STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235206	A. Building B. Wing	09/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Whitehall	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)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to resolve grievances in a timely manner for 2 residents (R1 and R5) of 3 residents reviewed for grievances.Finding includedReview of the facility policy for Concern (Grievances) Process. Dated 5/31/24 revealed Concerns, grievances, recommendations stemming from resident or family group council concerning issues of resident care in the facility will be documented. Actions on such issues will be responded to at or before the next resident or family meeting. Concerns/Grievances may be voiced in the following ways: -verbal complaint to staff member including the Grievance Officer. - The staff member will transcribe the concern onto the concern form or assist the complainant with completing the concern form. The staff member receiving the concern form will review the specifics of the grievance on the concern form. - take immediate actions needed to prevent potential violation of the resident's rights. - Forward concern to the Grievance Officer as soon as practicable.R1Review of R1's admission assessment dated [DATE] revealed she was a [AGE] year-old female with a last admission date of 3/22/25 and had diagnoses that included: Urinary Tract Infection onset 8/8/25, diabetes mellitus type 2, rheumatoid arthritis, lack of coordination, contractures, paraplegia (spinal cord injury affecting the lower body muscles and nerves) and retention of urine. She was her own responsible party.Review of R1's care plan dated 1/3/25 revealed, Resident has limited/impaired physical mobility r/t (related to) limited mobility d/t (due to) weakness r/t paraplegic (spinal cord damage affecting lower body). Interventions included: Bed mobility: Participates by: total assist with 2 staff. Eating: 1:1 feed at meals. Toileting - bed pan 2 assist.Review of R1's care plan dated 8/19/25 revealed, Resident requires Enhanced Barrier Precautions related to indwelling Urinary Catheter, resident prefers catheter to be place on to her bed during cares. Interventions included: encourage residents to put leg portion of the bed downward during cares, to encourage urine to flow to gravity, dated 9/9/25 (during survey). Use a gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray.During an observation and interview on 9/9/25 at 8:42 AM R1 was in bed and had a urinary catheter with the Foley bag attached to the right side of her bed below her bladder level. R1 reported she had to go to the hospital again yesterday for a urinary tract infection (UTI. R1 stated she was started on antibiotics yesterday and they changed her catheter. R1 complained of staff not always using gloves, gowns and masks (personal protective equipment (PPE)) when they provided care. She expressed concern that the lack of staff using PPE was contributing to her UTI. She expressed concerns of staff not using an alcohol swab to clean the tubing after they emptied the catheter bag. R1 was very upset that staff refused to help her with her catheter for over 2 hours recently when the balloon was stuck in her urethra (event 8/29/25). One of the staff members who refused to help her was the Registered Nurse Unit Manager (RNUM) J. She reported on-going care and treatment concerns with RNUM J which were not resolved. R1 said she reported these things to the Director of Nursing (DON) but nothing was being done. She said the DON wrote her concern on a sticky note about when the catheter balloon was stuck in her urethra, but she never got back to her. R1 said the DON did not provide her with a copy of any concerns she reported. R1 said she cannot write due to lack of hand coordination so staff would need to write her concerns. R1 was unable to move her fingers, and they were contracted in a fisted position.During an interview with two Certified Nursing Assistance (CNA's) the morning of 9/9/25 the CNA's wanted to remain anonymous but reported R1 has had ongoing concerns related to some staff not cleaning her catheter correctly, lack of PPE use and Registered Nurse Unit Manager (RNUM J) not addressing her medical concerns. The anonymous CNA's reported RNUM J also refused to follow with medical concerns they had brought to him related to R1's catheter care. They reported he was notified of R1's catheter leaking 9/9/25 right after morning care and his response was, It is not leaking. They said he refused to assist with care at that time. Both CNA's said management was aware of these concerns. They reported the concern to another nurse that did help R1. They denied completing any grievance forms related to R1's care concerns. During an interview with the Director of Nursing (DON) on 9/9/25 at 10:15 AM a request was made for all of R1's concern forms for the last two months.During an interview with the DON on 9/10/25 at 10:00 AM the DON confirmed that R1 had reported a concern about staff not helping her with catheter replacement a little over a week ago. The DON confirmed that she took that concern and she would get the concern form. No other concern forms were located related to ongoing care concerns between RNUM J and R1, or staff lack of using appropriate infection control during care.Review of R1's Concern Form dated 8/29/25 revealed, had

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interviews and record review the facility failed to safely transfer with an electronic lift 2 of 2 residents (R5 and R6) reviewed for lift transfers. Findings include:During an interview with R5 on 9/10/25 at 12:05 PM, R5 reported that he did not like the new electronic lift to get out of bed. R5 was not sure why he could not still use the other facility lift. R5 said the lift did not fit him right and when they got him out of bed on 9/8/25 he hit his head on the bar. Review of R5's Kardex (care guide) dated 9/10/25 revealed, Toileting - use toileting sling and hoyer, 2 assist. Transfer: [brand name of electronic lift] with 2 staff assistance for transfers. UP 2 TIMES A DAY IN WC (wheelchair) AS TOLERATED, CERVICAL PRECAUTIONS-NO BENDING, PUSHING/PULLING, NO OVERHEAD LIFTING, NO BENDING NECK DOWN.Review of R5's progress note dated 9/5/25 at 14:34 (2:34 PM) revealed, Quarterly Therapy screen completed: R5 has had a decline in function, but at this time is not getting up in wheelchair daily due to left hip pain. Provider aware of decline in ability to complete PT (physical therapy) with discharge 8/14/25. Awaiting follow up tests as x-ray of hip did not show a change that could be causing the pain. Discussed this week with management of patients not getting up in wheelchair. Will follow up with patient once follow up tests have been completed.Licensed Practical Nurse (LPN) O documented a progress note for R5 on 9/6/25 at 9:39 AM that revealed R5 had an evaluation for a significant change.During an interview with LPN O on 9/10/25 at 2:24 PM LPN O confirmed that she did the significant change evaluation for R5 on 9/6/25 and he had declined in function. When reviewing R5's Kardex she was able to see there were still instructions to get R5 up daily with an [brand name of electronic lift device], despite the therapy note indicating he was no longer getting up in the wheelchair. The Kardex did not indicate which brand of lift or size slings R5 should use. LPN O did not know who did the assessments for slings and was not aware what size sling R5 was able to safely use.On 9/10/25 at 12:10 PM Certified Nurse Aide (CNA) G confirmed the facility used two different brands of electronic lifts. CNA G was told there are only two residents allowed to use the old lift and many residents including R5 do not like the new lift. CNA G was aware R5 hit his head when he was transferred out of bed on 9/8/25. CNA G said they have had several residents complain about the new lift and they do not like that the bar is close to their head. She pointed out that the old lift has a different design and a bar doesn't get up in their face. CNA G said management was aware that residents do not like this lift and management informed them this was the replacement. CNA G was not aware if anyone reported that R5 hit his head on the transfer lift bar on 9/8/25. CNA G denied any training on lifts since the facility purchased this lift. CNA G stated she was getting ready to get R6 out of bed and asked Registered Nurse (RN) H to assist with transferring R6 out of bed.On 9/10/25 at 12:15 PM CNA G transferred R6 out of bed with the new lift with the assistance of RN H. When they lifted R6 up off the bed his bed was in the highest position and his buttock did not clear the mattress prior to starting to move him toward his chair. RN H and CNA G did not check to ensure the loops were all in place prior to starting to move him. When they lifted him and started to move him the legs of the lift were not in the open position. R6 could not speak or communicate with the staff. Both staff were questioned about checking the loops once the resident was off the surface, asked if the resident should have cleared the surface prior to moving him and asked if the leg on the lift should be in the fully open position. RN H and CNA G did not know they were to check loop placement, ensure the resident clears the surface being transferred from and the legs need to be in the fully open position.On 9/10/25 the Nursing Home Administrator (NHA) was informed of R5 concerns with the new lift and report of R5 hitting his head on the bar during a transfer out of bed on 9/8/25. The NHA was also informed of the safety concerns observed when staff transferred R6 out of bed today. The instruction manuals for both lifts were requested, all training and information related to residents' concerns related to the lifts. Upon exit no training was provided for the use of the new lift. No information that the facility was aware of R5 hitting his head on the lift on 9/8/25. Review of the electronic lift instruction manual page 34 revealed, The legs of the lift must be in the maximum open position for optimum stability and safety. If it is necessary to close the legs of the lift to maneuver the lift under a bed, close the legs of the lift only as long as it takes to position the lift over the patient and lift the patient off the surface of the bed. When the legs of the lift are on longer under the bed, return the legs of the lift to the maximum open position and immediately lock the shifter handle. Page 37 revealed, WARNING! - When the sling is elevated a few inches off the surface of the bed and before moving the patient, check again to ensure the sling is properly connected to the hooks of the hanger bar. If any attachments are NOT properly in place, lower the patient back onto the stationary surface and correct this problem; otherwise,

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2590962.Based on observations, interviews and record review the facility failed to provide proper infection control for 1 Resident (R1) of 3 residents sampled for infection control. Findings include:R1Review of R1's admission assessment dated [DATE] revealed she was a [AGE] year-old female with a last admission date of 3/22/25 and had diagnoses that included: Urinary Tract Infection onset 8/8/25, diabetes mellitus type 2, rheumatoid arthritis, lack of coordination, contractures, paraplegia (spinal cord injury affecting the lower body muscles and nerves) and retention of urine. She was her own responsible party. Review of R1's care plan dated 1/3/25 revealed, Resident has limited/impaired physical mobility r/t (related to) limited mobility d/t (due to) weakness r/t paraplegic (spinal cord damage). Interventions included: Bed mobility: Participates by: total assist with 2 staff. Eating: 1:1 feed at meals. Toileting - bed pan 2 assist. Review of R1's care plan dated 8/19/25 revealed, Resident requires Enhanced Barrier Precautions related to indwelling Urinary Catheter, resident prefers catheter to be place on to her bed during cares. Interventions included: encourage resident to put leg portion of the bed downward during cares, to encourage urine to flow to gravity, dated 9/9/25 (during survey). Use a gown and gloves when providing direct care. Face protection may be needed if performing activity with risk of splash or spray.During an observation and interview on 9/9/25 at 8:42 AM, R1 was in bed and had a urinary catheter with the Foley bag attached to the right side of her bed below her bladder level. R1 reported she had to go to the hospital again yesterday for a urinary tract infection (UTI). She said she started on antibiotics yesterday and they changed her catheter. R1 complained of staff not always using gloves, gowns and masks (personal protective equipment (PPE)) when they provided care. She expressed concern that the lack of staff using PPE was contributing to her UTI. R1 said she was in the hospital for several days in August in 2025 on intravenous (IV) antibiotics due to severe UTI. Review of R1's Hospital Infectious Disease noted dated 8/8/25 revealed, R1 is a [AGE] year-old woman with PMHx (past medical history) of rUTI (recurrent Urinary Tract Infection) in the past, previously seen by ID (Infectious Disease) multiple times and by urology for ureteral stenting (no longer has stent). She also has a history of multiple antibiotic allergies including Keflex, ceftriaxone and Bactrim. She was seen in the ER on 8/5 with complaint of flank pain/cva tenderness (costovertebral angle) (area on the back above the kidney) and nausea. She was seen initially in the ER (Emergency Room) 8/5 and diagnosed with pyelonephritis based on symptoms.She received 1 dose of ertapenem (an antibiotic) and then was initially discharged with ciprofloxacin (another antibiotic) given her history of multiple antibiotic allergies. She returns today with ongoing symptoms, and urine culture now confirms E coli which is resistant to ciprofloxacin.Given the clinical course with her worsening on ciprofloxacin, with isolation of a quinolone resistant organism I think reasonable to treat for 7 days.R1 was observed getting care on 8/9/25 at 9:14 AM by Certified Nurse Aides (CNA) E and F. They remove the Foley catheter bag from the privacy bag on the bed. The bag had an external plastic measuring device attached to it. The measuring device held 300 cc (cubic centimeters) of urine. CNA E placed the catheter bag on the bed (above the level of her bladder) and the urine from the measuring device went up the catheter tube into R1's bladder. When discussing the type of Foley bag being used the CNA's said, they were not familiar with the external measuring device and denied any training on precautions of placement with this type of device. When they turned R1 on her side the soaker pad had a large wet area (same color as the urine in R1's bag) approximately 5 inches by 10 inches. CNA E and F said R1 does not normally have leakage from her catheter. Review of R1's hospital Discharge summary dated [DATE] revealed two pages of instructions for Indwelling Urinary Catheter Care to Prevent Infection under the section, Be careful with your drainage bag revealed, Always keep the drainage bag below the level of your bladder. This will help keep urine from flowing back into your bladder. Step 3 after emptying the catheter bag revealed, 3. Use and alcohol wipe to clean the tip of the tubing attached to the bedside bag. Review of R1's hospital Discharge summary dated [DATE] revealed, Foley catheter was replaced today 9/8/25. Patient did receive dose of antibiotics, Fosfomycin, in ED (emergency department) today. Urine culture is sent and pending. Review of the facility Catheter Draining Bag Emptying policy dated 8/24/23 revealed no information on keeping the Foley bag below the level of the bladder to prevent back flow of urine or cleaning the emptying device tip with alcohol after emptying the bag. Review of R1's concern form dated 9/10/25 revealed, Resident care concerns regarding not being checked and changed last evening by 3rd shift CNA. Action taken Report sent to [name of online program that facilities use to report incidents to the State Survey