STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235458	A. Building B. Wing	08/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Grand Rapids	1950 32nd Street SE 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)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2583410 and 1214279.Based on observation, interview, and record review, the facility failed to provide respectful and dignified personal care and services for 4 (Resident #102, #103, #106, and #107) of 6 residents reviewed for dignity, resulting in unmet care needs, and feelings of diminished self-worth, sadness, and frustration. Findings include: Resident #102Review of an admission Record revealed Resident # 102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and major depressive disorder. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 8/8/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #102 was cognitively intact. Review of Resident #102's Care Plan revealed, Focus: ADL (activities of daily living) self-care deficit related to weakness . Date Initiated: 05/04/2025. Goal: Will receive assistance necessary to meet ADL needs. Date Initiated: 05/04/2025. Interventions: ADL Assist of 1 staff. Date Initiated: 05/04/2025. Assist with daily hygiene, grooming, dressing, oral care and eating as needed. Date Initiated: 05/04/2025 . Focus: Resident has urinary incontinence (loss of bladder control). Date Initiated: 05/04/2025. Goals: Will have no complications due to incontinence. Date Initiated: 05/05/2025. Interventions: Provide assistance with toileting. Date Initiated: 05/04/2025 . Review of Resident #102's Grievance form dated 5/14/25 revealed, Documentation of concern: (Resident #102) states that she doesn't get her call light answered . Action taken regarding concern: Nurse Manager are working on rearranging assignments. Call light education . Review of Resident #102's Grievance form dated 6/18/25 revealed, Documentation of concern: Diaper not changed. Has bed sores on behind. Action taken regarding concern: Resident stated that she was talking about past hx (history) and there is no open area in buttock. Nurse confirmed . It was noted that the action taken did not address Resident #102 being left in a soiled brief. Review of Resident #102's Grievance form dated 6/18/25 revealed, Documentation of concern: She (Resident #102) has her call light on. She did not see anyone for 5 hours . Action taken regarding concern: Followed up with resident and she states response time to call lights is better however she waited longer than usual to get assistance off the toilet, but it is during dinner time. 6/30/25- response time is better . It was noted that the action taken did not address Resident #102 waiting five hours for her call light to be answered. Review of Resident #102's Grievance form dated 7/2/25 revealed, Documentation of concern: (Resident #102) is claiming that on 6/30/25 it took staff 4 hours to answer the call light. She needed her medication and put to bed .Action taken regarding concern: .Physician visit explained to resident. Education to staff . Review of Resident #102's Grievance form dated 7/3/25 revealed, Documentation of concern: Claims call light was not answered timely . Action taken regarding concern: Physician visit process explained, NP (Nurse Practitioner) updated to review about sleep regimen . It was noted that the action taken did not address Resident #102's concern related to call lights not being answered timely. In an interview on 8/12/25 at 10:58 AM, Resident #102 reported that she had ongoing concerns with unmet care needs at the facility. Resident #102 reported that facility staff would often take hours to answer call lights, which would lead to Resident #102 being left in soiled briefs for extended periods of time. Resident #102 reported that if staff did answer call lights in a reasonable amount of time, they would often turn the light off and say that they would return to address the need, but it would take hours for staff to return. Resident #102 reported that she felt like many of the staff were rude and abrasive and would often enter resident rooms without knocking first and introducing themselves. Resident #102 reported that she was frequently woken up by staff turning on the lights, and being told It's time to get up. Resident #102 reported that she had talked to the facility management staff about her concerns several times, and she still felt that the issues were ongoing. Resident #102 reported feelings of frustration with how she was being treated by staff at the facility. In an observation on 8/12/24 at 10:18 AM, Social Worker (SW) KK was observed entering a resident room on the 400 hall without knocking or addressing the resident. SW KK then exited the resident room on the 400 hall and entered into another resident room on the 400 hall without knocking or addressing the resident in this room as well. SW KK continued to walk down the 400 hall to check in with residents, and it was noted that she did not knock on the resident's door or address the residents as she walked into their rooms. In an observation and interview on 8/14/25 at 1:29 PM, Certified Nursing Assistant (CNA) G was observed exiting Resident #102's room. CNA B reported that she had just gotten to Resident #102 for the first time that day to complete care. CNA G reported that she had provided incontinence care to Resident #102. CNA B reported that she was not sure

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2564458Based on interview and record, review the facility failed to inform in advance and accommodate the residents' responsible party (RP) to participate in formulation of a care plans with relevant disciplines (nursing, dietary, social services, and activities) related to assessed healthcare needs for 1 (Resident #104) of 3 residents reviewed for notification for care planning resulting in ineffective communication and the potential for unmet care needs. Findings include: Resident #104Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia, major depressive disorder, and schizoaffective disorder (a mental health condition marked by a mix of schizophrenia symptoms such as hallucinations and delusions and mood disorder symptoms such as depression and mania). Review of Resident #104's Care Plan revealed, (Resident #104) admitted to facility with Guardianship paperwork on file. (name redacted) is the responsible party. No intent for discharge due to need for 24-hour care . Date Initiated: 08/14/2024. Intervention: Keep (Resident #104) and family informed of changes in health and medical status for assist with continuum care planning and decision making. Date Initiated: 08/14/2024. In an interview on 8/13/25 at 12:06 PM, Family Member (FM) FF reported that she was the legal guardian for Resident #104. FM FF reported concerns with communication from the facility staff regarding Resident #104's care. FM FF reported that Resident #104 had recently been sent to inpatient psychiatric facilities twice due to increased behaviors. FM FF reported that since the facility had switched ownership, the care and communication had changed, and it seemed like the facility was changing a lot of aspects of Resident #104's care and not letting her know. FM FF reported that she wanted to be involved in care planning for Resident #104 and felt like the facility was not giving her the opportunity to do so, because they were not communicating with her. FM FF reported that Resident #104 had been readmitted to the facility on [DATE] from a psychiatric facility, and the facility had planned a care conference for 8/12/25 at 10:30 AM. FM FF reported that she had booked a hotel to stay in the area the night before the care conference. On the morning of 8/12/25, FM FF reported that she received all call from Social Worker (SW) KK who had told FM FF that she needed to cancel the in-person care conference, because it was not a good time to meet. FM FF reported that she asked to participate in the care conference via telephone and reported that SW KK told her that she would call her at the scheduled time. FM FF reported that SW KK called her before the scheduled time, and she missed the call, but she attempted to call SW KK right back twice, and she did not answer. FM FF reported that SW KK did not call her back, and she did not know if the facility completed the care conference without her. FM FF reported frustration with the lack of communication from the facility. In an interview attempt on 8/13/25 at 1:54 PM, This writer called SW KK and asked to speak with her. SW KK reported that she was Out of the facility and not willing to talk to this writer right now. This writer queried as to when SW KK would return to the facility so this writer could speak to her, and SW KK reported that she did not know and then ended the call on this writer. Review of Resident #104's Care Conference Note dated 8/13/25 and completed by SW KK revealed, Reason for care conference: return from hospital . date held: 8/13/25 .4. Did Family/responsible party attend? This was marked as yes. 4A. Names: (name redacted- Family Member FF) . In a follow up interview on 8/18/25 at 12:00 PM, FM FF reported that she did not attend the care conference on 8/13/25 that the facility held, because SW KK never called her back. FM FF reported that she had left two messages for SW KK and asked her to call her and let her know what she missed at the care conference, but she had not heard back from SW KK. Review of the facility's Care Plan- Comprehensive and Revision policy dated 8/8/22 revealed, Policy Overview: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .General Guidelines: Each resident's comprehensive person-centered care plan is consistent with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to: Participate in the planning process, participate in establishing the expected goals and outcomes of care .The resident is informed of his or her right to participate in his or her treatment, and provide advance notice of care planning conferences .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility to failed to ensure call lights were within reach for 1 (Resident #108) of 9 residents (reviewed for accommodation of needs, resulting in resident's inability to call for staff assistance with the potential for unmet care needs. Findings include: Resident #108Review of an admission Record revealed Resident # 108 was originally admitted to the facility on [DATE] with pertinent diagnoses which included lack of coordination, epilepsy (seizure disorder), muscle weakness, and difficulty walking. Review of a Minimum Data Set (MDS) assessment for Resident #108, with a reference date of 8/2/25 revealed Section GG: Functional abilities: Resident #108 was dependent for toileting assistance, personal hygiene and required substantial/maximum assistance with dressing. In an interview and observation on 8/14/25 at 10:26 AM, Resident #108 was sitting at the edge of his bed attempting to stand up on his own. Resident #108 was noted to be weak, and shaky as he attempted to stand. Resident #108 was stating over and over that he was ready to get up and needed help. This writer asked Resident #108 if he could turn on his call light for staff to come help him, and he reported that he couldn't use his call light because he didn't know where it was. It was noted that Resident #108's call light was under his bed, and out of his reach. In an interview on 8/14/25 at 10:30 AM, Registered Nurse (RN) NN reported that Resident #108 was a high fall risk and had recently had unwitnessed falls in the facility. RN NN reported that Resident #108 did use his call light for staff assistance. Review of the facility's Call Light policy dated 8/16/23 revealed, Policy Overview: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Guidance: Staff will ensure the call light is plugged in, functioning, within reach of residents, and secured, as needed .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from separation (from other residents, his/her room, or confinement to his/her room). (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0603 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent involuntary seclusion in one of 9 residents reviewed for abuse (Resident #109), resulting in the potential for residents to not meet their highest practicable level of well-being.Findings include: Resident #109Review of an admission Record revealed Resident #109 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia, disorientation, and cognitive communication deficit. Review of Resident #109's Care Plan revealed, Focus: (Resident #109) admitted to facility with temporary guardian. Her family member, (name redacted) was granted full guardianship on 4-14-21. Date Initiated: 08/13/2024. Interventions: Keep (Resident #109) and (Resident #109's family member) informed of changes in health and medical status for assist with continuum care planning and decision making. Date Initiated: 08/13/2024. Focus: (Resident #109) will occasionally wander into other resident's rooms, pick up other resident's belongings, and attempt to help other resident's by pushing them in their wheelchairs or telling staff that they need something (Resident #109) is noted to sleep in other resident's bed. Date Initiated: 08/13/2024. Interventions: Caregivers to provide opportunity for positive interaction, attention. Stop and talk with (Resident #109) as passing by. Date Initiated: 08/13/2024. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 08/13/2024. Focus: The resident has a behavior problem: (Resident #109) will at times become anxious and paranoid asking to call the police. She is diagnosed with hallucinations, unspecified dementia, anxiety disorder, and Altered Mental Status. (Resident #109) has a history of delusions prior to admission. Date Initiated: 08/13/2024. Interventions: .Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. Date Initiated: 08/13/2024. Focus: (Resident #109) is an elopement risk/wanderer AEB (as exhibited by) Disoriented to place, impaired safety awareness, wanders aimlessly, may push on doors, may state she needs to leave, and significantly intrudes on the privacy or activities of others. Resident presents with hitting, grabbing, kicking, pushing, expressing anger and screaming and, throwing food and bodily waste, refuses care, agitation. Date Initiated: 08/13/2024. Interventions: .Allow to vent feelings and/or frustration prn (as needed). Date Initiated: 02/21/2025. Check for Wander guard placement every shift and function daily. If not present, notify nurse immediately. Date Initiated: 08/13/2024. Distract (Resident #109) from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. M.J. enjoys orange juice, coloring, and ice cream. Date Initiated: 08/13/2024 .Identify pattern of wandering: Is wandering purposeful, aimless, or escapist? Is resident looking for something? Does it indicate the need for more exercise? Intervene as appropriate. Date Initiated: 08/13/2024.Provide structured activities: toileting, walking inside and outside, reorientation strategies including signs, pictures and memory boxes as (Resident #109) will allow. Date Initiated: 08/13/2024. Report to nurse if resident is actively exit seeking, packing their belongings, voicing desire or need to leave facility. Date Initiated: 02/21/2025 .In an observation on the locked dementia unit on 8/13/25 at 12:37 PM, Resident #109 was observed sleeping on another resident's bed in room [ROOM NUMBER]. It was noted that there was a male resident in the bed next to her in the room. In an interview on 8/13/25 at 12:38 PM: CNA JJ reported that the staff were allowing Resident #109 to sleep in the second bed in room [ROOM NUMBER] because that was the only spare bed that they had on the unit. When this writer queried as to why Resident #109 could not sleep in her own bed, CNA JJ reported that Resident #109 did not have a bed on the locked unit, because her guardian did not want her on the locked unit. When this writer queried as to why Resident #109 was on the locked unit when she did not have a room on the unit, CNA JJ reported that the facility management had told staff that they were going to have Resident #109 do day care on the memory unit until her guardian consented to having her moved. CNA JJ reported that it did not make sense that Resident #109 was on the unit, because she enjoyed wandering, and she could not wander as much on the locked unit. CNA JJ reported that she had not observed Resident #109 exit seeking before. In an interview on 8/13/25 at 12:45 PM: CNA Q reported that the facility had been placing Resident #109 in the locked unit until bedtime for awhile because they felt like with her wandering and behaviors, she needed more supervision. CNA Q reported that Resident #109 was considered a day care resident and went back to the main unit at night because her guardian did not want her on the locked unit. CNA Q reported that Resident #109 did wander a lot, but she had not observed her exit seeking. In an

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate Activities of Daily Living (ADL) care for 3 (Resident #102, #103 and #106) of 4 residents reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for resident's who are dependent on staff for assistance. Findings include: This citation pertains to intake 1214279. Resident #102Review of an admission Record revealed Resident # 102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and major depressive disorder. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 8/8/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #102 was cognitively intact. Review of Resident #102's Care Plan revealed, Focus: ADL (activities of daily living) self-care deficit related to weakness . Date Initiated: 05/04/2025. Goal: Will receive assistance necessary to meet ADL needs. Date Initiated: 05/04/2025. Interventions: ADL Assist of 1 staff. Date Initiated: 05/04/2025. Assist with daily hygiene, grooming, dressing, oral care and eating as needed. Date Initiated: 05/04/2025 . Focus: Resident has urinary incontinence (loss of bladder control). Date Initiated: 05/04/2025. Goals: Will have no complications due to incontinence. Date Initiated: 05/05/2025. Interventions: Provide assistance with toileting. Date Initiated: 05/04/2025 . Review of Resident #102's Grievance form dated 6/18/25 revealed, Documentation of concern: Diaper not changed. Has bed sores on behind. Action taken regarding concern: Resident stated that she was talking about past hx (history) and there is no open area in buttock. Nurse confirmed . It was noted that the action taken did not address Resident #102 being left in a soiled brief. Review of Resident #102 Bathing Tasks dated 7/23/25-8/16/25 indicated staff had documented that Resident #102 refused showers on 7/26/25, 8/2/25, and 8/9/25. In an interview on 8/12/25 at 10:58 AM, Resident #102 reported that she had concerns with waiting for hours for incontinence care and that the facility staff were frequently skipping her showers. Resident #102 reported that she was supposed to get showers on Wednesday and Saturday, but that she was lucky to get one shower a week. Resident #102 appeared disheveled, with messy hair, and wearing a hospital gown. In a follow up interview on 8/14/25 at 4:27 PM, This writer queried Resident #102 about the documented shower refusals. Resident #102 reported to this writer that she had never refused a shower at the facility. In an interview on 8/14/25, Certified Nursing Assistant (CNA) T reported that she cared for Resident #102 frequently. CNA T reported that she had been assigned to care for Resident #102 on 8/12/25 and that Resident #102 was upset that evening because she had been waiting hours for staff to provide care for her. CNA T reported that she had another staff member assist Resident #102 to bed that night, but she did not complete check and changes on Resident #102 throughout the night, because Resident #102 was upset with her. This writer queried about Resident #102's shower refusal on 8/9/25, which was documented by CNA T. CNA T reported that Resident #102 did not refuse a shower on 8/9/25, and she was unable to explain why Resident #102's shower was documented as refused. In an interview on 8/14/25 at 3:02 PM, CNA G reported that staff were frequently documenting that residents were refusing cares when they were not. CNA G reported that she cared for Resident #102 often, and that she had never experienced Resident #102 refusing cares or showers. CNA G reported that it was common for residents to have to wait for extended periods of time for ADL care, and that it was also common for residents to not get ADL care during a shift. In an interview on 8/14/25 at 4:09 PM, CNA H reported that the staffing at the facility made it hard for the staff to complete resident care. CNA H reported that she felt that the staff were forced to cut corners and skip care because they did not have enough staff to provide adequate ADL care. CNA H reported that first shift staff were typically assigned to complete 3-4 resident showers, and it was just not possible. CNA H reported that she knew that staff were documenting that residents were refusing care when they had not refused because staff were not able to get them done. CNA H reported that resident care was definitely rushed, and that she felt terrible about the care that she often had to provide, because it was not adequate.Resident #103Review of an admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and difficulty walking. Review of a Minimum Data Set (MDS) assessment for Resident #103, with a reference date of 7/25/25 revealed a Brief Interview for Mental Status (BIMS) score of 8/15 which indicated Resident #103 was moderately cognitively impaired.Review of Resident #103's Care Plan revealed, ADL self-care deficit related to physical limitations. Date Initiated: 04/23/2025. Goal: Will be clean, dressed, andwell-groomed daily to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that residents received treatment in accordance with professional standards of practice for 2 (Resident #103 and Resident #108) of 9 residents reviewed for quality of care resulting in missed neurological (neuro) assessments after unwitnessed falls and missed medication doses resulting in the potential for a lack of monitoring, unnoticed adverse reactions, unnoticed injury, and the potential to negatively impact the resident's psychosocial wellbeing.Findings include: Resident #108Review of an admission Record revealed Resident # 108 was originally admitted to the facility on [DATE] with pertinent diagnoses which included lack of coordination, epilepsy (seizure disorder), muscle weakness, and difficulty walking. Review of Resident #108's Medication Administration Record (MAR) revealed, cloBAZam Oral Tablet 10 MG (Clobazam) (Anti-seizure medication) Give 1 tablet by mouth one time a day for seizures. Start date: 7/1/2025. Lacosamide Oral Tablet 100 MG (Lacosamide) (Anti-seizure medication). Give 3 tablet by mouth at bedtime for Epilepsy admin 300 mg/dose. Start date: 7/17/2025. It was noted that Resident #108 missed a dose of clobazam on 7/1/25 and 8/1/25 and missed a dose of Lacosamide on 8/1/25. Review of Resident #108's Progress Note dated 8/1/25 revealed, Lacosamide Oral Tablet 50 mg: Give 250 mg by mouth in the morning for seizures. Only 150 mg available, NP (Nurse Practitioner) notified and waiting for orders. Pharmacy aware of situation. This was documented by Assistant Director of Nursing (ADON) C. Review of Resident #108's Progress Note dated 8/1/25 revealed, Clobazam Oral tablet 10 mg. Give 1 tablet by mouth one time a day for seizures. Medication out of stock here. NP informed so script can be written .Review of Resident #108's Progress Note dated 8/1/25 revealed, The resident is out of Lacosamide Oral tablet 50 mg and Clobazam 10 mg. The on-call NP was notified, and the nurse did a follow up with pharmacy. The pharmacy said that they do not have a script for clobazam 10 mg yet and Lacosamide 50 mg oral tablets is too soon to refill until next week. In an interview on 8/14/25 at 12:15 PM, ADON C reported that she could not recall why Resident #108 was missing his Clobazam and Lacosamide medications. ADON C confirmed that on 8/1/25, she administered 150 mg of Resident #108's Lacosamide order, which was not the full dose of 250 mg, because she did not have enough medication to administer the full dose. ADON C reported that nursing staff were responsible for reordering medications when there is one week supply left so that the resident did not miss medication doses. In an interview on 8/14/25 at 1:13 PM, Registered Nurse (RN) NN reported that she was caring for Resident #108 on 8/1/25 and she recalled contacting the pharmacy because the facility was out of Resident #108's clobazam and lacosamide medications. RN NN reported that the pharmacy told her that they could not fill Resident #108's medications because of insurance reasons, so she let Director of Nursing (DON) B knew and she addressed it. RN NN reported that nurses were responsible for re-ordering medications, and that residents' medications should be ordered at least 5 days prior, so residents do not miss medications. RN NN reported that agency staff were not good about reordering medications. In an interview on 8/14/25 at 1:54 PM, DON B reported that she did not recall any details of Resident #108's missing medications, and that she would need to look into the situation and follow back up with this writer. DON B confirmed that Clobazam and Lacosamide were controlled substances, and that the facility had to count and sign out the medications. DON B was not able to provide the narcotic count sheets for Resident #108's Clobazam and Lacosamide and reported that she thought that a former agency nurse took the sheets. In a follow up interview on 8/18/25 at 11:31 AM, DON B and Regional Nurse Consultant (RNC) O reported that they completed an investigation of Resident #108's medications and found that two nurses administered the wrong dosage of Lacosamide on 7/29/25 and 7/30/25. DON B reported that the correct dose of Lacosamide was given, but the number of tablets was incorrect, which lead to the count of Resident #108's lacosamide being incorrect, and therefore staff did not have the medication to administer on 8/1/25. DON B reported that staff had destroyed Resident #108's Clobazam when he went to the hospital on 6/26/25, and when he returned on 7/1/25, they did not have the medication ordered, so he missed a dose on 7/1/25, and also missed a dose on 8/1/25 because nursing staff had not re-ordered the medication in item. DON B confirmed that residents should never miss a dose of medication. Review of Resident #108's Incident Reports revealed that Resident #108 had three unwitnessed falls on 7/8/25, 7/11/25, and 7/16/25.This writer had requested documentation of Resident #108's neuro assessments for Resident #108's unwitnessed falls on 8/13/25 at 3:58 PM. The facility provided documentation of neuro assessments for Resident #108's falls on 7/11/25 and 7/16/25. It was noted that the

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	235458	A. Building B. Wing	08/18/2025

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Optalis Health and Rehabilitation of Grand Rapids	1950 32nd Street SE Grand Rapids, MI 49508

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide adequate supervision to ensure resident safety for 2 (Resident #104 and Resident #109) of 9 residents reviewed for supervision resulting in the potential for resident-to-resident abuse. Findings include: Resident #104Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia, major depressive disorder, and schizoaffective disorder (a mental health condition marked by a mix of schizophrenia symptoms such as hallucinations and delusions and mood disorder symptoms such as depression and mania). Review of Resident #104's Care Plan revealed, Focus: (Resident #104) is at risk for changes in mood and behavior related to alcoholic dementia with behavioral disturbance, anxiety, schizoaffective disorder .Targeted behaviors include sexually inappropriate (verbal, touching, and grabbing), Verbal (Aggressive, yelling swearing, threatening to hit), Physical (hitting at, pushing) Resident does not like men of color. Date Initiated: 08/14/2024. Interventions: . If (Resident #104) becomes agitated to the point of not being able to be re-directed or calmed down, place on 1 on 1. Date Initiated: 03/28/2025. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 08/14/2024 . When the resident becomes agitated, intervene before agitation escalates. Guide away from source of distress. Engage calmy in conversation. Offer food or drink, (Resident #104) prefers apple juice. Date Initiated: 03/28/2025 . Focus: The resident has a behavior problem r/t dementia and can be inappropriate with staff as evidenced by inappropriate touching; Resident does not like men of color. Date Initiated: 01/17/2025. Interventions: . Minimize potential for the resident's disruptive behavior of inappropriate touching by offering tasks/activities which divert attention. Date Initiated: 01/17/2025 . Focus: The resident is/has potential to be physically aggressive with ambulatory people not Caucasian. Date Initiated: 06/17/2025. Interventions: When the resident becomes agitated: Intervene before agitation escalates; Guide away from source of distress; Engage calmly in conversation, If response isaggressive, staff to walk calmly away, and approach later. Date Initiated: 06/17/2025 .Review of Resident #104's Nursing Progress Note dated 6/17/25 revealed, The CNA (Certified Nursing Assistant) assigned to (Resident #104) care stated that (Resident #104) walked swiftly up to another male resident on the unit and stood in front of him with his fist raised. The CNA stated that she ran and stood in between them and led (Resident #104) away from the other resident .Review of Resident #104's Psychiatry Note dated 6/17/25 revealed, . History of present illness: Associated symptoms: refusing showers, grabbing and sexually inappropriate . 6/9 CNA (Name redacted) reported that (Resident #104) grabbed her and was trying to kiss her. Was not easily redirected when (CNA) informed him that his behavior was inappropriate and he needs to stop . Behavior log review for past 30 days kicking/hitting x1, grabbing x1, wandering x2, abusive language x1, threatening behavior x1, sexually inappropriate x2, and rejection of care x2 .Social services report the resident is going to be sent out to the psychiatric hospital die to his behaviors .Review of Resident #104's Progress Note dated 7/13/25 revealed,(Resident #104) came up too close to a female visitor, staff intervened and redirected (Resident #104) away .Review of Resident #104's Progress Note dated 7/13/25 revealed,(Resident #104) denies pain, VSS (vital signs stable), using sexual and foul comments towards staff and visitors, disrobing in common area, attempting to touch female residents inappropriately, very difficult to distract and redirect.Review of Resident #104's Progress Note dated 7/13/25 revealed, (Resident #104) stood in the face of male family member visiting, balled up his fist in his face, staff quickly intervened .Review of Resident #104's Progress Note dated 7/13/25 revealed,(Resident #104) continues to pace back and forth and attempting to touch back and forth attempting to touch female residents, staff is constantly redirecting him and moving residents away from him. (Resident #104) is difficult to redirect and distract.Review of Resident #104's Progress Note dated 7/12/25 revealed, (Resident #104) . sexual behaviors mainly towards female staff, grabbing body parts, coming close to female staff, saying sexual words . attempting to touch people Review of Resident #104's Progress Note dated 7/12/25 revealed, (Resident #104) keeps pointing his finger and fist at other residents whenever they get close to him; Staff keeps redirecting (Resident #104) and other residents away from him . Review of Resident #104's Progress Note dated 7/12/25 revealed, (Resident #104) walked up to female staff and touched the staff buttocks with his right hand .Review of Resident #104's Progress Note dated 7/11/25 revealed, (Resident #104) had his fist balled up and was very close to another male resident. Staff quickly

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1214303, 1214279, and 2588205. Based on observation, interview and record review, the facility failed to provide sufficient nursing staff for 93 of 93 residents who reside in the facility, resulting in unmet care needs, as identified by the issues ascertained during the survey that included long call light wait times, residents left in soiled briefs for extended periods of time, residents missing showers and missing other activities of daily living (ADL) care, residents missing medications, treatments, and neurological assessments after falls, nursing staff feeling frustrated, overworked, exhausted, and management staff not available to assist direct care staff with Residents' care and needs, affecting the physical, mental, and psychosocial well-being of all 93 residents residing in the facility. Findings include: In an interview on 8/12/25, Licensed Practical Nurse (LPN) CC reported that staffing at the facility had been awful for months, and had not improved since the last time the State Agency was at the facility. LPN CC reported that the dementia unit required 1 nurse and 3 aides on first shift to adequately supervise the residents on the unit and manage resident behaviors. LPN CC that the unit often worked with less than 3 aides, and at night the facility was often scheduling the nurse on the locked unit and having the nurse float to the rehab unit, which was incredibly unsafe. LPN CC reported that she had voiced her concerns to the facility management several times, but they had not worked to improve staffing. LPN CC reported that management did not come to the floor to assist with resident care, and they were only on the floor when the State Agency was in the building. In an interview on 8/13/25 at 12:38 PM: CNA JJ reported that staffing at the facility was terrible, and that the staff were often working short, and that the facility did not care when they reported staffing concerns. CNA JJ reported that it was common for the locked unit to only have 2 CNA's on day shift, when they really needed 3 to safely supervise all of the residents. In an interview on 8/13/25 at 2:35 PM, Certified Nursing Assistant (CNA) R reported that staffing at the facility was not good. CNA R reported that when the facility had staff call in, they would attempt to fill in when the schedule was short staffed, but they were not always able to fill the schedule, and so staff were left to work short. CNA R confirmed that it was not uncommon for residents to wait over an hour and up to several hours for staff to answer their call lights. CNA R confirmed that staff were often not able to get to residents to complete their ADL care timely. CNA R reported that management did not come to assist staff when they worked short. CNA R reported that the facility needed 5 aides on first and second shift to work the Coast unit, and they were often working with less than 5 aides. In an interview on 8/13/25 at 2:56 PM, LPN M reported they felt that staffing at the facility was the worse that it had ever been. LPN C reported that the facility was not considering acuity of the residents, and that staff were not able to get to residents to provide care timely, and they were also not able to complete care for all residents on each shift. LPN M reported that it was not uncommon for residents to wait over an hour to have their call light answered, and that residents were missing showers and other treatments because the staff were just not able to get to them. LPN M reported that the staff were constantly bringing up their staffing concerns to facility management, but that the facility had not improved staffing ratios. LPN M reported that management never assisted staff when they were short staffed. In an interview on 8/14/25 at 9:24 AM, Former Unit Manager (F-UM) DD reported that she was aware of resident concerns related to long call lights, and that staff had reported concerns with managing the workload and acuity of residents. F-UM DD reported that when she was working at the facility, that they had tried changing assignments with staffing to improve long call light wait times. F-UM DD confirmed that she had continued to receive grievance/concern forms from residents related to long call light wait times after the facility had adjusted the staff assignments. In an interview on 8/14/25 at 11:20 AM, CNA J reported that she was unable to get Resident #106 up until after lunch because she needed to assist with mealtime. CNA J reported that the unit was working short that day because they had a CNA call in, and there were only 4 aides on the unit, instead of 5. In an interview on 8/14/25 at 3:02 PM, CNA G reported that staffing at the facility was awful, and that the CNA's were constantly working short. CNA G reported that it was common for residents to miss care and wait for more than an hour to have call lights answered because the facility did not staff to meet the resident's needs. In an interview on 8/14/25 at 3:18 PM, CNA T reported that staffing at the facility was not adequate, and she felt like the residents and staff were not safe because of staffing. CNA T reported that it was common for resident for over an hour, and even multiple hours for staff to answer call lights. CNA T reported that it was not possible for staff to complete all resident care when they worked short, which was often. CNA T reported

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1214304Based on interview and record review, the facility failed to maintain complete and accurate medical records for 4 of 9 residents (Resident #101, Resident #102, Resident #104, and Resident #108) reviewed for complete and accurate medical record documentation, resulting in the potential for staff and providers mismanaging care for residents.Findings include:Resident #101Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included repeated falls and chronic pain. Review of Resident #101's Medication and Treatment Administration Orders for August 2025 revealed: Ketamine HCl External Cream 5 % (Ketamine HCl (Topical). Apply to Feet and legs topically three times a day for Pain. Start date 8/6/25. It was noted that there was missing documentation for administration of this treatment order on 8/13/25.GlycoLax Powder (Polyethylene Glycol 3350) (Medication used for constipation). Give 17 gram by mouth two times a day for constipation mixed with 8 oz. water, juice, soda, coffee or tea. Start dated 8/6/25. It was noted that there was missing documentation for administration of this order on 8/7/25.House Liquid Protein (supplement) two times a day . start date: 7/29/25. It was noted that there was missing documentation for administration of this order on 8/7/25.Acetaminophen Oral Tablet (Acetaminophen). Give 1000 mg by mouth three times a day for pain. Start date 7/25/25. It was noted that there was missing documentation for administration of this order on 8/7/25.Wound Care Order Site: L Coccyx 1) Cleanse wound with NS 2) Pat Dry with Gauze 3) Apply Medihoney (wound care treatment medication) to wound bed 4) Cover with Bordered Gauze 5) Tape - (date and time the tape) everyday shift for wound care. Start date: 8/1/25. It was noted that there was missing documentation for administration of this order on 8/5/25, 8/6/25, and 8/7/25.Wound Care Order Site: L Coccyx 1) Cleanse wound with NS 2) Pat Dry with Gauze 3) Apply Medihoney to wound bed, Apply Triad (wound care treatment cream) to Peri Wound 4) Cover with ABD (type of gauze) 5) Tape - (date and time the tape) everyday shift for wound care. Start date: 8/8/25. It was noted that there was missing documentation for administration of this order on 8/13/25.Nephrostomy (kidney) tube care Q (every) shift and as needed every shift for Nephrostomy. Nephrostomy tube care q shift. Start date 7/25/25. It was noted that there was missing documentation for administration of this order on 8/6/25.Resident #102Review of an admission Record revealed Resident # 102 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and major depressive disorder. Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 8/8/25 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #102 was cognitively intact. Review of Resident #102 Bathing Tasks dated 7/23/25-8/16/25 indicated staff had documented that Resident #102 refused showers on 7/26/25, 8/2/25, and 8/9/25. In an interview on 8/12/25 at 10:58 AM, Resident #102 reported that she had concerns with facility staff frequently skipping her showers. Resident #102 reported that she was supposed to get showers on Wednesday and Saturday, but that she was lucky to get one shower a week. In a follow up interview on 8/14/25 at 4:27 PM, This writer queried Resident #102 about the documented shower refusals. Resident #102 reported to this writer that she had never refused a shower at the facility. In an interview on 8/14/25, Certified Nursing Assistant (CNA) T reported that she cared for Resident #102 frequently. This writer queried about Resident #102's shower refusal on 8/9/25, which was documented by CNA T. CNA T reported that Resident #102 did not refuse a shower on 8/9/25, and she was unable to explain why Resident #102's shower was documented as refused. Review of Resident #102's Treatment Administration Orders for July 2025 revealed, Cleanse B/L (bilateral) Buttock with soap and water, pat dry, apply dermaseptine (skin treatment cream) to B/L buttock every shift for Preventative. Start date: 7/2/25. It was noted that there was missing documentation for this treatment order on 7/21/25, and 7/25/25. Resident #104Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia, major depressive disorder, and schizoaffective disorder (a mental health condition marked by a mix of schizophrenia symptoms such as hallucinations and delusions and mood disorder symptoms such as depression and mania). In an interview on 8/13/25 at 12:06 PM, FM FF reported that Resident #104 had been readmitted to the facility on [DATE] from a psychiatric facility, and the facility had planned a care conference for 8/12/25 at 10:30 AM. FM FF reported that she had booked a hotel to stay in the area the night before the care conference. On the morning of 8/12/25, FM FF reported that she received all call from Social Worker (SW) KK who had told FM FF that she needed to cancel in