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	06/30/2026

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

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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 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. This citation pertains to intake #3051796Based on observation, interview and record review, the facility failed to a safe and orderly discharge was in place for 1 of 1 resident (Resident #100) reviewed for discharge, resulting in Resident #100 being abruptly discharged from the facility without adequate outpatient services, community resources, and/or training on medical needs causing increased anxiety, agitation and emotional distress. Findings include:Resident #100: Review of an admission Record revealed Resident #100 was a female, with pertinent diagnoses which included dysphagia (difficulty swallowing), COPD (chronic obstructive pulmonary disease - lung disease that block airflow and makes breathing difficult), depression, anxiety, emphysema (progressive irreversible lung disease in which the tiny air sacs in the lungs are gradually destroyed), acquired absence of part of stomach, pressure ulcer stage 2 sacral region (between the buttocks), chronic pain, retention of urine (inability to pass urine at all), severe protein malnutrition, and cachexia (unintentional weight loss, muscle wasting, and loss of fat which cannot be reversed by eating more calories or taking nutritional supplements, losing more than 5% of your body weight in six months without trying, significant & progressive atrophy (shrinking) of muscles)Review of Order dated 6/11/26, revealed, .Home Health to follow patient at discharge, skilled nursing for wound care, medication management, PT/OT (physical therapy/occupational therapy), home health aide, DME (durable medical equipment): peg tube supplies, oxygen therapy and wheelchair.Discontinued 06/11/2026. Review of the list of discharged for the last 90 Days received on 6/26/26, revealed, Resident #100 was noted as discharged home/community with services.Received the Notice of Medicare Non-Coverage (NOMNC) for date 6/13/26, signed on 6/11/26. In an interview on 6/30/26 at 09:58 AM, Resident #100 reported she received the notice of her medical coverage ending, she would be charged daily and she would be liable for the bill. Resident #100 reported she did appeal the decision but was denied so she discharged on her last day of coverage. Resident #100 reported when she discharged from the facility she had received four bottles of tube feeding with no education or other supplies for the tube feeding. Resident #100 did not have a pump to dispense the tube feeding so she and her son just did it manually as best as they could. Resident #100 reported she had gone 13 days without oxygen and she had to contact the company to get oxygen in her home. Resident #100 reported she had a pressure ulcer on her bottom which had worsened and had caused her pain since discharge. Resident #100 reported she did not receive any supplies to take care of her pressure ulcer after she was discharged . Resident #100 reported she did not received any supplies except for the four bottles of tube feeding. Resident #100 reported no home health care aides had come in to assist her with cares and she reported had to reach out to home health services after she had been home to see about receiving cares and support for her. Resident #100 reported she received no medical equipment when she went home as well, nothing was in place for her. Tube Feeding: Review of Orders dated 6/2/26 revealed, .Enteral Feed Order every shift Enteral Nutrition Formula Name: osmolite 1.5 (calorically dense tube feeding formula that provides complete balanced nutrition for patients), Rate: 40mL per hour, flush 30ml (water) pre 4 hours Duration: continuous.Type of Tube: G tube (a medical device inserted through the abdomen directly into the stomach. It bypasses the mouth and esophagus (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 0627 Level of Harm - Actual harm Residents Affected - Few	to provide a safe, direct route for delivering nutrition, fluids, and medications), Specify Method: via pump. Review of Nutrition/Dietary Note dated 6/12/26 at 12:24 PM, revealed, .Note Text : WEIGHT WARNING: Value: 72.0 (pounds) Vital Date: 2026-06-11 11:47:00.0, -5.0% change [5.0% , 3.8] Diet: full liquid diet, Tube feed: jevity 1.5 @ml/hr x 24 hours continuous proving 960 cc total(1440 kcals/day, 60g, 731ml) water flushes 30ml Q (every) 4 hours 180ml.Estimated needs: IBW(52kg) 1300-1560kcals/day and 52-62g, and 1300ml. She appears to be meeting protein needs at this time. RD (Registered Dietician) met with resident she reported she is very hungry and wishes to eat regular foods. RD and resident discussed tolerance. Noted she had just gotten back from therapy and was unhooked from tube feed. RD asked to adjust tube feed to meet more kcals and give rest.Noted wt (weight) appears to be down trending.She reports her appetite is improving. Rd and resident discussed supplements. She enjoys ensure clear (oral nutritional supplement designed for people on clear liquid restricted diets).RD and NP (Nurse Practitioner) discussed liquids diet restrictions and possible wt loss. It appears resident may need a GI (Gastroenterologist) referral, will adjust diet/tf (tube feeding) as needed r/t (related to) possible GI appt. If accurate wt loss is not beneficial or a part of plan. Will inquire about alternate supps. Review of Nursing -Progress Note dated 06/11/2026 at 10:44 AM, revealed, .Takes meds without difficulty via g tube. Appetite good. Continues to need assistance with ADLS (activities of daily living).Sacrum Stage 2 Pressure Ulcer:Review of Emar (Electronic Medication Administration Record) Administration Note dated 6/12/26 at 10:34 AM, revealed, .cleanse coccyx wound (pressure ulcer) with NS (normal saline), Apply medihoney (medical grade sterile honey used for advanced wound and burn care), calcium alginate (highly absorbent wound dressing) and foam dressing change every other day.everyday shift for wound.Review of Braden Evaluation dated 6/12/26 revealed, .Sensory Perception: No impairment. Moisture: Rarely moist. Activity: Bedfast. Resident is Slightly Limited: Makes frequent though slight changes in body or extremity position independently. Nutrition: Very poor. Friction and shear: Potential problem.Score of 15. (The Braden Score for Predicting Pressure Sore Risk score of 15 indicates a mild risk for developing pressure ulcers. This means the resident has a low level but present, susceptibility to skin breakdown and requires preventative interventions such as routine repositioning, skin care, and nutritional monitoring. https://nursingcecentral.com/braden-scale/)Catheter: Review of Nursing - Progress Note dated 05/28/2026 at 6:09 PM, revealed, .Resident arrived via ems from (Local Hospital).Does complain of general discomfort especially to abdomen. Peg tube in place and started osmolite via peg as ordered. Skin assessment completed. Foley catheter 16 french w (with) 10cc balloon in place (is a flexible, sterile tube passed through the urethra into the bladder to drain urine). Review of Order dated 5/29/26, revealed, .Maintain Foley Catheter and provide care every shift. Catheter Size/French: 16FR Balloon CC: 10cc. Diagnosis: every shift for Foley care. Note: There was no documentation of the catheter being removed prior to discharge. Review of Progress Notes revealed no discharge note completed by the social worker and no medical provider discharge note. Review of Care Conference assessment completed on 6/3/26, revealed no other disciplines present for the care conference, medical equipment needed rollator walker (4 wheeled walker with brakes and a seat), wheelchair, oxygen, hospital bed, (tube feeding and foley catheter supplies were not checked), UM wound nurse K completed Nursing Section: signed on 6/4/26, indicated Resident #100 did not have any wounds (had a Stage 2 Pressure Ulcer), Nutritional Interventions - not checked - is resident/family education and/or follow up needed - left blank.Review of MDS Discharge Assessment dated 6/14/26, revealed, Section GG: Toileting Hygiene: Substantial/Maximal assistance.Shower/Bathe Self: Substantial/Maximal assistance.Upper Body Dressing: Supervision or touching assistance.Lower Body Dressing: Substantial/Maximal Assistance.Putting on/taking off footwear: Dependent.Personal Hygiene: Substantial/Maximal Assistance.Section H: Indwelling catheter.resident had a catheter. Section K: Feeding Tube.Section M: Resident has a pressure ulcer.Stage 2.In an interview on 6/26/26 at 1:40 PM, Licensed Practical Nurse (LPN) M reported Resident #100 had left the faciity on a weekend as it was her last covered day and as she did not (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	want to be responsible for a bill. LPN M reported she was unsure why Resident #100 did not qualify for additional time to remain at the facility. LPN M reported Resident #100 was new to tube feeding and she was unsure how she could manage that by herself, she had failed a swallow study so she was on a clear liquid diet only beyond the tube feeding. LPN M reported Resident #100 she was always in pain, she weighed approximately 70 pounds, she was on oxygen and she did have a wound on her bottom. In an interview on 6/30/26 at 10:13 AM, Social Worker (SW) D reported when a resident discharged , the social worker should arrange or make a referral for would obtain home health care services and any durable medical equipment (DME). SW D reported the social worker would have the appropriate departments completed their sections of the discharge summary and nursing would go over the directions with the resident prior to the resident leaving the building. SW D reported the social worker had gone on medical leave the first week of June and she had started to fill in a few days a week; 6/10/26 was her first day in the building. SW D reported the care conference would be set up for 48-72 hours following a resident's admission. During the care conference, goals were discussed on what a resident would accomplish while at the facility and at discharge and a discharge care plan would be developed to address Resident #100's goals were and what was needed to meet those goals. SW D reported the facility was responsible for ordering durable medical equipment (DME) for the resident prior to discharge. SW D reported she was unsure who at the facility was responsible for that. SW D reported that nursing and/or administration was responsible for setting up home health care services for the time being. SW D reported for a resident with tube feeding would require home health care services for monitoring and extra assistance. SW D reported it was not very good for Resident #100 if there were no services in place at discharge. Resident #100 was pretty sick and unfortunately, she did not qualify to stay. In an interview on 6/30/26 at 11:01 AM, Registered Dietician (RD) H reported the nursing department was responsible for the education on the tube feeding pump and bolus amount. The current order would be added to the discharge summary either by the RD or nursing. RD H reported the team had gone back and forth on when Resident #100 was leaving, reported she had just seen her at the end of the week, just before she discharged over the weekend.In an interview on 6/30/26 at 11:47 PM, PT Program Manager F reported typically the social worker arranged for the resident at discharge for the durable medical equipment based on the needed equipment determined by therapy. PT Program Manager F reported it was also discussed that Resident #100's need at home for PT, OT and Speech therapy. PT Program Manager (PM) F reported the building had a managed care meeting every Wednesday and they discussed every patient where they were at, how progressing, and any updates to the insurance. PM F reported Resident #100 was not progressing with physical therapy and she would not want to get out of bed. Resident #100 had 6 stairs at her home to get in, and therapy worked with her on supervised 8 steps. PM F reported she had to be supervised when going up the stairs. In an interview on 6/30/26 at 10:45 AM, Business Office Manager (BOM) I reported the NOMC was discussed and explained to Resident #100. BOM I reported management staff discussed Resident #100 had received the NOMNC and the potential for discharge during the stand down meeting, and BOM I reported Resident #100 had signed the NOMNC. BOM I reported it was discussed that Resident #100's discharge would not be a safe discharge unless there was education and training completed with Resident #100 and a capable care taker on how to manage her tube feeding and other care. BOM I reported Resident #100 completed the appeal and she had heard the appeal was denied. BOM I reported services should have been set up for her prior to her discharge. Review of Discharge Summary started on 6/1/26 revealed, no transportation set up, not documented who was the primary provider and if there were any follow up appointments, pharmacy name and contact information not completed, In home care services only PT and OT were selected, no agencies who were contacted to provide home care services were noted in the summary, indicated no medical equipment was needed at discharge when a wheelchair, tube feeding supplies, oxygen (were listed as needed) Note: no mention of foley catheter care or supplies. Dietary: Regular diet, diet texture - regular, thin liquids.Nutritional Considerations: Tube feeding was not checked.Therapy and (continued on next page)

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F 0627 Level of Harm - Actual harm Residents Affected - Few	Activities sections were not completed.Urinary Function: Continent (Resident #100 had a foley catheter) which was an option to select in this section. Skin Integrity concerns: nothing was noted. (Note: Resident #100 had a stage 2 sacral pressure ulcer).Current treatments: Oxygen.Education provided: Oxygen. Note: Tube Feeding was an option which was not selected.Indicated Medication orders were provided. Review of DC (Discharge) Medications as a scanned document revealed, Resident #100 was provided with the 6 of 10 medications listed on the printed-out order summary dated 6/14/26 at 11:49 AM. Signed by staff member (illegible)/Resident #100). It was reported Resident #100 discharged on 6/13/26. Review of the medical record does not have any documentation by nursing staff to indicate the exact date of discharge. Review of the Minimum Data Set (MDS) Discharge Assessment revealed, Resident #100 was discharged , unplanned, return not anticipated on 6/14/26. In an interview on 6/30/26 at 11:09 AM, Unit Manager (UM) E reported she had contacted 3-4 home health care agencies but a couple of them did not have nurses to care for Resident #100 due to her medical diagnoses, only home health care aides. UM E reported one of the home health care agencies did not accept her insurance. UM E reported a progress note should have been entered when she had contacted the agencies documenting the progress, as well as when Resident #100 discharged from the facility a note should have been entered. UM E reported for a resident who was new to tube feeding, education should be provided to the resident and the care giver on how to manage tube feeding needs and this would be documented in the medical record the education was received. UM E reported Resident #100 needed oxygen at discharge and she had sent information to the oxygen and oxygen equipment supplier, and she had not heard anything back from them. UM E reported the oxygen service provider called her surprisingly, requested additional documentation and UM E reported she did not realize Resident #100 had not been receiving her oxygen as they never contacted me after she had submitted the request to them on 6/13/26. UM E reported at discharge it was not documented Resident #100 received any supplies at discharge for wound care and dressings, tube feeding supplies, and foley catheter supplies. In an interview on 6/30/26 at 10:49 AM, Director of Nursing (DON) B reported checks and balances should have been in place. DON B reported the unit manager was setting up home health care and ensuring that was in place as well as the durable medical equipment (DME). DON B reported education should be provided to the resident as well as any care takers and if the education was offered and refused there should have been a progress note in the record the education was offered and declined. DON B reported a recapitulation of Resident #100's stay should have been completed, the social worker should have entered a progress note, and the discharging nurse should have entered a progress note. DON B reported the nurse on duty when Resident #100 discharged from the facility was an agency nurse. In an interview 6/30/26 at 10:52 AM, Director of Nursing (DON) B reported she had heard Resident #100 had discharged when she returned to work on the following Monday (6/15/26). DON B reported Resident #100's discharge was not smooth, and the facility should have ensured the resident had home care, supplies, and equipment she needed after discharge. DON B reported Resident #100 had appealed the issuance of a NOMNC to attempt to get her more days. DON B reported the MDS nurse and Medical Records staff worked to get the records ready to submit the documentation for the review of her appeal. DON B reported the issuance of the NOMNC and her coverage ending had placed Resident #100 at risk for the discharge. DON B reported Resident #100 did have a g tube for tube feeding and received tube feeding as well as foley catheter for urine retention. DON B reported typically during a care conference each part of the interdisciplinary team would complete their section of the discharge summary, areas such as nursing, social work, therapy, activities, and dietary.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. This citation pertains to intake #3051796Based on interview and record review, the facility failed to adhere to the applicable components of the discharge summary for 1 (Resident #100) of 1 resident from the facility resulting in incomplete documentation that ensured the resident, family and outside health care providers were aware of Resident #100's medical needs. Findings include:Resident #100: Review of an admission Record revealed Resident #100 was a female, with pertinent diagnoses which included dysphagia (difficulty swallowing), COPD (chronic obstructive pulmonary disease - lung disease that block airflow and makes breathing difficult), depression, anxiety, emphysema (progressive irreversible lung disease in which the tiny air sacs in the lungs are gradually destroyed), acquired absence of part of stomach, pressure ulcer stage 2 sacral region (between the buttocks), chronic pain, retention of urine (inability to pass urine at all), severe protein malnutrition, and cachexia (unintentional weight loss, muscle wasting, and loss of fat which cannot be reversed by eating more calories or taking nutritional supplements, losing more than 5% of your body weight in six months without trying, significant & progressive atrophy (shrinking) of muscles)Review of Resident #100's Order dated 6/11/26, revealed, .Home Health to follow patient at discharge, skilled nursing for wound care, medication management, PT/OT (physical therapy/occupational therapy), home health aide, DME (durable medical equipment): peg tube supplies, oxygen therapy and wheelchair.Discontinued 06/11/2026. Review of the list of discharged for the last 90 Days received on 6/26/26 revealed, Resident #100 was noted as discharged home/community with services. In an interview on 6/20/26 at 10:31 AM, Social Worker D reported the capitulation (summary of the resident's diagnoses, orders, appointments, transfers), and the discharge note were typically completed by the social worker but in a situation like this there was not a note in eh medical record of who had spoken to community providers, a note about that should be completed in the record. Review of Resident #100's Discharge Summary started on 6/1/26 revealed, no transportation set up, not documented who was the primary provider and if there were any follow up appointments, pharmacy name and contact information not completed, In home care services only PT and OT were selected, no agencies who were contacted to provide home care services were noted in the summary, indicated no medical equipment was needed at discharge when a wheelchair, tube feeding supplies, oxygen (were listed as needed) Note: no mention of foley catheter care or supplies. Dietary: Regular diet, diet texture - regular, thin liquids.Nutritional Considerations: Tube feeding was not checked.Therapy and Activities sections were not completed.Urinary Function: Continent (Resident #100 had a foley catheter) which was an option to select in this section. Skin Integrity concerns: nothing was noted. Resident #100 had a stage 2 sacral pressure ulcer.Current treatments: Oxygen.Education provided: Oxygen. Note: Tube Feeding was an option which was not selected.Indicated Medication orders were provided. Review of DC (Discharge) Medications as a scanned document revealed, Resident #100 was provided with the 6 of 10 medications listed on the printed-out order summary dated 6/14/26 at 11:49 AM. Signed by staff member (illegible)/Resident #100). It was reported Resident #100 discharged on 6/13/26. Review of the medical record does not have any documentation by nursing staff to indicate the exact date of discharge. Review of the Minimum Data Set (MDS) Discharge Assessment revealed, Resident #100 was discharged , unplanned, return not anticipated on 6/14/26. In an interview on 6/30/26 at 11:09 AM, Unit Manager (UM) E reported she had contacted 3-4 home health care agencies but a couple of them did not have nurses to care for Resident #100 due to her medical diagnoses, only home health care aides. UM E reported one of the home health care agencies did not accept her insurance. UM E reported a progress note should have been entered when she had contacted the agencies documenting the progress, as well as when Resident #100 discharged from the facility a note should have been entered. In an interview on 6/30/26 at 10:49 AM, Director of Nursing (DON) B reported checks and balances should have been in place. DON B reported the unit manager was (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	setting up home health care and ensuring that was in place as well as the durable medical equipment (DME). DON B reported education would be provided to the resident as well as any care takers and if the education was offered and refused there should have been a progress note in the record the education was offered and declined. DON B reported a recapitulation of Resident #100's stay should have been completed, the social worker should have entered a progress note, and the discharging nurse should have entered a progress note. DON B reported the nurse on duty when Resident #100 discharged from the facility was an agency nurse.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #3002412Based on observation, interview, and record review, the facility failed to provide the necessary care and services to prevent, treat, and promote healing of pressure ulcers in 1 of 2 residents (Resident #106) reviewed for pressure ulcers, resulting in the lack of repositioning and implementation of care planned interventions, delayed healing of pressure ulcers for the resident, and the potential for infection and the development of new ulcers.Findings include: Resident #106: Review of an admission Record revealed Resident #106 was a female, with pertinent diagnoses which included pressure ulcer of sacral region (triangular bone at the base of the spine between lower back and tailbone), protein calorie malnutrition, sepsis (extreme life threatening response to an infection), diabetes, quadriplegia (partial or total loss of function in all four limbs and the torso), and high blood pressure. Review of Care Plan for Resident #106 dated 11/3/25 revealed the focus, .ADL (Activities of daily living) Self-care d/t (due to) impaired mobility, pain, hx (history) of wound infection, hx of neurogenic shock (spinal cord injury, severe damage to the central nervous system).hx of cervical fracture, functional quadriplegia. with the intervention .Bed mobility assist of 2. 7/16/25: Focus: alteration in skin integrity related to: impaired mobility, pain, stage 4 pressure ulcer to sacrum, right and left ischium. with the intervention .Administer treatment per physician orders.Barrier cream to peri area/buttocks as needed.Elevate heels as able.Encourage and assist as needed to turn and reposition; use assistive devices as needed.ensure green pads are available.Foam Medi boots in place to Bilateral feet, at all times, while in bed and as resident will allow.monitor Placement, functioning of low- air loss mattress and ensure settings are appropriate for the patient.Observe skin condition with ADL care daily; report abnormalities.Obtain Labs as ordered and report results to physician.Use pillows/positioning devices as needed. 10/31/24: Focus: Resident was admitted with stage 4 to left and right ischial, sacrum with risk for delayed wound healing secondary to progressing comorbidities, Debility and generalized weakness with decreased physical mobility and bowel/ bladder incontinence daily. with the intervention .Cushion to wheelchair, check placement prior to transfer.Frequent turning and repositioning.Provide wound care as ordered by physician and wound consult recommendations.Skin Evaluation weekly. Check oral cavity for redness, sores, white patches in the mouth, dried cracked lips or other manifestations reflecting oral conditions. Check skin for open areas, bruises, abrasions, DTI (deep tissue injuries), incisions. Review of Order dated 6/13/26, revealed, .Cleanse sacral area with generic wound cleanser, apply skin prep to periwound, apply medihoney, apply calcium alginate, then apply border foam to open area, change every other day and prn (as needed) every day shift.5/9/26: Paint toe wounds with Betadine and leave open to air daily, and place gauze between toes where needed. every day shift for wound care.6/13/26: Right ischial: Cleanse with generic wound cleanser, apply skin prep to periwound, apply medihoney, calcium alginate, border foam. Change every day and prn. every day shift.5/13/26: Skin Evaluation weekly. every day shift every Wed for monitoring.6/13/26: Wash left ischial with wound cleanser, pat dry, apply skin prep to peri wound, apply medihoney, apply calcium alginate, cover with border foam, change every day and prn every day shift for Pressure injury.6/18/26: Wound Cultures to butt wounds.Review of Treatment Administration Record (TAR) for May 26 revealed, missing sacral area dressing changes for 5/15/26, 5/17/26; Right ischial dressing changes for 5/15/26, 5/17/26; Left ischial dressing changes for 5/15/26, 5/17/26. Review of Treatment Administration Record (TAR) for June 26, revealed missing sacral area dressing changes on 6/1/26, 6/12/26, 6/15/26, & 6/28/26. ; Right ischial dressing changes for 6/15/26, & 6/28/26; Left ischial dressing changes for 6/1/25, 6/15/25, & 6/28/26. 3/20/26: Left Ischial Tuberosity. Issue type: Pressure ulcer / injury. Progress: Deteriorating: wound characteristics deteriorated. Stage 4. Full thickness skin and tissue loss. Length (cm): 3.99 Width (cm):2.67 Depth (cm): 0 Area (cm2): 6.85. Slough (soft, moist, yellowish or white tissue that delays healing, prevents healing tissue from growing): 50%. Eschar (thick, hard (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	layer of dead, necrotic tissue forms over deep wounds): 50%. Exudate amount: Moderate. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Dressing saturation: Moderate 26-75%.3/24/26: Left Ischial Tuberosity: Pressure Ulcer/Injury: Deteriorating: wound characteristics deteriorated. Stage 4: Length (cm): 4.11 Width (cm):2.41 Depth (cm): 0 Area (cm2): 6.16.Slough: 100% .Exudate: Moderate.Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown.Sacrum : Pressure Ulcer/Injury emerged. New wound. In house acquired. Length: 1.78.Width: 1.35.Depth: 0.Area: 1.26 CM.Granulation: 100% .Exudate: Light.Type: Serosanguineous: mixture of serous and sanguineous fluid, typically pale, red.Right Ischial: open area noted. 2 CM x 0.8 CM. Wound bed covered with pale green slough. Turn every 2 hours. 3/31/26:Left Ischial: Pressure ulcer, Stage 4, Length (cm): 3.5 Width (cm): 2.27 Depth (cm): 0 Area (cm2): 5.59. Granulation: 20%. Slough: 80%. Eschar: 0%. Exudate amount: Heavy. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown. Dressing appearance: Intact. Dressing saturation: Heavy > 75%.Sacrum: Pressure ulcer, Acquired in house, Length (cm): 1.39 Width (cm): 1 Depth (cm): 0 Area (cm2): 1.17. Granulation: 100%. Right gluteus: Pressure ulcer. New wound acquired in house, Length (cm): 1.77 Width (cm): 0.73 Depth (cm): 0 Area (cm2): 0.84; Exudate amount: Light. Seropurulent: mixture of purulent and serous, usually watery, yellow, green, tan or brown.4/4/26: Progress Note: Resident noted with multiple small open areas on the toes of the right foot 2,3, 5th digits and the left foot great toenail area and sole.Paint toes with betadine and leave open to air, place gauze between toes where needed daily.4/7/26:Right Gluteus pressure injury, deteriorating, acquired in house, Length (cm): 4.74 Width (cm): 1.38 Depth (cm): 0.3 Area (cm2): 4.18.Slough: 20%, Eschar: 80% .Exudate: Moderate, serosanguineous, Dressing saturation: 26-75%. 4/8/26: Wound Culture collected and sent to (laboratory). No skin assessment conducted week of 4/13/26. 4/23/26: Left Ischial: Pressure ulcer / injury. Stage 4 Pressure ulcer / injury - full thickness skin and tissue loss. Signs and symptoms of infection: Increased exudate. Length (cm): 5.12 Width (cm): 2.72 Depth (cm): 0 Area (cm2): 8.94. Odor after cleansing: Moderate. Dressing saturation: Heavy > 75%.Sacrum. Pressure ulcer / injury. Progress: Wound acquired in-house. Signs and symptoms of infection: Increased exudate. Length (cm): 2.93 Width (cm): 9.97 Depth (cm): 0 Area (cm2): 13.96. Dressing saturation: Heavy > 75%. Note: Wound worsened since last assessment. Right gluteus. Pressure ulcer / injury. Wound acquired in-house. Signs and symptoms of infection: Increased exudate. Length (cm): 5.18 Width (cm): 3.83 Depth (cm): 0 Area (cm2): 15.69. Note: [NAME] has worsened since last assessment. 4/23/26: Progress Note: .Pressure ulcer of sacral region, stage 3: Culture of wound shows proteus mirabilis-will treat for 14 days, continue with current wound dressing change. Others relevant intervention: Rocephin 1 gram IM (intramuscular) daily for 14 days.Augmentin 875 one tab twice daily for 14 days .04/26/2026: Nursing - Progress Note, revealed, .Resident continues on antibiotics for wounds to coccyx. Dressing changed as ordered. Continues to have large amount of greenish/ yellow colored drainage along with scant amount of blood from each of the wounds. Does have small amount of slough to each of the three wounds. Cleansed and new dressing reapplied.No skin assessment completed the week of 4/27/26.No skin assessment completed the week of 5/4/26.5/13/26: Left Ischial: Pressure ulcer / injury. Stage 4. Length (cm): 5.5 Width (cm): 2.85 Depth (cm): 0.2 Area (cm2): 11.1. Note: Wound worsened since last assessment. Sacrum: Pressure Ulcer / injury. Progress: Stalled: previously improving wound characteristics plateaued. Length (cm): 5.57 Width (cm): 9.46 Depth (cm): 0 Area (cm2): 36.97. Note: Wound worsened since last assessment. Right Gluteus: Pressure ulcer / injury. previously deteriorating wound characteristics plateaued. Length (cm): 4.64 Width (cm): 3.45 Depth (cm): 0.2 Area (cm2): 11.73. Granulation: 30%. Slough: 70%. Exudate amount: Moderate. Exudate type: Purulent: indication of pus, typically thick, yellow, green, tan or brown. Surrounding tissue: Maceration. Dressing saturation: Heavy > 75%. Cleansing.5/15/2026: Braden Scale for Predicting Pressure Ulcer Risk Evaluation: Moisture: Very moist. Activity: Chairfast. Resident is Very Limited: Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Friction and shear: Problem. Score: 14.0. (Score (continued on next page)

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	235395	A. Building B. Wing	06/30/2026

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 14 indicates a moderate risk for developing pressure ulcers or skin breakdown). No skin assessment completed the week of 5/18/26No skin assessment completed the week of 5/25/26No skin assessment completed the week of 6/8/26No skin assessment completed the week of 6/15/266/18/26: Collected wound cultures of butt wounds and sent to (Local Hospital) awaiting results. 6/20/26: Resident #106 .sent to emergency room due to abnormal wound cultures from butt wounds. Placed on antibiotics, Augmentin by mouth. 6/25/26: Resident #106 .continues on Augmentin for wounds to coccyx. Wounds do still have scant amount of green drainage on dressings.6/29/26: Resident #106 .got up in chair and then stated she didn't feel good. Laid back down. BP (blood pressure) dropped to 79/51 and came back up to 133/91. States feels better after laying down.No documentation of refusals of care/treatment in the progress notes during this time frame.During an observation on 06/25/26 at 2:42 PM, Resident #106 was not in her room and was not in her room until after 4:30 PM when this writer left the facility. During an observation on 06/26/26 at 10:49 AM, Resident #106 was observed seated in the dining room area participating in Bingo. Resident #106 remained up in her chair and in the dining room for lunch. During an observation and an interview on 6/26/26 at 4:40 PM, Resident #106 was observed in the dining room area with another lady sitting at the table. Resident #106 reported she had a lot of sores on her bottom, when I asked if she felt they were taking care of them she indicated she did not want to talk no more.During an observation on 6/30/26 at 1:42 PM, Resident #106 was observed in bed, the bed was high, was laying on her back. Head of the bed was approximately 45 degrees, nothing noted under her legs, and Resident #106 did not have boots on while lying in bed. Resident #106 had pillows located on her right and left sides in the bed but nothing under her four extremities. During an observation on 6/30/26 at 3:44 PM, Resident #106 was observed lying in bed positioned in the same observed earlier. No changes in interventions, no offloading and no boots while she was in bed. In an interview on 6/30/26 at 2:05 PM, Resident #106 reported she was paralyzed and couldn't feel from her abdomen area down, she can feel pressure when someone touches her but not pain. Resident #106 reported she had to rely on staff to tell her if her wounds were getting better or worse. Resident #106 did not have on her boots while she was in bed, they were located on the night stand. Observed her head of bed was approximately 60 degrees. In an interview on 6/30/26 at 9:14 AM, Certified Nursing Assistant (CNA) Z reported she was the only CNA on the hallway today. On D hallway there were 4 sometimes 5 residents who required two person assist with transfers. CNA Z reported it was hard to get things done and take care of the residents when you were the only CNA assigned to a hallway. In an interview on 6/30/26 at 9:22 AM, Scheduler Y reported she had to pull the second for D hall for a one to one, C hall staff had not showed for his shift, had to place someone on C hall. Scheduler Y reported C hall CNA was to assist the D hallway CNA. In an interview on 6/30/26 at 1:54 PM, CNA AA reported Resident #106 liked to get up for Bingo day, yesterday she was not feeling well, and she asked to lie back down, asked if she wanted to get up today and she said no. CNA AA reported she was to have a visitor today and asked again if she wanted to get up and Resident #106 reported she did not. In an interview on 6/25/26 at 3:08 PM, Licensed Practical Nurse (LPN) M reported the facility does not have a wound provider, wound nurse, and the facility nurses were the ones who provided assessment and treatment for all residents with wounds/pressure ulcers. LPN M reported when she transferred hallways Resident #106's wounds began to deteriorate due to not having a consistent nursing staff to view wounds. In an interview on 6/30/26 at 11:23 AM, Unit Manager (UM) E reported UM K was the main wound person, but she had quit. In an interview 6/30/26 at 10:52 AM, Director of Nursing (DON) B reported refusals for a dressing change should be documented in the medical record as well as no missing treatments or holes in the treatment record. DON B reported something should be documented, refused and the nurse would also need to enter a progress note. In an interview on 6/30/26 at 4:08 PM, DON B reported weekly skin assessment scheduled 1first day of the week of the resident's shower day was on, when a resident was on an antibiotic a sepsis screening was completed for monitoring as well as vitals. DON B reported for the last two weeks the facility had been completing treatments and almost (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	have the green stuff gone, smell was down, and the wound appeared cleaner. DON B reported the wound team used to be in the facility weekly to monitor the wounds. DON B reported the facility hadn't had a wound provider for a while and it was the unit manager who was doing the weekly measurement and pictures on all the wounds. The UM who was completing the weekly measurements had left the facility as she was an agency nurse. DON B reported skin issues assessments was where the skin concerns were documented in the medical record. DON B reported since the nurse left the facility was still trying to figure out monitoring and there were some gaps in the things that needed completed. DON B reported she attempted to monitor the treatment administration record (TAR) weekly. DON B reported Resident #106 had a recent wound culture and she was placed on an antibiotic due to infection. DON B reported she informed the NHA (Nursing Home Administrator) she would begin sending out the residents with wounds as there was not a skilled wound nurse in the building if the was not a wound provider secured soon. Positioning interventions redistribute pressure and shearing force to the skin. Elevating the head of the bed to 30 degrees or less decreases the chance of pressure ulcer development from shearing forces (WOCN, 2010). Change the immobilized patient's position according to tissue tolerance, level of activity and mobility, general medical condition, overall treatment objectives, skin condition, and comfort (NPUPA, EUPAP, PPPIA, 2014). A standard turning interval of to 2 hours does not always prevent pressure ulcer development. Consider repositioning the patient at least every 2 hours if allowed by his or her overall condition. When repositioning, use positioning devices to protect bony prominences (WOCN, 2010). The WOCN guidelines (2010) recommend a 30-degree lateral position (Figure 48-15), which should prevent positioning directly over the bony prominence. To prevent shear and friction injuries, use a transfer device to lift rather than drag the patient when changing positions (see Chapter 39). [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 72244-72253). Elsevier Health Sciences. Kindle Edition.Review of Fundamentals of Nursing ([NAME] and [NAME]) 9th edition revealed, .Usually the time that a patient sits uninterrupted in a chair is limited to 1 hour. This interval is shortened in patients who are at very high risk for skin breakdown. Reposition patients frequently because uninterrupted pressure causes skin breakdown. Teach patients to shift their weight in a chair every 15 minutes .Category/Stage 4: Full thickness tissue loss: Full thickness tissue loss with exposed bone, a tendon or muscle. Slough or eschar may be present. Often includes undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput (back of head) and malleolus (ankle) do not have (adipose/fat) subcutaneous tissue and these ulcers can be shallow. Category/Stage 4 ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur. Exposed bone/muscle is visible or directly palpable. http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-ulcer-stagescategories/

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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. This citation pertains to intake #3051796Based on interview and record review, the facility failed to provide medically related social services to support the physical and psychosocial health of 1 (Resident #100) of 3 residents reviewed for social services resulting in a lack of advocacy for Resident #100's rights during the discharge planning process. Findings include:Resident #100: Review of an admission Record revealed Resident #100 was a female, with pertinent diagnoses which included dysphagia (difficulty swallowing), COPD (chronic obstructive pulmonary disease - lung disease that block airflow and makes breathing difficult), depression, anxiety, emphysema (progressive irreversible lung disease in which the tiny air sacs in the lungs are gradually destroyed), acquired absence of part of stomach, pressure ulcer stage 2 sacral region (between the buttocks), chronic pain, retention of urine (inability to pass urine at all), severe protein malnutrition, and cachexia (unintentional weight loss, muscle wasting, and loss of fat which cannot be reversed by eating more calories or taking nutritional supplements, losing more than 5% of your body weight in six months without trying, significant & progressive atrophy (shrinking) of muscles)Review of Order for Resident #100 dated 6/11/26, revealed, .Home Health to follow patient at discharge, skilled nursing for wound care, medication management, PT/OT (physical therapy/occupational therapy), home health aide, DME (durable medical equipment): peg tube supplies, oxygen therapy and wheelchair.Discontinued 06/11/2026. Review of the list of discharged for the last 90 Days revealed, Resident #100 was noted as discharged home/community with services.Review of Progress Notes revealed no discharge note completed by the social worker and no medical provider discharge note. Review of Care Conference assessment completed on 6/3/26, revealed no other disciplines present for the care conference, medical equipment needed rollator walker (4 wheeled walker with brakes and a seat), wheelchair, oxygen, hospital bed, (tube feeding and foley catheter supplies were not checked), Unit Manager/Wound nurse K completed Nursing Section: signed on 6/4/26, indicated Resident #100 did not have any wounds (had a Stage 2 Pressure Ulcer), Nutritional Interventions - not checked - is resident/family education and/or follow up needed - left blank. Review of MDS Discharge Assessment for Resident #100 dated 6/14/26, revealed, Section GG: Toileting Hygiene: Substantial/Maximal assistance.Shower/Bathe Self: Substantial/Maximal assistance.Upper Body Dressing: Supervision or touching assistance.Lower Body Dressing: Substantial/Maximal Assistance.Putting on/taking off footwear: Dependent.Personal Hygiene: Substantial/Maximal Assistance. In an interview on 6/30/26 at 10:13 AM, Social Worker (SW) D reported when a resident discharged , the social worker would obtain home health care services and any durable medical equipment (DME) for the resident prior to discharge. SW D reported the social worker would have the appropriate departments completed their sections of the discharge summary and nursing would go over the directions with the resident prior to the resident leaving the building. SW D reported the social worker had gone on medical leave the first week of June and she had started to fill in a few days a week; 6/10/26 was her first day in the building. SW D reported the care conference would be set up for 48-72 hours following a resident's admission. During the care conference, goals were discussed on what a resident would accomplish while at the facility and at discharge and a discharge care plan would be developed to address Resident #100's goals were and what was needed to meet those goals. SW D reported the facility was responsible for ordering durable medical equipment (DME) for the resident prior to discharge. SW D reported she was unsure who at the facility took point on that after the social worker went on medical leave. SW D reported that nursing and/or administration should be setting up home health care services for residents prior to discharge. SW D reported for a resident who had a tube feeding, should be ensuring a home health care service provider was in place for monitoring of the resident and extra assistance when needed. SW D reported it was not very good for Resident #100 if there were no services in place at discharge. Resident #100 was pretty sick and (continued on next page)

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