STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235626	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Troy	925 W South Blvd Troy, MI 48085

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Complaint #2596436Based on interview and record review the facility failed to ensure timely medical appointments and debridement treatments were implemented to prevent the worsening of a wound for one (R302) out of two residents reviewed for pressure ulcers/wounds resulting in R302 being hospitalized for additional care. Findings include:A complaint was filed with the State Agency (SA) that reported that R302 was scheduled to see their wound surgeon for treatment and the facility sent them to the wrong office. R302 then had to wait another week to see the wound surgeon. On 8/7/25 the wound surgeon examined them at their office, and they immediately sent them to the hospital.Hospital Records were reviewed and documented in part, .(name redacted) Emergency Department 8/7/25.History.R302.presents with evaluation of right foot wound. Patient underwent amputation with Dr. Z 7 weeks ago due to gangrene of his right fifth toe.Patient was seen by Dr. Z today (8/7/25) for wound care. There was concern for further necrosis and infection and patient was sent today for further evaluation. He has been taken to the operating room for debridement and possible 4th toe.amputation.8/8/25.Patient does not speak English.Patient has missed appointments but was seen at the Wound Center yesterday and due to extensive necrosis of the wound it was advised that the patient present to the hospital.the fifth metatarsal was debrided and the right forth toe was amputation <sic> and the head of the right fourth metatarsal was resected, the fifth toe had been amputated on a previous surgery.8/9/25.Patient having pain to right foot relieved with doses of dilaudid. Wound vac in place. Outcome evaluation: Pt AxOx4 (patient alert and oriented to person, place, time and situation), speaks Korean, CyraCom (interpreter) used for explaining discharge.Plan: start vancomycin 1250 mg (milligrams) q (every) 12 hours and Zerbaxa(antibiotic) .culture growing MDR (Multidrug resistant infection) Pseudomonas osteomyelitis (bone infection) and MRSA (Methicillin resistant staphylococcus aureus).A review of R302's clinical record revealed the resident was initially admitted to the facility on [DATE] with diagnoses that included: Gangrene, acquired absence of other right toe and orthopedic aftercare following surgical amputation. A review of the residents Minimum Dat Set (MDS) noted the resident had a Brief Interview for Mental Status (BIMS) score of 14/15.Continued review of R302's clinical record noted the following:6/23/25: Wound Consult: .Patient reports having had infection and drainage in right toes resulting in hospitalization. It <sic> was totally there for 2 weeks and ended up having amputation as well due to osteomyelitis. Patient is currently on IV (intravenous) ABX (antibiotics).wound benefit from continued rehab.6/23/25: Nursing Skin/Wound Note: .R (right) foot surgery 5-digit amputee, 6 sutures.see.assessment for measurements.7/1/25: Administration Note: Wound Care Order Site: Right 5th digit.Cleanse wound with NS (normal saline) .Pat Dry with Gauze.Apply betadine.Cover with ABD (large abdominal dressing).Wrap in kerlix.Tape7/6/25: Wound Consult: .Skin.Right dorsum fifth digit toe amputation site arterial/surgical wound, 3x5 x2.8 x1.1.100% granular.light serosanguineous drainage.no infection.Cleanse area, dry, apply iodine, cover with ABD, wrap with Kerlix, secure with tape daily. Offloading interventions implemented. Wife at bedside updated on wound status/treatment.7/14/25: Order: .Follow-up consult.Patient will need STAT follow-up.initially ordered on 6/24 for 1-2 weeks. *It should be noted that there were no documents that noted R302 was seen by wound consultant within the two-week order.7/17/25: After Visit Summary: R302.7/17/25: 2 PM.Address A.Instructions: Return in about 2 weeks (around 7/31/25).Dressings: Right foot wound. Betadine to gauze, apply to wound cover with 4x4 gauze wrap with kerlix, affix with tape.Sutures removed. Today.Return visit in 2 weeks 7/31/25).7/25/25: Nursing Skin/Wound: Writer contact daughter for wound care concerns regarding pt (R302) waiting for a call back. Authored by Nurse I.7/25/25: Order: Wound care order site - Right foot 5th digit.cleanse wound with NS.Pat Dry with Gauze.Apply Medihoney to wound bed.Created by: Nurse I (7/25/25).Signed by Physician L on 8/6/25.7/30/25: Nursing Skin/Wound: .wound care education was preformed and given with daughter at bedside, writer explain all instructions to family and told them pt. attempts to do is own wound care tx (treatment) and is delaying process of healing, family understood and talk to pt to re direct Him, pt see wound clinic tomorrow 7/31 and writer will follow up.7/31/25: Wound Consult: .Right dorsum fifth digit toe amputation site.3.5x2.8x1.1, 100% granular peri wound, lift serosanguineous drainage.7/14: Continue Vanco (*It should be noted that R302 never received Vanco while at the facility. No order was found in the clinical record).Also indicate that patient will need to see podiatry for wound care and debridement.[electronic medical record] indicates the patient has an appointment with wound clinical today (7/31/25) today at 2:15 (PM). Authored by Nurse Practitioner (NP) M. *It should be

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2597366Based on interview and record review, the facility failed to ensure appropriate supervision was provided to a resident for one (R303) of two residents reviewed for transportation resulting in R303 being sent multiple times to medical appointments with no staff supervision. Findings include:A complaint was filed with the State Agency (SA) that alleged in part, .On 8/14/2025. (R303) was sent to the appointment and left in the lobby of the doctor's office without any caretaker from the facility.Review of the clinical record revealed R303 was admitted into the facility on 4/11/25 and readmitted [DATE] with diagnoses that included: dementia, convulsions and blindness right eye. According to the Minimum Data Set (MDS) assessment dated [DATE], R303 had moderately impaired cognition. The clinical record also indicated R303 had a Durable Power of Attorney (DPOA) that was the Responsible Party for financial and medical care. Review of a Physician Statement of Capacity for Medical Treatment and Decisions read in part, lacks the capacity to make reasoned medical decisions and/or provide informed consent for their medical affairs. The specific cause and/or contributing diagnosis to support this decision: impaired insight, impaired reasoning, impaired thinking and memory. It was signed by a Physician/Licensed Psychologist on 3/25/25 and Attending Physician on 3/26/25.Review of R303's physician orders revealed an order with a start date of 8/14/25 that read in part, PATIENT HAS AN APPOINTMENT ON THURSDAY AUGUST 14 @ 2:00 PM.Review of R303's Discharge Care Plan initiated 4/15/25 read in part, DPOA has decided that (R303) is appropriate for long term care placement, discharge plan is to remain long term for 24* care and/or supervision.Review of R303's physician consultation documents revealed a consult dated 7/30/25 that the consulting physician wrote, pt (patient) sent to office twice with no records, no information. She is not able to provide medical history. She does not know why she is here. Someone MUST (underlined) accompany here [sic] to appointments. On 9/4/25 at 12:05 PM, Unit Clerk (UC) F was interviewed and asked who arranged the transportation to appointments at the facility. UC F explained she made the appointments and arranged the transportation. UC F was asked if residents always were sent by themselves or did a staff member accompany them to appointments. UC F explained up until a couple weeks ago, they had been told staff did not accompany residents to appointments, now if the resident is incompetent a staff member goes with them. UC F was asked how it was determined if a resident was incompetent. UC F explained she would go talk to the resident or ask staff if the resident was competent. UC F was asked if R303 went to appointments alone. UC F explained R303 was sent alone.On 9/4/25 at 12:15 PM, Unit Manager (UM) C was interviewed and asked if residents went alone or were accompanied by staff on appointments. UM C explained it depended, if the resident was competent they could go alone. When asked about R303, UM C explained she could not say and would need to talk to the Director of Nursing (DON).On 9/4/25 at 12:17 PM, the DON was interviewed and asked about R303 being sent to appointments alone. The DON explained she had thought R303's family was going to meet her at the appointment. The DON was asked if the facility had its own transportation van with a staff member that drove it. The DON explained they did not, they used different companies that provided wheelchair transportation. The DON was asked if R303 could go on a Leave of Absence (LOA) by herself. The DON said no. When asked why was R303 allowed to be put in a transportation van by herself and leave the facility with no staff accompaniment, the DON acknowledged the concern. On 9/4/25 at 1:13 PM, the Administrator was interviewed and asked about R303 having a care plan for 24-hour care and/or supervision but was sent to multiple appointments via a transportation van by herself with no staff accompaniment. The Administrator acknowledged the concern.