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	10/22/2025

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 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. (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 0628 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 1) provide the resident representative a written notice for a bed hold upon a transfer to the hospital and 2) follow up with the resident/responsible party and document the follow up in the resident's medical chart for 1 resident (Resident #1) of 1 resident reviewed for hospital transfers resulting in the potential for a resident and/or resident's representative being uninformed of the bed hold policy.Findings include: Resident #1 (R1)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R1's initial admission date to the facility was on 10/16/2024 with pertinent diagnoses including dementia (decline in mental abilities such as memory, thinking and reasoning that is severe enough to interfere with daily life) and depression. Brief Interview for Mental Status (BIMS) reflected a score of 4 out of 15 which indicated R1 was severely cognitively impaired (00 to 07 is severe cognitive impairment). R1 was transferred to the hospital on [DATE] and returned to the facility on [DATE] with a closed left femoral neck fracture that required surgical intervention.During an interview on 10/20/2025 at 12:09 PM, FM E stated that the facility did not talk to her about holding R1's bed when R1 transferred to the hospital for her fracture but she was hoping R1 was going back to the facility because she could not take care of her at home. FM E was glad that they brought her back to the facility.Review of R1's chart revealed that there was no bed hold documentation or bed hold notice document found. During a phone conversation on 10/20/2025 at 12:30 PM, Licensed Practical Nurse (LPN) M stated that she sent a bed hold notice with R1with other paperwork when she went to the hospital which is standard protocol. LPN M said the nurse sends the paperwork with the resident and then management follows up with the resident/responsible party. During an interview on 10/20/2025 at 12:42 PM, Licensed Vocational Nurse (LVN) F stated the bed hold notice is at the nurses' station and is given to the resident to sign at the time of transfer to the hospital along with other items in the transfer packet. LVN F said then she makes a copy and gives it to management to follow up on. An email from Nursing Home Administrator (NHA) A on 10/21/2025 at 8:48 AM revealed When sending a resident out they get the bed hold policy and send it with the other paperwork. We attempted to call the daughter several times but were not successful. The hospital doesn't send a copy back.During an interview on 10/22/2025 at 8:50 AM, admission Director (AD) C stated that upon admission, residents are given a copy of the bed hold policy along with their admission paperwork. AD C said she explains what it means at the time and then the nurses are responsible for giving the bed hold notice to the resident/resident's representative upon transfer to the hospital. AD C stated that the Business Office Manager (BOM) follows up with the resident/resident's representative when there is a transfer to hospital to see if they would like to hold the bed. During an interview on 10/22/2025 at 9:00 AM, BOM S stated that the bed hold policy is given and explained upon admission by AD C and the clinical team sends a copy with the resident when there is a hospital transfer. BOM S said then AD C calls and follows up with the resident/responsible party to see if they want to hold the bed per facility policy. BOM S said that follow up should occur no matter what the payor source is per facility policy. During an interview on 10/22/2025 at 10:39 AM, Director of Nursing (DON) B stated that AD C gives the initial bed hold policy upon admission and then the nurses sends the bed hold notice to residents when they are sent out to the hospital and then BOM S follows up the resident/responsible party afterwards to see if they want to hold the bed. For R1, DON B stated that they don't keep a copy of the bed hold notice and that NHA A tried to contact R1's responsible party and had notes in R1's chart. During an interview on 10/22/2025 at 11:36 AM, NHA A stated that she didn't document anything in R1's chart because she knew R1 was coming back to the facility so she didn't see the need to call the responsible party about the bed hold. NHA A said she wasn't sure what the facility policy said but that AD C was in charge of the bed hold follow up. Review of the Bed Hold Procedure with a revision date of 4/18/2023 revealed Policy Overview: Upon a resident's transfer for hospitalization, the facility will provide the resident and the resident representative written notice which specifies the duration of the bed hold policy and address information explaining the return of the resident to the next available bed. Procedure. Upon discharge for emergency medical treatment the facility's admissions director or designee will attempt to contact the resident and/or the resident's representative within 24 hours and/or the next business day to confirm their decision related to a bed hold and document their attempt(s) and/or the resident's representatives bed hold decision in the resident's record. The admission Director or designee will also send a copy of the Bed Hold Notice to the resident's representative via e-mail or postal mail and

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2641096.Based on observation, interview, and record review, the facility failed to ensure adequate supervision to prevent resident to resident abuse for 1 resident (Resident #1) of 3 residents reviewed for abuse, resulting in Resident #2 who had a history of delusions, hallucinations and aggression, pushed Resident #1. Resident #1 fell and sustained a closed left femoral neck (hip bone) fracture and subsequent surgical intervention. Findings include: Review of the Facility Report Incident (FRI) initial report to the State Agency on 10/11/2025 revealed {Licensed Practical Nurse (LPN) M} notified the Administrator that at approximately 11:30 AM resident (Resident #1) was observed on the floor near the doorway of resident (Resident #2's) room. Upon assessment, (Resident #1) reported pain in her left hip, accompanied by impaired range of motion. resident was transported to the emergency room for further evaluation. Statements: (LPN M): LPN M reported that during her interview with (Resident #2), he verbalized that he pushed the female resident (Resident #1) because she was entering his room and he did not want her in there. (LPN M) also stated that (Resident #1) told her, That man pushed me.Resident #1 (R1)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R1's initial admission date to the facility was on 10/16/2024 with pertinent diagnoses including dementia (decline in mental abilities such as memory, thinking and reasoning that is severe enough to interfere with daily life) and depression. Brief Interview for Mental Status (BIMS) reflected a score of 4 out of 15 which indicated R1 was severely cognitively impaired (00 to 07 is severe cognitive impairment). R1 was transferred to the hospital on [DATE] and returned to the facility on [DATE] with a closed left femoral neck fracture that required surgical intervention.Review of R1's hospital records dated 10/11/2025 revealed .Summary: (R1) is a 78 y.o. female with PMHx (past medical history) of dementia who presented to the ED (emergency department) from SNF (Skilled Nursing Facility) after an unwitnessed ground level fall in the hallway. She was reportedly pushed by another resident after she walked into the wrong room. Unknown how long she was down. Patient is on Hospice but she and daughter, her DPOA (durable power of attorney), agrees to revoke Hospice for surgery with plan to go back on Hospice after. Patient denies any pain currently. ED Course: X-ray of the left hip showed a left femoral neck fx (fracture) with possibility of a superior pubic rami fx (fracture) . Orthopedic surgery was consulted.asked to admit.Review of R1's Discharge GG Evaluation dated 10/11/2025 revealed that R1 was independent with transfers prior to discharge to the hospital.During a phone interview on 10/20/2025 at 12:09 AM, Family Member (FM) E stated that R1 wandered around the facility independently since admission and could do ADLs (Activities of Daily Living) independently with some encouragement by staff prior to the incident.During a phone interview on 10/20/2025 at 11:53 AM, LPN M stated that she did not witness the incident on 10/11/2025. She said she was at the nurses' station and R1 was at the nurses' station and shortly after that CNA N came to her and said R1 was on the floor outside of R2's door, LPN M stated that R1 said that man pushed me (referring to R2). LPN M reported that since R1 came back from hospital, that she (R1) needs assistance with ADLs and walking where she was independent prior to the incident only needing guidance for the order of doing certain tasks such as pulling up her pants after using the bathroom. During an interview and observation on 10/20/2025 at 8:42 AM, R1 was lying in bed and said she needed to use the bathroom. She appeared confused and wasn't sure if she needed staff to help her use the bathroom. R1 did not remember the incident, how she got the fracture, or that a resident pushed her. Review of R1's admission Evaluation dated 10/16/2024 revealed .VII. Elopement.2. Mental Status: disoriented, wanders aimlessly. 3. Mobility: is independent with locomotion with or without an assisted device including a wheelchair.6. Wandering/exit seeking: behaviors redirectable .Review of R1's Behavior log from 7/1/2025 to 10/21/2025 revealed there were 12 days of documented behaviors related to wandering out of 112 days reviewed and with the question Has the resident exhibited this behavior before? yes was documented. Review of R1's care plan for behavior revealed At risk for changes in behavior and mood related to depression, anxiety, dementia, history of CVA (cardiovascular accident), cognitive communication deficit. Date initiated: 10/6/2025. interventions/tasks.encourage resident to attend activities of choice, date initiated 10/20/2025, evaluate for physical needs: hunger, thirst, positioning, toileting, pain, cold/warm, etc , date initiated 10/20/2025. May attempt distraction interventions: music, activities, relaxation techniques, positioning, etc., date initiated 10/6/2025, non-pharmacological interventions: invite to activities and talk with resident about cooking, jewelry making, animals (dogs/cats), watching tv (all kinds), music (country), date