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	04/02/2026

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 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** This citation pertains to intake #2736915.Based on interview and record review, the facility failed to honor resident preferences regarding heating/reheating his favorite foods brought in by family in 1 (Resident #1) of 3 residents reviewed for resident rights resulting in feelings of frustration, not being able to enjoy his favorite foods and potentially causing further weight loss. 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 6/26/2025 with pertinent diagnoses including Alzheimer's Disease (neurological disorder characterized by memory loss, cognitive decline and brain shrinkage), depression and severe protein calorie malnutrition (deficiency of protein, carbohydrates and fats leading to severe wasting, weight loss and edema). Brief Interview for Mental Status (BIMS) reflected a score of 2 out of 15 which indicated R1 was severely cognitively impaired. R1started Hospice care on 1/24/2026 and discharged from the facility on 2/18/2026.During an interview on 3/27/2026 at 2:26 PM, Family Member (FM) GG stated that the previous Nursing Home Administrator (NHA) C told her and her family to only bring shelf stable foods for R1 and told her to not bring food that had to be heated/reheated unless they did it themselves when they were there. FM GG said that NHA C said that she didn't trust the facility staff to heat and serve his meals. FM GG reported that this caused frustration since she couldn't bring R1's favorite foods in unless she was there to serve it to him and she was worried since he had weight loss. During an interview on 4/1/2026 at 11:07 PM, Registered Dietitian (RD) JJ stated R1 had a slow decline for months and had weight loss where she was working with the family to get R1's favorite foods on meal trays and nutritional supplements to prevent further weight loss. RD KK said that NHA C had a heating/reheating food issue and the family struggled with it. RD JJ said that the family was told to only bring food that was shelf stable or food that could be refrigerated and nothing that had to be heated up. During an interview on 4/1/2026 at 1:04 PM, Certified Nursing Assistant (CNA) K stated that staff have been told that they cannot heat/reheat resident foods. CNA K said they can only make popcorn in the breakroom for residents. CNA K stated I don't know why we can't take food to the kitchen and have them warm up it up. During an interview on 4/1/2026 at 1:40 PM, Corporate RD (CRD) KK stated that she wasn't sure what the facility policy said regarding heating/reheating food but outside food wasn't allowed in the kitchen. CRD KK said that family or facility staff can reheat food in the break room.During an interview on 4/2/2026 at 12:10 PM, NHA A and Agency Licensed Practical Nurse (LPN) FF stated that they were unaware of the heating/reheating food issue with R1. NHA A said residents should be able to heat foods up and enjoy it and facility staff should take it to the kitchen and have them take the temperature to make sure it is safe for them to consume. LPN FF said that there was a sign in the breakroom that said staff can only use the microwave to make popcorn for residents and they can't heat food up since there wasn't a thermometer there. When discussing the Outside Food Policy and the contradiction of what staff was told, NHA A said he would have to follow up on the issue. Review of the Outside Food Policy with an approval date of 10/2/2023 revealed . Guidelines: The facility will accommodate resident need to store food from the outside and reheat food safely. Reheating foods (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from the outside Foods from the outside can never be reheated using the main kitchen. Facilities may offer microwaves for reheating on the unit. Residents must ask a facility employee to reheat their food. Employees should never allow the resident to reheat themselves. Family members may have access to the microwave. Safe reheating methods shall be posted in each microwave area. Facilities shall provide temperature monitoring in each microwave area

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise a fall care plan for 2 residents (Resident #2, Resident #3) of 3 residents reviewed for fall care plan revision resulting in the potential for inaccurate care interventions that could potentially cause further falls. Findings include: Resident #2 (R2)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R2's pertinent diagnoses included history of falling, muscle weakness, left femur fracture (thighbone fracture) and cervical vertebrae fracture (neck fracture). Brief Interview for Mental Status (BIMS) reflected a score of 13 out of 15 which indicated R2 was cognitively intact.During an interview on 3/31/2026 at 2:12 PM, R2 stated that he had a neck fracture before he came to the facility and then he was set to go home from the facility and he had another fracture when he was out at a restaurant with friends. R2 said he had a few falls at the facility too. Review of the fall report dated 2/9/2026 revealed .Incident Description: Patient was observed on the floor. Resident indicated he was trying to transfer to bed.Pt (patient) noncompliant with asking for assistance to transfer from wheelchair to bed.Was notified of patient fall, patient states he was trying to get himself to bed independently. No apparent injury.Review of the progress note dated 2/11/2026 revealed IDT (Interdisciplinary Team) met to review residents recent fall without injury. Wide bed in place already and resident continues to fall out of bed. Resident continues to be non-compliant with fall interventions despite education. BIMS 13 indicating that resident is cognitively intact and able to retain education. Resident has been witnessed frequently sleeping in bed with his legs dangling off the side of the bed and will potentially benefit from extra support such as an enabler bar. Enabler bar (bed assist bar designed to help individuals with limited mobility get in and out of bed safely) ordered for immediate intervention.Review of R2's Care Plan revealed .Focus: At risk for falls secondary to hx (history) of falling with fracture, unsteadiness, pain, potential side effects from medications, poor safety awareness. Resident will refuse to follow fall risk precautions.recent fall outside of facility.Interventions/Tasks: Enabler bar to bed. Date initiated 2/11/2026.Review of R2's Kardex (resident information that Certified Nursing Assistants have access to) revealed Safety: .enabler bar to bed.Review of R2's orders revealed that there were no orders for the enabler bar.During an observation on 4/1/2026 at 2:48 PM, it was noted that R2's bed did not have enabler bars.Review of R2's progress note dated 3/15/2026 revealed At 1125 CNA (Certified Nursing Assistant) alerted me to the resident (R2) being on the floor. I went in the room and observed resident on the floor face down with his head against the bathroom door. He was alert and told me he hit his head. I asked him how he ended up like that, and he stated, I do not know. Previous to the fall he was alert but drowsy. He kept falling asleep in his wheelchair, and stated he did not sleep well the night before. he has a large hematoma (collection of clotted blood trapped in tissue) on his upper R (right) forehead with another raised contusion (bruise) above it in his scalp. Pt pupils are sluggish and won't constrict fully (concerning as he is on opiates (pain medication) and would expect pinpoint pupils(small constricted pupils)). Pt has upward right gaze and delayed responses. Called (Doctor) Notified Pt son.called report to (hospital name omittied) at 1200. EMS (Emergency Medical Services) arrived and transported Pt via stretcher at 1215.There was no fall report for the fall on 3/15/2026 with new interventions added after the fall. During an interview on 4/1/2026 at 3:39 PM, Agency Licensed Practical Nurse (LPN) FF stated after R2's fall on 2/9/2026, enabler bars were added as an intervention to the fall. LPN FF clarified that enabler bars were in R2's care plan. During an observation on 4/1/2026 at 3:55 PM, LPN FF and this surveyor went to R2's room and she agreed that R2 did not have enabler bars on his bed. LPN FF said she wasn't sure why he didn't have enabler bars but she said, I'm going to put a maintenance request in right now. During an interview on 4/1/2026 at 4:19 PM, LPN FF stated that there wasn't a fall report completed for R2's fall on 3/15/2026 since it was an agency nurse that (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed the progress note in the chart and the agency nurse didn't call her about the fall so they could put interventions in place. LPN FF said the agency nurse is not allowed to come back to the building. LPN FF stated that R2 ended up being sent out to the hospital for the fall and when he came back IDT did not discuss the fall or interventions. Resident #3 (R3)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R3's initial admission date to the facility was on 11/29/2023 with pertinent diagnoses including depression, anxiety and hemiplegia and hemiparesis following cerebral infarction (weakness and paralysis to one side after a stroke). Brief Interview for Mental Status (BIMS) reflected a score of 9 out of 15 which indicated R3's cognition was moderately impaired. During an interview on 3/31/2026 at 2:01 PM, R3 stated that he had a recent fall where he slid out of bed and he didn't remember what the intervention was. Review of R3's progress note dated 3/9/2026 revealed . Resident was observed sitting on the floor in his room. Resident was sitting with his back against the bed. Resident was assessed for any injuries and ROM (range of motion) was intact. Vital signs were obtained. Resident was assisted off of the floor by staff and assisted into his bed.Review of R3's fall report dated 3/9/2026 did not have any new interventions regarding the fall. Review of R3's Care Plan revealed Focus: (R3) is at risk for falls due to BKA (below knee amputation), hemiplegia, hemiparesis due to hx (history) of CVA (cerebrovascular accident), pain, potential medication side effects, impulsivity, poor vision. There were no new interventions listed from the fall on 3/9/2026. During an interview on 4/1/2026 at 3:48 PM, LPN FF stated on 3/9/2026 R3 fell out of bed reaching for his urinal. LPN FF said that they discussed several interventions in IDT but didn't get an intervention in the care plan and didn't have a progress note regarding the discussion. LPN FF stated that they discuss falls in morning meeting with IDT and they make sure interventions are put in place and care plans were updated. Review of the Fall Management Guidelines Policy with a revised date of 2/3/2026 revealed . Care Planning:.The resident's care plan and interventions will be reviewed and revised as indicated for the individual needs of the resident and effectiveness of interventions. Post Fall Evaluation: Complete an incident report in risk management.Attempt to determine the root cause of the event and initiate modifications in the resident's care plan as indicated.IDT review: The interdisciplinary team will review the resident's current care plan and interventions to ensure that the interventions are appropriate and the resident's post fall intervention(s) correlate to the root cause of the fall in an attempt to prevent future falls.Review of the Care Plan-Comprehensive and Revision Policy with a review date of 2/2/2026 revealed . General Guidelines.care plans are revised as information about the residents and the residents' condition change. The interdisciplinary team reviews and updates the care plan.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. This citation pertains to intake #2803349.Based on interview and record review the facility failed to ensure the Director of Nursing (DON) of record worked full time defined as 40 hours a week for 3 weeks (from 3/2/2026 to 3/22/2026) resulting in the potential for unmet care needs for all residents who resided in the building during those weeks. Findings include:During an interview on 3/27/2026 at 1:08 PM, Former Maintenance Director (FMD) II stated DON B's license was used as the DON of record on 3/3/2026 but she didn't start working full time in the facility until 3/23/2026. FMD II stated that the staff reported to Agency Licensed Practical Nurse (LPN) FF during this time which didn't meet regulations since the facility staff needed to report to a Registered Nurse (RN). Upon entrance to the facility on 3/31/2026 at 8:00 AM, Corporate HR (CHR) EE reported that DON B's date of hire was 3/3/2026 but she didn't officially start full time at the facility until 3/23/2026. CHR EE said before 3/23/2026 DON B was very part time about 6 hours a week. During an interview on 3/31/2026 at 9:00 AM, RN CC stated that Agency LPN FF was the acting DON from 3/3/2026 to 3/23/2026 when DON B officially started full time. During an interview on 3/31/2026 at 9:29 AM, LPN FF stated that she couldn't act as the DON in the facility because she wasn't a RN. During an interview on 3/31/2026 at 11:55 AM, Licensed Social Worker (LSW) T stated that LPN FF was contacted after hours for concerns until DON B started in the facility full time on 3/23/2026. LSW T said that DON B came to the facility a few times for a few hours in the evening prior to 3/23/2026.During an interview on 4/1/2026 at 9:50 AM, LPN X stated that there was always a need to contact the DON regarding incidents, scheduling and urgent needs. LPN X stated that that there wasn't a DON in the building for several weeks until DON B started on 3/23/2026. In the meantime, LPN X reported that LPN FF was the contact person for clinical needs and she was only an LPN. During an interview on 4/1/2026 at 10:37 AM, RN BB stated that a DON was contacted when there was a fall, staffing issues and when guidance was needed. RN BB stated that after the previous DON (DON D) left, the only clinical person available was LPN FF so they had to contact her with concerns.During an interview on 4/1/2026 at 3:03 PM, DON B stated that staff should get a hold of the DON for falls with injury, reportable events and when there was a lock down. DON B' stated that she started coming into the facility a few nights a week for 2 weeks after she was hired but she didn't start full time until 3/23/2026. DON B reported that LPN FF and Regional Clinical Director (RCD) OO took calls during 3/3/2026 to 3/23/2026 when she started full time. DON B said that LPN FF was the contact person for falls right now since she was new. During another interview on 4/1/2026 at 3:22 PM, LPN FF stated that DON B came in the evenings for several weeks before she started full time on 3/23/2026. LPN FF stated staff went to her for clinical needs until 3/23/2026 but she (LPN FF) had access to RCD OO if needed. During an interview on 4/2/2026 at 9:08 AM, LPN V stated that LPN FF was telling family members that she was the interim DON until DON B started and there was a paper she posted that said to contact her for clinical needs. Review of the document provided to staff on 3/3/2026 that was hanging on Human Resources door revealed For any clinical on call needs please call (LPN FF) at (phone number deleted). On 4/1/2026 at 4:20 PM, Human Resources (HR) R provided this surveyor with DON B's timesheet. HR R stated that DON B's date of hire was 3/3/2026. DON B's timesheet revealed that during the week of 3/2/2026 to 3/8/2026 she worked a total of 6.5 hours. The week of 3/9/2026 to 3/15/2026 she worked a total of 6.63 hours. The week of 3/16/2026 to 3/22/2026 she did not work at all. During an interview on 4/2/2026 at 9:53 AM, Nursing Home Administrator (NHA) A stated that DON B' came to facility at night and during the day since her date of hire. NHA A reported that LPN FF couldn't be the interim DON because she was an LPN. When discussing the lack of a full time DON in the facility for the 3 weeks prior to DON B's official start date on 3/23/2026, NHA nodded when it was clear DON B did not work 40 hours a week.

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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** This citation pertains to intake #2732469.Based on interview and record review, the facility failed to maintain complete and accurate medical records for bowel and bladder in 1 resident (Resident #1) of 3 residents reviewed for ADLs (Activities of Daily Living) resulting in incomplete information in the medical record and not knowing if a resident received appropriate care.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 6/26/2025 with pertinent diagnoses including Alzheimer's Disease (neurological disorder characterized by memory loss, cognitive decline and brain shrinkage), depression and severe protein calorie malnutrition (deficiency of protein, carbohydrates and fats leading to severe wasting, weight loss and edema). Brief Interview for Mental Status (BIMS) reflected a score of 2 out of 15 which indicated R1 was severely cognitively impaired. R1started Hospice care on 1/24/2026 and discharged from the facility on 2/18/2026. During an interview on 3/27/2026 at 2:26 PM, R1's Family Member (FM) GG stated that R1 was dependent on care and needed help with his ADLs such as using the bathroom and sometimes she wasn't sure he was being helped when she wasn't there.Review of R1's care plan revealed . Focus: ADL self-care deficit related to Alzheimer's dementia.Date initiated 6/26/2025. Interventions/Tasks: Toileting x 2 person with sit to stand mechanical lift. Date initiated 6/27/2025.Review of Section GG Evaluation Assessment for ADL status for R1 completed on 1/29/2026 revealed . Self-Care. 3. Toileting the ability to maintain perineal (region between the anus and genital organs) hygiene, adjust clothes before and after voiding or having a bowel movement. Dependent.Review of the Documentation Survey Report for Bladder Elimination for R1 revealed the following documentation of whether R1 was continent (able to control the bladder for retention or release) or not and whether he voided (passed urine): December: 42 times of documentation out of 93 opportunities; January: 36 times of documentation out of 93 opportunities; February: 19 times of documentation out of 53 opportunities. Review of the Documentation Survey Report for Bowel Elimination for R1 revealed the following documentation of whether R1 was continent (able to control bowels for retention or release) or not, had no bowel movement, size of his bowel movement and consistency of the bowel movement: December: 43 times of documentation out of 93 opportunities; January: 34 times of documentation out of 93 opportunities; February: 20 times of documentation out of 53 opportunities. During an interview on 4/2/2026 at 1:40 PM, Director of Nursing (DON) B reported she was aware of the holes in documentation.