

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235395	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/29/2025
NAME OF PROVIDER OR SUPPLIER  Optalis Health and Rehabilitation of Three Rivers		STREET ADDRESS, CITY, STATE, ZIP CODE  517 S Erie St Three Rivers, MI 49093	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.  (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake 1213927. Based on interview and record review, the facility failed to protect the resident's right to be free from verbal abuse by staff for 1 resident (Resident #101) of 4 residents reviewed for abuse, resulting in Licensed Practical Nurse (LPN) K intimidating and threatening to take away the resident's phone and the potential for psychosocial harm. Findings include: Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: legal blindness, cerebral palsy (neurological disorder that affects movement, posture and muscle coordination), post-traumatic stress disorder, anxiety, bipolar disorder (mental health condition characterized by extreme mood swings), blood cancer and seizure disorder. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 5/22/25 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated Resident #101 was cognitively impaired. Review of the Functional Abilities revealed that Resident #101 required the assistance of 1-2 staff for bed mobility, transfers and toileting. Review of an updated BIMS assessment completed on 7/29/25 revealed a score of 15, out of a total possible score of 15, which indicated Resident #101 was cognitively intact at the time of survey. Review of a Facility Reported Incident (FRI) submitted on 6/21/25 revealed, .06/20/2025 at 10:30 PM: Incident Summary CNA ( O), CNA ( D), and CNA ( C) reported to DON (Director of Nursing B) overhearing LPN ( K) raising his voice to (Resident #101) during a phone conversation. It was reported that both CNA's overheard (LPN K) stating to (Resident #101), You aren't going to be calling the damn facility phone all night because there are other residents that need help!. (LPN K) then reportedly ordered CNA ( C) go take residents cell phone from him. CNA refused, and (LPN K) then was witnessed telling (LPN L) to grow a pair of balls and go take (Resident #101's) phone away or he will do it himself. Investigation Summary After notification of incident, (LPN K) was immediately removed from the facility and suspended pending investigation. Like residents that were under the care of (LPN K) on the night of the incident were interviewed and determined that there were no reports of abuse or similar incidents reported. All residents indicated that they feel safe in the facility. The review of the facility's systems confirmed that the facility followed appropriate procedures as demonstrated by the following: Investigation completed by DON. Staff member immediately removed from facility to maintain safety of all residents. Residents and staff interviewed. Investigation completed by DON. Staff member immediately removed from facility to maintain safety of all residents. Residents and staff interviewed. (city) Police were not called as victim/family did not wish for this. Family(s) and/or responsible parties notified. Physician notified. Medical records reviewed by DON and Administrator. In an interview on 7/24/25 at 3:08 PM, Resident #101 reported he had told a CNA (unknown name) that he had to use the bathroom and she told him to go to the bathroom in his brief. Resident #101 reported that it was humiliating to him. This surveyor inquired about the incident that was reported involving an allegation of abuse on 6/21/25 and Resident #101 reported that staff frequently tell him not to use the call light so much and that he felt intimidated by a nurse that yelled at him and refused to give him his medication. In an interview on 7/22/25 at 2:46 PM, CNA D reported that Resident #101 frequently used his call light and his cell phone for assistance, and on 6/20/25 the resident called the nurse's station multiple times. CNA D reported that she witnessed LPN K yelling at Resident #101 on the phone and overheard LPN K say to the resident that he wasn't going to do this sh*t tonight, and if he didn't stop calling that he was going to take his fu**ing cell phone away. CNA D then reported that LPN K ordered another nurse to take the phone away. CNA D reported that Resident #101 was upset about how he was treated that night. In an interview on 7/23/25 at 3:08 PM, CNA C reported that LPN K was more frustrated than normal on 6/20/25 and he was angry with everyone. CNA C reported that LPN K picked up the phone when Resident #101 called the desk and told Resident #101 that he was a pain and that he needed to stop calling otherwise LPN K was going to take his phone away. CNA C reported that Resident #101 was lonely on 6/20/25 and wanted attention. Multiple attempts were made to interview LPN K on 7/22/25-7/24/25, with no return call prior to exit. In an interview on 7/22/25 at 8:45 AM, current NHA A reported that she was new to the facility and was not aware of the FRI for Resident #101 until this surveyor asked for the investigation. In an interview on 7/22/25 at 1:56 PM, DON B reported that she was called at home on 6/20/25, late at night by a CNA to report a concern of LPN K yelling at Resident #101 and threatening to take his phone away. DON B reported that she had the other nurse that was working that night talk to LPN K and escort him out of the facility immediately. DON B</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake 1213992,1213991, and 2570298.Based on observation, interview and record review the facility failed to ensure a resident received care in accordance with physician orders and professional standards of care in 1 resident (Resident #101) of 12 residents reviewed for quality of care, resulting in failure to adequately monitor Resident #101 with a history of recurrent Urinary Tract Infection (UTI), failure to accurately identify symptoms of UTI and provide necessary treatment, and failure to ensure hospital discharge physician orders for treatment of UTI were followed, resulting in Resident #101 requiring hospital intervention multiple times to receive treatment for UTI and the potential for negative resident outcomes. Findings include:Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: legal blindness and cerebral palsy (neurological disorder that affects movement, posture and muscle coordination). Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 5/22/25 revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated Resident #101 was cognitively impaired. Review of the Functional Abilities revealed that Resident #101 required the assistance of 1-2 staff for bed mobility, transfers and toileting. Review of an updated BIMS assessment completed on 7/29/25 revealed a score of 15, out of a total possible score of 15, which indicated Resident #101 was cognitively intact. In an interview on 7/22/25 at 2:15 PM, Director of Nursing (DON) B reported that Resident #101 went to the hospital on 7/17/25 due to abnormal vital signs. DON B reported that Resident #101 was being treated in the hospital for a UTI and receiving an IV antibiotic. Review of Resident #101's Provider Note dated 7/17/25 at 8:00 AM revealed, Notified resident is slurring words, confused, shaking. Temp (temperature) 102 (normal temperature is 98.6), HR (heartrate) 105. Not responding to commands.order given to send resident to ER (emergency room) for evaluation.Review of Resident #101's Change of Condition Note dated 7/17/25 at 10:54 PM revealed, .Altered level of consciousness .general weakness .decreased urine output .send to ED (emergency department) for eval .Review of Resident #101's Progress Notes for related documentation of health status leading up to hospitalization on 7/17/25 revealed a BCS (behavioral care services) Psychology Note dated 7/8/25 at 12:30 PM which revealed, .Chief Complaint: Facility dissatisfaction. Resident refuses all attempts to discuss any change in behavior, demonstrating continued rigid thinking patterns. Previously, resident was expressing concerns about groin pain with scheduled urology (specialist that focuses on the urinary tract) appointment. He had expressed hope that resolving this issue would allow him to improve his physical health by getting out of bed more.Review of Resident #101's History and Physical Hospital Record dated 7/18/25 at 2:18 AM revealed, .seen in ER (emergency room) for symptoms of UTI.Assessment/Plan: Acute dehydration: NS (normal saline)100ml/hr (intravenous fluids).Urinary Tract Infection: Rocephin (antibiotic) 2 gm (gram).Injection, IV (intravenous) push, q (every) 24h (hour) interval.7 days. Start date: 7/18/25 9:00 PM, Stop date: 7/24/25 9:00 PM.CBC (complete blood count lab) reveals hgb (hemoglobin: blood cells that carry oxygen from lungs to rest of body) 20.0 hct (hematocrit: percentage of red blood cells in the blood) 57.4 worrisome for dehydration.Review of Resident #101's Hospital Discharge Summary dated 7/23/25 revealed, admission date/time: 7/17/25 at 11:23 PM.Hospital Course: .Patient has had frequent UTI in the past.Imaging was concerning for cystitis (bladder inflammation) urethritis (inflammation of the tube that carries urine out of the body) and pyelonephritis (kidney infection). Patient's cultures grew MDRO (multidrug-resistant) E. coli (Escherichia coli: a bacteria found in the intestines).After discussion with pharmacy it was decided that patient would be treated with 4 weeks of antibiotic to treat this infection. With his history of antiseizure medications IV antibiotics he did not have a good choice. Pharmacy recommended oral tetracycline 500mg 4 times a day as an alternative which will not interact with his antiseizure medications. Prescription was sent to patient's nursing home and they will arrange for it.CT (detailed x-ray) abdomen and pelvis.Impression: Cystitis, in addition to ascending infection with associated right ureteritis and acute right pyelonephritis. This is new.Patient Summary: .Discharge Medication List: (new prescription) Tetracycline 500mg oral capsule 1 cap orally every 6 hours for 4 weeks. Last dose taken: none given at hospital. Next dose due: 7/23/25 at 6:00 PM.Review of Resident #101's Care Plan revealed, . resident is on antibiotic therapy r/t (related to) infection UTI. Date initiated: 6/17/25.Interventions: Administer antibiotic medications as ordered by physician. Monitor/document side effects and effectiveness q-shift (every shift) Monitor/document/report PRN (as needed) adverse reactions to antibiotic therapy</p>		

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide medically-related social services to help each resident achieve the highest possible quality of life.</p> <p>(continued on next page)</p>

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<p>F 0745</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake 1213992. Based on interview and record review, the facility failed to provide medically related social services to attain and maintain the highest practicable physical, mental and psychosocial well-being for 1 resident (Resident #112) of 3 residents reviewed for social services, resulting in Resident #112 not receiving assistance with identifying community placement options and completion of the application process based upon the resident's expressed desire to discharge to the community, and not receiving timely quarterly care conference. Findings include: Resident #112 Review of an admission Record revealed Resident #112 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #112, with a reference date of 7/2/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #112 was cognitively intact. In Section Q - Participation in Assessment and Goal Setting indicated that there was No active discharge plan in place for the resident to return to the community. In an interview on 7/23/25 at 4:08 PM, Resident #112 asked to speak with this survey and expressed that she was angry and frustrated with the facility. Resident #112 reported that she was completely independent and wanted to move out of the facility into an apartment, that she had expressed her desire to move out to the facility staff for several months and they have not done anything to assist her. Resident #112 reported that her family was not involved in her care. Review of Resident #112's Care Plan revealed, Patient does not show potential for discharge to the community due to need for 24/7 care and supervision. Date initiated: 7/10/25. Created by Social Work-Director (SW-D) G. Review of Resident #112's Behavioral Care Services visit note dated 7/3/25 revealed, .Patient denies depression, she expresses some anxiety as she wants to leave the facility. Review of Resident #112's Behavioral Care Services visit note dated 7/17/25 revealed, .states she is upset with the previous social worker, she states that she is going to fire all management. She states that she wants out of here, and she wants somebody to help her get her own apartment. Review of Resident #112's Social Work Progress Notes revealed that there no entries since 1/7/25, and none related to discharge planning. Review of Resident #112's most recent Care Conference dated 4/8/25 revealed, .Summary Note: .Resident voices that she would like to start looking at other housing such as her own apartment. SSD (social services director) will talk to family about this moving forward. There was no record of a July quarterly care conference. In an interview on 7/28/25 at 9:20 AM, Director of Nursing (DON) B reported that Resident #112 was her own person, was independent with cares, frequently left the facility for short periods of time, but had not expressed interest in moving into the community that she was aware of. DON B reported that the facility did not have a Social Worker and social service tasks were being split up between DON B, the corporate social worker (SW) G, and Assistant Director of Nursing (ADON) E was helping with discharges. DON B reported that she had not seen SW G in-person at the facility, but that she updated assessments and care plans remotely. In an interview on 7/28/25 at 9:20 AM, Nursing Home Administrator (NHA) A reported that the facility did not have a Social Worker since 6/16/25 when former SW DD quit. In an interview on 7/28/25 at 10:11 AM, ADON E reported that she was aware that Resident #112 had voiced wanting to discharge to the community, but ADON E had not followed up on it. In an interview via phone on 7/28/25 at 2:29 PM, SW G reported that the facility had been without a Social Worker since the middle of June and that she had been acting as a resource for guidance on complex tasks remotely. SW G reported that she had not been made aware of Resident #112's interest in discharging to the community. When this surveyor inquired about the resident's care plan indicating that she showed no potential for discharge to the community, SW G reported that she retrieved that information from the quarterly MDS assessment completed on 7/2/25. SW G reported that she had not been asked to attend care conferences and did not know who was responsible for ensuring that care conferences were completed quarterly, and/or who was responsible for completing the social services section of the MDS assessments. In an interview on 7/29/25 at 10:00 AM, MDS Coordinator (MDS-C) J reported that she completed Resident #112's MDS assessment on 7/2/25 based on a 7 day look back period, and there was no documentation during that time indicating that she was interested in discharging to the community, therefore it was coded as No on the assessment. MDS-C J reported that normally the facility's SW would complete the discharge section, but the facility did not currently have a SW. MDS-C J reported that she had scheduled Resident #112 for a quarterly care conference on 7/9/25 but confirmed that it did not get completed and/or rescheduled. In an interview on 7/29/25 at 10:15 AM DON B</p>		