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	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation at St. Francis	915 North River Road 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2721708 and the recertification survey. Based on observation, interview and record review, the facility failed to provide adequate nursing staff to ensure that the needs of their residents were met for 7 residents (#16, #40, #41, #43, #51, #87, #88) and residents identified through confidential family interviews, resulting in insufficient and unmet resident care needs, feelings of frustration, and complaints about not enough staff. Findings include: Record review of the facility 'Staffing' policy dated 4/18/2025 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' plans of care. licensed nurses and nursing assistants are available 24 hours a day, seven days a week to provide competent resident care services including: attaining or maintaining the highest practicable level of physical, mental, and psychosocial well-being of the residents, assessment, evaluating, planning and implementing resident care plans, responding to resident needs. 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. Record review on 02/11/2026 at 11:41 AM of Intake 2721708 complaint of short staffing. Pre-survey prep noted facility triggered 4th quarter PBJ, and multiple resident complaints during initial interview screening of long call lights for afternoon shift, staff turning off the light and not providing service, saying I'll be right back, and do not come back'.In an observation and interview on 02/10/2026 at 10:39 AM with Resident #41 had multiple concerns of no stomach pills for gas, and no diarrhea pills, just the liquid form. Observation of the residents' right upper arm Peripheral Inserted Central Catheter (PICC) dressing dated 2/7/2026, also has a dialysis port to right chest area, and goes to hemodialysis every Monday-Wednesday-Friday to the dialysis center. Resident #41 stated that they came to the facility for rehab therapy, but didn't go to the therapy gym today, Resident #41 can also do the exercises in his room. Intravenous Antibiotic Micafungin 150mg IV every morning for 21 days. Resident #41 stated that Some days there are enough helpers and other times there is none, its [NAME] or famine. In an interview on 02/10/2026 at 11:29 AM with Resident #16 revealed that the staffing is low especially on the afternoon shift, they just disappear. Resident #16 stated that she is supposed to get her brief checked or changed every 2 hours and some days it's 4 or 6 hours. Resident #16 stated that she had messed/soiled her pants waiting for staff. Resident #16 stated that she put the call light on at 8:30PM and it was bedtime before anyone came in to change her and get her ready for bed. Resident #16 stated that it was verified by the call lights. I have been here 5 years, it used to be better, that's why I chose this nursing home. The change in staffing came with the new management. The facility says that they are meeting the state requirements, but they are not meeting the residents' needs. In an observation and interview on 02/10/2026 at 11:38 AM with Resident #87 was observed with a left upper arm Peripheral Inserted Central Catheter (PICC) (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235249	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 - Few	line dressing dated 2/9/2025 and occlusive. Resident #87 stated that she had an infection in her right foot. Resident #87 Complained about call light wait times of 2 hours, she agrees with her roommate on call lights take too long, and the facility was short staffed. In an interview on 02/10/2026 at 11:46 AM with Resident #51 was asked about the facility staffing being timely in response. Resident #51 stated the afternoon shift is scarce, they waited 2 hours with the call light on, they had brought the wrong lunch, the resident can only eat certain foods. The resident #51 stated he understood, having to wait his turn and having no problem with that. But when they come in and shut the light off and don't come back. The afternoon shift is the worst for not responding to the call lights. In an interview on 02/10/2026 at 11:51 AM with Resident #43 revealed that the afternoon shift takes longer to get the call lights answered. In an interview on 02/10/2026 at 1:25 PM with Resident #40 stated that they wait for over an hour, and their room is pretty close to nurse station. The aides will come in, shut the light off and not help me, if I close my eyes because I wait so long that they come in and shut off the light and don't ask what it was on for. They had to tell the aides not to use their phones in the resident care areas, because they would be on their phones and not helping us with our care. It's the first and second shift aides that just don't care, they take a long time to respond to our needs. Record review of the resident council meeting notes for 6 months revealed concerns with:August 2025- Nursing concerns that resident showers are not getting done.September 2025- Nursing concerns that Certified Nurse Assistance (CNA) saying they will be right back, but don't come back, showers are not getting done or made up. October2025- Nursing concerns that CNAs are talking on their phones and earbuds during care, all residents. Residents are not being checked and changed every 2 hours, causing them to pee through their briefs and leave puddles on the floor. After being put to bed residents don't see any CNAs the rest of the night. Residents are being doubled brief.November 2025- Residents not getting showers and hair washed. December 2025- CNAs keep disappearing out of the dining room during mealtimes. Staff sit plates down and do not help set food up. Resident left in dining room after meals. Not getting what's on the meal ticket or getting things crossed offJanuary 2025- Not enough CNAs in the dining room during meals. Record review of the facility 'Resident Council Meetings' policy dated 11/1/2020 revealed the facility supports the right of residents to organize and participate in resident groups in the facility . Definition: Resident group is defined as a group of residents that meet regularly to discuss and offer suggestions about facility policies and procedures affecting resident care, treatment, and quality of life; support each other; plan resident and family activities; participate in educational activities; or for any other purpose . (7.) The facility shall act upon concerns and recommendations of the council, make attempts to accommodate recommendations to an extent practicable, and communicate its decisions to the council .Record review of the 'Facility Assessment' dated 8/14/2025 revealed staffing guidelines: The facility staffing is based on resident population and acuity. The following represents the daily staffing at the facility utilizing the number of employees: licensed nurse 12 hour shift 6:00 AM -6:30PM 3-4 (nurses) late shift 6:00PM -6:30AM 2-3 (nurses), and 6:00PM-10:00PM 1-2 nurses. The facility assessment did not define acuity/complexity of the residents.