Facility reviewed on 10/01/2024 revealed the following: Medication and Treatment carts will be kept clean of dirt, spillage, grime, and other foreign materials.Medication, treatments, biologicals, and supplies will be maintained per manufacturer guidelines. |