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	12/30/2025

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 Note: The nursing home is disputing this citation.	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: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to complaint 2689220 Based on interview record review, the facility failed to provide timely on-going assessment and intervention for one resident (R401) of one reviewed for change of condition resulting in a hospitalization to rule out stroke (CVA). Findings include:A complaint was submitted to the State Agency (SA) on 12/8/25 that alleged the facility did not get the resident to scheduled doctor appointments causing a delay in treatment for CVA, neck fracture and wounds that were not reported nor treated. On 12/30/2 at 9:30 AM, a phone interview was conducted with family member (FM A), who reported that in February they had went to visit R401 and the resident reported to them that they were having a stroke. FM A reported that they told the facility, but nothing was being done and the facility delayed giving R401 the proper care and treatment. FM A also reported that the facility made R401 miss their schedule neurology appointment two times and when they finally were able to see the neurologist, they sent them to the hospital to rule out stroke and obtain a cat scan (CT). FM A reported that the day they went to see R401, their left side was very weak and they were no longer able to walk. They also stated that the physical therapy department left a voicemail stating the significant change in condition in the function. A review of the record revealed that R401 was admitted to the facility on [DATE] with the diagnosis of TRANSIENT ISCHEMIC ATTACK (TIA), AND CEREBRAL INFARCTION WITHOUT RESIDUAL DEFICITS, ENCEPHALOPATHY, UNSPECIFIED and ESSENTIAL (PRIMARY) HYPERTENSION. With a Brief interview for mental status score (BIMs) of 12 which indicates mild cognitive impairment. A review of the record revealed a progress note on 2/27/25 from the nurse taking care of R401 at 10:36 AM which read : Pt (Patient) received in bed a&O (alert and oriented) to baseline, pt stated he felt as if he was having a stroke. pt stated he had tingling to L (left) arm, and can't grab anything with L hand. L hand grasp weak pulse strong. Pt denied dizziness, headache, nausea, blurred vision, numbness to face. Speech is clear, no facial drooping or drooling and no difficulty swallowing. BP (blood pressure) 175/81 HR (heart rate) 64 R (respirations) 18 even and unlabored. NP (Nurse Practitioner) notified. A further review of the record revealed a progress note on 2/27/25 at 11:58 AM from the Nurse Practitioner (NP) which read in part: .Seen at patient request because concerned he is having stroke Called to bedside by staff to evaluate patient as patient states he is concerned he is having a stroke. Patient is unable to elaborate on what the signs are beyond having some new weakness. Patient appears to be at baseline mentation of [NAME] x 2. No changes in mentation or physical presentation noted by nursing staff . Order for one-time vital now placed into [EMR-electronic medical record]. Recommend every 2 to every 4 hours blood pressure monitoring for the time being. Can DC (discontinue) in 24 hours On 12/30/25 at 12:36 PM, an interview with the Director of Nursing (DON) was conducted. The DON was asked what the facility's expectations for someone experiencing stroke like symptoms. The DON reported that the expectation is to assess the resident and if they are having new symptom, send them out immediately because it is time sensitive being that we can not treat strokes in the facility. The DON was asked did the facility have a STROKE protocol or policy, she replied, no. The DON was then asked, why was R401 not sent to the hospital if they had stated they were having a stroke the DON reported, that they should have been sent out for further evaluations since the facility did not have the proper equipment to treat such acute conditions. The DON was also asked where the documentation (the added blood pressure monitoring) that was recommended by the NP found? The DON reported that the facility did not do any follow up on the suspected change in condition. The DON was asked about R40's missed scheduled neurology appointments. The DON reported they would investigate the missed appointments. On 12/30/25 at 1:22 PM, the NP B was called via telephone and interviewed. The NP B was askedif someone complains of having a stroke, what would be done? The NP B reported that they would assess them and see if there were any signs of a stroke. The NP was then asked, for R401, who has a history of strokes and felt as though they were having one, with new onset of left sided weakness, if they should have been further evaled? The NP B explained a new onset of left sided weakness was not considered a stroke symptom and that there needed to be more than one change to be considered a stroke. The NP B was then asked did she reassess or inform the medical provider of R401's new change in condition. The NP B replied I do not know. A Review of the Hospital paper work documented that on 3/27/25 at 6:32 PM a CT of the brain was completed it read in parts Provided History: [AGE] years old Male Neuro deficit, acute, stroke suspectedTechnique: CT imaging of the brain was performed from the skull base to the vertex without contrast.Findings:1. No acute intracranial