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	09/04/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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

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

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F 0609 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 2602017Based on interviews and record review, the facility failed to implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act for 1 (Resident #504) of 3 residents reviewed for abuse resulting in an of injury of unknown origin not being reported to the state agency. Findings include: Resident #504Review of an admission Record revealed Resident #504 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic pain and vascular dementia. Review of a Minimum Data Set (MDS) assessment for Resident #504, with a reference date of 8/25/25 indicated under Section GG: Functional abilities that Resident #504 was Dependent (01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity) for rolling left to right and chair/bed transfers. Section J- Health Conditions: Has the resident had any falls since admission/entry or reentry or the prior assessment? No. Review of Resident #504's Hospital Record dated 8/25/25 revealed, .Assessment/Plan: Diagnosis: Closed fracture of the distal radius, unspecified fracture morphology, initial encounter On my assessment, patient is chronically ill-appearing. He is lying in bed and is A&O (alert and oriented) times 0 . On physical exam, there is swelling and tenderness to palpation over the left forearm and elbow. There is no obvious deformity . Plain films of the left upper extremity were completed and there does appear to be a very subtle nondisplaced distal radius (long bone in the forearm that extends from elbow to wrist) fracture on x-ray. Orthopedic surgery was consulted and evaluated the patient. Additional elbow and shoulder films were completed and negative for acute fracture . Imaging: DR (digital radiography) Humerus (long bone of upper arm) final result: Poor visualization of the glenoid margin and medial aspect of the humeral head and fractures in these areas cannot be excluded. Consider further evaluation with CT (computed tomography) If clinically indicated. DR forearm left 2 views: Findings: Bones are diffusely demineralized, and this limits evaluation for fracture. There is a lucency distal radius which extends intraarticular, and this is concerning for a nondisplaced fracture. Heavy vascular calcifications (calcium deposits build up) are present. Coiled metallic densities (implanted medical device or retained foreign object) within the soft tissues of the forearm are seen. Please clinically correlate. IV tubing is also present. Final Result: 1. Lucency (area on an x-ray that appears darker, indicating less density compared to surrounding tissues) distal radius which extends intra-articular and is concerning for a nondisplaced fracture. 2. Coiled metallic densities within the soft tissues of the forearm are seen. Please clinically correlate. DR Wrist Left Mimium 3 views: Findings: Bones are osteopenic (loss of bone density) and this limits evaluation for fracture. Final Result 1. Lucency distal radius extending intra-articular concerning for a nondisplaced fracture. 2. Osteopenia (bone loss). Physical Exam: . Musculoskeletal: Comments: Status post bilateral lower extremity AKA (above knee amputation), right hand amputation . Swelling of left arm noted, patient yells out in pain with movement of left arm at elbow or wrist. Assessment/Plan: Left distal radius fracture: Orthopedic surgery does not recommend surgical intervention. Supportive care with splinting, pain control .Review of the Facility Reported Incident (FRI) investigation dated 8/26/25 at 9:00 AM revealed, Incident Summary: Facility requested updates on resident; in reviewing report, hospital stated DPOA had concerns of neglect . Investigation Report: Allegation of abuse and Neglect: Findings: Findings (Resident #504) re-admitted to (Facility) following a lengthy hospitalization that spanned from July 28, 2025 through August 19, 2025 . Resident #504 re-admitted on [DATE] and until his discharge on [DATE], he received bed baths on August 21, 2025, August 22, 2025, and August 24, 2025. Clean clothing was consistently provided to (Resident #504) except for one exception where a previously worn shirt was mistakenly placed on resident's wheelchair and not removed. This error was immediately acknowledged by staff . Based on the facility's internal investigation and hospital documentation acquired/ the facility attests that allegations of abuse and neglect are unsubstantiated. It was noted that the FRI folder did contain Resident #504's hospital records which noted the injury to Resident #504's left arm/wrist, but that the facility did not address the injury of unknown origin in the report to the state agency or in the investigation. In an interview on 9/2/25, Family Member (FM) Y reported that on 8/25/25 she had arrived at the facility to visit Resident #504 and found Resident #504 in his room whimpering in pain and bleeding from his fistula (a surgically created connection between an artery and vein to serve as a long-term access point for someone that requires dialysis). FM Y reported that Resident #504's fistula began to profusely bleed, and facility staff responded and cared for

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 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 2602017Based on interview and record review, the facility failed to identify and thoroughly investigate an injury of unknown origin for 1 (Resident #504) of 3 residents reviewed for abuse, resulting in the potential for ongoing injuries due to an incomplete investigation of an injury of unknown origin. Findings include:Resident #504Review of an admission Record revealed Resident #504 was originally admitted to the facility on [DATE] with pertinent diagnoses which included chronic pain and vascular dementia. Review of a Minimum Data Set (MDS) assessment for Resident #504, with a reference date of 8/25/25 indicated under Section GG: Functional abilities that Resident #504 was Dependent (01. Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity) for rolling left to right and chair/bed transfers. Section J-Health Conditions: Has the resident had any falls since admission/entry or reentry or the prior assessment? No. Review of Resident #504's Hospital Record dated 8/25/25 revealed, .Assessment/Plan: Diagnosis: Closed fracture of the distal radius, unspecified fracture morphology, initial encounter On my assessment, patient is chronically ill-appearing. He is lying in bed and is A&O (alert and oriented) times 0 . On physical exam, there is swelling and tenderness to palpation over the left forearm and elbow. There is no obvious deformity . Plain films of the left upper extremity were completed and there does appear to be a very subtle nondisplaced distal radius fracture on x-ray. Orthopedic surgery was consulted and evaluated the patient. Additional elbow and shoulder films were completed and negative for acute fracture . Imaging: DR (digital radiography) Humerus (long bone of upper arm) final result: Poor visualization of the glenoid margin and medial aspect of the humeral head and fractures in these areas cannot be excluded. Consider further evaluation with CT (computed tomography) If clinically indicated. DR forearm left 2 views: Findings: Bones are diffusely demineralized, and this limits evaluation for fracture. There is a lucency (area on an x-ray that appears darker, indicating less density compared to surrounding tissues) distal radius which extends intraarticular, and this is concerning for a nondisplaced fracture. Heavy vascular calcifications (calcium deposits build up) are present. Coiled metallic densities (implanted medical device or retained foreign object) within the soft tissues of the forearm are seen. Please clinically correlate. IV tubing is also present. Final Result: 1. Lucency distal radius which extends intra-articular and is concerning for a nondisplaced fracture. 2. Coiled metallic densities within the soft tissues of the forearm are seen. Please clinically correlate. DR Wrist Left Mimium 3 views: Findings: Bones are osteopenic (loss of bone density) and this limits evaluation for fracture. Final Result 1. Lucency distal radius extending intra-articular concerning for a nondisplaced fracture. 2. Osteopenia. Physical Exam: . Musculoskeletal: Comments: Status post bilateral lower extremity AKA (above knee amputation), right hand amputation . Swelling of left arm noted, patient yells out in pain with movement of left arm at elbow or wrist. Assessment/Plan: Left distal radius fracture: Orthopedic surgery does not recommend surgical intervention. Supportive care with splinting, pain control .Review of the Facility Reported Incident (FRI) investigation dated 8/26/25 at 9:00 AM revealed, Incident Summary: Facility requested updates on resident; in reviewing report, hospital stated DPOA (durable power of attorney) had concerns of neglect . Investigation Report: Allegation of abuse and Neglect: Findings: Findings (Resident #504) re-admitted to (Facility) following a lengthy hospitalization that spanned from July 28, 2025 through August 19, 2025 . Resident #504 re-admitted on [DATE] and until his discharge on [DATE], he received bed baths on August 21, 2025, August 22, 2025, and August 24, 2025. Clean clothing was consistently provided to (Resident #504) except for one exception where a previously worn shirt as mistakenly placed on resident's wheelchair and not removed. This error was immediately acknowledged by staff . Based on the facility's internal investigation and hospital documentation acquired/ the facility attests that allegations of abuse and neglect are unsubstantiated. It was noted that the FRI folder did contain Resident #504's hospital records which noted the injury to Resident #504's left arm/wrist, but that the facility did not address the injury of unknown origin in the report to the State Agency or in the investigation. In an interview on 9/2/25, Family Member (FM) Y reported that on 8/25/25 she had arrived at the facility to visit Resident #504 and found Resident #504 in his room whimpering in pain and bleeding from his fistula (a surgically created connection between an artery and vein to serve as a long-term access point for someone that requires dialysis). FM Y reported that Resident #504's fistula began to profusely bleed, and facility staff responded and cared for Resident #504 until paramedics could arrive to take Resident #504 to the hospital. FM Y reported that

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 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 2602017Based on interview and record review the facility failed to accurately and thoroughly assess, adequately monitor and provide quality care and treatment for pressure ulcers for 1 of 3 residents (Resident #504) reviewed for wound care resulting in the potential of worsening of a pressure wound. Findings include:Resident #504Review of an admission Record revealed Resident #504 was originally admitted to the facility on [DATE] with pertinent diagnoses which included reduced mobility and type 2 diabetes (long term condition in which the body has trouble controlling blood sugar and using it for energy). Review of Resident #504's Care Plan revealed, Focus: At risk for alteration in skin integrity related to: decreased mobility .Date Initiated: 05/22/2025. Interventions: Administer treatment per physician orders. Date Initiated: 05/22/2025. APM (alternating pressure mattress) to bed Date Initiated: 05/28/2025. Barrier cream to peri area/buttocks as needed. Date Initiated: 05/22/2025. Diet and supplements per physician order. Date Initiated: 05/22/2025. Encourage and assist as needed to turn and reposition; use assistive devices as needed. Date Initiated: 05/22/2025.Observe skin condition with ADL (activities of daily living) care daily; report abnormalities. Date Initiated: 05/22/2025. Pressure redistributing device on bed/chair. Date Initiated: 05/22/2025. Provide preventative skin care routinely and prn (as needed). Date Initiated: 05/22/2025. Focus: Risk for Pressure Injury Formation related to compromised skin tensile strength to buttocks r/t (related to) scar tissue . Resident need staff assistance with incontinence care, turning and repositioning. Date Initiated: 05/22/2025. Interventions: Bilateral mobility bars to aid with turning and mobility in bed. Date Initiated: 05/22/2025. Braden scale to be completed per facility protocol. Date Initiated: 05/22/2025.Consult wound care team prn. Date Initiated: 05/22/2025. Encourage intake of 75-100% of diet and fluids daily. RD (Registered Dietitian) to assess dietary needs quarterly and with significant changes. Date Initiated: 05/22/2025. Encourage or assist resident to turn and reposition frequently as resident tolerates PRN. Date Initiated: 05/22/2025. Monitor skin daily during care for redness, excoriation, or breakdown. Date Initiated: 05/22/2025. Preventive skin care post incontinence care daily/prn. Date Initiated: 05/22/2025. Provide surface support and pressure redistribution, position changes, and offloading daily. Date Initiated: 05/22/2025. Review of Resident #504's Braden Skin assessment dated [DATE] indicated that Resident #504 had very limited sensory perception, was noted to be occasionally moist, was bedfast (confined to bed), was completely immobile, had adequate nutrition, and required moderate to maximum assistance in moving. Resident #504's Braden skin score was 11, indicating that Resident #504 was high risk for skin breakdown. Review of Resident #504's Skin and Wound Evaluation dated 8/19/25 and documented by Licensed Practical Nurse (LPN) G revealed, Wound type: MASD (Moisture Associated Skin Damage). MASD Type: IAD (incontinence associated dermatitis-skin condition caused by prolonged exposure to urine or stool, leading to irritation and discomfort). Acquired: Present on admission. Exact date: 8/19/25. Staged by: Other. Wound Measurements: Area: 0.1 cm2. Length: 0.5 cm. Width: 0.3 cm. Depth: 0.1 cm. Undermining: not applicable. Tunneling: not applicable. Evidence of infection: none. Exudate: (fluid released through pores or a wound) none. Surrounding tissue: Denuded (area of skin where the top layer has been removed, exposing underlying layer): loss of epidermis (skin layer) caused by exposure to urine, feces, wound exudate, or friction. Induration (a thickening and hardening of the skin): none present. Edema (swelling): no swelling or edema. Periwound temperature: Normal. Wound pain: this section was not completed. Orders: Goal of care: Healable. Treatment: None. Progress: this section was not completed. Review of Resident #504's Physician Orders did not reveal treatment orders for Resident #504's wound on his coccyx (a small triangular bone at the base of the spinal column). Review of Resident #504's Hospital Records dated 8/25/25 revealed, ED Disposition: . On my assessment, patient is chronically ill-appearing .He was rolled and has multiple chronic appearing shallow pressure ulcers over the sacral and lumbar areas . Wound Care Assessment and Plan dated 8/27/25: Pressure injury of sacral region (lower area of spine), unstageable. Worsening compared to prior photos and family report . Left buttock portion of wound appears superficial with frayed edges suggesting shearing force. Mid sacral wound bed is 50/50 granulation (tissue that forms in wound bed during healing process) and adherent slough (dead, non-viable tissue that accumulates in a wound bed)/subq (subcutaneous) fat. Right buttock portion of wound is 10% granulation at superior wound edge with remaining 90% thick adherent slough/eschar. This is firm and not boggy. This area likely will continue to evolve. May require bedside or surgical debridement (medical procedure that involves

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2597303.Based on observation, interview, and record review the facility failed to ensure appropriate supervision and assistance was provided during toileting for 1 (Resident #503) of 3 residents reviewed for falls resulting in a head injury, fracture of a patella (kneecap), and pain.Findings include:Resident #503:Review of the facility's facility reported incident report for Resident #503 (R#503), submitted 7/30/2025, stated, .Incident Summary. Staff entered resident's (R#503) bathroom and observed resident on the floor; resident sent to emergency room.Investigation Summary. Individual(s) Involved: (R#503) (Resident) A [AGE] year-old female.has diagnoses of Alzheimer's (form of dementia; brain disorder that destroys memory/thinking skills).abnormalities of gait (manner of walking or moving on foot) and mobility, unsteadiness on feet.chronic pain.history of falls, dementia (unspecified severity; without behavioral/psychotic/mood disturbance; without anxiety). restlessness and agitation.anxiety.She is dependent on staff x2 (two staff members) for all Activities of Daily Living (ADLs) and is unable to make her needs known. A BIMS (Brief Interview for Mental Status) score was attempted on July 1, 2025 but was unable to be completed due to (R#503) cognitive decline (This reflected R#503 had severe cognitive impairment). Summary of Events On July 29, 2025, (Registered Nurse (RN) R) was administering medications when she heard a loud noise coming from (R#503's room number). Upon entering the resident's room, (R#503) was observed lying sideways on the floor in front of her bedside commode. (R#503) was transferred to [Hospital Name] for evaluation. (R#503) re-admitted to the [Nursing Facility] on July 30, 2025 where it was revealed she suffered a fracture of her left patella (kneecap). Statements (Certified Nurse Aide (CNA) H) was requested by R#503's Guardian (family member responsible for making decisions due to the resident's inability to do so), (R#503)'s daughter, to place the resident on her bedside commode and then transfer her back to her recliner when toileting was completed. (R#503) had not successfully voided (evacuated urine and/or feces) by the time CNA H completed her shift, so information was exchanged during shift rounding that (R#503) remained on the toilet until voided was successful. As (RN R) was completing her medication administration, she heard a loud noise coming from (R#503's) room and upon arrival, observed (R#503) lying sideways on the floor.On-call physician was notified who ordered resident be transferred to the emergency room for evaluation.When (date and time) did the problem occur? 07/29/2025 10:00 PM (other facility documentation included below indicated the fall was at 6:50 PM or 7:00 PM).During an observation on 9/3/25 at 10:16 AM, Resident #503 was in her room, lying in her bed flat on her back, and was non-verbal. During an interview on 9/3/25 at 09:00 AM, Director of Nursing B reported Resident #503 had been left alone on the bed side commode (toilet) prior to the fall incident on 7/29/25 and should not have been.During an interview on 9/4/25 at 9:31 AM, Resident #503's Guardian X reported she had never wanted her mom (Resident #503) left alone on the commode. Guardian X confirmed her mom had been confused and was confused and non-verbal during her stay at the facility. Guardian X reported her mom is unable to use a call light and felt had someone been in the room with Resident #503 while she was on the bed side commode she would not have fallen.During an interview on 9/4/25 at 11:40 AM, Certified Nurse Aide (CNA) H was asked if Resident #503 should have been left on the bed side commode alone and stated, No. CNA H reported she didn't feel Resident #503 was left unattended because the door was open while she was on the commode and staff were huddled outside Resident #503's room for shift change report. CNA H confirmed no one was within arm's reach of Resident #503 while she was on the bed side commode on 7/29/25 before the fall happened.During an interview on 9/4/25 at 8:52 AM, Certified Nurse Aide (CNA) K reported she would never leave Resident #503 alone on the bed side commode if she had been caring for her. CNA K reported Resident #503 required two staff assistance for toileting and once transferred onto the commode one staff member should have stayed with the resident to prevent a fall. CNA K confirmed Resident #503 had dementia, was unable to use her call light to request help, and there was no reason a nurse or CNA shouldn't have been with #503 during toileting on the commode.During an interview on 9/4/25 at 8:58 AM, Certified Nurse Aide (CNA) N reported she would never leave a cognitively impaired resident, which she confirmed Resident #503 was, alone on a commode (toilet). Review of Resident #503's Investigation Report (a packet/file of information) for the 7/29/25 fall with fracture stated, Fall with injury events and conclusion: Resident Information.Cognitive Status: Severely impaired cognition.Safety Awareness: Poor; high fall risk. Location: Resident's (Resident #503) room Type of Incident: Unwitnessed fall Activity at Time of Fall: Using