STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235626	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/02/2026

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 0600 Level of Harm - Actual harm Residents Affected - Few	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 pertains to Intake: 2746350.Based on observation, interview and record reviews the facility failed to protect Residents' (R's 64 & 65) right to be free from sexual abuse by another resident (R66) for three of three residents reviewed for abuse, resulting in inappropriate and unwanted sexual contact that would cause the reasonable person severe psychosocial harm (feelings of being violated, embarrassment, humiliation, fear & worthlessness) as a result of the sexual abuse. Findings include:A review of a Facility Reported Incident (FRI) documented that Certified Nursing Assistant (CNA) A observed R66 in the bed of R65 with their hands down the front of the brief of R65. The report went on to note that both residents' were immediately separated and R66 was immediately placed on increased supervision.A review of the medical record revealed R66 was admitted to the facility on [DATE], with diagnoses that included: Parkinson's and dementia. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 5 (which indicated severely impaired cognition).Further review of the medical record noted R66's daughter to have been appointed full guardianship due to R66 to have been deemed legally incapacitated.On 3/2/26 at 8:12 AM, R66 was observed sleeping in bed. CNA C was observed in a chair next to R66. CNA C confirmed that they were scheduled to be R66's one on one for the duration of their shift. R66 did not wake up with verbal stimuli.A review of the progress notes revealed the following:On 10/3/25 at 8:13 AM, a Nursing note documented Resident does not sleep well. Resident is up throughout the night wandering and calling out for his spouse, enters others resident rooms and space causing them to be upset.On 11/9/25 at 5:25 PM, a Nursing note documented Resident stumbled into another residents room looking for his wife. The other resident grew upset due to the language barrier and threatened the resident to get out of the room. Writer and staff entered the room to separate the residents and interview both regarding what happened. The other resident threatened to Kick his ass with the cane if he didn't get out now. Both residents were assessed for any signs of injury. Both residents redirected. Supervisor notified of the incident.On 11/9/25 at 9:26 PM, a Nursing note documented . Resident was looking for his wife and went into room [ROOM NUMBER] because he believed that was her room. advised him that his wife isn't in there and to ask a nurse next time because the resident that is in that room don't know him. spoke with the other resident as well who stated he was fine.On 11/14/25- a Nursing note documented that R66's wife passed away in the facility.On 11/30/25 at 2:29 AM, a Nursing note documented Resident has been anxious and restless since beginning of shift. Flooded bathroom, hasn't slept, entering roommates space, making him upset.On 1/9/26 at 10:00 PM, a Nursing note documented- Writer heard something pouring in resident room, when writer approached, he had his penis out urinating on the floor. Writer got materials to clean/dry up urine for resident wouldn't fall. Writer administered meds and he spit out meds in hand. Resident wouldn't allow BS (blood sugar) to be drawn. Resident grabbed writer breast about six times while trying to provide care. He continued to laugh and yell something we couldn't understand. This note was documented by LPN B.On 1/11/26 at 9:00 PM, a Nursing note documented Resident received in room picking in trash can. Resident was roaming and entering other resident's rooms and (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 0600 Level of Harm - Actual harm Residents Affected - Few	bathrooms. Tried to get in bed with resident next door. Resident hit writer on rear end and laughed. Resident also urinated on floor as if he was standing over the [NAME]. This note was documented by Licensed Practical Nurse (LPN) B. This note was documented by LPN B.On 1/19/26- a Nursing note documented that R66 was transferred to another unit.On 2/3/26 at 8:38 AM, a Nursing note documented Pt (patient) is wandering at night into different residents rooms. He is being redirected all night.On 2/4/26 at 2:41 AM, the Director of Nursing (DON), documented . Writer notified via telephone of inappropriate resident-to-resident contact observed by staff during routine rounds. Writer was not physically present in the facility at the time of the incident. Writer provided direction to staff. Administrator & MD (Doctor) notified. Resident placed with 1:1 supervision. Care plans updated.On 3/2/26 at 10:45 AM, the Administrator was asked to provide all resident to resident incident reports that pertained to R66- from admission to 3/2/26.One incident report was provided by the Administrator.A review of the incident report provided revealed the following, . 2/4/26 at 12:01 AM. Writer was made aware by Cna (Certified Nurse Assistant) that resident was in another residents room. Writer removed pt from hallway and called management. Skin assessment was obtained on both pt, no rare findings. Family was contacted and resident was put on 1 on 1. Resident unable to give description. Resident was brought to the common area and placed on 1-on-1. No injuries observed at time of incident. CNA stated that resident was lying in bed during rounding and she seen another resident which is a male in the bed with the resident. The other resident had his hand in the resident brief.On 3/2/26 at 1:44 PM, LPN B was interviewed and asked about the 1/11/26 incident with R66 trying to get into the bed of another resident. LPN B replied they were in the middle of passing medications and noticed that (R66) was not in their room. LPN B went into R64's room and observed R66 attempting to get into the bed with R64. LPN B stated R66 was holding R64's bed blanket in their right hand, while attempting to get into R64's bed. LPN B stated they observed R64 shaking their blanket and pulling the blanket in attempts to get R66 away. LPN B stated they immediately took R66 back to their room. When asked, LPN B stated R66 used a wheelchair to get around but also walked without the wheelchair which was a concern because R66 was known to wander into other resident rooms. LPN B was then asked about R66's sexually focused behaviors and replied R66 is known to wander into female resident rooms, make sexual remarks to female staff and continues to do so, which is why they felt it was important to document it. LPN B stated the Administration staff had never followed up on their concerns or documentation in R66's record until after the 2/4/26 incident. LPN B expressed their frustration of the lack of support with the Administration staff regarding R66's wandering and sexual behaviors.A review of the medical record revealed R65 was initially admitted to the facility on [DATE], with diagnoses that included: dementia, anxiety and adult failure to thrive. A MDS assessment dated [DATE], noted severely impaired cognitive skills for daily decision making.Further review of the medical record noted R65's son as their guardian.On 3/2/26 at 2:35 PM, R65 was observed laying back in a geri chair in the hallway across from the unit nurse station. An interview was attempted with R65, however unsuccessful. R65 did not make eye contact when spoken to and did not respond to their name or any questions asked.A review of the care plans revealed no implementation of interventions for R66's wandering or sexual behaviors until 2/3/26, that noted staff to sit outside R66's room from 11 PM to 7 AM. This intervention was not effectively conducted by staff as it did not prevent the incident on 2/4/26 that occurred with R65.On 3/2/26 at 10:47 AM, CNA A was interviewed and asked about the incident with R66 and 65 on 2/4/26. CNA A stated they were doing their rounds and turned the light on in (R65's room) and observed R66 in the bed with R65, with R66's hand down the front of R65's brief. CNA A stated they screamed for the nurse and Nurse (LPN D) arrived and helped to remove R66 from the room. CNA A stated they stayed with R65 to observe their skin and change their brief. CNA A stated R65 is non-verbal and did not respond, however R66 was yelling and upset . because I caught him. CNA A stated R66 has a language barrier and they were unable to understand what they were yelling about. CNA A stated they did not remember to have used the language translation system or devices to communicate with R66 after the (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	incident.On 3/2/26 at 11:08 AM, LPN D was interviewed and asked about the incident with R's 66 and 65 on 2/4/26. LPN D explained they were at the nurses station when (CNA A) came to get them and stated (R66) was in the bed with another resident. LPN D stated when they arrived to (R65's) room they observed R66 in the bed with R65, however did not witness R66's hands down the brief of R65. LPN D stated R66 initially refused to get out of the bed and was upset, however they were able to get R66 back into their wheelchair and out of the room. When asked, LPN D stated they usually communicate with the resident through the translate on their personal cellphone but did not remember using it to ask R66 about the incident.On 3/2/26 at 12:12 PM, the facility's camera footage of the 2/4/26 incident was reviewed with the Administrator, Director of Nursing (DON) and survey team in attendance.The camera footage revealed no staff stationed outside of R66's room from 11 PM as noted as an intervention on the care plan. R66 was observed on the camera coming out of their room in a wheelchair at 10:43 PM. R66 looked up and down the hallway before entering the room of R65. CNA A is observed to identify R66 in the room and bed of R65 with their hands down their brief at 11:59 PM (more than an hour after entering the room). CNA A leaves R66 in the bed with R65, exits the room to obtain assistance from another staff member to help remove R66 from the room. Shortly after, CNA A and the second staff member are seen entering the room.On 3/2/26 at 12:25 PM, the Administrator (who serves as the facility's Abuse Coordinator) and the DON was interviewed and both were asked about the numerous documentation in R66's medical record that identified behaviors of wandering into other resident rooms & sexually focused behaviors, which had not been identified to be a concern with interventions implemented to protect other residents prior to 2/3/26. The Administrator explained that after the 1/11/26 incident the IDT (interdisciplinary team) met and thought it was a good idea to move R66 away from R64 and onto another unit. The Administrator and DON was asked to confirm that the facility's IDT team met and felt it was a good idea to move R66 to the unit where the majority of the facility's most vulnerable resident's (Alzheimer's and dementia) resided. The Administrator stated as far as they knew R66's wandering . wasn't a repetitive habit and wasn't a night thing and easily redirectable. The Administrator was asked if they reviewed R66's progress notes that reflected the multiple identified wandering incidents and the Administrator stated they had specifically asked the staff.Review of a facility policy titled Abuse revised 5/24/23, documented in part . Residents have the right to be free from abuse. Prevention consists of facility systems designed to detect, identify, correct, and prevent the occurrence of abuse. Completing ongoing assessments and care planning for appropriate interventions, and monitoring of residents with behaviors, including but not limited to. Sexually aggressive behavior (inappropriate touching, grabbing, saying sexual things etc. Wandering into other's rooms or space. communication disorders or those who speak a different language. and those that are dependent upon staff for care.On 3/2/26 at 3:34 PM, a telephone interview was conducted with the Guardian E of R65 and their spouse (with the approval of the guardian). Guardian E and their spouse was asked about the incident with R65 and R66. Guardian E 's spouse stated they were informed that a man had been found in the bed with their mother. When asked if they were informed of the man to have had their hands down the brief of their mother, Guardian E and the spouse stated they were not informed of that. The spouse stated the facility notified them that a man was found in the bed with their mother and they had since removed the man to another floor and unit to protect their mother. Guardian E and the their spouse stated they were worried about their mother and other resident's well-being with the man resident. When asked how they felt their mother would have reacted to this incident if they were in right mind, they stated in part . No, she would have not (consented to the sexual act) and she would have been very upset. Guardian E and their spouse stated . We didn't put her there for her to be abused. Guardian E and their spouse stated they declined to prosecute when the police contacted them because the facility said that they handled the situation, moved the resident and assured them that it would not happen again.No further explanation was provided by the Administrator or DON before the end of the survey.