

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/17/2025
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation of Muskegon		STREET ADDRESS, CITY, STATE, ZIP CODE 1061 West Hackley Avenue Muskegon, MI 49441	

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to assess to determine if resident was appropriate for lone transfer in accordance with professional standards of care related to mental and physical conditions for one (Resident #1) of three residents reviewed for quality of care. Findings include: Resident #1 (R1) A review of R1's Electronic Medical Record (EMR) indicated that R9 was originally admitted to the facility on [DATE] with diagnosis including functional quadriplegia, chronic pain syndrome, morbid obesity, abnormalities of gait and mobility, weakness, spinal stenosis, and adjustment disorder with mixed anxiety and depressed mood. The EMR revealed a Brief Interview for Mental Status (BIMS) was performed on 9/25/25 where R1 scored a 10 out of 15, meaning R1 has moderate problems with thinking and memory. Therapy progress notes dated 8/20/25: Quarterly Therapy Screen Completed: Patient demonstrates minimal out of bed activity with deficits in mobility, strength, and ADLs. Patient would benefit from skilled OT (Occupational Therapy) or PT (Physical Therapy) services but continues to refuse despite max encouragement. Thus, evaluation is not recommended at this time. On 11/20/25 another quarterly therapy screen was completed noting Patient is dependent for mobility and self-care tasks, which is her baseline. Patient frequently refuses therapy services. No skilled PT or OT services are warranted at this time. On 12/2/25, R1 was placed into a wheelchair, and sent with a medical transportation company that has a contract with the facility, to a dermatology appointment. According to information provided in complaint 2687175: R1 arrived at the dermatologist office sliding down out of the wheelchair, and R1's feet with only socks on, were wet as they had slid off the foot pedal as the transportation worker brought R1 into the dermatology office. Since R1 did not have any strength, it took four people to slide R1 back into the wheelchair, but R1 continued to slide out while crying out in pain. The Licensed Practical Nurse (LPN) Manager B from the facility contacted Emergency Medical Services (EMS) to transport R1 back to the facility. LPN Unit Manager B stated R1 never sits in a chair, so it is unknown why R1 was sent this way. R1 was taken to the hospital by EMS. There was no progress note in the EMR on 12/2/25 that indicated R1's status or the fact that R1 left the building for an appointment with medical transportation. At 11:22 AM on 12/16/25, the NHA (Nursing Home Administrator) stated the facility did their own investigation into what happened with R1 at the dermatology appointment. The NHA stated she was informed that the dermatology office intended to report it to the state, so the facility did an investigation. The NHA stated the transportation company collected R1 who was appropriately seated in the wheelchair upon R1's departure from the facility. The NHA stated the transportation driver called the facility after the dermatologist had refused to see R1, as they were crying out in pain. The transportation driver did not feel comfortable transporting R1 back to the facility while R1 was crying out in pain. The NHA stated R1 is their own person and was plenty capable of going to the appointment on her own. The NHA stated R1 had their own wheelchair and did get up into it at the facility. On 12/16/25 at 12:15 PM an interview was conducted with the NHA, DON (Director of Nursing) and LPN Unit Manager B. The DON stated R1 was seated in a standard large facility wheelchair when R1 left to go to the dermatologist appointment. This contradicted the NHA's statement of R1 having their own wheelchair. When asked why the facility would send a resident with a BIMS of 10 to an appointment on their own, the NHA, DON, and LPN Unit Manager B all felt that this was in error, and the BIMS didn't show exactly how R1's mentation was, so they did not see an issue with sending R1 out without facility staff. LPN Unit Manager B stated EMS had notified her that R1 was hypotensive, which could have been because R1 was not getting up in a wheelchair very often anymore. An EMR progress note stated, 12/17/25 0737 (7:37 AM): late entry for 12/16/25 at 19:45 (7:45 PM). Resident returned to facility at 1930. Upon return to facility resident assessed and the following significant findings were noted: resident A&O to self only. Unable to recall staff members from our facility without reminders. Resident unable to hold meaningful conversation related to inattention. During an interview on 12/17/25 at 10:40 AM Certified Nursing Assistant (CNA) F stated R1 refused everything, R1 would fight you to do brief change and everything. CNA F stated he could not remember the last time R1 had been out of bed, up in a wheelchair. On 12/17/25 at 10:50 AM an interview was conducted with CNA E. CNA E stated R1 barely allows staff to get themselves out of bed to the shower. CNA E stated she was able to get R1 in the shower one day due to maintenance working on R1's room, so R1 had to get in a wheelchair and taken out of the room. CNA E stated she took R1 directly into the shower room and showered R1 with R1 cursing her the entire time. R1 told CNA F after they felt better but wanted to go back</p>		