STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2749417 Based on observation, interview, and record review the facility failed to provide an environment that promoted and enhanced resident dignity in 1 Resident (#130) of 3 residents reviewed for dignity resulting in feelings of humiliation, frustration, embarrassment, and negative psychosocial outcomes impacting the residents' quality of life. Findings include:Resident #130Review of an admission Record revealed Resident #130 was originally admitted to the facility on [DATE] with pertinent diagnoses which included end stage renal disease and chronic pain syndrome. Review of a Minimum Data Set (MDS) assessment for Resident #130, with a reference date of 2/3/26 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #130 was cognitively intact. During a medication administration observation on 3/18/2026 at 8:02 AM, Licensed Practical Nurse (LPN) JJJ was preparing medications at her medication cart outside of Resident #130's room. Resident #130's door was open, and she was lying in bed crying out Please come help me. It was noted that her call light was on. LPN JJJ yelled out to Resident #130 that she was going to have to wait . LPN JJJ then turned to this writer and said She's going to just yell out nonstop; she always does. It's because she is a drug addict. Noted that LPN JJJ was right in front of Resident #130's room and at a distance that Resident #130 could hear LPN JJJ when she called her a drug addict. LPN JJJ continued to dispense medications as Resident #130 continued to scream out for help. LPN JJJ loudly sighed every time that Resident #130 yelled and continued to state, you just have to wait. After LPN JJJ had all of Resident #130's medications prepared, she walked into Resident #130's room without knocking or identifying herself and asked Resident #130 What is wrong with you? Resident #130 was on her personal cell phone with 911, and she told LPN JJJ that she was calling 911 for help because nobody helped her while she yelled out. Resident #130 was noted to be tearful. LPN JJJ yelled out to the 911 operator that Resident #130 was fine and did not need assistance, and the dispatcher ended the call. Resident #130 then reported that she was in pain and LPN JJJ said Well I have Tylenol for you. She then gave Resident #130 her medications and walked out of her room. Resident #130 stated I still need help as LPN JJJ was exiting her room, and LPN JJJ ignored Resident #130 and continued to exit her room. It was noted that LPN JJJ did not assess Resident #130's pain or offer any other non-pharmacological interventions. After LPN JJJ walked out of Resident #130's room, she stated to this writer She (Resident #130) is drug seeking, she is probably withdrawing right now. It was noted that Resident #130 continued to yell out for help and LPN JJJ continued to ignore her. During an interview on 3/18/2026 at 12:58 PM, Resident #130 reported that she was very frustrated with how staff at the facility treated her. Resident #130 reported that she felt like she had to yell out to get help because the staff just ignored her. Resident #130 reported that she had overheard LPN JJJ call her a drug addict earlier that morning and that she often heard staff complaining about her and that she felt like they treated her like ghetto trash. Resident #130 was noted to be tearful during the interview. Review of the facility's Dignity policy dated 9/21/23 revealed, Policy Overview: It is the policy of this facility that each resident will be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235103	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with life, feelings of self-worth, and self-esteem. General guidelines: Residents will be treated with dignity and respect at all times .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes: 2802001, 2802220, 2798542, & 2737401Based on interview and record review, the facility failed to inform the resident representative, in advance, of care to be provided for 2 (Resident #15 and Resident #39) of 6 residents reviewed for resident rights, resulting in: 1. Resident #15 receiving psychotropic medication without consent from his resident representative. 2. Resident #39 attended an offsite medical appointment without representation from her Durable Power of Attorney (DPOA).Findings include: Findings include: Resident #15 Review of an admission Record revealed Resident #15 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: schizoaffective disorder, bipolar type (chronic mental health condition combining hallucinations, delusions, disorganized speech with severe mood swing, specifically mania and often depression). Review of a Minimum Data Set (MDS) assessment for Resident #15 with a reference date of 2/10/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 14/15, which indicated the resident was cognitively intact. Section N of the MDS revealed Resident #15 was taking an antipsychotic and an antianxiety medication. Section Q of the MDS revealed the resident had a legal guardian. Review of a State of Michigan Probate Court Report of Physician for Resident #15, with a reference date of 6/3/25, revealed .3. Based on the examination.the individual suffers from.schizoaffective disorder, moderate cognitive impairment.4. These infirmities interfere in the following ways with the individual's ability to receive or evaluate information in making decisions: process and understand medical information.6. I believe the individual.is not able to make informed decisions in the following areas.authorizing or refusing medical treatment. Review of a Determination of Inability to Participate in Complex Decision Making form for Resident #15, with a reference date of 6/20/25, revealed I have evaluated (Resident #15) and based on my observations, evaluation and professional opinion, he IS NOT able to make medical treatment decisions and IS NOT able to participate in making medical treatment decisions. The document was signed by 2 physicians. Review of a Psychotropic Medication Use policy with a reference date of 2/3/26 revealed: Policy Overview.The facility will.obtain consent from the resident or authorized representative for each psychotropic medication ordered.Upon admission, the facility will identify when a resident is prescribed a psychotropic medication.the resident or authorized representative will be educated on the risks versus benefits of the psychotropic medication and informed consent obtained. In an electronic communication on 3/19/26 at 10:50am, Nursing Home Administrator (NHA) A agreed to provide all Psychotropic Medication Consent forms for Resident #15. Review of a Physician's Order for Resident #15 with a reference date of 5/28/25 revealed Perphenazine (antipsychotic medication) Oral Tablet 4 MG (milligrams) 2 tablets by mouth two times (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a day Review of a Psychotropic Medication Consent form with a reference date of 8/8/25 for Perphenazine for Resident #15, revealed I. Medication Class antipsychotic, Perphenazine Oral Tablet 4MG, 2 tablets by mouth two times a day.Education was provided to and consent received from (Resident #15). Of note, this consent form for Perphenazine was chronologically closest to the start date of this medication which was 5/28/25. Review of a Physician's Order for Resident #15 with reference date of 8/8/25 revealed Alprazolam (anti-anxiety medication) oral tablet .25mg, give 1 tablet by mouth every 8 hours as needed until 8/22/25. Review of a Psychotropic Medication Consent form with a reference date of 8/11/25 for Alprazolam for Resident #15, revealed Medication class.Antianxiety.Education was provided to and consent received from (Resident #15). In an interview on 3/19/26 at 12:28pm Social Services Coordinator (SSC) X reported residents/their representatives must give informed consent prior to the use of psychotropic medications because the medications are mood altering, can present risks to the resident's health, and may cause undesirable side effects. In an interview on 3/19/26 at 12:42pm Social Services Coordinator (SSC) E reported if a resident has been deemed unable to make medical decisions, such as with Resident #15, informed consent for the use of psychotropic medications must either be received from the legal guardian or the authorized resident representative. SSC E confirmed Resident #15 could not make medical decisions for himself, did not have a legal guardian when he was initially prescribed Alprazolam or Perphenazine, and his authorized resident representative did not provide consent for the use of the medications Resident #39 Review of an admission Record revealed Resident #39 was originally admitted to the facility on [DATE] with pertinent diagnoses which included paranoid schizophrenia (chronic and serious mental health condition that can significantly affect how a person thinks, feels, and behaves) and cognitive communication deficit. Review of Resident #39's Letters of Co-Guardianship dated 9/30/25 revealed that Resident #39 had been appointed two-co guardians. During an interview on 3/17/2026 at 12:52 PM, Family Member (FM) MMM reported Resident #39 had been admitted to the facility on [DATE] after a hospitalization. FM MMM reported her and her sister were Resident #39's co-guardians, and that they had made all of Resident #39's medical treatment decisions. FM MMM reported Resident #39 was followed by a (Local Mental Health Authority-company that provided public services for mental health, substance use, and developmental disabilities) and that the Mental Health Authority would review her medications each month and provide her monthly Haldol (antipsychotic medication) injection. FM MMM reported that on 2/2/26, the facility sent Resident #39 to an outside medical appointment with a staff member from the facility without notifying her or Resident #39's other co-guardian. FM MMM reported that Resident #39 was not able to participate in the appointment, so the office cancelled the appointment. FM MMM reported that on 2/19/26 the facility sent Resident #39 to an appointment at the Local Mental Health Authority (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	without a staff member to assist her. FM MMM reported that she and Resident #39's other guardian had not been notified about Resident #39's appointment, and that she was very upset when she found out that Resident #39 had attended the appointment by herself. FM MMM reported that she had always attended Resident #39's appointments with her because she was not capable of making her own decisions. FM MMM reported that the facility was aware that she wanted to be notified of all appointments with Resident #39 so that she could attend with her. FM MMM reported that she learned that Resident #39 had attended another appointment without her knowledge when Resident #39 informed her. FM MMM reported she was never notified of any appointments that the facility had scheduled for Resident #39, and if she had been made aware, she would have attended the appointments with her. During an interview on 3/18/2026 at 4:28 PM, Mental Health Authority Nurse ([NAME]) BB reported she was one of the nurses that assisted Resident #39 when she came to her appointment on 2/19/26 without her guardian or a staff member from the facility. [NAME] BB reported she thought it was unusual for Resident #39 to attend her appointment without FM MMM because she always went to Resident #39's appointments with her. [NAME] BB reported Resident #39 was able to participate in her appointment, but that she was notably more confused. [NAME] BB reported that FM MMM had always been a great resource and advocate for Resident #39, so she did feel that it was beneficial for her to participate in Resident #39's medical appointments. During an interview on 3/19/2026 at 11:11 AM, Unit Clerk (UC) U reported she was responsible for scheduling outside medical appointments for residents at the facility. UC U reported she could not recall if she had scheduled Resident #39's appointment with an outside medical provider on 2/2/26, but that she thought that the appointment had been cancelled, and she did not know any further details related to that appointment. UC U reported she had scheduled Resident #39's appointment on 2/19/26. UC U reported that if a resident had a guardian, she would write down the appointment information on a slip to give to the guardian. UC U reported she had completed a slip for Resident #39's appointment to give to her guardian, and that when she went to give it to her (FM MMM) when she was at the facility, FM MMM was in the middle of a conversation with another staff member at the facility in the dining area. UC U reported she waited for over 20 minutes for FM MMM but that she did not want to interrupt the conversation, so she placed the slip that included the appointment information Resident #39's meal tray in her room. UC U first reported that she did not know if FM MMM had received the slip she left for her on Resident #39's meal tray. UC U then reported that she had spoken with FM MMM on the phone after she had left the slip, and that FM MMM confirmed that she was aware of the appointment. When this writer further queried, UC U reported that she could not recall the date or information that she had shared with FM MMM regarding her appointment on 2/19/26. When asked by this writer for documentation to verify that UC U had spoken with and informed FM MMM of Resident #39's medical appointment on 2/19/26, UC U was not able to provide any documentation. UC U reported that anytime a resident at the facility had a guardian, she was supposed to ensure that the guardian was aware of their outside appointments, and if they could not attend with the resident, the facility would send a staff member to attend with them. UC U was unable to report if Resident #39 required a staff member to assist her at an appointment if her guardian was not able to attend, but did report that typically, a resident with a guardian would need staff assistance if the guardian could not attend.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes: 2802001, 2802220, 2798542, & 2737401. Based on interview and record review, the facility failed to ensure proper notifications were made after the identification of a significant medication error for 1 (Resident #39) of 2 residents reviewed for notifications, resulting in the lack of assessments, monitoring, and potential for worsening medical conditions. Findings include:Resident #39 Review of an admission Record revealed Resident #39 was originally admitted to the facility on [DATE] with pertinent diagnoses which included paranoid schizophrenia (chronic and serious mental health condition that can significantly affect how a person thinks, feels, and behaves) and cognitive communication deficit. Review of Resident #39's Care Plan revealed, Focus: (At risk for changes in behavior & mood r/t (related to) paranoid schizophrenia .Interventions: Administer medications per physician orders. Date Initiated: 01/29/2026 .Review of the facility's Medication Error Investigation revealed, Resident #39 was admitted on [DATE] . On 1/28/26, Licensed Practical Nurse (LPN) P entered an order for Haloperidol (Haldol) Deaconate (antipsychotic medication) intramuscular solution 100 mg/mL (milligrams per milliliter) give 2.5 ml IM (intramuscular) to be given one time a day on the 16th-21st. In the additional directions it was noted to give every 21 days. The correct order was to give Haloperidol Deaconate intramuscular solution 100 mg/mL give 2.5 ml IM to be given one time a day once every 21 days. The error in order transcription resulted in the resident receiving doses of IM Haldol on 2/17/26, 2/18/26, and 2/21/26 . Noted that the investigation report indicated the incorrect dates that Resident #39 received the Haldol injections. Review of Resident #39's Medication Administration Record (MAR) revealed, Haloperidol Decanoate Intramuscular Solution 100 MG/ML (Haloperidol Decanoate) Inject 2.5 ml intramuscularly one time a day starting on the 16th and ending on the 21st every month for schizophrenia every 21-day IM inject. Start date: 2/17/26. The medication was documented as administered by LPN LLL on 2/17/26 and by LPN EE on 2/20/26 and by 2/21/26. During an interview on 3/17/2026 at 12:52 PM, Family Member (FM) MMM reported that Resident #39 had been admitted to the facility on [DATE] after a hospitalization. FM MMM reported that Resident #39 was followed by a (Local Mental Health Authority-company that provided public services for mental health, substance use, and developmental disabilities) and that the Mental Health Authority would review her medications each month and provide her monthly haldol injection. FM MMM reported that on 3/6/26, she was informed by the Mental Health Authority that Resident #39 had received three doses of her monthly haldol injection at the facility in error. FM MMM reported that she was informed by the Mental Health Authority's Nurse (MHAN) BB that she had talked to LPN EE at the facility on 2/27/26 when she called to discuss Resident #39's medication orders, and it was discovered that the facility had transcribed the order wrong and administered multiple does. FM MMM reported that she had not been contacted by the facility until 3/9/26. FM MMM reported that she had noticed a decline in her mother's condition since February when Resident #39 had received the multiple doses of Haldol injections which included a decline in participating in therapy, increased tremors and confusion. During an interview on 3/18/2026 at 4:28 PM, MHAN BB reported that when Resident #39 came in for her medication review appointment on 2/19/26, she had planned to administer Resident #39's monthly Haldol injection, but she was told by Resident #39 that she had just gotten the injection at the facility, so she did not administer the injection and requested Resident #39's medication records from the facility to review. MHANBB reported that she called the facility on 2/27/26 to review Resident #39's medications because she had not yet received Resident #39's medication records from the facility. MHAN BB reported that she spoke to LPN EE on 2/27/26 and reviewed Resident #39's orders with him. MHAN BB reported that when LPN EE read Resident #39's Haldol order to her, she informed LPN EE that the order was incorrect, and Resident #39 should have only received 1 Haldol injection every 21 days. MHAN BB reported that LPN EE told her that he (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thought the order looked incorrect, so he asked a supervisor about it, and he was told to administer the medication anyway. Review of Resident #39's Nursing Narrative note dated 2/27/26 from the Mental Health Authority revealed, This RN called (Facility) nursing line to inquire about medication records regarding this patient's Haldol 250mg Q3wks (every 3 weeks). This RN spoke to a (LPN EE) who stated that the last time this patient received this medication was on 02/21. (LPN EE) also stated that the order was written as, Haldol 250mg from 02/16-02/21, therefore, this patient received multiple doses within a week. (LPN EE) did state that the patient refused the medication a few times, but states that he knows she got it at least twice from him. (LPN EE) states, I thought the order looked weird. He states that he asked his supervisor at (Facility) for clarification and was told to give the medication as the order stated . Review of Resident #39's Progress Note dated 3/7/26 (8 days after the telephone call with MHAN BB on 2/27/26) and documented by LPN EE revealed, Spoke with nurse at (Local Mental Health Authority) and was asked to do a complete medication review of this resident's medications. During the review, it was brought to the attention of this nurse that there was a discrepancy regarding resident's Haloperidol Deaconate Intramuscular solution 100 mg/ml. The order in (electronic medical record) reads Inject 2.5 ml intramuscularly one time a day starting on the 16th and ending on the 21st of every month for schizophrenia every 21 days which was incorrect. Two doses were administered by this nurse. The nurse was asked about the resident's condition and asked to obtain a set of vitals. The resident was fairly new to this unit, so nurse didn't have knowledge of their baseline . the resident's mental state to the nurse seemed to be AOx 2-3 (alert and oriented) and her vitals were exceptionally great (did not indicate what vital signs were) . During an interview on 3/18/2026 at 3:55 PM, LPN EE reported that he had administered two doses of Resident #39's Haldol injection on 2/20/26, and 2/21/26. LPN EE reported that he recalled questioning the order, and so he had asked his Unit Manager about the order and was instructed to administer the injections anyway. When this writer queried as to which Unit Manager instructed him to administer the injections, LPN EE reported that he could not recall. LPN EE reported that he had been made aware of the medication errors when he completed a medication review with MHAN BB. LPN EE reported that he could not recall the date that he spoke to MHAB BB or when he reported the incident to the facility. LPN EE could not recall if he had contacted the physician to inform him of the medication error. During an interview on 3/18/2026 at 1:51 PM, Nurse Practitioner (NP) OOO reported that she was notified on 3/9/26 regarding the medication errors that occurred in February 2026. NP OOO reported that by the time she had been notified of the medication errors, Resident #39 was planning to discharge from the facility, so she encouraged her to go to the hospital for an evaluation which she was agreeable to. During an interview on 3/19/2026 at 1:33 PM, Nursing Home Administrator (NHA) A reported that the facility had discovered the medication error that had occurred with Resident #39 on 3/6/26. NHA A confirmed that LPN EE had not notified the facility's provider, Resident #39's guardians, or any of the nurse managers of the medication errors that had occurred with Resident #39 when he found out about the errors on 2/26/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2731057.Based on observation, interview, and record review, the facility failed to maintain a clean and comfortable environment for 3 residents (R8, R108, and R12) of 4 residents reviewed for a sale/clean/comfortable homelike environment, resulting in unclean/unkempt resident rooms and the potential for cross contamination, bacterial harborage, and the potential for a reasonable person to experience feelings of embarrassment, shame, and/or loss of self -esteem. Findings include:R8According to R8's Minimum Data Set (MDS) dated [DATE], indicated R8 was cognitively intact with a BIMS of 13/15. Section GG-Functional Status indicated the resident was dependent on staff for transfers and did not stand or walk during this time of assessment. During an observation on 3/17/26 at 11:25 AM, there was a dresser behind R8's bed that had dust and debris under a bottle of stoma powder lying on its side, a jar of chicken bouillon, various wound and ostomy supplies, and a pair of scissors with plastic wrap on the blades. During an observation and interview on 3/17/26 at 12:18 PM, a bottle of stoma powder was on a dresser behind R8 was lying on its side. The top of the dresser had dust and debris under the bottle of stoma powder. A syringe, scissors that had plastic pieces hanging off the blades, and wound dressings were on top of the dust and debris. Also on the table was a jar of chicken bouillon. R8 stated he could not get out of bed on his own and staff took care of things in his room. Observed on 3/18/26 at 11:33 PM, in R8's room a dresser next to the wall, were piled up supplies, including the stoma powder lying on its side the same as the previous day. Also on the table was a jar of chicken bouillon. Observed on 3/19/26 at 9:33 AM, in R8's room, a dresser next to the wall, were piled up supplies, including the stoma powder lying on its side along with the jar of chicken bouillon the same as the previous day. The dirt, dust, and debris were also clearly seen as from the previous two days. In addition to the clutter on top of the dresser, there were additional various ostomy supplies piled on top with the red-handled scissors still opened with the plastic hanging on the blades. R108 According to R108's Minimum Data Set (MDS) dated [DATE], indicated R108 was unable to complete the BIMS (Brief Interview Mental Status) and was severely cognitively impaired with a score of 00/15. Section GG-Functional Status indicated the resident was dependent on staff for all ADLs (activities of daily living). Review of R108's Care Plan, dated 12/26/25, ADLs self-care deficit related to physical limitations indicated the goal for R108 was to receive assistance necessary to meet ADL needs using interventions that included assist to bath/shower as preferred.assist with daily hygiene, grooming, dressing. Review of R108's Care Plan, dated 2/5/26, included a focus of Need for Feeding Tube, indicating the resident had a resident-specific treatment plan for enteral feeding. During an observation on 3/17/26 at 11:10 AM, in R108's room, under the heat register was a purple container of deodorant. A chair next to the resident's enteral feeding pole was a wadded-up fleece jacket and tube of ointment were all splattered with a dried sticky substance resembling the enteral feeding that was hung on a pole next to the chair. R108's high backed wheelchair had the rubber missing from the right wheel all the way around it. Dirt, dust, and debris along the floorboards, and dressers. Personal belongings of R108 were on the floor next to carrying totes that were in a corner. It resembled someone who had gone through the bags of belongings, spilling items out, and leaving them on the floor without picking them up. During an interview on 3/17/2026 at 1:24 PM, Family Member (FM) PP stated she had concerns regarding R108's hygiene and environment. I have spoken to the facility numerous times about (R108's) personal hygiene. I've agreed to shower her once a week. I saw (R108) yesterday (3/16/26) she was given a shower by staff but she said she still stinks. In between showers on Mondays (R108) does not receive showers. (R108's) linens should be changed at the same time. When staff give her a bed bath the sheets don't get changed. When I come to the facility, I ask staff to put (R108) in her wheelchair and then I end up changing her sheets. Before I started giving (R108) showers, her hair (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not washed because it had built up of hair oil. (R108) skin is dry with white flakes. I write grievances that (R108's) skin is dry from her chest up to her face. I always bring in (R108's) hygiene items and shave her armpits. You can tell (R108) doesn't get clean by staff when deodorant clumps up under (R108's) armpits. I bring in body wash, diabetic lotion, Vaseline for her body, vapor rub for her feet, special lotion, and deodorant. The facility does not use it. I put lotion on (R108) and staff does not. It makes her feel like the facility does not care. Although (R108) has had strokes she still knows when her armpits stink and she tells me. When staff provide brief changes and clean (R108) she asks why does her private parts smell so bad. They do smell. There are days (R108) wear the same clothing back-to-back. I found (R108) wearing a hospital gown during the week. I do her laundry and have a sign up in her room asking staff to dress her every day. I've seen used gloves on the floor, dirty wipes left inside the drawers next to her bed, stuff on the floor like spilled hair condition. The chair for visitors is covered with feeding tube (enteral feeding) drippings that I saw yesterday (3/16/26), it was dripping from the bottle. Underneath her bed, smashed on the floor by a wheel from her bed, was a bottle of hair conditioner. It was leaking all over. I saw a staff member put it on the dresser and left it there dripping. I threw it away when I saw they did that. I work in a skilled nursing facility. I would never do this to a resident. It is a dignity issue. This is about dignity and (R108's) personal hygiene. This is about no lotion being put on (R108). Not put on her back and legs or her feet and legs. They need lotion especially since (R108) is diabetic. I washed (R108's) forearms once and the dirt was rolling off in the water. It was disgusting. My mother, (R108) did not live that when she was independent. She does not like smells or body odor and will tell staff and me. I ask the staff why they don't use the items I bring in and they don't answer me. My mother needs to have lotion because of the dry skin and she itches. She can't do it herself and she must lie there until I come in. I work full-time and can't be there every day. During an interview on 3/18/2026 at 10:44 AM, Housekeeping EEE reported resident rooms should be swept, mopped, and items picked up off the floor daily. Observed on 3/18/26 at 11:11 AM, in R108's room, under the heat register was a purple container of deodorant. A chair next to the resident's enteral feeding pole was a wadded-up fleece jacket and tube of ointment were all splattered with a dried sticky substance resembling the enteral feeding that was hung on a pole next to the chair. Dirt, dust, and debris along the floorboards, and dressers. Personal belongings of R108 were on the floor next to carrying totes that were in a corner. It resembled someone who had gone through the bags of belongings, spilling items out, and leaving them on the floor without picking them up. High-backed wheelchair had rubber missing completely around the right wheel. Observed on 3/19/2026 at 10:54 AM, R108 was in bed awake. At bedside was the tube feeding pole with pump. The pump, pole, pole base, floor underneath, and chair next to it were splattered with a dried sticky substance resembling tube feeding. The chair still had the tube of ointment and wadded up fleece jacket in it. On the floor next to the chair were the resident's belonging partially in the tote bags and partially out of the bags on the floor. Underneath the register was a purple container of deodorant. The resident's high-backed wheelchair had no rubber on the right rear wheel. During an interview on 3/19/2026 at 11:19 AM Unit Manager (UM) LL stated, (R108) Her daughter comes on Monday to give her a shower. Floors are the responsibility of housekeeping. Whoever sees the spill or leak should clean up and notify housekeeping to sanitize if needed. The aides and nursing staff are responsible for keeping rooms and belongings neat and tidy, including hygiene items and clothing. Staff are also responsible for respecting resident belongings. Whoever finds an issue with equipment puts it in TELS (a work order system for facility maintenance) and notify maintenance. R12Review of R12's Minimum Data Set (MDS) dated [DATE], revealed R12 had a BIMS (Brief Interview Mental Status) of 15/15 indicating he was cognitively intact. Section GG-Functional Status indicated R12 was dependent on staff for assistance with bed to chair transfer. Diagnoses included debilitating cardiorespiratory conditions. Review of R12's Care Plan Limited Physical Mobility, dated 1/5/26, revealed R12's limited mobility was related to bilateral total shoulder arthroplasties (restoring joint function by replacing joint) and removal of right shoulder. The goal was to remain free of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complications using interventions that included providing supportive care and assistance with mobility as needed. During an observation and interview on 3/17/2026 at 10:17 AM, R12 was awake in bed. R12's room was crowded with bedside dresser, walker, wheelchair, bedside commode, and dresser against wall with no clear path to bathroom. On the floor under the bedside commode was a cookie in a wrapper, a plastic hanger, and the lid from the bedside commode. Along the floorboards, where the wall meets the floor, there was an accumulation of dirt and debris. During an observation and interview on 3/18/2026 at 11:48 AM, R12 was awake in bed. A picture was on the floor and the frame was broken. Next to it was the lid of bedside commode, a cookie in wrapper, and a plastic hanger same as day prior. Along the floorboards, where the wall meets the floor, there was an accumulation of dirt and debris. During an interview and observation on 3/19/2026 at 10:44 AM, R12 was in bed. The room had little space to move around with bedside commode, walker, and wheelchair. Underneath the bedside commode was the lid, along with a plastic hanger, in the same spot as the day prior (3/18/26). Along the floorboards, where the wall meets the floor, there was an accumulation of dirt and debris. The room was in the same condition as the two consecutive days prior except for the packaged cookie. There was a cookie on the bedside table that resembled the cookie that had been on the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 - Minimal harm or potential for 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 incident is linked to intake 2612225.Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff for 1 resident (R14) of 3 reviewed for abuse, resulting in facility staff verbally assaulting R14 resulting in feelings of frustration, mental anguish, and a loss of autonomy (freedom from external control or influence). Findings include:According to the Minimum Data Set (MDS) dated [DATE], R14 was cognitively intact as evidence of a score of 15/15 on her Brief Interview Mental Score (BIMS) with a preferred language of Kinyardwanda and needed an interpreter to communicate with doctor or health care staff. R14 was independent with her ADLs (activities of daily living) and had diagnoses that included anemia, diabetes, PTSD (post-traumatic stress disorder), and cirrhosis of liver. Review of R14's Care Plan dated 11/25/25, Communication concerns, Cognitive deficits, Language barrier.speaks Kinyarwanda. The goal for R14 was to continue to communicate at present level with optimal understanding. Interventions to meet the resident's goals included interpretation services and the use of simple questions/commands, ask open-ended questions, and give resident time to respond. Review of R14's Care Plan, Behavior Problem related to history of trauma, dated 11/25/25, revealed the goal for the resident was to have no evidence of behavior problems. Interventions used to meet goal included caregivers to provide opportunity for positive interaction.speak in a calm manner. Review of Progress Note dated 8/15/26 at 4:55 PM, indicated R14 went to the facility Social Services Coordinator to report an incident with a CNA (Certified Nursing Assistant). A translation device was used for communication. R14 gave a detailed report on a verbal exchange with a CNA and alleged a hostile attitude, curse words, and insults were used. R14 reported she was very scared and could not sleep the rest of the night. During an interview on 3/19/26 at 8:52 AM, Social Services Coordinator (former employee) stated, I remember that incident centered around a CNA pulling something away from (R14). (R14) could be kind. During an interview on 3/19/26 at 12:30 PM, Registered Nurse (RN) DD stated, I was working on the night of the incident with (CNA SSS). (CNA SSS) was passing waters to the residents on the 600 hall. (R14) wanted two cups of water while (CNA SSS) explained the water was for other residents and would got get (R14) another cup of water. When (CNA SSS) told (R14) No, (R14) grabbed a cup of water and then grabbed (CNA SSS) by the back of the neck. (CNA SSS) told (R14) Don't touch me. I stepped in and told (CNA SSS) to finish passing waters and to stay at the other end of the hall with me. No other staff were around. It was just me, (CNA SSS) and R14 in the hall during the incident. (Nursing Home Administrator (NHA) A) did not interview me. No one contacted me or said anything to me.During an interview on 3/19/26 at 12:49 PM, NHA A reported he was the Abuse Coordinator. NHA A stated, I interviewed (RN DD) because CNA NN was down by the low 600 hall rooms when CNA SSS was passing waters. CNA NN was in room [ROOM NUMBER] and overheard (CNA SSS) call (R14) a Bitch.During an interview on 3/19/26 at 2:42 PM, CNA NN stated, I was working the night of the incident between (CNA SSS) and (R14). When the incident happened, I was on my way to answer a resident's call light. (CNA SSS) had her ear buds in her ears and was talking. I went into room [ROOM NUMBER]. (R14) was sitting next to (CNA SSS) near the nursing station between 1 AM and 5 PM. (CNA SSS) could not understand (R14) because of the different language (R14) spoke. I heard (CNA SSS) say, This Bitch got me messed up. I don't know who she was talking to. I don't know if she was talking to someone on her earbuds or who she was talking to. I believe (CNA SSS) was talking about (R14). (CNA SSS) had been a bully to me all week and I didn't want to get between her and (R14) so I just turned and walked away. I told the nurse (RN DD) that (CNA SSS) was fussing at (R14) but not until the next morning. I did not check on the resident. My responsibility is to the residents and to keep them safe, but I wanted to stay away from (CNA SSS) because she was a bully. During an interview on 3/19/26 at 3:00 PM, CNA SSS stated, I was passing ice waters on (R14's) end of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 - Minimal harm or potential for actual harm Residents Affected - Few	hall. When I went into (R14's) room I gave the husband water and I gave (R14) one. R14 wanted two waters. I told (R14) I would get her one when I was done passing water to the other residents. (R14) followed me out to the hall speaking in her language (Kinyarwanda). I picked up a cup of water to go into another room. (R14) snatched it from me and I told her no. She grabbed my shirt. I pulled away from her. I told her NO! You don't grab me. At that point of time, I had the cups labeled with date and room number. So, she had to wait until I was done passing all waters. I wanted to pass the cups of water I had ready before I gave her another cup of water. (R14) was fussing at me in her language. (RN DD) got (R14) water. I did not call (R14) any names. I didn't touch her. I told her not to grab me. It was me and (RN DD), and one other CNA who was coming down the hall during the incident. I've not had any other encounters with (R14). (R14) will tell you about her needs. She knows more English (language) than she lets on. I did not receive abuse education. I have had in-services on abuse 1-2times a year. I've had dementia and behavioral training. I would never harm any resident. It was a language barrier. When I talked to (NHA A), I told him there is no way to communicate with a different language. There was not way to explain what I was doing and for her to understand. Language plays a big part of communication. I did not know there was an app or have a phone to use it. During an interview on 3/19/26 at 4:00 PM, R14 was leery at first speaking to surveyor but with aid of translator was cooperative. R14 stated she remembered the incident when CNA SSS was passing water and would not give her 2 cups of water. I don't know why she could not give me 2 cups of water. She (CNA SSS) said No, those are for the other people. She did not tell me why, just no. I reached for a cup of water and she pushed at me, told me Fuck, Fuck Bitch She was not nice at all. Why did she have to be like that? What she said and did to me did not make me feel good at all. R14 appeared sad and shook her head.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2608884Based on interview and record review, the facility failed to safeguard credit card numbers for 1 resident (Resident #127) of 3 residents reviewed for abuse, resulting in a staff member making an unauthorized purchase using a resident's credit card.Findings include:Review of an admission Record revealed Resident #127 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: frontotemporal neurocognitive disorder (early onset decline in cognitive function). Review of a Facility Reported Incident (FRI) dated 8/13/25 at 11:08 AM regarding misappropriation for Resident #127 revealed, On 8.13.25 at approximately 10:30am, business office manager (BOM O) was on the phone with the resident's brother (Family Member (FM) SS) who handles the resident's financial transactions for billing. He stated he had had to block his old card and that was why a patient bill amount had been rejected and so he needed to establish a new card. (BOM O) asked him how that had happened, he stated it was because of a purchase at the ([NAME] name omitted) of $205 for a motorcycle battery that had occurred on 7.19.25 over the phone and shipped to this facility. He stated that he brought the concern to (Administrator in Training (AIT) R). Investigation Summary.Regarding (Resident #127) and Former Employee (AIT R).Shortly after the time (FM SS) stated he had come to talk to (AIT R) about this CC (credit card) transaction, he (AIT R) submitted notice of his resignation on 8.3.2025. His last day worked was 8.8.2025 Summary of Incident: On 8.13.2025 at approximately 10:15am, the facility Business Office Manager (BOM O), spoke with the resident's guardian, (FM SS), regarding the declination of his credit card when attempting to process (Resident #127's) payment to the facility for the month. (FM SS) stated that he had to have his card blocked a few weeks ago (approx. end of July 2025) because of a transaction he had noticed on his card. The purchase was for a motorcycle battery at the ([NAME] name omitted) made on 7.19.2025. He stated that when he went to the store to inquire about it they told him that the purchase had been a phone order that had been placed and shipped to this facility's address. (FM SS) brought this information to meet with someone at the facility and was waiting in the hall to talk with the (BOM O) when (AIT R) approached him and said he could assist. (AIT R) received the information about the credit card transaction and told (FM SS) he would follow up on it for him. According to (FM SS), about 1 week later, (AIT R) approached him with cash equivalent to the credit card transaction that had been made and told him it was from a special fund and that he should be all set now and that this kind of thing happens all the time. (FM SS) believed him and was satisfied with the follow up. No details of this situation were ever disclosed or reported by (AIT R) to anyone else in the facility. Immediate Action: (BOM O) reported to the NHA (Nursing Home Administrator A) the suspicious activity. The NHA called (FM SS) and asked if he could come in right away to review his CC statement, which he did. The statement line itemed a purchase at the ([NAME] name omitted) on 7.19.2025 for $204.99. The NHA called the ([NAME] name omitted) and using the facilities main number of (XXX-XXX-XXXX), the sales associate was able to locate an invoice for a phone purchase made with the residents mastercard for $204.99 for a motorcycle battery that was under the name (facility name omitted) with this facility's address for shipping the item. A copy of that invoice was obtained . The NHA attempted to contact (AIT R) via telephone, who answered. When the NHA explained to him what was being inquired about, he refused to answer and stated that he had something going on and needed to go. He stated he would call back but never did. Ongoing Investigation/Action: .Further discussion with (BOM O) revealed that it was sometime back in March 2025 when the residents first monthly payment was due that she received the credit card information from (FM SS) via a text message. She attempted to forward this text to her company email but was not successful. She then forwarded the text to (AIT R), who assisted her with getting the image of the card formatted and copied into an email back to her. To her knowledge (AIT R) was the only other employee outside of the business office that would've had access to this card information. The NHA (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	also recalled that it was around the end of July that (AIT R) had begun riding his motorcycle to work.Conclusion: Evidence strongly suggests due to the nature of the purchase (motorcycle battery), the use of this facilities phone and address to make the purchase, the access to the card that (AIT R) had via text message, along his failure to report anything about it when brought to him by (FM SS), along with his re-imbursement of (FM SS) from an unknown cash source and then resignation shortly after, that a financial misappropriation did occur.In an interview on 03/18/2026 at 10:09 AM, FM SS reported that he had given a copy of Resident #127's credit card that was pre-loaded with his social security funds, to BOM O for his bills at the facility and in July he had noticed a purchase on the card for a motorcycle battery that was made on 7/19/25. FM SS reported that he went to the store where the motorcycle battery was purchased and they printed the invoice for him and said that it was a charge made over the phone from someone at the facility. FM SS reported that he drove to the facility to discuss his concern with BOM O but was approached by AIT R who assured him that it would be taken care of. FM SS reported that a couple weeks later AIT R contacted him and wanted to meet at a gas station to reimburse FM SS for the $205 that was charged to the credit card. FM SS reported that he and AIT R met and he received the cash and didn't think again about it until 8/13/25 when NHA A called FM SS to inform him that they were investigating the unauthorized charges that were made on the credit card. FM SS reported that at the time he did not choose to press charges.In a phone interview on 03/18/2026 at 10:35 AM, Former staff, AIT R reported that he resigned from the facility in August 2025. AIT R replied to all of this surveyor's questions by stating I don't recall or I don't know. This surveyor asked if he was aware of an issue with a resident's credit card being used to purchase a motorcycle battery on 7/19/25, did BOM O ask for his assistance with a credit card image for a resident, did NHA A contact him about an issue with an unauthorized credit card purchase, did he speak with a family member about an unauthorized credit card purchase, and did he meet a family member and/or give a family member cash to reimburse for an unauthorized credit card purchase. AIT R declined to provide any other answers prior to ending the call.In an interview on 03/18/2026 at 12:43 PM, NHA A reported that BOM O had notified NHA A on 8/13/25 about a conversation that she had with Resident #127's guardian FM SS related to having to block a credit card due to an unauthorized charge and that AIT R had reimbursed for the charge. NHA A reported that he had started working at the facility just prior to them finding the issue and AIT R had resigned 5 days before the issue was identified. NHA A reported that Resident #127's guardian FM SS was asked to come into the facility for his statement and the police were called. NHA A reported that they concluded that the misappropriation occurred as a result of AIT R using Resident #127's credit card number for a personal purchase for his motorcycle, based on the evidence from the ([NAME] name omitted) and the consistency in reports from FM SS and BOM O. NHA A reported that after the misappropriation was identified, all resident's that had credit cards on file were assessed and guardians were contacted to ensure that no further misappropriation had occurred. NHA A reported that the facility performs weekly Advocate Rounds with residents, which includes asking if they feel their belongings are safe and secure. NHA A was not able to find the Advocate Rounds tool document to review the questions with this surveyor but said that Concierge BB keeps track of those.In an interview on 03/18/2026 at 1:35 PM, Concierge BB reported that the Advocate Rounds tool did not include any questions related to safety and security of belongings or personal funds and they were instructed to ask the questions word for word.Review of Advocate Rounds Tool blank document which revealed, Ask open ended questions: How are you today? Did you get enough to eat at mealtime? Has the staff been kind, courteous, and friendly? Is your call light answered timely? Are you comfortable? Do you have any questions about your care? Do you need some water? Are you satisfied with your doctor? Has the housekeeping staff been keeping your room clean? Do you have any concerns/issues with your clothing? Is there anything I can do for you?In an interview on 03/19/2026 at 9:16 AM, BOM M reported that she started about 3 months ago and had no knowledge of Resident #127's credit card issue and/or that there was ever an issue with a resident's credit card being used by a staff (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	member.In an interview on 03/19/2026 at 9:41 AM, Former staff, BOM O reported that she was looking into why Resident #127's payment did not process for August of 2025 and contacted his guardian FM SS for more information. BOM O reported that FM SS said that he would have to unlock the card for the payment to process; he had locked in a couple weeks earlier when he noticed an unauthorized charge on 7/19/25. FM SS went on to explain to BOM O that former staff AIT R had assisted him with getting reimbursed for the charge, getting cash from a special fund, because the unauthorized charge had been made by someone at the facility. BOM O reported that she immediately reported the concern to NHA A and it was investigated. BOM O reported that several months prior she had received Resident #127's credit card image because they were applying for Medicaid and due to the unusual card type they required an imagine. BOM O reported that she could not open the image that FM RR had sent, therefore she contacted the former NHA and was instructed to send it to AIT R and that he would print it for BOM O. BOM O reported that normally they do not receive images of credit cards. BOM O reported that AIT R and BOM O would have been the only people at the facility with access to Resident #127's credit card number.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235103	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2612225.Based on interview and record review the facility failed to ensure facility staff implemented the abuse policy in 1 of 1 residents (R108) reviewed for abuse, resulting in a delay in reporting of staff to resident verbal abuse to the state agency. Findings include: R108According to the Minimum Data Set (MDS) dated [DATE], R14 was cognitively intact as evidence of a score of 15/15 on her Brief Interview Mental Score (BIMS) with a preferred language of Kinyardwanda and needed an interpreter to communicate with doctor or health care staff. R14 was independent with her ADLs (activities of daily living) and had diagnoses that included anemia, diabetes, PTSD (post-traumatic stress disorder), and cirrhosis of liver.Review of R14's Care Plan dated 11/25/25, Communication concerns, Cognitive deficits, Language barrier.speaks Kinyarwanda. The goal for R14 was to continue to communicate at present level with optimal understanding. Interventions to meet the resident's goals included interpretation services and the use of simple questions/commands, ask open-ended questions, and give resident time to respond.Review of R14's Care Plan, Behavior Problem related to history of trauma, dated 11/25/25, revealed the goal for the resident was to have no evidence of behavior problems. Interventions used to meet goal included caregivers to provide opportunity for positive interaction.speak in a calm manner.Review of Progress Note dated 8/15/26 at 4:55 PM, indicated R14 went to the facility Social Services Coordinator to report an incident with a CNA (Certified Nursing Assistant). A translation device was used for communication. R14 gave a detailed report on a verbal exchange with a CNA and alleged a hostile attitude, curse words, and insults were used. R14 reported she was very scared and could not sleep the rest of the night.During an interview on 3/19/26 at 12:00 PM, Nursing Home Administrator (NHA) A stated, I am the Abuse Coordinator. Staff are to report to me any type of abuse at any time.During an interview on 3/19/26 at 12:30 PM, Registered Nurse (RN) DD reported she had seen the incident between CNA SSS and R14. CNA SSS was passing water to residents and R14 asked for two cups of water. R14 was told No by CNA SSS but would bring her a second cup when she was done passing waters. R14 grabbed a cup of water and was told No by CNA SSS then R14 grabbed CNA SSS by the back of the neck. RN DD stated she had not reported the incident to the Abuse Coordinator (Nursing Home Administrator (NHA A) timely and maybe should have.During an interview on 3/19/26 at 2:42 PM, CNA NN stated, I heard (CNA SSS) saying This B**** got me messed up. I don't know who she was talking to. I just turned and walked away. (CNA SSS) had been a bully to me all week and I did not want to get between (CNA SSS) and (R14). I told the nurse (RN DD) that (CNA SSS) was fussing at (R14) but not until the next morning. I did not check on the resident. My responsibility is to the residents and to keep them safe, but I wanted to stay away from (CNA SSS) because she was a bully. I told the (NHA A) but I don't know when I reported the incident. I guess I don't remember if I reported it right away to the Administrator. I have been trained who to report it to.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. This citation pertains to intakes 2696710.Based on interview and record review the facility failed to report allegations of abuse and neglect to the State survey agency and/or other officials when applicable for 13 (Residents #13, 22, 27, 35, 37, 41, 75, 77, 86, 97, 122, 139, and140) of 13 residents reviewed for reporting of alleged violations resulting in the State survey agency and/or nurse licensing department not being notified or notified timely, a delay in officials being aware of abuse/neglect allegations, and the potential for abuse and/or neglect to occur and/or reoccur. Findings include:Residents #13, 22, 27, 35, 37, 41, 75, 77, 86, 97, 122, 139, and 140:Review of the facility's Investigation Summary .Allegation: Potential Neglect - Medication Administration Delay, that occurred on 12/2/25, stated, .it was identified that an agency nurse (Licensed Practical Nurse (LPN) NNN) assigned to the afternoon shift left the facility mid-shift without providing notice to the leadership team or completing assigned medication administration duties.for a portion of the assigned residents (Residents #13, 22, 27, 35, 37, 41, 75, 77, 86, 97, 122, 139, and 140) .Reporting Determination .Based on the findings of the investigation.this event was determined not to meet criteria for reportable neglect .As the individual involved was an agency employee, any employment-related actions or reporting to the State Board of Nursing are the responsibility of the agency . Review of the facility's Summary of Medication Errors on 12/2 (2025), dated 12/2 (2025), indicated Residents #13, 22, 27, 35, 37, 41, 75, 77, 86, 97, 122, 139, and 140 all were noted to have scheduled medications not offered or given for the night shift due to .recent medication error where agency nurse (LPN NNN) failed to pass HS (at bed time) medications or .nurse (LPN NNN) failed to pass HS medication.During an interview on 03/19/2026 at 3:17 PM, Nursing Home Administrator (NHA) A confirmed LPN NNN worked approximately the first 2 hours of her night shift (Scheduled 7 PM - 7 AM) on 12/2/25, proceeded to end her shift without telling anyone, and left the building without returning. NHA A confirmed the facility had not reported LPN NNN to the State Survey Agency or to the State's Nurse Licensing Department (The facility proceeded to submit a late complaint to the State's Nurse Licensing Department on 3/19/26).Attempts were made to reach LPN NNN to discuss the incident but no response was received before the end of the survey. Resident #75:Review of Resident #75's .Medication Error report, dated 12/2/25, stated, Nursing leadership was notified just before midnight 12/3 (night of 12/2/25 going into the morning of 12/3/25) that the assigned agency nurse (LPN NNN) for 200 hall had left the job assignment around 9pm, locking her med (medication) cart keys in the med room without.giving report to another nurse, Agency provided a replacement nurse (Registered Nurse (RN) PPP) around 4 am.As DON (Former DON YY) was reviewing 24 hour summary, it was noted that resident didn't receive their bedtime medications.Statements.Certified Nurse Aide S.Statement.this nurse acted like she was overwhelmed.she went on break around 9 (PM) but we didn't see her again so we started looking around and saw her med (sic) keys in the med (sic) room. We called the on call nurse as soon as we notice (sic) her keys (LPN NNN's medication keys) and that was around midnight. We got a replacement nurse around 330 am (3:30 AM). The Statement from RN PPP on this report stated, (RN PPP) had been the nurse that took over on the assignment for the nurse that had walked out without notifying anyone. She reports she clocked in around 0330 (3:30 AM) and her agency reports the same. She verified that when she arrived to the facility, none of the HS medications for rooms 207-216 had been administered. RN PPP's statement on the report also stated, .I looked at the MAR (medication administration record) and saw noting (sic) was given. It was after 4am by that time and too late to give any of the meds.Review of the facility's nurse license complaint submission to the State of Michigan's Licensing and Regulatory Affairs' Professional Licensing department, undated (Facility reported it was submitted 3/19/26), stated, Nurse (LPN NNN) was working thru (through) agency at [Facility Name] on 12/2/2025, when she walked off the job not alerting anyone that she had left. She abandoned her position resulting in 13 patients not receiving (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	their HS meds (medications). The facility assumed that the agency [The Nurse Agency's Company Name] would report the license, but do not believe they have.Review of the facility's abuse policy, updated 5/24/2023, stated, Initial Reporting: The facility will ensure that all allegations involving abuse, neglect, . are reported immediately to the Administrator and: .Reported to the State Survey Agency immediately but not later than two hours after the allegation is made if the allegation involves abuse or results in serious bodily injury and to other officials .Reported to the State Survey Agency no later than 24 hours if the allegation does not involve abuse and does not result in serious bodily injury to the State Survey Agency and to other officials.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 - Some

Provide appropriate treatment and care according to orders, resident?s preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY This citation pertains to intake 2696710 Based on observation, int erview, and record review, the facility failed to ensure that residents received care in accordance with professional standards in 17 (#130, #4, #5,#13,#22,#27,#35,#37,#41,#75,#77,#86,#97,#122,#139,#140,and #2) out of 17 residents reviewed for quality of care resulting in missed medications, inaccurate documentation of medications and treatments administered, medications given without order parameters, and missing neurological (neuro) assessments after unwitnessed falls. Findings include:Inaccurate documentation of medications and treatments administered

Resident #130

Review of an admission Record revealed Resident #130 was originally admitted to the facility on [DATE] with pertinent diagnoses which included end stage renal disease and chronic pain syndrome.

Review of a Minimum Data Set (MDS) assessment for Resident #130, with a reference date of 2/3/26 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #130 was cognitively intact.

Review of Resident #130's Care Plan revealed, Focus: The resident needs hemodialysis (life-sustaining treatment for kidney failure that filters waste, toxins, and excess fluids from the blood when kidneys can no longer function effectively) r/t (related to) renal failure. Date initiated: 2/10/26. Interventions: Administer medications per physician orders. Date Initiated: 12/31/2025 .

During a Medication Administration observation on 3/18/2026 at 8:02 AM, Licensed Practical Nurse (LPN) JJJ prepared the following medications to administer to Resident #130: Senna Plus (stimulant laxative and stool softener), Omeprazole (medication used to treat heartburn), Eliquis (anticoagulant medication), Methocarbamol (muscle relaxant), Midodrine (medication used to treat low blood pressure), Sevelamer (medication used to treat high phosphorus levels in adults with chronic kidney disease), and Tylenol. LPN JJJ placed all of the medications into a cup and entered Resident #130's room. Resident #130 took all of the medications noted except the three Sevelamer tablets, which she had asked LPN JJJ to bring back after she had breakfast as she was supposed to take that medication with food. LPN JJJ left Resident #130's room with the three pills that Resident #130 did not take in the medication cup that she labeled and placed in her medication cart.

Review of Resident #130's Medication Administration Record (MAR) revealed that LPN JJJ had documented the following medications and treatments as completed at the same time that she had documented the following medications as administered to Resident #130 at the same time that this writer had observed the medication administration: Lidocaine External Patch 4 %, (topical pain medication patch), Lokelma Oral Packet 10 GM (medication used to treat adults with high potassium levels), Sevelmaer, Colace (stool softener). It was noted that the above listed medications had not been administered during the observation. Also noted that LPN JJJ had also documented the treatment order weight daily before breakfast one time a day for heart failure weight gain of 2 to 3 pounds call provider. at the same time that she had documented the medications as administered.

Review of Resident #130's Weights revealed that Resident #130 had not had a daily weight documented since 3/10/26.
(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 - Some	In a follow up interview on 3/18/2026 at 9:37 AM, LPN JJJ reported that she did not give Resident #130 her lidocaine patch. When this writer queried as to why it was documented that she had administered the patch, LPN JJJ reported that she would just strike out the documentation and was not able to provide a reason why she had documented the medication as administered. This writer then queried as to if she had given Resident #130 her Lokelma oral packet, LPN JJJ reported that she did not know what that was. LPN JJJ then walked to her medication cart with this writer and looked through her cart to find Resident #130's lokelma packet. She then reported that she would get one to her. LPN JJJ was not able to report why she had documented the medications (lokelma, sevelamer, and colace) as administered when they had not been. In an additional follow up interview on 3/18/2026 at 12:50 PM, LPN JJJ reported that she never gave Resident #130 her sevelamer medication with her breakfast as she had requested. Noted that LPN JJJ did not change her documentation in Resident #130's record to indicate that Resident #130 had missed her morning dose of sevelamer. In an interview on 3/18/2026 at 12:58 PM, Resident #130 confirmed that she had not received her lidocaine patch that morning, and she never received her morning dose of sevelamer that she had requested to take with her breakfast. Resident #130 also reported that she had not had her weight obtained that morning. In a follow-up interview on 3/19/2026 at 12:01 PM, LPN JJJ confirmed that she did not obtain Resident #130's daily weight on 3/18/26. In an interview on 3/18/2026 at 4:00 PM, Unit Manager (UM) T reported that nurses were expected to document medications and treatments as administered only after the medication and treatment was completed. In an interview on 3/19/2026 at 12:28 PM, Director of Nursing (DON) B reported that nurses were expected to document medications and treatments as administered only after the medication and treatment was completed. DON B confirmed that documenting a medication or treatment as administered without completing it was not an accurate reflection of the resident's medical record. DON B reported that nurses were expected to report all missed medications and treatments to the Unit Manager and Provider if indicated. In an interview on 3/18/2026 at 1:51 PM, Nurse Practitioner (NP) OOO reported that it was her expectation that nurses were communicating and notifying her when medications were missed and not given so she could monitor the plan of care. NP OOO confirmed that she had not been notified regarding missed medications for Resident #130. Medications given without order parameters Resident #130 Review of Resident #130's Orders revealed, Midodrine HCl oral tablet 5 MG. Give 1 tablet by mouth two times a day for hypotension and 3 tablets by mouth as needed for hypotension (low blood pressure), may give with scheduled dose. Start date: 3/10/26. This order was transcribed by LPN FFF and signed off on by NP OOO. During a Medication Administration observation on 3/18/2026 at 8:02 AM, Licensed Practical Nurse (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 - Some	(LPN) JJJ prepared midodrine and placed the medication in a cup. LPN JJJ placed the medication into a cup and entered Resident #130's room. It was noted that LPN JJJ did not assess Resident #130's vitals (blood pressure, heart rate, temperature and oxygen saturation) prior to administering medications. LPN JJJ gave Resident #130 her medications, including the midodrine, which she took. Review of Resident #130's Vital Signs in her electronic medical record on 3/18/26 at 10:00 AM noted that she did not have a vital sign assessment documented for 3/18/26. In an interview on 3/19/2026 at 12:01 PM, LPN JJJ reported that she thought that she took Resident #130's vital signs prior to administering her medications and that she had documented the vital sign assessment in Resident #130's record. When this writer queried LPN JJJ about where she had documented Resident #130's vital signs, LPN JJJ reviewed Resident #130's record reported that she must have forgot to document them, but they were fine. LPN JJJ reported that midodrine was a medication that required a blood pressure assessment prior to administering. LPN JJJ was unable to report what the parameters to hold Resident #130's midodrine order, because there were not parameters indicated on the order. During an interview on 3/18/2026 at 2:22 PM, LPN FFF reported that she had entered the order for Resident #130's midodrine. LPN FFF reported that the order should have had parameters for blood pressures noted, and she was not sure how this was missed. During an interview on 3/18/2026 at 4:00 PM, Unit Manager (UM) T reported that nurses should assess vital signs prior to administering midodrine. UM T reviewed Resident #130's midodrine order with this writer and confirmed that the order was missing blood pressure parameters. In an interview on 3/18/2026 at 1:51 PM, Nurse Practitioner (NP) OOO reported that all midodrine orders should have a blood pressure parameter indicated so that the nurse knows when they need to hold the medication. NP OOO reviewed Resident #130's midodrine order with this writer and confirmed that the order was missing parameters, and therefore nursing staff were administering the medication without clarification on when they would need to hold the medication. Missed Medications Resident #4 Review of an admission Record revealed Resident #4 was originally admitted to the facility on [DATE] with pertinent diagnoses which included type 2 diabetes with diabetic neuropathy (chronic condition where the body resists the effects of insulin or fails to produce enough to maintain normal blood sugar levels) and obstructive sleep apnea (serious sleep disorder where breathing repeatedly stops and starts because throat muscles relax too much, causing the airway to collapse). Review of Resident #4's MAR revealed, Ozempic (once-weekly injection that improves blood sugar control in adults with type 2 diabetes) Subcutaneous (fatty tissue layer between the skin and muscle) solution pen. Inject 0.25 mg one time a day every Friday for DMII (Diabetes Mellitus Type 2). Start date 3/6/26. This order was documented as not given 3/13/26 by LPN FFF. Noted that there was not documentation to indicate that LPN FFF had contacted the provider to inform that Resident #4 did not receive his medication. During an interview on 3/18/2026 at 2:22 PM, LPN FFF reported that she did not administer Resident (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 - Some	#4's Ozempic on 3/13/26 because she could not find it. LPN FFF reported that she thought that she had contacted the provider and she had re-ordered the medication from the pharmacy, but she could not recall if she had documented that she did. During an interview on 3/19/26 at 9:50 AM, Pharmacy Tech (PT) RRR reported that the last time that the pharmacy had sent Resident #4's Ozempic medication to the facility was on 3/3/26. PT RRR reported that the facility was responsible for re-ordering the medication, and that the pharmacy had not received a refill request for Resident #4's Ozempic for the month of March. During an interview on 3/18/2026 at 1:51 PM, NP OOO reported that she had not been made aware that Resident #4 missed his Ozempic injection on 3/13/26. Review of the facility's Medication Administration policy dated 8/7/23 revealed, Policy Overview: To safely and accurately prepare and administer medicaˆon according to physician order, professional standards of practice, and resident needs General Instructions: . Administer medication in accordance with frequency prescribed by physician and standards of practice . If a pharmacy supplied medication is not available, refer to the pharmacy policy and procedures related to emergency pharmacy delivery and emergency supply kit usage . Resident refusal of medications: Document refusal on MAR, Notify physician of refusal as clinically indicated . Missing neurological (neuro) assessments after unwitnessed falls Resident #4 Review of Resident #4's Incident Report dated 10/18/25 revealed, Unwitnessed fall. Incident Description: Nursing Description: At 1030, Nursing staff observed resident was on the floor. Resident was laying on his back. resident stated he needed to go to the bathroom .Immediate action taken: Head to toe assessment performed. no alterations to skin integrity noted. neuro check initiated . Review of Resident #130's Neurological Assessment form for the 10/18/25 fall revealed, Directions: Complete neurological evaluation with vital signs initially, then every 30 minutes x2, then everyhour x4, then every 4 hours x6, then every shift x 3 days . Noted that there was a missing documentation of a neurological assessment completed on 10/22/25 for the 7AM-7PM shift. Review of Resident #4's Incident Report dated 1/6/26 revealed, Unwitnessed fall. Nursing Description: At 1330 (1:30 PM), resident was noted laying on the floor between his wheelchair and the bed .Resident stated he hit his head . Immediate action taken: head to toe assessment was performed. No alterations to skin integrity noted. no redness or bruising to head. resident denied pain. resident was transferred from floor to bed via mechanical hoyer lift. vital signs obtained and neuro check initiated . Review of Resident #130's Neurological Assessment form for the 1/6/26 fall revealed, Directions: Complete neurological evaluation with vital signs initially, then every 30 minutes x2, then every hour x4, then every 4 hours x6, then every shift x 3 days. It was noted that there was missing documentation of neurological assessments completed on 1/7/26 at 02:30 AM, and 6:30 AM, on 1/9/26 from 7AM-7PM and on 1/10/26 from 7AM-7PM. During an interview on 3/19/2026 at 11:27 AM, LPN GGG reported that nurses were Absolutely required to complete neurological assessments on any resident after an un-witnessed fall. LPN GGG (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 - Some	reported that the nurses were supposed to document their assessment on the Neurological Assessment sheet and continue the assessments until the last date as indicated on the sheet. During an interview on 3/19/2026 at 11:39 AM, LPN GG reported that nurses were required to initiate and complete neurological assessments for all residents after an unwitnessed fall. During an interview on 3/19/2026 at 12:28 PM, Director of Nursing (DON) B reported that nurses were required to complete neurological assessments on all residents after an unwitnessed fall. DON B reviewed Resident #4's Neurological Assessments with this writer and confirmed that the facility was missing documentation to verify that Resident #4 had not missed any neurological assessments. Resident #5 Review of an admission Record revealed Resident #5 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: bipolar disorder (a chronic mental illness characterized by dramatic shifts in mood, energy, and activity levels). Review of a Minimum Data Set (MDS) assessment for Resident #5 with a reference date of 1/9/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Review of a Care Plan for Resident # 5 with a reference date of 1/2/26 revealed the following focus/goals/interventions: Focus: The resident needs dialysis (life-saving medical procedure that acts as an artificial kidney to remove waste and toxics from the blood) r/t (related to) end stage renal (kidney) disease, Dialysis 7:05-11:30am, pick up at 6:15am every Monday, Wednesday, Friday. Goal: The resident will have no signs.of complications.Administer medications per physician orders. During an observation on 3/18/26 at 10:38am it was noted that Resident #5 was not in her room. Review of a Treatment Administration Record for Resident #5 at 10:39am on 3/18/26 revealed RN JJJ had already documented the following for this date, despite the fact that Resident #5 was absent from the building since 6:25am(prior to the start of RN JJJs shift): 1. For the entire shift Resident #5 had no episodes in which she voiced feeling sad and/or lonely. The order read Complete based on individual observation of patient. 2. RN JJJ documented she had observed the resident's dialysis site to monitor for skin integrity management. The order read my initials indicate skin intact without concerns, 3. Enhanced barrier precautions were maintained throughout the shift, and 4. RN JJJ monitored Resident #5's dialysis port for s/s (signs and symptoms) for infection and bleeding. In an interview on 3/18/26 at 10:48am, Registered Nurse (RN) JJJ reported she was Resident #5's nurse for the day. RN JJJ reported her shift began at 7:00am. In an interview on 3/18/26 at 11:02am Receptionist V reported per the appointment schedule calendar, Resident #5 left the building at 6:25am on this date and had not returned to the facility as of this time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 - Some	In an interview on 3/18/26 at 11:05am, Certified Nursing Assistant (CNA) OO reported she was working on Resident #5's unit today and the resident had already left for dialysis before CNA OO began her shift at 7:00am. During an observation on 3/18/26 at 12:03pm, Resident #5 exited a transportation van in the circle driveway of the building and entered through the main door. In an interview on 3/18/26 at 12:04pm, Resident #5 reported she left the building while the overnight shift was still on duty, at approximately 6:25am, and had not seen RN JJJ prior to leaving. Residents #13, 22, 27, 35, 37, 41, 75, 77, 86, 97, 122, 139, and 140:Review of the facility's Investigation Summary .Allegation: Potential Neglect - Medication Administration Delay, that occurred on 12/2/25, stated, .it was identified that an agency nurse (Licensed Practical Nurse (LPN) NNN) assigned to the afternoon shift left the facility mid-shift without providing notice to the leadership team or completing assigned medication administration duties.for a portion of the assigned residents (Residents #13, 22, 27, 35, 37, 41, 75, 77, 86, 97, 122, 139, and 140) . Review of the facility's Summary of Medication Errors on 12/2 (2025), dated 12/2 (2025), indicated Residents #13, 22, 27, 35, 37, 41, 75, 77, 86, 97, 122, 139, and 140 all were noted to have scheduled medications not offered or given for the night shift due to .recent medication error where agency nurse (LPN NNN) failed to pass HS (at bed time) medications or .nurse (LPN NNN) failed to pass HS medication. This summary revealed the following residents and the number of missed scheduled night time medications from 12/2/25:Residents #13 (4 missed medications), #22 (5 missed medications), #27 (4 missed medications), #35 (4 missed medications), #37 (9 medications), #41 (1 missed medication), #75 (2 missed medications), #77 (1 missed medication), #86 (8 missed medications), #97 (2 missed medications), #122 (3 missed medications), #139 (8 missed medications), and #140 (4 missed medications). During an interview on 3/18/2026 at 3:50 PM, Former Director of Nursing (FDON) YY reported she was the Director of Nursing on 12/2/25, confirmed LPN NNN left her shift early before passing out all scheduled night time medications, and confirmed this resulted in the residents listed in the 12/2/25 missed medication investigation/summary (noted above) not receiving their night time medications. Attempts were made to reach LPN NNN to discuss the incident but no response was received before the end of the survey. Resident #75:Review of Resident #75's .Medication Error report, dated 12/2/25, stated, Nursing leadership was notified just before midnight 12/3 (night of 12/2/25 going into the morning of 12/3/25) that the assigned agency nurse (LPN NNN) for 200 hall had left the job assignment around 9pm, locking her med (medication) cart keys in the med room without.giving report to another nurse, Agency provided a replacement nurse (Registered Nurse (RN) PPP) around 4 am.As DON (Former DON YY) was reviewing 24 hour summary, it was noted that resident didn't receive their bedtime medications.Statements.Certified Nurse Aide S.Statement.this nurse acted like she was overwhelmed.she went on break around 9 (PM) but we didn't see her again so we started looking around and saw her med (sic) keys in the med (sic) room. We called the on call nurse as soon as we notice (sic) her keys (LPN NNN's medication keys) and that was around midnight. We got a replacement nurse around 330 am (3:30 AM). The Statement from RN PPP on this report stated, (RN PPP) had been the nurse that took over on the assignment for the nurse that had walked out without notifying anyone. She reports she clocked in around 0330 (3:30 AM) and her agency reports the same. She verified that when she arrived to the facility, none of the HS medications for rooms 207-216 had been administered.I looked at the MAR (medication administration record) and saw noting (sic) was (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER: Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE: 2320 E Beltline SE, Grand Rapids, MI 49546	

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 - Some	given. It was after 4am by that time and too late to give any of the meds. During an interview on 03/19/2026 at 10:22 AM, NHA A reported the abbreviation MP PM as seen on Resident #75's electronic medication administration record indicated Medication Pass PM (at night) and the window of time to pass medications scheduled to be given for the Hours of MP PM were 7PM-10PM. Review of Resident #75's electronic medication administration record, dated 12/1/25-12/31/25, revealed that on 12/2/25 two medications, mirtazapine (antidepressant) tablet 7.5 milligrams by mouth at bedtime and melatonin (helps regulate sleep) 6 mg by mouth, were not given and had been scheduled to be given during the Hours of MP PM (7PM-10PM window per the facility).Review of Resident #75's progress notes, dated 12/3/2025 at 5:17 AM, indicated the melatonin and mirtazapine were Not given, out of range (out of the range of time they could be given). This citation is linked to intake 2689014. R2 According to the Minimum Data Set (MDS) dated [DATE], R2 was cognitively intact per his BIMS (Brief Interview Mental Status) of 14/15. R2 diagnoses included unspecified conjunctivitis in bilateral (both) eyes. Review of R2's Order Summary did not contain a current order for antibiotics to treat conjunctivitis. During an observation and interview on 3/17/2026 at 12:00 PM R2's eyes had light green drainage coating upper and lower lashes. Both eye's sclera looked red and irritated looking. Resident said he did not know what was going on with his eyes. R2 then used his right hand to rub both eyes. During an observation and interview on 3/18/2026 at 10:49 AM, R2 was awake in bed reading. Both eyes had light green drainage coating upper and lower lashes. Both eye's sclera looked red and irritated looking. R2 stated he has something in his eyes, and he should wipe them out with warm water. He said he would wait until nursing would tell him what to do with his eyes. During an interview and record review on 3/19/26 at 11:19 AM, Unit Manager (UM) LL stated, (R2) does not allow staff to keep his hands clean and he rubs his eyes. (R2) does not allow staff to administer eye drops. (R2) has a Care Plan for refusing care. (R2) also has refusal on MAR/TAR. I do not see where (R2) has a diagnosis of conjunctivitis. The order for antibiotic eye drops was for 7 days back in November 2025 for conjunctivitis. While looking in R2's medical chart, UM LL stated, (R2) does have conjunctivitis right now. Currently he does not have anything ordered for the infection. It should be documented in progress notes and MAR/TAR when (R2) refuses warm compresses and treatments. Gentamycin was started 3/10/26 and finished 3/15/26. UM LL reviewed R2's medical chart to see if R2 allowed administration in his MAR, stating, The refusal should be progress notes with his care plan updated. (R2) missed one dose of Gentamycin on 3/13/26. The refusal was not charted. At noon on 3/12/26 06 as documented. UM LL stated, The 06 should be documented on that date in his progress notes. UM LL looked in R2's progress notes and stated, (R2) has 02 documented at 6 PM on 3/11/ and 3/13/26. He was at dialysis those days and missed the dose. Residents that are at dialysis or an appointment should be getting their antibiotics when they come back. The physician should be contacted of missed doses and obtain a new order, then document in the resident's progress notes. On 3/12/26 07 was documented in (R2's) MAR and progress notes and it was not. I'm looking in (R2's) MAR for March (2026) to see if an order was obtained to give his antibiotic eye drops after he came back from dialysis, and there is no order for late administration of (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 - Some	the medication. There is a progress note dated 3/12/26 at 1:16 PM that states NA. Obviously after looking at R2's progress notes are not being done as expected. The progress notes are not being followed up on and they should be so the facility knows what is going on with the resident. According to (R2's) Physician Orders he was to receive antibiotic eye drops 4 times a day starting 3/10/2026 and ending 3/15/26. (R2) continues to have conjunctivitis because he did not get his full dose of antibiotics. Nurses are to notify the physician with every missed dose of antibiotic. I'm looking at correspondence between nursing and the provider and there are no messages to the provider that (R2) still has the infection. I am ultimately responsible for letting the provider know the infection continues. During an interview and record review on 3/19/2026 at 1:05 PM, Regional Infection Control Preventionist (ICP) AA, reported she was at the facility 2 days a week to fill in until the facility has a full-time ICP. While reviewing R2's medical chart with Director of Nursing (DON) B, ICP AA stated, (R2) has conjunctivitis. His first treatment was 2/23-28/26 with Gentamycin. To my knowledge, the antibiotic was completed. On 3/10-3/15/26 Gentamycin was again ordered and documented it was completed. Unit Managers expected to follow the infections on their halls and fill out an Infection Control Work Sheet and return it back to me. While reviewing R2's Infection Control Work Sheet, ICP AA stated, (UM LL) assigned to (R2) did not fill out the sheet that stated the antibiotic was completed. It was another Unit Manager (UM T). (UM T) got her information from the medical director's note and he in turn would get his information from medical records and reassessment of the resident. ICP AA reviewed R2's medical records discovering the medical director had not placed a note stating (R2) was reassessed. During an interview on 3/19/26 at 4:00 PM, Nurse Practitioner (NP) II stated, I was not notified (R2) missed doses of his antibiotic, did not complete the entire series of antibiotic, or that he still had conjunctivitis until today, after you spoke with (ICP AA). I just assessed (R2) before talking to you and yes, he still has conjunctivitis in both eyes. Review of facility policy Antibiotic Stewardship reviewed date 2/4/25, revealed, .Recommendations and interventions of an effective antibiotic stewardship program are designed to ensure that residents who meet criteria for infection receive the right antibiotic for the right duration.Facility staff and medical practitioners have a responsibility to assure that antibiotics are requested and provided .only for the length of time needed to adequately treat the infection.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2731057.Based on observation, interview, and record review, the facility failed to ensure adequate labeling, dating/timing, and maintain cleanliness of enteral feeding equipment for 2 residents (R108 and R8) of 2 residents reviewed for enteral feeding, resulting in the potential for spoiled enteral feeding supplement and infections. Findings include:R108According to R108's Minimum Data Set (MDS) dated [DATE], indicated R108 was unable to complete the BIMS (Brief Interview Mental Status) and was severely cognitively impaired with a score of 00/15. Section K-Swallowing/Nutritional Status revealed nutritional approaches included R108 had a feeding tube. Diagnoses included cerebrovascular accident (CVA/stroke) and calorie-deficient malnutrition.Review of R108's Order Summary, dated 2/6/26, revealed, Enteral Feed.OFF 9:00 AM.Review of R108's Care Plan, dated 2/5/26, included a focus of Need for Feeding Tube, indicating the resident had a resident-specific treatment plan for enteral feeding.During an observation and interview on 3/17/26 at 11:10 AM, R108's enteral (tube) feeding was running via a pump. The feeding was a light tan color. The pump administering the enteral feeding along with the pole, pole base, surrounding floor, chair, and resident belongings (fleece jacket and tube of ointment) in a chair was splattered with a dried and sticky substance resembling the tube feeding. R108's feeding pump alarm was going off with an error message. Licensed Practical Nurse (LPN) N was in the hallway outside R108's room heard the alarm and entered the room. LPN N pressed a button on the pump, and the error message disappeared. LPN N stated she did not normally work the hall R108 lived on and had no idea why the pump was sounding off. When asked when the feeding was started and how long it was to run LPN N stated she had no idea when the feeding started or how long it was to run and then read off the pump until finished stating I guess that is when it ends. LPN N made no mention of the condition of the pump, pole, base, floor or chair with resident belongings that had splatters of sticky and dried substance resembling tube feeding. It was noted, R108's enteral feeding was to be off at 9:00 AM per the Order Summary.During an observation and interview on 3/17/2026 at 11:20 AM, R108's enteral feeding pump alarm was peeping with an error code Er. The pump was not running. The alarm could only be heard when standing directly outside of room. Observed five staff walk directly by R108's room with the door open and alarm going off. Registered Nurse (RN) W walked twice past R108's room with the alarm going off. RN W stated, I do not have that room. RN W did not approach R108's room and kept walking down the hall. R108 appeared frustrated and was waving her left hand in the hand with an angry look on her face. It was noted on the Order Summary the enteral feeding was to be off at 9:00 AM. During an interview on 3/17/2026 at 1:24 PM, Family Member (FM) PP stated, The chair for visitors next to (R108's) bed is covered with feeding tube (enteral feeding) drippings that I saw yesterday (3/16/26), it was dripping from the bottle. My mother did not live like that when she was independent. During an observation on 3/18/2026 at 11:11 AM, R108's enteral feeding was hung on a pole and attached to the pump. A bag of clear fluids was hung on the pole and attached to the pump via clear tugging. The pump, pole, pole base, floor under the pole base, a chair next to the pole with a wadded-up fleece jacket and tube of ointment were all splattered with a dried sticky substance resembling the enteral feeding. R8According to R8's Minimum Data Set (MDS) dated [DATE], indicated R8 was cognitively intact with a BIMS of 13/15. Section K-Swallowing/Nutritional Status revealed nutritional approaches included R8 had a feeding tube.Review of R8's Diagnoses, dated /29/25, indicated the resident had chronic vascular disorders of the intestine.Review of R8's Order Summary, dated 3/11/26, indicated the resident received enteral feeding every night shift related to duodenal obstruction (blockage in the first part of the small intestine, restricting food flow).Review of R8's Care Plan, dated 1/1/2026, included a focus of Need for Feeding Tube (enteral feeding), indicating the resident had a resident-specific treatment plan for enteral feeding.During an (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation on 3/17/26 at 11: 25 AM, R8 was awake in bed stating his wife wishes for him to have the enteral feeding. There was no labeling/dating on the enteral feeding container or the fluid bag.During an interview on 3/17/26 at 11:30 PM, Director of Nursing (DON) B stated, Tube feeding and fluids should be labeled with resident's name, date, and time they were labeled so staff will not reuse the feeding or fluid or know when they were hung for infection control.During an observation and interview on 3/17/2026 at 12:18 PM, R8 had an enteral feeding container, hung on a pole and connected through a pump via clear tubing along with a bag of clear fluids. Neither the enteral feeding nor the fluids were labeled with resident's name or dated/timed when they were hung. Both enteral feeding and fluids were partially full. The tubing had residual of the enteral feeding in it. Observed the pump, pole, pole base, and floor to have splatters of a sticky and dried substance resembling enteral feeding. During an observation and interview on 3/18/26 at 11:33 PM, R8 was awake in bed. R8's enteral feeding pump, pole, pole base, and floor under pole were splattered with a sticky substance resembling enteral feeding. During an interview and record review on 03/19/2026 11:19 AM Unit Manager (UM) LL stated, (R8) is on enteral feeding. The tube feeding and fluid should be dated and labeled to know when it was hung, if it is fresh, and is staff is following physician orders. Enteral feeding equipment should be kept clean for infection control.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 2802001, 2802220, 2798542, & 2737401. Based on interview and record review, the facility failed to identify incorrect medication orders during the monthly medication regimen review for 1 of 6 residents (Resident #39), reviewed for medication regimen reviews, resulting in the unnecessary administration of an antipsychotic medication and the potential for worsening medical conditions. Findings include:Resident #39 Review of an admission Record revealed Resident #39 was originally admitted to the facility on [DATE] with pertinent diagnoses which included paranoid schizophrenia (chronic and serious mental health condition that can significantly affect how a person thinks, feels, and behaves) and cognitive communication deficit. Review of Resident #39's Medication Regimen Review dated 1/30/26 and completed by Consulting Pharmacist (CP) AAA revealed, Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident'smedication regimen contained no new irregularities .Review of Resident #39's Medication Regimen Review dated 2/6/26 completed by CP AAA revealed, Based upon the information available at the time of the review, and assuming the accuracy and completeness of such information, it is my professional judgement that at such time, the resident'smedication regimen contained no new irregularities .Review of the facility's Medication Error Investigation revealed, Resident #39 was admitted on [DATE] . On 1/28/26, Licensed Practical Nurse (LPN) P entered an order for Haloperidol (Haldol) Deaconate (antipsychotic medication) intramuscular solution 100 mg/mL (milligrams per milliliter) give 2.5 ml IM (intramuscular) to be given one time a day on the 16th-21st. In the additional directions it was noted to give every 21 days. The correct order was to give Haloperidol Deaconate intramuscular solution 100 mg/mL give 2.5 ml IM to be given one time a day once every 21 days. The error in order transcription resulted in the resident receiving doses of IM Haldol on 2/17/26, 2/18/26, and 2/21/26 . Noted that the investigation report indicated the incorrect dates that Resident #39 received the Haldol injections. Review of Resident #39's Medication Administration Record (MAR) revealed, Haloperidol Decanoate Intramuscular Solution 100 MG/ML (Haloperidol Decanoate) Inject 2.5 ml intramuscularly one time a day starting on the 16th and ending on the 21st every month for schizophrenia every 21-day IM inject. Start date: 2/17/26. The medication was documented as administered by LPN LLL on 2/17/26 and on 2/20/26 and 2/21/26 by LPN EE. During an interview on 3/17/2026 at 12:52 PM, Family Member (FM) MMM reported that Resident #39 had been admitted to the facility on [DATE] after a hospitalization. FM MMM reported that Resident #39 was followed by a (Local Mental Health Authority-company that provided public services for mental health, substance use, and developmental disabilities) and that the Mental Health Authority would review her medications each month and provide her monthly haldol injection. FM MMM reported that on 3/6/26, she was informed by the Mental Health Authority that Resident #39 had received three doses of her monthly haldol injection at the facility in error. During an interview on 3/18/2026 at 4:28 PM MHAN BB reported that when Resident #39 came in for her medication review appointment on 2/19/26, she had planned to administer Resident #39's monthly Haldol injection, but she was told by Resident #39 that she had just gotten the injection at the facility, so she did not administer the injection and requested Resident #39's medication records from the facility to review. MHANBB reported that she called the facility on 2/27/26 to review Resident #39's medications because she had not yet received Resident #39's medication records from the facility. MHAN BB reported that she spoke to LPN EE on 2/27/26 and reviewed Resident #39's orders with him. MHAN BB reported that when LPN EE read Resident #39's Haldol order to her, she informed LPN EE that the order was incorrect, and Resident #39 should have only received 1 Haldol injection every 21 days. MHAN BB reported that LPN EE told her that he thought the order looked incorrect, so he asked a supervisor about it, and he was told to administer (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the medication anyway. Review of Resident #39's Nursing Narrative note dated 2/27/26 from the Mental Health Authority revealed This RN (MHAN BB) called (Facility) nursing line to inquire about medication records regarding this patient's Haldol 250mg Q3wks (every 3 weeks). This RN spoke to a (LPN EE) who stated that the last time this patient received this medication was on 02/21. (LPN EE) also stated that the order was written as, Haldol 250mg from 02/16-02/21, therefore, this patient received multiple doses within a week. (LPN EE) did state that the patient refused the medication a few times, but states that he knows she got it at least twice from him. (LPN EE) states, I thought the order looked weird. He states that he asked his supervisor at (Facility) for clarification and was told to give the medication as the order stated . Review of Resident #39's Progress Note dated 3/7/26 (8 days after the telephone call with MHAN BB on 2/27/26) and documented by LPN EE revealed, Spoke with nurse at (Local Mental Health Authority) and was asked to do a complete medication review of this resident's medications. During the review, it was brought to the attention of this nurse that there was a discrepancy regarding resident's Haloperidol Deaconate Intramuscular solution 100 mg/ml. The order in (electronic medical record) reads Inject 2.5 ml intramuscularly one time a day starting on the 16th and ending on the 21st of every month for schizophrenia every 21 days which was incorrect. Two doses were administered by this nurse. The nurse was asked about the resident's condition and asked to obtain a set of vitals. The resident was fairly new to this unit, so nurse didn't have knowledge of their baseline . the resident's mental state to the nurse seemed to be AOx 2-3 (alert and oriented) and her vitals were exceptionally great (did not indicate what vital signs were) . During an interview on 3/18/2026 at 11:50 AM, LPN P reported that she had entered Resident #39's Haldol order when she was admitted to the facility. LPN P reported that she knew that the order was supposed to be scheduled for every 21 days, and she was not sure she made the error in transcribing the order. During an interview on 3/18/2026 at 3:55 PM, LPN EE reported that he had administered two doses of Resident #39's Haldol injection on 2/20/26, and 2/21/26. LPN EE reported that he recalled questioning the order, and so he had asked his Unit Manager about the order and was instructed to administer the injections anyway. During an interview on 3/19/2026 at 12:12 PM, CP AAA reported that she had completed Resident #39's monthly medication reviews. CP AAA reported that she had noticed that Resident #39's Haldol injection was scheduled to administer for multiple days in a row, but she thought that was for the nurse to have time to give the medication if it did not arrive on time. CP AAA confirmed that she did not report this order and she had missed that the order was transcribed incorrectly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes: 2802001, 2802220, 2798542, & 2737401.Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 8 of 9 Residents (#39, #76, #86, #139, #27, #140, #37, #22) reviewed for medication errors when a.) Medication orders were transcribed and administered incorrectly and B.) medications were not administered as ordered resulting in Resident #39 receiving excessive doses of an antipsychotic medication and Resident's #76, #4, #86, #139, #27, #140, #37, #22's medications were omitted resulting in the decompensation (functional deterioration of a physical or mental system) for Resident #76, and the potential for health complications. Findings include: Resident #39 Review of an admission Record revealed Resident #39 was originally admitted to the facility on [DATE] with pertinent diagnoses which included paranoid schizophrenia (chronic and serious mental health condition that can significantly affect how a person thinks, feels, and behaves) and cognitive communication deficit. Review of Resident #39's Care Plan revealed, Focus: (At risk for changes in behavior & mood r/t (related to) paranoid schizophrenia .Interventions: Administer medications per physician orders. Date Initiated: 01/29/2026 . Review of the facility's Medication Error Investigation revealed, Resident #39 was admitted on [DATE] . On 1/28/26, Licensed Practical Nurse (LPN) P entered an order for Haloperidol (Haldol) Deaconate (antipsychotic medication) intramuscular solution 100 mg/mL (milligrams per milliliter) give 2.5 ml IM (intramuscular) to be given one time a day on the 16th-21st. In the additional directions it was noted to give every 21 days. The correct order was to give Haloperidol Deaconate intramuscular solution 100 mg/mL give 2.5 ml IM to be given one time a day once every 21 days. The error in order transcription resulted in the resident receiving doses of IM Haldol on 2/17/26, 2/18/26, and 2/21/26 . Noted that the investigation report indicated the incorrect dates that Resident #39 received the Haldol injections. Review of Resident #39's Medication Administration Record (MAR) revealed, Haloperidol Decanoate Intramuscular Solution 100 MG/ML (Haloperidol Decanoate) Inject 2.5 ml intramuscularly one time a day starting on the 16th and ending on the 21st every month for schizophrenia every 21-day IM inject. Start date: 2/17/26. The medication was documented as administered by LPN LLL on 2/17/26 and on 2/20/26 and 2/21/26 by LPN EE. During an interview on 3/17/2026 at 12:52 PM, Family Member (FM) MMM reported that Resident #39 had been admitted to the facility on [DATE] after a hospitalization. FM MMM reported that Resident #39 was followed by a (Local Mental Health Authority-company that provides public services for mental health, substance use, and developmental disabilities) and that the Mental Health Authority would review her medications each month and provide her monthly haldol injection. FM MMM reported that on 3/6/26, she was informed by the Mental Health Authority that Resident #39 had received three doses of her monthly haldol injection at the facility in error. FM MMM reported that she was informed by the Mental Health Authority's Nurse (MHAN) BB that she had talked to LPN EE at the facility on 2/27/26 when she called to discuss Resident #39's medication orders, and it was discovered that the facility had transcribed the order wrong and administered multiple does. FM MMM reported that she (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0760 Level of Harm - Actual harm Residents Affected - Few	had not been contacted by the facility until 3/9/26. FM MMM reported that she had noticed a decline in her mother's condition since February when Resident #39 had received the multiple doses of Haldol injections which included a decline in participating in therapy, increased tremors and confusion. During an interview on 3/18/2026 at 4:28 PM MHAN BB reported that when Resident #39 came in for her medication review appointment on 2/19/26, she had planned to administer Resident #39's monthly Haldol injection, but she was told by Resident #39 that she had just gotten the injection at the facility, so she did not administer the injection and requested Resident #39's medication records from the facility to review. MHANBB reported that she called the facility on 2/27/26 to review Resident #39's medications because she had not yet received Resident #39's medication records from the facility. MHAN BB reported that she spoke to LPN EE on 2/27/26 and reviewed Resident #39's orders with him. MHAN BB reported that when LPN EE read Resident #39's Haldol order to her, she informed LPN EE that the order was incorrect, and Resident #39 should have only received 1 Haldol injection every 21 days. MHAN BB reported that LPN EE told her that he thought the order looked incorrect, and he asked a supervisor about it, but that he was told to administer the medication anyway. Review of Resident #39's Nursing Narrative note dated 2/27/26 from the Mental Health Authority revealed This RN called (Facility) nursing line to inquire about medication records regarding this patient's Haldol 250mg Q3wks (every 3 weeks). This RN spoke to a (LPN EE) who stated that the last time this patient received this medication was on 02/21. (LPN EE) also stated that the order was written as, Haldol 250mg from 02/16-02/21, therefore, this patient received multiple doses within a week. (LPN EE) did state that the patient refused the medication a few times, but states that he knows she got it at least twice from him. (LPN EE) states, I thought the order looked weird. He states that he asked his supervisor at (Facility) for clarification and was told to give the medication as the order stated . Review of Resident #39's Progress Note dated 3/7/26 (8 days after the telephone call with MHAN BB on 2/27/26) and documented by LPN EE revealed, Spoke with nurse at (Local Mental Health Authority) and was asked to do a complete medication review of this resident's medications. During the review, it was brought to the attention of this nurse that there was a discrepancy regarding resident's Haloperidol Deaconate Intramuscular solution 100 mg/ml. The order in (electronic medical record) reads Inject 2.5 ml intramuscularly one time a day starting on the 16th and ending on the 21st of every month for schizophrenia every 21 days which was incorrect. Two doses were administered by this nurse. The nurse was asked about the resident's condition and asked to obtain a set of vitals. The resident was fairly new to this unit, so nurse didn't have knowledge of their baseline . the resident's mental state to the nurse seemed to be AOx 2-3 (alert and oriented) and her vitals were exceptionally great (did not indicate what vital signs were) . During an interview on 3/18/2026 at 11:50 AM, LPN P reported that she had entered Resident #39's Haldol order when she was admitted to the facility. LPN P reported that she knew that the order was supposed to be scheduled for every 21 days, and she was not sure she made the error in transcribing the order. During an interview on 3/18/2026 at 3:55 PM, LPN EE reported that he had administered two doses of Resident #39's Haldol injection on 2/20/26, and 2/21/26. LPN EE reported that he recalled questioning the order, and so he had asked his Unit Manager about the order and was instructed to administer the injections anyway. When this writer queried as to which Unit Manager instructed him to administer the injections, LPN EE reported that he could not recall. LPN EE reported that he had been made aware of the medication errors when he completed a medication review with MHAN BB. LPN EE (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0760

Level of Harm - Actual harm

Residents Affected - Few

reported that he could not recall the date that he spoke to MHAB BB or when he reported the incident to the facility. LPN EE could not recall if he had contacted the physician to inform him of the medication error.

During an interview on 3/18/2026 at 1:51 PM, Nurse Practitioner (NP) OOO reported that she was notified on 3/9/26 regarding the medication errors that occurred in February 2026. NP OOO reported that by the time she had been notified of the medication errors, Resident #39 was planning to discharge from the facility, so she encouraged her to go to the hospital for an evaluation which she was agreeable to.

During an interview on 3/19/2026 at 9:55 AM, Facility Pharmacist (FP) CCC reported that haldol injections that are given monthly are dose dependent and specific for each person that receives the medication. FP CCC reported that the typical effective dosage was between 50-200 mg per month (noted that Resident #39 received 300 mg in one month), and that any dose greater than 450 mg per month had limited clinical experience to determine potential complications. FP CCC reported some of the risks of receiving haldol and a dose greater than ordered included hyponatremia (condition where sodium levels in the blood are too low), Agranulocytosis (severe, life-threatening condition defined by a dangerously low white blood cell count making the body unable to fight infections), parkinsonian symptoms (tremor, shaking at rest, bradykinesia (slowness of movement), limb rigidity, and postural instability (poor balance). FP CCC reported that it would be important to monitor the resident's complete blood count (CBC- is a standard lab panel measuring components of blood—white cells, red cells, and platelets—to evaluate overall health and detect conditions) after this medication error.

During an interview on 3/19/2026 at 11:30 AM, Director of Therapy (DOT) UU reported that she was familiar with Resident #39 as she was seen regularly by Physical and Occupational therapy at the facility. DOT UU reported that therapy staff had noted concerns with Resident #39 and how she was presenting in therapy during the last two weeks of February. DOT UU reviewed Resident #39's therapy notes and reported that it was noted that they had to downgrade tasks for Resident #39 on 2/18/26 due her having difficulty grabbing small items on 2/18/26, which DOT UU reported was abnormal for Resident #39. On 2/19/26, therapy staff noted that she required moderate verbal cues throughout therapy session due to poor sequencing, which she felt was a decline from Resident #39's baseline. DOT UU reported that she did also recall that Resident #39 seemed more confused, and lethargic during the last two weeks of February.

Resident #76

Review of an admission Record revealed Resident #76 was originally admitted to the facility on [DATE] with pertinent diagnoses which included schizoaffective disorder, depressive type (chronic mental health condition combining schizophrenia symptoms including hallucinations, delusions, disorganized thinking with major depressive episodes, specifically without mania).

Review of Resident #76's Care Plan revealed, (Resident #76) has/is at risk for a behavior problem /change in mood r/t (related to) dx (diagnosis) of schizoaffective disorder. Date initiated: 1/7/26. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 01/07/2026 .

Review of Resident #76's MAR revealed, Haloperidol Decanoate Intramuscular Solution 100 MG/ML (Haloperidol Decanoate) Inject 2 ml intramuscularly one time a day every 28 day (s) for Schizophrenia
(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER: Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE: 2320 E Beltline SE Grand Rapids, MI 49546	

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 0760 Level of Harm - Actual harm Residents Affected - Few	Please inform SW (Social Worker), DON (Director of Nursing), provider if she refuses. The order was documented as refused on 2/16/26 by LPN JJJ. Noted that LPN JJJ did not document if she had notified the SW, DON, or provider that Resident #76 refused her injection. During an interview on 3/18/2026 at 11:50 AM, LPN P reported that she frequently cared for Resident #76, and for the last month she had fallen, and had an increase in her behaviors which she felt was due to Resident #76 missing her monthly injection. LPN P reported that it was common for residents to miss medications, because there were several nurses at the facility that were not good at following up on missed or refused medications. LPN P reported that Resident #76's behaviors and confusion were usually manageable and that she was usually able to be redirected when she was upset, but over the last month she noted Resident #76 was screaming out more, attempting to self-transfer more often, and overall seemed more irritable. During an interview on 3/19/2026 at 11:46 AM, Certified Nursing Assistant (CNA) I reported that she cared for Resident #76 often and was very familiar with her. CNA I reported that she had definitely noticed an increase in behaviors over the last month (February). CNA I reported that Resident #76 had been attempting to self transfer more often, and that she did have a fall on 2/27/26 and 3/3/26. CNA I reported that Resident #76 would refuse cares and could become verbally aggressive, which she also felt had increased over the last few weeks. Review of Resident #76's Progress Note dated 3/7/26 revealed, Attempt to assist with res (resident) am (morning) care this am. res denied for assigned CNA to assist with cares, res yelling out I hurt, I hurt. Writer able to med (medicate) res with scheduled am oxy/Ativan (oxycodone- pain medication, Ativan-anti-anxiety medication). res refused am meal, lunch meal taken with consuming approximately 50% meal tray, res refused to allow assigned CNA or writer to assist with ADL (activities of daily living) care, multiple attempts offered . Review of Resident #76's Progress Note dated 3/10/26 revealed, Res ref (refused) to allow assigned staff until time noted (3:11 PM) to change res, dress, and get up . Review of Resident #76's Progress Note dated 3/12/16 revealed, Staff assigned CNA offered for res to get up into w/c (wheelchair) with refusal, approximately 5 minutes later res had self-transferred into w/c and propelling self in 100 hall, observation of res sitting in half in and half off w/c seat base with yellow anti tippers pushed off to the corner, addressed res safety needs with returning res back to room, donning (putting on) pants . Review of Resident #76's Progress Notes dated 3/12/26 revealed, Res sitting in the hallway spontaneously verbalizing so this is the time the men's penis' get cut off . res also verbalized about how she had become sterile and she is not even sexually active. Review of Resident #76's IDT (Interdisciplinary Team) note dated 3/13/26 revealed, Discussed recent fall with IDT. Resident had medication changed due to graduating hospice. She was observed on the ground lying on right side . resident has been making delusional statements to staff . Discussed resident with (local psych service provider) after she assessed resident's recent behaviors. Recommendation to increase monthly Haldol from every 28 days to every 21 . Noted that this note did not address that Resident #76 had missed her February 2026 Haldol injection. Review of Resident #76's Progress Note dated 3/13/26 and documented by NP QQQ revealed, . resident is seen for psychiatry follow up . staff report that patient (Resident #76) had an increase in (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0760 Level of Harm - Actual harm Residents Affected - Few	delusions and behaviors significantly and has not been at baseline .It was determined that patient did not receive her scheduled haloperidol injection that was due last month on 2/16. This is likely contributing to her current decompensation . She states that she is very depressed . She has delusional expressions throughout visit . During an interview on 3/18/2026 at 4:00 PM, Unit Manager (UM) T reported that if a resident refused a medication, nursing staff were expected to contact the Unit Manager and the facility's provider so that the facility could follow up and ensure that the medication was offered again. UM T confirmed that once a nurse documents a medication as refused, they must complete a follow up notification to create a new order for the medication to be offered again. UM T' reported that she was not made aware that Resident #76 had not received her monthly Haldol injection in February 2026. UM T reviewed Resident #76's record and confirmed that LPN JJJ had documented the medication as refused, but she did not notify the Unit Manager, Social Worker, or Provider to ensure that the injection was offered again. During an interview on 3/19/2026 at 12:28 PM, Director of Nursing (DON) B reported that nurses were supposed to ensure that if they were not able to administer a medication that they contacted the Physician and Unit Manager. DON B confirmed that she was not aware that Resident #76 had missed her monthly Haldol injection on 2/16/26. During an interview on 3/18/2026 at 1:51 PM, NP OOO reported that she had not been notified that Resident #76 had refused her Haldol injection on 2/16/26. NP OOO reported that if she had been made aware that Resident #76 had refused her injection, she would have placed an order to ensure that the injection was offered again. NP OOO reported that she expected nurses to let her know when residents' medications were omitted, so she could manage their care and orders adequately. Review of the facility's Medication Administration policy dated 8/7/23 revealed, Policy Overview: To safely and accurately prepare and administer medicaˆon according to physician order, professional standards of practice, and resident needs General Instructions: . Administer medication in accordance with frequency prescribed by physician and standards of practice . If a pharmacy supplied medication is not available, refer to the pharmacy policy and procedures related to emergency pharmacy delivery and emergency supply kit usage . Resident refusal of medications: Document refusal on MAR, Notify physician of refusal as clinically indicated . Residents #86, 139, 27, 140, 37, and 22: Review of the facility's Investigation Summary .Allegation: Potential Neglect - Medication Administration Delay, that occurred on 12/2/25, stated, .it was identified that an agency nurse (Licensed Practical Nurse (LPN) NNN) assigned to the afternoon shift left the facility mid-shift without providing notice to the leadership team or completing assigned medication administration duties.for a portion of the assigned residents. (This included Residents #86, 139, 27, 140, 37, and 22) Review of the facility's Summary of Medication Errors on 12/2 (2025), dated 12/2 (2025), indicated Residents #86, 139, 27, 140, 37, and 22 were all noted to have scheduled medications not offered or given for the night shift due to .recent medication error where agency nurse (Licensed Practical Nurse (LPN) NNN) failed to pass HS (at bed time) medications or .nurse (LPN NNN) failed to pass HS medication. In reviewing the missed medications for each resident from the night of 12/2/25, the medication errors that were considered to be significant medication errors based on the possibility of jeopardizing a resident's health and safety were:Residents #86 was not offered and did not receive doses of Seroquel (an antipsychotic medication used to treat the mental health conditions of schizophrenia and/or bipolar disease and it carries a Federal and Drug Administration (FDA) black box warning (serious warning issued for medications that carry significant (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Kent-Crossing	2320 E Beltline SE Grand Rapids, MI 49546

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 0760 Level of Harm - Actual harm Residents Affected - Few	risks) 150 milligrams, Keppra (anti-seizure medication) 100 milligrams per milliliter-7.5 milliliters, and topamax (anti-seizure medication) 50 milligrams.Resident #139 was not offered and did not receive a dose of oxycodone (a potent opioid medication for treating moderate to severe pain that carries a FDA black box warning) 10 mg.Resident #27 was not offered and did not receive doses of her metoprolol (tartrate) (beta-blocker medication to treat high blood pressure) 25 mg and norco (a potent pain medication which combines an opioid (hydrocodone) and acetaminophen to treat moderate to severe pain) 10-325 mg.Resident #140 was not offered and did not receive a dose of lasix (a potent diuretic/water pill; helps treat fluid retention) 20 mg.Resident #37 was not offered and did not receive a dose of risperidone (an antipsychotic medication that carries a FDA black box warning) 1.5 mg.Resident #22 was not offered and did not receive a dose of olanzapine (an antipsychotic medication that carries a FDA black box warning) 10 mg. Attempts were made to reach LPN NNN to discuss the incident but no response was received before the end of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235103	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Optalis Health & Rehabilitation at Kent-Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 2320 E Beltline SE Grand Rapids, MI 49546	

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to maintain a safe, functional, sanitary, and comfortable environment. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living.Findings Include:On 3/18/26 at 9:12 AM, observation of the underside of the three-compartment sink found a volleyball sized hole in the wall.On 3/18/26, starting at 9:42 AM, observation of station one and station three pantries found the underside cabinetry under a sink and the ice machine shows increased accumulation of debris, black spots, and water damage.On 3/18/26 at 10:35 AM, observation of the 500-hall soiled utility room found a strong odor emanating from the room. A review of the room found a mop sink positioned behind the door. The mop sink looked dry at the bottom and as this surveyor placed his hand over the floor drain of the mop sink, hot air was felt pushing up the drain, indicating the p-trap had evaporated and sewer gas was being let into the room. Further review of the mop sink found that it was connected to a chemical pre-dispense unit, and the faucets handles were left on (so staff can get chemicals more easily). This set up creates undue back pressure on the faucets internal vacuum breaker ruining the integrity of the unit.On 3/18/26 at 10:38 AM, observation of the 500-hall spa room found large tuffs of matted hair in each of the shower chairs wheels.On 3/18/26 at 10:48 AM, observation of the 100-hall soiled utility room found the underside cabinetry to the sink was dilapidated with old stains and water damage. Further review on the underside of the cabinet found the back wall juncture was observed to be deteriorating with holes for pests to utilize.On 3/18/26 at 11:05 AM, observation of the 600-hall spa tub room found soaking wet washcloths, towels, and pieces of toilet paper lying in the tub of the unit. Further review of the room found a shower chair with brown and yellow staining and streaking down the legs of the chair.On 3/18/26 at 12:53 PM, observation of the garden activity room found bubbling and chipping paint and drywall in the greenhouse area off the back of the room. Routine roof leaks have caused the wall juncture under the roof to deteriorate. An interview with Maintenance Director (MD) G, found that this area is looking to get renovated with the transition of the dialysis onsite, and this is one of the locations being reviewed.On 3/18/26 at 1:13 PM, observation of the 600-hall clean linen room, across from resident room [ROOM NUMBER], found multiple water fixtures that were leaking or had possible stagnant lines. The room was converted from a shower room and contained working wall fixtures for a commode, a hand sink, a shower, and a tub. At this time, the [NAME] valve (a built-in backflow protection device) coming out of the wall to service the commode was found with a slow leak leaving a puddle of water on the ground.On 3/18/26 at 1:24 PM, observation of the 600 high Soiled Utility room found the hopper was leaking from the wall. MD G stated that he was addressing the issue.On 3/18/26 at 1:35 PM, observation of the 700-hall lounge found a cushioned chair with increased accumulation of debris and trash under the seat cushion. Further review found increased trash and debris on top of the vending machine as well as black spots and accumulation in and on the heating and cooling unit located on the wall above the vending machines.On 3/18/26 at 2:16 PM, observation of the 300-hall shower room found a shower bed with black staining underneath the mat of the shower bed.