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	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Whitehall	916 East Lewis Street Whitehall, MI 49461

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(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 - 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** Based on observations, interviews, and record review, the facility failed to protect the resident's (R6, R7, R9, R15, R26, R34, R35, R58 and F60) right to be free from mental abuse and verbal abuse by R52 resulting in fear and physical anguish in the resident's home. Findings include:Resident #58 (R58)Review of an Face Sheet revealed R58 admitted to the facility 3/4/2025 with pertinent diagnoses which included heart failure, acute respiratory failure, anxiety disorder, and major depressive disorder. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R58, with a reference date of 12/8/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R58 was cognitively intact. Review of R52's Progress Note dated 2/7/26 at 5:05 AM indicated that R52 went into R58's room and stood over her while she laid in bed. There was no documentation of this incident in R58's electronic medical record besides the following psychology notes. Review of a psychology follow-up visit dated 2/10/26 at 4:18 PM revealed .Mood symptoms worsened over the past two weeks with increased depressive symptoms triggered by a situational stressor involving a confused male resident (R52) who repeatedly entered R58's room. This led to increased fear. Symptoms are now improving, with yesterday and today showing decreased symptoms as resident is reassured, he is not returning to the facility. R58 experienced increased depression and anxiety symptoms triggered by a confused male resident (R52) at the facility. Symptoms included fear, avoidance behaviors, and nausea. Review of a psychology follow-up visit dated 2/24/26 at 11:30 AM revealed .R58 reported increased anxiety symptoms related to another resident recently admitted to the hall. Resident states that R52 came to her doorway and stands there staring into her room. She stated she had redirected him back to his own room. R58 stated she had been keeping her door closed for this reason, however R52 had also opened her door and came into her room on multiple occasions. R58 stated her daughter was here yesterday when R52 entered her room and was also unable to redirect R52 out of the room. R58 stated her daughter put the call light on for assistance, however both were anxious while waiting for staff to respond. R58 stated she had voiced her concerns to several people in the facility but feels like no changes will be made.which scared R58. During an interview on 03/04/2026 at10:00 AM, R58 stated the man who walks around next door, (R52), will stand in my doorway and stare. R58 stated she tried to keep her door closed to prevent R52 from entering her room and he opened it just this week. R58 stated that R52 will stand in her room by the curtains (5ft to R58's bed from the curtain). R58 stated she heard a loud noise the previous night and when she looked in the hallway, R52 had pulled out a supper tray from the cart, and it was on the floor. R58 stated that R52 makes her feel anxious and very leery. R58 reported to one person about the situation with R52, when asked who that was R58 stated the administrator. R58 requested for R52 to be moved from the hall and R58 was told we are working on it. R58 stated that he (R52) still is next door to her and stated, that bothers me a lot. R58 stated I should feel safe and secure. R58 reported that her feelings haven't changed any. R58 stated I don't think he should be on our hallway. A review of R58's Electronic Medical Record on 3/4/26 at revealed (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 0600 Level of Harm - Actual harm Residents Affected - Few	no further documentation with exception of the psychologist Progress Notes on 2/10/26 and 2/24/26 of any incident that occurred or intervention that had been offered or put into effect.During an interview on 3/4/26 at 12:21 PM, R58's Family Member (FM) N stated R52 scared R58 on 2/23/26 when FM N had been visiting. FM N stated that R52 showed up multiple times in R58's doorway. R58 responded to R52 and said, Your room is down there.your room is down there!. R52 did enter R58's room again and FM N stated she rang R58's call light for assistance. During this interview, FM N stated that R58 fears R52. FM N stated that on a subsequent visit on the weekend, R52 was in R58's doorway multiple times and needed to be redirected away from R58's room. FM N stated that R58 went to the administrator with concerns regarding R52's presence in R58's room and FM N reported that the facility had planned to move R52 to a different location. FM N stated that R52s actions weighs heavily on R58 and causes high anxiety for R58 Resident #26 (R26)Review of a Face Sheet revealed R26 admitted to the facility 1/14/2019 with pertinent diagnoses which included depression, decreased range of motion, and dementia. During an interview on 3/4/2026 at 2:09 PM, Family Member (FM) O reported that R58 had been very afraid of R52 after he walked into her room at night and R58 has been anxious related to the incident ever since. FM O added that R58 feels uneasy when R52 walks in front of the door or stands in the doorway so R58 had shut the door and R52 opened it and walked in anyway. FM O stated that this week R52 had walked into R26's room and FM O stated this is a lady's room, please leave. FM O stated I do have a fear of what R52's going to do and why he's in here. Resident #60 (R60) Review of an Face Sheet revealed R60 originally admitted to the facility 6/15/2022 with pertinent diagnoses which included chronic obstructive pulmonary disease, dementia, and generalized anxiety disorder. Review of a MDS assessment for R60, with a reference date of 12/12/2025 revealed a score of 07, out of a total possible score of 15, which indicated R60 was severely cognitively impaired. Review of R52's Progress Note dated 2/7/26 at 5:05 AM indicated that R60 was crying and had stated to staff that he was scared to have R52 in the room. In an interview on 3/4/26 at 10:15 AM, R60 was asked if he had any concerns with other residents, if he was fearful of another resident. R60 stated I want to forget that. R60 stated his old roommate (R52) wanted to die. R60 stated R52 went batty. When further questioned, R60 stated R52 kept talking about dying and thoughts of suicide. R60 stated he did not feel threatened at this time. In a review of R60's Electronic Medical Record on 3/4/26 at 1:30 PM, revealed no documentation that any incident had occurred. Resident #6 (R6) Review of an Face Sheet revealed R6 originally admitted to the facility 2/15/2022 with pertinent diagnoses which included chronic heart failure, dysphagia (difficulty swallowing), obesity, and type II diabetes mellitus. Review of an MDS assessment for R6, with a reference date of 2/3/2026 revealed a BIMS score of 15, out of a total possible score of 15, which indicated R6 was cognitively intact. In an interview on 3/2/26 at 8:10 AM, R6 stated that a strange man (R52) had been walking in and out of her room and staff had to redirect him. In an interview on 3/5/26 at 8:55 AM, R6 stated a male resident (R52) came into her room just this week. R6 was unable to recall the specific day this occurred. R6 stated that R52 gets through the door and he stood in her room. R6 reported that staff usually get R52 and redirect him out of her room. R6 reported that if R52 was at her bedside, she would be scared. Resident #7 (R7) Review of an Face Sheet revealed R7 originally admitted to the facility on [DATE] with pertinent diagnoses which included neuropathy, chronic obstructive pulmonary disease, and stage IV sacral pressure ulcer. Review of an MDS assessment for R7, with a reference date of 12/18/2025 revealed a BIMS score of 15, out of a total possible score of 15, which indicated R7 was cognitively intact. In an interview on 3/5/26 at 9:02 AM, R7 stated that R52 was in his room yesterday (3/4/26). R7 stated when R52 had been in his room he uses his call light to alert staff to assist R52 out of his room. R7 stated that he told R52 he had been in the wrong room and to turn around and R52 complied. Resident #34 (R34) Review of an Face Sheet revealed R34 originally admitted to the facility on [DATE] with pertinent diagnoses which included cerebral infarction (blocked blood flow to the brain), morbid obesity, spinal stenosis, and depression. Review of an MDS assessment for R34, with a reference date of 12/15/2025 revealed a BIMS score (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	with recurrent visual hallucinations presenting to the emergency department with repeat episodes of confusion and wandering around other people's apartments. Review of R52's Behavior Note documented by Licensed Practical Nurse (LPN) P on 2/7/26 at 5:05 AM, . R52 used a wheelchair foot pedal as a potential weapon tonight, holding it up to swing it at a Certified Nursing Assistant (CNA). R52 also made multiple comments to staff and his roommate R60 regarding shooting people, guns, and it would only take one bullet. R60 cried and had stated to staff that he is scared of R52 in his room. LPN P was also informed that R52 went into R58's room and stood over her while she laid in bed. LPN P and an Agency Nurse transferred R52 to the emergency department regarding these two occurrences. Emergency department (ED) reported to LPN P that R52 attempted to elope the ED and became physical with ED security.R52 received 2 doses of intramuscular Ativan (an anti-anxiety medication) and Risperidone (an antipsychotic medication) to assist with anxiety. R52 obtained a skin tear in ED. R52 is currently awake and ready for transfer back to facility. Review of a hospital record Psychiatric Consultation Note dated 2/8/26, .R52 brought to the emergency department from his nursing home for agitation and aggressive behaviors on 2/6/26.R52's chief complaint was I was in a lockout situation . Review of R52's Progress Note dated 2/7/26 at 9:56 AM, .R52 arrived back to facility approximately 8:45AM.R52 placed into room [ROOM NUMBER] bed 2 related to history of aggressive behaviors (this room is directly beside R58's room) .R52 shows signs of delusions and confusion.R52 continues to walk down hallways without shoes and unsteady gait. Review of R52's Progress Note dated 2/7/26 at 12:50 AM, .R52 restless, running through hallways, trying to get out of the facility.R52 gait is unsteady.R52 walking into other resident's rooms. Director of Nursing (DON) notified an a one to one for R52 was initiated . Review of R52's Progress Note dated 2/7/26 at 13:54 PM, .on call Nurse Practitioner (NP) and DON notified and approved for R52 to be transferred to ED for psychiatric evaluation. R52 was transported from facility at approximately 1:50PM. Further review of Progress Notes, R52 returned to the facility on 2/11/26. Review of R52's Progress Note dated 2/12/26 at 12:38 AM, .R52 was up and wandering around hallway and wandered into another resident's room. Staff attempting to remove resident from other room and resident became physically violent. closed fist attempting to punch nurse aides in face. R52 finally came out of other residents' room and went back into his room where R52 grabbed his bedside table and attempted to [NAME] it at his CNA. Administrator notified, Unit Manager (UM) notified, on call physician assistant notified and in agreement to sending the resident to ER for evaluation. Review of R52's Progress Note dated 2/12/26 at 1:25 AM, .R52 was 1:1 with police officer after he arrived on scene. Police officer 1:1 with R52 until ambulance arrival. R52 became verbally agitated and aggressive with female Emergency Medical Technician (EMT).R52 was transported via ambulance service to the ED for evaluation. Review of R52's Progress Note dated 2/12/26 at 6:00 PM, .R52 has been up wandering the halls the entire shift today.R52 was paranoid we were giving him sleeping medication. Review of R52's Progress Note dated 2/12/26 at 9:39 PM, .R52 received his nighttime medication, and medication has had no effect on this R52.R52 continues to wander around hallway and enter other resident's rooms. R52 becomes verbally agitated when asked to leave other resident rooms . R52 given a job to help keep an eye on the hallway, R52 focused on this task for brief time, then was attempting to enter a female resident room.R52 stopped by staff and assisted back to his room. Review of R52's Progress Note dated 2/12/26 at 11:34 PM, .R52 was up wandering around and entered other resident's rooms, R52 became agitated when asked to leave the residents room. R52 redirected briefly back to his own room. R52 keeps asking where we keep the ammo. Review of R52's Progress Note dated 2/12/26 at 11:34 PM, .R52 assisted back to his room again.R52 was observed going into restroom and coming out of another resident room. Male Residents in the other room have been resting. R52 becomes agitated when staff redirect him . R52 escorted out of a female resident room again and is now back in his own room sitting on edge of his bed. Review of R52's Progress Note dated 2/15/26 at 11:06 PM, .R52 has been up wandering into several other resident's rooms. R52 is not wearing clothing but has a blanket wrapped around him. Staff that attempted to redirect have been met with resistance. R52 helped with (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	getting dressed and R52 refused. R52 was pushing staff away and continued to wander very unsteadily down the 300 and 400 halls. Res continued to attempt to go to exit doors and in and out of other resident rooms. R52 has been muttering to himself and speaking in a non-sensical fashion. Review of R52's Progress Note dated 2/17/26 at 05:05 AM, .R52 was up wandering during the beginning of this shift. Staff attempted to redirect were met with resistance. R52 continued to attempt to go to exit doors. R52 was muttering to himself and spoke in a non-sensical fashion. Review of R52's Progress Note dated 2/24/26 at 11:52 PM, .R52 was walking down the hallway. R52 had no socks or pants on, just underwear and a T-shirt. R52 was lookinginto every room. R52 had to be guided out of other resident rooms. Review of R52's Progress Note dated 3/2/26 at 1:30 AM, .R52 noted to be walking frantically in hallway. R52 noted to have visual and auditory hallucinations, irrational beliefs, and incoherent and illogical jumbling of words. R52 cannot organize his thoughts and becomes increasingly agitated when staff attempts to assist him or offer distraction. R52 is redirected for a few seconds then proceeded to enter other residents' rooms talking about guns and not having any ammo. Review of R52's Progress Note dated 3/2/26 at 2:23 AM, .Despite R52's one time dose of Ativan, R52 continued to be anxious, constantly pacing up and down hallway trying to enter other residents' rooms. Resident became agitated when staff tried to redirect him out of other residents' rooms. Hallucinations continue.R52 kept yelling about a boat, and someone is supposed to pick him up so he can go get ammo for his gun. Review of R52's care plan At risk for changes in behavior and mood dated 2/3/2026, R52's interventions were initially documented on 2/3/26 that included administer medications per physician orders. encourage resident to attend activities of choice.offer snacks.ice cream. The last updated intervention was dated 2/3/26. Review of R52's care plan Exit seeking/elopement risk dated 2/3/26, R52's interventions are to allow to vent feelings and frustrations, alert bracelet.calmy redirect. There are no updated interventions after 2/3/26. In an interview and record review on 3/4/2026 at 9:24AM, Nursing Home Administrator (NHA) reported that the facility had transferred R52 to the hospital on 2/7/26 related to aggression toward staff and hallucinations. Upon review of the Behavior Note on 2/7/26, NHA reported she did not see the note before today. NHA stated that R52 had been wandering at night and was redirectable as the staff had R52 sort papers at the nurse's station. NHA stated she had encouraged a sleep aid so R52 could slow down. NHA reported that R58 was still scared of R52 and NHA had been counseling her. NHA reported the facility did not move R52 to a different room or hallway because it could turn into a larger concern. NHA reported that she believed she did not get all the details from the event on 2/7/26 and after reading the note stated it may be possible abuse and reportable (as an allegation of abuse to the state agency). NHA reported there were no incident reports completed from the occurrence on 2/7/26 between residents R52, R58, and R60. In an interview and record review on 3/4/2026 at 11:32AM, DON stated R52 had Wernicke's with bouts of agitation and became agitated on the evening of 2/7/26. DON stated R52 had been swinging a wheelchair pedal at a CNA and facility transferred R52 to the ED for evaluation. DON stated the facility did attempt a stop sign for R58 but R58 did not like the stop sign and it was removed. DON unable to locate further documentation related to the stop sign initiation. DON confirmed that she was unaware of the 2/7/26 behavior note until it was read in the Interdisciplinary Team Meeting (IDT) on Monday (2/9/26) morning. DON confirmed that members of the IDT were present, including the NHA. DON reported that she was unsure if the entire IDT team listened to the report completely, but team was present. DON reported there were no incident reports completed from the occurrence on 2/7/26 between R52, R58, and R60. DON stated if R52 had directly threatened with R60 with a gun it would be considered abuse and reportable. DON stated the facility is unable to meet R52's needs presently and he does present a risk. Upon review of the psychiatric notes for R58 on 2/10/26 and 2/24/26 regarding her ongoing fear of R52, DON had no response. In an interview on 3/5/26 at 1:07 PM, LPN UM F stated that R52 is newer to the facility. LPN UM F reported that the facility does not have the right or enough staff to care for R52 and he should have been a 1:1 upon return from the hospital. LPN UM F stated that we are failing R52 in this facility and I (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to monitor weights in a CHF resident and drug allergies in one (R89) and failed to implement and monitor ace wrap orders for one (R40) of two residents reviewed for change in condition, contributing to R89's death in the facility. Findings include:R89Review of a Face Sheet revealed R89 had pertinent diagnoses of congestive heart failure (CHF), diabetes and vascular dementia. Allergies: . Morphine (Opioid). WeightsReview of R89's weights revealed between January 2025 and July 2025 his weights averaged between 331 pounds (lbs) to 336 pounds. On August 17, 2025, R89's weight was 347 lbs. These weight values include but are not limited to:7/4/25- 333.1 lbs9/17/25- 343.9 lbs10/15/25- 357.6 lbs10/28/25- 365 lbs11/19/25- 359 lbs12/17/25- 363.5 lbs, next weight is 12/31/25.12/31/25- 350 lbs1/7/26-350.4 lbs, the last weight before expiration on 1/12/26. A 19.4 lbs average weight difference in 6 months and no daily weights since chest Xray on 1/6/26 and orders for increased Lasix 3 times a day on 1/6/26. R89 weights were done on an average of once a week, and no goal weight was established. Review of a Dietary Progress note dated 8/19/25 for R89 revealed: WEIGHT WARNING:Value: 347.4 (lbs (pounds)), +10.0% change [10.8%, 34.0] . Residents CBW (calculated body weight) is 347 lb and his BMI (body mass index) is 45 (obesity). Resident is triggering for sig (significant) weight gain, he has gained 10 lb this month. NP (Nurse Practitioner) assessed resident yesterday. weight gain likely related to fluid; resident is on a diuretic. oral intake is high, on average consumes 76-100% of meals, also on liquid protein BID (twice a day). will continue to monitor weight for any further fluid retention. Review of a Dietary Progress note dated 10/28/25 for R89 revealed: WEIGHT WARNING:Value: 365.0 (lbs) . Residents CBW is 365 lb and his BMI is 47, he has gained 27 lb since August, over the last month he has gained ~18 lb, weight gain is not beneficial given elevated BMI. weight gain likely related to CHF, lymphedema and diuretic use. NP notified of recent sig weight gain. Review of a Dietary Progress note dated 11/19/25 for R89 revealed: WEIGHT WARNING: Value 358.8 (lbs), +10% change . Residents CBW (is 259 lb and his BMI is 46, resident continues to gain weight, non beneficial given elevated BMI, an additional 10 lb since [DATE]. weight tends to fluctuate up and down with overall weight gain. weight gain likely related to CHF, lymphedema and diuretic use. Review of a Dietary Progress note dated 12/17/25 for R89 revealed: . recent sig (significant) weight gain, 20 lb since September, non beneficial weight gain. At risk for weight fluctuations (related to) CHF. will continue with current plan of care, monitoring weights for any sig changes . Change of ConditionReview of a Chest Xray dated 1/6/26 for R89 revealed: Impression: On comparison with prior study dated 12/3/2025; There is cardiomegaly (enlarged heart) noted. Accentuated bronchovascular (airway and blood vessels in the lungs) markings noted with prominence in the pulmonary vascularity, right sided pleural effusion, consistent with congestive heart failure. Advice 2D echocardiography for further evaluation. Review of a Nursing Progress note dated 1/7/26 for R89 revealed: Note Text: chest x-ray reviewed. Called physician. New orders received for lasix 40mg extra dose once a morning for 3 days. Potassium chloride 10meq (milliequivalent) once a day the am times 3 days. Orders placed in MAR. Medications given this AM to resident. Resident resting in bed. 02 sat 94% on 2L NC. Resident reporting difficulting (sic) breathing. Head of bed elevated to assist in breathing. Will continue to monitor. No full nursing assessment documented in the Electronic Medical Record (EMR). Review of the January 2026 Medication Administration Record (MAR) for R89 revealed the following orders and administration:-Lasix (Furosemide- a diuretic), 40 mg one time a day for vascular congestion for 3 days. Start 1/7/26 and discontinued 1/8/26. Documented as given once each day at 7 AM.-Lasix- 40 mg twice a day for CHF for 3 days. Start 1/8/26. Received one dose on 1/8 at 1PM, 1/9 at 1PM, 1/10 at 9AM and 1PM.-Lasix, 40 mg every morning and bedtime for diuretic. Start date 3/13/25, hold from 1/8/26 to 1/11/26. Received break (breakfast) dose on 1/8 and on hold after that. Review of the Lasix administration shows R89 did not receive 40 mg of Lasix three times a day as ordered between (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	1/9/26 through 1/12/26. No documentation to show why R89 did not receive the ordered medication and if the Practitioner was notified. Review of the January 2026 Medication Administration Record (MAR) for R89 revealed the following orders and administration:Aldactone (Spironolactone- a diuretic), 25 mg once a day for diuretic/heart failure, ordered 11/26/25 and discontinued 1/14/26. R89 did not receive this medication on 1/9, 1/11, or 1/12. No documentation indicating if the Practitioner was notified. Review of a Nursing Progress note dated 1/8/26 for R89 revealed: Note Text: resident seems sleepy this AM, refused meal although did take meds with a glass of fluid. Bilateral lower edema noted although this is not abnormal, no wheezing note O2 96% on O2 and no temp. No depth of R89's edema is documented. Review of the LATE ENTRY (unclear of date) Practitioner Progress note back dated 1/8/26 for R89 revealed: Note Text : CC: CXR (chest Xray) results . CXR results along w/ lab results from 1/6 reviewed .No reported fever, CP, SOB Labs: 1/6 CXR right pleural effusion, CHF. 12/3 CXR with infiltrates in right lung with small right pleural effusion concerning for congestive cardiac failure with possible infection, concern for pulmonary edema .A/P (Assessment and Plan): COPD (chronic obstructive pulmonary disease), Right pleural effusion, Hypercapnia (high levels of carbon dioxide in blood) .-Increase furosemide 40mg/d to BID x3 days .-Recent weight down (350lbs)-ECHO 2D (ultrasound to assess heart function) recommended based on 1/6 CXR (ordered)-Increase furosemide 40mg BID x3 days then resume 40mg/day The EMR revealed the ECHO was not done. Review of a Nursing Progress note dated 1/10/26 at 6:32 PM for R89 revealed: Note Text: Res noted to desaturate on 2L to 86%. Difficult to rouse from sleep. Shake and shout elicits eyes slightly open. [Guardian] on call said to put Res on comfort care. DON (Director of Nursing) notified. On call physician also notified. Waiting for response. No documentation indicated there was a follow up from the Practitioner. Review of a Nursing Progress note dated 1/10/26 at 10:20 PM for R89 revealed: .bed this evening and lethargic and stuporous, on 2 liters of oxygen with sats at 98%, no work of breathing noted, patient diaphoretic, not eating or drinking at this time . No documentation indicating the Practitioner was aware of R89's change in condition. Allergy Warning/Medication Interaction WarningReview of the Medication Orders for R89 revealed the following:Allergies to. Morphine, .-Morphine Sulfate (concentrate) ordered 1/11/26, give 5 mg by mouth every 4 hours as needed for moderate/severe pain. Documented as given on 1/11/26 at 3:04 PM and on 1/12/26 at 1:16 PM. No documentation or clarification indicating the Practitioner was aware of R89's allergy to Morphine. Review of a Nursing Progress note dated 1/11/26 at 11:00 AM and again at 1:13 PM for R89 revealed: Note Text: The system has identified a possible drug allergy for the following order: Morphine Sulfate Oral Solution 20 MG/5ML (Morphine Sulfate) *Controlled Drug* Give 5 mg by mouth every 4 hours as needed for pain and discomfort. Give 0.25 ml. No documentation or clarification indicating the Practitioner was aware of R89's allergy to Morphine. Review of a Nursing Progress note revealed system warnings for R89 regarding R89s allergy to Morphine and drug interactions to the Morphine dated 1/11/26 at 11:00 AM revealed: Note Text: The order you have entered Morphine Sulfate Oral Solution 20 MG/5ML (Morphine Sulfate) *Controlled Drug* Give 5 mg by mouth every 4 hours as needed for pain and discomfort. Give 0.25 ml has triggered the following drug protocol alerts/warning(s):Drug to Drug InteractionThe system has identified a possible drug interaction with the following orders:traZODone HCl Oral Tablet 50 MGSeverity: ModerateInteraction: Morphine Sulfate Oral Solution 20 MG/5ML may enhance the serotonergic effect of Sertraline HCl Oral Tablet 25 MG, Sertraline HCl Oral Tablet 50 MG, and traZODone HCl Oral Tablet 50 MG. This could result in serotonin syndrome.Amiodarone HCl Oral Tablet 200 MGSeverity: ModerateInteraction: Plasma concentrations and pharmacologic effects of morphine may be increased by P-glycoprotein / ABCB1 Inhibitors (e.g., Amiodarone HCl Oral Tablet 200 MG). Butrans (opioid pain patch) Transdermal Patch Weekly 7.5 MCG/HRSeverity: SevereInteraction: Buprenorphine, the partial mu opioid agonist and [NAME] antagonist, may diminish the analgesic effect of opioid agonists andprecipitate withdrawal symptoms in patients chronically maintained on full agonist opioids (e.g., HYDROcodone-(opioid pain medication) Acetaminophen Oral Tablet 5-325 MG and Morphine Sulfate Oral Solution 20 MG/5ML). The opiate (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	receptor antagonist effects of buprenorphine are expected at higher doses.Butrans Transdermal Patch Weekly 7.5 MCG/HRSeverity: SevereInteraction: Buprenorphine, the partial mu opioid agonist and [NAME] antagonist, may diminish the analgesic effect of opioid agonists and precipitate withdrawal symptoms in patients chronically maintained on full agonist opioids (e.g., HYDROcodone-Acetaminophen Oral Tablet 5-325 MG and Morphine Sulfate Oral Solution 20 MG/5ML). The opiate receptor antagonist effects of buprenorphine are expected at higher doses.Sertraline HCl TabletSeverity: ModerateInteraction: Morphine Sulfate Oral Solution 20 MG/5ML may enhance the serotonergic effect of Sertraline HCl Oral Tablet 25 MG, Sertraline HCl Oral Tablet 50 MG, and traZODone HCl Oral Tablet 50 MG. This could result in serotonin syndrome.Sertraline HCl Tablet, Give 75 milligram by mouth one time a day for DepressionSeverity: ModerateInteraction: Morphine Sulfate Oral Solution 20 MG/5ML may enhance the serotonergic effect of Sertraline HCl Oral Tablet 25 MG, Sertraline HCl Oral Tablet 50 MG, and traZODone HCl Oral Tablet 50 MG. This could result in serotonin syndrome. Review of a Nursing Progress noted dated 1/11/26 at 11:40 AM for R89 revealed: Called to Res (Resident) room by CNA (Certified Nursing Assistant) stating that he is calling for help and looks bad. Res SpO2 (oxygen saturation) 79% 2L (liters). Res present short of breath. Low Fowler position (head of bed elevated 15-30 degrees). HOB (head of bed) elevated. DON notified of change of condition. On call notified with O2 (oxygen) 4L to keep sats > 88. Ativan 0.5mg po q 6 hours PRN (as needed) for anxiety. Roxanol (Morphine) 5mg (0.25ml) q (every) 4 hours PRN for pain and discomfort. Pharmacy also notified after orders signed by on call. Review of a Nursing Progress note dated 1/11/26 at 1:13 PM for R89 revealed: Note Text: The system has identified a possible drug allergy for the following order: Morphine Sulfate (Concentrate) Oral Solution 100 MG/5ML (Morphine Sulfate) *Controlled Drug* Give 5 mg by mouth every 4 hours as needed for moderate/severe pain. Review of the MAR for R89 revealed he received 5 mg of Morphine on 1/11/26 at 3:04 PM and another dose on 1/12/26 at 1:16 AM. Review of a LATE ENTRY Nursing Progress note dated 1/12/26 (unclear of the original entry date) at 11:58 PM by the Director of Nursing (DON) for R89 revealed: Note Text: Medication held today until clarification completed with physician. Last done at 0115 overnight. no c/o of nausea or vomiting at this time. Review of a Nursing Progress note dated 1/12/26 at 3:58 PM for R89 revealed: Note Text: Noted allergy to morphine, this is not a true allergy and list as an intolerance. [Hospital] documentation lists nausea and vomiting as the intolerance. Resident has had no c/o of nausea and vomiting. [Nurse Practitioner] and stated its fine to give and to Dc (discontinue) it from hisallergy list. Review of a Nursing Progress noted dated 1/12/26 at 4:06 PM for R89 revealed: Note Text: resident was found without breaths or pulse after this nurse entered room to assess effectiveness of PRN med given 40 min prior. Review of the Care Plan for R89 revealed a focus of Resident has altered cardiovascular status related to CHF, Hyperlipidemia, Hypertension, Date Initiated: 12/08/2025. Interventions included but not limited to: . Monitor daily weights as ordered Date Initiated: 12/08/2025, Monitor/document/report PRN any s/sx (signs and symptoms) of CAD (coronary artery disease): chest pain or pressure especially with activity, heartburn, nausea and vomiting, shortness of breath, excessive sweating, dependent edema, changes in cap refill, color/warmth of extremities, Date Initiated: 12/08/2025. Administer medications per physician orders. Date Initiated: 12/08/2025. Diet to be followed as prescribed, Date Initiated: 12/09/2025. Assess for shortness of breath and cyanosis every shift, Date Initiated: 12/08/2025. Daily weights were not ordered, edema was not accurately/consistently assessed, Review of the Care Plan for R89 revealed no concise Focus, goals, or interventions related to CHF such as decreasing cardiac output, for fluid overload/excess fluid volume, positioning (e.g. semi-Fowlers position-sitting at a 30-45-degree angle to improve breathing and comfort), restricting sodium and fluid intake, and resident education. During an interview on 3/5/26 at 11:30 AM, the Director of Nursing (DON) reported the facility does not have a CHF policy or protocol to care for residents with CHF. Daily weights or other interventions would be resident specific for care. The DON did remember reporting a weight gain for R89 to the Practitioner and dietary has documentation that shows a weight gain in December. The (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Practitioner did order Lasix dose to increase to 3 times a day for 3 days in December and in January. The DON was not aware of an ideal goal weight for R89 and could not find documentation of nursing assessments for typical CHF assessments such as edema measurements, fluid/sodium intake, and a baseline goal weight without extra fluid retention. The DON suggested the staff were not documenting what they were doing for R89. The DON reported she would follow nursing standards of practice such as [NAME] and [NAME] for good reference. The DON conveyed she understood the concern of R89's increased weight gain, establishing a baseline weight, lack of nursing assessments for edema, and closer monitoring of weights in December and January. Labs were ordered and a positive chest X-ray was acknowledged, but no close monitoring or follow-up assessments were documented. In an interview on 3/5/26 at 1:30 PM, the Nurse practitioner (NP) Q reported she started working with R89 in December 2025 and reported the expectation of a resident assessment for congestive heart failure would include weights, respiratory status, increased orthopnea (shortness of breath when laying down), edema, and low oxygen saturations. R40Review of a Face Sheet revealed R40 had pertinent diagnoses of spinal stenosis, heart failure, and diabetes. Review of the Physician Orders dated 2/14/26 for R40 revealed: Please wrap with ACE wraps MONITORING TIGHTNESS BLE (bilateral lower extremities) two times a day for edema. Please apply in the morning and remove at night. Review of the Medication Administration Record (MAR) for R40 revealed as of 1:40 PM on 3/5/26 ACE wrap bandages were not documented as applied to R40. There is no documentation in the EMR to show any tightness in her BLE were monitored for tightness. Review of a Practitioner Progress note dated 3/3/26 for R40 revealed R40 admitted on [DATE] after a back surgery and is positive for lower extremity edema. Her weight was 256 lbs on 2/22 and is now 263 pounds. During an observation and an interview on 3/5/26 at 1:45 PM, R40 was sitting up in a wheelchair and reported her legs were to be wrapped up in bandages before she gets out of bed due to edema that pools in her legs. R40 reported she was here for short term rehab. She saw her surgeon the day before and told her the facility needs to make sure they do that first thing in the morning and to take them off when she goes to bed. She said she has lots of fluid in her legs and they need to be wrapped. R40 reported she wants to go home too just like the staff here do and doesn't want to be at the facility any longer than she needs to be. R40 reported she gained 17 pounds since she has been at the facility and is trying to prevent CHF. R40 reported she told the Social Worker about not getting her legs wrapped in the past who said he would tell the nursing staff to address it. R40 reported she already had therapy this day and her legs have not been wrapped since she got up. During an observation and an interview on 3/5/26 at 2:00 PM, Licensed Practical Nurse (LPN) A was in the hallway and reported R40's nurse was in another room admitting a new resident and would check R40's orders and provide treatment if needed. In an interview on 3/5/26 at 2:51 PM, the DON was informed of R40 not getting her legs wrapped since she has been up and out of bed. The DON reported they could look at her schedule and change the orders to wrap her legs when in bed. At this time the DON understood that it would not be ideal since R40's legs are dominant during the day and would cause more swelling if not wrapped during the day.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent further pressure ulcer development for 1 resident (R7) out of 2 residents reviewed for pressure ulcers resulting in 3 facility acquired pressure ulcers for R7. Findings include:Review of an Face Sheet revealed R7 originally admitted to the facility on [DATE] with pertinent diagnoses which included neuropathy, chronic obstructive pulmonary disease, and stage IV sacral pressure ulcer. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R29, with a reference date of 12/18/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R7 was cognitively intact. Further documentation revealed Active Diagnoses included I5600 Malnutrition (imbalances in a person's intake of energy and nutrients) and documented 1 unhealed pressure injury. In an observation on 3/2/26 at 9:05 AM, R7 was positioned slightly on his left side with right ankle and foot touching the bed sheet, a pillow was observed between the bed sheet and R7's shin. R7's back and buttocks were flat on the bed sheet. R7's bedspread was folded and sitting on top of his right foot.Review of R7's Progress Note Details by a visiting wound clinic Nurse Practitioner (NP) dated 1/6/26 revealed: Wound #1 - Right Gluteal Fold a chronic stage 4 (full-thickness wound with exposed muscle, tendon or bone) facility acquired pressure ulcer. Measurements were 2.1cm (centimeters) length x 0.9cm width x 0.7 cm depth with tunneled (narrow, deep channels that form beneath the top layer of skin, extending from a wound into surrounding subcutaneous tissue or muscle) area of 1.6cm. There is no change noted in the wound progression and the treatment for Wound #1 remained unchanged. Wound #2 - Right, Dorsal Second Toe a stage 4 new facility acquired pressure ulcer dated 12/23/25. Measurements were 0.9cm length x 1cm width x 0.2cm depth. There was no change in the progression of the wound and treatment remained unchanged for Wound #2.Review of R7's Progress Note Details by a visiting wound clinic NP documented a new facility acquired wound dated 1/13/26. Progress Notes revealed: Wound #3 - Right, anterior thigh was a full-thickness trauma wound on 1/13/26 and initial measurements were 1.5cm length x 0.9cm width and 0.1m depth. There was a moderate amount of purulent drainage documented. Review of R7's Order Summary Report revealed treatment for the right thigh trauma wound was ordered on 1/20/26 (a week after the wound was evaluated by the wound clinic NP) with the first documented treatment completed on 1/22/26.Review of R7's Progress Note Details by a visiting wound clinic NP dated 1/20/26 documented a new facility acquired sacral stage 3 (a deep, full-thickness pressure injury extending through the skin into subcutaneous fat) wound (wound #4) that measured 2cm length x 3.6cm width x 0.1cm depth. There was a small amount of serosanguineous (thin, watery, pink-to-light-red fluid) drainage documented at the time of the assessment. Review of R7's Order Summary Report revealed treatment for the new facility acquired sacral stage 3 wound was ordered on 1/20/26 and the first treatment was declined by R7 on 1/22/26. Upon further review of R7's January 2026 Treatment Administration Record (TAR), treatment was not completed for R7's sacrum wound until 1/24/26. Review of R7's Progress Note Details by a visiting wound clinic NP dated 2/24/26 revealed Wound #1 measured at 2.4cm length x 0.9cm width x0.3cm depth and tunneling 1.1cm. Upon further review, Wound #1 within the 8-week time frame of NP visits from 1/6/26 to 2/24/26 wound #1 had minimal healing documented and not one change in treatment. Wound #2 measured 0.3cm length x 0.7cm width and no depth. Wound #3 measured 4.2cm length x 1.0cm width x 0.1cm depth. Wound #3 had deteriorated within the same 8-week period with only 2 treatment changes documented. Wound #4 measured 3.5cm x 5.0cm x.2cm. Wound #4 had 2 treatment changes within the 8-week period and continued to deteriorate. In an observation and interview on 03/03/2026 at 1:59 PM R7 was observed slightly on his left side with back and buttocks that touched the bed sheet. R7's right foot and toes are covered with a white sock as they touched the bed sheet, and a pillow was (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	underneath his right lower leg between the knee and ankle. R7's right foot and toes were directly placed on the top of the bed sheet and were not bridged. R7's bedspread was folded and sitting on top of his right foot. R7 did not have a heel boot placed on his right foot. R7 had spaghetti on his shirt which he reported had been what he ate for lunch. R7 states that he needed assistance to be turned and repositioned. R7 reported that staff usually repositioned him at least once during the night shift and approximately 3 times during the day shift. R7 reported that the wound clinic that does weekly visits will not be visiting any longer. R7 stated that he does not decline to be turned and repositioned and he lets staff do care. Review of a Progress Note dated 1/5/2026 revealed R7 to be completely immobile and unable to make even slight changes in body or extremity position without assistance. In an observation on 3/3/36 at 4:30 PM, R7 was in the same position he was observed in more than two hours prior.In an observation and interview on 03/04/2026 7:04 AM, R7 was positioned on his back with a pillow situated on his right side. A pillow was noted from R7's right knee to right heel with right foot and toes that touched the bed sheet. R7's bedspread was folded and sat on top of his right foot. Right foot had a white sock on it. R7 did not have a heel boot placed on his right foot. R7 stated the last time the staff turned and repositioned him was last night. R7 was unable to recall the time staff repositioned him only that it was between supper (the day before) and breakfast (today). In an observation and interview on 03/04/2026 9:22 AM, R7 was positioned on his back with a pillow situated on his right side. R7's bedspread was folded and sitting on top of his right foot. Right foot had a white sock on it. R7 did not have a heel boot placed on his right foot. A pillow was observed from R7's right knee to right heel and R7's right foot and toes were positioned on the bed sheet. R7 stated the last time the staff turned and repositioned him was last night.In an interview on 3/4/26 at 10:05 AM, Certified Nursing Assistant (CNA) L reported that R7 was her assigned resident. CNA L reported that R7 had not received care or had been repositioned since her arrival at 6:00 AM. CNA L stated that R7 should be checked and turned every 2 hours. CNA L revealed she was unsure of other interventions R7 had in place to prevent skin breakdown. CNA L reported that she was unsure when R7 was turned last because night shift and day shift do not communicate when residents are last repositioned in report.Review of a care plan Actual Pressure Injury Formation. revealed R7 had a pressure ulcer to right ischium and a wound to left second toe. interventions for R7 indicated staff were to provide surface support and pressure redistribution, position changes, and off-loading.Alternate pressure mattress.encourage R7 to float heels or wear heel boots.staff to assist in keeping any pressure from blankets off from R7's toe. monitor wound for any significant changes and alert physician of changes. Upon further review of R7's Actual Pressure Injury Formation. care plan the last intervention initiated was dated 12/24/2025. During an interview and record review on 3/4/26 at 10:43 AM, the Director of Nursing (DON) was unsure of the causation of Wound #2 stating that R7 doesn't put anything on his toes. DON reported that R7's new pressure injury to the left thigh (Wound #3) was due to a catheter stat lock (stabilization device that used adhesive to secure catheter tubing). DON stated that the intervention for Wound #3 was to rotate the catheter stat lock to different sites on R7's leg. DON stated it was an expectation that R7 be turned and repositioned every 2 hours for prevention of further pressure injuries. DON reported that staff should have been communicating related to R7's care specifically to report when R7 had last been turned and repositioned. DON stated that wound #3 and wound #4 were not addressed in R7's plan of care and should have been addressed with new pressure injuries and interventions. DON could not provide an incident report for wound #2, #3, or #4. DON stated that R7 had declined heel boot and other preventative interventions. DON could not provide documentation of R7's declinations of interventions to prevent new pressure injuries related to wound #2, wound #3, and wound #4. Record review of R7's progress notes revealed two wound check-ins on 1/29/26 and 2/25/26. When asked if wound check-ins were interdisciplinary collaboration, DON stated they were not. When asked if the interdisciplinary team had any collaboration to discuss R7's pressure wounds and what could be implemented to prevent further breakdown of his skin, DON replied no.Review of R7's Kardex Report (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	as of 3/1/26 revealed no documentation to change position of R7's catheter stat lock. Further review of R7's medical record did not reveal documentation to the staff to rotate R7's catheter stat lock. In an observation on 3/5/26 at 9:02 AM, R7 stated he was turned and repositioned once in the night last night. R7 was on his back with head of bed up approximately 35 degrees and he was slumped over on his left side. There is no sock or boot on R7's right foot. R7's right foot and toes contacted bed sheet.In an interview on 3/5/26 at 12:57 PM, Licensed Practical Nurse (LPN) Unit Manager (UM) F stated that facility would normally complete an incident report for Wound #2, #3, and #4 but that was not part of her job duties. LPN UM F stated that R7 had a boot for his right foot and only wore the boot while in bed. LPN UM F stated that she is unsure why R7 is positioned on his back continually. LPN UM F reported that she completed wound rounds with the visiting wound clinic NP every week and the NP was not concerned about changing treatments to R7's wounds if they were deteriorating. When asked if LPN UM F voiced any concern to the visiting NP from the wound clinic regarding any possible treatment change related to deteriorating wounds, LPN UM F replied that was beyond my scope. LPN UM F stated it was her expectation to stay on top of R7's care planning to prevent any further pressure injuries. When asked how frequently staff should be in R7's room to turn and reposition him, LPN UM F stated every 2 hours.In an interview on 3/5/26 at 2:01 PM, Regional Nurse (RN) M reported that there was no incident reports completed for R7's wound #2, #3, and #4. RN M reported that there are no notifications to primary physician related to deterioration of R7's wounds. RN M stated that the expectation for care planning interventions and updating wounds in R7's care plan would be the next business day from the start of the wound.Review of facility policy/procedure Skin and Wound Guidelines revised 2/4/26 revealed .the individualized comprehensive care plan addresses the resident's problem (i.e. at risk for skin breakdown or actual wound), the goal for prevention and/or treatment, and individualized interventions to address the resident's specific risk factors and the plan for reduction of risk.

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Optalis Health & Rehabilitation of Whitehall	916 East Lewis Street Whitehall, MI 49461

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview and record review, the facility failed to ensure sufficient staff were available to provide care and services for dependent resident's and meet resident needs including (R40 and R45) out of 87 residents who live the facility.Findings include:An early entry survey was conducted as a result of staffing concerns; because of the potential for ongoing concerns an additional early entry observation occurred on 3/5/26.On 03/05/2026 at 5:40 AM, Registered Nurse (RN) A revealed they currently had two nurse's and four aides working in the building. On 3/05/2026 at 5:42 AM, R52 was observed in his bed sleeping and wearing the same clothes he had been wearing for the past 2 days.On 3/05/2026 at 5:50 AM, Certified Nursing Aide (CNA) B revealed (Name of R52) behavior/mood had been better the last couple of days because they started him on some new medication on Monday night. I was worried about him because he usually is wandering, but he's sleeping tonight. I usually have to be on it (watching/always being observant) in order to protect my residents from him. CNA B stated, I have several residents that are scared of (Name of R52) because he goes into their rooms and looms over them in their beds and from the doorways including R58 and R60. I took (Name of R58) and wheeled her up to (Name of DON's) office because she is afraid of him. She reported her concerns and nothing changed. CNA B revealed, she usually doesn't take breaks because she needs to protect her residents and there would be no one to watch him (R52) if she took a break. CNA B stated she has taken (Name of R52) out of another female resident's room numerous times. CNA B revealed a staffing concern, One morning I had to call (use my phone) for help because (Name of R52) had a fall and I could not find anyone to help me get him up. My coworkers were working in other rooms, and I could not find anyone, so I called. No, we don't have enough help, we are often running 3rd shift with 2 aides and one nurse on each side. It runs better when we have 3 aides (one on each hall and one that helps in both hallways, but really, we need at least 2 on each hall at night because of behaviors and high acuity. We have several residents that need 2 aides to assist with the hoyers and sit-to- stands. We have a few residents that always require 2 staff because of behaviors and allegations against staff while others just need 1 to 1. So, no, we don't have enough staff.During an interview on 3/05/2026 at 6:03 AM, Certified Nursing Aide (CNA) C revealed an incident that happened involving R60 with his old roommate R52. States R60 has woken up scared because (Name of R52) was standing, hovering over him while he slept. CNA C revealed she was working the night (Name of R52) was talking about guns, shooting, and only needing one bullet. He has made numerous gun/shooting comments. He is just intimidating. CNA C revealed another recent incident she had with R52, she stated, I found him standing naked over a resident while she was sleeping. The resident did not know he was there. I got him out of her room and took him back to his room. I don't know what would have happened if I hadn't been looking for him. CNA C further stated, We do not have enough staff to take care of our residents, 2-3 aides on a side are not enough for our residents. Aides are constantly coming in early and staying late, but that does not fill the open spots or the need.During an interview on 3/05/26 at approximately 6:15AM, RN A stated, We do not have enough staff to fill the spots. RN A revealed the following about staffing on her weekends, It's awful, last weekend I only had 4 aides and 2 nurses for the building, and it wasn't enough. We have a lot of meds to pass, wounds to look at/do, help the CNA's and watch for behavior. Six people for a high acuity, high resident need building is not enough. On this hallway I have maybe 8-9 residents that get up during the night that require 2 people to get them to the bathroom. If my 2 aides are assisting a resident who is watching the hallway? It's a concern, I have a few residents that need to be redirected often throughout the night. For example, I have one resident that will start yelling and pulling things down, then he gets the other residents in surrounding rooms yelling, frightened and stirred up. When this resident starts, you need to be able to get to him quick and redirect his behavior before he wakes other residents up. There are 50 plus residents for me and 2 aides to assist even (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	with us constantly running/moving we do not have enough staff to meet their needs. During an interview on 3/5/26 at 6:35 AM, Certified Nurse's Aide (CNA) D revealed I worked last weekend, we only had 2 nurses and four aides for the building. I clocked 70 hours last week; I picked up a 12 hour shift last weekend because they did not have enough staff. We do not have enough staff to take care of these residents; some require lots of care, many have behaviors and need re-direction it's a concern.During an interview on 3/05/26/at approximately 10:20 AM, DON stated, Yes, we do not have enough staffing. We do not have enough staff to take on new residents. However, we have been told we don't turn anyone away. On 03/05/2026 at 12:14 PM, NHA revealed there are staffing concerns and she is trying to get staff. NHA also confirmed concerns about providing timely service/labs for residents and that she is working on it. During an interview the NHA was asked to provide an Acuity list for residents that live on the 300 & 400 hallways and include those that require assistance with eating.On 3/5/26 an acuity list for the 28 residents living on the 300 Hallway was provided. Review of the list reflected 6 residents using a Sit to Stand (a piece of equipment that aids transfers) and 12 residents use a Hoyer that requires 2 staff to assist in transferring them. Out of 18 residents that require staff assistance for transferring, six of these residents require staff assistance to eat.On 3/5/26 an acuity list for 26 residents living on the 400 Hallway revealed 3 residents used a Sit to Stand, 9 use a Hoyer and 1 resident uses both the Sit to Stand or Hoyer. Out of the 13 residents, 2 of them require assistance to eat.Review of the acuity on both the 300 & 400 hallways reflect 31 out of the 54 residents living on it require extensive staff assistance, including 8 that require staff assistance to eat their meals. The level of acuity shows the increase potential of not meeting resident care needs during low weekend staffing and staffing overnight. On 3/5/26 at approximately 4:55 PM, R52 was observed walking in the hallway wearing the same gray t-shirt with white lettering and blue jeans for the third day in a row. R40Review of a Face Sheet revealed R40 had pertinent diagnoses of spinal stenosis, heart failure, and diabetes. Review of the Physician Orders dated 2/14/26 for R40 revealed: Please wrap with ACE wraps MONITORING TIGHTNESS BLE (bilateral lower extremities) two times a day for edema. Please apply in the morning and remove at night. Review of the Medication Administration Record (MAR) for R40 revealed as of 1:40 PM on 3/5/26 ACE wrap bandages were not documented as applied to R40. There is no documentation in the EMR (Electronic Medical Record) to show any tightness in her BLE were monitored for tightness. During an interview on 3/5/26 at 1:30 PM, the Nurse Practitioner (NP) Q and the Unit Manager (UM) C was questioned about residents receiving care based on concerns reported. The NP Q verified R40 has not had her bandages wrapped around her legs as ordered and talked to the floor nurse about it. The floor nurse reported she did not have time to wrap R40's legs. NP Q reported the Medical Director has shared concerns about the facility being understaffed that were expressed to the Nursing Home Administrator (NHA) and the Director of Nursing (DON). At this time UM C started to cry and reported the staff are so stressed because they know what kind of care they are capable of and want to provide good care and did they best they could and it affects them.During an observation and an interview on 3/5/26 at 1:45 PM, R40 was sitting up in a wheelchair and reported her legs were to be wrapped up in bandages before she gets out of bed due to edema that pools in her legs. R40 reported she was here for short term rehab. She saw her surgeon the day before and told her the facility needs to make sure they do that first thing in the morning and to take them off when she goes to bed. R40 reported she told the Social Worker about not getting her legs wrapped in the past who said he would tell the nursing staff to address it. R40 reported she already had therapy this day and her legs have not been wrapped since she got up. During an interview on 3/5/26 at approximately 2:10 PM, the Social Worker (SW) B reported R40 told him the nurse was not wrapping her legs up as ordered by the physician. When asked what he did with that information, SW B reported he told the Nursing Staff in the past that they needed to do it. During an observation and an interview on 3/5/26 at 2:00 PM, Licensed Practical Nurse (LPN) A was in the hallway and reported R40's nurse was in another room admitting a new resident and would check R40's orders and provide treatment if needed. During an (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview on 3/5/26 at 2:51 PM, the DON (Director of Nursing) was informed of R40 not getting her legs wrapped since she has been up and out of bed. The DON reported they could look at her schedule and change the orders to wrap her legs when in bed. At this time the DON understood that it would not be ideal since R40's legs are dominant during the day and would cause more swelling if not wrapped during the day. The DON reported that the nurse in that hall is a very good nurse and acknowledged the concern of admitting new residents when the current residents care is not being provided.R45Review of a policy titled Showers last revised 1/7/25 revealed: It is the practice of the facility to assist residents with showering to maintain proper hygiene. Guidelines: Residents will be provided with showers as per request and per facility schedule based upon resident preference and safety. Review of the Electronic Medical Records (EMR) revealed R45 had pertinent diagnoses of contractures, morbid obesity, and paraplegia. During an observation and an interview on 3/2/26 (Monday) at 9:48 AM, R45 was lying in bed and not able to provide cares for herself. R45 reported she required extensive assistance from 2 staff for many activities of daily living (ADL's) due to her contractures. R45 had concerns about not having enough staff available to provide her with showers twice a week. Her last shower was 2 1/2 weeks ago and had to really push to get that shower so she could get her hair washed. R45 reported she gets a shower maybe once a month. Review of the Care Plan for R45 revealed she is to get a shower on Mondays and Fridays and is totally dependent on 2 staff for showers. During an interview on 3/4/26 at approximately 2:00 PM, R45 reported she did not get her shower on Monday 3/2/26. In an interview on 3/4/26 at approximately 2:23 PM, Certified Nursing Assistant (CNA) S and CNA T reported R45 requires 2 staff for bathing which would only leave one CNA on the floor to answer call lights. R45 likes to have her baths in the morning before breakfast and that would be hard to provide her with a shower at that time. The CNA's reported they will stay later on their shifts at times to provide her with a shower. Review of the Bathing/Shower task documentation for R45 revealed she was getting bathed but was not clear of when she was provided with a shower. In an interview on 3/4/26 at 11:51 AM, the Director of Nursing (DON) reported she addressed R45s showers a few weeks ago with R45. The DON looked into the EMR and verified that R45 was to receive showers on Mondays and Fridays and it was not clearly documented when the last time R45 received her shower. During an interview on 3/5/26 at 10:15 AM, the DON reported she talked to R45 about her showers and reported it takes 2 staff to provide the showers. R45 wants her showers before breakfast and needs to be more forceful with staff to ensure she gets them. There are usually 3 aides on the floor and if two aides provide her with a shower, that would leave one aide on the floor during mealtime. The facility did not have a shower aide at this time. Has addressed staffing with the Corporate Administrators who do not take in the acuity of a resident regarding staffing. They only look at the census. The facility does not have control over the acuity of a new admission or how many residents they admit because it is all pushed by the Corporate Administrators. The DON reported she will work on the floor as a floor nurse at times when they are short staffed. The DON reported she was not aware of the regulations of not serving as a charge nurse when the average facility census is 60 or greater. The facility census for this survey was 87. The DON reported that she is an Infection Control Nurse too. Review of a policy titled Staffing last revised on 4/18/25 revealed: The facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for the residents in accordance with the residents plan of care. Guidelines: Licensed nurses and nursing assistants are available 24 hours a day, seven days a week to provide competent resident care services including: o Assuring resident safetyo Attaining or maintaining the highest practicable level of physical, mental, and psychosocial well-being of the residents.o Assessment, evaluating, planning and implementing resident care plans.o Responding to resident needs.Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care, the resident assessments, and the facility assessment. Factors considered in determining appropriate staffing ratios and skills include an evaluation of the diseases, conditions, physical or cognitive limitations of the resident population, (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and acuity. Minimum staffing requirements imposed by the state, if applicable, are adhered to when determining staff ratios but are not necessarily considered a determination of sufficient and competent staffing.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on observation, interview and record review, the facility failed to prevent the Director of Nursing (DON) from working as a nurse on the floor. This deficient practice affects all 89 residents who resided at the facility.Findings include: During an observation and interview on 3/3/26 at 7:30 AM, the Director of Nursing (DON) was observed as a floor nurse attending a medication cart and passing medications. The DON reported there was a nurse that called in and was passing medications until relief was obtained. The DON reported she must work the floor sometimes.During an interview on 3/5/26 at 10:15 AM, the DON reported she has addressed staffing concerns with the Corporate Administrators who do not take in the acuity of a resident regarding staffing. They only look at the census. The facility does not have control over the acuity of a new admission or how many residents they admit because it is all pushed by the Corporate Administrators. The DON reported she will work on the floor on average once a week to cover staffing shortages. The DON reported she was not aware of the regulations of not serving as a charge nurse when the average facility census is 60 or greater. The facility census for this survey was 87. The DON reported that she is an Infection Control Nurse too. Review of a Staffing policy last revised 4/18/25 revealed: The facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for the residents in accordance with the resident's plan of care. Guidelines: The director of nursing services (DNS)/(DON) may serve as the charge nurse only when the average daily occupancy of the facility is 60 or fewer residents.

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a Compliance and Ethics Program. Based on interview and record review, the facility failed to implement policies and procedures to ensure an effective Compliance and Ethics program. Findings: During an interview on 3/5/2026 at 2:31 PM, Regional Nurse (RN) M reported that the parent organization of the facility has a corporate director of compliance. RN M said staff can report suspected violations to a hotline.During the interview on 3/5/2026 at 2:31 PM, the Nursing Home Administrator (NHA) said she did not recall having training on the facility Ethics and Compliance program, but thought the online training was scheduled yearly. The NHA said she thought there were postings for the Compliance and Ethics hotline in common areas and indicated that the sorts of violations that would be reported were patient privacy/HIPAA (Health Insurance Portability and Accountability Act) violations, resident care concerns and staffing concerns. The NHA was not aware of any reported violations and had not responded to any alleged violations. When asked, the NHA was not aware who the facility Compliance liaison was and was not familiar with the procedures, but she would review the policy and find out. Review of a policy provided to the survey team Compliance and Ethics Program and Policy was dated 11/01/2019. When asked, RN M reached out to the corporate director of compliance for a more updated policy. RN M indicated that the corporate compliance director was based on the other side of the state and had not visited the facility. In an email sent on 3/5/2026 at 3:49 PM, the NHA wrote Per policy, it was confirmed that I am the Compliance Liaison. Prior to the interview on 3/5/2026 at 2:31 PM and the email follow up at 3/5/2026 at 3:49 PM, the facility NHA was not aware she was the designated facility Compliance and Ethics liaison. therefore, could not implement written policies and procedures and standards of conduct, was not involved with conducting effective training and education, was not involved in conducting internal monitoring and auditing, was not involved with enforcing standards and well-publicized disciplinary guidelines and was not involved in developing effective lines of communication with staff and ensuring participation in a compliance committee at the facility and with the Corporate Compliance officer. Review of a policy Corporate Compliance and Ethic Program Policy - Policy 227 revised 12/09/2024 reflects The facility is committed to Compliance and high Ethical standards. A Corporate Compliance and Ethic Program have been established in accordance with the Industry Segment-Specific Compliance guidelines. The program is designed to promote Quality of Care, Quality of Life, and prevent and detect criminal, civil and administrative violations. The Facility has developed a Corporate Compliance work plan in accordance with the Office of Inspector General (OIG) and the Department of Health and Human Services (DHHS). The Corporate Compliance Plan (Work Plan) allows the facility to participate in the nationwide efforts to reduce health care fraud and abuse. The work plan will help the facility achieve its goals to provide the highest practicable quality of care and quality of life for its residents; to have efficient and effective operations, to provide accurate financial reporting and to legally be compliant. The facility provides a structure that makes it easy for employees to communicate questions and concerns. The Work Plan with the Code of Conduct will help the facility detect and correct errors and improper conduct. Compliance is defined as following the rules and regulations while Ethics is our adopted concept of doing the right thing because it is the right thing.Further review of the policy reflects As part of the facility's Culture of Compliance, the facility develops and distribute written standards of conduct, policies and procedures, and protocol that promote the facility's commitment to compliance with areas of potential fraud and abuse and quality of care and quality of life issues. The facility should maintain designated compliance and ethic program contact to which employees may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution. The reporting system includes a Hotline number that is posted throughout each facility, an email address and a drop box for written methods of reporting. The Compliance Officer and/or Compliance Liaison will conduct random Compliance and QAPI audits in each facility. Audit types may include but are not limited to sufficient staffing, comprehensive care plans, use of (continued on next page)

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F 0895 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	psychotropic medications, pressure ulcers, abuse, submission of accurate claims, quality of care/quality of life, therapy services kickbacks, environmental and resident safety. The facility administrator will be responsible for keeping a binder containing all documentation supporting facility QAPI efforts to ensure continued Compliance and Ethical implementation of patient care, state and federal regulations as well as policies and procedures.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document in the medical record in a complete, accurate, and timely fashion for 4 residents (R7, R52, R58 and R60) out of 19 sampled residents. Findings:Resident #7 (R7)Review of an Face Sheet revealed R7 originally admitted to the facility on [DATE] with pertinent diagnoses which included neuropathy, chronic obstructive pulmonary disease, and stage IV sacral pressure ulcer. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R29, with a reference date of 12/18/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R7 was cognitively intact. Further documentation revealed Active Diagnoses included I5600 Malnutrition (imbalances in a person's intake of energy and nutrients) and documented 1 unhealed pressure injury.NOTE: Electronic copies of R7's progress notes were retained during the survey on 3/2/2026.Review of R7's Progress Note Details by a visiting wound clinic Nurse Practitioner (NP) dated 1/6/26 revealed: Wound #1 - Right Gluteal Fold a chronic stage 4 (full-thickness wound with exposed muscle, tendon or bone) facility acquired pressure ulcer. Measurements were 2.1cm (centimeters) length x 0.9cm width x 0.7 cm depth with tunneled (narrow, deep channels that form beneath the top layer of skin, extending from a wound into surrounding subcutaneous tissue or muscle) area of 1.6cm. There is no change noted in the wound progression and the treatment for Wound #1 remained unchanged. Wound #2 - Right, Dorsal Second Toe a stage 4 new facility acquired pressure ulcer dated 12/23/25. Measurements were 0.9cm length x 1cm width x 0.2cm depth. There was no change in the progression of the wound and treatment remained unchanged for Wound #2.Review of R7's Progress Note Details by a visiting wound clinic NP documented a new facility acquired wound dated 1/13/26. Progress Notes revealed: Wound #3 - Right, anterior thigh was a full-thickness trauma wound on 1/13/26 and initial measurements were 1.5cm length x 0.9cm width and 0.1m depth. There was a moderate amount of purulent drainage documented. Review of R7's Order Summary Report revealed treatment for the right thigh trauma wound was ordered on 1/20/26 (a week after the wound was evaluated by the wound clinic NP) with the first documented treatment completed on 1/22/26.Review of R7's Progress Note Details by a visiting wound clinic NP dated 1/20/26 documented a new facility acquired sacral stage 3 (a deep, full-thickness pressure injury extending through the skin into subcutaneous fat) wound (wound #4) that measured 2cm length x 3.6cm width x 0.1cm depth. There was a small amount of serosanguineous (thin, watery, pink-to-light-red fluid) drainage documented at the time of the assessment. Review of R7's Order Summary Report revealed treatment for the new facility acquired sacral stage 3 wound was ordered on 1/20/26 and the first treatment was declined by R7 on 1/22/26. Upon further review of R7's January 2026 Treatment Administration Record (TAR), treatment was not completed for R7's sacrum wound until 1/24/26. Review of R7's Progress Note Details by a visiting wound clinic NP dated 2/24/26 revealed Wound #1 measured at 2.4cm length x 0.9cm width x0.3cm depth and tunneling 1.1cm. Upon further review, Wound #1 within the 8-week time frame of NP visits from 1/6/26 to 2/24/26 wound #1 had minimal healing documented and not one change in treatment. Wound #2 measured 0.3cm length x 0.7cm width and no depth. Wound #3 measured 4.2cm length x 1.0cm width x 0.1cm depth. Wound #3 had deteriorated within the same 8-week period with only 2 treatment changes documented. Wound #4 measured 3.5cm x 5.0cm x.2cm. Wound #4 had 2 treatment changes within the 8-week period and continued to deteriorate.Review of a care plan Actual Pressure Injury Formation. revealed R7 had a pressure ulcer to right ischium and a wound to left second toe. interventions for R7 indicated staff were to provide surface support and pressure redistribution, position changes, and off-loading.Alternate pressure mattress.encourage R7 to float heels or wear heel boots.staff to assist in keeping any pressure from blankets off from R7's toe. monitor wound for (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation of Whitehall	916 East Lewis Street Whitehall, MI 49461

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	any significant changes and alert physician of changes. Upon further review of R7's Actual Pressure Injury Formation. care plan the last intervention initiated was dated 12/24/2025. Review of R7's Kardex Report as of 3/1/26 revealed no documentation to change position of R7's catheter stat lock. Further review of R7's medical record did not reveal documentation to the staff to rotate R7's catheter stat lock. During an interview and record review on 3/4/26 at 10:43 AM, the Director of Nursing (DON) was unsure of the causation of Wound #2 stating that R7 doesn't put anything on his toes. DON reported that R7's new pressure injury to the left thigh (Wound #3) was due to a catheter stat lock (stabilization device that used adhesive to secure catheter tubing). DON stated that the intervention for Wound #3 was to rotate the catheter stat lock to different sites on R7's leg. DON stated it was an expectation that R7 be turned and repositioned every 2 hours for prevention of further pressure injuries. DON reported that staff should have been communicating related to R7's care specifically to report when R7 had last been turned and repositioned. DON stated that wound #3 and wound #4 were not addressed in R7's plan of care and should have been addressed with new pressure injuries and interventions. DON could not provide an incident report for wound #2, #3, or #4. DON stated that R7 had declined heel boot and other preventative interventions. DON could not provide documentation of R7's declinations of interventions to prevent new pressure injuries related to wound #2, wound #3, and wound #4. Record review of R7's progress notes revealed two wound check-ins on 1/29/26 and 2/25/26. When asked if wound check-ins were interdisciplinary collaboration, DON stated they were not. When asked if the interdisciplinary team had any collaboration to discuss R7's pressure wounds and what could be implemented to prevent further breakdown of his skin, DON replied no.On 3/4/2026 at 12:23 PM, the DON provided a previously unavailable Injury incident report, documented by the DON. The DON also provided Progress Notes that had also NOT been present in the clinical record, retrieved and retained on 3/2/2026. The progress notes were dated 12/23/2025 and 12/26/2025 indicated the IDT reviewed the new wound (this was previously denied by the DON). The discrepancy between originally retained records and the newly provided records reflected an unreasonably late entry into the clinical record, over two months late. On 3/5/2026 the Director of Nursing (DON) provided a previously unavailable incident report pertaining to R7's right thigh, dated 1/13/2026. The DON also produced Late Entry notes that were back dated 1/13/2026 and 1/14/2026 pertaining to the right thigh which alleged the IDT team had discussed the wound and the care plan had been reviewed and updated. (See above noted care plan and Kardex which do not indicate any updates had been made to the care plan since 12/24/2025.)During an investigation regarding resident-to-resident mental abuse, conducted during an annual survey from 3/2/2026-3/5/2026, involving R52, R58 and R60, it was discovered that staff failed to document late entry progress notes in a reasonable timeframe. Resident #58 (R58)Review of an Face Sheet revealed R58 admitted to the facility 3/4/2025 with pertinent diagnoses which included heart failure, acute respiratory failure, anxiety disorder, and major depressive disorder. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R58, with a reference date of 12/8/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R58 was cognitively intact.Review of R52's Progress Note dated 2/7/26 at 5:05 AM indicated that R52 went into R58's room and stood over her while she laid in bed. There was no documentation of this incident in R58's electronic medical record besides following psychology notes. Review of a psychology follow-up visit dated 2/10/26 at 4:18 PM revealed .Mood symptoms worsened over the past two weeks with increased depressive symptoms triggered by a situational stressor involving a confused male resident (R52) who repeatedly entered R58's room. This led to increased fear. Symptoms are now improving, with yesterday and today showing decreased symptoms as resident is reassured, he is not returning to the facility. R58 experienced increased depression and anxiety symptoms triggered by a confused male resident (R52) at the facility. Symptoms included fear, avoidance behaviors, and nausea.Review of a psychology follow-up visit dated 2/24/26 at 11:30 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administrator (NHA) reported that the facility had transferred R52 to the hospital on 2/7/26 related to aggression toward staff and hallucinations. Upon review of the Behavior Note on 2/7/26, NHA reported she did not see the note before today. NHA stated that R52 had been wandering at night and was redirectable as the staff had R52 sort papers at the nurse's station. NHA stated she had encouraged a sleep aid so R52 could slow down. NHA reported that R58 was still scared of R52 and NHA had been counseling her. NHA reported the facility did not move R52 to a different room or hallway because it could turn into a larger concern. NHA reported that she believed she did not get all the details from the event on 2/7/26 and after reading the note stated it may be possible abuse and reportable (as an allegation of abuse to the state agency). NHA reported there were no incident reports completed from the occurrence on 2/7/26 between residents R52, R58, and R60. In an interview and record review on 3/4/2026 at 11:32AM, DON stated R52 had Wernicke's with bouts of agitation and became agitated on the evening of 2/7/26. DON stated R52 had been swinging a wheelchair pedal at a CNA and facility transferred R52 to the ED for evaluation. DON stated the facility did attempt a stop sign for R58 but R58 did not like the stop sign and it was removed. DON unable to locate further documentation related to the stop sign initiation. DON confirmed that she was unaware of the 2/7/26 behavior note until it was read in the Interdisciplinary Team Meeting (IDT) on Monday (2/9/26) morning. DON confirmed that members of the IDT were present, including the NHA. DON reported that she was unsure if the entire IDT team listened to the report completely, but team was present. DON reported there were no incident reports completed from the occurrence on 2/7/26 between R52, R58, and R60. DON stated if R52 had directly threatened with R60 with a gun it would be considered abuse and reportable. DON stated the facility is unable to meet R52's needs presently and he does present a risk. Upon review of the psychiatric notes for R58 on 2/10/26 and 2/24/26 regarding her ongoing fear of R52, DON had no response.Further review of the Electronic Medical Record (EMR) for R52 and R58 on 3/5/2026 (a day after NHA and DON were made aware of the feelings of mental abuse by R58 and R60), the DON created progress notes withing R52 and R58's EMR that appeared as if they were present in the EMR at the time of the occurrences. Close review of the EMR reflects the notes added were in fact late entries, but this is not reflected in the text of each note, easily understood by the reader. The DON also created incident reports for R58 and R60 that were dated 2/7/2026 which the DON denied having during an interview and record review on 3/4/2026.Review of a Nursing Progress Note, discovered in R58's EMR, effective date 2/7/2026 at 1:24 PM, CREATED on 3/4/2026 at 3:32 PM reflected Male resident (R52) wondered (sic) into resident's room during the over nigh (sic) hours and it scared (R58). No verbal aggression or physical aggression occurred. But resident reported being scared of resident entering her room on this evening. Resident was re-directed out of resident's room. Review of a Nursing Progress Note, discovered in R52's EMR, effective date 2/9/2026 at 3:15 PM, CREATED on 3/4/2026 at 3:16 PM reflected Resident (R52) had episodes of aggression and was sent to ER over the weekend. Facility physician aware, Son notified. Resident returned and was placed in a private room aware with no roommate for safety of other residents. Resident also has his night dose of Risperdal increased with consent from son to assist with agitation and behaviors. Care plan reviewed and updated as needed. Will continue to follow care plan.Review of a Nursing Progress Note, discovered in R58's EMR, effective date 2/11/2026 at 2:12 PM, CREATED on 3/4/2026 at 2:15 PM, the DON documented Resident has been utilizing a stop sign at her door to help deter wandering residents from entering. Resident (R58) is not preferring this on her door, says it is keeping other visitors from seeing her. Stop sign was taken off her door per her preference.Review of a Nursing Progress Note, discovered in R52's EMR, effective date 2/11/2026 at 2:12 PM, CREATED on 3/4/2026 at 2:15 PM, the DON documented an identical progress note found in R58's clinical record with the same effective and CREATED on date, Resident has been utilizing a stop sign at her door to help deter wandering residents from entering. Resident (R58) is not preferring this on her door, says it is keeping other visitors from seeing her. Stop sign was taken off her door per her preference.Review of a Social Work note, discovered in R58's EMR, (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	effective date 2/16/2026 at 11:07, CREATED on 3/4/2026 at 10:36 AM, Social Worker (SW) E documented SS met with resident (R58) for a wellness visit r/t (related to) the incident with the gentleman. Resident appeared calm and was smiling throughout the visit. Resident did endorse anxiety over the situation but states she does not feel threatened or fearful. Resident is A&O X 4 and her own decision maker. Affect observed as appropriate. No signs of acute emotional distress noted. Resident able to verbalize feeling safe in the facility. Resident does not appear fearful at this time.Review of a policy Documentation in the Medical Record reviewed 2/3/2026 reflected The purpose of this policy is to provide guidelines for documentation in the medical record.Principles of documentation include , but are not limited to: Documentation should be factual, objective and resident centered. False information will not be documented. Record descriptive and objective information based on knowledge of the assessment, observation, or service provided. Subjective information will be recorded only as relevant, such as the resident's verbalizations. Documentation should be accurate, relevant, and complete. Documentation should be timely and in chronological order . Documentation should be completed at the time of service or by the end of the shift in which the evaluation, observation, or care service occurred.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Timely entries are essential in a patient's ongoing care, as delays in documentation can lead to unsafe patient care.It is necessary to document all the nursing care you provide for each patient, including assessment data, nursing problems or diagnoses, interventions, and evaluation of patient responses, in the health record. Your data enable providers and outside reviewers of the medical record to track a patient's clinical course.It is also crucial that your documentation accurately reflects the status of the patient and responses to interventions, especially upon admission, transfer, or discharge. [NAME] RN, MSN, PhD, FAAN, [NAME] A.; [NAME] RN, MSN, EdD, FAAN, [NAME] G.; Stockert RN, BSN, MS, PhD, [NAME] A.; Hall RN, BSN, MS, PhD, CNE, [NAME]. Fundamentals of Nursing - E-Book . Elsevier. Kindle Edition.

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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. Based on observation and interview, the facility failed to maintain general cleanliness and repair of facility. This resulted in an increased potential for contamination and a possible decrease in satisfaction of living of residents. Findings Include:On 03/03/2026 at 9:13AM, observed on wall near the nurses' station on 200 hall, a wall mounted mini-split unit had grey and green crusted material on the unit. This crusted material was observed both on interior of the mini-split and the face of the unit. On 03/03/2026 at 3:00PM during tour of facility with Maintenance Director (MD) R, MD R confirmed observation of crusted material on the mini-split and stated the mini -splits in the facility are not in use during the winter and were scheduled to be professionally cleaned before starting them up for the year. On 03/03/2026 at 2:44PM, observed in the shower room on the 400 hall, tile coving at the wall and floor juncture was broken and chipped, exposing the wall to moisture and humidity from the shower and general cleaning of the room. There were sections of the wall (average length of six inches) with tiles missing on the wall across from the shower table washing area and areas adjacent to the shower area. During this observation, MD R stated that the tile coving in the shower room was scheduled for removal and replacement within the next month. MD R indicated equipment used in the room to facilitate bathing of residents is causing the damage to the tile when the equipment runs into the tile. On 03/03/2026 at 2:50PM, observed in 300 hall shower room, portions of tile coving adjacent to the shower area, have tiles that are broken and chipped. MD R confirmed the tile condition at time of observation. On 03/03/2026 at 2:58PM, observed in 200 hall shower room, portions of the coving tile are missing, chipped or broken in several areas of the room. MD R confirmed the condition of the tile. On 03/03/2026 at 3:03PM, observed in 100 hall shower room, portions of the coving tile are missing, chipped or broken, affecting several areas in the room. MD R indicated that all the shower rooms' tile coving will be replaced with a rubber coving but did not have a timeline as to when it would be started or completed with exception of the shower room in 400 hall that will be replaced within the next month.

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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** Based on interview and record review, the facility failed to honor the resident's right to set their own schedule for 1 resident (R24) out of 2 residents reviewed for dignified care. Findings:Review of a Face Sheet reflected R24 admitted to the facility on [DATE] with diagnoses that included congestive heart failure, adjustment disorder with anxiety and insomnia. During an interview on 3/2/2026 at 11:50 AM, R24 reported the facility is short staffed and a second shift Certified Nurse Aide (CNA) wanted her to go to bed for the night at 7:00 PM for staff convenience. R24 said she would like to stay up until after taking their evening medications and when she refused to be put to bed at 7:00 PM a CNA told the resident that they would have to wait for third shift to arrive because they couldn't accommodate the resident's preference for staying up a few more hours. R24 said that a few days over the weekend she didn't get her evening medications until 1:30 AM. An audit of a February 2026 Medication Administration Record including administration time confirmed that on 2/28/2026 R24's evening medication was not administered until 1:26 AM. During an interview on 3/4/2026 at 2:20 PM, Agency Registered Nurse (RN) D reported that she did administer R24's evening medications at almost 1:30 AM on 2/28/26. RN D said she arrived at the facility at approximately 12:40 AM to relieve Unit Manager (UM) C who was already covering a staffing shortage. RN D said that R24 was not in bed when she brought her evening medications.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to evaluate 1 resident (R6) out of 4 residents reviewed every 14 days before as needed benzodiazepine (psychotropic) medication was renewed. Findings include:Review of an Face Sheet revealed R6 originally admitted to the facility 2/15/2022 with pertinent diagnoses which included chronic congestive heart failure, type II diabetes mellitus, anxiety, and morbid obesity. Review of R6's Physician Orders dated 12/16/25, revealed an order for . Clonazepam (used to treat panic disorder, anxiety, and various seizure disorders by calming the brain and nerves) tablet 0.5 milligrams (MG) take one by mouth every 12 hours as needed for anxiety for 90 days. Review of R6's Electronic Medication Record (MAR) documented Clonazepam was administered 8 times from 12/16/25 to 12/31/25. Further review of the R6's MAR revealed Clonazepam was administered 15 times in January, 12 times in February and 4 times in March of 2026. In an interview and record review on 3/4/2026 at 11:27 AM, the Director of Nursing (DON) reported she was aware that R6's medication required a physician to evaluate the medication use every 14 days before it was continued and had spoken to R6's provider regarding this evaluation. DON was unable to reveal an evaluation every 14 days for R6's use of Clonazepam and stated she would continue to review R6's electronic medical record for further evaluations. Review of an Progress Note provided by the DON with an effective date of 2/3/26 and a created date of 3/4/2026 (indicating the progress note had been created a month late) revealed documentation by Nurse Practitioner (NP) Q that R6 may use Clonazepam 0.5mg every 12 as needed because benefits are greater than risks at this time. Further documentation revealed a Progress Note dated 3/3/26 by a physician that stated Clonazepam 0.5mg every 12 hours as needed to be continued because benefits are greater than risks at this time. No further evaluation related to R6 and the continued use of the as needed Clonazepam were revealed or provided. Review of facility policy/procedure Psychotropic Medication Use, reviewed 2/3/2026, revealed .if the resident is prescribed a PRN psychotropic medication, the medication should only be used when the medication is necessary to treat a documented diagnosed condition, and it should only be used for a limited period of time.prior to ordering a new PRN psychotropic medication, staff should first attempt and document non-pharmacological interventions and whether or not they were successful.all PRN psychotropics (excluding antipsychotics) should be limited to 14 days. If the prescribing practitioner believes that the PRN order should be extended past 14 days, they should document their rationale in the resident's medical record and indicate the specific duration of the PRN order. o This process should be completed every time the physician believes it is necessary to extend the PRN order.all PRN antipsychotics are limited to 14 days with no exceptions. If the prescribing practitioner believes the resident would still benefit from continued antipsychotics, they must: evaluate the resident and assess their current condition and progress to determine if the PRN antipsychotic is still warranted.document why the PRN antipsychotic is still needed on a PRN basis, explain the benefit of the medication to the resident and if the resident's indications of distress improved as a result of the PRN antipsychotic.all residents prescribed PRN psychotropic medications will be tracked and reviewed by facility staff routinely.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act. Findings include:Resident #58 (R58)Review of an Face Sheet revealed R58 admitted to the facility 3/4/2025 with pertinent diagnoses which included heart failure, acute respiratory failure, anxiety disorder, and major depressive disorder. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R58, with a reference date of 12/8/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R58 was cognitively intact.Review of R52's Progress Note dated 2/7/26 at 5:05 AM indicated that R52 went into R58's room and stood over her while she laid in bed.Review of a psychology follow-up visit dated 2/10/26 at 4:18 PM revealed .Mood symptoms worsened over the past two weeks with increased depressive symptoms triggered by a situational stressor involving a confused male resident (R52) who repeatedly entered R58's room. This led to increased fear. Symptoms are now improving, with yesterday and today showing decreased symptoms as resident is reassured, he is not returning to the facility. R58 experienced increased depression and anxiety symptoms triggered by a confused male resident (R52) at the facility. Symptoms included fear, avoidance behaviors, and nausea.Review of a psychology follow-up visit dated 2/24/26 at 11:30 AM revealed .R58 reported increased anxiety symptoms related to another resident recently admitted to the hall. Resident states that R52 came to her doorway and stands there staring into her room. She stated she had redirected him back to his own room. R58 stated she had been keeping her door closed for this reason, however R52 had also opened her door and came into her room on multiple occasions. R58 stated her daughter was here yesterday when R52 entered her room and was also unable to redirect R52 out of the room. R58 stated her daughter put the call light on for assistance, however both were anxious while waiting for staff to respond. R58 stated she had voiced her concerns to several people in the facility but feels like no changes will be made.which scared R58.In an interview on 03/04/2026 at10:00 AM R58 stated the man who walks around next door, (R52) he will stand in my doorway and stare. R58 stated she tried to keep her door closed to prevent R52 from entering her room and he opened it just this week. R58 stated that R52 will stand in her room by the curtains (5ft to R58's bed from the curtain). R58 stated she heard a loud noise the previous night and when she looked in the hallway, R52 had pulled out a supper tray from the cart, and it was on the floor. R58 stated that R52 makes her feel anxious and very leery. R58 reported to one person about the situation with R52, when asked who that was R58 stated the administrator. R58 requested for R52 to be moved from the hall and R58 was told we are working on it. R58 stated that he (R52) still is next door to her and stated, that bothers me a lot. R58 stated I should feel safe and secure. R58 reported that her feelings haven't changed any. R58 stated I don't think he should be on our hallway. In an interview on 3/4/26 at 12:21 PM, R58 Family Member (FM) N stated R52 scared R58 on 2/23/26 when FM N had been visiting. FM N stated that R52 showed up multiple times in R58's doorway. R58 responded to R52 and said, Your room is down there.your room is down there!. R52 did enter R58's room again and FM N stated she rang R58's call light for assistance. FM N stated that R58 fears R52. FM N stated that on a subsequent visit on the weekend, R52 was in R58's doorway multiple times and needed to be redirected away from R58's room. FM N stated that R58 went to the administrator with concerns regarding R52 presence in R58's room and FM N reported that the facility had planned to move R52 to a different location. FM N stated that R52 weighs heavily and causes high anxiety for R58. In a review of R58's Electronic Medical Record on 3/4/26 at 12:30 PM, revealed no further documentation with exception of the psychologist Progress Notes on 2/10/26 and 2/24/26 of any incident that occurred or intervention that had been (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered or put into effect.Resident #26 (R26)Review of an Face Sheet revealed R26 admitted to the facility 1/14/2019 with pertinent diagnoses which included depression, decreased range of motion, and dementia. In an interview on 3/4/2026 at 2:09 PM, Family Member (FM) O reported that R52 resided next door to R26 and R58 (roommates). FM O stated that R58 had been very afraid of R52 after he walked into her room at night. FM O stated that R58 was anxious related to R52 during the night that he would walk into her room. FM O reported that she felt uneasy when R52 would walk in front of the door and stand at the doorway of R26 and R58's room. FM O reported that R58 had shut the door and R52 had opened it and walked in. FM O reported that this week R52 had walked into R26 room and FM O stated this is a lady's room, please leave. FM O stated I do have a fear of what R52's going to do and why he's in here. Resident #60 (R60)Review of an Face Sheet revealed R60 originally admitted to the facility 6/15/2022 with pertinent diagnoses which included chronic obstructive pulmonary disease, dementia, and generalized anxiety disorder. Review of a MDS assessment for R60, with a reference date of 12/12/2025 revealed a score of 07, out of a total possible score of 15, which indicated R60 was severely cognitively impaired.Review of R52's Progress Note dated 2/7/26 at 5:05 AM indicated that R60 was crying and had stated to the facility staff that he was scared to have R52 in the room. In an interview on 3/4/26 at 10:15 AM, R60 was asked if he had any concerns with other residents, if he was fearful of another resident. R60 stated I want to forget that. R60 stated his old roommate (R52) wanted to die. R60 stated R52 went batty. When further questioned, R60 stated R52 kept talking about dying and thoughts of suicide. R60 stated he did not feel threatened at this time. In a review of R60's Electronic Medical Record on 3/4/26 at 1:30 PM, revealed no documentation that any incident had occurred.Resident #52 (R52)Review of an Face Sheet revealed R52 originally admitted to the facility on [DATE] with pertinent diagnoses which included Wernicke's encephalopathy (acute neurological emergency caused by severe vitamin B1 deficiency), dementia, delusional disorders, and hallucinations. Review of an BIMS Evaluation dated 2/6/26, R52 had a score of 15, out of a total possible score of 15, which indicated R52 was cognitively intact.Review of a hospital record History and Physical dated 1/9/2026, .R52 was a [AGE] year-old male with recurrent visual hallucinations presenting to the emergency department with repeat episodes of confusion and wandering around other people's apartments.Review of R52's Behavior Note documented by Licensed Practical Nurse (LPN) P on 2/7/26 at 5:05 AM, . R52 used a wheelchair foot pedal as a potential weapon tonight, holding it up to swing it at a Certified Nursing Assistant (CNA). R52 also made multiple comments to staff and his roommate R60 regarding shooting people, guns, and it would only take one bullet. R60 cried and had stated to staff that he is scared of R52 in his room. LPN P was also informed that R52 went into R58's room and stood over her while she laid in bed. LPN P and an Agency Nurse transferred R52 to the emergency department regarding these two occurrences. Emergency department (ED) reported to LPN P that R52 attempted to elope the ED and became physical with ED security.R52 received 2 doses of intramuscular Ativan (an anti-anxiety medication) and Risperidone (an antipsychotic medication) to assist with anxiety. R52 obtained a skin tear in ED. R52 is currently awake and ready for transfer back to facility.Review of a hospital record Psychiatric Consultation Note dated 2/8/26, .R52 brought to the emergency department from his nursing home for agitation and aggressive behaviors on 2/6/26.R52's chief complaint was I was in a lockout situation .Review of R52's Progress Note dated 2/7/26 at 9:56 AM, .R52 arrived back to facility approximately 8:45AM.R52 placed into room [ROOM NUMBER] bed 2 related to history of aggressive behaviors (this room is directly beside R58's room) .R52 shows signs of delusions and confusion.R52 continues to walk down hallways without shoes and unsteady gait.Review of R52's Progress Note dated 2/7/26 at 12:50 AM, .R52 restless, running through hallways, trying to get out of the facility.R52 gait is unsteady.R52 walking into other resident's rooms. Director of Nursing (DON) notified an a one to one for R52 was initiated .Review of R52's Progress Note dated 2/7/26 at 13:54 PM, .on call Nurse Practitioner (NP) and DON notified and approved for R52 to be transferred to ED for psychiatric evaluation. R52 was transported from facility at approximately 1:50PM. Further review of Progress (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notes, R52 returned to the facility on 2/11/26. Review of R52's Progress Note dated 2/12/26 at 12:38 AM, .R52 was up and wandering around hallway and wandered into another resident's room. Staff attempting to remove resident from other room and resident became physically violent. closed fist attempting to punch nurse aides in face. R52 finally came out of other residents' room and went back into his room where R52 grabbed his bedside table and attempted to [NAME] it at his CNA. Administrator notified, Unit Manager (UM) notified, on call physician assistant notified and in agreement to sending the resident to ER for evaluation.Review of R52's Progress Note dated 2/12/26 at 1:25 AM, .R52 was 1:1 with police officer after he arrived on scene. Police officer 1:1 with R52 until ambulance arrival. R52 became verbally agitated and aggressive with female Emergency Medical Technician (EMT).R52 was transported via ambulance service to the ED for evaluation.Review of R52's Progress Note dated 2/12/26 at 9:39 PM, .R52 received his nighttime medication, and medication has had no effect on this R52.R52 continues to wander around hallway and enter other resident's rooms. R52 becomes verbally agitated when asked to leave other resident rooms . R52 given a job to help keep an eye on the hallway, R52 focused on this task for brief time, then was attempting to enter a female resident room.R52 stopped by staff and assisted back to his room.Review of R52's Progress Note dated 2/12/26 at 11:34 PM, .R52 was up wandering around and entered other resident's rooms, R52 became agitated when asked to leave the residents room. R52 redirected briefly back to his own room. R52 keeps asking where we keep the ammo.Review of R52's Progress Note dated 2/12/26 at 11:34 PM, .R52 assisted back to his room again.R52 was observed going into restroom and coming out of another resident room. Male Residents in the other room have been resting. R52 becomes agitated when staff redirect him . R52 escorted out of a female resident room again and is now back in his own room sitting on edge of his bed.Review of R52's Progress Note dated 2/15/26 at 11:06 PM, .R52 has been up wandering into several other resident's rooms. R52 is not wearing clothing but has a blanket wrapped around him. Staff that attempted to redirect have been met with resistance. R52 helped with getting dressed and R52 refused. R52 was pushing staff away and continued to wander very unsteadily down the 300 and 400 halls. Res continued to attempt to go to exit doors and in and out of other resident rooms. R52 has been muttering to himself and speaking in a non-sensical fashion.Review of R52's Progress Note dated 2/24/26 at 11:52 PM, .R52 was walking down the hallway. R52 had no socks or pants on, just underwear and a T-shirt. R52 was looking into every room. R52 had to be guided out of other resident rooms.Review of R52's Progress Note dated 3/2/26 at 1:30 AM, .R52 noted to be walking frantically in hallway. R52 noted to have visual and auditory hallucinations, irrational beliefs, and incoherent and illogical jumbling of words. R52 cannot organize his thoughts and becomes increasingly agitated when staff attempts to assist him or offer distraction. R52 is redirected for a few seconds then proceeded to enter other residents' rooms talking about guns and not having any ammo.Review of R52's Progress Note dated 3/2/26 at 2:23 AM, .Despite R52's one time dose of Ativan, R52 continued to be anxious, constantly pacing up and down hallway trying to enter other residents' rooms. Resident became agitated when staff tried to redirect him out of other residents' rooms. Hallucinations continue.R52 kept yelling about a boat, and someone is supposed to pick him up so he can go get ammo for his gun.In an interview and record review on 3/4/2026 at 9:24AM, Nursing Home Administrator (NHA) reported that the facility had transferred R52 to the hospital on 2/7/26 related to aggression toward staff and hallucinations. Upon review of the Behavior Note on 2/7/26, NHA reported she did not see the note before today. NHA stated that R52 had been wandering at night and was redirectable as the staff had R52 sort papers at the nurse's station. NHA stated she had encouraged a sleep aid so R52 could slow down. NHA reported that R58 was still scared of R52 and NHA had been counseling her. NHA reported the facility did not move R52 to a different room or hallway because it could turn into a larger concern. NHA reported that she believed she did not get all the details from the event on 2/7/26 and after reading the note stated it may be possible abuse and reportable (as an allegation of abuse to the state agency). NHA reported there were no incident reports completed from the occurrence on 2/7/26 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	between residents R52, R58, and R60. Review of facility policy/procedure Abuse, revised 2/2/2026, revealed .facility completing ongoing assessments and care planning for appropriate interventions, and monitoring of residents with behaviors, including but not limited to. verbally aggressive behaviors (screaming, cursing, demanding, insulting, etc.). physically aggressive behaviors (hitting, kicking, biting, spitting, throwing objects, threatening gestures, etc.). wandering into other's rooms or space, Taking/touching/rummaging through other's property. protective actions depend upon the people involved. any allegation of abuse must be immediately reported to the supervisor and the Abuse Prevention Coordinator. The Administrator initiates investigating any allegation of abuse against a patient.if a resident is the alleged perpetrator, the facility will ensure other residents are protected as determined by the circumstances, which may include but are not limited to resident room changes, increased supervision, or immediate transfer or discharge, if indicated. the facility will ensure that all allegations involving abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, and crimes 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 (including adult protective services and/or law enforcement, when applicable) or 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 (including adult protective services and/or law enforcement, when applicable) .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement and update individualized care plans for 3 residents (R6, R7, and R52) of 12 residents reviewed. Findings include:Resident #6 (R6)Review of an Face Sheet revealed R6 originally admitted to the facility 2/15/2022 with pertinent diagnoses which included chronic congestive heart failure, type II diabetes mellitus, anxiety, and morbid obesity. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R6, with a reference date of 2/3/2026 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R6 was cognitively intact.In an observation on 3/2/26 at 8:34 AM, R6 stated her skin is always itchy. R6 had multiple small scabs that traveled up R6's left upper arm. R6 reported facility did think it was scabies at one time, and the rash had not healed. Review of a current Skin Care Plan intervention for R6, initiated on 5/29/2025, revealed R6 had concerns she had scabies and was on precautions until a dermatologist appointment. Further review revealed a treatment to apply petroleum jelly to arms, torso, and back twice per day initiated 4/21/2025. Review of a current Order Summary Report dated 3/2/2026 revealed hydrocortisone cream (assists with itching) to buttocks every shift to prevent scratching. Further review of R6's current orders did not reveal a treatment for R6's rash to her left upper arm. In an interview on 3/4/26 at 11:32 AM, the Director of Nursing (DON) stated that R6 did visit the dermatologist, and she would locate the document from that visit. DON reported that the care plan should be updated to reflect the status of R6. Review of R6's Patient Handout provided by the DON, dated 6/2/2025, Plans.rash likely secondary to xerosis (abnormally dry skin) .no burrows suggestive of scabies.recommend using Vaseline as a moisturizer.Resident #7 (R7)Review of an Face Sheet revealed R7 originally admitted to the facility on [DATE] with pertinent diagnoses which included neuropathy, chronic obstructive pulmonary disease, and stage IV sacral pressure ulcer. Review of R7's Progress Note Details by a visiting wound clinic Nurse Practitioner (NP) documented a new facility acquired wound dated 1/13/26. Progress Notes revealed: Wound #3 - Right, anterior thigh was a full-thickness trauma wound on 1/13/26 and initial measurements were 1.5cm length x 0.9cm width and 0.1m depth. There was a moderate amount of purulent drainage documented. Review of R7's Progress Note Details by a visiting wound clinic NP dated 1/20/26 documented a new facility acquired sacral stage 3 (a deep, full-thickness pressure injury extending through the skin into subcutaneous fat) wound (wound #4) that measured 2cm length x 3.6cm width x 0.1cm depth. There was a small amount of serosanguineous (thin, watery, pink-to-light-red fluid) drainage documented at the time of the assessment. Review of a care plan Actual Pressure Injury Formation revealed R7 had a pressure ulcer to right ischium and a wound to left second toe. interventions for R7 included for staff to provide surface support and pressure redistribution, position changes, and off-loading.Alternate pressure mattress.encourage R7 to float heels or wear heel boots.staff to assist in keeping any pressure from blankets off from R7's toe. monitor wound for any significant changes and alert physician of changes. Upon further review of R7's Actual Pressure Injury Formation. care plan the last intervention initiated was dated 12/24/2025. During an interview and record review on 3/4/26 at 10:43 AM, the Director of Nursing (DON) DON stated that the trauma wound to R7's thigh and Stage 3 wound to R7's sacrum had not been addressed in R7's plan of care and should have been addressed with the new pressure injuries and interventions. Resident #52 (R52)Review of an Face Sheet revealed R52 originally admitted to the facility on [DATE] with pertinent diagnoses which included Wernicke's encephalopathy (acute neurological emergency caused by severe vitamin B1 deficiency), dementia, delusional disorders, and hallucinations. Review of a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) Evaluation dated 2/6/26, R52 had a score of 15, out of a total possible (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	score of 15, which indicated R52 was cognitively intact.Review of R52's Progress Note dated 2/15/26 at 11:06 PM, .R52 has been up wandering into several other resident's rooms. R52 is not wearing clothing but has a blanket wrapped around him. Staff that attempted to redirect have been met with resistance. R52 helped with getting dressed and R52 refused. R52 was pushing staff away and continued to wander very unsteadily down the 300 and 400 halls. Res continued to attempt to go to exit doors and in and out of other resident rooms. R52 has been muttering to himself and speaking in a non-sensical fashion.Review of R52's Progress Note dated 2/7/26 at 9:56 AM, .R52 arrived back to facility approximately 8:45AM.R52 placed into room [ROOM NUMBER] bed 2 related to history of aggressive.R52 shows signs of delusions and confusion.R52 continues to walk down hallways without shoes and unsteady gait.Review of R52's Progress Note dated 2/7/26 at 12:50 AM, .R52 restless, running through hallways, trying to get out of the facility.R52 gait is unsteady.R52 walking into other resident's rooms. Director of Nursing (DON) notified an a one to one for R52 was initiated .Review of R52's Progress Note dated 2/17/26 at 05:05 AM, .R52 was up wandering during the beginning of this shift. Staff attempted to redirect were met with resistance. R52 continued to attempt to go to exit doors. R52 was muttering to himself and spoke in a non-sensical fashion.Review of R52's care plan At risk for changes in behavior and mood dated 2/3/2026, R52's interventions were initially documented on 2/3/26 that included administer medications per physician orders. encourage resident to attend activities of choice.offer snacks.ice cream. The last updated intervention was dated 2/3/26. Review of R52's care plan Exit seeking/elopement risk dated 2/3/26, R52's interventions are to allow to vent feelings and frustrations, alert bracelet.calmy redirect. There are no updated interventions after 2/3/26. In an interview on 03/05/2026 at 1:06 PM, License Practical Nurse (LPN) Unit Manager (UM) F stated that the team discusses issues as they come. LPN UM F reported that there has been no time for her to update plans of care for residents related to working the floor so much. LPN UM F stated that she attempts to attend care conferences and update plans of care for residents, but she is stretched thin. In an interview on 3/5/26 at 2:01 PM, Regional Nurse (RN) M reported the expectation for care planning interventions and updating wounds and changes in a resident's plan of care would be the next business day. Review of facility/policy Care Plan - Comprehensive and Revision, reviewed 2/2/2026 revealed .assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.the interdisciplinary team reviews and updates the care plan.when there has been a significant change in the resident's condition.when the desired outcome is not met.when the resident has been readmitted to the facility from a hospital stay.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medication was administered according to professional standards for 5 residents (R3, R24, R38, R93, R94) out of 19 residents reviewed. Findings:R24Review of a Face Sheet reflected R24 admitted to the facility on [DATE] with diagnoses that included congestive heart failure, adjustment disorder with anxiety and insomnia. During an interview on 3/2/2026 at 11:50 AM, R24 reported that due to staffing problems at the facility she did not get her evening medications until 1:30 AM over the previous weekend. An audit of a February 2026 Medication Administration Record including administration time confirmed that on 2/28/2026 R24's evening medication, scheduled to be given at 7:00 PM on 2/27/2026, was not administered until 1:26 AM on 2/28/2026. During an interview on 3/4/2026 at 2:20 PM, Agency Registered Nurse (RN) D reported that she did administer R24's evening medications at almost 1:30 AM on 2/28/26. RN D said she arrived at the facility at approximately 12:40 AM to relieve Unit Manager (UM) C who was already covering a staffing shortage. RN D said that four or five residents had not been given their evening medications that night. RN D reported that she did not notify the physician of the late administration or obtain orders confirming the late administration would be appropriate because she assumed UM C had done so already. R38Review of a Face Sheet reflects R38 admitted to the facility with diagnoses that included sepsis, acute respiratory failure with hypoxia, high blood pressure and heart failure. An audit of a February 2026 MAR, including administration time reflected on 2/28/2026 R38's evening medication, scheduled to be given at 7:00 PM on 2/27/2026, was not administered until 12:32 AM on 2/28/2026. R93Review of a Face Sheet reflected R93 admitted to the facility with diagnoses that included burns involving 10-19% of body surface with 0% to 9% third degree burns, severe protein malnutrition, obstructive sleep apnea and insomnia. An audit of a February 2026 MAR, including administration times, reflected that R93 did not receive his evening medication, scheduled to be given at 7:00 PM on 2/27/2026, were not administered until 1:16 AM on 2/28/2026. R94Review of a Face Sheet reflected R94 admitted to the facility with diagnoses that included Type 2 Diabetes, high blood pressure, depression and anxiety. An audit of February 2026 MAR, including administration times, reflected R94 did not get a medication scheduled for 8:00 PM on 2/27/2026 until 12:24 AM on 2/28/2026 and did not receive Insulin Glargine (long-acting insulin) scheduled to be given at 7:00 PM on 2/27/2026 until 12:24 AM on 1/28/2026. During an interview on 3/5/2026 at 1:05 PM, UM C reported that she had to work very late on 2/27/2028 and into 2/28/2026 because she had to cover for a staffing shortage. UM C said the expectation is that medications not administered at the right time would require an order approving the late administration. UM C said she did not obtain orders authorizing the late medication (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administration. During an interview on 3/5/2026 at 1:10 PM, the MARs for R24, R38, R93, & R94 were reviewed with Nurse Practitioner (NP) Q. After each medication was considered, NP Q reported she would approve the late administration, however, she would have expected a request for approval to administer the medications late due to the potential for significant errors. Review of a policy Medication Administration dated 8/7/2023 reflected Medications are administered in accordance with the following rights of medication administration: . Right time and frequency . Administer medication in accordance with frequency prescribed by physician and standards of practice. Review of an Face Sheet revealed R3 originally admitted to the facility on [DATE] with pertinent diagnoses which included bipolar disorder, type II diabetes mellitus, and depression. Review of R3's Physician's Orders revealed an active order for Lispro Insulin (a prescription medication used to treat diabetes), Inject 10 units subcutaneously (underneath the skin) with meals, hold if BS (blood sugar) is (less than) <120, with a start date of 7/29/2025. Review of R3's Medication Administration Record (MAR) on 3/4/2026, revealed nursing staff were not holding the Lispro Insulin for a BS less than 120 and administering the 10 units on the following day and times: 12/17/25 at 8:00AM, Blood sugar was 112. 1/4/26 at 8:00AM, Blood sugar was 107. 1/29/26 at 8:00AM, Blood sugar 95. 2/6/26 at 5:00PM, blood sugar 68. 2/13/26 at 8:00AM, Blood sugar 113. 2/20/26 at 5:00PM, Blood Sugar 108. In an interview on 3/4/26 at 11:34 AM, the Director of Nursing (DON) reported that she was unaware of the Lispro Insulin not being held for blood sugars less than 120 for R3 on those dates and times. DON stated she would review R3's medical record and reveal if there was documentation that could be provided that the Lispro insulin was held or documented about. In an interview on 3/5/26 at 2:01 PM, Regional Nurse (RN) M reported that facility was unable to reveal any other documentation regarding R3's Lispro insulin not being held when his blood sugar was less than 120. Review of facility policy/procedure Medication-Insulin Administration, revealed .review and follow blood glucose parameters in the physician order for when to hold insulin administration and/or when to call the medical practitioner.

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	235206	A. Building B. Wing	03/05/2026

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Optalis Health & Rehabilitation of Whitehall	916 East Lewis Street Whitehall, MI 49461

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to provide showers for 1 (R45) of 1 resident reviewed for showers.Findings include:Review of the Electronic Medical Records (EMR) revealed R45 had pertinent diagnoses of contractures, morbid obesity, and paraplegia. During an observation and an interview on 3/2/26 (Monday) at 9:48 AM, R45 was lying in bed and not able to provide cares for herself. R45 reported she required extensive assistance of 2 staff for many activities of daily living (ADL's) due to her contractures. R45 had concerns of not enough staff available to provide her showers twice a week. Her last shower was 2 1/2 weeks ago and had to really push to get that shower so she could get her hair washed. R45 reported she gets a shower maybe once a month. Review of the Care Plan for R45 revealed she is to get a shower on Mondays and Fridays and is totally dependent on 2 staff for showers. During an interview on 3/4/26 at approximately 2:00 PM, R45 reported she did not get her shower on Monday 3/2/26. In an interview on 3/4/26 at approximately 2:23 PM Certified Nursing Assistant (CNA) S and CNA T reported R45 requires 2 staff for bathing which would only leave one CNA on the floor to answer call lights. R45 likes to have her baths in the morning before breakfast and that would be hard to provide her with a shower at that time. The CNA's reported they will stay later on their shifts at times to provide her with a shower. Review of the Bathing/Shower task documentation for R45 revealed she was getting bathed but was not clear of when she was provided with a shower. In an interview on 3/4/26 at 11:51 AM, the Director of Nursing (DON) reported she addressed R45s showers a few weeks ago with R45. The DON looked into the EMR and verified that R45 was to receive showers on Mondays and Fridays and it was not clearly documented when the last time R45 received her shower.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent falls and injuries for 1 Resident (R52) contributing to increase and likelihood of further injuries and potential for harm.Findings include:Resident #52 (R52)Review of a Face Sheet revealed R52 originally admitted to the facility on [DATE] with pertinent diagnoses which included Wernicke's encephalopathy (acute neurological emergency caused by severe vitamin B1 deficiency), dementia, delusional disorders, and hallucinations. Review of a Psychiatry Note dated 4/13/26 reflected, BIMS (Brief Interview of Mental Status, a mental status assessment) score declined significantly from 15 on 2/16/2026 to 3 on 4/14/2026 which indicated resident is severely cognitively impaired.Observation of the locked 100 Hallway on 4/13/26 at approximately 5:43AM, revealed that the hallway was absent of staff, it was quiet and the lights were low with one bright light noted at the far end of the hallway.Observation on 4/13/26 at 5:45 AM, revealed R52 had his own room, he was asleep in a low positioned bed. Further observation revealed a wheelchair was being stored in the hallway, and his walker was not observed.During an interview on 4/13/26 at 5:51 AM, Agency Certified Nurse's Aide (A-CNA) D stated, Today was my first night on this unit, and the second night being in this building. Last night I had 10 residents on the 300 and 400 hallways. A-CNA D was observed sitting in the 100 hallways' dining/seating area on the couch in front of a TV, on her phone. The hallway and the call lights were not visible from her location. A-CNA D stated she was the only one working this hallway, The nurse and other aide were outside the locked unit doors.During an interview on 4/13/26 at 8:16 AM, the NHA revealed they had increased supervision, they hired an additional unit manager, brought 3rd shift nurse to 1st to help with wounds, hired some hospitality aides, and are still hiring staff. The NHA further revealed that R52 is now on the locked unit and revealed they have cameras on the unit where they can watch him. (During the survey it was revealed that their system with the cameras are live feed and can be watched on the computer monitors so other staff can assist if needed) It was brought to NHA's attention that the 3rd shift staff were observed working on the units and were not watching monitors to see if the aide on the locked unit needed assistance.During an observation on 4/13/26 at 8:30 AM, R52 was observed in his room eating breakfast wearing a gray T-shirt, black jeans, and shoes on his feet. Resident has a bandage dated 4/13 on his right arm. R52 was also observed to have two skin tears/injuries on his left arm. One above the crease of his elbow the other just below the crease. Both skin tears are about the size of a quarter around, dark red in color and have black- and purple-colored bruises in the area surrounding the tears.During an observation on 4/14/26 at 8:27 AM, R52 was in his room eating breakfast and was unaware of where he was (Nursing Home). Resident believed he was working at one of his friend's businesses. Resident's wheelchair, gait belt and walker were not located in his room at this time.Review of the current Care Plan Report (on 4/13/26) reflected, page 4, Focus of R52 At risk for falls secondary to Wernicke's encephalopathy initiated 2/03/2026, with a Goal of Minimize risk for falls initiated on 2/03/2026 with a target date of 6/27/2026. The following Interventions were initiated on 2/03/2026: Bed at transfer height with assistive device (walker, wheelchair with brakes locked) at bedside. 2.) Bed in low position when resident is resting. Further interventions included, Resident to wear gait belt during ambulation as tolerated. Date initiated 3/12/2026. Keep walker near resident and encourage use of walker, push bedside table away when not in use. Date initiated 4/03/2026.Review of the current Care Plan Report (on 4/13/26) reflected, page 4, Focus of R52 At risk for alteration in skin integrity related to Wernicke's encephalopathy at risk for bruising due to poor safety awareness, history of falls, and bumps to his body on walls and other items in the facility. Date Initiated: 02/03/2026. The following Intervention was initiated on 2/10/2026: Provide preventative skin care routinely and prn.During an interview on 4/14/26 at 8:34 AM, Certified Nurse's (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Aide (CNA) O revealed, We really need at least 2 people at all times on the unit (locked unit) to help watch the residents. [Name of R52] is a huge fall risk. Even more since he had a fall a week or so ago. When he does not have his walker sometimes, he will get up and push his wheelchair, or he will just get up and leave it and take off walking. He has been more unsteady, seems to want to sprint often rather than walk. He's quick.On 4/14/26 at 8:43 AM, while CNA O picked up R52's breakfast tray, R52 stated he did not know where his walker or wheelchair were. CNA O stated he was using the wheelchair outside his door. The wheelchair outside of his door was noted to have a different resident's name on the back, and the previous resident who had used the wheelchair had passed away. CNA O found a front wheeled walker and attempted to have him use it. R52 reported he was 6'3 (appeared to be factual). The walker provided by CNA O was not adjusted to his height. R52 had a very forward posture when he pushed it. While using the walker R52 would not keep his right hand on the walker and at times stumbled with his right leg. At one point, R52 left his walker and walked away unassisted. CNA O ended up holding R52's left arm to get him to walk into the dining room. R52 needed physical assistance to turn to sit in the chair at the table. CNA O did not offer/provide a gait belt prior to walking with him. Further observation of the wheelchair (located outside of R52's room) appeared to be on the small/ short side compared to resident's tall frame/stature.On 4/15/26 at 9:05 AM, R52 was observed exiting the unit's dining/sitting area and ambulating in the hallway without a gait belt or walker (both interventions listed on his care plan) while Hospitality Aide (HA) P followed him. HA P did not notify other staff working on the unit that she needed any assistance with R52. (The Nurse was passing meds and CNA working on the unit was assisting other residents.)During an interview with the Director of Nursing (DON) on 4/15/26 at 11:55 AM, the DON was made aware of the observation of R52 walking with HA P without a gait belt and/or walker. The DON confirmed that R52 required physical assistance with the use of a gait belt when walking and Hospitality Aides cannot do care or walk residents with gait belts. Review of a Nursing Progress Note Effective Date 4/13/26 at 10:10 (AM) reflected, Noted resident in bed, supine position prior to breakfast. His eyes were closed. Respirations even and unlabored. Noted to his right elbow a skin tear with total flap loss. When asked, resident lifted up his arm to look at it and stated, I bumped it. He was unable to report where or on what. Area cleansed, a dressing was applied. Treatment orders updated. Observations left elbow, noted that a prior skin tear to this area was closed, blue discoloration continues. He denied pain. Will update treatment plan to include glen sleeves for protection of his arms. Call placed to (Name of R52's son) unable to leave message will retry. Resident placed on the provider list for further update. Review of a Nursing Progress Note Effective Date 4/13/2026 at 14:27, revealed, This nurse was notified by staff members at noon that they noted a small abrasion like area to the left cheek. This nurse and facility wound nurse assessed. Resident did state it is tender to touch. Superficial abrasion noted with petechiae eye present to left cheek. Physician notified. A message has been left with the son to call the facility back. No reported incident of causation. Staff statements say it was not noted to be present this AM upon their observations. Resident does not have safety awareness and history of falls. Has a history of bumping into items including walls in the facility. Resident is ambulatory and has been witnessed putting himself on the floor and getting himself off the floor without assistance from staff members. Due to cognition of the resident and injury on unknown origin state reportable was made to the state of Michigan and the local Police Department. Five-day investigation to continue.Review of Physician Team Progress Note Effective Date 4/14/2026 at 11:49, .Pt (patient) seen today for f/u (follow-up). Nursing reporting that pt has a laceration to his left cheek from unknown source, has right sided weakness, and back pain. PE (Physical Exam): NAD, non-labored breathing on RA, small area of petechiae on left cheek w/some xerosis, no facial drop, no slurred speech, facial nerve intake (can puff out cheeks), bilateral UE (Upper Extremity) ROM (Range of Motion) is normal, grips/strength equal, bilateral LE (Lower Extremity) is equal .Review of IDT Progress Note Effective Date 4/14/2026 at 12:16, reflected, Resident met to review new skin tear that was observed on right elbow yesterday. Wound nurse assessed, treatment in place, physician (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and son notified. [NAME] sleeves Initiated for protection of arms. Resident has known risk for bumping into items due to poor safety awareness, no spatial awareness, and impulsivity and requires directing and queuing by staff. Care plan review and updated.