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	12/29/2025

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

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intakes: 2663490, 2673806.Based on interview and record review, the facility failed to protect the residents' right to be free from resident to resident and staff to resident physical abuse for 3 (Resident #1, Resident #2, and Resident #9) of 8 residents reviewed for abuse, resulting in Resident #1 being struck by Resident #2 and Resident #9 being struck by a staff member.Review of Incident Summary dated 10/16/25 at 9:47 PM, revealed, .CNA (Certified Nursing Assistant) heard resident (Resident #1) yelling No, No, no stop; CNA went to source of yelling and observed (Resident #2) smack (Resident #1) on the mouth. Both residents immediately separated. (CNA U) was interviewed and stated that she was rounding on her residents and when she arrived at the room of (Resident #1), she heard her state, No, No, No. She opened the door to (Resident #1's) room and observed (Resident #2) strike her across the mouth. She immediately re-directed (Resident #2) to her room.The resident-to-resident interaction appears to have been an unprovoked incident by (Resident #2) . (Resident #2) was placed on 15-minute checks.transferred to the hospital for evaluation. Resident #1: Review of an admission Record revealed Resident #1 was a female with pertinent diagnoses which included Alzheimer's disease (a type of dementia), anxiety, dementia, difficulty in walking, and pain. Resident #2: Review of an admission Record revealed Resident #2 was a female with pertinent diagnoses which included dementia, mood disorder with manic features, and anxiety, In an interview on 12/29/25 at 2:29 PM, Registered Nurse (RN) ZZ reported Resident #2 had hit Resident #1. RN ZZ reported the residents were separated at the dining room table first and then she was able to attack Resident #1 again as she was able to ambulate around the unit. RN ZZ reported the incident occurred approximately 6:00-6:30 PM. RN ZZ reported Resident #2 had a history of being aggressive and assaultive with other residents. If an individual crossed her the wrong way she would hit them. Review of Behavior Note for Resident #2 dated 10/6/2025 at 12:33 PM, revealed, .Resident exhibiting s/s (signs/symptoms) of anger today, not directed towards anyone, just start with good conversation and she becomes agitated by the end of conversation. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of (Behavioral Health Provider) – Psychiatry note for Resident #2 dated 10/8/25, revealed, . Since the last visit the resident episodes of verbal behaviors. Severity: Mild. Associated symptoms: being upset, aggressive towards peers and confusion. Modifying factors: medication, staff, redirection and socialization. Nursing notes reports on 09/14 ambulating without walker at times. get upset when reminded to use her walker. get agitated and argue a lot with other residents stating, they are stealing things from me. got mad with other residents with no reason, 09/18 resident is in the DR (dining room) being aggressive towards other residents. She called one a bitch, when staff tried redirected her, she pushed her. Telling residents to shut up, 09/28 Resident went to outside door and insisted she was leaving, advised that door alarm would blast loudly, states she didn't care and was leaving any way, verbally abusive, nurse stood at door, and she eventually stated she wasn't going to stay here and walked down hall. No other issues at this time, 09/29 Resident attempt to be helpful to other residents, redirected several times to allow CNA's to assist them, 09/30 Resident was verbally abrasive with Staff this evening. She was difficult to redirect, 10/01 Nursing reported that pt (patient) is having increased episodes of evening bouts of anger, aggression, and exit-seeking behaviors. She was originally on clonazepam 0.5mg (used to treat anxiety and panic attacks) three times per day but was GDR'd (gradual dose reduction) down to once daily, 10/06 Resident exhibiting s/s of anger today, not directed towards anyone, just start with good conversation and she becomes agitated by the end of conversation and refusing labs, and 10/08 Resident standing up in living room when another resident was walking by with her walker. (Resident #2) was trying to assist the other resident by holding her walker. Staff redirected resident, became upset with staff, but was redirectable and then ambulated out to the dining area, mumbling and then allowed staff to take her for a walk; nursing notes reviewed from 09/11 through 10/08. Behavior log review for the past 30 days reports episodes of pushing others x 1, physically aggressive towards others x 1, cursing at others x 1 and screaming at others x 2 . Review of Behavior Note for Resident #2 dated 10/11/2025 at 10:39 AM, revealed, .Resident argumentative, with staff and residents, resident redirectable, and sitting at table alone at this time. Review of Behavior Note for Resident #2 dated 10/13/2025 at 5:47 PM, revealed, .Nurse was interviewing new resident, (Resident #2) continues to but in, nurse asked kindly to let resident answer questions, she became angry told CNA she was going to push nurse over. Review of Nursing Progress Note for Resident #2 dated 10/14/25 at 2:51 PM, revealed, .Resident become upset as nurse entered another resident room, she became angry and verbally aggressive towards nurse. Resident was entering other resident rooms and asked not to, she continued to enter the room. Nurse did not engage in arguing. Resident approached another resident and grabbed her walker, nurse asked her to please let go, nurse stepped between resident and (Resident #2) proceeded to push nurse several times and attempt to get around nurse to resident. Nurse called for additional assistance and resident was redirected. During an observation on 12/23/25 at 12:18 PM, Resident #2 was expressing some verbal agitation and staff was attempting to redirect her to her room. Licensed Practical Nurse (LPN) YY reported Resident #2 was agitated and she does have the behavior quite frequently. LPN YY redirected Resident #2 away from the lunchroom table and asked Resident #2 if she would like some coffee and asked her if she would like to have her lunch in her room. Resident #2 stopped to speak to this writer for a moment and headed down the hallway to her room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/29/25 at 10:55 AM, LPN JJ reported supervision on the memory care unit can be difficult to ensure the safety of the residents when there were less staff or staff who were not familiar with the residents working on the unit. LPN JJ reported the memory care unit needed to be monitored at all times and with less staff it could turn into a dangerous situation. She reported as the nurse she attempted to monitor the unit but with her duties and the phone calls, labs, visitors, questions from family and other staff, it can be difficult to see everything that was happening on the unit. Review of current Care Plan for Resident #2, revised on 10/17/25, revealed the focus, .Altered behavior in which resident acts characterized by ineffective coping; verbal/physical aggression related to cognitive impairment secondary dementia with psychotic disorder, mild neurocognitive disorder, and anxiety disorder.I have a hx (history) of physically striking others. with the intervention .Identify stressful times of day for the resident – and schedule her activities at other times.If I become agitated, please attempt to redirect me to an area of more supervision and less stimulation. Note: No behavior care plan was implemented prior to the resident-to-resident incident on 10/16/25 between Resident #1 and Resident #2. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, Abuse updated 5/24/23, revealed, .Residents have the right to be free from abuse, neglect, exploitation, mistreatment, and misappropriation of resident property.Prevention consists of facility systems designed to detect, identify, correct, and prevent the occurrence of abuse. The facility utilizes the QAPI process to review care practices, trends, and patient outcomes in order to maintain continued performance improvement. The facility's procedures include: Identifying, correcting, and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur in accordance with the facility's Quality Assurance and Performance Improvement Plan (QAPI) . Ensuring staff are deployed, trained, and qualified to meet the needs of the residents and that resources are available to meet the needs of the residents in accordance with the Facility Assessment .Completing ongoing assessments and care planning for appropriate interventions, and monitoring of residents with behaviors, including but not limited to: Verbally Aggressive Behaviors (screaming, cursing, demanding, insulting, etc.), Physically aggressive behaviors (hitting, kicking, biting, spitting, throwing objects, threatening gestures, etc.), Sexually aggressive behavior (inappropriate touching, grabbing, saying sexual things, etc.), Wandering into other's rooms or space, Taking/touching/rummaging through other's property, communication disorders or those who speak a different language, history of self-injurious behaviors, and those that are dependent upon staff for care .Providing residents, representatives, and staff information on how and to whom they report any allegations of abuse, neglect, mistreatment, exploitation, misappropriation of resident property, injuries of unknown origin, concerns, incidents, and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed .Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors . Abuse against residents can be perpetrated by various people within the facility. The facility supports and protects patients, family members, and staff from harm during an investigation of alleged abuse including retribution and retaliation. Protective actions depend upon the people involved. Any allegation of abuse must be immediately reported to the supervisor and the Abuse Prevention Coordinator. The Administrator initiates investigating any allegation of abuse against a patient . The facility will make efforts to ensure all residents are protected from physical and psychosocial harm during and after the investigation. Examples include but are not limited to: immediately removing the resident from contact with the alleged abuser .Evaluation of the physical and psychosocial condition of the resident and providing emotional support to the patient during and after the investigation as needed .Providing a safe and secure environment for all patients: If a staff member is the alleged perpetrator, that staff member should be immediately removed from the facility and the schedule pending the outcome of the investigation .If a resident Is the alleged perpetrator, the facility will ensure other residents are protected as determined by the circumstances, which may Include but are not limited to resident room changes, increased supervision, or immediate transfer or discharge, if indicated .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) . Resident # 9 Review of an admission Record revealed Resident # 9 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: depression (persistent sad mood or loss of interest in activities causing significant impairment in daily life). (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for Resident #9 with a reference date of 12/30/2025, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Review of a Care Plan for Resident #9 with a reference date of 8/28/25 revealed the following focus/goal/interventions: Focus: At risk for changes in.mood related to.depression. Goal: Resident will accept care and medication.Interventions.offer choices to enhance sense of control. In an interview on 12/22/25 at 12:08pm, Resident #9 reported in mid-November, an agency nurse struck him during an argument. Resident #9 reported he was in the dining area when a nurse (Licensed Practical Nurse (LPN) SS) he had not previously met, approached him in the dining room but would not give him an insulin injection in the public area, despite that being his (Resident #9's) preference. Resident #9 reported LPN SS later reapproached him for the injection when the resident was in his room, they began to argue, and Resident #9 pushed LPN SS. Resident #9 reported at that time, LPN SS hit him in the face with his hand. Resident #9 reported he was remorseful for pushing the LPN SS but felt very frustrated by LPN SS's inappropriate response. Resident #9 stated he (LPN SS) was supposed to be here to take care of me. Resident #9 reported a member of the facility's management team told him the nurse would no longer be allowed to care for residents at the facility. Resident #9 reported he was satisfied with the facility's response to the situation. In an interview on 12/29/25 at 12:27pm, Family Member (FM) UU reported she was contacted by the interim Director of Nursing (DON) VV in November 2025 and told Resident #9 had been hit by a nurse during an argument. FM UU reported she was told at that time that the nurse would no longer be caring for Resident #9. In an interview on 12/29/25 at 1:26pm, hospice Certified Nursing Assistant (CNA) N reported on 11/15/25 she was caring for a resident in a room on Resident #9's hall when she heard yelling. CNA N reported as she entered the hallway, she saw Resident #9 crawling on the floor on his knees, while using both arms to aggressively push a wheelchair toward LPN SS. CNA N reported Resident #9 stated to LPN SS, You hit me!. CNA N confirmed she did not witness what had occurred between Resident #9 and LPN SS prior to when she entered the hallway. CNA N reported 2 other CNAs arrived and began to intervene. In an interview on 12/29/25 at 2:16pm, CNA LL reported she was caring for a resident in another room when she heard yelling coming from the hallway on 11/15/25. CNA LL reported she stepped into the hall and saw LPN SS yelling at Resident #9 and pointing his finger at the resident. CNA LL reported LPN SS appeared angry and used a loud tone of voice which he directed at Resident #9. In an interview on 12/29/25 at 2:51pm, CNA I reported she was standing near the nurse's station on 11/15/25 when she heard 2 voices yelling near Resident #9's room. CNA I reported she ran to Resident #9's room and found the resident on the floor on his knees, holding onto his wheelchair. CNA I reported she saw blood on Resident #9's lip. CNA I reported Resident #9 told her he hit LPN SS, and the nurse hit him back. CNA I reported she provided a verbal statement and text to interim Director of Nursing (DON) VV which included what she saw and heard that day. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/22/25 at 3:44pm, FM RR reported he was visiting a relative on Resident #9's hall on 11/15/25 when he heard loud, 2 male voices yelling and swearing. FM RR reported he became concerned that other residents were upset by the loud yelling and responded to the situation that was occurring in the hallway. FM RR reported Resident #9 and LPN SS were in the hallway yelling and swearing at each other with several other staff member's trying to intervene. FM RR reported Resident #9 stated You hit me! to LPN SS. FM RR reported he heard LPN SS respond to Resident #9 and say, You hit me first!. FM RR reported he got in between Resident #9 and LPN SS, told LPN SS to walk away, which he did. FM RR reported no one from the facility interviewed him about what he saw or heard that day. In an interview on 12/29/25 at 10:34am, LPN SS reported he approached Resident #9 while he was in the dining room on 11/15/25 and asked the resident to come to his room for an insulin injection. LPN SS reported Resident #9 was frustrated and stated he wanted to receive his injection in the dining room. LPN SS reported he was not comfortable doing that, so he left and reapproached Resident #9 approximately an hour and half later in his room. LPN SS reported Resident #9 voiced frustration with the situation and poked LPN SS in the chest with 2 fingers. LPN SS reported in response, he pushed Resident #9's hands away and the resident stumbled. When queried, LPN SS denied Resident #9 fell or was on the floor on his knees at any time. LPN SS reported he was concerned he was going to get in trouble and refused to answer additional questions. In an interview on 12/29/25 at 1:54pm, Nursing Home Administrator (NHA) A reported interim DON VV conducted the investigation for the incident involving LPN SS and Resident #9. NHA A confirmed the only written witness statement taken was that of CNA N. When further queried, NHA A reported it was her understanding that none of the other staff working witnessed any of the interactions between Resident #9 and LPN SS. NHA A confirmed to her knowledge, no other staff or guests were interviewed. Attempts to interview interim DON VV were unsuccessful prior to the conclusion of the survey. Review of a police department Incident Report Form with a reference date of 11/15/25 at 7:13pm revealed Offense Descriptions: 1. A&B/SIMPLE ASSAULT.Suspect Interview . (LPN SS) explained he was attempting to administer medication and (Resident #9) needed his blood sugar checked and his dose of insulin. (Resident #9) refused to leave the dining room.approximately an hour later (LPN SS) found (Resident #9) in his room and asked if he wanted his medication. (Resident #9) began swearing and argued.poked (LPN SS) in the chest with a single finger. (LPN SS) reacted the (sic) slapped (Resident #9's) hand away. Review of an Abuse policy with a reference date of 4/13/22 revealed POLICY OVERVIEW: Residents have the right to be free from abuse.DEFINITIONS: Physical Abuse.Includes, but not limited to hitting, slapping.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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F 0602 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 2615390Based on interview and record review the facility failed to prevent misappropriation of narcotic medications for 2 (Resident #7 and Resident #8) of 2 residents reviewed for misappropriation of personal property, resulting in the potential for ineffective pain management.Findings include:Review of Incident Summary dated 8/31/2025 at 7:27 PM revealed .while processing a resident to discharge home, narcotic card count and sheet count were off by 3 cards total, effecting 2 residents. Narcotic card count sheet was changed by Agency (Registered Nurse (RN) BBB) nurse. When further questioned as to why the card count was changed, she stated the medications were finished however she could not detail what she did with the blister packs or signed narcotic sheets.Resident #7 Review of an admission Record revealed Resident #7 was originally admitted to the facility on [DATE] for a 5-day respite stay while admitted to hospice. Review of Order Summary for Resident #7 revealed .Respite care- admitted to (Name Omitted) hospice care with a start date of 8/26/25 and Hydrocodone-Acetaminophen (Norco) Tablet 5-325 mg (milligram) give 1 tablet by mouth every 6 hours as needed for pain; Hydrocodone-Acetaminophen Tablet 5-325 mg Give 1 tablet my mouth in the evening for pain with a start date of 8/27/25.Review of Packing Slip from (Name Omitted) pharmacy service dated 8/26/25 revealed . Rx (prescription) Resident #7, Quantity 13. 0, Medication Hydrocodone-APAP 5-235 mg. The packing slip was noted to be signed by receiving staff on 8/26/25 at 9:20 pm.Review of Medication Administration Record (MAR) for Resident #7 revealed . documented administration of 3 scheduled hydrocodone-acetaminophen 5-325 mg tablets, on 8/28/25, 8/29/25, and 8/30/25 all at 18:00 (6:00 PM). No other documentation was noted as indicating the administration of other tablets to Resident #7 during her stay.Review of the controlled substance shift inventory sheet revealed on 8/30 at 7:00 PM RN M signed as the off going nurse and Agency RN BBB signed as the oncoming nurse, they narcotic card count was documented as 17. On 8/31/25 at 7:00 AM Agency RN BBB signed as the off going nurse, the total number of RX's at the start of the shift was documented to be 17 and total at the end of the shift was 14. The column for empty or to DON (director of nursing) was blank. There was no noted documented reason for the removal of 3 narcotic cards on 8/31/25. Review of Witness Statement completed by Former Director of Nursing (DON) TT on 8/31/25 at 11:30 AM, revealed This writer (Former DON TT) asked Agency RN BBB where Resident #7's medicine was at and she reported she used it all. This writer asked where the controlled receipts and disposition records was. She didn't know.Review of Witness Statement completed by Former DON TT on 8/31/25 at 14:30 (2:30 PM) revealed The writer (Former DON TT) Agency RN BBB calls back with the nurse from day shift (RN M) They both confirm they started the count with 17 cards. When we counted last it was 17 total. Resident #7 had 2 blister packs left. RN M spoke with Agency RN BBB on 8/30 on who would be discharged . 2 people this week. Resident #7. and both those residents' medications are missing. The witness statement was noted to be signed and dated for 8/31/25 by RN M and Former DON TT. In a telephone interview on 12/23/25 at 12:13 PM Agency RN BBB reported the count was accurate when she took the keys on 8/30/25 there was an issue with the count when she left on 8/31/25 after her shift. Agency RN BBB reported it was not her signature on the shift-to-shift count form, and she did not know what happened to the missing narcotic medication cards of the count sheets.In a telephone interview on 12/29/25 at 9:94 AM, Former DON TT reported the day before Resident #7 was to discharge home she had gone through the medication cart narcotic drawers and counts. Former DON TT reported she was present when Resident #7 was discharging on 8/31/25 from the facility and she noticed that Resident #7 narcotic medication and the count sheets were missing. Former DON TT reported she counted all the narcotic cards and count sheets and determined 3 narcotic cards were missing. Former DON TT reported she interviewed RN M and Agency RN BBB, and her investigation determined the cards went missing during the shift that started on 8/30/25 and ended on 8/31/25 when Agency RN BBB was assigned to Resident #7. Former DON TT reported the narcotic medications, cards, and count sheets were never located.Resident #8 Review of an admission Record revealed Resident #8 was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: burn of multiple sites of left lower limb, burn of abdominal wall, fracture of part of scapula, right shoulder, and fracture of fifth lower lumbar vertebra.Review of Order Summary for Resident #8 revealed . Oxycodone HCl oral tablet 10 mg give 1 tablet by mouth every 4 hours as needed for pain with a start date of 8/20/25 Review of Packing Slip from (Name Omitted) pharmacy service dated 8/26/25 revealed . Rx

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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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to intake # 2673806Based on interview and record review, the facility failed to thoroughly investigate an allegation of staff-to-resident abuse for 1(Resident #9) of 8 residents reviewed for abuse, resulting in an incident of staff-to-resident physical abuse not being identified due to a lack of thorough investigation, and a potential for additional abuse to go unrecognized.Findings include:Resident # 9In an interview on 12/22/25 at 12:08pm, Resident #9 reported in mid-November, an agency nurse struck him during an argument. Resident #9 reported he was in the dining area when a nurse (Licensed Practical Nurse (LPN) SS) whom he had not previously met, approached him in the dining room but would not give him an insulin injection in the public area, despite that being his (Resident #9's) preference. Resident #9 reported LPN SS later reapproached him for the injection when the resident was in his room, they began to argue, and Resident #9 pushed LPN SS. Resident #9 reported at that time, LPN SS hit him with his hand. Resident #9 reported a member of the facility's management team told him the nurse would no longer be allowed to care for residents at the facility.In an interview on 12/29/25 at 12:27pm, Family Member (FM) UU reported she was contacted by the interim Director of Nursing (DON) VV in November 2025 and told Resident #9 had been hit by a nurse during an argument. FM UU reported she was told at that time that the nurse would no longer be caring for Resident #9.In an interview on 12/29/25 at 2:51pm CNA I reported she was standing near the nurse's station on 11/15/25 when she heard 2 voices yelling near Resident #9's room. CNA I reported she ran to Resident #9's room and found the resident on the floor on his knees, holding onto his wheelchair. CNA I reported she saw blood on Resident #9's lip. CNA I reported Resident #9 told her he hit LPN SS, and the nurse hit him back. CNA I reported she provided a verbal statement and a text to interim Director of Nursing (DON) VV which included what she saw and heard that day.Reviewed of typed list of Witness Statements compiled by interim DON VV revealed Name (CNA I), Date: 11/16/25 Statement: I did not witness the interaction between nurse and resident. I observed resident kneeling on his wheelchair.In an interview on 12/29/25 at 2:16pm, CNA LL reported on 11/15/25 at approximately 3:00pm, she was in another resident's room when she heard yelling in the hallway. CNA LL reported upon entering the hallway she saw LPN SS pointing his finger at Resident #9 and yelling loudly.Review of the typed list of Witness Statements complied by interim DON V revealed no statement was taken from CNA LL.In an interview on 12/22/25 at 3:44pm, FM RR reported he was visiting a relative on Resident #9's hall on 11/15/25 when he heard loud, yelling and swearing from 2 male voices. FM RR reported he became concerned that other residents were upset by the loud yelling and responded to the situation that was occurring in the hallway. FM RR reported Resident #9 and LPN SS were in the hallway yelling and swearing at each other with several other staff member's trying to intervene. FM RR reported Resident #9 stated You hit me! to LPN SS. FM RR reported he heard LPN SS respond to Resident #9 and said, You hit me first!. FM RR reported he got in between Resident #9 and LPN SS, told LPN SS to walk away and LPN SS did so. FM RR reported no one from the facility interviewed him about what he saw or heard that day.In an interview on 12/29/25 at 1:54pm, Nursing Home Administrator (NHA) A reported interim DON VV conducted the investigation for the incident involving LPN SS and Resident #9. NHA A confirmed the only written witness statement she had was from CNA N. When further queried, NHA A reported it was her understanding that none of the other staff working witnessed any of the interactions between Resident #9 and LPN SS. NHA A confirmed to her knowledge, no other staff or guests were interviewed.Attempts to interview interim DON VV were unsuccessful prior to the conclusion of the survey.Review of a police department Incident Report Form with a reference date of 11/15/25 at 7:13pm revealed Offense Descriptions: 1. A&B/SIMPLE ASSAULT.Suspect Interview . (LPN SS) explained he was attempting to administer medication and (Resident #9) needed his blood sugar checked and his dose of insulin. (Resident #9) refused to leave the dining room.approximately an hour later (LPN SS) found (Resident #9) in his room and asked if he wanted his medication. (Resident #9) began swearing and argued.poked (LPN SS) in the chest with a single finger. (LPN SS) reacted the (sic) slapped (Resident #9's) hand away.Review of an Abuse policy with a reference date of 4/13/22 revealed .INVESTIGATION: . Once reported, the center conducts a.thorough investigation. The investigation process includes: .Identifying and interviewing all involved persons.witnesses.and others who might have knowledge of the allegations (such as.family members.) .Providing complete and thorough documentation of the investigation.

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	235458	A. Building B. Wing	12/29/2025

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

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 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 follow professional standards of nursing practice for medication administration for 1 of 1 residents (Resident #11) reviewed for medication administration resulting in the not following the physician's order for administration, administering a medication late and not contacting the provider and the potential for affected resident not maintaining or achieving their highest practical physical well-being.Findings include: Resident #11:Review of an admission Record revealed Resident #11 was a female with pertinent diagnoses which included paroxysmal atrial fibrillation (irregular heartbeat), pulmonary embolism (blood clot in the lung), popliteal vein thrombosis (blood clot forms in the vein behind the knee), high blood pressure, heart failure, and low blood pressure.Review of Care Plan for Resident #11 revised on 5/28/25, revealed the focus, .The resident has altered cardiovascular status r/t (related to) chronic diastolic CHF (congestive heart failure), hypertension (high blood pressure), morbid obesity, OSA (obstructive sleep apnea), atrial fibrillation. with the intervention .Administer medications per physician's orders.Obtain vital signs and notify physician as needed.Monitor for chest pain. Monitor/report to MD (medical doctor) changes in lung sounds on auscultation (listening to lung sounds via a stethoscope) (i.e. crackles), edema and changes in weight. Review of Order dated 11/20/25 for Resident #11 revealed, .Midodrine HCl Oral Tablet 10 MG (Midodrine HCl).Give 1 tablet by mouth with meals for hypotension Hold if systolic BP (blood pressure) greater than 130.Review of Order dated 11/20/25 for Resident #11 revealed, .Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 25 MG (Metoprolol Succinate).Give 1 tablet by mouth one time a day for cardiac arrhythmia SBP (systolic blood pressure) <100, and/or DBP (diastolic blood pressure) <60 or HR (heart rate) 55.Do not give midodrine and metoprolol at the same time per cardiologist. During an observation on 12/23/25 at 09:28 AM, Licensed Practical Nurse (LPN) Agency Nurse BB entered Resident #11's room to check her blood pressure and administer her medications. At 09:31 AM, LPN Agency Nurse BB exited the room to obtain a different blood pressure cuff, and she had Resident #11's medications in a cup in her other hand which she reported were Metoprolol and Midodrine for cardia arrythmia. LPN Agency Nurse BB obtained Resident #11's blood pressure was 117/60 and pulse was 96 and she reported if the systolic was below 100 she would hold the medication. In an interview on 12/23/25 at 09:39 AM, Resident #11 reported she took the medication administered by LPN Agency Nurse BB.In an interview on 12/23/25 at 12:54 PM, LPN Agency Nurse BB reported the metoprolol could be administered between 0700-1100 AM. LPN Agency Nurse BB reviewed the medical record and reported the Midodrine was given at 09:39 AM with the Metoprolol and per the order was scheduled for 08:00 AM, therefore the medication was late and the two medications were not to be given together per the Metoprolol order. LPN Agency Nurse BB reported when passing medications the nurse would be interrupted to do other tasks or services for the residents and it was hard to keep up with administration of medications. In an interview on 12/29/25 at 12:09 PM, Unit manager (UM) AAA reviewed the medical record for Resident #11 and reported Metoprolol and Midodrine were administered at the same time at 09:39 AM. UM AAA reviewed the order and reported Midodrine was to be administered with a meal as it had potential for upsetting Resident #11's stomach, the administration times were 0800 AM, 1200 PM, and 1700 (5:00 PM) and it was administered late. UM AAA reported Metoprolol had an administration time of 0700-1000 AM and it was not to be administered at the same time as the Midodrine. UM AAA reported the medications worked in different ways, the Metoprolol brought the blood pressure down and the Midodrine brought the blood pressure up, so the medications counteracted each other as if she was not taking either. Review of .Drug Interactions Between Metoprolol and Midodrine should not be taken as they can have opposing effects on the heart and blood pressure, which may cause a dangerously slow heart rate (bradycardia).Metoprolol works by slowing the heart rate and reducing blood pressure.Midodrine used to treat severe low blood pressure by narrowing blood vessels and increasing blood pressure.When combined, the opposing actions can interfere with each other and potentially lead to a medical emergency. The primary concern is that Midodrine may cause slow heart rate when taken with Metoprolol that also reduces heart rate. https://www.drugs.com/drug-interactions/metoprolol-with-midodrine-1615-0-1629-0.htmlReview of Fundamentals of Nursing ([NAME] and [NAME]] revealed, Professional standards such as Nursing: Scope and Standards of Practice [ANA, 2010) .apply to the activity of medication administration. To prevent medication errors, follow the six rights of medication administration consistently every time you administer medications. Many medication

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes: 2694470 and 2685061Based on interview and record review the facility failed to perform cardiopulmonary resuscitation (CPR) on [DATE] for 1 (Resident #13) of 1 resident reviewed for code status (medical orders that indicate a resident's preference for treatment in a medical emergency) orders, resulting in an immediate jeopardy when Resident #13 was found unresponsive and subsequently died.Findings include:Interviews and record reviews verified that Agency Registered Nurse (RN) AA did not perform CPR on Resident #13, who was a full code, and was found unresponsive on [DATE] at approximately 5:02 am and subsequently died.The immediate jeopardy began on [DATE] when staff did not perform CPR on a full code resident (Resident #13). On [DATE] at 3:20 PM, the Nursing Home Administrator was verbally notified and received written notification of the immediate jeopardy. This surveyor confirmed by observation, interview, and record review, the immediate jeopardy was removed on [DATE], but noncompliance remains at a scope of isolated and severity of actual harm due to the fact that all staff including agency had not been educated and sustained compliance had not yet been verified by the State Agency.According to the 2025 American Heart Association Guidelines for CPR and ECC (CPR and ECC Guidelines | American Heart Association CPR & First Aid), Healthcare Professionals (HCPs) have a prima facie obligation to follow institutional policies regarding ethical issues in resuscitation in addition to the guidelines in this document. In turn, institutions have an obligation to develop ethically sound policies, educate HCPs on both policies and ethical guidelines, and provide the resources necessary to adhere to these standards and resolve difficult issues when they arise.Once initiated, resuscitation can be discontinued, but the decision not to initiate treatment is often irrevocable. Thus, HCPs should generally err on the side of providing resuscitation when uncertainty exists.focusing on the special circumstances as etiologies of cardiac arrest, provide and evaluate specific treatment options meant to be administered in addition to, and alongside, traditional resuscitation care. Unless otherwise specified, all patients should receive standard airway management, support of breathing, and treatment of hypotension, arrhythmias, and cardiac arrest consistent with local protocols and the resources available at the site of treatment.Resident #13Review of an admission Record revealed Resident #13 was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: hereditary ataxias (poor muscle control and clumsy movements), dysphagia following cerebral infarction (difficulty swallowing after a stroke), and Parkinson's disease (a movement disorder of the nervous system of the body that worsens over time).Review of Order Summary for Resident #13 revealed .admitted to (Name Omitted) hospice services.Adv Directive (advance directive-code status) Full Cardiopulmonary Resuscitation (CPR) with start dates of [DATE].Review of Care Plan for Resident #13 revealed no care plan documentation regarding code status, advance directives, or preference related to medical emergency treatment.Review of Nursing Progress Note for Resident #13 dated [DATE] at 05:18 (5:18 am) authored by Agency Registered Nurse (RN) AA revealed Staff reported resident was unresponsive at 0502 [DATE] (5:02 am) pt (patient) heart and lungs sounds were examined there were no heart or lung sounds present. No spontaneous cardiac or respiratory activity present in response to verbal or painful stimuli no capillary reflex present pupils are fixed and dilatated, resident was pronounced dead at [DATE] at 0508 (5:08 am) pt was presently Hospice with (Name Omitted).In a telephone interview on [DATE] at 11:08 AM Hospice Supervisor (HS) OO reported Resident #13 was originally admitted to hospice services in December of 2024. HS OO reported Resident #13 was on and off services a couple of times during the last year. HS OO reported Resident #13, and her family, had made the decision for Resident #13 to remain a full code while on hospice services. HS OO stated Resident #13 was a full code the entire time she was on our services, including the most recent re-admission to hospice on [DATE] until her death. In an interview on [DATE] at 11:35 AM, CNA I and CNA D reported a resident's code status was in their record, in their care plan, and on the Kardex (medical patient information system that stores information regarding patient needs for nursing staff to access quickly). CNA I and CNA D reported if a resident was found unresponsive and was a full code the nurse would have to start a code. CNA I and CNA D reported CNAs cannot assist with CPR, they are not certified, but they can be instructed by the nurse to do other things during a code.In an interview on [DATE] at 1:05 PM, Attending Physician (AP) MM reported a resident's code status requires a physician order. AP MM reported if a resident was a full code, and there was a medical emergency, CPR should be initiated and continue until EMS (emergency medical services/911) arrives.In a telephone interview on [DATE] at 1:13 PM, Agency RN

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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** This citation pertains to Intake: 2611992 Based on observation, interview and record review, the facility failed to assess, monitor, document, and provide treatment per professional standards of practice for 1 resident (Resident #11) of 1 resident reviewed for quality of care, resulting in hospitalization for fecal impaction, potassium levels at a dangerous level, and implementation of treatment of weeping wounds with a potential for a decline in overall physical, mental, and psychosocial well-being. Findings include: Resident #11:Review of an admission Record revealed Resident #11 was a female with pertinent diagnoses which included iron deficiency, slow transit constipation, anxiety, mixed irritable bowel syndrome (alternating bouts of constipation and diarrhea along with abdominal pain, gas, bloating, cramping, often cycling between the two extremes), GERD (gastro-esophageal reflux disease), lymphedema (chronic swelling caused by a buildup of protein rich lymph fluid when the lymphatic system is damaged or blocked) and hyperkalemia (high potassium). Review of a Minimum Data Set (MDS) assessment for Resident #11, with a reference date of 10/15/25 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated Resident #11 was cognitively intact.Review of Care Plan for Resident #11 revised 10/15/25, revealed the focus, .I have chronic areas of skin integrity and pannus (excess skin and fat hang down from the abdomen) r/t (related to) chronic lymphedema, fragile skin, I wear lymphedema boots to help decrease my lymphedema. with the intervention .Follow WC (wound care) NP (nurse practitioner) orders for treatment.weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations. Review of Care Plan for Resident #11 revised 5/28/25, revealed the focus, .The resident is on diuretic therapy r/t hypertension and heart failure. with the intervention .Report pertinent lab results to MD (medical doctor) (Especially HCT (hemocrit-blood test how much of your blood consists of red blood cells), Na+ (sodium), K+ (potassium).Review of Care Plan for Resident #11 revised 5/28/25, revealed the focus, .Bowel incontinence related to impaired mobility, morbid obesity, weakness. with the intervention .Report changes in bowel movement frequency, consistency, control, etc. In an interview on 12/23/25 at 09:07 AM, Resident #11 reported the facility was currently completing weekly lab draws for her but in September she had to go to the hospital as she was experiencing significant pain from constipation and had begged for an enema and the facility refused to give her one. Resident #11 reported while at the hospital it was discovered her potassium level was elevated but unsure of the number. This writer observed a brief located under Resident #11's right upper thigh area. Resident #11 reported she had lymphedema, and her legs had open areas which weeped. Resident #11 reported the facility had placed the brief there to capture the drainage as the blue pads (sterile fiber gelling wound dressings used to absorb fluids) had run out last week, so they were using the brief under her legs. Resident #11 reported the nurses were not cleaning her open areas and she had to clean them herself, observed wound cleanser on the table on the side of her bed. Resident #11 reported the weeping was so heavy it would leak on the bed and on the floor due to the saturation of the dressings and them not being changed when saturated. Resident #11 reported the wound nurse did not come last week to assess her skin and she reported she had new openings on her legs. Resident #11 reported she had lymphedema in her legs, and the nurses were to use the lymphedema boots, but the staff had a hard time getting the boots up her legs and under her legs, so they were not able to work right. Resident #11 reported the staff had to place a towel between her knee and ankle area due to the size of her thighs and the boots were not working appropriately while on her legs without the towels. She reported that the lymphedema boots expand and put pressure on her legs to aid in drainage of the fluid. Resident #11 reported she had not had the boots on since last Friday/Saturday she couldn't remember for sure which day, but it had been a few days. Review of Internal Medicine History & Physical at (Local Hospital) dated 9/7/25, revealed, .Acute hyperkalemia (dangerous condition with dangerously high blood potassium requiring immediate treatment)-Repeat BMP (basic metabolic panel - chemical balance, metabolism, kidney function, and blood sugar) reviewed -Give insulin and dextrose, IV lasix 60mg (diuretic - water pill), lokelma (used to treat high potassium levels in blood). Repeat BMP this early afternoon. If it remains elevated, will consult nephrology (kidney specialist).-Patient states she has been taking her torsemide (diuretic) and zaroxolyn (diuretic used to treat fluid retention and high blood pressure).Severe constipation/fecal impaction: Disimpacted in the ED (emergency department). Give fleet enema Miralax BID (twice a day), 2 tabs senokot BID, PRN (as needed) mag citrate (laxative)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to Intake: 2611992 Based on observation, interview, and record review, the facility failed to ensure appropriate external catheter care, monitoring, and cleaning for 1 (Resident #11) of 1 resident reviewed for catheter care, resulting in the potential of a urinary tract infection.Findings include: The Pure Wick at Home for females is an external catheter which sit outside the body, held in place by the anatomy of most users, and the wick is multi-layered with soft absorbent fabric designed to pull voided urine through tubing and into the connected collection canister. https://www.purewickathome.comResident #11:Review of an admission Record revealed Resident #11 was a female with pertinent diagnoses which included acute cystitis with hematuria (bladder inflammation often from a bacterial infection causing painful, frequent urination, and visible blood), overactive bladder, neuromuscular dysfunction of bladder (nerve damage causing poor bladder control, incontinence, or incomplete emptying), and carrier of carbapenem-resistant enterbacterales (CRE- an infection from antibiotic resistant germs). Review of Care Plan revised on 5/28/25, revealed the focus, .Use of external urinary catheter (pure wick) needed due to dx (diagnosis) of neuromuscular dysfunction of bladder. with the intervention .Change urinary collection bag as needed.Empty and clean pure wick canister pure (sic) orders. Review of Resident #11's Order revealed, . Allow patient use of Pure Wick External Catheter due to urinary incontinence. Replace external catheter every 8 to 12 hours, or immediately if soiled with feces.every shift for urinary incontinence.dated 11/19/25. During an observation and interview on 12/23/25 at 09:20 AM, Resident #11 reported when she placed her call light on for assistance the nursing staff would indicate they would come right back, they never come back to assist her, and her need would not be met. Resident #11 reported at times she would have to sit in feces for hours, sometimes as long as 5 hours. Resident #11 reported the Pure Wick was not perfect as at times it wasn't always suctioning all the fluid up and she had pads under her for the leakage. Resident #11 reported she had to correct the Certified Nursing Assistant (CNA) on how to re-attach the tubing after she had emptied the container as it was not on correctly and if it was not on correctly the fluid would not be suctioned into the canister and it would leak out and created a mess. Resident #11 reported the CNAs rinse out the canister and Resident #11 reported she had to inform the CNA the canister needed to be cleaned out. Resident #11 had found the suction was in the off position on the machine and then there would be leakage on the bed pad. In an interview on 12/23/25 at 12:13 PM, CNA KK reported for the catheter system, the CNAs would empty it and rinse it out the same as if a resident had an internal catheter. In an interview on 12/29/25 at 11:15 AM, Resident #11 reported she had no patient care, until 0600 PM at night all weekend. Her pure wick canister was left full or over halfway full and the staff weren't coming in until later in the evening to empty it. Resident #11 reported the Pure Wick machine had not been cleaned out in two or three days. In an interview on 12/29/25 at 11:50 AM, UM AAA reported Resident #11 wanted a brief under her for any incontinence she experienced as well as to collect any drainage from the lymphedema (chronic swelling in the arm or leg, caused by buildup of protein rich lymph fluid when the system is damaged or blocked) to keep the moisture away from her legs. In an interview on 12/29/25 at 11:53 PM, UM AAA reviewed the orders for Resident #11. UM AAA reported there were no orders in the record for how to clean the Pure Wick canister, no order which indicated the Pure Wick canister needed to be emptier prior to becoming over half way full, and when the canister and tubing needed to be replaced. UM AAA reported she was unsure on how to care for the system and she had not provided education to the nursing staff on how to do so. Review of Resident #11's medical record revealed no evaluation and monitoring of Resident #11 for the demonstration of use and education of the Pure Wick for Resident #11. Review of the medical record revealed, Resident #11 had multiple urinary tract infections and tested positive for CRE with in the previous year. Review of Pure Wick at Home Clinician Facts Page reviewed on 12/30/25, revealed, .Crucial for infection control and skin health: Replacing the Pure Wick external catheter regularly is crucial for infection control and skin health. The Pure Wick system is designed for single use and must be replaced at least every 8 to 12 hours or sooner if soiled. This replacement schedule is essential to maintain proper hygiene and prevent potential complications like urinary tract infections (UTIs) or skin irritation. Attempting to clean and reuse a Pure Wick wick significantly increases the risk of skin breakdown and infection from pathogens that accumulate over time. Therefore, it is recommended to replace the wick immediately if it becomes soiled with feces or blood, and to perform perineal care before placing a new wick. https://www.purewickathome.com/clinician-faqs.htmlReview of Resident #11's Kardex revealed, she was a two person assist with all cares and Toileting; x2

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation and interviews, the facility failed to ensure current daily facility staffing hours were posted in a prominent location readily accessible to residents, staff, and visitors.Findings include:On 12/22/25 at 11:20 AM, staffing hours dated 12/09/25 were observed posted on a bulletin board in a glass enclosed case in the hallway directly behind the entry way and reception of the building.On 12/22/25 at 2:52 PM, staffing hours dated 12/22/25 were observed taped to the glass enclosure of the bulletin board in the hallway directly behind the entry way and reception of the building.On 12/23/25 at 11:02 AM, staffing hours dated 12/22/25 were observed taped to the glass enclosure of the bulletin board in the hallway directly behind the entry way and reception of the building.On 12/29/25 at 8:42 AM, 10:40 AM, and 11:23 AM staffing hours dated 12/22/25 were observed taped to the glass enclosure of the bulletin board in the hallway directly behind the entry way and reception of the building.In an interview on 12/29/25 at 11:24 AM Scheduler (S) K reported it was her responsibility to post the staffing hours. S K reported she had taken over the role of staffing coordinator from Staffing Coordinator (SC) X on 12/29/25, and she knew posting hours was part of her responsibilities. S K reported the hours did not get posted on a regular basis like they should; and that she had not yet posted todays staffing hours.In an observation and interview on 12/29/25 at 11:33 AM, Nursing Home Administrator (NHA) A reported staffing hours were to be posted daily. NHA A escorted this surveyor to the glass enclosure of the bulletin board in the hallway directly behind the entry way and reception of the building and stated, staffing hours are posted here while she gestured to the two pieces of paper taped to the glass. NHA A reported the key to the glass enclosure of the bulletin board was missing and the staffing hours had to be taped to the front of it. NHA A was observed reading and then removed the papers from the glass and stated, I will get the updated one right now. On 12/29/2025 at 3:22 PM, NHA A was observed unlocking the glass enclosure, removing the staffing hours postings from the bulletin board, and giving verbal instructions to S K regarding her role in posting staffing hours on the bulletin board.

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	12/29/2025

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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident food choices were obtained and honored for 1 (Resident #11) of 1 resident reviewed for meal services, resulting in resident dissatisfaction with their meal experience and the potential for inadequate food/fluid intake. Findings include:Resident #11: Review of an admission Record revealed Resident #11 had pertinent diagnoses which included iron deficiency, slow transit constipation, and mixed irritable bowel syndrome (alternating bouts of constipation and diarrhea along with abdominal pain, gas, bloating, cramping, often cycling between the two extremes). Review of Care Plan for Resident #11, revised on 9/23/25, revealed the focus, .The resident is at nutritional and hydration risk r/t (related to) Lymphedema (chronic swelling usually in an arm or leg from a buildup of protein-rich lymph fluid when the lymphatic system is damaged or blocked), Radiculopathy (irritation or compression of a spinal nerve root causing numbness, pain, tingling or weakness), CHF (congestive heart failure), Morbid obesity, hx(history) of recurrent UTI (urinary tract infection), HTN (high blood pressure), Depression, hx of healed pressure injury, chronic non-pressure ulcer. with the intervention . Diet: Regular diet, regular texture, thin liquids (Vegetarian Diet).Independent with eating. Offer food and beverage selections.Offer substitutes as requested or indicated.RD (Registered Dietician) to evaluate and make diet change recommendations PRN (as needed). In an interview on 12/23/25 at 9:28 AM, Resident #11 reported she was informed she would not be receiving the planned lunch meal for Christmas due to the facility not ordering some of the items. Resident #11 reported she was looking forward to eating spinach, [NAME], and feta quiche, which was what the facility had on the menu. Resident #11 expressed concern and frustration as she reported this was not the first time, she would not receive the meal as listed on the menu. In an interview on 12/23/25 at 10:05 AM, Dietary Manager (DM) CCC reported the corporate office made a vegetarian menu. DM CCC reported Dietary Clerk EEE took Resident #11's dietary menu for 3 days of the week at a time. DM CCC reported the cook would make the meals for Resident #11. DM CCC and this writer reviewed the selected menu items for Resident #11 for the next 3 days. DM CCC reported she forgot to order the [NAME] for the lunch meal on Christmas. DM CCC reported this was not the first time she had made errors with the ordering and forget little stuff. In an interview on 12/23/25 at 10:15 AM, Registered Dietician (RD) DDD reported Resident #11's menu was selected a couple of days ahead of time and the staff would be able to go to (Food Supplier) to obtain the missing items. RD DDD reported some of the items Resident #11 preferred to eat for her personal preference were not provided by the supplier so she would go and speak with Resident #11 to discuss other options. In an interview on 12/29/25 at 11:15 AM, Resident #11 reported she was having veggie chicken nuggets for lunch this day and the facility did not have a sauce she could eat. Resident #11 reported she shouldn't have to add cabbage soup to add moisture to her food as she can't eat the chicken nuggets without a sauce. Resident #11 reported over the weekend she did not receive the lentil meatloaf she was supposed to receive for dinner and ended up with a wrap which had a bunch of black beans. Resident #11 reported she felt like the facility expected her to purchase her own food as they had a limited number of items for her to eat. Resident #11 reported she shouldn't have to supply her own food and there were very few items on the alternative menu she could eat and you get tired of eating omelets and grilled cheese sandwiches.In an interview on 12/29/25 at 12:35 PM, Dietary Clerk (DC) EEE reported she took Resident #11's order for meal 3 days at a time. DC EEE reported Resident #11 was upset as she wanted a certain sauce for her veggie nuggets as her mouth was sore. In an interview on 12/29/25 at 12:40 PM, DM CCC reported the lentil meatloaf did not get made for Resident #11 over the weekend, but she was unsure why and she would have a talk with the cook. RD DDD reported that was unacceptable and the lentil meatloaf should have been made for Resident #11 as that was what was on the menu.