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	05/07/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Number 2997890.Based on observations, interview and record review, the facility failed to ensure that one resident (Resident #2) had an appropriate call light to meet his safety needs, and that one resident's (Resident #6) call light was within reach of two residents reviewed for accommodations of needs.Findings Include:Resident #2:On 5/6/2026 at approximately 2:15 PM, an audit of call light functionality was completed of resident rooms with Maintenance Staff C. It was found that room [ROOM NUMBER]-2 (Resident #2) did not have a call light and there was a black dowel in the call light panel on the wall (where the call light cord would connect into). Resident #2 was asked where his call light was and he stated he did not have one as the facility thought he was going to hang himself, so they (the facility) took it from him and never gave it back. Resident #2 reported he uses his roommate's call light. There was no other accommodation in place for Resident #2 to alert staff when he needed assistance.On 5/6/2026 at approximately 4:00 PM, a review was conducted of Resident #2's medical records and it revealed he was admitted to the facility on [DATE] with diagnoses that included, Vascular Dementia, Parkinsion's, Major Depressive Disorder, Bipolar II Disorder, Anxiety and Suicidal Ideations. Further review of the record yielded the following:Care Plan: .Anticipate and meet needs. Be sure call light is within reach and respond promptlyto all requests for assistance.Call light within reach. Kardex:There is nothing in Resident #2's Kardex regarding his call light being removed from his room and the alternative for him. On 5/7/2026 at 8:30 AM, CNA (Certified Nursing Assistant) D stated Resident #2 does not have a call light or bell to ring in his room and they (the aides) just check in on him. She was unsure how long he had been without a call light, but it was due to his suicide attempt. CNA D was queried if anything was mentioned in Resident #2's care plan related to him not having a call light due to his prior attempt. She stated she did not think there was. Review was conducted of Resident #2's care plan and there were no alternatives listed in lieu of him not having a call light.On 5/7/2026 at 1:53 PM, Nurse E reported Resident #2 had a bell that he can ring if he needs anything. The resident is not deemed safe to have a call light due to a past suicide attempt and subsequent inpatient psychiatric hospitalization. Nurse E continued Resident #2 does tend to move things around, but his care plan should reflect the reasoning why he does not have the standard call light accessible to him. On 5/8/2026 at 9:24 AM, Unit Manager F reported Resident #2 has not had a standard call light in sometime as he wrapped it around his neck in a suicide attempt. She reported he was 1:1 when he initially readmitted from the psychiatric unit but that was a few years back. Manager F continued Resident #2 utilized his roommates call light if he needed assistance.On 5/7/2026 at 8:20 AM, Resident #2 was observed in bed turned toward the wall. He was asked where the call light was and he said, right here. After the privacy curtain was pulled back the call light card was visualized on the floor where the foot of bed 1 meets the head of bed 2. The call light was on the floor between the two beds and unable to be accessed by either resident. 184-1 explained a long time ago the facility thought Resident #2 was going to kill himself by means of wrapping the call light around his neck. Since then, he has not had a call light and they share his. He added sometimes they have a hard time finding it as when staff come into clean and such it gets moved.On 5/7/2026 at approximately 3:00 PM, in the presence of the DON (Director of Nursing), (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #2's room was observed. The DON started he does not have a standard call light due to past suicide attempts with the cord but should have a bell in the room. There was no handbell that was in the room. The DON stated Resident #2 should have his own mechanisms to alert staff if he is in need. The DON reported at one point he did have a handbell and she is unsure what happened to it. On 5/7/2026 at approximately 3:30 PM, a review was completed of Resident #2's care plan with the DON and there was no mention of safety concerns for a standard call light due to a prior suicide attempt. The DON reported he was admitted to an inpatient psychiatric unit in August 2023 after wrapping his call light cord around his neck. There was nothing listed in the care plan regarding alternatives in lieu of the safety concerns. The DON stated he will have a handbell that he can ring to alert staff that he needs assistance. Resident #6:On 5/7/2026 at 11:10 AM, Resident #6 touch pad call light was observed on the floor next to his dresser (by the foot of the bed). The resident was resting in bed at the opposite end of the bed, and the call light was not accessible to him. On 5/7/2026 at 11:30 AM, a review was conducted of Resident #6's records and it revealed he was admitted to the facility on [DATE] with diagnoses that included, Anoxic Brain Damage, Anxiety Disorder, Vascular Dementia, Diabetes, Hypertension. Further review of his care plan yielded the following: .have a soft touch call light that needs to be attached to my clothing as I allow. On 5/7/2026 at 1:10 PM, Resident #6 was still observed resting in bed with his eyes closed. His call light was observed still on the floor, next to the dresser toward at the opposite end of the bed. On 5/7/2026 at 3:10 PM, DON was taken to Resident #6's room- he was observed to be resting in bed. His touch pad call light was still at the foot of the bed by his dresser. The DON stated the call light should be within reach of the resident. The DON was informed this was the third observation of the resident with his call light in the same location throughout the day. A review was conducted of the facility policy entitled, Call Light Accessibility and Timely Response, reviewed 2.2.2026. The policy stated, .facility is adequately equipped with a call light at each residents' bedside.Staff will ensure the call light is plugged in, functioning, within reach of residents.The call system will be accessible to residents while in their room at bedside.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to have results of the most recent survey readily accessible to facility residents, their families, and their legal representatives.Findings Include:On 5/7/2026 at approximately 11:00 AM, Family Member A shared that for the past two weeks they have been unable to locate the survey results book. They stated It is typically located in the lobby, underneath the bulletin board, on a brown high-top table. The area the family member referenced was observed and there was no book/binder with the survey results located. Receptionist B (located just inside the main office) was queried if she knew where the survey results binder was relocated too? She reported it was on the high-top table in the lobby. She was informed it was not there. She searched for the book in her area and could not locate it. Receptionist B stated that she could not recall the last time she observed the survey results binder. She then contacted the Administrator regarding the location of the book.At approximately 11:20 AM, the survey binder had not been provided, and it was shared that the Administrator was bringing the survey book. The Administrator was observed with the survey book (reviewing the contents), and the DON (Director of Nursing) handed her the most recent 2026 survey results to add into the binder. On 5/7/2026 at approximately 11:40 AM, the survey binder was reviewed, the facility was surveyed in February 2026 for their annual recertification and those results along with their approved plan of correction were not in the book.