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	03/05/2026

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review the facility failed to ensure a call light was within reach for 1 (Resident #110) of 3 residents reviewed for accommodation of needs, resulting in the potential for the resident to not meet their highest practicable level of well-being.Findings include:Resident #110Review of an admission Record revealed Resident #110 was a female, with pertinent diagnoses which included: other recurrent depressive disorders, muscle weakness (generalized), difficulty in walking not elsewhere classified, and cognitive communication deficit. Review of a current Care Plan for Resident #110 revealed a focus of At risk for falls due to history of falls. with revision on 11/9/25 and care planned interventions which included, Orient to surroundings and use of call light with a date initiated of 4/24/25.During an observation on 3/4/26 at 9:27 AM, Resident #110 was in her room in her bed. Resident #110's call light was not visible and was found to be hanging on the bottom of her bed frame behind the head of her bed near the floor. The call light was not within reach of Resident #110.During an observation on 3/4/26 at 11:07 AM, Resident #110 was in her room in her bed. Resident #110's call light was found to be hanging on the bottom of her bed frame behind the head of her bed near the floor. The call light was not visible to or within reach of Resident #110.During an observation on 3/4/26 at 2:54 PM, Resident #110 was in her room in her bed. Resident #110's call light was found to be hanging on the bottom of her bed frame behind the head of her bed near the floor. The call light was not visible to or within reach of Resident #110.During an observation on 3/5/26 at 8:49 AM, Resident #110 was in her room in her bed. Resident #110's call light was found to be hanging on the bottom of her bed frame behind the head of her bed near the floor. The call light was not visible to or within reach of Resident #110.In an interview on 3/5/26 at 8:59 AM, Certified Nurse Aide (CNA) JJ reported call lights were supposed to be within reach of the resident. CNA JJ reported call lights have to be in physical reach of the resident so the resident can touch it and turn it on.In an interview on 3/5/26 at 9:01 AM, CNA N was in Resident #110's room. CNA N reported she had just found Resident #110's call light on the bed frame area behind Resident #110's bed. CNA N reported Resident #110's call light should have been clipped on her or near her where she could reach it. CNA N confirmed Resident #110 did use her call light sometimes.In an interview on 3/5/26 at 9:06 AM, CNA R reported call lights were supposed to be placed on or near the body so the resident could reach it.In an interview on 3/5/26 at 12:21 PM, Assistant Director of Nursing (ADON) C reported call lights were supposed to be within reach of the resident. ADON C reported it was not acceptable for the call light to be behind the resident on the bed frame near the floor and out of reach of the resident.

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2740840 and #2788540.Based on interview and record review, the facility failed to prevent the worsening of pressure injuries in 2 residents (Resident #104 & #101) of 5 residents reviewed for pressure ulcers, resulting in harm to Resident #104 when staff did not transcribe and enter hospital wound instructions, did not perform an initial wound assessment, and did not ensure measures were in place to promote healing of an Unstageable pressure injury (a full-thickness wound where the true depth and extent of tissue damage cannot be determined because the wound bed is covered by slough (moist dead tissue), eschar (crusty dead tissue), or both) on sacrum (tailbone) which led to hospitalization for sepsis (life threatening condition due to infection) due to wound infection. Resident #101 did not receive consistent wound care for an Unstageable pressure injury to the right heel, resulting in worsening of the wound and infection that required antibiotic (medication to treat infection) interventions. Findings include: Resident #104Review of an admission Record revealed Resident #104 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: metabolic encephalopathy (altered mental status). Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 2/12/26 revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, which indicated Resident #104 was cognitively impaired. Review of the Functional Status revealed that Resident #104 was dependent on staff for bed mobility and toileting.Review of Resident #104's Skin Care Plan revealed, Focus: At risk for alteration in skin integrity related to pressure ulcer right hip, history of scrotum and gluteal cleft wounds, diabetes mellitus, incontinence associated dermatitis.Date initiated: 2/6/26, Revision on: 2/20/26.Will refuse showers, will refuse cares and positioning. Interventions: .Barrier cream to peri area/buttocks as needed. Date initiated: 2/6/26 .Elevate heels as able. Date initiated: 2/10/26 .Incontinence care as needed. Date initiated: 2/10/26 . It was noted that the care plan did not identify a wound on the sacrum and there were no interventions created to address the revision on 2/20/26 for refusal of care. Review of Resident #104's Pressure Ulcer Care Plan created on 2/20/26 revealed, Focus: Resident admitted to facility with a pressure ulcer of sacrum unstageable related to impaired mobility, incontinence, refusal of care, refuses to be repositioned, and will refuse to get out of bed . Interventions: .Administer treatments per physician orders.APM (alternating pressure mattress) .Incontinence management .Date initiated 2/20/26. It was noted that the pressure ulcer care plan was developed on 2/20/26 (14 days after admission) and all interventions were developed on 2/20/26. Review of Resident #104's Incontinence Care Plan revealed, Focus: Urinary incontinence and urinary retention. Date initiated: 2/10/26. It was noted that the care plan did not indicate that the resident refused incontinence care and/or that the resident required frequent incontinence care. Review of Resident #104's Hospital Discharge Summary dated 2/6/26 at 12:44 PM obtained from Resident #104's facility records revealed, .Hospital problem list: .skin ulcer right hip with fat layer exposed, incontinence associated dermatitis (skin condition caused by contact with urine or stool, leading to redness, rash, erosion, and increased risk of infection and pressure ulcers). There was a handwritten note attached that included admission information obtained via phone call between hospital staff and an unknown facility staff that indicated, .hard to turn, very stiff.open spots to bottom, sore right hip Monday, Wednesday, Friday change xeroform/mepilex (bandage). This information was not transcribed to Resident #104's facility records.Review of Resident #104's Hospital Patient After-Visit Summary (Discharge Instructions) dated 2/6/26 obtained from Resident #104's facility records revealed, .Wound care instructions: Right hip wound: cleanse with wound cleanser or normal saline and gauze, apply single layer Xeroform (a non-stick anit-bacterial bandage) to wound bed, cover with bordered foam dressing. Change every M/W/F (Monday, Wednesday, Friday) and as needed. Turn and reposition frequently to offload wound. Twice a day and after toileting, cleanse buttocks and scrotum gently and dry. Apply (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	thin layer zinc barrier (like desitin or over the counter diaper rash cream with zinc oxide) to denuded skin (when the outer layer of skin is removed, exposing the sensitive underlying tissue, making it vulnerable to injury and infection) and peri-area (genitals and buttocks) to protect from incontinence (urine and stool). Avoid friction and shear with transfers and repositioning in chair/bed. Goal: to protect denuded skin and keep skin folds clean and dry. If your wound does not heal within 2 weeks of discharge, we recommend that you follow up with your primary care physician for wound check as you may need a referral.Pressure prevention measures are very important, including offloading wounds. Turn side to side to side every 2 hours when in bed. Float heels. Please discuss wound healing need for high protein diet and vitamin supplements with your primary care provider . There was extensive printed information related to the prevention of a pressure ulcer attached to the after-visit summary. The wound care instructions were not transcribed to the resident's treatment orders and/or care plan upon admission.Review of Resident #104's Admissions Assessment-Total Body Evaluation documented by Licensed Practical Nurse (LPN) L dated 2/6/26 at 9:59 PM revealed, . Describe abnormalities: Right trochanter (hip) surgical site 35 cm (centimeter) x 6 cm. There was no documentation of any open wounds and/or refusals for skin assessment.Attempts were made to contact LPN L for an interview with no return call prior to survey exit.Review of Resident #104's Physician Orders revealed, no orders related to wounds or skin on the sacrum in the resident's record from admission on [DATE] through 2/12/26.Review of Resident #104's Treatment Administration Order (TAR) for February 2026) revealed, no skin treatments were administered to Resident #104's from admission on [DATE] through 2/12/26.Review of Resident #104's Facility Provider Visit Note dated 2/9/26 did not include documentation that the provider assessed Resident #104's wounds, and the assessment/plan did not include any skin related diagnoses and/or treatment orders.Review of Resident #104's Skin/Wound Note dated 2/9/26 at 2:45 PM created by Assistant Director of Nursing (ADON) C revealed, Attempted to assess the resident for skin issues. It is documented in his admission eval that he has a surgical incision on his right hip. Resident denies having a surgical incision on his hip. He would not allow me to assess his skin by moving him.Review of Resident #104's Facility Provider Visit Note dated 2/11/26 revealed, .follow up after admission to facility on 2/6/26. He reports his back is hurting. Physical exam: .Skin-no masses, no rashes, no lesion on exposed skin. The assessment/plan did not include any skin related diagnoses and/or treatment orders.Review of Resident #104's Nursing Note dated 2/11/26 revealed, discussed resident during weekly Medicare meeting. He admitted on [DATE] with an admitting dx (diagnosis) of Metabolic Encephalopathy (change in mental status) .Barriers to d/c (discharge): little participation from resident to participate in therapy sessions, resident c/o (complains of) pain in bilateral legs at times. There was no documentation related to skin wounds or the resident refusing care.Review of Resident #104's Progress Notes written on 2/11/26 by LPN W revealed, Resident incontinent of bowel and bladder. Refuses to get out of bed d/t (due to) BL (bilateral) IE (lower extremity). Able to make needs known. Refuses therapy at this time. There were 4 separate, identical notes created on 2/11/26 but they were given effective dates of 2/7/26, 2/8/26, 2/9/26 and 2/10/26.In a subsequent interview on 3/3/26 at 4:39 PM, LPN W reported that she did not normally work on Resident #104's unit and did not remember caring for the resident.Review of Resident #104's Nutrition/Dietary note dated 2/12/26 (6 days after admission) revealed, .Skin: surgical incision. There was no documentation related to skin wounds or a need to increase protein in diet due to wounds.Review of Resident #104's Skin/Wound Note dated 2/13/26 at 11:15 AM revealed, New skin issue, location: sacrum. Issue type: pressure ulcer/injury . Pressure ulcer staging: Stage 3 pressure ulcer/injury-full thickness skin loss. Wound was present on admission. Exact date: 2/13/26 .length: 7.92 (cm) Width: 8.1 (cm) Depth: 0.2 (cm) . granulation: 100%. Exudate (drainage) amount: moderate. The information related to how long the wound had been present was noted to be inconsistently documented. The attached photo was reviewed and showed multiple open areas on the buttocks where the top layer of skin was missing. The skin between the open areas and directly surrounding the wound was dark black. Review of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #104's Physician Orders revealed, Start date: 2/14/26: Wound Care: Cleanse affected area on sacral region with generic wound cleanser and pat dry. Apply a cut to fit collagen sheet (promotes healing) only to the wound bed and cover with a 5x5 bordered foam dressing in the evening every other day for wound care.Review of Resident #104's Nursing Note dated 2/15/26 at 1:25 PM revealed, Resident A&Ox4 (alert and oriented), able to make needs known.Requires extensive assist x 2 with turning and repositioning, incontinence care. Total dependent with transfers. Is incontinent of bowel and bladder. Dressing to bilateral buttocks intact. There was no documentation related to Resident #104 refusing care.Review of Resident #104's Nursing Note dated 2/16/26 at 2:49 PM revealed, Resident A&Ox4, able to make needs known.Requires extensive assist x 2 with turning and repositioning, incontinence care. Total dependent with transfers. Is incontinent of bowel and bladder. Dressing to bilateral buttocks intact. It was noted that this documentation was identical to the day before.Review of Resident #104's Wound Provider Rounds dated 2/17/26 at 11:11 AM revealed, .Unstageable Sacral Pressure Ulcer.Noted in hospital records it was gluteal stage 2. Patient presently in a regular bed. No heel protectors. Wound measurements 7.5 cm x 9.9 cm x 0.2 cm (depth). 60% granulation, 40% slough. Wound pink. Heavy serosanguineous drainage. Edges intact. Surrounding tissue pink, fragile. Assessments/Plans: Pressure ulcer of sacral region, unstageable. Recommendations cleanse with generic wound cleanser/normal saline, pat dry, apply sheet of honey coated absorbent dressing Manuka (protects against bacteria and maintains moist environment to promote healing) and cover with two 6 x 6 silicone foam super absorbent dressings since 1 on each buttock. CHANGE EVERY DAY. Recommend APM (alternating pressure mattress) bed. Recommend heel protectors. Recommend offloading. Frequent incontinence changes. Noted below the orders were entered inaccurately for every other day, instead of every day as written above, and the resident did not have pressure ulcer interventions (heel protectors and APM bed) in place during the provider's visit. Review of Resident #104's Physician Orders revealed, Start date: 2/17/26: Wound Care: Cleanse affected area on sacral region with generic wound cleanser and pat dry. Apply a sheet of Manuka to the wound bed and cover with two 5x5 bordered foam dressings (one on each buttock) in the evening every other day for wound care. It was noted that the wound care was entered incorrectly, to be completed every other day instead of every day as ordered by the wound provider on 2/17/26 which resulted in the next wound care due 2/19/26. The administration record indicated that LPN X performed the wound care on 2/19/26, and there was no documentation that the care was performed on 2/21/26. There was no other documentation in progress notes that any additional wound care was performed and/or attempted. There was no order for PRN (as needed) wound care. In an interview on 3/4/26 at 1:41, LPN X reported that she did not remember Resident #104 and could not recall the wound care that had her initials on it.Review of Resident #104's Physician Orders revealed, Start date: 2/17/26: House liquid protein, two times a day Pro Stat 30 cc (about 1 ounce) for wound healing. The administration record indicated that Resident #104 missed 2 of 9 opportunities due to the treatment not available. In an interview on 3/4/26 at 12:58 PM, Certified Nursing Assistant (CNA) Z reported that Resident #104 was very hard to roll and reposition and required at least 2 people at all times, but he did not refuse cares. CNA Z reported that Resident #104 was incontinent and would press his call light if he needed incontinence care. CNA Z reported that Resident #104 had developed a very bad wound after he admitted .Review of Resident #104's Toileting and Incontinence Care Record completed by the CNA's from 2/6/26-2/22/26 revealed that the resident did not have any refusals of care.In an interview on 3/4/26 at 2:56 PM, CNA F reported that when Resident #104 first admitted to the facility he was very alert and had a lot of pain when staff would perform incontinence care and repositioning. CNA F reported that towards the end of her shift on Saturday 2/21/26 at approximately 6:45 AM she had noticed Resident #104 had a large bandage covering his sacrum that smelled badly and was soiled with urine. CNA F reported that Resident #104 was not talking to staff or eating/drinking like normal. CNA F notified LPN K about the concern with Resident #104's mental status and that his bandage needed to be changed. LPN K brought in a new bandage and sat it on the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	table but said she would come back later to change it. CNA F reported that she left for the day around 7:00 AM and then returned at 7:00 PM for her next shift and found that Resident #104's bandage was still on the table. CNA F reported that Resident #104 was staring off into space and could not hold a cup to take a drink. CNA F notified LPN K again regarding the concerns about Resident #104 change in mental status and that his dressing was still completely soiled and smelled bad. CNA F reported that several hours later LPN L (a nurse from the other unit) walked over to assess Resident #104 and change the bandage. CNA F reported that LPN L quickly replaced Resident #104's bandage with a clean one but did not cleanse the wound. CNA F reported that soon afterwards on 2/22/26 (early AM) Resident #104 was sent to the hospital. In an interview on 3/5/26 at 8:22 PM, LPN K reported that on 2/21/26 around 7:00 AM the CNA's reported that Resident #104 was not acting like himself, and LPN K knew that the provider was suspecting a wound infection but did not call the provider regarding Resident #104's condition until 2/22/26 at approximately 1:00 AM (18 hours later). LPN K reported that Resident #104's wound looked very bad, had a lot of drainage and smelled awful prior to the resident being sent to the hospital. LPN K reported that the wound dressing order was just to clean the wound and put a new bandage on it, and she had never heard of a sheet of Manuka to be applied to the wound bed. LPN K reported that she had asked LPN L to help with the wound care on 2/21/26; LPN L reported that she not received any wound care training except for what she learned in school and rarely saw management on the night shift.Review of Resident #104's Change of Condition documented by LPN K dated 2/22/26 at 1:28 AM revealed, .Altered mental status, seems different than usual .Possible sepsis from coccyx wound .send to ER (emergency room) .Review of Resident #104's Hospital records dated 2/22/26 revealed, .Patient comes from (skilled nursing facility) first noticed fever and low oxygen saturation yesterday .Of note, the patient was just discharged approximately 2 weeks. has chronic wounds to the sacrum and right hip.The ulcer on his sacrum is deep, foul-smelling and dark in color questioning necrosis (dead tissue). has been evaluated by general surgery and plastic surgery, with plan for possible OR (operating room) for debridement (removal of dead tissue) tomorrow. Positive blood cultures (indicate an infection in the bloodstream). He is being treated with Rocephin (antibiotic) and flagyl (antibiotic). Assessment and Plan: .Sepsis secondary to sacral decubitus ulcer. Surgery Consultation Note: .Sacral pressure sore: 13 cm x 8 cm unstageable pressure sore with black eschar .anticipate the wound extends deeper beneath the eschar. Wound images were attached that indicated an Unstageable pressure wound on the sacrum and Deep Tissue Injuries (a serious form of pressure injury where underlying tissue is damaged causing a dark colored area without an open lesion) to the right and left heel.In an interview on 3/4/26 at 11:24 AM, Unit Manager (UM) P reported that she was aware of the concerns about wound care not being performed as ordered and had been trying to monitor the reports in the computer to identify missed treatments. UM P reported that it was her understanding that ADON C was planning to complete re-education to nursing staff.In an interview on 3/5/26 at 10:25 AM, ADON C reported that she managed wounds for the facility. ADON C reported that when she assessed Resident #104 on 2/9/26 she was not aware of a wound on his sacrum but was trying to follow up on the right hip surgical incision that was noted on his admission assessment by LPN L which she determined was a healed surgical scar. ADON C reported that she did not know about the wound orders on Resident #104's hospital paperwork and was not aware of any concerns related to the sacrum until the resident's nurse brought it to her attention on 2/13/26. ADON C reported that she had not reviewed Resident #104's hospital paperwork until she had reviewed it that day with this surveyor. ADON C reported that based on the written note attached to the discharge summary, it appeared a facility staff member, likely LPN L had received wound information verbally from the hospital prior to the resident's admission on [DATE] but did not document an assessment of the wound and/or wound care orders in the resident's record. ADON C reported that Resident #104's hospital after-visit summary also included wound care instructions, but they were not transcribed into the resident's record. ADON C reported that Resident #104's wound orders should have been entered into the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	resident's physician orders at the facility on 2/6/26. ADON C reported that she initiated wound dressing/treatment orders for Resident #104's wound on 2/13/26 and then followed up along with the wound care provider on 2/17/26. ADON C reported that on 2/17/26 the provider changed the wound dressing orders and ordered a culture of the wound. ADON C reported that she first discovered in December (3 months ago) that other residents were not getting their wound dressings changed and she was working with UM P to ensure that the wound care was being performed as ordered. ADON C reported that there were no refusals documented for incontinence care, skin checks and/or wound care except for one time on 2/9/26 when the resident would not move his body for ADON C to assess his surgical scar. In an interview on 3/5/26 at 2:50 PM, Director of Nursing (DON) B reported that nursing staff had not documented any refusals for incontinence care and/or wound care for Resident #104. DON B reported that she had been aware of wound care not being completed for other residents in the past and along with ADON C they were monitoring staff and orders closely.In an interview on 3/5/26 at 2:44 PM, Nursing Home Administrator (NHA) A reported that she was not aware of any issues related to wound care and dressing changes not being completed. NHA A reviewed her QAPI (Quality Assurance and Performance Improvement) book and reported that the only wound related discussions during the meetings had been the number of wounds that the facility had.Review of Resident #104's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 2/6/26 at 8:10 PM revealed, Sensory perception: slightly limited. Moisture: occasionally moist. Activity: chairfast, resident is completely immobile, does not make even slight changes in body or extremity position without assistance. Nutrition: adequate. Friction and shear problem. Braden Score: 13. There was a subsequent evaluation on 2/14/26 with a score of 14 and on 2/21/26 the score was 15. (a score of 18 or higher: Low risk, 15-17: Moderate risk, 13-14: High risk and 12 or lower: Very high risk.) The assessments indicated the resident's risk for pressure ulcers improved. Resident #101Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: weakness and falls. Review of Resident #101's Pressure Ulcer Care Plan revealed, .has pressure injury, with risk for delayed wound healing.Right heel.Last Revision: 11/8/25. Interventions: .Provide wound care as ordered by physician.Skin evaluations weekly.In an interview on 3/4/26 at 11:24 PM, UM P reported that she was aware of Resident #101's right heel wound and was aware of issues in December and again in January with wound dressings not getting changed and incomplete documentation. Reviewing the current treatments and assessments, UM P reported that Resident #101 did not normally refuse wound care but had 6 documented refusals for wound care in February (2/5, 2/7, 2/16, 2/17, 2/21, 2/22, and 2/26). UM P would expect the nurses to enter a progress note recording the refusal and documenting an attempt to perform the wound care at another time but there was no documentation of either. In addition to that, UM P reported that Resident #101 had missed several weekly full skin checks the past couple months (2/17/26, 1/27/26, 1/6/26).In an interview on 3/4/26 at 10:50 AM, Nurse Practitioner (NP) DD reported that on 12/17/25 when she first assessed Resident #101's right heel wound, the dressing was grossly soiled, dated 12/11/25 (6 days old) and the dressing in place was not consistent with the orders on record at that time. NP DD reported that she was concerned about cellulitis and ordered an oral antibiotic. NP DD discussed her concerns to the nursing managers related to the dressing not being changed every other day as ordered. When NP DD followed up on 1/13/26 the wound was deteriorating, therefore NP DD changed the orders every day and added a topical antibiotic. Then NP DD returned on 1/27/26 the wound had not improved and again the dressing was soiled and dated 1/22/26 (5 days old). NP DD reported her concerns to the nursing managers related to the dressing not being changed daily as ordered and the facility not having the topical antibiotic available. That was the last time NP DD saw the resident.Review of Resident #101's Wound Provider Rounds dated 12/17/26 revealed, .Wound consult for right heel ulcer.Most recent dressing dated 12/11/25 without honey fiber present.Assessment/Plan: Pressure ulcer of right heel unstageable.Wound nurse notified and aware of lack of dressing change. Unable to debride due to adherent eschar.Concerns for cellulitis (skin (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	infection). Recommend Clindamycin (oral antibiotic).Review of Resident #101's Wound Provider Rounds dated 1/6/26 revealed, Wound consult for right heel ulcer.Wrong wound dressing.wound care nurse aware.Review of Resident #101's Wound Provider Rounds dated 1/13/26 revealed, Wound consult for right heel ulcer.Deteriorating.Review of Resident #101's Wound Provider Rounds dated 1/27/26 revealed, Wound consult for right heel ulcer.notes painful heel.Mupirocin not started. Last dressing changed 1/22. Concern for infection.strong odor .Review of Resident #101's Physician Orders for February revealed, Wound care: Right heel.Cover the wound bed with cut to fit xeroform gauze and cover with a super absorbent foam border dressing daily and PRN. Start date 2/11/26. It was noted that from 2/11/26 through 2/28/26 Resident #104 missed 1 treatment (2/12) and refused 4 treatments (2/16, 2/21, 2/22 and 2/26). There were no progress notes and/or PRN wound care documented for these days.Review of Resident #101's Physician Orders for January revealed Wound care: Right heel: Cleanse right heel with 3% acetic acid and pat dry. Apply mupirocin 2% (antibiotic) ointment into wound bed. Cover the affected area with dermablue foam (bandage used for wound with heavy drainage) then cover with silicone super absorbent dressing daily and PRN, Start date 1/13/26 It was noted that from 1/13/26 through 2/10/26 Resident #101 missed 4 treatments (1/14, 1/17, 1/22, and 1/24) and refused 4 treatments (1/27, 1/30, 2/5 and 2/7). There were no progress notes and/or PRN wound care documented for these days. There was also an oral antibiotic started 1/27/26, Doxycycline tablet 100 mg give 1 tablet two times a day for RIGHT HEEL INFECTION for 10 days. It was noted that Resident #101 received 19 of 20 doses. This record is consistent with NP DD's recollection of events.Review of Resident #102 Physician Orders for December revealed Wound care: Right heel.cut honey fiber to fit wound bed.cover with silicone super absorbent dressing every other day and PRN. Start date 12/1/26. It was noted that from 12/1/25 through 12/31/25 Resident #101 missed 7 treatments (12/3, 12/15, 12/17, 12/18, 12/20, 12/24, and 12/28.) There was also an oral antibiotic started 12/17/25, Clindamycin capsule 300 mg give 1 capsule.three times a day for WOUND INFECTION for 7 days. It was noted that Resident #101 received 20 of 21 doses. This record was consistent with NP DD's recollection of events.In an interview on 3/4/26 at 12:17 PM, LPN S reported he worked with Resident #101 often and he was not aware of the resident having any wounds or dressing change orders for a long time and reported that he did not see a dressing on the resident on 3/3/26. LPN S noted that normally dressing changes are completed on the night shift. LPN S reported that Resident #101 does not normally refuse and overall, the facility doesn't have many residents that refuse dressing changes. LPN S reported that there have been times when agency nurses will not complete wound dressing changes.In an interview on 3/4/26 at 12:24 PM, LPN H, who was assigned to Resident #101 that day, reported that she was not aware of a wound dressing on the resident and had been in the room that morning to administer medications. It was noted that LPN H had documented checking placement of Resident #101's right heel dressing that morning.In an interview and observation on 3/4/26 at 12:53 PM, CNA Z reported that Resident #101 still complains that his heel is sore but reported that she did not remove his socks that morning when she got him out of bed. Resident #101 was in his wheelchair in the TV room and allowed CNA Z to remove his sock and this surveyor observed a large bandage on Resident #101's heel.In an interview on 3/5/26 at 10:25 AM, ADON C reported that she had found Resident #101's dressing not changed and the documentation was missing and/or the documentation indicated the dressing had been changed more than one time in the past. ADON C reported that she was aware the wound care provider had been upset about finding dressing not being changed a couple months ago. ADON C reported that they had determined that most of the issues were with agency nurses and/or because first shift nurses didn't have time to do the dressing changes. ADON C reported that they have since changed all wound care orders to the night shift.

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	03/05/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2740840. Based on interview and record review, the facility failed to ensure medical records were complete and accurate for 1 resident (Resident #101) of 5 residents reviewed for skin and wound documentation, resulting in the potential for staff and providers mismanaging the necessary care and treatments of 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: weakness and falls. Review of Resident #101's Pressure Ulcer Care Plan revealed, .has pressure injury, with risk for delayed wound healing.Right heel.Last Revision: 11/8/25. Interventions: .Provide wound care as ordered by physician.Skin evaluations weekly.In an interview on 3/4/26 at 11:24 PM, Unit Manger (UM) P reported that she was aware of Resident #101's right heel wound and was aware of issues in December and again in January with wound dressings not getting changed and incomplete documentation. Reviewing the current treatments and assessments, UM P reported that Resident #101 did not normally refuse wound care but had 6 documented refusals for wound care in February (2/5, 2/7, 2/16, 2/17, 2/21, 2/22, and 2/26). UM P would expect the nurses to enter a progress note recording the refusal and documenting an attempt to perform the wound care at another time but there was no documentation of either. In addition to that, UM P reported that Resident #101 had missed several weekly full skin checks the past couple months (2/17/26, 1/27/26, 1/6/26).In an interview on 3/4/26 at 10:50 AM, Nurse Practitioner (NP) DD reported that on 12/17/25 when she first assessed Resident #101's right heel wound, the dressing was grossly soiled, dated 12/11/25 (6 days old) and the dressing in place was not consistent with the orders on record at that time. NP DD reported that she was concerned about cellulitis and ordered an oral antibiotic. NP DD discussed her concerns to the nursing managers related to the dressing not being changed every other day as ordered. When NP DD followed up on 1/13/26 the wound was deteriorating, therefore NP DD changed the orders every day and added a topical antibiotic. Then NP DD returned on 1/27/26 the wound had not improved and again the dressing was soiled and dated 1/22/26 (5 days old). NP DD reported her concerns to the nursing managers related to the dressing not being changed daily as ordered and the facility not having the topical antibiotic available. That was the last time NP DD saw the resident.Review of Resident #101's Physician Orders for February revealed, Wound care: Right heel.Cover the wound bed with cut to fit xeroform gauze and cover with a super absorbent foam border dressing daily and PRN (as needed). Start date 2/11/26. It was noted that from 2/11/26 through 2/28/26 Resident #104 missed 1 treatment (2/12) and refused 4 treatments (2/16, 2/21, 2/22 and 2/26). There were no progress notes and/or PRN wound care documented for these days.Review of Resident #101's Physician Orders for January revealed Wound care: Right heel: Cleanse right heel with 3% acetic acid and pat dry. Apply mupirocin 2% (antibiotic) ointment into wound bed. Cover the affected area with dermablue foam (bandage used for a wound with heavy drainage) then cover with silicone super absorbent dressing daily and PRN, Start date 1/13/26 It was noted that from 1/13/26 through 2/10/26 Resident #101 missed 4 treatments (1/14, 1/17, 1/22, and 1/24) and refused 4 treatments (1/27, 1/30, 2/5 and 2/7). There were no progress notes and/or PRN wound care documented for these days. There was also an oral antibiotic started 1/27/26, Doxycycline tablet 100 mg give 1 tablet two times a day for RIGHT HEEL INFECTION for 10 days. It was noted that Resident #101 received 19 of 20 doses. This record is consistent with NP DD's recollection of events.Review of Resident #102 Physician Orders for December revealed Wound care: Right heel.cut honey fiber to fit wound bed.cover with silicone super absorbent dressing every other day and PRN. Start date 12/1/26. It was noted that from 12/1/25 through 12/31/25 Resident #101 missed 7 treatments (12/3, 12/15, 12/17, 12/18, 12/20, 12/24, and 12/28.) There was also an oral antibiotic started 12/17/25, Clindamycin capsule 300 mg (continued on next page)

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	03/05/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	give 1 capsule.three times a day for WOUND INFECTION for 7 days. It was noted that Resident #101 received 20 of 21 doses. This record was consistent with NP DD's recollection of events.Review of Resident #102 Treatment Administration Record dated 3/4/26 revealed, Checked Placement of wound dressing on right heel. If soiled or missing perform wound care. Start date 2/13/26. It was noted that Licensed Practical Nurse (LPN) H had documented completing the order.In a subsequent interview on 3/4/26 at 12:24 PM, LPN H reported that she was not aware of a wound dressing on Resident #101 and had been in the room that morning to administer medications. It was noted that LPN H had documented checking placement of Resident #101's right heel dressing that morning. In an interview on 3/5/26 at 10:25 AM, Assistant Director of Nursing (ADON) C reported that she had found Resident #101's dressing not changed and the documentation was missing and/or the documentation indicated the dressing had been changed more than one time in the past. ADON C reported that she was aware the wound care provider had been upset about finding dressing not being changed a couple months ago. ADON C reported that they had determined that most of the issues were with agency nurses and/or because first shift nurses didn't have time to do the dressing changes. ADON C reported that they have since changed all wound care orders to the night shift.