| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 235626 | A. Building<br>B. Wing | 06/16/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Optalis Health and Rehabilitation of Troy | 925 W South Blvd<br>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) |
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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 3040204.Based on observation, interview and record review the facility failed to ensure adequate supervision for a resident with dementia, failed to timely implement adequate elopement interventions and failed to ensure all staff received adequate elopement training for residents that wear a monitoring device, for one (R307) of three residents reviewed for elopements, resulting in an Immediate Jeopardy (IJ). The facility failed to ensure the safety of R307 when the resident was allowed to leave the facility unnoticed wearing a monitoring alarm device, without staff knowledge of the elopement, until notified by the family. The resident entered into the car of a stranger and was transported approximately 11 miles away from the facility placing the resident at risk for serious harm, injury, and/or death.The IJ was identified on 6/16/26.The IJ began on 5/30/26.The Administrator was notified of the IJ on 6/16/26 at 2:52 PM, and a plan of removal was requested.The IJ was removed on 6/9/26 based on the provider's implementation of removal and verified onsite on 6/16/26. Although the immediacy was removed the facility's deficient practice was not corrected and remained isolated with the potential for harm that is not immediate jeopardy.Findings include:A review of a Facility Reported Incident (FRI) submitted to the State Agency (SA) documented in part, . On 05/30/2026 at approximately 7:20 PM, (Licensed Practical Nurse - LPN A name) was unable to locate Resident (R307 name) during shift change. Within approximately five minutes, the residents daughter. called the facility to report that (R307 name) had arrived at her former home address. (R307 name) had exited the facility without staff awareness. 5:34 PM. camera footage shows Resident (R307 name) pushing the elevator button. 5:34 PM. camera footage shows Resident (R307 name) exiting the elevator onto the first floor headed towards the front door. it is presumed that Resident (R307 name) exited via the front door while the two visitors were entering (tailgating through an already open door. Resident was wearing a (monitoring alarm device) upon return. The device alarmed appropriately when she entered the building. Contributing Factors. Thorough elopement education of front desk staff possibly not provided at time of hire. Testing confirmed the (monitoring alarm device) is functioning properly.A review of the medical record revealed R307 was admitted to the facility on [DATE] with diagnoses that included: dementia and unsteadiness on feet. A Minimum Data Set (MDS) assessment dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 6, which indicated severely impaired cognition.A review of the preadmission hospital documents provided to the facility upon R307's admission documented in part . Hospital Problems. (Principle) Altered mental status. dementia w (with)/superimposed delirium 2/2 (secondary to) change in environments (pt (patient) has been recently staying w/daughter and now in hospital). s/p (status post) sitter, restraints. Present to EC (emergency care) with worsening of over all dementia symptoms. The patient lived with her husband who was taking care of her. One week ago the house got on fire due to the old furnace, and the couple had to move in with their daughter. Pt's husband had to be hospitalized which made a change in pt's life even more traumatizing. Her dementia now has more episodes of aggression, she stopped sleeping. For her safety and well being she would need to be placed in a place providing care for people with advanced<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 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | dementia. Impression/plan. Pt with worsening dementia requiring placement in a Memory care.On 6/16/26 at 8:09 AM, R307 was observed sleeping in bed and was unable to be awakened by verbal stimuli. Certified Nursing Assistant (CNA) B was observed sitting in the room. When asked, CNA B explained they were assigned to watch over both residents that resided in the room. An observation of R307 revealed a monitoring alarm device around their right ankle.A review of a facility document titled Physician Statement of Capacity for Medical Treatment and Decisions with the attending Physician signature noted on the date of 2/19/26, noted the resident . 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: Dementia. The lack of capacity activated the resident's Durable Power of Attorney for Health Care that documented R307's husband and two daughters as their patient advocates.On 6/16/26 at 8:48 AM, an interview was conducted with R307's Daughter C. Daughter C reported around approximately 6:30 PM on 5/30/26 their mother was in the living room of their uncle's home. Daughter C stated their uncle called their dad and said . Your wife is in my living room. Daughter C stated their sister and dad went to their uncle house to get their mother. Daughter C explained their uncle resided on the same street that their parents' home was before the fire. Daughter C reported their sister called the facility to inform them that they had their mother around 7:00 PM. Daughter C confirmed that neither themselves, their sister or father was informed by the facility staff of their mother to have been identified as missing. Daughter C said when their sister called the facility staff had not realized that R307 was missing. Daughter C reported that a female stranger picked their mother up from the side of the road and drove her to the street of her mothers old address. Daughter C reported when their sister (Daughter J) brought their mother back to the facility and R307 walked through the front door the monitoring alarm device previously placed on the resident by the facility staff triggered the alarm.On 6/16/26 at 10:12 AM, an interview was conducted with R307s daughter - Daughter J. Daughter J explained that her and her dad were leaving a funeral when they received a call from her uncle informing them that her mom was in their uncle's living room. Daughter J stated at approximately 7:00 PM, they called the facility and talked to the Nurse and asked them if they were missing a patient. Daughter J stated . they had no idea that she was missing at that time. When asked Daughter J believed it was the Nursing Supervisor they had talked to. Daughter J stated the Nurse told them they would check on it and call them back. Daughter J said they brought their mom back to the facility at 7:30 PM. Daughter J stated . I just want to know how she got out with a (name of the monitoring alarm device) on. What if she would have got hit by a car? A passer by picked her up. I mean, come on. She has no safety awareness. Daughter J went on to explain that their parent's had a house fire in January and her parents started living with her. Daughter J stated their mother (R307) was not sleeping at night and her dementia had gotten worse. Daughter J stated they took their mom to the hospital for help to find placement for a secure facility that could care for her properly.On 6/16/26 at 8:15 AM, a request to Nurse Manager (NM) D was made to provide the surveyor with one of the facility's monitoring alarm device. Once provided, a walk through the second unit hallway to the elevator revealed no triggering alarm. Upon exiting the elevator onto the first floor hallway, towards the facility front door, no alarm triggered. The Front Door Receptionist (FDR) F was asked to buzz the front door open to allow Maintenance Director (MTD) E to walk through. MTD E was observed to have walked through the front door and the surveyor followed with the monitoring alarm device in hand, which triggered the facility's alarm system to go off. MTD E returned back into the facility and was observed to input a number in the keypad which silenced the alarm system.On 6/16/26 at 10:45 AM, Receptionist (RT) G (the receptionist that was on duty at the time of R307's elopement on 5/30/26) was called. RT G answered the phone and asked if they could call the surveyor right back. A returned phone call was not received by the end of the survey.A review of R307's medical record revealed an admission elopement assessment completed on 2/10/26 at 5:11 PM, that deemed the resident to not be an elopement risk.A review of the progress notes revealed the following:A Nursing note dated the day after admission on [DATE] at 10:54 PM, (continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | documented . Resident confused. Stated she wants to go home. Wandering through the hallway.A Psychiatry Note dated 2/26/26 at 3:08 PM, documented in part . Prior to admission, the patient was hospitalized with complaints of altered mental status, worsening dementia, insomnia and agitation. She was treated for worsening dementia requiring placement, was stabilized, and transferred for subacute rehabilitation.A Nursing note dated 2/28/26 at 5:47 PM, documented in part . Husband visited, shortly after he left resident started sundowning having behaviors, resident verbally expressed she doesn't want to be here and wants to go home.A Nursing note dated 3/2/26 at 3:49 PM, documented in part . resident started sundowning having behaviors, resident verbally expressed she doesn't want to be here and wants to go home.A Nursing note dated 4/17/26 at 2:23 PM, documented . Patient noted with increased agitation about being in facility keeps stating she wants to go home, and why is she here writer and family explained to patient several times about her stay. Patient noted walking in and out off <sic> room, and wandering the second floor hallways. Patient is hard to re-direct, and keeps asking to leave.A review of a facility policy titled Elopement - For Facilities With a Wander Alert Bracelet System review date 6/3/26, documented in part . The purpose of this policy is to provide guidelines to evaluate residents for risk of elopement, implement risk reduction strategies for those identified as an elopement risk. An Elopement Risk Evaluation is available to be completed under the resident's assessment tab in (Electronic Medical System name) as needed when a resident has a new or increased verbal or physical behavior of wandering and/or exiting seeking.The facility staff failed to complete a new Elopement Risk Evaluation for the multiple . new or increased verbal or physical behavior of wandering and/or exiting seeking. as noted above.A late entry note created on 6/4/26 at 10:48 AM and back dated to 5/8/26 at 12:30 PM, documented in part . At 12pm writer observed resident wandering and pacing the hallway, saying she wants to go home. Resident. with confusion, easily redirected, Resident like to play cards, writer played a few hands with resident to decrease elopement risk, writer placed (monitoring alarm device name) bracelet applied to right ankle, verify and working, update care plan and elopement assessment completed, Order placed for psychiatric to reevaluate medication list, IDT (Interdisciplinary team) notified and MD (Medical Doctor), Daughters notified of current status and safety measure implemented, Staff update to monitoring resident for wandering, Will continue with POC (Plan of Correction).On the date of 5/8/26 the facility staff completed a new Elopement Risk Evaluation that deemed R307 to be an elopement risk and implemented interventions for a care plan titled Exit seeking / elopement risk.A review of the medical record revealed no documentation on why the ankle monitoring alarm device was placed on the resident on 5/8/25 despite the same behaviors to have been observed and noted multiple times. Further review of the medical record revealed no documentation of the incident regarding the elopement on 5/30/26 to have been documented.On 6/16/26 at 12:11 PM, the Administrator and Director of Nursing (DON) were asked to provide all attempts and actual elopement incident reports for R307. Two incident reports were provided for 5/8/26 and 5/30/26.A review of the 5/8/26 incident report, noted the same documentation as noted in the 5/8/26 progress note.On 6/16/26 at 12:46 PM, the facility's camera footage was reviewed (with the DON in attendance) for the date of 5/30/25. At 4:34 PM, R307 is seen wandering the hallways of the second floor and going towards the second floor elevator. At 4:35 PM, the resident is observed getting off the elevator on the first floor walking in the direction of the facility's front door. Four minutes later at 4:39 PM, visitors are observed walking on to the first floor hallway from the direction of the front door.The facility's front door is locked and requires the receptionist to press a button to allow people in or out. The front door will unlock after 15 seconds of pushing on it, an alarm will be triggered which would require a staff member to input a code to silence the alarm. The wandering alarm device (bracelet) that was located on R307's ankle would have triggered the alarm as they exited through the front door and again would require a staff member to input a code to override the alarm system and silence the alarm.A second attempt was made to interview the Receptionist - RT G at 11:27 AM, but was unsuccessful. The DON was asked to reach out to RT G and (continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | have them return the surveyor's call. The DON was asked again at 11:57 AM - with no response. At 12:14 PM, the Administrator and DON was again asked to reach out to RT G and have them return the surveyor's call.On 6/16/26 at 11:00 AM, LPN A (the nurse assigned to R307 at the time of the 5/30/26 elopement) was interviewed and asked how they were made aware of R307 to have been missing from the facility. LPN A reported that the CNA came to them and asked if they had seen R307. LPN A stated they then began to take steps to locate the resident. When asked if they received the call from R307's daughter on 5/30/26 asking if they were missing a resident, LPN A stated . she called the supervisor work phone. When asked who the weekend supervisor was, LPN A stated the name of Weekend Nurse Supervisor (WNS) H.On 6/16/26 at 12:17 PM, WNS H was interviewed and asked who first informed them of R307 to have been missing from the facility on 5/30/26 and WNS H stated LPN A 's name. When asked if they talked to R307's daughter, WNS H confirmed they had. When asked about R307's daughter to have called them on 5/30/26 to ask if they were missing a resident and for them (WNS H) to have replied to the daughter that they would look into it and call them back, WNS H denied that it was them that the daughter initially talked to. WNS H stated they did not speak to R307's daughter until after LPN A spoke to the daughter.On 6/16/26 at 12:37 PM, an attempt to interview Registered Nurse (RN) I the oncoming nurse that was relieving LPN A, who was also assigned to R307 and was present at the facility when the staff was notified by R307's daughter of the resident to have been found at their uncle's home, was called. A voicemail box was not set up, however a text message was sent to RN I with no return response or return phone call by the end of the survey.On 6/16/26 at 1:30 PM, an attempt to contact CNA K (the aide assigned to the resident at the time of the 5/30/26 elopement) was made. A voicemail was left to return the call. A return phone call was not received by the end of the survey.On 6/16/26 at 12:54 PM, the DON was interviewed and asked about the delayed implementation of R307 to be deemed an elopement risk and the delayed interventions for the elopement behaviors. The DON stated they were unaware of the prior documented incidents in R307's record. The DON said they were made aware of the 5/8/26 incident when the monitoring alarm device was placed on R307. When asked, the DON confirmed the monitoring alarm device would not be triggered by the resident leaving the second floor on to the elevator, however stated it would have triggered when the resident left out the front door. The DON was asked about the video footage to show the resident to have last been seen in the facility at 4:35 PM, despite the facility to have reported to the SA that the resident was last seen on the video footage on 5:34 PM. The DON explained they came to the facility on 5/31/26, the day after the elopement incident and identified the camera system to be off by an hour. The camera footage was discussed with the DON regarding the likelihood of RT G to have let R307 walk out the front door, the alarm to have been overrode and silenced and the visitors to have been let in four minutes after. The DON was asked whose responsibility it was to train RT G on the facility's elopement residents and protocol and the DON responded . She should have been trained by the girl that's sitting up there now. The DON was referencing another facility's receptionist. The DON was asked if they were able to get in touch with RT G to have them return the surveyor's call and the DON stated they informed the Administrator to have RT G call the surveyor.On 6/16/26 at 1:36 PM, the Administrator was interviewed and asked about the 5/8/26 incident and why the monitoring alarm device was applied to the resident this incident despite the multiple documentation of the same wandering behavior and verbalization of wanting to leave the facility. The Administrator stated that this incident was different because the resident actually attempted to go out the facility's front door but was unsuccessful. The Administrator was asked why that was omitted from the progress note and incident report and the Administrator again stated the resident was unsuccessful. The Administrator was asked about the camera footage that revealed the resident to have likely exited out the front door, with the receptionist present at the front desk and four minutes later a family observed walking on to the first floor. The Administrator was asked about the education provided and if the receptionist was aware of what a monitoring alarm device purpose is, how to identify the residents in the facility that are<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Immediate jeopardy to resident health or safety<br><br>Residents Affected - Few | deemed an elopement risk and what to do when the alarm is triggered in the facility. The Administrator replied that it was the facility's presumption as well that the chain of events occurred as discussed above. The Administrator reported they interviewed the receptionist on two different occasions with similar questions and the receptionist denied hearing an alarm or seeing a resident go out. The Administrator then stated in part . She (Receptionist RT G was newly hired on May 6th (2026) and May 30th was the first weekend on her own. (RT G) said the resident looked like a visitor. It was discussed with the Administrator that RT G statement to them verbalizing that . the resident looked like a visitor. confirmed that RT G did observe R307 and likely allowed them to walk out the front door which likely triggered the alarm system with no further intervention. The Administrator was asked how it was possible for the Receptionist to think that R307 was a visitor if their picture was on the desk and in the elopement binder at the receptionist desk as one of the residents categorized as an elopement risk and the Administrator replied . It should not have been possible with the binder and pictures. The Administrator was asked if they were able to get ahold of RT G to have them return the surveyors call and the Administrator replied . Yes, I reached out to her.A return phone call was not received by RT G by the end of the survey despite multiple attempts.The Immediate Jeopardy that began on 5/30/26 was removed on 6/9/26 when the facility took the following actions to remove the immediacy:On 5/30/26, the facility identified an Immediate Jeopardy situation related to resident elopement risk. Immediate actions were implemented to protect Resident [NAME] and all other residents identified as being at risk for elopement.Resident was safely returned to the facility and a 1:1 staff member was initiated on 5/30 for continuous supervision.The resident's wander guard placement and functionality were assessed and tested with no malfunction identified. The resident's elopement assessment, physician orders, and care plan interventions were reviewed and verified.A facility-wide audit of all residents identified as being at risk for elopement was completed by 6/2/26 to verify assessments, physician orders, care plans, wander guard placement, and functionality.Elopement binders were updated and verified at all nursing stations and the front desk. Exit doors, alarm systems, and resident monitoring systems were tested. Facility-wide elopement drills were conducted on 6/1/26 and 6/2/26.Re-education began on 5/30 to all staff regarding the Elopement - For Facilities With a Wander Alert Bracelet System policy, which also encompasses education on the wander alert system, i.e., placement, functionality and alarms. Elopement education included risk assessment, care planning, interventions, identification, physician and guardian notification, elopement binders, change of condition, transfer, supervision, reporting, assessments, and alarm response. In addition to the above receptionist were educated on review of the elopement binder, informing nursing staff of elopement behaviors, , sign in/out procedures and the LOA (leave of absence) process. Education concluded on 6/5. Ad Hoc QAPI meetings were conducted on 6/1/26 and 6/2/26 to review the event, identify root causes, and implement corrective actions. |