STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235395	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Three Rivers	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2616813Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from resident-to-resident verbal abuse for 2 (Resident #101 and Resident #100) of 3 residents reviewed for abuse, resulting in Resident #101 experiencing verbal threats, insults and mocking by Resident #100. Findings include:Resident #100 Review of an admission Record revealed Resident #100 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: Borderline intellectual functioning (indicating cognitive abilities below average, but not low enough to be classified as an intellectual disability), bipolar disease (a mental health condition that causes extreme mood swings), and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 9/19/25 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #100 was cognitively intact. In an interview on 10/6/25 at 11:18 AM, Resident #100 reported she was having problems with her anger, and she recalled being involved in an incident with Resident #101. Resident #100 reported Resident #101 continued to come near her and continued to make her angry. Resident #100 stated I told him if you don't leave me alone, I'm going to beat your ass. In an interview on 10/8/25 at 10:40 AM, Activity Aide (AA) BB reported she observed Resident #100 state out loud to Resident #101 that she would hit him if her came near her. AA BB reported she intervened and removed Resident #101 from the dining room area. AA BB reported she reported the situation to both DON B and NHA A. Review of Communication with Resident dated 9/11/25 at 13:39 (1:39) PM, revealed .Don (DON B) spoke with resident regarding concerns that were reported to [NAME] that resident stated to a nursing staff member that she wants to beat another resident's ass. When resident was questioned about statement, resident stated she believes the resident has dementia, but knows what hes doing. Resident educated on disease process and encouraged to removed herself from any situation that she may feel could potentially cause her to be uncomfortable or unsafe and alert appropriate authority or personnel. Resident verbalized understanding. (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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(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	In an interview on 10/7/25 at 3:18 PM, DON B reported Resident #100 had a problem with Resident #101. When queried regarding Resident #100 making threats about physical harm to Resident #101, DON B reported that Resident #100 did make the statement if he comes close me, I'm just going to beat his ass regarding Resident #101, and DON B stated she says things like that regularly. When further queried regarding the safety of residents from Resident #100, DON B stated I don't think she has any incidents of abusing anyone that I can recall. In an interview on 10/7/25 at 3:42 PM, NHA A reported she was concerned for Resident #101's safety from Resident #100, specifically what she would do to him. NHA A reported she could hear Resident #100 while in the hallway announce the whereabout of Resident #101. NHA A stated in my opinion, Resident #100 was watching Resident #101 more than he was watching her. NHA A reported Resident #100 had come to her office, angry and wanted to know why people who were messed up in the head were allowed to be in the facility. NHA A reported that the Resident #100's behavior escalated and that she continued to seek Resident #101 out in the building. NHA A reported she was concerned that Resident #100 was targeting Resident #101. Review of Heightened emotional contagion in mild cognitive impairment and Alzheimer's Disease is associated with temporal lobe degeneration. https://pmc.ncbi.nlm.nih.gov/articles/PMC3683715/, 2013, revealed Emotional contagion, the tendency to mirror others' emotions, is heightened in people with dementia, leading them to strongly reflect the emotional state of . others around them. This increased sensitivity occurs as memory and thinking abilities decline, possibly due to damage in brain regions like the right temporal lobe. Consequently, a caregiver's calm or happy demeanor can help keep a person with dementia calm, while their anxiety can lead to the person mirroring those negative emotions. Resident #101 Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: dementia (general term used for loss of memory, language, thinking skills that interfere with daily life) with behavioral disturbance. Review of a Minimum Data Set (MDS) assessment for Resident #101 with a reference date of 9/11/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 3/15, which indicated the resident was severely cognitively impaired. Section E of the MDS revealed Resident #101 did not display the presence of wandering during the 7-day assessment period. Review of a Care Plan for Resident #101 with a reference date of 7/23/25 revealed the following focus/goal/interventions: Focus: Altered behavior in which resident acts (are) sic characterized by ineffective coping skills.Goal: Decrease episodes of anxiety.Interventions.if (Resident #101) becomes agitated in congested areas assist him into a less congested area. Involve resident in 1:1 recreational activity, keep schedules routine and predictable. During an observation on 10/8/25 at 10:30 am, Resident #101 sat supported in his bed, was aware when he was spoken to; smiled, made eye contact, and verbalized short statements in response to a friendly greeting. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/8/25 at 10:15am, Durable Power of Attorney (DPOA) GG reported she visited Resident #101 several times a week and although he had dementia, Resident #101 understood simple phrases and would be emotionally upset if someone spoke to him harshly. In an interview on 10/7/25 at 8:53am, DPOA GG reported she received a telephone call on 9/11/25 from Admissions Coordinator (AC) Z who told her Resident #101 had to transfer to another skilled nursing facility on this date because he was being targeted by a female resident who verbally threatened him. In an interview on 10/7/25 at 11:45am, admission Coordinator (AC) HH, who worked at the facility Resident #101 transferred to, reported the referral for Resident #101 was done via telephone by Nursing Home Administrator (NHA) A. AC HH reported she was told Resident #101 was being targeted by a female resident who had verbally harassed him. In an interview on 10/7/25 at 12:58pm, Registered Nurse (RN) II reported the facility was aware a few female residents, whom the staff nicknamed the mean girls, were complaining about Resident #101 because he self-propelled his wheelchair around the dining room, through group activities, and touched items in the common areas of the facility. RN II reported the situations were discussed in an Interdisciplinary Team (IDT) meeting but weren't taken very seriously. When further queried, RN II reported the female residents were ganging up on him. In an interview on 10/8/25 at 2:23pm, Director of Nursing (DON) B reported Certified Nursing Assistant (CNA) W came to her and told her staff separated Resident #100 and Resident #101 when an incident occurred in the dining room, during which Resident #100 yelled at Resident #101. DON B confirmed CNA W reported Resident #100 said she was going to kick his ass (referring to Resident #101). DON B reported she did not know if Resident #101 was still in the dining room when Resident #100 made the verbal threat and no additional investigation was completed. (DON) B reported the concerning interactions directed at Resident #101 by Resident #100 were a continuous thing. When queried about interventions put in place to address the issue, DON B stated We didn't suspect harm happened to Resident #101, so we didn't investigate it further. In an interview on 10/7/25 at 3:41pm, NHA A reported she witnessed Resident #100 in the hallway, appearing very emotionally upset, when she referred to Resident #101 as someone who was messed up in the head. NHA A reported she observed instances in which Resident #100 followed Resident #101 and boisterously announce his whereabouts around the facility. NHA A described Resident #100 as hyperaware of Resident #101's location. NHA A reported she also witnessed Resident #100 speak directly to Resident #101 in a voice that was too loud to use toward a resident with dementia, as she made repeated comments such as You can't go down there! You can't go down there!. NHA A reported she attempted to educate Resident #100 about appropriate interactions with others who had dementia, but Resident #100 had intellectual limitations. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/8/25 at 2:55pm, NHA A reported she was aware of a recent situation in which Resident #100 threatened that she would whoop his ass if Resident #101 came closer to her in the dining area. When queried, NHA A reported there was no investigation completed, and the facility had no documentation of any interventions that were put in place to avoid Resident #101 experiencing negative interactions with Resident #100. NHA A confirmed that verbal threats could be a type of abuse. NHA A agreed to provide any documentation the facility had regarding new interventions that were put in place to maintain Resident #101's safety from Resident #100 was requested. No additional information was received by the conclusion of the survey. In an interview on 10/7/25 at 4:01pm, DPOA GG reported on 9/11/25 she spoke with NHA A who told her Resident #101 was being verbally threatened by another resident. DPOA GG reported she asked NHA A what had been done to prevent the situation from reoccurring, but NHA A did not respond. Review of an Abuse policy with a reference date of 5/24/23 revealed POLICY OVERVIEW: Residents have the right to be free from abuse.DEFINITIONS: Mental abuse.The use of verbal or nonverbal conduct which may cause the resident to experience.intimidation, fear.agitation or degradation.Verbal Abuse: Use of oral.or gestured communication or sounds to residents within hearing distance regardless of their age, ability to comprehend, or disability. To include but not limited to harassment, mocking, insulting, ridiculing, yelling or hovering with the intent to intimidate, threatening, etc. Using the reasonable person concept, although Resident #101 was not able to verbally express his feelings related to being physically threatened, referred to in a derogatory manner, or mocked, it is reasonable to assume that Resident #101 experienced anxiety, intimidation and humiliation as the result of Resident #100's actions toward him.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of abuse to the State Agency for 2 (Resident #100 and Resident #101) of 2 residents reviewed for abuse. Findings include:Resident #100Review of an admission Record revealed Resident #100 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: Borderline intellectual functioning (indicating cognitive abilities below average, but not low enough to be classified as an intellectual disability), bipolar disease (a mental health condition that causes extreme mood swings), and anxiety disorder.Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 9/19/25 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #100 was cognitively intact. In an interview on 10/6/25 at 11:18 AM, Resident #100 reported she was involved in an incident with Resident #101, and he continued to make her angry. Resident #100 stated I told him if you don't leave me alone, I'm going to beat your ass.In a telephone interview on 10/7/25 at 1:03 PM, Licensed Practical Nurse (LPN) II reported there was a group of female residents, the mean girls, who would get irritated with other residents who had memory issues. LPN II reported this female group of residents would target, gang up, and pick on other residents. LPN II reported the behaviors and the things that were being said about other residents with memory issues by this group of female residents were discussed in the IDT (interdisciplinary) meetings, but it was not something we took very seriously. LPN II reported Resident #100 was one of the residents who made negative statements towards residents with memory issues. In an interview on 10/7/25 at 1:50 PM, Certified Nurse Assistant (CNA) Q reported Resident #100 was a part of the mean girl club and the group of residents would mock and target other residents.In an interview on 10/7/25 at 2:10 PM, Registered Nurse (RN) G reported that in the past it was reported to her by a CNA that Resident #100 was saying mean things to another resident.In an interview on 10/7/25 at 2:19 PM, CNA W reported she heard Resident #100 yelling in the dining room, and when she entered the dining room to see what was going on, she observed Resident #100 yelling I dare you to hit me at Resident #101. CNA W reported she also overheard Resident #100 saying He's not right in the head regarding Resident #101 to other residents sitting near her when she was removing Resident #101 from the dining room and taking him to the nurse's station. CNA W reported Resident #100 had been observed barking at Resident #101 and CNA W reported that Resident #100 would bully residents, who had cognition issues by making comments out loud to other residents about them. CNA W reported she did not recall exactly when that incident occurred, she thought it was a few weeks before Resident #101 discharged from the facility. CNA W reported she did report the situation to her nurse, who ensured she was able to tell DON B and NHA A, who were in a meeting together in DON B office at the time. CNA W confirmed when queried, that she did report Resident #100 yelling at Resident #101 directly to DON B and NHA A.In an interview on 10/7/25 at 3:18 PM, DON B reported she was previously Resident #100's full time nurse and was very familiar with her behaviors and reported that Resident #100 did not have any history of abusing any other residents in the building.In an interview on 10/8/25 at 10:40 AM, Activity Aide (AA) BB reported she observed a situation in the dining room where Resident #100 stated out loud she would hit him (Resident #101) if he came near her. AA BB reported she intervened and removed Resident #101 from the dining room area. AA BB reported she reported the situation to both DON B and NHA A. AA B reported the situation occurred within a couple of weeks before Resident #101 discharged from the facility, but she didn't know the exact date.Resident #101Review of an admission Record revealed Resident #101 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: dementia with behavioral disturbances (the loss of cognitive functioning including the ability to think, remember, or reason), cerebral infarction (stroke- interruption of blood floor to an area of the brain), and joint replacement surgery.Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 7/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 which indicated Resident #100 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment).In a telephone interview on 10/7/25 at 8:53 AM, Family Member (FM) GG reported Director of Nursing (DON) B told her Resident #101 was being targeted by 2 female residents in the building and they were threatening him and making verbal threats against him. In a telephone interview on 10/7/25 at 1:03 PM, Licensed Practical Nurse (LPN) II reported there was a group of residents who would get irritated with Resident #101 and this group was targeting Resident #101 and they would gang up on him

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to investigate an allegation of abuse for 2 (Resident #100 and Resident #101) of 2 residents reviewed for abuse resulting in the potential for allegation to not be thoroughly investigated and further abuse to occur. Findings include:Resident #100Review of an admission Record revealed Resident #100 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: Borderline intellectual functioning (indicating cognitive abilities below average, but not low enough to be classified as an intellectual disability), bipolar disease (a mental health condition that causes extreme mood swings), and anxiety disorder.Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 9/19/25 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #100 was cognitively intact.In an interview on 10/6/25 at 11:18 AM, Resident #100 stated I told him (Resident #101) if you don't leave me alone, I'm going to beat your ass. Resident #100 reported Resident #101 wandered around the facility and would make her angry when he was around her.In an interview on 10/8/25 at 10:40 AM, Activity Aide (AA) BB reported she observed a situation in the dining room where Resident #100 stated out loud she would hit him (Resident #101) if he came near her. AA BB reported she intervened and removed Resident #101 from the dining room area. AA BB reported she reported the situation to both DON B and NHA A and she did not provide a written statement about what happened between the two residents, when she was told this was something they were already dealing with, and no one asked for her to provide a written statement. Resident #101Review of an admission Record revealed Resident #101 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: dementia with behavioral disturbances (the loss of cognitive functioning including the ability to think, remember, or reason), cerebral infarction (stroke- interruption of blood floor to an area of the brain), and joint replacement surgery.Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 7/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 which indicated Resident #100 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment).In a telephone interview on 10/7/25 at 8:53 AM, Family Member (FM) GG reported Director of Nursing (DON) B told her Resident #101 was being targeted by 2 female residents in the building and they were threatening him and making verbal threats against him. In a telephone interview on 10/7/25 at 1:03 PM, Licensed Practical Nurse (LPN) II reported there was a group of residents who would get irritated with Resident #101 and this group was targeting Resident #101 and they would gang up on him with their complaints.In an interview on 10/7/25 at 2:19 PM, CNA W reported she observed an incident where Resident #101 was the victim/target when Resident #100 was yelling I dare you to hit me and barking at and stating out loud He's not right in the head while both residents were in the dining room, with other residents in the room. When queried, CNA W reported she did not recall any other questions from DON B or NHA A regarding the situation between Resident #100 and Resident #101. In an interview on 10/8/25 at 2:22 PM, DON B reported she remembered when CNA W came into a meeting and mentioning that Resident #100 and Resident #101 were separated. DON B reported that nothing that was told to her about the situation indicated that abuse had occurred. DON B reported no contact was made between the two residents, no profanity was used, no one was harmed, none of that indicated abuse or that anything needed to be investigated.In an interview on 10/8/25 at 2:54 PM, NHA A reported there was a continuous situation between Resident #100 and Resident #101 and the incident that was reported by CNA W regarding Resident #100 and Resident #101 was investigated in the moment, but nothing more came of the situation. NHA A reported she did not recall the situation reported by AA BB.Review of facility policy Abuse with a date of 5/24/2023 revealed .The facility will develop and implement written policies and procedures that include. investigating abuse.The facility will educate their staff.identify what constitutes abuse.investigation.to investigate all alleged violations.identify the staff responsible for the investigation. determining the purpose of the investigation. interviewing all involved persons, including the alleged victim, perpetrator, witnesses, others who might have knowledge of the allegations.Mental abuse the use of verbal or nonverbal conduct which may cause the resident to experience humiliation, intimidation, fear, shame, agitation.Verbal Abuse use of oral, written or gestured communication and sounds to residents within hearing distance. to include but not limited to harassment, mocking, insulting, ridiculing, yelling or hovering with intent to intimidate, threatening, etc

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F 0627 Level of Harm - Actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2616813Based on observation, interview and record review, the facility failed to prevent an unnecessary discharge by providing individualized care for 1 of 1 resident (Resident #101) reviewed for discharge, resulting in Resident #101 being abruptly discharged from the setting in which he was familiar, to an unfamiliar locked memory care unit and subsequently experiencing increased anxiety, agitation and emotional distress requiring pharmacological treatment.Findings include:Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: dementia (general term used for loss of memory, language, thinking skills that interfere with daily life) with behavioral disturbance.Review of a Minimum Data Set (MDS) assessment for Resident #101 with a reference date of 9/11/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 3/15, which indicated the resident was severely cognitively impaired. Section E of the MDS revealed Resident #101 did not display the presence of wandering during the 7-day assessment period.Review of a Care Plan for Resident #101 with a reference date of 7/23/25 revealed the following focus/goal/interventions: Focus: Altered behavior in which resident acts (are) sic characterized by ineffective coping skills.Goal: Decrease episodes of anxiety.Interventions.if (Resident #101) becomes agitated in congested areas assist him into a less congested area. Involve resident in 1:1 recreational activity, keep schedules routine and predictable. Review of a Behavior Monitoring and Interventions Report for Resident #101 with a reference date of 8/1-9/9/25, revealed the resident had no behaviors for on 34/40 days. Resident #101 had 2 occurrences of swearing, expressing frustration, agitation/restlessness, 1 episode of wandering/exit seeking, 1 episode of pushing and 1 episode of hitting staff.In an interview on 10/7/25 at 12:58pm, Unit Manager/Registered Nurse (UM/RN) II reported Resident #101 was redirectable and had no unsafe situations regarding his behaviors. UM/RN II reported the facility was concerned about other residents who were ganging up on (Resident #101) because of his memory issues and because he spent much of his time maneuvering his wheelchair through the common areas of the facility. UM/RN II reported the decision to send admission referrals for Resident #101 to seek a transfer to another facility, was made by the Interdisciplinary Team (IDT). When further queried, UM/RN II reported Nursing Home Administrator (NHA) A and Director of Nursing (DON) B decided to send admission referrals out for Resident #101. When asked about interventions the facility put in place regarding other residents ganging up on Resident #101, UM/RN II reported the only intervention was to encourage staff to supervise him as available.In an interview on 10/7/25 at 1:53pm, Certified Nursing Assistant (CNA) U reported she cared for Resident #101 and felt he did not have any behavioral issues that could not be managed at the facility. CNA U reported staff were told the keep a better eye on Resident #101 related to how other residents treated him.In an interview on 10/7/25 at 2:21pm, Assistant Director of Nursing (ADON) F reported Resident #101 wandered at times but was easily redirected, and that he seemed content at the facility. ADON F reported another resident was frustrated with Resident #101because he wandered through the common areas. ADON F reported the facility initiated transferring Resident #101 to another facility, but she was unsure why.In an interview on 10/7/25 at 8:53am, DPOA GG reported she received a telephone call on 9/11/25 from Admissions Coordinator (AC) Z at approximately 1:00pm, who told her Resident #101 had to transfer to another skilled nursing facility on this date. DPOA GG reported she was told she had to come to the facility immediately to transport the resident and was never given the option of appealing the discharge and was not told this discharge was voluntary. DPOA GG reported she was aware the facility had decided to send admission referrals to other nearby facilities due to Resident #101's need for dementia care, but she wanted to keep the resident where he was because he seemed content, recognized some staff members, and had developed a daily routine that included maneuvering his wheelchair around the facility. DPOA GG reported Resident #101 liked to walk the sun in the halls. DPOA GG reported during her visits when Resident #101 would get antsy she would walk next to him, while he was in is wheelchair and they would walk down each hall, touch the door at the end, return to the beginning of the hall, and then walk down the next hall, until they returned to his room; due to the shape of the hallways (4 halls branching from the circle in the middle) she referred to the activity as walking the sun. DPOA GG reported Resident #101 wandered as a stress relief. DPOA GG reported she insisted on meeting with Nursing Home Administrator (NHA) A when she arrived at the facility to transport the resident to another facility on 9/11/25. During the meeting she was told the facility felt Resident #101 needed to move immediately because he was wandering

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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 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 notification was completed for 1 resident (Resident #101) of 2 residents reviewed for the discharge process, resulting in Resident #101's Durable Power of Attorney (DPOA) GG not receiving written notification of the reason for discharge and the right to appeal.Findings include:Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: dementia (general term used for loss of memory, language, thinking skills that interfere with daily life) with behavioral disturbance.Review of a Minimum Data Set (MDS) assessment for Resident #101 with a reference date of 9/11/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 3/15, which indicated the resident was severely cognitively impaired. Section E of the MDS revealed Resident #101 did not display the presence of wandering during the 7-day assessment period.Review of a Care Plan for Resident #101 with a reference date of 7/23/25 revealed the following focus/goal/interventions: Focus: Altered behavior in which resident acts (are) sic characterized by ineffective coping skills.Goal: Decrease episodes of anxiety.Interventions.if (Resident #101) becomes agitated in congested areas assist him into a less congested area. Involve resident in 1:1 recreational activity, keep schedules routine and predictable.In an interview on 10/7/25 at 8:53am, DPOA GG reported she received a telephone call on 9/11/25 from Admissions Coordinator (AC) Z at approximately 1:00pm, who told her Resident #101 had to transfer to another skilled nursing facility on that date. DPOA GG reported she was told she had to come to the facility immediately to transport the resident and was never given the option of appealing the discharge and was not told this discharge was voluntary. DPOA GG reported when she arrived at the facility, Nursing Home Administrator (NHA) A told her Resident #101 was being harassed by another resident and had to leave. DPOA GG reported if given the choice, she wanted Resident #101 to remain at the facility because he had adjusted to living there.In an interview on 10/7/25 at 3:41pm, NHA A confirmed DPOA GG was not given a written notification of discharge that included the rationale for discharge when Resident #101 was abruptly discharged on 9/11/25. Review of a Transfers and Discharge policy with a reference date of 4/18/25 revealed The facility transfer/discharge notice will be provided to the resident and the resident's representative in a language and manner in they can understand. The notice will include the following at the time it is provided: The specific reason and basic for transfer or discharge.an explanation of the right to appeal.information on how to obtain an appeal form, information on obtaining assistance in completing and submitting the appeal hearing request.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement person centered individualized care plan interventions for 2 (Resident #100 and Resident #101) of 5 residents reviewed for person centered individualized care plans resulting in the potential for residents to not attain or maintain their highest practicable physical, mental, and psychosocial well-being.Findings include:Resident #100Review of an admission Record revealed Resident #100 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: Borderline intellectual functioning (indicating cognitive abilities below average, but not low enough to be classified as an intellectual disability), bipolar disease (a mental health condition that causes extreme mood swings), and anxiety disorder.Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 9/19/25 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #100 was cognitively intact.In an interview on 10/6/25 at 11:18 AM, Resident #100 reported she had problems managing her anger, she didn't know what would come out of her mouth, and she was afraid of what she could do when she was angry. Resident #100 reported Resident #101 kept getting her angry and she told Resident #101 she would beat his ass if he didn't leave her alone.Review of Care Plan for Resident #100 revealed .has hx (history) of suspiciousness of other patients entering room.with interventions including: assist resident to develop more appropriate methods of coping and interactions, do not invade personal space, if reasonable discuss the resident's behavior, intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation, and take to alternat location as needed, monitor behavior episodes; all initiated on 5/2/24.In an interview on 10/7/25 at 2:02 PM, Minimum Data Set/Registered Nurse (MDS/RN) E reported that each department was responsible for their own care plan and the interdisciplinary team worked together to update care plan interventions as needed. MDS E reported that Resident #100 would occasionally yell out but did not have any other behavioral issues she was aware of, nor anything she was being monitored for.In an interview on 10/7/25 at 3:42 PM, Nursing Home Administrator (NHA) A reported Resident #100 was increasingly angry with her due to consequences of an incident with Resident #101. NHA A reported she believed that Resident #100 was fixated on Resident #101 after the incident. When queried regarding what interventions the facility put into place regarding Resident #100, NHA A replied we tried to keep them separated, and we passed the information word of mouth, the staff was aware, I don't know what we put into place exactly, or if care plans were updated, or what we did differently.In an interview on 10/8/25 at 9:47 AM, Certified Nurse Assistant (CNA) R and CNA P reported they did not have to monitor Resident #100 for any behaviors.In an interview on 10/8/25 at 9:51 AM, Registered Nurse (RN) I reported she was not aware of any reason Resident #100 would need to be monitored.In an interview on 10/8/25 at 10:15 AM, Licensed Practical Nurse (LPN) J reported she did not provide care for Resident #100 and did not need to monitor any of her behaviors.In an interview on 10/8/25 at 10:20 AM, CNA U reported she did not have to monitor Resident #100, she was independent. In an interview on 10/8/25 at 11:25 AM, MDS/RN E reported that social work care plans were updated remotely by the corporate social worker and the ADON prior to the social work position being filled.In an interview on 10/7/25 at 10:05 AM, Nursing Home Administrator (NHA) A reported the assistant director of nursing was responsible for the clinical side of the social services role when there was not social worker from July 2025 to the middle of September 2025. Resident #101Review of an admission Record revealed Resident #101 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: dementia with behavioral disturbances (the loss of cognitive functioning including the ability to think, remember, or reason), cerebral infarction (stroke-interruption of blood floor to an area of the brain), and joint replacement surgery.Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 7/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 which indicated Resident #100 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment).Review of IDT late entry note for Resident #101 dated 9/5/25 at 12:35 PM, revealed .wandering throughout the facility per usual today and is easily redirectableReview of IDT note for Resident #101 dated 9/8/25 at 9:42 AM, revealed .met with resident this morning who is wandering down hallway per baseline. Resident remains confused per baseline and easily redirectable. In a telephone interview on 10/7/25 at 8:53 AM, Durable Power of Attorney (DPOA) GG reported Resident #101 liked to walk the sun in the halls. DPOA GG reported during her visits when Resident

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

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2616813Based on interview and record review, the facility failed to provide medically related social services to support the mental and psychosocial health of 2 (Resident #101 and Resident # 100) of 3 residents reviewed for social services resulting in a lack of advocacy for Resident #101's rights, and a lack of individualized behavior management interventions and discharge planning for Resident #100 and Resident #101.Findings include:Resident #101Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: dementia (general term used for loss of memory, language, thinking skills that interfere with daily life) with behavioral disturbance.Review of a Minimum Data Set (MDS) assessment for Resident #101 with a reference date of 9/11/25, revealed a Brief Interview for Mental Status (BIMS) assessment score of 3/15, which indicated the resident was severely cognitively impaired. Section E of the MDS revealed Resident #101 did not display the presence of wandering during the 7-day assessment period.Review of a Care Plan for Resident #101 with a reference date of 7/23/25 revealed the following focus/goal/interventions: Focus: Altered behavior in which resident acts (are) sic characterized by ineffective coping skills.Goal: Decrease episodes of anxiety. Interventions.if (Resident #101) becomes agitated in congested areas assist him into a less congested area. Involve resident in 1:1 recreational activity, keep schedules routine and predictable. Resident #101's care plan reflected no interventions related to wandering or maintaining his safety around other residents who were frustrated by him.Review of Progress Notes for Resident #101 with a reference date of 7/7-10/8/25 revealed no social work interventions documented.In an interview on 10/7/25 at 8:53am, DPOA GG reported she received a telephone call on 9/11/25 from Admissions Coordinator (AC) Z at approximately 1:00pm, who told her Resident #101 had to transfer to another skilled nursing facility on this date. DPOA GG reported she was told she had to come to the facility immediately to transport the resident and was never given the option of appealing the discharge and was not told this discharge was voluntary. DPOA GG reported she was aware the facility had decided to send admission referrals to other nearby facilities due to Resident #101's need for dementia care, but she wanted to keep the resident where he was because he seemed content, recognized some staff members, and had developed a daily routine that included maneuvering his wheelchair around the facility.In an interview on 10/7/25 at 12:58pm, Unit Manager/Registered Nurse (UM/RN) II reported Resident #101 was redirectable and had no unsafe situations regarding his behaviors. UM/RN II reported the facility was concerned about other residents who were ganging up on (Resident #101) because of his memory issues and because he spent much of his time maneuvering his wheelchair through the common areas of the facility. UM/RN II reported the decision to send admission referrals for Resident #101 to seek a transfer to another facility, was made by the Interdisciplinary Team (IDT). When further queried, UM/RN II reported Nursing Home Administrator (NHA) A and Director of Nursing (DON) B decided to send admission referrals out for Resident #101. When asked about interventions the facility put in place regarding other residents ganging up on Resident #101, UM/RN II reported the only intervention was to encourage staff to supervise him as available.In an interview on 10/7/25 at 2:21pm, Assistant Director of Nursing (ADON) F reported Resident #101 wandered at times but was easily redirected, and that he seemed content at the facility. ADON F reported another resident was frustrated with Resident #101because he wandered through the common areas. ADON F reported the facility initiated transferring Resident #101 to another facility, but she was unsure why.In an interview on 10/7/25 at 3:41pm, Nursing Home Administrator (NHA) A reported Resident #101 was discharged because he was having increased behaviors a little bit including wandering. NHA A reported Resident #101 would propel his wheelchair up to exit doors and push the release bar but did not have enough strength to open the door, and wasn't trying to get out. When asked about additional interventions were put in place to address Resident #101's behaviors related to his dementia, NHA A stated I don't know. NHA A reported she became increasingly concerned for Resident #101's safety when Resident #100 became frustrated with him, made a verbal threat toward him, began announcing his whereabouts regularly and asked, why do we have to people that are messed up in the head, referring to Resident #101. When queried about interventions put in place to maintain Resident #101's safety, NHA A reported she attempted once to educate the other resident about dementia, but the resident was upset and did not receive the information. NHA A reported Resident #100 was able to discharge any time she wants to but it's not her goal. NHA A then reported the facility did not have a social worker at that

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain clear and accurate medical records for 2 (Resident #100 and Resident #101) of 5 residents reviewed for clear and accurate medical records resulting in an incomplete reflection of resident's behaviors, ongoing care needs, and the need for Resident #101 to discharge from the facility. Findings include:Resident #100 Review of an admission Record revealed Resident #100 was a female who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: Borderline intellectual functioning (indicating cognitive abilities below average, but not low enough to be classified as an intellectual disability), bipolar disease (a mental health condition that causes extreme mood swings), and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 9/19/25 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #100 was cognitively intact. Review of Care Plan for Resident #100 revealed .has hx (history) of suspiciousness of other patients entering room.with interventions including: assist resident to develop more appropriate methods of coping and interactions.intervene as necessary to protect the rights and safety of others.monitor behavior episodes; all initiated on 5/2/24. In an interview on 10/7/25 at 2:19 PM, CNA W reported she heard Resident #100 yelling in the dining room, and when she entered the dining room to see what was going on, she observed Resident #100 yelling I dare you to hit me at Resident #101. CNA W reported she also overheard Resident #100 saying He's not right in the head regarding Resident #101 to other residents sitting near her. Review of Resident #100's medical record revealed no noted documentation regarding a yelling incident between her and Resident #101. In an interview on 10/7/25 at 3:42 PM, Nursing Home Administrator (NHA) A reported she believed that Resident #100 was fixated on Resident #101 after a resident-to-resident altercation at occurred on 9/4/25. NHA A reported staff was informed after the incident, via word of mouth to monitor Resident #100 and Resident #101's interactions. In an interview on 10/7/25 at 1:50 PM, Certified Nurse Assistant (CNA) Q reported Resident #100 was a part of the mean girl club; a group of residents who would mock and target other residents. CNA Q was unaware of any behaviors that needed to be monitored in Resident #100. In an interview on 10/7/25 at 3:18 PM, Director of Nursing (DON) B reported after the resident-to-resident incident with Resident #101, Resident #100 was focused on Resident #101. DON B reported that Resident #100 stated to her she would beat his ass speaking of Resident #101. DON B reported Resident #100 regularly said things like that and that she was familiar with her behaviors. In an interview on 10/8/25 at 9:47 AM, Certified Nurse Assistant (CNA) R and CNA P reported they did not have to monitor Resident #100 for any behaviors. (continued on next page)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/8/25 at 9:51 AM, Registered Nurse (RN) I reported she was not aware of any reason Resident #100 would need to be monitored. In an interview on 10/8/25 at 10:15 AM, Licensed Practical Nurse (LPN) J reported she did not provide care for Resident #100 and did not need to monitor any of her behaviors. In an interview on 10/8/25 at 10:20 AM, CNA U reported she did not have to monitor Resident #100, she was independent. Review of Behavior Monitoring and Interventions Report for Resident #100 from 8/1/25 to 10/1/25 revealed all documented entries were no behaviors observed. Resident #101 Review of an admission Record revealed Resident #101 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: dementia with behavioral disturbances (the loss of cognitive functioning including the ability to think, remember, or reason), cerebral infarction (stroke-interruption of blood floor to an area of the brain), and joint replacement surgery. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 7/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 4/15 which indicated Resident #100 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment). Review of IDT late entry note for Resident #101 dated 9/5/25 at 12:35 PM, revealed .wandering throughout the facility per usual today. In a telephone interview on 10/7/25 at 8:53 AM, Family Member (FM) GG reported Resident #101 wandered as a stress relief and was often confused on where is room was; FM GG reported Resident #101 had 3 different rooms during his stay. In a telephone interview on 10/7/25 at 10:54 AM, admission Coordinator (AC) C reported Resident #101 was adamant in his exit seeking and entering other resident's rooms when he was in the facility. In an interview on 10/7/25 at 2:02 PM, MDS E reported Resident #101 was often wheeling around the building, wandering. In an interview on 10/7/25 at 1:46 PM, LPN L reported Resident #101 would spend all day going up and down the hallways. In an interview on 10/7/25 at 1:50 PM, CNA Q reported that Resident #101 would wander down the halls and sit at the door and look outside. In an interview on 10/7/25 at 3:18 PM, DON B reported a couple of weeks before Resident #101 discharged his behaviors increased, he was wandering more, he was more agitated, and he was escalating faster than before. DON B reported Resident #101 disease process was advancing, and he required a more specialized secure unit for his increased care needs. DON B confirmed Resident #101 discharged on 9/11/25. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 10/7/25 at 3:42 PM, NHA A reported Resident #101 was experiencing increased behaviors, wandering up and down the hallways, at the exit doors and pushing on the doors. NHA A reported Resident #101 needed a more specialized dementia like care for his safety. Review of Care Plan for Resident #101 revealed altered behavior in which resident acts characterized by ineffective coping; verbal/physical aggression. related to agitation.Interventions initiated on 7/24/25 included administer medications per MD (doctor) orders, becomes agitated in congested areas, assist him into a less congested area, involve resident in 1:1 recreational activity, keep schedules routine. No documented indication that Resident #101 wandered the building, was unable to locate his room, or that he would enter other resident's rooms. Review of Behavior Monitoring and Interventions Report for Resident #101 from 8/29/25 to 9/11/25 revealed Resident #100 had two documented episodes of cussing, frustration, and agitation and one documented episode of being anxious, screaming, and hitting in the two weeks prior to discharge. No documentation was noted regarding Resident #101 wandering. In an interview on 10/8/25 at 9:47 AM, CNA R and CNA P reported Resident #101 wandered around the facility, in and out of other resident's rooms. In an interview on 10/8/25 at 9:51 AM, Registered Nurse (RN) I reported Resident #101 wandered around the building and didn't know how to get to his room. Review of Behavior Monitoring and Interventions Report for Resident #101 from 8/1/25 to 9/11/25 revealed 13/81 documented entries included a specific behavior was observed. Of those 13 documented entries, elopement/exit seeking was documented 1 time. Wandering, while an option, was never documented for Resident #101. In an interview on 10/7/25 at 3:41pm, NHA A confirmed DPOA GG was not given a written notification of discharge that included the rationale for discharge when Resident #101 was abruptly discharged on 9/11/25. NHA A confirmed the notification of discharge should be provided and uploaded into the resident's medical record. Review of a Provider Discharge Summary for Resident #101 with a reference date of 9/11/25 at 8:00am, revealed Dementia.with behavioral disturbance: Patient appears stable, he is non-verbally communicating at this time, but is cooperative. Medications: Continue- Rivastigmine transdermal patch.Notes. (Resident #101) . is being discharged today from this facility and transferring to (name of facility omitted). He has behavioral and mental health changes and appears stable on his current medication regime. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Transfers and Discharge policy with a reference date of 4/18/25 revealed .GENERAL GUIDELINES: .Once admitted , the resident has the right to remain at the facility unless their transfer or discharge meets one of the following specified exemptions: The discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.DISCHARGE WHEN NEEDS CANNOT BE MET OR SAFETY OR HEALTH OF INDIVIDUALS IS ENDANGERED: The facility's transfer/discharge notice will be provided to the .resident's representative.For circumstances where the discharge.is necessary for the resident's welfare and the facility cannot meet the resident's needs.the resident's physician must document information about the basis for the discharge and will include: The specific reason resident needs the facility could not meet, the facility efforts to meet those needs and the specific services the receiving facility will provide to meet the needs of the resident which cannot be met at the current facility.

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Optalis Health and Rehabilitation of Three Rivers	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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hire a qualified full-time social worker in a facility with more than 120 beds. Deficiency Text Not Available