STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235004	A. Building B. Wing	05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Muskegon	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 0689 Level of Harm - 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 refers to Intake 3012437. Based on interview and record review, the facility failed to prevent a fall with injury for 1 of 3 residents (R2) reviewed for accident hazards, resulting in R2 sustaining a fractured nasal bone and lacerations to the face. Findings include: A review of R2's Face Sheet, dated 5/26/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R2's Face Sheet revealed they had multiple diagnoses that included cerebral infarction (a stroke), lack of coordination, and muscle spasm. A review of R2's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 3/12/26, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15 which revealed R2 was cognitively intact. In addition, R2's MDS revealed they were dependent on staff for bed mobility (rolling side-to-side) and for toileting hygiene. A review of R2's progress notes, dated 4/26/26 to 5/26/26, revealed the following: - Nursing - Progress Note, dated 4/29/26, revealed, .1900) (7:00 PM) Nurse at med (medication) cart outside res (resident) room heard loud crash then CENA (Certified Nursing Assistant) call out. Nurse entered room and res was laying on floor between bed and Nightstand closer to room door. Nurse noted lg amt (large amount) of blood under res head. Res was answering questions correctly and denied pain. Nurse had CENA obtain ice pack and nurse called on call physician (1902- 7:02 PM), order received to send res to ED (emergency department) to eval (evaluate) and treat. This nurse called 911 and per their instruction did not move res for further assessment. Ice applied to left side of face/ head. EMS (emergency medical services) arrived at about 1915 (7:15 PM) and res out to ED at about 1925 (7:25 PM) . - Nursing - Progress Note, Late Entry: dated 5/6/26 for 4/30/26, revealed, .Resident returned from hospital in stretcher accompanied by 2 EMTs (emergency medical technicians). ER (emergency room) reports resident has a closed fracture of the nasal bone and has stitches in bridge of nose. Resident also has lacerations to forehead that were glued closed. - Progress Note, dated 5/1/26, revealed, .Resident c/o (complaining of) headache and body pain. Resident states, Norco is not working. Provider in facility to eval (evaluate) resident and her meds. - IDT (Interdisciplinary Team) note, dated 5/1/26, revealed, .During cares CNA (Certified Nursing Assistant) noted bruise to resident's posterior RLE (back of her right lower extremity (leg)). Resident did not know the bruise was there but stated I got that in therapy. Resident is at an increased risk of bruising secondary to being on two anticoagulants. - IDT note, dated 5/1/26, revealed, Resident had a witnessed change in elevation from bed to floor. She had obvious injury to her face, and is on blood thinners. In addition, the note revealed that R2 was sent to the emergency department for an evaluation. A review of R2's - Fall Risk Assessment, dated 3/8/26, revealed R2 was routinely incontinent, had moderate/severe unsteadiness, took 3 or more medications that could put her at risk for falls, and had 3 or more diseases/conditions that put her at risk for falls. A review of R2's hospital After Visit Summary, dated 4/30/26, revealed on 4/29/26 R2 was seen in the emergency department for a fall. R2's hospital After Visit Summary also revealed that R2 had a facial laceration to the forehead that required adhesive and stitches to close and a closed fracture of the nasal bone. A review of R2's skin assessment, dated 5/2/26, revealed R2 had a left (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 Level of Harm - Actual harm Residents Affected - Few	elbow abrasion, front of left knee abrasion, and facial bruising and sutures. The skin assessment revealed these injuries were from a fall. During an interview on 5/26/26 at 9:00 AM, R2 stated a CNA rolled her out of bed and onto the floor. She stated the CNA was cleaning her up after she had a bowel movement and asked her where the bruise came from. R2 stated she went to look at what the CNA was referring to and she rolled out of bed. She stated the CNA had her on her side facing the doorway when she rolled out of bed. R2 stated she hit her head on her nightstand when she fell. She denied any other injuries. My head broke the fall. She stated the facility sent her to the hospital. R2 stated at the time they were only using one CNA to provide incontinent care to her. She stated the facility now uses two CNA's. R2 stated the CNA at the time of the fall did not seem like she was in a hurry or rushing through the care. She stated, It was just an accident. During an interview on 5/26/26 at 4:50 PM, Certified Nursing Assistant (CNA) D stated she went into R2's room to provide care. She stated she rolled R2 away from her and R2 was too close to the edge. CNA D stated during care she noticed a bruise to the back of R2's leg and asked R2 about it. She stated R2 tried to look at it and it threw off her balance and she rolled off the bed. CNA D stated R2's bedside drawer was open and R2 hit it on the way to the floor. CNA D stated after R2 fell to the floor she opened up the door and told the nurse that R2 had fallen out of bed. She stated the nurse was right outside R2's door with the medication cart and immediately came into the room. She stated when the nurse came in the room she saw that R2 was bleeding and the bed was at a high height (CNA D had raised the bed prior to starting care). CNA D stated the nurse called 911 while she stayed with R2 and tried to clean her up to the best of my ability prior to EMS arriving. CNA D stated she and another aide moved R2's bed because R2 was leaning up against it and R2 was uncomfortable. She stated they did not move R2. She stated EMS arrived and took her to the hospital. During the interview on 5/26/26 at 4:50 PM, CNA D stated R2 was a one-person with care at the time of the incident. She stated they are technically not supposed to roll residents away from themselves when they are alone. She stated she knew she was not supposed to roll R2 away from her at the time. CNA D stated she did it anyway because she was just trying to clean R2 up after she had an extra-large bowel movement in her brief. She stated she should have called for help instead of doing the care herself, but she did not think anything would happen. CNA D stated trying to do the care herself and rolling R2 away from her and not towards her was a lack of judgement. She stated she received individual written education for the incident. A review of CNA Ds Employee Counseling & Corrective Action Record, dated 5/1/26, revealed she received her Final Written Warning on 5/1/26 for Carelessness or Negligence, Neglect of Duty related to a resident (R2) being rolled away from her, rolling out of bed, and sustaining an injury on 4/29/26. She was educated on the proper policy and procedure for repositioning. A review of the facility's Repositioning Policy and Procedure, revised on 4/24/25 and reviewed on 2/2/26, revealed when repositioning a resident in the bed, staff are to position resident so that when they are turned they are in the middle of the bed and they are to reach across the resident and place one hand behind their shoulder and the other behind the hip and gently roll the resident towards you.