STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235249	A. Building B. Wing	03/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation St Francis	915 N River Rd Saginaw, MI 48609

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - 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** 22347 This citation pertains to Intake Number MI00150995. Based on observation, interview and record review, the facility failed to ensure supervision for 1 resident (Resident #101) with a known history of falls prior to admission and after admission (who fell on [DATE], with a facial injury) of 3 resident's reviewed for falls, resulting in a contusion above the left eye, skin tear on bridge of nose, pain and hospitalization . Findings Include: Resident #101: Review of the Face Sheet, Minimum Data Set, dated dated dated ,d+[DATE], nursing and physician notes dated 2/24/25 through 3/4/25, and facility fall assessments dated 2/26/25 and 3/4/25 (total of 8 day's), revealed Resident #101 was [AGE] years old, admitted to the facility on [DATE] and discharged after a fall on 3/4/25, confused with a BIMS (cognitive assessment, 1 to 15) of 0, had memory loss, was unsteady, repeatedly attempted to self-transfer, had poor safety awareness, required total Activities of Daily Living assistance and had a history of falls prior to admission and at the facility. The resident's diagnosis included, diabetes, anxiety, severe depression, Alzheimer's Disease, Dementia, disorder of muscle, muscle weakness, reduced mobility, and lack of coordination. Review of the facility nurse's notes dated 2/26/25, revealed the resident was found lying by her bed on the floor. This was the first fall in the facility. No injury was documented at this time. Review of the facility fall assessment dated [DATE], revealed the resident was at risk for falls due to a history of falls, unsteadiness, decreased cognition, repeated self-transfer attempts and failure to use the call light. Review of the resident's Fall Care Plan dated 2/24/25, revealed she had a low bed, was orientated to the use of her call light, and had a soft touch call light; she did not have bedside mats due to trip hazard. The resident had a BIMS of 0, was forgetful, self-transferred repeatedly, had a history of falls and had documented behaviors. No intervention of increased supervision was found after this fall at the facility on her care plan. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of facility video of resident #101's fall on 3/4/25 was done on 3/18/25 at approximately 1:00 p.m. , with the Director of Nursing. The resident was in her wheelchair next to the fire double doors on her unit sitting. She abruptly stood up, tripped over the foot peddles and fell to her left side, hitting her head on the metal door frame. Nurse A was charting at the nursing station, and the resident was not in her view. She looked up, caught her standing; when she began to fall, the nurse immediately ran over to the resident. Review of the facility nurse's notes dated 3/4/25 at 8:44 p.m., stated The resident was sitting in the hallway in her wheelchair and the resident started to walk and fell and hit her head on the floor. The resident had a laceration above her left eye and another small skin tear on her nose. The resident was transferred to the hospital for further evaluation. During a phone interview done on 3/19/25 at 9:00 a.m., Nurse, LPN A stated It was at shift change; I asked (family member of Resident #101) to let me know when he left so we could watch her, he didn't because he said there were people at the desk, so he left her there (near the fire doors). I did not see her there. I saw her start to fall, and I yelled for someone to get her, it was too late she fell . I did not see her hit the door frame, I saw her on the floor and ran to get her. I did neuros and vitals on her and we sent her out for a head injury. Nurse A denied the resident had lost consciousness. Review of hospital ED (Emergency Department) note dated 3/4/25 at 8:23 p.m., stated 4 cm with large hematoma seen by critical care service and trauma. Per resident's left eye laceration dated 3/4/25, looked to be approximately 3.5 cm in length (a ruler was held up above the laceration). It was red, swollen and open, requiring sutures. Review of the hospital ED note dated 3/4/25 at 10:24 p.m., stated The patient's (patient) stood up from her wheelchair and then fell forward hitting her head against a metal door frame. They report that the patient did have a loss of consciousness. Review of the hospital ED note dated 3/4/25, stated We discussed the need for admission, the resident was admitted to the hospital critical care unit. Review of the hospital critical care note dated 3/4/25 at 11:02 p.m., stated she stood up from her wheelchair and fell forward, striking her left forehead against a metal door frame. She sustained a 4 cm scalp laceration that has been sutured. Review of the nurse's notes dated 3/4/25, revealed the resident fell when she got up and tried to walk in the hallway, hit her head and was transferred to the hospital and was admitted to the ICU (intensive care unit). Review of the Fall Care Plan dated 3/4/25, revealed an intervention of increased supervision, the resident was to be taken to activities when out of her room. This was done after her second fall with injury at the facility (within 8 days). During an interview done on 3/19/25 at 10:10 a.m., Administrator, Director of Nursing and Assistant Director of Nursing reviewed resident's facility and hospital documentation and no new information was given.