

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235206	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/17/2025
NAME OF PROVIDER OR SUPPLIER  Optalis Health & Rehabilitation of Whitehall		STREET ADDRESS, CITY, STATE, ZIP CODE  916 East Lewis Street Whitehall, MI 49461	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation is related to intakes MI00152587, MI00152791, and MI00152955.</p> <p>Based on observation, interview, and record review, the facility failed to provide meal assistance to one of four residents (Resident #116) reviewed for accommodation of needs.</p> <p>Findings:</p> <p>Resident #116 (R116)</p> <p>Review of an admission Record revealed R116 was an [AGE] year old female, last admitted to the facility on [DATE], with pertinent diagnoses of fractured right shoulder that required surgical repair, dementia, and lack of coordination. R116 sustained the broken shoulder in early May 2025 while out on leave with a family member.</p> <p>During an observation on 06/16/25 at 8:48 AM, R116 laid in bed, had a sling on her right arm and the breakfast tray sat untouched on the over bed table, lids were still on the plate, cups, and bowl, and the over bed table sat out of reach and out of sight of R116.</p> <p>Review of the task monitoring documentation system revealed that staff documented on R116's breakfast intake on 06/16/25 as resident not available.</p> <p>During an interview and observation on 06/17/25 at 8:50 AM, R116 sat in her room in a wheelchair and the breakfast tray sat on the over bed table. R116 reported that staff left the meal tray for her to try and eat by herself. It's not easy.</p> <p>Review of the task monitoring documentation system revealed that staff documented at 08:14 AM on 06/17/25 that R116 had consumed 50% of the breakfast.</p> <p>Review of a Care Plan for R116 reflected the following interventions for meal intake: Eating 1:1 assist due to broken arm.</p> <p>Review of the Kardex (a care guide for staff to reference quickly without having to review the entire care plan to learn a residents needs) for R116 reflected: Eating-1:1 assist due to broken arm.</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake #MI00152587</p> <p>Based on interview and record review the facility failed to follow professional standards for three of three residents (Resident #100, Resident #109, and Resident #113) reviewed for medication administration.</p> <p>Findings:</p> <p>Resident #100 (R100)</p> <p>Review of an admission Record revealed R100 was a [AGE] year old male, originally admitted to the facility on [DATE], with pertinent diagnoses of diabetes mellitus.</p> <p>During an interview on 06/16/25 at 9:00 AM, R100 stated that a week or so ago he was given an incorrect dose of insulin and had to go to the emergency room for monitoring. It was scary.</p> <p>Review of an incident report for R100, dated 06/07/25, reflected the following: (a) nurse read wrong record and gave resident (R100) too much insulin, and (b) (R100) was sent to the emergency room for monitoring due to potential risk for hypoglycemia ( low blood sugar).</p> <p>Resident #109 (R109)</p> <p>Review of an admission Record revealed R109 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: type 2 diabetes mellitus.</p> <p>Review of R109's Order Summary dated 3/17/25 revealed, Insulin Aspart FlexPen 100 UNIT/ML Solution pen-injector Inject 20 unit subcutaneously before meals for DM 2 (diabetes mellitus type 2) HOLD FOR BS (blood sugar) LESS THAN 120.</p> <p>Review of R109's Medication Administration Record revealed:</p> <p>*On 5/30/25 R109's blood sugar was 116 and his 8:00 AM insulin was administered.</p> <p>*On 6/13/25 R109's blood sugar was 112 and his 12:00 PM insulin was administered.</p> <p>*On 6/15/25 R109's blood sugar was 70 and his 08:00 AM insulin was administered.</p> <p>*On 6/15/25 R109's blood sugar was 107 and his 12:00 PM insulin was administered.</p> <p>Review of R109's Electronic Medical Record revealed no documentation for the rationale for the administration of the insulin outside of parameters or a provider order to administer the insulin outside of parameters.</p> <p>Review of the nurse binder located on the medication cart revealed a list titled Orders with Parameters for Holding (medications) for the 400 Hallway. R109 was not included on the list.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #113 (R113)</p> <p>Review of an admission Record revealed R113 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension (high blood pressure).</p> <p>Review of R113's Order Summary dated 5/15/25 revealed, Losartan Potassium Oral Tablet 25 MG (Losartan Potassium) Give 1 tablet by mouth at bedtime for Hold for SBP (systolic blood pressure [top number]) less than 110 and DBP (diastolic blood pressure [bottom number]) less than 60 and Losartan Potassium Tablet 50 MG Give 50 mg by mouth in the morning for Hold for SBP less than 110 hold for DBP less than 60.</p> <p>Review of R109's Blood Pressure Summary and Medication Administration Record revealed:</p> <p>*On 5/15/2025 at 2:24 PM R113's blood pressure was 118/47 and at 9:42 PM R113's blood pressure was 145/55. R109's evening dose of Losartan was administered.</p> <p>*On 5/28/25 there was no morning blood pressure assessment prior to the administration of the Losartan.</p> <p>*On 5/31/2025 at 4:00 PM R113's blood pressure was 153/51 and evening dose of Losartan was administered.</p> <p>*On 6/1/2025 at 10:56 AM R113's blood pressure was 128/55 and the morning and evening dose of Losartan was administered. There was no blood pressure assessment obtained closer to the evening dose of Losartan.</p> <p>*On 6/3/2025 at 7:17 AM R113's blood pressure was 141/54 and the morning dose of Losartan was administered.</p> <p>*On 6/3/2025 at 3:11 PM R113's blood pressure was 139/58 and the evening dose of Losartan was administered.</p> <p>*On 6/12/25 there was no morning blood pressure assessment prior to the administration of the Losartan.</p> <p>*On 6/13/25 there was no morning blood pressure assessment prior to the administration of the Losartan.</p> <p>*On 6/13/2025 at 9:52 PM R113's blood pressure was 110/55 and the evening dose of Losartan was administered.</p> <p>Review of R113's Electronic Medical Record revealed no documentation for the rationale for the administration of the Losartan outside of parameters or a provider order to administer the Losartan outside of parameters.</p> <p>Review of the nurse binder located on the medication cart revealed a list titled Orders with Parameters for Holding (medications) for the 300 Hallway. R113 was not included on the list.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review, the facility failed to 1.) provide care following professional standards of practice and facility policy to prevent the development of a pressure injury, 2.) promptly notify the provider of a new pressure injury, 3.) promptly notify the DPOA (Durable Power of Attorney) of a new pressure injury and subsequent treatment changes, and 4.) ensure ordered treatments were completed for 1 of 4 residents (Resident #106) reviewed for pressure injury prevention/management.</p> <p>Findings:</p> <p>Resident #106 (R106)</p> <p>Review of an admission Record revealed R106 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: multiple sclerosis.</p> <p>Review of R106's Care Plan revealed:</p> <p>The resident has Stage 2 pressure ulcer (Partial-thickness skin loss with exposed dermis) to right buttock r/t (related to) Immobility and at risk for recurring skin impairment to sacrum. Date Initiated: 05/08/2025 .Avoid positioning the resident on right side. Date Initiated: 05/08/2025 .</p> <p>(R106) has the potential/current for impairment of skin integrity due to decreased mobility, incontinence, unable to verbalize - Date Initiated: 11/19/2021 .Elevate heels off bed surface while at rest in bed. Date Initiated: 11/19/2021 .Resident has limited physical mobility r/t MS Date Initiated: 11/18/2021 .</p> <p>During an observation on 06/17/2025 7:37 AM, R106 was in bed on her back with the head of her bed at 30 degrees. There was a pillow behind the right and left side of her back and a pillow under both knees and calves. She had fleece socks on, and her heels were resting on the bed. There was an additional pillow in the room propped on the wheelchair.</p> <p>During an observation on 06/17/2025 8:50 AM, R106's position was unchanged. She was in bed on her back with the head of her bed at 30 degrees. There was a pillow behind the right and left side of her back, a pillow under both knees and calves, and her heels were resting on the bed.</p> <p>During an observation on 06/17/2025 9:43 AM, R106's position was unchanged. She was in bed on her back with the head of her bed at 30 degrees. There was a pillow behind the right and left side of her back, a pillow under both knees and calves, and her heels were resting on the bed.</p> <p>During an observation on 06/17/2025 10:10 AM, R106's position was unchanged. She was in bed on her back with the head of her bed at 30 degrees. There was a pillow behind the right and left side of her back, a pillow under both knees and calves, and her heels were resting on the bed.</p> <p>During an observation on 06/17/2025 10:45 AM, R106's position was unchanged. She was in bed on her back with the head of her bed at 30 degrees. There was a pillow behind the right and left side of her back, a pillow under both knees and calves, and her heels were resting on the bed. The additional pillow in the room propped on the wheelchair remained untouched.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an observation on 06/17/2025 11:40 AM, staff were in her room providing care. R106's clothing had been changed, and she remained in bed on her back with the head of her bed at 30 degrees. There was a pillow behind the right and left side of her back and a pillow under both knees and calves. She had fleece socks on, and her heels were resting on the bed. The additional pillow in the room propped on the wheelchair had not been utilized to offload pressure or readjust her position.</p> <p>During an observation on 06/17/2025 12:02 PM, R106's position was unchanged. She was in bed on her back with the head of her bed at 30 degrees. There was a pillow behind the right and left side of her back, a pillow under both knees and calves, and her heels were resting on the bed.</p> <p>During an observation on 06/17/2025 12:58 PM, R106's position was unchanged. She was in bed on her back with the head of her bed at 30 degrees. There was a pillow behind the right and left side of her back, a pillow under both knees and calves, and her heels were resting on the bed.</p> <p>During an observation on 06/17/2025 1:27 PM, R106's position was unchanged. She was in bed on her back with the head of her bed at 30 degrees. There was a pillow behind the right and left side of her back, a pillow under both knees and calves, and her heels were resting on the bed.</p> <p>During an interview on 06/17/2025 at 12:56 PM, Certified Nursing Assistant (CNA) A reported that R106 was to be repositioned at least every 2 hours and at times more frequently if she needed incontinence care or requested.</p> <p>Review of R106's Nursing admission Screening/History dated 4/19/25 revealed, .bottom pink/blanching, [NAME] (sic) cream applied.</p> <p>Review of R106's Skin Observation Tool dated 4/26/25 revealed, 2 open sores in coccoyx (sic) area. treatment in place.</p> <p>Review of R106's Electronic Health Record revealed no documentation that the provider or the DPOA were notified of the pressure injury, there were no ordered treatments, and no new care planned interventions.</p> <p>Review of R106's Skin Observation Tool dated 5/2/25 revealed, .2 open sores in coccoyx (sic) area. treatment in place.</p> <p>Review of R106's Electronic Health Record revealed no documentation that the provider or the DPOA were notified of the pressure injury, there were no ordered treatments, and no new care planned interventions.</p> <p>Review of R106's Skin Alteration Evaluation dated 5/8/25 confirmed a facility acquired stage II pressure injury. The onset date was documented as 5/8/25 and not the date it was initially identified (4/26/25). It was documented that the provider was notified at that time (12 days after the identification of the pressure injury). There was no documentation that the DPOA was notified of the pressure injury.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R106's Progress Note dated 5/8/25 revealed, IDT (interdisciplinary team) met to discuss new wound. Wound nurse aware of wound. Wound nurse to evaluate today. Treatment in place, physician aware . There was no documentation that the DPOA was notified of the pressure injury or the new treatment order.</p> <p>Review of R106's Skin Alteration Evaluation dated 5/14/25 revealed R106's DPOA was notified of the facility acquired pressure injury at that time. (18 days after the identification of the wound and 6 days after a new treatment was ordered.)</p> <p>During an interview on 06/17/2025 at 9:58 AM, Family Member (FM) R reported she was R106's DPOA. FM R Reported that she had been notified approximately one month ago that R106 had a pressure injury, but was told it wasn't very big. FM R reported that she had not received any updates on the wound and based on the lack of communication from the facility presumed it had healed because no news is good news. FM R reported that R106 has had pressure injuries in the past but the facility always say it's small and they caught it early. FM R reported that she wants R106 up out of bed and is told that R106 gets up to her wheelchair and attends activities and sits at the nurses' station. FM R reported she does not want R106 in her bed in her room all day confined to 4 walls.</p> <p>Review of R106's Order Summary dated 5/08/25 revealed, Wound Care for right buttock: Cleanse with NS (normal saline), apply xeroform to open area, cover with border gauze; every day shift and PRN (as needed). every day shift for wound care.</p> <p>Review of R106's May and June Treatment Administration Record revealed the ordered treatment was not completed on 5/16/25, 6/3/25, or 6/8/25.</p> <p>Review of R106's Order Summary dated 6/11/25 revealed, Wound Care for right buttock: 1) Cleanse with NS and pat dry 2) Mix small amount of hydrogel and collagen then apply to macerated area of peri wound 3) Cover with border gauze 4) Change daily and PRN every day shift for wound care. There was no documentation that the DPOA was notified of the new treatment order or updated on the condition of the pressure injury.</p> <p>During an interview on 06/17/2025 at 12:48 PM, Wound Nurse (WN) J reported that she had not had a chance to notify R106's DPOA of the recent treatment change but had attempted to contact her today (6/17/25). WN J reported that the expectation is for licensed nurses to complete a wound assessment with measurements at the time a wound is identified, notify the provider, and implement a treatment as ordered by the provider. The licensed nurses were to then notify her of the wound so she could evaluate and monitor the progress of the wound.</p> <p>During an interview on 06/17/2025 at 12:30 PM, Director of Nursing and Regional Nurse (RN) S reported that they had identified a facility acquired pressure injury and completed a plan of correction to ensure there were no additional residents with skin injuries and confirmed that all treatments and preventative interventions were implemented. Additionally, all CNAs and licensed nurses received education on the Skin Monitoring and Management policy. DON and RN S reported that they were in compliance as of 5/22/25. The continued noncompliance had not been identified by the DON.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility policy Skin Monitoring and Management- Pressure Ulcer dated 7/11/18 revealed, .Once a wound has been identified, assessed, and documented, nursing shall administer treatment to each affected area as per the Physician's Order .2. PREVENTION In order to prevent the development of skin breakdown or prevent existing pressure ulcers from worsening, nursing staff shall implement the following approaches as appropriate and consistent with the resident's care plan C. Reposition the resident .F. If the resident is incontinent, make sure that his/her skin remains clean and dry with regular pericare and toileting when appropriate .3. DOCUMENTATION A. If the clinical assessment/evaluation indicates a change in condition or decline in the wound, the assessing/evaluating nurse will notify the physician and create a narrative nurse's note documenting that notification. 5. MONITORING A. Daily via medication administration and treatment administration records .*Ensure all orders have been implemented as ordered .D. Weekly skin check conducted by a facility licensed nurse .Any skin issues identified as a result of the weekly skin check should be documented and responded to as outlined above .6. COMMUNICATION OF CHANGES A. Any changes in the condition of the resident's skin as identified daily, weekly, monthly, or otherwise, must be timely communicated to: *The resident's physician *The resident/responsible party *Others as necessary to facilitate healing .</p> <p>Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Early identification of high-risk patients helps prevent pressure injuries (see Chapter 48). Interventions aimed at prevention include turning and positioning and the use of therapeutic support surfaces and devices (e.g., low air loss mattresses, heel boots, flotation mattresses) to relieve pressure .Reposition patients frequently because uninterrupted pressure causes skin breakdown . [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 845). Elsevier Health Sciences. Kindle Edition.</p>		