STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235261	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Leonard	1700 Leonard Street NE Grand Rapids, MI 49505

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure menus were consistently followed for 5 (Residents #26, 50, 55, 3, and 63) of 15 residents reviewed for dining and 9 of 11 residents from a confidential resident council meeting with the potential to affect all residents who consume food/beverages from the facility's kitchen resulting in dissatisfaction with meals, being provided incorrect foods, and/or being provided incorrect serving sizes with the potential for decreased oral intake and weight loss.Findings include:Resident #26: Review of Resident #26's diet order, dated 12/7/25, stated, Diabetic (condition that affects blood sugar levels) / Consistent Carb (carbohydrate) / Controlled Carb diet . (A consistent carbohydrate diet meal plan is one that aims to provide a consistent amount of carbohydrates at each meal.) Review of Resident #26's brief interview for mental status, dated 2/18/26, was scored 15 which reflected she was cognitively intact.During an interview on 04/07/2026 at 9:23 AM, Resident #26 reported her meal ticket (a meal ticket indicated the residents' diet order, what items to serve from the menu, and other information to guide meal service) wasn't followed consistently. During an observation and interview on 04/09/2026 at 8:32 AM, Resident #26 was served breakfast in her room. On Resident #26's meal tray was a meal ticket that indicated she was on a diabetic consistent carbohydrate diet and should have received 1/2 a banana, but she was served a full banana. Review of the facility's Menu Spreadsheets Report, for breakfast on 4/9/26, indicated a diabetic consistent carbohydrate diet was supposed to have received .1/2 banana 1 each and the regular diet (not carbohydrate controlled) was to receive a Banana 1 each (a full banana). Resident #50:Review of Resident #50's physician order page indicated she was readmitted to the facility on [DATE] with a primary diagnosis of pulmonary hypertension (condition that affects the blood vessels in the lungs) due to lung diseases. Her diet order, dated 6/3/25, stated, NAS (No Added Salt) diet, Regular texture, Thin consistencyReview of Resident #50's brief interview for mental status, dated 3/4/26, was scored 13 which reflected she was cognitively intact. Review of the facility's Menu Spreadsheets Report, dated 4/6/26-4/12/26, indicated .Sausage Link 2 each. should have been the serving size for Resident #50's breakfast on 4/8/26. During an observation and interview on 04/08/2026 at 8:21 AM, Resident #50 was seated upright in bed for breakfast in her room. Resident #50's meal ticket on the tray stated, .HOT.Sausage Link – 2 each. Resident #50's breakfast was served with only 1 sausage link and Resident #50 reported she wanted the full serving, 2 sausage links. Resident #50 reported it was irritating not knowing if her (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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meals would be delivered with everything she was supposed to get. During an interview on 04/08/2026 at 10:09 AM, Registered Dietitian (RD) LL confirmed Resident #50 should have received two sausage links for breakfast on 4/8/26 as indicated on the menu and meal ticket. RD LL reported Resident #50 wasn't on small portions or any restriction that would have limited her to 1 sausage link. RD LL summarized the meal service process and reported one dietary aide on the tray line reads off pertinent information from residents' meal tickets to the cook plating the meal. RD LL confirmed if something was missed (Food/beverage item(s) given in error or item(s) left off the tray in error) it could have been due to a breakdown in communication between the two dietary staff. Resident #55:Review of Resident #55's diet order, dated 5/27/25, indicated he was to receive Regular diet, Regular texture, Thin consistency. Review of Resident #55's brief interview for mental status, dated 1/15/26, was scored 15 which reflected he was cognitively intact. Review of the facility's Menu Spreadsheets Report, dated 4/6/26-4/12/26, indicated .Sausage Link 2 each. should have been the serving size for Resident #55's breakfast on 4/8/26. During an observation and interview on 04/08/2026 at 8:40 AM, Resident #55 was lying in bed with his breakfast served to him on his bedside table. Resident #55 was served 1 sausage link on the plate/tray. During an observation and interview on 04/08/2026 at 10:47 AM, Resident #55 reported he only received one breakfast sausage for breakfast that morning, 4/8/26. Resident #55's meal consumption was observed to be approximately 100 percent. Resident #55 reported he wanted 2 sausage links and would have eaten 2 sausage links if they had been provided. Resident #55 reported his meals were served with inaccuracies approximately 60 percent of the time and felt dietary staff was not organized enough to strictly follow the meal ticket. During an interview on 04/08/2026 at 10:09 AM, Registered Dietitian (RD) LL confirmed Resident #55 should have received two sausage links for breakfast on 4/8/26 as indicated on the menu and meal ticket. RD LL reported Resident #55 wasn't on small portions or any restriction that would have limited him to 1 sausage link.Resident #3:Review of Resident #3's brief interview for mental status, dated 4/3/26, was scored 8 which reflected he had moderate cognitive impairment. During an observation and record review on 04/09/2026 at 12:06 PM, Resident #3 was eating lunch in his room. Resident #3's meal ticket on the tray indicated he was on a diabetic consistent carbohydrate diet with mechanical soft texture (designed to have soft and easy to chew foods for those with difficulty chewing and/or swallowing) and was to be served Lunch .HOT .Peas and Carrots. Resident #3 was served diced cooked carrots but there were no peas. At that time, the facility's menus were reviewed and the facility's Menu Spreadsheets Report, dated 4/6/26-4/12/26, indicated mechanical soft diets for lunch on 4/9/26 should have been served Guacamole 2 ounces. During an observation and interview on 04/09/2026 at 12:17 PM, RD LL reported she had approved a change of the menu yesterday (4/8/26) afternoon which was to serve peas and carrots instead of guacamole. In the kitchen on the tray line, there were two pans that contained carrots. One pan was mechanical soft carrots (diced cooked carrots) and the other was pureed carrots. Neither carrot dish (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had any peas in it and there was no separate pan of peas. [NAME] MM reported the facility only had carrots and didn't have any peas to prepare/serve. RD LL confirmed the menu for 4/9/26 for mechanical soft diets, such as for Resident #3, were supposed to have received peas and carrots, but only received carrots. RD LL reported the cooks were provided production sheets that reflected the change and it indicated to provide peas and carrots instead of guacamole. Resident #63: During an observation on 04/09/2026 at 12:40 PM, Resident #63 was served lunch in her room and her meal ticket indicated she was on a mechanical soft diet and should have received HOT .Peas and Carrots . Resident #63 was served only diced cooked carrots with no peas. During a confidential resident council interview on 04/08/2026 at 1:00 PM, 9 of 11 residents in attendance reported they didn't feel the menus were consistently followed and were bothered by this. The group reported dinner meals each day and weekend meals were the worst when it came to the menu not being followed. Review of the facility's Resident Council Meeting Minutes, dated 1/7/26, stated, .Discussion of Old Business .Area identified for Improvement .Kitchen running out of menu items. Review of the facility's Portion Control Policy, reviewed date 4/1/26, stated, .The clients/residents will receive the appropriate portions of food on the corporate menu. Control at the point of service is necessary to ensure that the standard portions of nutritionally adequate meals are served .The menu should list the specific portion size for each food item by using the menu calendar with portion sizes added or spreadsheets and be made accessible to the cooking staff . On 4/7/26 at 11:20 AM, a review of the lunch menu in the dining room found that residents were to have Lemon Chicken and [NAME] soup, Chili Dogs, Curly Fries, and [NAME] pudding. On 4/7/26 at 11:35 AM, an interview with Dietary Manager OO found that tickets are reviewed by staff while meals are plated and put on trays. The cook plating meals is told what the next meal is and then the plate is put together and reviewed by two staff on the tray line as they are adding drinks, desserts, and specialty items that the resident may request. A final review should happen from staff on the floor as they deliver the trays to residents. On 4/7/26 at 11:40 AM, observation of lunch service found that instead of curly fries, tater tots were being offered and instead of rice pudding, tapioca pudding was being offered. At this time, an interview with Dietary Manager (DM) OO found that they had extra potato and pudding products that they wanted to use up, and this was the reason for the slight menu change. On 4/7/26 at 11:41 AM, kitchen staff realized that part of the main lunch entrée of Lemon Chicken and [NAME] soup had not been prepared yet for residents on a puree diet texture. DM OO stated that staff will reheat tomato soup for those residents instead of pureeing the Lemon Chicken and [NAME] soup that is on the menu. On 4/7/26 at 3:30 PM, an interview with Registered Dietitian LL, regarding the use of tomato soup for puree residents for lunch, found that puree residents should receive the same menu items as regular texture diets.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure food preferences were consistently honored for 4 (Residents #26, 1, 24, and 50) of 15 residents reviewed for dining and 11 of 11 residents from a confidential resident council meeting resulting in dissatisfaction with meals and the potential for decreased oral intake and weight loss. Findings include:Resident #26:Review of Resident #26's brief interview for mental status, dated 2/18/26, was scored 15 which reflected she was cognitively intact.During an interview on 04/07/2026 at 9:23 AM, Resident #26 was in her room and reported her meal tickets (a meal ticket indicated the residents' diet order, food preferences and other information to guide meal service) weren't followed consistently.During an observation and interview on 04/08/2026 at 8:11 AM, Resident #26 was served breakfast in her room. Resident #26's meal ticket on the tray indicated under .MEAL PREFERENCES. to provide 6 ounces of coffee and 8 ounces of sugar free punch. Resident #26 did not receive either beverage and the only beverage served was milk which was used for the cold cereal served with the meal. Resident #26 proceeded to contact Certified Nurse Aide V and informed her that the meal was missing her two beverages and requested what she wanted to drink.Resident #1:Review of Resident #1's brief interview for mental status, dated 4/8/26, was scored 14 which reflected intact cognition.Review of Resident #1's diet order, dated 2/6/25, included Order .Regular diet .Directions .NO MILK. Review of Resident #1's nutrition care plan, dated 2/2/26, included interventions of Dislikes: Milk ., Food Intolerance: Lactose, and .No .snacks with milk for Snacks per (Resident #1's) request . During an interview on 04/07/2026 at 10:23 AM, Resident #1 reported he can't have any dairy (containing or made from milk or milk products) or any products that contain dairy because if consumed they could cause him to vomit and/or experience excessive stools (bowel movements). Resident #1 reported the facility served him items with dairy in error approximately 1 meal a day. Resident #1 expressed concern that the facility staff wasn't following his food preferences/meal ticket.During an observation and interview on 04/08/2026 at 8:01 AM, Resident #1 was served breakfast and eating independently in his room. Resident #1's meal ticket stated, Breakfast.COLD.Butter Pat - 1 each.ALLERGENS DAIRY Products Milk.MEAL PREFERENCES.Margarine Pat. Resident #1 was not served a margarine pat and instead was served salted butter which contained milk. Resident #1 reported he received the suitable margarine here and there (not consistently).During an interview on 04/08/2026 at 10:09 AM, Registered Dietitian LL reported the butter Resident #1 was served at breakfast on 04/08/2026 contained milk.During an observation on 04/09/2026 at 8:25 AM, Resident #1 was served breakfast in his room and he was eating independently. Resident #1's meal ticket stated, .MEAL PREFERENCES.Peanut Butter Packet - 1 each. There was no peanut butter packet served with the meal and Resident #1 confirmed he did not receive a peanut butter packet at the meal. Resident #1 appeared visibly frustrated and reported he has gotten used to not getting what he was supposed to.Resident #24:Review of Resident #24's brief interview for mental status, dated 3/20/26, was scored 14 which reflected she was cognitively intact.During an interview on 04/08/2026 at 8:15 AM, Resident #24's breakfast meal was served on her bedside table. The meal ticket on Resident #24's meal tray indicated to give COLD.Banana - 1 each. No banana was served with the meal.During an interview on 04/08/2026 at 10:26 AM, Resident #24 confirmed she never got a banana with her breakfast that morning. Resident #24 appeared frustrated and reported they (facility staff) didn't follow the ticket, so she didn't expect to receive the correct items anymore. Resident #50:Review of Resident #50's physician order page indicated she was readmitted to the facility on [DATE] with a primary diagnosis of pulmonary hypertension (condition that affects the blood vessels in the lungs) due to lung diseases. Her diet order, dated 6/3/25, stated, NAS (No Added Salt) diet, Regular texture, Thin consistency.Review of Resident #50's brief interview for mental status, dated 3/4/26, was (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scored 13 which reflected she was cognitively intact.During an observation and interview on 04/08/2026 at 8:21 AM, Resident #50 was seated upright in bed for breakfast in her room. Resident #50's meal ticket on the tray indicated she should have received cream of wheat, have no added salt, and been provided with 3 creamer packets and 4 sugar packets. Her meal was served with an added salt packet, and the cream of wheat was missing. Resident #50 reported she only received 1-2 packets of creamer and sugar and had to request and wait for more. Resident #50 reported it was irritating not knowing if her meals would be delivered with everything she was supposed to get and reported this occurred almost every day. During an observation on 04/09/2026 at 8:36 AM, Resident #50 was served and eating breakfast independently in her room. Resident #50's meal ticket indicated under .MEAL PREFERENCES. to give frosted flakes (sugar coated cold cereal) but instead was given circular O-shaped cold cereal instead. Resident #50 reported she wanted and preferred the frosted flakes. The meal ticket indicated not to give a salt packet, but a salt packet was provided on Resident #50's meal tray.During a confidential resident council interview on 04/08/2026 at 1:00 PM, 11 of 11 residents in attendance reported concerns about their meal ticket's food preferences not being followed. 5 out of the 11 residents reported they felt their food preferences not being honored were getting worse recently. One resident questioned why they even bother telling the facility their food dislikes and preferences if they weren't going to get followed. Another resident reported they felt like dietary staff didn't look at resident meal tickets and instead just gave them what they wanted to serve. Review of the facility's Resident Council Meeting Minutes, dated 1/7/26, stated, .Discussion of Old Business .Area identified for Improvement .No condiments on trays.Review of the facility's Resident Council Meeting Minutes, dated 2/11/26, stated, .Discussion of New Business .Dining Services .working with evening meal staff for consistency w/ (with) trays.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain best practices in the food service area resulting in the potential to spread food borne illness to all residents that consume food from the kitchen.Findings include: On 4/7/2026 at 9:15 AM, an initial tour of the kitchen was conducted with Dietary Manager (DM) O. An interview with DM OO found that he has been in the position for a couple of months.On 4/7/26 at 9:37 AM, observation of the can opener on the preparation table found that the blade was covered in dried red debris. When asked if the can opener had been used today, DM OO asked staff working the in the kitchen, and stated no. On 4/7/26 at 9:43 AM, observation of the underside of the juice machine found accumulations of debris where the spouts are mounted to the unit. DM OO agreed he could see the accumulation on the underside of the machine and stated it should get cleaned daily. On 4/7/26 at 9:55 AM, observation of the clean utensils found one mechanical scoop with dried on food debris in the ladle portion of the scoop.On 4/7/26 at 10:00 AM, observation of the inside of the milk cooler found increased accumulation of white and yellow staining and debris on the bottom and sides of the cooler. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.On 4/7/26 at 12:20 PM, an interview with DM OO found that some items from lunch service might be saved if there is enough. When asked about the soup, DM OO looked at how much was still left on the steam table and stated it would probably be kept for another couple days.On 4/7/26 at 2:59 PM, a follow up tour of the kitchen found a 12-quart container of Lemon Chicken and [NAME] soup, left over from lunch, in the two-door reach in cooler with the lid ajar for venting. At this time, the temperature of the soup was 115F in the center of the container.On 4/7/26 at 3:02 PM, an interview with DM OO found that the soup was saved after lunch but was not exactly sure when it started cooling. When asked the time temperature frequency for proper cooling, DM OO stated it needed to get down to 41F but was unsure of how long the process could take. DM OO took a temperature of the product at this time and found it to be over 100F. According to the 2022 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. According to the 2022 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to ensure: 1.) facility staff's use of Personal Protective Equipment (PPE) for enhanced barrier and transmission based precautions, 2.) cleaning of shared resident equipment, and 3.) cleaning of respiratory equipment for 5 (Residents #17, #30, #50, #39 and #5) of 24 resident reviewed for infection control practices, resulting in the potential for the introduction of infection, cross-contamination, and disease transmission.Findings include:Enhanced Barrier Precautions Resident #39 Review of an admission Record revealed Resident #39 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and chronic pain syndrome. Review of Resident #39's Care Plan revealed, (Resident #39) requires enhanced barrier precautions related to: Indwelling medical device. Date Initiated: 03/27/2026. Interventions: Staff will wear a gown and gloves during high contact resident activities. Date Initiated: 03/27/2026. During an observation on 4/09/2026 at 8:14 AM, Licensed Practical Nurse (LPN) G entered Resident #39's room and assisted Resident #39 with repositioning in her bed. LPN G then placed a blood pressure cuff on Resident #39's arm and assessed Resident #39's blood pressure. Noted that LPN G was not wearing a gown or gloves when providing care to Resident #39. After LPN G exited Resident #39's room, she placed the blood pressure cuff that she used on her medication cart. It was noted that LPN G did not clean the blood pressure cuff after she used it on Resident #39. Resident #5 Review of an admission Record revealed Resident #5 was originally admitted to the facility on [DATE] with pertinent diagnoses which included pressure ulcer, unstageable (a full thickness wound where the actual depth cannot be determined because it is covered by dead tissue.) Review of Resident #5's Care Plan revealed, Focus: (Resident #5) has a Stage 3 pressure ulcer to her right shoulder. Date Initiated: 03/26/2026. It was noted that there were no interventions related to Enhanced Barrier Precautions. During an observation on 4/8/2026 at 8:49 AM, Unit Manager (UM) I and Wound Care Nurse Practitioner (WCNP) E entered Resident #5's room. UM I removed Resident #5's wound dressing and began to clean the wound on Resident #5's shoulder. UM I reported to WCNP E that the drainage from Resident #5's wound looked much better. After UM I cleaned Resident #5's wound, WCNP E measured and took photos of Resident #5's wound. After WCNP E took photos of Resident #5's wound, UM I applied a new dressing. It was noted that UM I and WCNP E did not wear gowns during the wound care treatment for Resident #5. During an interview on 4/8/2026 at 2:19 PM, UM I reported that the facility had not initiated Enhanced Barrier Precautions for Resident #5 because the drainage coming from Resident #5's wound was not a type of drainage that would require precautions. UM I confirmed that Resident #5 did have an open wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #17 Review of an admission Record revealed Resident #17 was originally admitted to the facility on [DATE] with pertinent diagnoses that included: unspecified disorders of the lung and unspecified asthma (chronic incurable inflammatory disease of the airways that causes breathing difficulties such as wheezing and coughing). Review of a Minimum Data Set (MDS) assessment for Resident #17 with a reference date of 3/6/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Review of a Care Plan for Resident #17 with a reference date of 3/31/26 revealed the following focus/goal/interventions: Focus: Actual infection of COVID 19(coronavirus disease 2019) .Goal: Resident will have no adverse outcomes r/t (related to) current infection. Interventions: Isolate r/t active COVID 19 Infection: Maintain airborne and contact precautions while using proper PPE including: N95, goggles or face shield, gown and gloves.wear PPE per facility protocol. During an observation on 4/7/26 at 1:20pm, signage on Resident #17's door stated Airborne Precautions.Put on a fit-tested N-95 or higher-level respirator before room entry.door to room must remain closed.Sequence for putting on PPE.1. Gown. 2. Mask 3. Goggles or Face Shield. 4. Gloves. During an observation on 4/7/26 at 1:24pm, housekeeper (HSK) II entered Resident #17's room without donning googles. HSK II's cart was parked in the middle of the hallway. HSK II walked out of Resident #17's room several times while wearing the same gown, gloves and N-95 mask, retrieved supplies from her cart and then returned to the room. The room door remained open throughout the time HSK II cleaned the room. At one point, HSK II exited Resident #17's room, removed her soiled gloves, retrieved supplies from her cart with her unwashed hands, then donned (put on) new gloves without washing her hands, before re-entering the room. During an observation on 4/8/26 at 9:57am, Licensed Practical Nurse (LPN) BB donned PPE, excluding googles or a face shield, and entered Resident #17's room with the portable vitals monitor. LPN BB then exited the room at 10:00am as she pushed the portable vitals monitor. LPN BB doffed (removed) her PPE and pushed the vitals monitor down hall. LPN BB parked the vitals monitor near the medication cart. During an observation on 4/8/26 from 10:00am-10:36am, the soiled portable vitals monitor sat unattended in the 200 hallway. During an observation on 4/8/26 at 10:48am, LPN BB used the portable vitals monitor on a resident in room [ROOM NUMBER]. After taking the resident's vital signs, LPN BB exited the room with the vitals monitor, sanitized her hands and parked the soiled vitals monitor next to medication cart again. LPN BB then walked away. In an interview on 4/8/26 at 10:58am, Certified Nursing Assistant (CNA) V reported all staff who entered an isolation room should wear the PPE that was posted on the door. CNA VV confirmed staff should wear gown, gloves, N95 mask and googles or a face shield when entering Resident #17's room. CNA V reported staff were expected to use disposable equipment or equipment already in the room to monitor Resident #17's vital signs, rather than taking the portable vitals monitor that was shared with other residents. (continued on next page)

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Optalis Health & Rehabilitation at Leonard	1700 Leonard Street NE Grand Rapids, MI 49505

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/8/26 at 11:32am, Housekeeping Manager (HM) GG reported all staff should wear a gown, gloves, N95 mask and goggles or a face shield when entering Resident #17's room. HM GG reported the housekeeping staff should take all the supplies they needed with them when they entered the room to clean, rather than going back and forth to their cart. HM GG reported the door to the room should remained closed while the housekeeper cleaned. In an interview on 4/9/26 at 10:10am, Infection Preventionist (IP) I reported staff were expected to use disposable stethoscopes and equipment assigned specifically to Resident #17 to monitor her vital signs, not the portable vitals tower that was used for everyone else on the hall. IP I reported any equipment used for Resident #17 should immediately be disinfected and left to sit and dry for 2 minutes before using it for anyone else. When further queried, IP I reported staff were expected to immediately clean all shared equipment after use and then return the equipment to the hallway. IP I reported staff understood that if equipment was in the hallway, that meant it has been cleaned and was ready for use again. IP I reported all staff were expected to wear a gown, gloves, N-95 mask and goggles or a face shield when entering Resident #17's room. When queried about the procedure the housekeeping staff should follow when cleaning Resident #17's room, IP I reported they should follow the whatever protocol HM GG recommended. Review of a Covid-19 policy with a reference date of 2/3/26 revealed Policy Overview: To establish a facility wide-system for the prevention.and control practices designed to minimize transmission of Covid-19.Covid-19 PPE Usage.N95 masks, eye protection, gown, and gloves should be worn.during care of a resident in transmission based precautions for confirmed or suspected Covid-19. Review of the facility's Enhanced Barrier Precautions policy dated 2/6/26 revealed Policy Overview: The purpose of this policy is to provide guidelines for the use of enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDRO). General Guidelines: Enhanced barrier precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs). Enhanced barrier precautions involve gown and glove use during high-contact resident activities for residents known to be colonized with a CDC targeted MDRO (where contact precautions do not apply) as well as those residents at increased risk of MDRO acquisition, such as chronic wounds or indwelling medical devices . Wounds: Wound - in relation to enhanced barrier precautions wound does not include shorter-lasting open wounds such as scratches, abrasions, skin tears, etc. covered with a band aid or similar dressing. It refers to more chronic wounds with skin opening(s) that require a dressing including but not limited to; Stage 3/ 4, or unstageable pressure injuries . High contact resident activities include (for all residents on Enhanced Barrier Precautions): dressing, bathing/showering, transferring, providing hygiene . wound care: any skin opening requiring a dressing . Oxygen Concentrator R30 According to the MDS dated [DATE], R30 scored 13/15 on his BIMS, indicating he was cognitively intact. R30 was dependent on staff for ADLs (activities of daily living). Diagnoses included stroke, traumatic brain injury, and a trachea-esophageal fistula following a tracheostomy (a rare but serious complication involving an abnormal connection between the trachea and esophagus). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 4/8/26 at 9:08 AM, R30 was awake in bed. Next to the bed was an oxygen concentrator (a medical device that provides supplemental oxygen to people with breathing disorders by filtering and concentrating oxygen from the surrounding air) running a 2 lpm (liters per minute). R30 was wearing a nasal cannula (NC) that was connected to the oxygen concentrator via clear tubing dated 4/5 (Sunday). The oxygen concentrator was covered with splatters of multi-colored dried substances, and accumulation of dirt, dust, and debris including substances that resembled food crumbs. Observations 4/9/26 at 9:30 AM, R30 in bed wearing an NC attached to an oxygen concentrator via tubing dated 4/5. Oxygen was running at 2 lpm. The oxygen concentrator was covered with splatters of multi-colored dried substances, and accumulation of dirt, dust, and debris including substances that resembled food crumbs. During an observation and interview on 4/9/26 at 11:40 AM, Facility Respiratory Therapist FF stated, (Name of respiratory equipment supply company) is responsible for keeping oxygen concentrators clean and wiping them down weekly. I am here at the facility on Tuesday and Thursday each week. I change oxygen tubing weekly. Last week, I saw how dirty (R30's) oxygen concentrator was and sent the (respiratory equipment supply company) a picture of (R30s) oxygen concentrator. The condition of (R30's)the oxygen concentrator was unacceptable. The concentrator was dirty and had dribbles of a dried substance. I can wipe down oxygen concentrators, but I did not wipe down (R30's) last week. The company replied they would be out by the end of the day (Thursday 4/2/26). I did not tell any facility staff about (R30's) oxygen concentrator nor did I follow up on it when I was here this week on Tuesday. During an observation and interview on 4/9/26 at 11:45 AM, Director of Nursing (DON) B stated while observing R30's oxygen concentrator. Anyone can wipe down and clean equipment they see is dirty, including the facility respiratory therapist. You don't tell someone else to do something you can do. The concentrator should have been cleaned right when it was found to be dirty for infection control reasons. Yes, (R30's) oxygen concentrator is dirty and it should have been cleaned right away. Resident #50: Review of Resident #50's physician orders, included Bilevel positive airway pressure (BiPAP; device used to assist with breathing) to be used at night, dated 3/20/26, and Clean BIPAP per policy.every day shift every Thu (Thursday), dated 3/5/26. Review of Resident #50's oxygen care plan, dated 3/12/26, stated, (Resident #50) has oxygen therapy r/t (related to) COPD (Chronic Obstructive Pulmonary Disease; breathing-related problems), chronic hypoxic respiratory failure (insufficient oxygen levels), with hypercapnia (undesirable high levels of carbon dioxide in the blood) & pulmonary edema (too much fluid in the lungs) . The care plan included an intervention, dated 3/12/26, that indicated the BiPAP was to be used each night. Review of Resident #50's brief interview for mental status, dated 3/4/26, was scored 13 which reflected she was cognitively intact. During an observation and interview on 04/07/2026 at 10:41 AM, Resident #50's BiPAP machine's tubing and face mask were draped over the bedside oxygen concentrator and resting directly on the floor. The BiPAP machine was placed past the head of the bed out of the resident's reach and in the corner of the room on a nightstand. There was an empty clear plastic equipment storage bag attached (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the BiPAP machine. Resident #50 was lying in her bed and reported she could not reach her BiPAP machine or face mask and staff were needed to help her put on and take off the mask. The mask was visibly soiled with unknown white debris/build up and some red flakes. Resident #50 reported Respiratory Therapist (RT) FF took care of her BiPAP equipment. During an observation on 04/07/2026 at 2:33 PM, Resident #50's BiPAP mask was in the clear plastic storage bag attached to the BiPAP machine in the corner of the room. The mask appeared visibly soiled as it had been on 04/07/2026 at 10:41 AM. During an observation and interview on 04/07/2026 at 4:01 PM, Resident #50 was lying in bed, her BiPAP mask was in the storage bag attached to the BiPAP machine, and the mask in the bag was still visibly soiled with white and red debris. Resident #50 confirmed she did not put the dirty BiPAP face mask back into the storage bag and confirmed it would have been staff who would have done it. During an observation and interview on 04/08/2026 at 7:55 AM, Resident #50's BiPAP mask was in the clear plastic storage bag attached to the BiPAP machine. The mask remained visibly soiled and presented with the white and red debris on the mask as it was observed the day prior, 04/07/2026. Resident #50 confirmed she used her BiPAP machine the night of 04/07/2026. During an observation and interview on 04/09/2026 at 8:01 AM, Resident #50 was awake in bed and her BiPAP face mask was in the clear storage bag attached to the BiPAP machine in the corner of the room. The mask remained visibly soiled with white and red debris as had been observed on 04/07/2026 and 04/08/2026. Resident #50 confirmed she used her BiPAP machine the night of 04/08/2026. During an interview on 04/09/2026 at 8:11 AM, Licensed Practical Nurse X reported it was her understanding that BiPAP face masks would be cleaned daily and not cleaned only once a week. During an interview on 04/09/2026 at 1:29 PM, RT FF reported BiPAP and CPAP (Continuous Positive Airway Pressure; device used to assist with breathing) machines were sterilized by her on Thursdays. RT FF confirmed if a BiPAP or CPAP face mask was visibly soiled before the scheduled cleaning it should be cleaned.

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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 observation, interview, and record review, the facility failed to provide care and services to promote dignity and respect in 1(Resident #39) of 24 residents reviewed for reviewed for dignity and respect ; and 6 of 11 residents from the confidential group meeting resulting in unmet care needs and the potential for feelings of diminished self-worth, sadness, and frustration. Findings include:Resident #39 Review of an admission Record revealed Resident #39 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and chronic pain syndrome (a persistent, long-term pain condition lasting 3–6 months or more, often continuing after an initial injury has healed). Review of a Minimum Data Set (MDS) assessment for Resident #39, with a reference date of 3/10/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #39 was cognitively intact. Review of Resident #39's Care Plan revealed, Focus: (Resident #39) has ADL self-care deficit related to (r/t) impaired mobility . Date initiated: 1/11/26. Interventions: ADL (Activities of Daily Living) assist of 2 staff. Date initiated: 3/27/26 . Review of Resident #39's Behavior Tracking Log indicated that No behaviors were observed for Resident #39 (including accusing of others) in April 2026, and one behavior of accusing of others was documented in March 2026. During an observation on 4/8/2026 at 7:55 AM, Resident #39 was calling out for help from her bed. Director of Nursing (DON) B entered Resident #39's room and told Resident #39 she would get someone to come help her. DON B then exited Resident #39's room. It was noted that Resident #39's call light was not on as DON B exited her room. DON B continued down the hallway and did not ask the Licensed Practical Nurse (LPN) or Certified Nursing Assistant (CNA) on the hall to assist Resident #39. At 8:07 AM, Resident #39 began yelling out for help again. It was noted that LPN G remained in the hallway near Resident #39's room but did not check on Resident #39 when she was yelling out for help. During an observation at 8:10 AM, this writer entered Resident #39's room. Resident #39 was lying in her bed on her back and leaning over the right side of her bed near her tray table. It noted that Resident #39's call light was on the ground under her bed and out of her reach. Resident #39 reported that she was yelling out for help because she did not have her call light. Resident #39 reported that she had asked DON B for assistance to get straightened up in bed and that DON B had told her that she would get someone to help her. During an interview on 4/8/2026 at 8:13 AM, LPN G reported that she was aware that Resident #39 had been yelling out for assistance and stated, that is just (Resident #39), sometimes she yells out for help, and sometimes she uses her call light. Noted that LPN G did not go assist Resident #39. During an interview on 4/8/26 at 8:57 AM, Resident #39 reported she felt like some of the staff at the facility did not care for her or want to take care of her because she was high maintenance. This writer (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	queried as to what Resident #39 about what her belief of high maintenance, Resident #39 reported she required two staff members to assist her with ADL care, so she required more time from staff. Resident #39 reported staff would often turn her call light off and tell her that they would be back but would not always return to assist with her needs. Resident #39 reported it was also common for staff to forget to give her a call light, so she would have to yell out for help. During an observation on 4/9/2026 at 8:23 AM, Resident #39 was yelling out for help. LPN G entered Resident #39's room and Resident #39 reported that she had spilled a cup of water. Noted that there was water on the floor surrounding Resident #39's bed. LPN G told Resident #39 that she would turn on Resident #39's call light to have someone come clean up the spilled water. LPN G then exited Resident #39's room. During an observation on 4/9/26 at 8:33 AM, LPN G returned to Resident #39's room to administer medications to Resident #39. It was noted that Resident #39's call light was off, but the water on the floor in her room had not yet been cleaned up. Resident #39 queried LPN G about her floor being cleaned up, and LPN G reported staff would be in to take care of it. LPN G then exited Resident #39's room. Noted that Resident #39's call light remaimed off. During an interview on 4/9/2026 at 11:46 AM, CNA D reported the facility staff would often turn off call lights without addressing the resident's needs. CNA D reported that she had residents voice concerns to her about their needs not being met and having to turn their call lights back on. CNA D reported this was something that she had reported to management. CNA D reported she knew residents had complained to others about this. CNA D confirmed that Resident #39 had voiced concerns to staff about staff turning off her call light without addressing her care needs. During an interview on 4/9/26 at 12:30 PM, Unit Manager (UM) I reported that she was aware that residents had voiced concerns about staff turning off their call lights without addressing the resident's need. UM I reported that the facility had been working on educating staff to ensure that they are not turning off call lights without assisting residents first. During an interview on 4/9/2026 at 12:48 PM, DON B reported that she was aware that residents had voiced concerns about staff turning off call lights without addressing the resident's needs, and staff reporting that they would be back and not returning timely. DON B reported her expectation for when staff turned off a call light before meeting a resident need would depend on what the request was. Review of the facility's Dignity policy dated 2/3/26 revealed, Policy Overview: It is the policy of this facility that each resident will be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feelings of self-worth, and self-esteem . Review of the facility's Call Light policy dated 2/2/26 revealed, Policy Overview: The purpose of this policy is to assure that the facility is adequately equipped with a call light at each resident's bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response . Process: . turn off call light when resident's request is met. During a confidential resident council interview on 04/08/2026 at 1:00 PM, 6 of 11 residents in attendance reported a concern that at times staff would turn off their call lights, tell them they'd come back to complete the care need being requested, staff wouldn't return, they'd have to put their (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	call light back on, and have to wait for staff to respond to their call light/care need request again.Review of the facility's Resident Council Meeting Minutes, dated 3/4/26, stated, .Discussion of New Business .Nursing .(2 Confidential Resident Council Attendees/Residents were listed as having the concern) - call light concerns, turn off light, need not met. Review of the facility's Resident Council Meeting Minutes, dated 2/11/26, stated, .Discussion of New Business .Nursing .(3 Confidential Resident Council Attendees/Residents were listed as having the concern) - aid (Certified Nurse Aide) comes in and turns off call light and leaves, eventually come back.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to honor resident preferences for customary routines and activities for 1 (Resident #39) of 24 reviewed for self-determination resulting in feelings of frustration and the potential for diminished quality of life.Findings include:Resident #39Review of an admission Record revealed Resident #39 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and chronic pain syndrome. Review of a Minimum Data Set (MDS) assessment for Resident #39, with a reference date of 3/10/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #39 was cognitively intact. Review of Resident #39's Care Plan revealed, Focus: (Resident #39) has ADL self-care deficit related to (r/t) impaired mobility . Date initiated: 1/11/26. Interventions: ADL (Activities of Daily Living) assist of 2 staff. Date initiated: 3/27/26 . Focus: (Resident #39) needs assistance for meeting emotional, intellectual, physical, and social needs r/t Physical Limitations r/t weakness- needs assistance in w/c (wheelchair). Date Initiated: 03/27/2026. Goal; The resident will maintain involvement in cognitive stimulation, social activities as desired through review date. Date Initiated: 03/27/2026. Interventions: The resident needs assistance/escort to activity functions. Date Initiated: 03/27/2026.During an interview on 4/8/2026 at 8:57 AM, Resident #39 reported she felt like some of the staff at the facility did not care for her or want to take care for her because she was high maintenance. This writer queried as to what Resident #39 about her belief of high maintenance, Resident #39 reported she required two staff members to assist her with ADL care, so she required more time from staff. Resident #39 reported she liked to eat breakfast in her room and then get up for the day so she could attend morning activities at the facility which usually started at 10:00 AM. Resident #39 reported that she often was not able to get up until 10:00 AM- 12:00 PM. Resident #39 reported that she thought the staff would wait to complete her care last because she required two staff members to assist her. In an observation on 4/8/26 at 10:16 AM, staff entered Resident #39's room to assist her with her morning care. During an interview on 4/9/2026 at 11:16 AM, Certified Nursing Assistant (CNA) V' reported that staffing for the CNA's at the facility had been difficult lately, and when the facility had call ins, it was much harder to get residents up at their preferred times, especially if the resident required two person staff assistance. CNA V confirmed that Resident #39 preferred to get up for the day after she ate breakfast, but she did have to wait until lunch time often. During an interview on 4/9/2026 at 11:35, Licensed Practical Nurse (LPN) G confirmed Resident #39 liked to get up for the day after she ate breakfast, and that staff were not always able to get Resident #39 up when she requested. LPN G reported she was aware that Resident #39 had voiced concerns about not getting up at the time of day she preferred and stated (Resident #39) is very persistent, she gets very upset when we cannot get her up when she wants to get up. During an interview on 4/9/2026 at 12:01 PM, CNA D reported she was aware that Resident #39 liked to get up in the morning after she ate breakfast so that she could attend the morning activities at the facility. CNA D confirmed that staff were not usually able to get Resident #39 up until later in the morning or afternoon because she required two-person assistance, and the facility did not always have the staff to accommodate this. CNA D reported that the staff were supposed to pick up breakfast trays before they got residents up, and that was time consuming, and often delayed resident care as well. During an interview on 4/9/2026 at 10:15 AM, CNA R reported she frequently cared for Resident #39 and she was aware that Resident #39 liked to get up for the day after she had breakfast. CNA R reported that it was common for Resident #39 to have to wait to get up for the day after her preferred time, and sometimes she did have to wait until lunch time (12:00 PM). During an interview on 4/9/2026 at 10:24 AM, CNA NN reported she frequently cared for Resident #39 and was aware that she preferred to get up for the day after breakfast. CNA NN reported that this was difficult for staff to accommodate (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	because Resident #39 required two-person assistance, as did several other residents on the unit, and Resident # had to wait until between 10:00 am and 12:00 PM to get up for the day. CNA NN reported there were other residents on the same unit as Resident #39 that had to get up to attend dialysis (medical treatment that removes waste, toxins, and excess fluid from the blood when the kidneys are unable to perform this function) appointments, and on the days when those residents needed to get ready for dialysis, they were not able to get Resident #39 up until after they helped the other residents, so Resident #39 typically would get up later than she preferred on the days when other residents on the unit had to attend dialysis. Review of Resident #39's Psychiatry Note dated 3/5/26 at 9:51AM revealed, . (Resident #39) is waiting to get up with the aide and states that she feels like they are too slow. She did notify her aide but was told they must pick up food trays first During an interview on 4/9/26 at 12:30 PM, Unit Manager (UM) I reported she was aware of Resident #39's ongoing concern about not being able to get up in the morning at the time she preferred. UM I reported that because Resident #39 required two-person assistance, staff had to prioritize and find a middle ground to accommodate all residents on the unit, because other residents were expressing concerns that they had to wait to get up too. UM I reported Resident #39 was typically not getting up once or twice a week due to staffing and the need to prioritize other residents. During an interview on 4/9/2026 at 12:48 PM, Director of Nursing (DON) B reported she was aware that Resident #39 had voiced concerns about not being able to get up for the day at her preferred time. DON B reported that she felt that Resident #39's preferences varied based on her cognition, but that she felt that staff were typically able to accommodate her request to up when she wanted to.During an interview on 4/9/2026 at 2:16 PM, Activity Director (AD) E reported Resident #39 enjoyed attending morning activities at the facility. AD E confirmed that there were occasions where Resident #39 missed morning activities or got to the activity late because she was waiting for staff to get her up for the day.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident rooms were kept clean and in good repair for 3 (Resident #21, #22 and #30) of 24 Residents reviewed for home-like environment, resulting in emotional distress and a potential for increased risk of infection and/or injury.Findings include: Resident #21 Review of a Minimum Data Set (MDS) assessment for Resident #21 with a reference date of 3/1/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section GG revealed Resident #21 was independent with self-propelling her wheelchair up to 50 feet. During an observation on 4/8/26 at 12:31pm, the walls in Resident #21 were noted to be in disrepair. Approximately 6 dime sized holes were noted in the walls of Resident #21's room, along with multiple areas of deep gouges and scraped off paint, including an area above the head of bed that contained sections 2x4 (inches) gouges in which the paint was scraped off, exposing the white drywall underneath. An area approximately 2'x3' (feet), to the right of Resident #21's sink in her room, was covered with deep scrapes, gouges, and peeling paint. The metal corner bead (piece of steel used for protecting and finishing external 90-degree corners) was exposed in several areas from the base of the floor to approximately 3'high. Resident #21 sat in her wheelchair near the exposed, rough metal corner bead that was at the same level as her lower leg. During an observation and interview on 4/7/26 at 10:47am, Resident #21 sat in her wheelchair in her room, the clothing she wore left her legs exposed and a bandage was noted on her right shin. Resident #21 reported she did not like condition of the walls in her room. When queried, Resident #21 reported the damaged walls in her room were depressing and she wished her room was better maintained. Resident #21 reported she always wore clothing that left her legs exposed and her skin broke open easily, so she was concerned she could injure herself on the exposed metal corner near her sink. Resident #21 confirmed she usually sat in the same spot in her room. During a tour of the facility on 4/7/26 at 9:21am the shared bathroom between rooms [ROOM NUMBERS] was noted to have dried drops of brown liquid scattered across 6 wall tiles, behind the base of the toilet. There was a strong smell of urine in the bathroom. Thick brown buildup was present on the sealant around the base of the toilet. During a tour of the facility on 4/8/26 at 12:28pm, in the shared bathroom between rooms [ROOM NUMBERS], the tiles behind the base of the toilet remained soiled, 10 dried drops of a brown substance were noted on the tiles. Thick brown buildup was present on the sealant around the base of the toilet. In an interview on 4/8/26 at 11:32am Housekeeping Manager (HM) GG confirmed the resident bathrooms should be cleaned daily. Resident #22:Review of Resident #22's brief interview for mental status score, dated 3/18/26, was scored 7 which indicated severe cognitive impairment. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 04/07/2026 at 4:27 PM, Resident #22 was in his room in his bed. Resident #22 was confused and unable to answer questions about the state of his wall. The wall that the head of the bed was closest to had approximately 10 areas of gouges and/or missing paint. The areas of disrepair on the wall ranged in size from thin scratches to an area of missing paint that measured approximately 8 inches long by half an inch wide. During an observation on 04/09/2026 at 7:55 AM, Resident #22's wall in disrepair presented the same way it did on 04/07/2026 at 4:27 PM. Applying the reasonable person concept, an individual would want their living environment to be maintained in good repair and likely would have feelings of discontent if it was not maintained in such a manner. Resident #30 (R30) According to the MDS dated [DATE], R30 was cognitively intact as evidenced by a BIMS score of 13/15. During an observation and interview on 4/8/26 at 9:00 AM, R30 was awake in bed. It was difficult to get next to R30's bed due to a high-backed wheelchair, oxygen concentrator, bedside table and visitors straight chair lined up to the right of the resident's bed. The left side of R30's bed was against the wall. The wall was gouged with peeling and missing paint. R30 said, That doesn't look good. I'd like it painted. During an observation and interview on 4/8/26 at 9:08 AM, R30 was awake in bed. On the wall to the left of R30 were multiples gouges with peeling/missing paint. Maintenance Q observed R30's wall, stating, Yes, I know that wall needs repair. When (R30's) head of bed was there, it would gouge up the wall when staff moved the bed around. Even though the paint I use to paint resident rooms is low fumes, I don't like to paint when the residents are in the room. I know there are other rooms that need to be painted too, but I can only do so much. During an interview on 4/8/26 at 3:50 PM, Guardian CC stated, (R30's) room does have missing paint on the wall right by his bed. It does not look nice. I would expect it to be taken care of. During an observation and interview on 4/9/26 at 10:15 AM, Maintenance L stated while observing R30's bed area, The rooms in this building are small. Beds get smashed into walls when staff move them to care for residents. If I put a wider bed in (R30's) room, it will take up more room and gouge up the wall on two sides of the room. I don't like how nursing has the bed positioned in here now (left side of bed against wall). Staff ram the beds into the walls when having to do cares and staff really don't have room here to do that. I have enough to paint now. During an observation and interview on 4/9/26 at 11:45 am, Director of Nursing (DON) B stated while observing R30's bed area, The walls are gouged up. The walls may get scratched up, but maintenance can fix them. During a tour of the facility on 4/7/26, rooms 301 (beds 1 and 2), 302 (beds 1 and 2), and 304 (beds 1 and 2), multiple gouges and scratches in the walls by the head of the bed (HOB) with peeling and mission paint. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/7/26 at 1:43 PM, observation of the 100-hall spa, with Maintenance Director L and Housekeeping Manager (HM) GG, found multiple wet washcloths on the dry floor of the shower and resident's dirty clothes to the side and under the sink. An interview with HM GG found that her staff would come in daily to sweep and mop the room, take out trash and clean surfaces, but typically Nursing would clean and tidy up shower rooms as needed between residents. On 4/7/26 at 2:21 PM, observation underneath the mattress of the shower bed in the 300-spa room, found accumulations of dirt and debris from previous residents, including wet pieces of paper and trash, pieces of plastic debris, a small metal spring, a studded diamond looking [NAME], and a nickel coin.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure proper discharge notifications were completed in 1(Resident #39) of 2 residents reviewed for discharge process, resulting in Resident #39 not receiving written notice of bed hold when she was discharged from the facility to the hospital. Findings include:Resident #39Review of an admission Record revealed Resident #39 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and chronic pain syndrome. Review of Resident #39's Electronic Medical Record (EMR) revealed that Resident was transferred to the hospital on 1/16/26. This writer was unable to locate documentation of written notice of bed hold for Resident #39's transfer on 1/16/26. This writer requested documentation of written notice of bed hold for Resident #39's transfer on 1/16/26 via email to Nursing Home Administrator (NHA) A on 4/8/26 at 4:20 PM. During an interview on 4/8/2026 at 4:27 PM, NHA A and Director of Nursing (DON) B reported that the nurse caring for Resident #39 on 1/16/26 had not given Resident #39 written notice of a bed hold transfer. The facility was granted a Past Non-Compliance at the time of exit due to the facility's identification of the failure to provide a written notice of bed hold, verification of re-education for the nursing staff, and the clarification Admissions Coordinator's responsibility to initiate contact with the hospital and/or responsible party within 24 hours of transfer. The resident census was reviewed to ensure that all residents who had been transferred to the hospital had documented evidence of written notice of bed hold notification and appropriate follow-up communication. Any missing documentation was immediately reconciled. The facility reviewed their Bed Hold Policy to clearly outline staff responsibilities, including nursing's requirement to provide and document written notice of bed hold rights at the time of transfer, and Admissions Coordinator's responsibility to contact the hospital or responsible party within 24 hours and continue communication throughout the hospitalization. A standardized Bed Hold Notification form and Hospital Transfer Checklist were posted at the nurse's station.

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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 observation, interview, and record review, the facility failed to follow professional standards of practice for medication administration that included administration and monitoring of a narcotic medication by a licensed professional in 1 (Resident #20) of 5 residents reviewed for medication administration, resulting in the potential for narcotic diversion, unrelieved pain, and the worsening of medical conditions. Findings include: Resident #20Review of an admission Record revealed Resident # 20 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia (diagnosis used when cognitive decline, memory loss, and functional impairment are present, but the specific type (e.g., Alzheimer's, vascular) cannot be determined. Review of a Minimum Data Set (MDS) assessment for Resident #20, with a reference date of 2/18/26 revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated Resident #20 was severely cognitively impaired. Review of Resident #20's Care Plan revealed, Focus: (Resident#20) has a behavior concern r/t (related to) dementia with behavioral disturbances. Date Initiated: 01/27/2026. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness, explain all procedures to the resident before starting and allow the resident time to adjust before proceeding. Date initiated: 1/27/26 .Review of Resident #20's Medication Administration Record (MAR) revealed, Order: Morphine Sulfate (Concentrate) Oral Solution 20 MG/ML (Milligrams/Milliters) . Give 0.25 ml by mouth three times a day for chronic pain. Start date: 4/6/26.During a medication administration observation on 4/9/2026 at 8:14 AM, Licensed Practical Nurse (LPN) G prepared a syringe with 0.25 mL (milliliters) of Morphine for Resident #20 and then placed the syringe of morphine in an 8-ounce cup of cranberry juice. LPN G reported Resident #20 refused her medications, so the facility had obtained an order from her hospice (specialized, compassionate care for individuals with terminal illnesses, focusing on comfort, pain management, and quality of life rather than curing the disease) provider to administer her morphine in juice. LPN G then took the cup of cranberry juice and placed the cup on Resident #20's breakfast tray which was sitting on the cart of meal trays that were being passed out to residents on the unit. When this writer queried LPN G about why she was not taking Resident #20's medication to her room to administer to her, LPN G reported she could not give Resident #21 the juice, because Resident #20 would not take medications from her. When this writer queried LPN G how she was able to determine that Resident #20 had received all of her medication, and that the medication was not given to someone else, LPN G reported the CNA's on her unit knew that she put Resident #20's morphine in her juice, and that she stayed near her room when she had the medication. LPN G then marked the morphine as administered in Resident #20's MAR and began to prepare medications for another resident. This writer noted that LPN G left her medication cart which was parked outside of Resident #20's room to administer medications to another resident. It was noted that LPN G continued on with passing medications to several other residents as Certified Nursing Assistant (CNA) R delivered Resident #20's meal tray to her. During the time that Resident #20 was eating her breakfast and drinking her juice in her room, LPN G was out of view of Resident #20 as she entered five different resident rooms to administer medications to other residents. When this writer queried LPN G as to how she was able to ensure that Resident #20 was drinking her juice that had the narcotic in it as she continued to enter other resident rooms, LPN G reported she knew how to keep her eyes on Resident #20. LPN G then entered Resident #20's room with this writer, it was noted that CNA R had already removed Resident #20's breakfast tray and juice cup which had the morphine in it. LPN G told this writer, See, she already drank it all. When this writer queried as to where the order was that indicated that Resident #20 could have morphine administered in her juice, LPN G reported that she did not know where it was, but she knew it was an order. During an interview on 4/9/2026 at 10:15 AM, CNA R confirmed that she was aware that Resident #20 had been receiving some kind of medicine in her cranberry juice in the morning. CNA (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R confirmed that she saw Resident #20 drink all of the cranberry juice because she was in Resident #20's room assisting her roommate with eating. CNA R confirmed that she removed Resident #20's cup of cranberry juice before LPN G had come in to check on Resident #20. CNA R reported that she knew that if Resident #20 didn't drink all of her juice in the morning, she would leave it on her tray table to drink at lunch. (Noted that Resident #20's morphine order was scheduled for three times a day, and she was scheduled to receive her next dose of morphine at 1:00 PM). During an interview on 4/9/2026 at 10:24 AM, CNA NN reported that she was aware that Resident #20 was getting medication in her juice cup. CNA NN reported that sometimes nursing staff would put Resident #20's morphine in milk, which she didn't really like, so she would not usually drink all of the milk. During an interview on 4/9/2026 at 11:16 AM, CNA V reported that she often cared for Resident #20 and she had no clue that nurses were putting medications in her drinks, and that was not communicated to her from the nursing staff at the facility.During an interview on 4/9/2026 12:26 PM, Unit Manager (UM) I reported she was aware that LPN G had been placing Resident #20's morphine in juice, but she did not know what her process was for ensuring that Resident #20 was being supervised during medication administration. UM I reported that Resident #20 had not been assessed to self-administer medications, and that nurses were expected to follow the rights of medication administration. UM I reported nursing staff should were supposed to supervise residents as they were taking medications to ensure that they received the medications. During an interview on 4/9/2026 at 12:48 PM, Director of Nursing (DON) B reported she was not aware that nurses at the facility were administering Resident #20's morphine in cups of juice/milk. DON B reported that nurses were supposed to observe residents when they were administering their medications to ensure that they received the medication. Review of the facility's Standards of Practice policy dated 2/3/26 revealed, Policy Overview: Residents will receive services, treatments, and care in accordance with professional standards of practice . Review of the facility's Medication Administration policy dated 2/3/26 revealed, Policy Overview: To safely and accurately prepare and administer medication according to physician order, professional standards of practice, and resident needs. General Instructions: Medications are administered in accordance with the following rights of medication administration: right resident, right medication, right dose, right route, right time and frequency, right documentation, right of resident to refuse, and right clinical indication .Administer medication: . remain with resident until administration of medication is complete .sign MAR after medication is administered .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate Activities of Daily Living (ADL) care (provide showers and/or washing hair) for 2 (Residents #39 and Resident #21) of 4 residents reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for resident's who are dependent on staff for assistance. Findings include: Resident #39 Review of an admission Record revealed Resident #39 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and chronic pain syndrome. Review of a Minimum Data Set (MDS) assessment for Resident #39, with a reference date of 3/10/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #39 was cognitively intact. Review of Resident #39's Care Plan revealed, Focus: (Resident #39) has ADL self-care deficit related to (r/t) impaired mobility . Date initiated: 1/11/26. Interventions: ADL (Activities of Daily Living) assist of 2 staff, assist to bath / shower as preferred per shower schedule and as needed, provide sponge bath when a full bath or shower cannot be tolerated. Dated initiated: 3/27/26 . During an interview on 4/8/2026 at 8:57 AM, Resident #39 reported she felt like some of the staff at the facility did not care for her or want to take care for her because she was high maintenance. This writer queried as to what Resident #39 about her definition of high maintenance, Resident #39 reported she required two staff members to assist her with ADL care, so she required more time from staff. Resident #39 reported she did not feel like she always received adequate ADL care, and she did miss showers/bed baths at times. Noted that Resident #39's hair was disheveled and greasy. During an interview on 4/9/2026 at 12:01 PM, Certified Nursing Assistant (CNA) D reported that when the facility had call ins, which happened often, CNAs could not provide care timely and adequate ADL care. CNA D reported residents who required longer times of assistance, did not get showers or bed baths when CNA staffing was less than 5 CNA on day and evening shift. CNA D confirmed that Resident #39 would be considered a resident that required a long shower and it would not be possible to complete a shower or bed bath for her if they facility had less than 5 CNAs on the floor. During an interview on 4/9/2026 at 10:24 AM, CNA NN reported that she frequently cared for Resident #39. CNA NN reported that this was difficult for staff to accommodate because Resident #39 required two-person assistance, so her care took more time for staff to complete. CNA NN reported that Resident #39's was missing showers regularly because they did not have the staff to take two staff members off the floor to assist her. Review of Resident #39's Bathing Task Documentation on 4/9/26 indicated that Resident #39 received one shower and one bed bath in April 2026. Resident #39 had one bed bath documented as completed in March 2026, and two refusals documented in March 2026. Resident #39 had one shower documented as completed in February 2026. Review of Resident #39's Shower Sheets revealed that Resident #39 received showers on 2/3/26 and 2/6/26, 2/20/26 and 4/3/26 and bed baths on 3/6/26, 3/29/26 and 4/7/26. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/9/2026 at 12:48 PM, Director of Nursing (DON) B reviewed Resident #39's bathing documentation and shower sheets with this writer and confirmed that the facility was missing documentation to verify that Resident #39 was receiving her scheduled twice weekly showers/baths or documentation of refusals. DON B reported CNA's were supposed to complete a shower sheet and document the shower/bath in the bathing tasks in the resident's electronic health record (EMR). DON B reported she was aware that the facility had issues ensuring all residents were receiving their scheduled showers/baths, and that the facility was working on it. Resident #21 Review of a Face Sheet revealed Resident #21 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: adjustment disorder with depressed mood (stress related mental health condition characterized by significant sadness) and seborrheic dermatitis (chronic inflammatory condition causing itchy, greasy, red patches covered with white or yellow scales, often called dandruff on the scalp). Review of a Minimum Data Set (MDS) assessment for Resident #21 with a reference date of 3/1/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Review of a Care Plan for Resident #21 with a reference date of 1/27/26 revealed the following focus/goal/interventions: Focus: ADL (Activities of Daily Living) self-care deficit related to physical limitations.Goal: Will receive assistance necessary to meet ADL needs. Interventions.Bathing/Showering as preferred per shower schedule.needs medicated shampoo. Review of a Physician's Order for Resident #21 with a reference date of 2/22/26 revealed Ketoconazole External Shampoo 2% (percent)(topical).Apply to scalp topically every day shift every Wed (Wednesday) , Fri (Friday) for scalp sensitivity. During an observation on 4/7/26 at 11:04am in Resident #21's room, Resident #21's hair appeared shiny and soiled with distinct comb lines from the hair sticking together after being combed. In an interview on 4/7/26 at 11:05am, Resident #21 reported she had not had her hair washed in 2 weeks and was bothered by the state of her hair. Resident #21 reported a staff member normally helped her wash her hair by backing her wheelchair up against the sink in her room and then washing her hair for her, but that staff member left a few weeks ago, so her hair had not been washed. Resident #21 described her hair as dirty and oily. Resident #21 reported due to her oily scalp, she used to wash her hair daily when she was at home and could still do it herself. Resident #21 confirmed she could no longer wash her hair on her own. During an observation on 4/8/26 at 12:34pm in Resident #21's room, Resident #21's hair was pulled back in a ponytail. The surface of her hair appeared shiny, deep comb marks were present and the hair in the ponytail appeared stuck together. In an interview on 4/8/26 at 12:36pm, Resident #21 reported she still had not had her hair washed and was increasingly frustrated. Resident #21 stated I've got enough oil in this hair; I think I'm going to bottle it!. In an interview on 4/9/26 at 12:07pm, Resident #21 reported her head was very itchy prior to having (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her hair washed the evening prior to this date. Resident #21 reported she needed to use medicated shampoo/have her hair washed on a regular basis to avoid having extremely itchy scalp. Review of a Shower Record for Resident #21 with a reference date of March 2026, revealed the resident received assistance with showering 4 times during the month. Review of an Activities of Daily Living policy with a reference date of 2/2/26 revealed Policy Overview: .Appropriate care and services will be provided for residents who are unable to carry out ADL independently.in accordance with the plan of care.

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	235261	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health & Rehabilitation at Leonard	1700 Leonard Street NE Grand Rapids, MI 49505

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F 0686 Level of Harm - Minimal harm or potential for 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 ensure implementation of resident-specific comprehensive care plans for 2 residents (R13 and R52), and prevent the development of a pressure ulcer for 1 resident (R13) of 4 residents reviewed for pressure ulcers, resulting in the development of a pressure ulcer for R13 and the potential for skin breakdown for R52. Findings include: Resident #13 Review of an admission Record revealed Resident #13 was originally admitted to the facility on [DATE] with pertinent diagnoses which included limitations of activities due to disability. Review of a Minimum Data Set (MDS) assessment for Resident #13, with a reference date of 4/6/26 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #13 was cognitively intact. Review of Resident #13's "Care Plan revealed, Focus: (Resident #13) has ADL (Activities of daily living) self-care deficit related to muscle weakness . Date initiated:1/13/26. Interventions: Bed Mobility: One person assist. Date Initiated: 01/20/2026. Focus: Actual pressure injury formation related to: Resident has pressure injury DTI (deep tissue injury) with risk for delayed wound healing secondary to progressing comorbidities such as . DTI left 5th metatarsal phalangeal joint (the knuckle of the little toe, connecting the long foot bone (metatarsal) to the base of the smallest toe): 2/4 intact blister. DTI right dorsal 5th metatarsal phalangeal joint (the joint located on the top (dorsal) side of the foot where the fifth metatarsal bone connects to the smallest toe, situated on the outer edge of the ball of the foot). - 2/4 intact blister. Date Initiated: 01/21/2026. Interventions: Frequent turning and repositioning .Date Initiated: 01/21/2026 Review of Resident #13's Orders revealed, Wound Care Order Site: R (right) & L (left)5th metatarsal intact blisters 1) Cleanse wound with NS (normal saline) 2) Pat Dry with Gauze 3) Paint with betadine (topical antiseptic) 4) Apply dry bordered gauze dressing to left and right foot. everyday shift for wound management. Start date: 3/26/26. Review of Resident #13's Wound Progress Note dated 4/8/26 revealed, . Skin Issues Note: L (left) 5th metatarsal deteriorating related to the superficial layer lifting. Treatment orders will change to xeroform (type of gauze dressing) cut to wound bed & covered with dry bordered gauze dressing . During an observation and interview on 4/07/2026 at 10:41 AM, Resident #13 was lying in her back on her back. Resident #13 was wearing prevalon boots (medical device designed to prevent and treat heel pressure injuries by completely elevating (floating) the heel off the mattress surface.) on both of her feet which were noted to be lying directly on the foot of her bed. Resident #13 reported that she had developed pressure ulcers on her feet at the facility because she was too tall for her bed so her feet would lie directly on the foot of her bed. Resident #13 reported that she had been told that the facility was not able to add a bed extender to her bed because her room was not big enough for a larger bed. During an observation on 4/07/2026 12:56 PM, Resident #13 was noted to be in the same position as previous observation, with her feet lying directly on the foot of her bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a wound care observation on 4/08/2026 at 8:17 AM, Wound Care Nurse Practitioner (WCNP) EE and Unit Manager I entered Resident #13's room and noted that her feet were lying directly on the foot of the bed, so they boosted(refers to the coordinated and assisted maneuver of moving a dependent patient up toward the head of the bed or repositioning them) Resident #13 up in her bed. As UM I was completing wound care on the wound on Resident #13's foot, she reported that the top layer of the skin on her foot was starting to become detached. WCNA EE assessed Resident #13's left foot wound and noted that she was going to update the treatment plan. In an interview on 4/08/2026 at 8:27 AM, WCNP EE reported that Resident #13 had developed both wounds on her feet at the facility, due to her bed being too small for her. WCNP EE reported that she thought that Resident #13 was in a long bed. WCNP EE confirmed that she needed to update Resident #13's treatment order for the wound on her left foot because the blister on top of the wound became detached, and that the wound was deteriorating. During an interview on 4/8/2026 at 2:08 PM, UM I reported that Resident #13 had developed pressure ulcers on her feet due to her feet touching the end of her bed. UM I reported that Resident #13 had been wearing prevalon boots before she obtained the pressure injuries, and she believed that staff had not been boosting resident up in her bed often enough, so her feet were lying on the foot of the bed frequently. UM I reported that the facility was not able to put a bed extender on Resident #13's bed because her room was too small for one. UM I reported that the facility had not considered or offered to move Resident #13 to a room that could accommodate a larger bed for her. During an observation on 4/09/2026 at 8:49 AM, Resident #13 was lying in bed on her back. Resident #13 was wearing her prevalon boots with her feet lying directly on the foot of her bed. During an observation on 4/09/2026 at 10:05 AM, Resident #13 was in the same position as previous observation at 8:49 AM. During an interview on 4/9/2026 at 10:15 AM, Certified Nursing Assistant (CNA) R reported that she cared for Resident #13 often, and that she rarely got out of bed. CNA R reported that she would typically boost Resident #13 in the morning when she would check on her, but she did not have a schedule for how often she checked on and boosted Resident #13 throughout the day. During an interview on 4/9/26 at 10:24 AM, CNA NN reported that the staff did not have any kind of schedule for when to boost Resident #13 to make sure her feet were not lying on the foot of her bed. During a follow up interview on 4/9/2026 at 12:38 PM, UM I reported that the facility had never considered offering Resident #13 to move to a room where she could have a longer bed. During an interview on 4/9/26 at 12:48 PM, Director of Nursing (DON) B reported that she felt that Resident #13's pressure ulcers were unavoidable due to her underlying medical conditions. DON B confirmed that she was aware that Resident #13 was tall enough that her feet would often lie directly on the foot of the bed. DON B reported that she thought that Resident #13 was now in a longer bed. R52 Observed on 4/07/2026 at 9:34 AM, R52 in his room sitting in a high-backed wheelchair (Broda). R52 was not wearing blue Prevalon heel boots on either foot. Both boots were in a chair in the corner of his room. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the Minimum Data Set (MDS) dated [DATE], R52 scored 15/15 on his BIMS (Brief Interview Mental Status) signifying he was cognitively intact. His diagnoses included diabetes, traumatic brain dysfunction, arthritis, non-Alzheimer's dementia, and partial paralysis in right arm and leg. Section GG-indicated R52 was dependent on staff for his ADLs (activities of daily living). Section M-indicated R52 was at risk of developing pressure ulcers/injuries, had a pressure ulcer/injury, MASD (moisture associated skin damage), and received interventions/treatments that did not include a turning/repositioning program. Review of R52's Order Summary dated 8/30/2024, revealed, Skin prep to left toes-keep blankets off of toes as much as possible for resident allows at bedtime for left toe redness. Print date 4/9/25 at 1:41 PM. Review of R52's Order Summary, dated 9/5/24, revealed, Prevalon Boots (Prevalon boots (aka (also known as) heel boots or blue boots) a medical device designed to prevent and treat heel pressure injuries (bedsores) by completely elevating (floating) the heel off the mattress surface) on at all times. Every day and night shift for Wound care/ prevention. Check placement. Print date 4/7/26 at 2:38 PM. Review of R52's Medication/Treatment Administration Record (MAR/TAR) dated 4/1/26-4/30/26, revealed Prevalon boots on at all times. Every day and night shift for wound care/prevention. check placement. Start date: 9/5/2024 7:00 PM Discontinue date: 4/8/26 12:49 PM. It was noted, survey started on 4/7/26. Review of R52's Order Summary dated 4/8/26, revealed, Prevalon Boots on when in bed for pressure relief at bedtime for wound care/prevention check placement. Print dated 4/9/26 at 1:41 PM. Further review of R52's MAR/TAR dated 41/26-4/30/26 and Care Plan for Potential/Actual Impairment to Skin Integrity, did not include the resident-specific treatment of R52 to have the Prevalon Boots in bed for pressure relief at bedtime. Review of R52's Care Plan, dated 2/20/26, Potential/actual impairment to skin integrity related to contracture with use of orthotics (splints and braces), weakness/debility with impaired mobility.multiple comorbidities including Diabetes with neuropathy and Dementia.history of redness to left great toe. The goal for R52 was to heal within the limits of the disease process. Interventions included Elevate heels off bed surface . Prevalon boots on at all times. Further review of R52's Care Plan, dated 2/20/26, Potential/actual impairment to skin integrity related to contracture, did not have the newest 4/8/26 order for Prevalon boots on when in bed for pressure relief at bedtime for wound care/prevention check placement. The Braden Scale is used to assess the resident's level of risk for development of pressure ulcers. The evaluation is based on six indicators: sensory perception, moisture, activity, mobility, nutrition, and friction or sheer. Scoring includes: At Risk: 15-18, Moderate Risk: 13-14, High Risk: 10-12, and Very High Risk: 9 or below. Review of R52's Braden Score for Predicting Pressure Ulcer Risk Evaluation, dated 1/2/2026, indicated a score of 17.0 and on 1/10/26, a score of 16.0. The two assessments indicated R52 was at risk for developing a pressure ulcer/injury. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 4/8/26 at 9:15 AM, R52 was in bed with eyes closed without covers over his lower legs. R52 was not wearing blue Prevalon heel boots on either foot. Both residents knees were bent with both of his heels resting directly on the mattress. Observed two blue Prevalon boots on the closet floor with personal belongings lying on top of them. During an observation and interview on 4/8/26 at 12:30 PM, R52 was being pulled backwards in his high-backed wheelchair by Certified Occupational Therapy Assistant (COTA) KK down the hall towards therapy. R52 was not wearing blue Prevalon heel boots on either foot. COTA KK stated he did not need to wear the blue Prevalon heel boots. During an interview and record review on 4/9/26 at 1:30 PM, Unit Manager (UM) I stated, (R52) wore the Prevalon boots for pressure ulcer prevention. He does not have pressure ulcers on his heels. He does receive care on top of his toes for redness and prevent a pressure wound. UM I reviewed R52's medical records, specifically order summary and care plans. It was noted therapy discontinued the order for Prevalon boots but did not update the care plan. UM I stated, I'm new to Long Term Care, and don't know much about care plans. I will discuss with therapy to update care plans when they change orders, and I will have the DON educate me on care plans.