

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2025
NAME OF PROVIDER OR SUPPLIER Optalis Health and Rehabilitation of Grand Rapids		STREET ADDRESS, CITY, STATE, ZIP CODE 1950 32nd St S E Grand Rapids, MI 49508	
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>41424</p> <p>This citation pertains to Intake: MI00150382</p> <p>Based on observation, interview, and record review, the facility failed to provide an environment that promoted resident dignity in 1 (Resident #108) of 10 residents reviewed for dignity, resulting in the potential of feelings of frustration, embarrassment, and loss of self-worth, and a negative psychosocial outcome for the residents impacting their quality of life.</p> <p>Findings include:</p> <p>According to Your Rights and Protections as a Nursing Home Resident revealed, .At a minimum, Federal law specifies that nursing homes must protect and promote the following rights of each resident. You have the right to .Be Treated with Respect: You have the right to be treated with dignity and respect, as well as make your own schedule and participate in the activities you choose . https://downloads.cms.gov/medicare/your_resident_rights_and_protections_section.pdf</p> <p>Resident #108:</p> <p>Review of an Admission Record revealed Resident #108 was a female with pertinent diagnoses which included right artificial hip joint, joint replacement surgery, muscle weakness, difficulty in walking, necrosis of the bone (loss of blood supply to the bone causing it to die) and history of falling.</p> <p>Review of current Care Plan for Resident #108, revised on 2/11/25, revealed the focus, .At risk for falls due to total right hip replacement . with the intervention .Provide assist to transfer and ambulate as needed .</p> <p>Review of current Care Plan for Resident #108, initiated on 2/10/25, revealed the focus, .Resident has an ADL self-care performance deficit related to: activity intolerance, ADL abilities will fluctuate with therapy staff and nursing staff, limited mobility . with the intervention .Locomotion: x1 assist x 100' with fww (four wheeled walker) .Toilet Use: 1 person assist with fww .Transfer: 1 person assist with fww .</p> <p>(continued on next page)</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 235458	Facility ID: 235458 If continuation sheet Page 1 of 30

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/18/25 at 12:57 PM, Resident #108 reported when she called staff for assistance to use the restroom, Certified Nursing Assistant (CNA) E responded to her request. Resident #108 reported she asked her for assistance to get to the restroom and Resident #108 reported CNA E informed her she was here for therapy, she needed to learn to be independent, and she just stood there watched her struggle. Resident #108 reported she felt the way she had spoke to her was not acceptable, condescending, and demeaning. Resident #108 reported she just needed a little help with her leg, and she needed to get to the restroom. Resident #108 reported she did not assist her with transferring out of her bed either. Resident #108 reported she was in pain and she was concerned for her safety. Resident #108 reported she was really frustrated by her inaction to assist and disappointed in the lack of empathy she had for her as she struggled to ambulate to the restroom while she stood there and watched her and provided no assistance. Resident #108 reported she was at the mercy of the staff. Resident #108 indicated she was in pain and couldn't hardly take herself to the restroom, she had expressed herself with animation of body movement and increased volume in her voice due to her frustration of how she was treated.</p> <p>In an interview on 2/19/25 at 12:22 PM, Administrator A reported CNA E was suspended pending investigation, due to concerns with her interactions with Resident #108 and with another resident.</p> <p>This writer attempted to contact CNA E and did not receive a response from her prior to exiting the facility.</p> <p>In an interview on 2/20/25 at 11:01 AM, Administrator A reported the facility did not have training for communication and customer service completed the last twelve months for the facility staff.</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>Based on interview and record review, the facility failed to resolve resident concerns for 1 (Resident #107) of 1 sampled resident reviewed for resolution of concerns resulting in feelings of frustration and a potential decline in psychosocial and mental well-being.</p> <p>Findings include:</p> <p>Review of Admission Record revealed Resident #107 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression.</p> <p>Review of Resident #107's Care Conference Note dated 1/16/25 revealed, .Conference Summary: . Blood draws no results given to resident, UA (urinalysis) not having results. Discussed outside medication being delivered to the facility. Unit Manager will research the appropriateness of these medication (sic). Ears plugged up. This problem still exists. Unit Manager to resolve. Resident stated her spasm has been awful from the UTI (urinary tract infection). Discussed flushing of catheter. Tooth issues. (Dental Provider) does extractions. Dr to review medication and medical diagnosis. Activities: special crafts in her room. Devotions are loved resident wants to continue. Snacks down the hall resident has been left out</p> <p>During an interview on 2/19/25 at 3:11 PM, Resident #107 reported that she had several concerns that she felt that the facility was not addressing. Resident #107 reported that she had concerns with the facility not being able to accommodate her vegetarian diet, her CPAP (medical device that delivers pressurized air through a mask worn during sleep), constant tooth pain and wanting to see a dentist, wanting to see a podiatrist, MRI scheduling, not being included in the nightly snacks, not being included in activities, not receiving 1:1 visits from the Social Worker as she had been promised, and concerns with billing. Resident #107 reported that she had tried to talk to Nursing Home Administrator (NHA) A and Director of Nursing (DON) B about her concerns, and they were also discussed in her most recent care conference on 1/16/25, but there had been no updates on any of her concerns. Resident #107 reported that she felt like the facility did not take her seriously or care about her needs. Resident #107 reported that she had voiced her concerns to multiple staff members at the facility. It was noted that during the interview, NHA A attempted to enter Resident #107's room three times to meet with her.</p> <p>On 2/19/25 at 4:05 PM, NHA A approached this writer and reported to this writer, Just so you know, I have addressed all of Resident #107's concerns already.</p> <p>On 2/20/25 at 9:01 AM, this writer requested all grievance forms for Resident #107. NHA A provided one grievance form dated 2/20/25 with an attached email dated 2/15/25 that was sent to NHA A and DON B from Ombudsman JJ.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #107's Follow Up Email dated 2/15/25 revealed, . As discussed, I am sending a list of the outstanding concerns from the 1/16/25 Care Conference . Dietary: we were told that the dietician would follow up with (Resident #107) and that had not happened. I mentioned one staff member that has gone above and beyond to help but her vegetarian diet is not well accommodated. For example, we were told they would provide greek yogurt as a protein source but she has not seen that. Another example, she was served sausage for breakfast this morning instead of the ordered scrambled eggs. The alternative options menu she has been given offer items not actually available. Dental/Podiatry/Optomety: She has a tooth that is possibly decaying . she needs to have a dentist look at it and have it arranged for her to go out for tooth extraction if that is what she needs. She needs her toenails cut. This was mentioned in the last meeting and (Social Worker SWFF) said she would get (Resident #107) on (local facility care services provider) and that the podiatrist would be there on 1/21/25 to do her toe nails. She did not see anyone on 1/21 or have any follow up to the dental concerns or getting on the (local facility care services provider) program. CPAP: it is not being cleaned. Medications: Not consistently accurate, on time, or given at all . Therapy: .At the care conference we did talk with (therapy provider) about looking at some goals for positioning techniques, possible use of wedges, ect. and for therapy to also provide staff training regarding any positioning recommendations. They have not addressed that . Wound Care: we discussed that the weekly wound care team is monitoring her. They tell her it is a courtesy. Wound care issues were discussed at length at the 1/16 meeting with the nurses agreeing that her wound care was not being done appropriately. She has been told she is to have daily wound care with cleaning and dressing changes . but this care is hit and miss . Bed baths: these are just not consistently done .MRI: She is still waiting for this to be ordered/scheduled . Waiver program: (SW FF) said at the 1/16 meeting that she would do a referral to waiver. there has been no updates since then</p> <p>During an interview on 2/19/25 at 11:23 AM, Licensed Practical Nurse (LPN) EE reported that the facility used to have a form to complete for resident concerns, but she did not think they had a form anymore, and they were just supposed to let NHA A know when the resident voiced a concern.</p> <p>During an interview on 2/20/25 at 9:22 AM, Certified Nursing Assistant (CNA) G reported that she was unaware of the facility's process for handling resident's concerns/grievances, and that she thought that staff just needed to communicate concerns to NHA A.</p> <p>During an interview on 2/20/25 at 9:37 AM, CNA J was unable to report the facility's process for completing resident grievance/concern forms.</p> <p>During an interview on 2/20/25 at 9:57 AM, LPN S was unable to report the facility's process for completing resident grievance/concern forms.</p> <p>During a follow up interview on 2/20/25 at 10:03 AM, Resident #107 reported that she had never had a staff member complete a grievance form with her. Resident #107 was not aware that he facility had a grievance process. Resident #107 reported that NHA A never returned to speak with her on 2/19/25.</p> <p>During an interview on 2/20/25 at 10:47 AM, DON B reported that she did not know if any of Resident #107's concerns had been addressed. DON B reported that she met with Resident #107 daily to check on her, but that she had not had a chance to look into or address any of Resident #107's concerns. DON B reported that NHAA was responsible for addressing grievances for residents.</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/20/25 at 12:45 PM, Social Worker (SW) FF reported that she was unaware of any concerns for Resident #107 and she could not recall the concerns discussed in Resident #107's care conference on 1/16/25. SW FF reported that there was nothing for her to oversee or complete for Resident #107. SW FF' reported that NHAA was responsible for addressing grievances for residents.</p> <p>During an interview on 2/20/25 at 10:31 AM, NHA A reported that she had not been made aware of the grievances brought forth buy Resident #107 until Ombudsman JJ emailed her on 2/14/25. NHA A reported that the facility was working on all of the concerns brought forth by Resident #107. When this writer further queried about the status of each concern, NHA A was unable to provide any updates on what had been completed for each concern. NHA A then reported she had not had time to look into the concerns. NHA A reported that staff were aware of the grievance process and the importance of completing forms, but she could not report why there were no grievance forms for any of Resident #107's concerns. NHA A reported that she was not responsible for following resident grievances, and that this responsibility was dedicated to the department head of the area which the resident has a concern.</p> <p>Review of the facility's Concern (Grievance) Process policy dated 5/31/24 revealed, It is the policy of the facility to support each resident's and family member's rights to voice concerns (grievances) without discrimination, reprisal, or fear of discrimination or reprisal. General Guidelines: The administrator is the Grievance Officer of the facility. The Grievance Officer is responsible for overseeing the concern (grievance process) which included receiving and tracking concerns through their conclusion, maintaining the confidentiality of information associated with grievances, and issues written grievance decisions to the resident upon their request .</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>This citation pertains to intake MI00150229.</p> <p>Based on interview and record review, the facility failed to implement its policy and procedures on abuse and neglect by staff not reporting an allegation of abuse immediately to the abuse coordinator for 1 residents (Resident #105) of 5 residents reviewed, resulting in the potential for ongoing mistreatment, abuse or neglect.</p> <p>Findings include:</p> <p>Resident #104</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 12/18/24 revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses included psychotic disorder.</p> <p>Resident #105</p> <p>Review of Admission Record revealed Resident #105 was originally admitted to the facility on [DATE] with pertinent diagnoses which included adult failure to thrive.</p> <p>Review of an Incident Report dated 1/11/25 revealed, Incident Summary: (Resident #104) was seen touching (Resident #105) breast on top of her gown in her bed. (Resident #105) was calling out for help several times, staff entered the room and removed (Resident #104). He was placed on 1:1 (1 staff member monitoring resident at all times) . It was noted that the incident occurred at 1/11/25 at 8:00 PM, and was reported to the state agency on 1/12/25 at 12:09 AM.</p> <p>Review of the Investigation Report revealed, Incident Summary: On 1/10/25, it was reported that (Resident #104) entered the room of (Resident #105) and it was witnessed by Certified Nursing Assistant (CNA) T. CNA T heard yelling from (Resident #105) to help her, CNA T entered the room and saw (Resident #104) sitting on the bed, and had her by her arm and was feeling on her upper body- breast area. CNA T said that (Resident #104) entered the room twice while she was redirecting him. CNA T reported this to Licensed Practical Nurse (LPN) F. LPN F said that around 8:30 PM, it was reported to her that CNA T saw (Resident #104) in another resident's room rubbing on her arm. Per the nurse (LPN F) he was redirected and educated on not entering others rooms . Findings and conclusions: . Staff were re-educated on abuse and when to call the Administrator and on-call for nursing .LPN F written statement: At around 8:00 PM, it was reported to his nurse by an aide that (Resident #104) was found in another resident's room rubbing her arm. He was redirected to his room and educated on the importance of him not entering others rooms. I was unaware of policy to report to administrator. I wrote a progress note .</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/19/25 at 10:56 AM, Former Assistant Director of Nursing (ADON) D reported that she had been made aware of Resident #104 entering Resident #105's room the evening that it happened. ADON D reported that LPN F had wrote a progress note about the incident, and when she read it that evening, she went to the facility to educate staff on reporting abuse immediately to the abuse coordinator.</p> <p>During an interview on 2/19/25 at 11:23 AM, LPN EE reported that staff were required to report allegations of abuse immediately to the abuse coordinator. LPN EE reported that the abuse coordinator was NHA A.</p> <p>During an interview on 2/19/25 at 12:20 PM, Certified Nursing Assistant (CNA) I reported that staff were required to report allegations of abuse immediately to the abuse coordinator. CNA I reported that the abuse coordinator was NHA A.</p> <p>During an interview on 2/19/25 at 12:45 PM, CNA L reported that staff were required to report allegations of abuse immediately to the abuse coordinator. CNA L reported that the abuse coordinator was NHA A.</p> <p>During an interview on 2/19/25 at 4:21 PM, LPN GG reported that staff were required to report allegations of abuse immediately to the abuse coordinator. LPN GG reported that the abuse coordinator was NHA A.</p> <p>During an interview on 2/20/25 at 9:22 AM, CNA G reported that staff were required to report allegations of abuse immediately to the abuse coordinator. CNAG reported that the abuse coordinator was NHA A.</p> <p>During an interview on 2/20/25 at 9:22 AM, CNA J reported that staff were required to report allegations of abuse immediately to the abuse coordinator. CNAJ reported that the abuse coordinator was NHA A.</p> <p>On 2/20.25 at 11:57 AM, This writer attempted to contact CNA T. CNA T was unable to be interviewed prior to survey exit.</p> <p>On 2/20/25 at 12:01 PM, This writer attempted to contact LPN F. LPN F. was unable to be interviewed prior to survey exit.</p> <p>During an interview on 2/20/25 at 1:40 PM, NHA A reported that all staff in the facility had been educated on the abuse policy by 1/12/25.</p> <p>Review of the facility's Abuse policy dated 5/24/23 revealed, Policy Overview: Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property . Initial reporting: The facility will ensure that all allegations involving abuse, neglect, exploitation, mistreatment, injuries of unknown source, misappropriation of resident property, and crimes are reported immediately to the administrator and: Reported to the State Survey Agency immediately but not later than two hours after the allegation is made if the allegation involves abuse or results in serious bodily injury and to other officials (including adult protective services and/or law enforcement, when applicable .</p> <p>(continued on next page)</p>		

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<p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included educating all staff members in the facility on the abuse policy. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>This citation pertains to intake MI00150232, MI00150229, MI00150376.</p> <p>Based on observation, interview, and record review, the facility failed to thoroughly investigate allegations of abuse and neglect in 4 (Resident #103, #104, #105, and #107) of 5 residents reviewed for abuse and neglect resulting in incomplete abuse investigations and the potential for future mistreatment and/or abuse.</p> <p>Findings include:</p> <p>Resident #103</p> <p>Review of Admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included history of falling.</p> <p>Review of an Incident Report submitted by Nursing Home Administrator (NHA) A dated 1/12/25 revealed, . Details: (Resident #103) was seen in the bathroom laying on his back with an abrasion on his forehead, he was able to tell staff that he didn't hit his head, but he had a change in condition and staff notified on-call physician and an order was to send to local hospital. (Resident #103) returned with a hemorrhage. A full investigation will follow .</p> <p>Review of Resident #103's Fall Investigation file was reviewed by this writer. The file included Resident #103's facesheet, progress notes from 1/10/25-1/12/25, fall risk evaluation dated 1/10/25, and incident audit report.</p> <p>It was noted that Resident #103's Fall Investigation file did not include any resident outcomes, whether the incident was reported to Resident #103's family or any other agency, summaries of interviews for staff caring for resident before, during, and after the incident, summary of documents obtained such as hospital/medical records, conclusion of the investigation, and corrective active taken as a result of the investigation.</p> <p>During an interview on 2/20/25 at 1:40 PM, NHA A reported that she had completed the investigation of Resident #103's fall. NHA A was unable to report the findings from her investigation as to why Resident #103 fell , and what changes the facility made to decrease further falls. NHA A was unable to provide evidence that she had interviewed staff related to Resident #103's fall. NHA A was unable to report when she had spoke with Resident #103's family. NHA A confirmed that she had not reviewed Resident #103's hospital records, and she just took Resident #103's family word for what happened at the hospital. NHA A confirmed that Resident #103 had not been checked on since 11:00 AM and she thought that Resident #103 had fallen around 8:00 PM. NHA A was not able to report any kind of corrective action that she had taken to ensure residents did not go several hours without being checked on. NHA A confirmed that her investigation of Resident #103's fall was sloppy, and missing many critical details. It was noted that NHA A was unaware that Resident #103 had been diagnosed with multicompartamental acute intracranial hemorrhage prior to his fall at the hospital.</p> <p>Resident #104</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 12/18/24 revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses included psychotic disorder.</p> <p>Resident #105</p> <p>Review of Admission Record revealed Resident #105 was originally admitted to the facility on [DATE] with pertinent diagnoses which included adult failure to thrive.</p> <p>Review of an Incident Report submitted by NHA A dated 1/12/25 revealed, Incident Summary: (Resident #104) was seen touching (Resident #105) breast on top of her gown in bed. (Resident #105) was calling out for help several times, staff entered room and removed (Resident #104) at once, he was placed on a 1:1 (one staff member supervising resident at all times)</p> <p>Review of the Investigation File for the incident between Resident #104 and Resident #105 was reviewed by this writer. The file included facesheets for each resident, a signed statement from a staff member acknowledging the abuse policy dated 1/15/25, a copy of the facility's abuse policy, a five day follow up investigation report, and written statements from the staff working on the date that the incident occurred.</p> <p>Review of the Five-Day Follow-up Investigation report revealed, .Findings and Conclusions: No signs of bruising, or physical harm were identified. Investigation determined that (Resident #104) did enter the room and touch (Resident #105) in a way that she did not want to be touched. Staff were re-educated on abuse and when to call the Administrator and the on-call phone for nursing. (Resident #104) was placed on a 1:1: but doesn't remember the incident. (Resident #105) had a stop sign placed on her door and doesn't remember the incident that occurred .</p> <p>It was noted that the investigation file did not include any assessments completed by the facility for Resident #104 and Resident #105, there were no details of any physician assessments or psychosocial assessments completed for Resident #104 of Resident #105, there was no evidence to confirm that the facility had ensured that Resident #105 felt safe at the facility, there were no details in the investigation report to determine what the root cause of the incident could have been, or changes the facility had made to prevent further incidents from occurring.</p> <p>During an observation on 2/18/25 at 10:01 AM, Resident #105 was lying in bed and loudly calling out for help. It was noted that Resident #105 called out for help for about 10 minutes before staff entered the room to assist her. It was noted that Resident #105's room was right across from Resident #104's room.</p> <p>During an interview on 2/18/25 at 10:25 AM, Certified Nursing Assistant (CNA) J reported that Resident #104 often had sexually inappropriate behavior with staff. CNA J reported that Resident #104 was easily triggered by other residents and staff and she had observed Resident #104 get aggressive with other residents in the past. CNA J reported that she had noticed that Resident #104 was triggered by loud noises and that Resident #105 frequently yelled out for help. CNA J reported that Resident #105 usually didn't need help when she was calling out, but that she was lonely and wanted staff to spend time with her. CNA J reported that she thought that Resident #104 may have been triggered by Resident #105 yelling out, and she had asked management to consider moving one of the residents, but they did not.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/19/25 at 10:56 AM, Former Assistant Director of Nursing (ADON) D reported that Resident #104 had a history of being inappropriate with staff and residents. ADON D reported that she felt like the facility did not complete accurate investigations after incidents would occur, and that she was very vocal about this. ADON D reported that she had verbalized to Nursing Home Administrator A that she did not feel like the facility had the staffing to have Resident #104 on a 1:1 checks, and that this was not a feasible way to keep residents safe, but her concerns were ignored. ADON D reported that she did not feel like NHA A took abuse allegations seriously, and would not complete thorough investigations. ADON D reported that NHA A would not interview all residents and staff, and follow up on concerns that residents did report. ADON D reported that she had tried to collaborate with NHA A and help complete investigations, but she was told that NHA A was responsible for the investigations, and she was not needed.</p> <p>During an interview on 2/19/25 at 11:23 AM, Licensed Practical Nurse (LPN) EE reported that Resident #104 frequently had inappropriate behaviors towards staff.</p> <p>During an interview on 2/19/25 at 12:20 PM, CNA I reported that she had observed Resident #104 being inappropriate with other staff members, and had heard about him being inappropriate with other residents too. CNA I reported that Resident #104 was often triggered by loud noises and that she had observed Resident #104 get upset because of Resident #105 yelling out before. CNA I confirmed that Resident #105 yelled out often, and could be heard from Resident #104's room.</p> <p>During an interview on 2/20/25 at 12:16 PM, CNA E reported that she had observed Resident #104 being inappropriate to staff before, and that he seemed very unpredictable. CNA E confirmed that Resident #104 was easily triggered, especially by loud noises.</p> <p>On 2/20/25 at 11:57 AM, This writer attempted to contact CNA T. CNA T was unable to be reached prior to survey exit.</p> <p>On 2/20/25 at 12:01 PM, This writer attempted to contact LPN F. LPN F was unable to be reached prior to survey exit.</p> <p>During an interview on 2/20/25 at 1:40 PM, NHA A reported that she had completed the investigation of the incident between Resident #104 and Resident #105. NHA A was unable to report her investigation process and how she determined the root cause of why the incident between Resident #104 and Resident #105 had occurred. NHA A reported that she did not think that Resident #104 was acting inappropriately towards Resident #105, and that he was just touching Resident #105's arms. NHA A did not think that Resident #104 was inappropriate with other residents or staff. NHA A reported that Resident #105 and Resident #105 had been assessed by the Social Worker, but she was unable to provide documentation of the assessments. NHA A reported that she has been checking on Resident #105 to ensure she felt safe every day, but that she did not have any documentation to verify this. NHA A was unable to report any other measures that the facility had taken to prevent further resident to resident abuse situations.</p> <p>During an interview on 2/20/25 at 12:45 PM, Social Worker (SW) FF reported that she did not complete any psychosocial assessments on Resident #104 and Resident #105.</p> <p>Resident #107</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Admission Record revealed Resident #107 was originally admitted to the facility on [DATE] with pertinent diagnoses which included depression.</p> <p>Review of an Incident report dated 2/6/25 revealed, .Incident Summary: According to (Resident #107) the CNA (CNA E) was very rough with care while cleaning her peri area (perineum) . Investigation Summary/Actions taken: (Resident #107) claimed that a staff member delivered rough care to her but after interviewing other residents it appears that no rough care was done .</p> <p>Review of the Investigation file included a Five-Day Follow-Up Investigation Report, handwritten notes which included CNA E 's statement and handwritten notes of statements from other residents on the same unit as Resident #107.</p> <p>It was noted that the Investigation file did not include summary information from the investigation such as relevant portions of Resident #107's clinical record, care plan, nurses notes, social service notes and assessments, physician assessments, or adequate evidence to verify that the allegation was refuted, and any corrective actions that the facility had taken to prevent further allegations from occurring.</p> <p>Review of the statements from other residents revealed that one resident reported that CNA E tries to roll me out of bed, I want her fired, another resident reported that CNA E was kinda mean . and another resident reported that CNA E treated me like crap, rude. two days later she was fine .</p> <p>Review of the Five-Day Follow-Up Investigation Report revealed, .Incident Summary: On 2/4/25 at 2:00 AM, (Resident #107) reported that she had gotten rough care on the midnight shift by (CNA E). (Resident #107) said that (CNA E) had left her exposed and left the room to go get the nurse, she hurt me when she turned me from side to side, she shoved me while turning me towards the nurse and the nurse had to catch me, and she cleaned the front of me and made me feel awkward. This is per (Resident #107). She (sic) told 13 residents on the same hall were questioned if this CNA was rough with them or if they felt safe with her. There were no real complaints, but 3 residents said she was mean or rude but then she was fine, and she works hard. No residents said that they felt unsafe or threatened .Findings and conclusions: No signs of abuse was identified. Investigation determined the resident wasn't abuse (sic) .</p> <p>During an interview on 2/18/25 at 12:36 PM, Resident #107 reported that she felt that the care she received by CNA E was rough and made her feel uncomfortable. Resident #107 reported that NHA A had come in to interview her about the incident, when her lunch arrived so NHA A told her that she would return to finish the interview and she never came back. Resident #107 reported that no other staff members in the facility had discussed the incident with her, and she did not know what happened with the investigation. Resident #107 reported that she felt like the facility was not taking her concerns seriously.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/20/25 at 1:40 PM, NHA A reported that she had learned of Resident #107's allegations against CNA E from the nurse that was working with CNA E that night. NHA A reported that her investigation included interviewing Resident #107 and all the other residents on the same unit as Resident #107. When this writer queried about the three residents that reported concerns with CNA E, NHA A reported that she had completed additional interviews with those residents and they no longer had concerns. NHA A was unable to provide documentation of the follow up interviews she reported that she had completed. NHA A reported that she had updated Resident #107's care plan to include two caregivers due to the allegations, and felt that the allegation was not substantiated. NHA A confirmed that CNA E was currently suspended pending another allegation of abuse from a separate resident.</p> <p>Review of the facility's Abuse Policy dated 5/24/23, revealed, .Investigation: Key to investigation abuse allegations is an environment that facilitates the reporting of such allegations. Once reported, the center conducts a timely, thorough, and objective investigation of any allegation of abuse . The investigation process includes: identifying staff responsible for abuse. Determining the purpose of the investigation and issues to be investigated, whether or not the alleged violation has occurred, the extent and cause. Identifying and interviewing all involved persons, including the alleged victim, alleged perpetrator, witnesses and others who might have knowledge of the allegations (such as other residents, family members, staff who work closely with the alleged perpetrator and victim). Conducting observations of the alleged victim, including identification of any injuries as appropriate, the location where the alleged situation occurred, interactions and relationships between staff and the alleged victim and/or other residents, and interactions/relationships between resident to other residents as applicable. Identifying and reviewing all relevant medical records and facility documents as applicable. If the alleged perpetrator is a staff member, review their employment records. Exercising caution in handling evidence that could be used in a criminal investigation. Providing complete and thorough documentation of the investigation. After completion of the investigation, the evidence should be analyzed, and the Administrator or designee will make a determination regarding whether the allegation is substantiated or unsubstantiated. The Administrator will determine if modifications to existing policies and procedures (or new policies and procedures) are needed to prevent similar incidents or injuries from occurring in the future in accordance with it's QUAPI plan</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>This citation pertains to intake MI00150232.</p> <p>Based on interview and record review, the facility failed to ensure residents received quality care based on professional standards for 1 (Resident #103) of 3 residents reviewed for unwitnessed falls, resulting in a delay in identifying a change in condition and treatment for multicompartmental acute intracranial hemorrhage (brain bleed).</p> <p>Findings include:</p> <p>Resident #103</p> <p>Review of an Admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included history of falling.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 10/16/24, revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #103 was moderately cognitively impaired.</p> <p>Review of Resident #103's Care Plan revealed, (Resident #103) is at risk for falls r/t (related to) dementia, requires assist with ADL's (activities of daily living), skin impairment to heel with recommended cushion boots, new environment, seizure disorder, psychoactive medication use, hx (history) of falls, hx of intracranial hemorrhage, hx of alcohol abuse. (Resident #103) becomes restless while in bed, at times, attempting to stand. Date initiated: 8/14/24. Interventions: Anticipate needs. Date initiated: 8/14/24 . Bed in low position when resident is in bed. Date initiated: 9/25/24 .Call light within reach. Date initiated: 8/14/24 .Encourage Resident to remain in common areas while awake. Date initiated: 8/16/24. Encourage resident to stay out in common area until HS (night time) meds given. Date initiated: 9/25/24. Have commonly used articles within easy reach. Date initiated: 8/14/24. Keep bed at transfer height. Date initiated: 9/30/24. Low bed at all times. Date initiated: 8/14/24 .Offer resident frequent reminders to use call light during interactions. Date initiated: 8/14/24 . Offer toileting frequently throughout the day. Date initiated: 9/20/24 .</p> <p>Review of Resident #103's Fall Risk Evaluation dated 12/26/24 indicated that Resident #103 was confused most/all of the time, had a history of 3 or more falls within the last 3 months, was routinely incontinent, had adequate vision, was moderate/severely unsteady and required physical assistance. Resident #103 was impulsive, lacked understanding of physical and cognitive limitations and forgot or did not always use assistive devices. Resident #103 took three or more medications which increased risks for falls and Resident #103 had 3 or more predisposing diseases and conditions which increased risk for falls .</p> <p>Review of an Incident Report submitted by Nursing Home Administrator (NHA) A dated 1/12/25 revealed, . Details: (Resident #103) was seen in the bathroom laying on his back with an abrasion on his forehead, he was able to tell staff that he didn't hit his head, but he had a change in condition and staff notified on-call physician and an order was to send to local hospital. (Resident #103) returned with a hemorrhage. A full investigation will follow .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #103's Progress Note dated 1/10/2025 and documented by Registered Nurse (RN) HH revealed, Patient(Resident #103) was observed laying on the floor in restroom/ bedroom. This nurse was informed by CNA (Certified Nursing Assistant) that patient fell . Patient wheelchair was in the hallway. Patient was observed in a supine position (lying on back) face upward. Patient was assessed for injury and vital signs obtained. Patient has abrasion noted to bil (bilateral) elbows, and abrasion noted to left knee x2. Patient was transferred from floor to bed via hoyer. Patient is denying hitting head and pain and discomfort at this time. Provider notified of this fall along with DON (Director of Nursing). This nurse attempted to reach out to patient family unable to reach. Patient was treated with schedule pain medication. Patient appears to be in no pain or discomfort at this time. Provider gave orders to dress the abrasion with xerofoam (type of sterile gauze) and cover with Meplix (type of dressing) foam change QOD (every other day) until Monday when wound staff can follow up.</p> <p>Review of Resident #103 Progress Note dated 1/11/24 at 07:54 AM revealed, eMAR - Administration Note. Note Text: Assess Resident for Pain Every Shift every shift for Pain. Facial grimacing, he stated I hurt all over .</p> <p>Review of Resident #103 Progress Note dated 1/11/2025 at 9:27 AM and documented by Licensed Practical Nurse (LPN) EE revealed, Incident Note: Note Text: Res had a fall yesterday on second shift, he was complaining of generalized pain this morning, routine Tylenol and Ultram given as ordered, but he is denying pain at this time but facial grimacing, BP (blood pressure) is high 184/67, will retake, he normally eats breakfast and drinks his coffee, but he refused. DPOA (durable power of attorney) notified via phone call.</p> <p>Review of Resident #103's Progress Note dated 1/11/2025 at 9:28 AM and documented by LPN EE, revealed , Incident Note: Note Text: Abrasions noted to his forehead, and some blood on the carpet by his bed.</p> <p>Review of Resident #103's Progress Note dated 1/11/2025 at 11:01 AM and documented by LPN EE revealed, Note Text: still facial grimacing but denying pain, routine Tylenol and Ultram is coming up soon, BP is still high 159/84.</p> <p>Review of Resident #103's Progress Note dated 1/11/2025 at 12:23 PM and documented by LPN EE revealed, Note Text: 170/80, staff had to assist him with eating, this is new, he normally will get himself out of bed but has not done that either since the start of shift. He continues to deny pain but facial grimacing and frowning noted.</p> <p>Review of Resident #103's Progress Note dated 1/11/2025 at 1:51 PM and documented by LPN EE revealed, Note Text: spoke to his DPOA again for recent updates, not able to feed himself at lunch, did try to get of bed but staff helped him back quickly, he ate poorly at lunch with full staff assistance. continues to rest in bed.</p> <p>Review of Resident #103's Progress Note dated 1/12/2025 at 8:04 AM and documented by LPN EE revealed, Note Text: . resident is not alert as usual, bp is still high 173/68, he is sleeping a lot, total care now, this quite a change, eating less and coughing with meals and drinks.</p> <p>(continued on next page)</p>		

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F 0684 Level of Harm - Actual harm Residents Affected - Few	<p>Review of Resident #103's Progress Note dated 1/12/2025 at 10:39 AM and documented by LPN EE revealed, Note Text: Hey (Name redacted- Facility Physician Assistant C, running a low-grade fever of 99.3, cold compress applied. 157/67, P-88, O2-93%RA (oxygen saturation on room air), res (respirations) is 20, occasional coughing noted as well. Family is asking for some tests.</p> <p>Review of Resident #103's Progress Note dated 1/12/2025 at 10:59 AM and documented by LPN EE revealed, Note Text: On call provider (Physician Assistant C), ordered stat chest x-rays to views, order placed .</p> <p>Review of Resident #103 Progress Note dated 1/12/2025 at 12:12 PM, and documented by LPN EE revealed, Note Text: ADON (Former Assistant Director of Nursing) D asked for him to be sent out, and family agrees, sending out to (local hospital)</p> <p>Review of Resident #103's Progress Note dated 1/12/2025 11:11 PM and documented by LPN EE revealed, Note Text: The ER discharging nurse reported that res (Resident #103) has significant brain bleed, family declined treatment and want Hospice/comfort, (local hospice) Hospice nurse is coming in early in the morning to meet with family.</p> <p>Review of Resident #103's Hospital Records dated 1/12/25 revealed, . Chief Complaint: Fall Injury (Unwitnessed fall on Friday evening, did not seek medical attention at that time. Staff reports that patient is more somnolent (drowsy) since either yesterday or this morning, is normally confused but alert and conversative.) . Treatment Plan: Patient seen and examined by myself as well as my attending physician for a chief complaint of a fall on Friday for which he did not seek medical attention with increased somnolence/decreased mentation over the last 24 to 48 hours. At bedside patient Semi-Fowler's (lying on back with head of bed elevated) in bed, nontoxic-appearing, mumbling, not answering questions appropriately, not following commands. Vital signs assessed and patient was mildly hypertensive 180/100 . Physical exam findings did reveal a contusion over patient's left and right forehead with no deformity or crepitus or overlying laceration. Patient also had a significant number of bandages over all major joints with various dates from multiple falls over the last couple weeks no evidence of joint instability in extremities . Based on patient's initial presentation my initial clinical suspicion included intracranial hemorrhage from recent fall . I independently interpreted patient's head CT (computed tomography scan) and did appreciate what appears to be a significant intracerebral hemorrhage with no obvious fracture or dislocation . Given the protracted nature of time since the onset of symptoms and unsure disposition, patient's DPOA(durable power of attorney)contacted who is his eldest daughter and states the patient is currently a DNR (Do Not Resuscitate) and that she would like to discuss the case with her younger sibling to decide how to proceed whether or not to bring patient home for comfort care or if they would like patient admitted with more aggressive measures .Patient's DPOA/eldest daughter did contact me and states after discussing the case with her sister they do believe that they would like to have patient brought back to the sending facility and would be contacting hospice . Shortly after updating patient's daughter on the plan nursing alerted me that patient had fallen out of bed and landed on his face resulting in a significant laceration to the forehead and bridge of the nose. Patient was cleaned up and assisted back to bed by nursing. Given the goals of care as well as known intracranial hemorrhage no repeat imaging was performed based on goals of care wishes. Patient's lacerations were closed without complication; .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/19/25 at 12:52 PM, CNA Z reported that she was the staff member that had found Resident #103 after his fall on 1/10/25. CNA Z reported that she had gone to check on Resident #103 when he had not arrived in the dining area for dinner and she found him lying on the bathroom floor. CNA Z was unable to report the last time that she had checked on Resident #103, so she did not have any idea how long Resident #103 had been lying on the floor. CNA Z reported that she recalled Resident #103 had some blood on both of his legs, but she did not remember if he had any abrasions or bumps on his head.</p> <p>During an interview on 2/19/25 at 9:10 AM, RN HH reported that she was the nurse caring for Resident #103 the night that he fell . RN HH reported that she was notified by CNA Z that Resident #103 was on the floor and she went to assess him. RN HH reported that she did not notice any abrasions on Resident #103's head (as found in the hospital report). RN HH reported that she notified the provider on call, and the Director of Nursing (DON) about Resident #103's fall. RN HH reported that she had not noticed any changes with Resident #103 after his fall, but that she had never worked with him before, so she was not familiar with his baseline.</p> <p>During an interview on 2/19/25 at 1:17 PM, CNA BB reported that she had cared for Resident #103 after his fall on 1/10/25 and that Resident #103's assistance needs had increased to requiring total assistance from staff. CNA BB confirmed that Resident #103 was independent with tasks such as eating and dressing prior to his fall. CNA BB reported that this was a significant change for Resident #103.</p> <p>During an interview on 2/19/25 at 11:23 AM, LPN EE reported that she was the nurse that cared for Resident #103 on 1/11/25 and 1/12/25 after his fall. LPN EE reported that she had noted that Resident #103 appeared to be in pain, and she noticed an abrasion on his head near his hairline. LPN EE confirmed that Resident #103's blood pressure had increased since his fall, he was not eating, and requiring total assistance from staff, which was a change in condition for him. LPN EE reported that she had notified the on call provider, Physician Assistant (PA) C of the changes she had noticed with Resident #103. LPN EE reported that PA C had instructed her to order a chest x-ray since Resident #103 had a cough, and continue to monitor Resident #103. LPN EE reported that she was not sure if Resident #103's change in condition was related to his fall, but she did feel like Resident #103 would have benefited from going to hospital. LPN EE reported that she did not advocate to PA C for Resident #103 to be sent to the hospital, because he was the provider and she felt like she could trust his judgement. LPN EE reported that she did not know if PA C was aware that Resident #103 had an unwitnessed fall. LPN EE confirmed that PA C was not at the facility to assess Resident #103, and that the provider relied on nursing assessments and communication to make treatment decisions.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/19/25 at 10:56 AM, Former Assistant Director of Nursing (ADON) D reported that she was the staff member that instructed LPN EE' to send Resident #103 to the hospital on 1/12/25. Former ADON D reported that since she was the nursing manager, she had been included on all communication messages between nurses and PA C. Former ADON D reported that on 1/12/25 she had checked the messages from her home and when she read the communication between LPN EE' and PA C' about Resident #103, she was shocked that Resident #103 had not been sent out to the hospital yet. Former ADON D reported that from the messages she had read it was clear that Resident #103 was experiencing a change in condition and likely a closed head injury based on the symptoms. Former ADON D reported the symptoms she felt were likely related to a closed head injury included increased blood pressure, decline in ADL's, sleepiness, and an increased temperature. Former ADON D reported that she immediately called LPN EE and told her to send Resident #103 to the hospital. Former ADON D reported that she felt that LPN EE and PA C missed the change in condition for Resident #103, and that he should have been sent to the hospital as soon as changes were noted since Resident #103's fall was unwitnessed and he had an abrasion on his forehead, so it was likely that he had hit his head.</p> <p>During an interview on 2/19/25 at 2:13 PM, PA C reported that he was the provider on call on 1/11/25 and 1/12/25. PA C confirmed that he had been made aware that Resident #103 had a fall on 1/10/25, and that Resident #103 had an abrasion on his head and he did not eat breakfast. PA C reported that he was not aware of Resident #103's increased blood pressure. PA C' reported that he had not been contacted on 1/12/25. This writer read LPN EE's progress notes from 1/11/25 and 1/12/25 to PA C and queried as to what his clinical judgement was for the symptoms noted in the progress notes. PA C reported that the symptoms noted in LPN EE 's progress notes on 1/11/25 and 1/12/25 were all potential symptoms of a closed head injury. PA C reported that if he had been aware that Resident #103 was experiencing a change in condition and decline after a fall, he would have requested a virtual health visit to assess Resident #103, and then send him to the emergency department if he felt like it was necessary. PA C reported that he relied on the nurse's communication of changes to make treatment decisions because he was not in the facility to assess residents.</p> <p>On 2/19/25 at 1:11 PM, this writer requested a copy of the messages sent between LPN EE and PA C. NHA A reported that the messages were not available, and were deleted after 14 days.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>41424</p> <p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>Based on observation, interview and record review, the facility failed to prevent the further development of pressure ulcers for 1 (Resident #109) of 1 sampled resident reviewed for pressure ulcers, resulting in the development of 1 facility acquired pressure ulcer.</p> <p>Findings include:</p> <p>Resident #109:</p> <p>Review of an Admission Record revealed Resident #109 was a male with pertinent diagnoses which included mild cognitive impairment, Alzheimer's disease, weakness, restlessness and agitation, dementia, and pain.</p> <p>Review of current Care Plan for Resident #109, revised on 01/22/2025, revealed the focus, .Actual Pressure Injury Formation Related to decreased mobility, friction, prediabetes, overall decline with hospice care in place. Left heel St (stage) III, resolved 1/21/25 per wound care consult. Risk continues for maintaining resolved wound status secondary to progressing comorbidities, friction and shearing r/t resident rubbing heels on mattress with removal of foam heel boots. Debility and generalized weakness with decreased physical mobility and overall decline with hospice care in place . with the intervention .Apply skin prep to left heel once a day and float heels while in bed for 2 weeks to prevent wound from re-opening .Encourage and assist as needed to turn and reposition per policy; use assistive devices, pillows as needed .Encourage resident to float heels and /or wear heel boots .Frequent turning and repositioning .Monitor wound for any significant changes (decline or improvement), alert physician of any changes Skin Evaluation weekly-Check skin for open areas, bruises, abrasions, DTI (deep tissue injury-pressure injury that occurs where prolonged pressure or shear forces damage the underlying soft tissues, such as muscle, tendons, and bones), incisions</p> <p>Review of Braden Scale from Predicting Pressure Sore Risk dated 2/3/25, revealed, .Ability to respond meaningfully to pressure-related discomfort .3. Slightly limited .cannot always communicate discomfort or the need to be turned or has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities .Very moist .Chairfast: Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair .Mobility: Slightly Limited .Friction & Shear: Problem: Requires moderate to maximum assist in moving .Frequently slides down in bed or chair .Requiring frequent repositioning with maximum assistance .</p> <p>Review of Skin & Wound Evaluation dated 11/5/24, revealed, .Pressure, Stage 3, Left Heel, In-house acquired .New .5.4 CM area .3.0 CM length .2.3 CM width .granulation .100% of wound filled .light exudate (fluid that leaks out of blood vessels into surrounding tissues) .serosanguineous (fresh blood) .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of (Wound Provider Service) Follow-up dated 1/14/2025 at 10:27 PM, revealed, .CHIEF COMPLAINT: Wound 1 Left heel, Pressure, Stage 3 .Nursing staff notes a pressure wound on the patient's left heel. Wound specialist consulted for evaluation and treatment .SKIN: history of a pressure ulcer .Support Surface(s): Group 2 mattress, Pressure reduction cushion, Sponge boots, Offloading pillows .</p> <p>AMBULATION/MOBILITY: Has limited ambulation, Out of bed mobility with a wheelchair, Impaired mobility with transfer from supine to sitting, Dependent for bed mobility .WOUND ASSESSMENT: Wound: 1 . Location: Left heel .Primary Etiology: Pressure .Stage/Severity: Stage 3 .Wound Status: Improving without complications .Odor Post Cleansing: None .Size: 0.6 cmx 0.5 cm x 0.1 cm. Calculated area is 0.3 sq cm . Exposed Tissues: Scab, 100% .PLAN: Wound # 1 Left heel Pressure: Treatment Recommendations: 1. Cleanse with wound cleanser .2. Apply Skin Prep .3. Secure with Leave open to air .4. Change and PRN, Daily .Continue routine offloading and repositioning per facility protocol, Use sponge boots for heel offloading, Use pillows for repositioning and offloading .ADDITIONAL DATA: Float Heels while in bed .</p> <p>Review of Skin & Wound Evaluation dated 1/21/25, revealed, .Pressure, Stage 3, Left Heel, In-house acquired .staged by health care provider .Resolved .</p> <p>Review of Skin-Total Body Evaluation dated 2/17/25 at 10:57 AM, revealed, .Comments: Red spots noted to face, legs, and thighs; redness noted to heels .</p> <p>During an observation on 2/18/25 at 11:06 AM, Resident #109 was lying in his bed, the bed appeared to be too small for him, his feet were on the footboard and his knees were bent. Resident #109 was observed to not have any socks on or non-slip socks. Resident #109 did not have pressure reducing boots on his feet nor did he have a pillow or other device to elevate his heels off the bed. Resident #109 was in supine position, head of bed was approximately 40 degrees.</p> <p>During an observation on 2/18/25 at 1:15 PM, Resident #109 was observed lying in his bed, he was leaning over and grabbing the privacy curtain, had his legs bent at the knees, and had his feet off to the right side. The head of his bed was elevated approximately 60 degrees, pillow behind his head which had pushed his head forward. Resident #109 did not have pressure reducing boots on his feet nor did he have a pillow or other device to elevate his heels off the bed.</p> <p>During an observation on 2/20/25 at 09:21 AM, Resident #109 was observed in his bed, he had his feet out under the sheet and he did not have boots on his feet. Resident #109 did not have pillows under his feet, he had his legs drawn up, knees bent, and his legs were leaning to the right side. He had the head of the bed up approximately 40 degrees.</p> <p>In an interview 2/20/25 at 10:09 AM, Director of Maintenance AA reported a bed extender would probably need to be ordered due to the bed controls were in the footboard. The foot board would not be able to be removed as well due to the controls imbedded in footboard.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/20/25 at 09:25 AM, Certified Nursing Assistant (CNA) Z reported Resident #109 does not like to wear his boots, he always takes them off, he will get mad if we put them on there. The boots were located on the shelf in the room, she donned gloves and examined his feet, on the outer edge of the bottom of his left heel he had an area which appeared red/purplish, dry, opened splits in the skin. CNA Z reported he does slide down in the bed and the staff have to reposition him back up in the bed. CNA Z was observed leaving Resident #109's room and obtained a pillow and pillow case and placed a pillow under his feet. Observed no bed extended on the bed frame. CNA Z reported she would report to the nurse what she had observed on his heel.</p> <p>In an interview on 2/20/25 at 09:42 AM, LPN II reported she observed Resident #109's foot and she was going to put in a note to have the wound nurse take a look at it when they come in. LPN II reported the nurse comes in once a week and does rounds. LPN II reported he was a tall man and would scooch down in the bed and they would have to re-adjust him, right now he was okay, we discussed the potential for him to obtain a wound on his foot and was asked if the facility had bed extenders due to his height it that might best due to him placing his feet on the bed, had big feet too she said. LPN II reported the nurses were able to enter a work order right in the electronic medical record for the maintenance staff to come and take a look at to get him a bed extender and she was entering the request for Resident #109. LPN II reported it would make sense for him to have a extender due to his scooching down, his height, and his placement of his feet on the foot board.</p> <p>In an interview on 2/20/25 at 12:01 PM, Director of Nursing (DON) B reported for residents prone to pressure ulcers on their heels, and would obtain a bed extender for Resident #109 as he was tall and his feet were on the footboard. DON B reported if the resident refused to use the boots, the staff should have implemented the use of a pillow or other means to keep his heels off the bed.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>This citation pertains to intake MI00150232.</p> <p>Based on interview and record review, the facility failed to 1.) Provide adequate supervision and assistance to prevent falls with injury for 2 (Resident #103 and Resident #101) of 3 residents; 2.) implement and revise care plan interventions to prevent falls for 2 (Resident #103 and #108) resulting in Resident #103 falling and sustaining a multicompartamental acute intracranial hemorrhage (brain bleed), Resident #101 falling and sustaining T3 and T8 (spine locations) fractures, and the potential for a fall with injury for Resident #108.</p> <p>Findings include:</p> <p>Resident #103</p> <p>Review of Admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included history of falling.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of [DATE], revealed a Brief Interview for Mental Status (BIMS) score of ,d+[DATE] which indicated Resident #103 was moderately cognitively impaired.</p> <p>Review of Resident #103's Care Plan revealed, (Resident #103) is at risk for falls r/t (related to) dementia, requires assist with ADL's (activities of daily living), skin impairment to heel with recommended cushion boots, new environment, seizure disorder, psychoactive medication use, hx (history) of falls, hx of intracranial hemorrhage, hx of alcohol abuse. (Resident #103) becomes restless while in bed, at times, attempting to stand. Date initiated: [DATE]. Interventions: Anticipate needs. Date initiated: [DATE] . Bed in low position when resident is in bed. Date initiated: [DATE] .Call light within reach. Date initiated: [DATE] .Encourage Resident to remain in common areas while awake. Date initiated: [DATE]. Encourage resident to stay out in common area until HS (night time) meds given. Date initiated: [DATE]. Have commonly used articles within easy reach. Date initiated: [DATE]. Keep bed at transfer height. Date initiated: [DATE]. Low bed at all times. Date initiated: [DATE] .Offer resident frequent reminders to use call light during interactions. Date initiated: [DATE] . Offer toileting frequently throughout the day. Date initiated: [DATE] .</p> <p>Review of Resident #103's Fall Risk Evaluation dated [DATE] indicated that Resident #103 was confused most/all of the time, had a history of 3 or more falls within the last 3 months, was routinely incontinent, had adequate vision, was moderate/severely unsteady and required physical assistance. Resident #103 was impulsive, lacked understanding of physical and cognitive limitations and forgot or did not always use assistive devices. Resident #103 took three or more medications which increased risks for falls and Resident #103 had 3or more predisposing diseases and conditions which increased risk for falls .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of an Incident Report submitted by Nursing Home Administrator (NHA) A dated [DATE] revealed, . Details: (Resident #103) was seen in the bathroom laying on his back with an abrasion on his forehead, he was able to tell staff that he didn't hit his head, but he had a change in condition and staff notified on-call physician and an order was to send to local hospital. (Resident #103) returned with a hemorrhage. A full investigation will follow .</p> <p>Review of Resident #103's Progress Notes dated [DATE] and documented by Registered Nurse (RN) HH revealed, Patient (Resident #103) was observed laying on the floor in restroom/ bedroom. This nurse was informed by CNA (Certified Nursing Assistant) that patient fell . Patient wheelchair was in the hallway. Patient was observed in a supine position face upward. Patient was assessed for injury and vital signs obtained. Patient has abrasion noted to bil (bilateral) elbows, and abrasion noted to left knee x2. Patient was transferred from floor to bed via hoyer. Patient is denying hitting head and pain and discomfort at this time. Provider notified of this fall along with DON (Director of Nursing). This nurse attempted to reach out to patient family unable to reach. Patient was treated with schedule pain medication. Patient appears to be in no pain or discomfort at this time. Provider gave orders to dress the abrasion with xerofoam (type of sterile gauze) and cover with Meplix (type of dressing) foam change QOD (every other day) until Monday when wound staff can follow up.</p> <p>Review of Resident #103's Hospital Records dated [DATE] revealed, . Chief Complaint: Fall Injury (Unwitnessed fall on Friday evening, did not seek medical attention at that time. Staff reports that patient is more somnolent (drowsy) since either yesterday or this morning, is normally confused but alert and conversative.) . Treatment Plan: Patient seen and examined by myself as well as my attending physician for a chief complaint of a fall on Friday for which he did not seek medical attention with increased somnolence/decreased mentation over the last 24 to 48 hours. At bedside patient Semi-Fowler's (lying on back with head of bed elevated) in bed, nontoxic-appearing, mumbling, not answering questions appropriately, not following commands. Vital signs assessed and patient was mildly hypertensive ,d+[DATE] . Physical exam findings did reveal a contusion over patient's left and right forehead with no deformity or crepitus or overlying laceration. Patient also had a significant number of bandages over all major joints with various dates from multiple falls over the last couple weeks no evidence of joint instability in extremities . Based on patient's initial presentation my initial clinical suspicion included intracranial hemorrhage from recent fall . I independently interpreted patient's head CT (computed tomography scan) and did appreciate what appears to be a significant intracerebral hemorrhage with no obvious fracture or dislocation . Given the protracted nature of time since the onset of symptoms and unsure disposition, patient's DPOA(durable power of attorney)contacted who is his eldest daughter and states the patient is currently a DNR (Do Not Resuscitate) and that she would like to discuss the case with her younger sibling to decide how to proceed whether or not to bring patient home for comfort care or if they would like patient admitted with more aggressive measures .Patient's DPOA/eldest daughter did contact me and states after discussing the case with her sister they do believe that they would like to have patient brought back to the sending facility and would be contacting hospice . Shortly after updating patient's daughter on the plan nursing alerted me that patient had fallen out of bed and landed on his face resulting in a significant laceration to the forehead and bridge of the nose. Patient was cleaned up and assisted back to bed by nursing. Given the goals of care as well as known intracranial hemorrhage no repeat imaging was performed based on goals of care wishes. Patient's lacerations were closed without complication; .</p> <p>It was noted that there were no care plan interventions added to Resident #103's Care Plan after his falls on [DATE] or [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #103's Progress Not dated [DATE] revealed, Note Text: (Resident #103) was noted on the floor mat next to his bed by a CNA (Certified Nursing Assistant) assigned to the unit. (Resident #103) was alert and talkative upon assessment. Zero injury noted . He stated that he was trying to get himself to the bathroom because he had to urinate. This Nurse explained to him that there was a catheter in place to catch his urine .</p> <p>During an interview on [DATE] at 12:52 PM, CNA Z reported that she was the staff member that found Resident #103 on his bathroom floor after an unwitnessed fall on [DATE]. CNA Z reported that Resident #103 was found on his bathroom floor, and that he had reported to her that he was trying to get up to go to the bathroom. CNA Z was unable to report the last time she had checked on Resident #103. CNA Z was unable to report how often staff were supposed to check on Resident #103. CNA Z confirmed that Resident #103 was supposed to be assisted to the restroom every two hours. CNA Z reported that she had no clue when Resident #103 had last been assisted to the toilet. CNA Z reported that Resident #103 would sometimes use his call light, but that he was also impulsive, and would frequently self transfer without asking for assistance. CNA Z did not know other care plan interventions that were in place to decrease Resident #103's risks for falls.</p> <p>During an interview on [DATE] at 9:10 AM, Registered Nurse (RN) HH reported that she was the staff member that assessed Resident #103 after his fall on [DATE]. RN HH reported that she had never cared for Resident #103 before, and was not aware that he was a high fall risk. RN HH reported that she had reached out to the Director of Nursing (DON) for assistance after Resident #103's fall for assistance, and she was told that the DON would complete the incident report and create new care plan interventions to reduce Resident #103's risks for more falls. RN HH confirmed that she did not implement any immediate interventions to reduce Resident #103's risks more falls.</p> <p>During an interview on [DATE] at 11:23 AM, Licensed Practical Nurse (LPN) EE reported that Resident #103 was a fall risk. LPN EE reported that Resident #103 would frequently attempt to self-transfer. LPN EE reported that Resident #103 would occasionally use a call light, but he often would try to do things himself. LPN EE reported that the only fall prevention interventions in place for Resident #103 that she could recall were a fall mat in his room, and grippy socks.</p> <p>During an interview on [DATE] at 4:21 PM, LPN GG reported that Resident #103 was frequently restless and confused, and would often try to self transfer. LPN GG confirmed that Resident #103 had fallen frequently at the facility. LPN GG reported that she did not think that Resident #103 was on a toileting schedule, or how often staff were supposed to check on him. This writer queried what frequently was defined as for Resident #103's care plan intervention which stated Offer toileting frequently throughout the day. Date initiated: [DATE]. LPN GG reported that she did not know what frequently was defined as, and confirmed that Resident #103's care plan intervention was not descriptive enough for staff to follow. LPN GG reported that the facility had struggled with staffing, and the unit that Resident #103 resided on required more staffing to provide adequate supervision of all of the residents, which they did not always have.</p> <p>During an interview on [DATE] at 9:42 AM, Unit Manager (UM) DD reviewed Resident #103's care plan with this writer and confirmed that Resident #103's care plan was not descriptive enough for staff to follow.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on [DATE] at 10:56 AM, Former Assistant Director of Nursing (ADON) D reported that staffing at the facility had been a major issue, and it had affected resident care, including staff being able to provide adequate supervision. ADON D reported that the facility was wildly out of control and residents were frequently falling. ADON D confirmed that the facility did not have IDT (interdisciplinary) meetings after resident falls to review the fall and implement new care plan interventions to reduce further falls.</p> <p>During an interview on [DATE] at 10:47 AM, DON B reviewed Resident #103's care plan with this writer and confirmed that the care plan interventions were too broad and not easy for staff to follow.</p> <p>During an interview on [DATE] at 1:40 PM, Nursing Home Administrator (NHA) A reported that she was responsible for investigating Resident #103's fall on [DATE]. NHA A was unable to report the findings from her investigation as to why Resident #103 fell , and what changes the facility made to decrease further falls. NHA A confirmed that the facility IDT team had not met after Resident #103's falls on [DATE] and [DATE] to implement new interventions to reduce further falls. NHA A reported that Resident #103 had last been assisted to the toilet around 11:00 AM, and she thought that Resident #103 had fallen around 8:00 PM. NHA A confirmed that she did not know how long it had been since Resident #103 had been checked on by staff. NHA A reported that she did not review Resident #103's hospital records from his fall on [DATE], and she was unaware that Resident #103 had been diagnosed with multicompartmental acute intracranial hemorrhage prior to his fall at the hospital. NHA A confirmed that Resident #103 fell on [DATE] after he returned from the hospital.</p> <p>Review of the facility's Fall Policy dated [DATE] revealed, Policy Overview: The purpose of this policy is to provide guidelines to assist with a fall risk identification and fall management of residents in the facility .Care Planning: The facility staff, with input from the attending physician, will implement a resident centered comprehensive care plan that addresses the fall management program, the goal for fall management, individualized interventions to address the residents modifiable risk factors, interventions to try to minimize the consequences of risk factors that are not modifiable, and the plan for reduction of risk or risk for injury related to falls .The resident's care plan and interventions will be revived and revised as indicated for the individual needs of the resident and effectiveness of of interventions .Post fall evaluation: . if there is evidence of injury, provide appropriate first aide and/or obtain medical treatment immediately .IDT review: The interdisciplinary team will review the resident's fall including: the circumstances surrounding the resident's fall and any changes in the resident's risk factors, conditions, and/or functional status to validate/determine the root cause of the fall. The interdisciplinary team will review the resident's care plan and interventions to ensure the interventions are appropriate for the resident's post-fall interventions correlate to the root cause of the fall in an attempt to prevent future falls .</p> <p>41424</p> <p>Resident #101:</p> <p>Review of an Admission Record revealed Resident #101 was a male with pertinent diagnoses which included Alzheimer's disease, heart failure, muscle weakness, repeated falls, difficulty in walking, spinal stenosis (narrowing of one or more spaces within your spinal canal), and dislocation of T,d+[DATE] thoracic vertebra (middle segment of the spine have moved out of their normal position).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of current Care Plan for Resident #101, revised on [DATE], revealed the focus. .At risk for falls and safety risks due to Alzheimer's disease with impaired cognition, history of repeated falls, impaired balance, weakness, potential medication side effects, visual impairment related to glaucoma, congestive heart failure, cardiomyopathy (), anemia (low iron in the blood), protein calorie malnutrition, hx (history) syncope (fainting). (Resident #101) has impaired safety awareness and frequently attempts to self-transfer without assistance . with the intervention .Assist to chair and high traffic area when awake as resident allows .bed in low position when resident is in bed .call light within reach .Encourage to transfer and change positions slowly .Have commonly used article within easy reach .Provide assist to transfer and ambulate as needed .Reinforce need to call for assistance .Therapy evaluation and treatment per orders .</p> <p>Review of Admission Evaluation dated [DATE] at 4:06 PM, revealed, Resident #101 had occasional confusion, ,d+[DATE] falls in the last 3 months, balance/unsteady while standing, transferring and/or walking - moderate/severe unsteadiness - required physical assist. Resident #101's safety awareness was attempts to self-transfer or ambulate when not recommended to do so, impulsive, lack of understanding of physical and cognitive limitations. The baseline care plan for Resident #101 was minimize risk for falls. Resident #101 was screened for transfers which revealed resident was not able to stand pivot transfer with contact guard assist or less, was not able to move from supine to sitting, and required manual, supervised transfers with a gait belt.</p> <p>Requested and reviewed a list of falls for the last 30 days which revealed, Resident #101 had 4 unwitnessed falls.</p> <p>Review of Incident Reports dated ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], ,d+[DATE], and ,d+[DATE] revealed immediate interventions were not implemented for Resident #101's safety as he was considered a high fall risk and required additional supervision to prevent further falls</p> <p>Review of Resident #101's care plan revealed the care plan was not updated after each fall incident to aid in the prevention of further falls.</p> <p>Review of History and Physical dated [DATE] at 00:00 AM, revealed, .Patient required sitter during hospital admission due to impulsivity, confusion, and behaviors .</p> <p>Review of No Type Specified note dated [DATE] at 11:08 AM, revealed, .Attempting to stand up, looking for his car, lots of redirections, called his significant other, they are currently talking on the phone . Note: This was not included as an intervention for Resident #101's care plan.</p> <p>Review of Nursing -Progress Note dated [DATE] at 11:54 PM, .Patients' roommate put on call light for assistance. Staff went into room to answer call light and observed patient on the floor sitting on his buttocks with feet in front of him and back against the wall next to the bathroom door. Patient was barefoot and walker still next to bed. Patient stated he had just gone to the bathroom and lost his balance and fell . Nursing assessment completed, no injuries or bruises noted. Neuro checks implemented, Vss (vitals) BP,d+[DATE] P (pulse) 88 R(respirations)16 T (temperature) 97.60296% rm air. On call provider and nursing team notified. Patient is currently resting in bed with no known concerns at this time . Note: No intervention to provide frequent rounding, signage to remind resident to use his walker, or staff increased requests to assist to restroom were not included as interventions for Resident #101's care plan.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #101's care plan did not include an intervention for grippy non-slip socks or footwear.</p> <p>Review of Fall-Risk Evaluation dated [DATE] at 00:22 AM, revealed, Resident #101 had occasional confusion, ,d+[DATE] falls in the last 3 months, poor/impaired vision, and he was impulsive, forgets or does not always use assistive devices, lack of understanding of physical and cognitive limitations, and attempted to self-transfer.</p> <p>Review of Nursing -Progress Note dated [DATE] 02:05 AM, revealed, .Patient continues to try and self-transfer out of bed throughout the night. Patient was asked what he needs. Patient stated, I don't know I was trying to get a sheet!! Patient had sheet and blanket covering him. Staff asked patient was he cold and needed extra blankets? patient begin to yell at staff saying, leave me alone! Patient reminded once again to use call light and to not get up without assistance .</p> <p>Review of Nursing -Progress Note dated [DATE] at 01:15 AM, revealed, .At 2300 (11:00 PM) Assigned Nurse went to do rounds, Patient was observed lying on the floor next to his sink and bathroom door. The bathroom door was halfway open with lightbulb on. Patient's Head was against the bottom of the bathroom door, legs out in front of him, sitting on his buttocks. Patient bed was in the low position did not see walker in room. Wheelchair was on the other side of room. Patient had on pjs with regular socks. Patient stated that he doesn't remember what he was doing and asked me to go get the neighbors with the truck to help him up. nursing assessment completed patient complained of pain in his lower back. Patient stated that he cannot sit up and kept falling over could not sit straight up. On Call provider notified and patient sent out to (Local Hospital) for further eval. VSS BP,d+[DATE] P80 R18 0296% rm air. Neuro checks implemented .</p> <p>Review of Nursing -Progress Note dated [DATE] at 06:47 AM, revealed, .This nurse received report from ER (emergency room) Nurse (First Name) stating that resident is on his way back from (Local Hospital) ER. ER Nurse stated that resident has a T3 & T8 fracture. ER Nurse states that patient has a follow up appointment in a few weeks but at this time it is nothing they can do for the fractures and will let them heal on their own and have patient continue therapy .</p> <p>Review of Progress Note for (Local Hospital) Emergency Department dated [DATE] revealed, .HPI: The patient is a [AGE] year-old male presents emergency depart chief complaint of fall . States that today he was found down in the bathroom. Unsure of the mechanism. The patient is altered at baseline but able to answer basic questions. States that he does not remember any of the symptoms prior to the fall. Does not remember if he hit his head or not. Not on any blood thinners. Main complaint is lower back pain .Musculoskeletal: Comments: Lower back tenderness. Full range motion of upper and lower extremities. No reproducible tenderness over extremities .Assessment/Plan: DIAGNOSIS at time of disposition: 1. Fall, initial encounter . 2. Closed fracture of third thoracic vertebra, unspecified fracture morphology, initial encounter (HCC) .3. Closed fracture of eighth thoracic vertebra, unspecified fracture morphology, initial encounter (HCC) .CT scans .The scans revealed fractures of the T3 and T8 vertebrae .</p> <p>Review of No Type Specified dated [DATE] at 08:02 AM, revealed, .CNA observed res standing and walking in his room unassisted, staff assisted him to his wheelchair and back into the dining room .</p> <p>Review of Nursing -Progress Note dated [DATE] at 11:12 PM, revealed, .Res is attempting to transfer himself all the time, not using the call light for help .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of No Type Specified dated [DATE] at 06:50 AM, revealed, ,(Resident #101) was alert and restless during the evening. He wheeled himself from the common area of the unit back and forth to his room several times.(Resident #101) was noted transferring himself from his wheelchair and standing in his room. He was redirected by staff and encouraged to ask for help many times during the evening.(Resident #101) would not wait for staff to assist him. He continued to take himself back to his room each time staff tried to keep him within sight for the purpose of his safety due to his poor safety awareness ,(Resident #101) continued to attempt to self- transfer late during the night. Staff had to visit his room frequently to check to make sure he was safe. VSS. Neurological assessment is WNL (within normal limits) ,(Resident #101) did not complain of pain. This Nurse suggests placing a tab alarm on Resident due to his restlessness, poor safety awareness, and frequent falls .</p> <p>Review of Incident Note dated [DATE] at 2:06 PM, revealed, .Resident was observed laying on the floor in his room. He was laying on his right side, and he was holding his head up. No injury noted as of now. Voice message left for significant other, on call supervisor notified via phone call, on call provider notified via tiger text message. Alert charting and neurological assessment initiated .</p> <p>Review of Incident Report dated [DATE] at 9:30 PM, revealed, .At about 9:30 PM, res was observed laying on floormat by his bedside .Level of pain: 4 .</p> <p>Review of Nursing - Progress Note dated [DATE] at 06:05 AM, revealed, .Patient continued to self-transfer out of bed during the night. Patient is impulsive and does not put on call light to have staff assist him to the bathroom. Patient was given a urinal to keep at bedside but often forgets to use it and stills try to self-transfer himself out of bed .</p> <p>Review of Nursing - Progress Note dated [DATE] at 11:22 PM, revealed, .Urine sample obtained, called (Local Hospital) lab for pick up .</p> <p>Review of Incident Report dated [DATE] at 11:43 AM, revealed, .At 1130, (Resident #101) was observed sitting in the hallway with legs stretched out with his back leaning against the wall. He was next to his wheelchair. Had grippy socks on .Res. stated help me please .</p> <p>Review of IDT dated [DATE] at 11:18 AM, revealed, .Pt (patient) was observed on the matt next to his bed laying on the floor. Resident had on his gripper socks . Note: Fall mat was not included as an intervention in Resident #101's care plan.</p> <p>In an interview on [DATE] at 12:15 PM, Registered Nurse (RN) CC reported when a resident had a fall, she would go to them to assess, take vitals, perform ROM (if necessary), ask if the resident had pain or hit their head, if necessary start neuro checks on the resident. RN CC reported then you would try to determine why the fall occurred and create interventions to assist with preventing the incident from happening again. RN CC reviewed the green folder for Falls at the nurse's station, which contained a document named Falls Risk management checklist .3. Immediate interventions to ensure they don't fall again? When queried RN CC reported Try to come up an intervention so they don't repeat with the same cause of the fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on [DATE] at 12:36 PM, Unit Manager (UM) DD reported the nurse would create a risk management report for an incident and the nurse reviewed the care plan, update it with an intervention, and if there was not a focus already one would be created with interventions. UM DD reported an immediate intervention would be created with each fall. UM DD reported when a risk management report was generated additional tabs would be opened for additional assessments such as a fall risk evaluation. She indicated there was a point in the risk management report where the nurse was able to add witness statements from the staff present. UM DD reported the care plan were able to be updated by the nurses. UM DD reported for residents who were impulsive and had multiple falls, the facility would develop interventions to help keep that individual safe such as, possibly the resident needed a different chair. For example, when a resident utilized a broda chair, they may not be comfortable in it and attempt to get out of it. For residents who wander, they may need a lot of redirection, for those who forget to use their walkers -reminders to use their walkers. The staff on the floor needed to continue re-orienting the residents, keep reinforcing the use of the walker. Staff would need to have eyes on the floor, and when residents were in their rooms as well by looking in on them frequently. The staff should be walking the hallway, laying eyes on the residents, redirecting them, possibly have the residents come out and participate in activities, encourage them to come out of their rooms, do activities with the residents or give them something to work on like a puzzle, cards, or just talking with the residents. UM DD reported the staff should be making rounds on the floors, monitoring residents as they were the first line on the floor.</p> <p>In an interview on [DATE] at 11:09 AM, Director of Nursing (DON) B reviewed Resident #101's care plan and reported the first intervention noted in the care plan was dated [DATE]. DON B reported there were not interventions developed for Resident #101 following each fall. She reported an immediate intervention was to be created after each fall to ensure the resident's safety and minimize the risk for injury. DON B reported the falls were reviewed each morning during the morning meeting with all the disciplines involved for different perspectives for possible reasons for falls, and they would review the interventions to determine if the immediate intervention was a good intervention or revise the care plan. On [DATE] at 11:42 AM, DON B reported antitippers was the initial intervention for Resident #101 at entry for a baseline care plan.</p> <p>Resident #108:</p> <p>Review of an Admission Record revealed Resident #108 was a female with pertinent diagnoses which included right artificial hip joint, joint replacement surgery, muscle weakness, difficulty in walking, necrosis of the bone (loss of blood supply to the bone causing it to die) and history of falling.</p> <p>Review of current Care Plan for Resident #108, revised on [DATE], revealed the focus, .At risk for falls due to total right hip replacement . with the intervention .Provide assist to transfer and ambulate as needed .</p> <p>Review of current Care Plan for Resident #108, initiated on [DATE], revealed the focus, .Resident has an ADL self-care performance deficit related to: activity intolerance, ADL abilities will fluctuate with therapy staff and nursing staff, limited mobility . with the intervention .Locomotion: x1 assist x 100' with fww (four wheeled walker) .Toilet Use: 1 person assist with fww .Transfer: 1 person assist with fww .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Physical Therapy: PT Evaluation & Plan of Treatment dated [DATE], revealed, Reason for Therapy: chronic h/o (history of) arthritis underwent s/p R THA (total hip arthroplasty), presents with R (right) LE (lower extremity) weakness, poor dynamic balance (ability to maintain stability while moving your body), difficulty standing, walking and cannot walk for any length of time .Fall Predictors: Inadequate postural control, inadequate ankle dorsiflexion (movement of the ankle joint where the foot is raised towards the shin), reduced quad strength (thigh muscles) and weak trunk and hip extensors .</p> <p>In an interview on [DATE] at 12:57 PM, Resident #108 reported when she called staff for assistance to use the restroom, Certified Nursing Assistant (CNA) E responded to her request. Resident #108 reported asked her for assistance to get to the bathroom and Resident #108 reported CNA E informed her she was here for therapy, she needed to learn to be independent, and she just stood there watched her struggle. Resident #108 reported she just needed a little help with her leg and she needed to get to the bathroom. Resident #108 reported she did not assist her with transferring out of her bed either. Resident #108 reported she was in pain and she was concerned for her safety.</p> <p>In an interview on [DATE] at 09:15 AM, Director of Therapy O reported Resident #108 came in as a one assist with ambulation, transfers, toileting. Director of Therapy O reported one assist was with one staff member with a gait belt for ambulation, transfers, and toileting with contact and steady hand to stabilize Resident #108 if she needed it.</p> <p>In an interview on [DATE] at 10:35 AM, Licensed Practical Nurse (LPN) II reported the resident's information - how they transfer, ambulation, the basics of to care for them was on the communication board. LPN II reported the information was entered prior to the resident coming, also the nurse at the hospital gives a nurse to nurse report. LPN II reported all staff have access to the communication board and she would also speak to the CNAs to share information with them as well. CNA R was present, and she reported the CNAs would also look at the Kardex as that would tell them how to care of the resident.</p> <p>In an interview on [DATE] at 11:09 AM, Director of Nursing (DON) B reported the admission process was a current work in progress. DON B reported the baseline care plan was created from the admission assessment. DON B reported the care plan created a Kardex for the staff to refer to. DON B reported the nurse created the care plan, she would give report to the CNA, after that can review the Kardex and update that form for them.</p> <p>In an interview on [DATE] at 11:09 AM, Director of Nursing (DON) B reported a one person assist would require the staff to provide support or supervision to the resident. DON B reported with a resident who had a recent join surgery the expectation was for staff to provide support to the resident for safety.</p> <p>This writer attempted to contact CNA E who did not reach back prior to exit from the facili [TRUNCATED]</p>		