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	04/30/2026

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 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. This citation pertains to Intake # 2977605.Based on interview, and record review, the facility failed to follow professional standards of practice to ensure safety in 1 of 3 residents (Resident #102) reviewed for safety/supervision, resulting in the lack of a comprehensive assessment for injury by a licensed nurse post-fall and the potential for injury.Findings include:Resident #102Review of a Face Sheet revealed Resident #102 was a male, with pertinent diagnoses which included right-sided hemiplegia/hemiparesis (paralysis/weakness) following a stroke, abnormal gait/mobility, depression, dementia, chronic kidney disease, and high blood pressure.Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 3/20/26, revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, indicating moderate cognitive impairment.Review of a current Care Plan for Resident #102 revealed the focus .At risk for falls due to CVA (stroke) with right sided weakness, hypertension (high blood pressure) with periods of hypotension (low blood pressure), cognitive impairment, CKD (chronic kidney disease) stage 3, history of toxic metabolic encephalopathy (an acute brain dysfunction caused by systemic illnesses, toxins, or metabolic imbalances), history of failure to thrive, potential medication side effects . revised 9/26/25.Review of an Incident/Accident Report for Resident #102, dated 4/5/26 at 1:15 AM, revealed the resident experienced an unwitnessed fall in his room. The Nursing Description of the incident revealed .CNA (Certified Nursing Assistant) notified this nurse of fall. Upon entry to room, resident was sitting on the bed . The Resident Description of the incident revealed .tripped over the tubing and fell. Denies hitting his head . The section Immediate Action Taken revealed .Skin assessed, vitals WNL (Within Normal Limits), ROM (Range of Motion) performed, Neuro's (a systemic assessment of a resident's nervous system function to monitor for changes following trauma or potential brain/spinal issues) started, immediate intervention is to stop (hypodermoclysis - subcutaneous infusion of fluids) fluids and encourage thickened liquids with staff standing by while resident drinks and to record amount . Per the report, no injuries were identified. The section Other Info (Information) revealed .Resident took the IV pole with him to the bathroom but not his walker. Call light was not put on until after resident tripped on IV tubing and fell .Review of a Post Fall Evaluation form for Resident #102, dated 4/5/26 at 1:15 AM, revealed .What did the guest/resident say they were trying to do just before they fell? Use the bathroom and tripped on IV tubing .Gait Assist devices at time of fall .Has device but was not in use .held on to IV pole .Call light activated at the time of fall .Yes .Root Cause of this Fall .IV line/pole .Review of a Nursing - Progress Note for Resident #102, dated 4/5/26 at 7:41 AM, revealed .Resident fall (reported) to this nurse by CNA. Upon entry to room, resident was sitting on the bed. Skin assessed, vitals WNL, ROM performed, Neuro's started, immediate intervention is to stop (hypodermoclysis) fluids and encourage thickened liquids with staff standing by while resident drinks and to record amount. On-call manager, DON (Director of Nursing), provider and family notified .In an interview on 4/29/26 at 4:22 PM, Licensed Practical Nurse (LPN) T reported she was Resident #102's assigned nurse at the time of his fall on 4/5/26. LPN T reported at the time of his fall, Resident #102 had self-transferred to the bathroom and tripped over his IV tubing. LPN T reported she assessed the resident in bed and did not identify any injuries.In an interview on 4/30/26 at 9:28 AM, CNA CC reported she responded to Resident #102's room on 4/5/26 at approximately 1:15 AM due to (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235458	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/30/2026
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an activated bathroom call light. CNA CC reported when she approached the room, she heard the resident call out from the bathroom to notify her that he had fallen. CNA CC reported Resident #102 had his IV pole in the room in front of the sink, and he was sitting upright on the floor with his hands on the assist bars (which were connected to the wall). CNA CC reported the resident did not appear to have any injuries, so she helped the resident get up off the floor and assisted him back to bed before going to notify the nurse about the fall. CNA CC stated .I made sure he was on his bed and sitting comfortably before I left to get his nurse . CNA CC reported the nurse came and assessed the resident in bed and did not identify any injuries. CNA CC reported she would normally not move a resident from the floor prior to notifying the nurse and having the nurse complete an assessment.In an interview on 4/30/26 at 12:27 PM, CNA V reported if a resident falls, the nurse should be notified immediately to complete an assessment of the resident for injury before moving the resident or providing transfer assistance.In an interview on 4/30/26 at 1:11 PM, DON B reported Resident #102's fall on 4/5/26 was reviewed after the incident. DON B reported she was not aware that the CNA had moved the resident up from the floor prior to the completion of an assessment by the nurse. DON B reported when a resident falls, staff should notify the nurse immediately and an assessment of the resident should be completed .from the floor . DON B reported once the resident has been assessed by the nurse, the resident can then be transferred from the floor if it is safe to do so.In an interview on 4/30/26 at 1:34 PM, Assistant Director of Nursing (ADON) I reported if a resident falls, they should not be moved prior to being assessed for injury by the nurse.Review of the policy/procedure Fall Management Guidelines, dated 2/3/26, revealed .The purpose of this policy is to provide guidelines to assist with fall risk identification and fall management of residents in the facility .POST-FALL EVALUATION .If a resident has just fallen or is observed on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities prior to moving the resident .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake # 2977605.Based on interview, and record review, the facility failed to ensure baths/showers were provided per resident preference and plan of care in 1 of 4 residents (Resident #102) reviewed for Activities of Daily Living (ADL) care, resulting in the potential for dissatisfaction with care, hygiene concerns, skin irritation, and low self-esteem.Findings include:According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition.Personal hygiene affects patients' comfort, safety, and well-being. Hygiene care includes cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities such as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation, foster a positive self-image, promote healthy skin, and help prevent infection and disease .Resident #102In an interview on 4/29/26 at 11:12 AM, Family Member DD reported concerns with provision of scheduled showers/baths at the facility. Family Member DD reported Resident #102 was supposed to receive showers on Mondays, Wednesdays, and Fridays, but those were not always completed as scheduled.Review of a Face Sheet revealed Resident #102 was a male, with pertinent diagnoses which included right-sided hemiplegia/hemiparesis (paralysis/weakness) following a stroke, abnormal gait/mobility, depression, and dementia.Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 3/20/26, revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, indicating moderate cognitive impairment.Review of a Nursing - Progress Note for Resident #102, dated 3/18/26, revealed .Showers dates updated per resident request to Mondays, Wednesday and Friday's (sic) evenings .Review of a current Care Plan for Resident #102 revealed the focus .ADL (Activities of Daily Living) Self-care deficit related to CVA (stroke) with right sided weakness, cognitive impairment, history of failure to thrive . revised 9/26/25, with interventions which included .Assist to bathe/shower as preferred per shower schedule and as needed . initiated 3/18/25, and .Resident prefers showers on evening shift, scheduled Monday, Wednesday and Fridays . revised 3/18/26.Review of a Kardex (a concise, frequently updated document of essential resident information used for quick reference by nursing staff to guide resident care) for Resident #102, dated 4/29/26, revealed .Resident prefers showers on evening shift, scheduled Monday, Wednesday and Fridays .Review of the shower/bath documentation for Resident #102, from 4/1/26 through 4/30/26 revealed a total of three missed showers (no documentation on Friday 4/3/26, Monday 4/20/26, and Monday 4/27/26) from a total of 13 scheduled showers.In an interview on 4/30/26 at 1:11 PM, Director of Nursing (DON) B reported Resident #102's shower schedule was changed to three times per week, on Mondays, Wednesdays, and Fridays, per family request. Requested documentation for any showers/baths offered/completed for Resident #102 on 4/3/26, 4/20/26, and 4/27/26. No documentation provided for those dates prior to survey exit.Review of the policy/procedure Activities of Daily Living (ADL), dated 2/2/26, revealed .Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, personal, and oral hygiene .Appropriate care and services will be provided for residents who are unable to carry out ADL(s) independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with .Hygiene (bathing, dressing, grooming, and oral care) .The amount of assistance the resident needs to complete their ADL care will be documented in the resident's care plan and on the resident's Kardex .

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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 2990940 and 2970809. Based on interview and record review, the facility failed to maintain accurate medical records for 3 (Resident #101, #103 and #105) of 5 residents reviewed for complete and accurate medical record documentation, resulting in staff and providers mismanaging care for residents.Findings include:Resident #101Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and type 2 diabetes mellitus (chronic metabolic condition where the body develops insulin resistance and inadequate insulin production, causing high blood sugar levels.)Review of Resident #101's Treatment Administration Record (TAR) revealed, Order: Apply compression stockings early morning. one time a day for Edema (swelling). Start date: 1/22/26. Noted missing documentation to indicate if the treatment had been completed on the following dates: 4/1/26, 4/4/26, 4/6/26, 4/8/26, 4/9/26, 4/11/26, 4/14/26, 4/17/26, 4/18/26, 4/21/26, and 4/22/26. Review of Resident #101's TAR revealed, Order: Monitor vitals with Spo2 (oxygen saturation) daily one time a day for Monitoring. Start date: 4/8/26. Noted missing documentation to indicate if the treatment had been completed on the following dates: 4/18/26 and 4/21/26. Review of Resident #101's TAR revealed, Order: Allow patient use of PureWick External Catheter due to urinary incontinence. Replace external catheter every 8 to 12hours, or immediately if soiled with feces. every shift. Start date: 1/20/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 4/14/26, 4/18/26, and 4/21/26. Review of Resident #101's TAR revealed, Cleanse buttocks with soap and water, pat dry apply Calmoseptine (moisture barrier cream) every shift and as needed for MASD (moisture associated skin damage) every shift for Skin care. Start date: 1/22/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 4/14/26, 4/18/26, and 4/21/26. Review of Resident #101's TAR revealed, Place alternating pressure mattress on bed for pressure reduction. Monitor alternating pressure mattress functioning and check that the settings are appropriate for the patient. every shift. Start date: 1/22/26. Noted missing documentation to indicate if the treatment was completed on the following dates: 4/14/26, 4/18/26, and 4/21/26. Review of Resident #101's TAR revealed, Place LYMPHEDEMA (chronic condition causing swelling) boots to right and left leg . every shift for Lymphedema. Enter PN (progress note) if any refusal. Start date: 2/26/26. Noted missing documentation or progress notes to indicate if the treatment was completed on 4/2/26, 4/14/26, 4/18/26, and 4/21/26.Review of Resident #101's TAR revealed, Right lateral thigh: Cleanse with normal saline/wound wash, pat dry, apply with super absorbent pads, secure with tape daily and as needed. every shift for skin care. Start date: 1/21/26. Noted missing documentation to indicate if the treatment was completed on 4/14/26, 4/18/26, and 4/21/26. During an interview on 4/30/26 at 11:42 AM, Director of Nursing (DON) B reported nurses were supposed to document in the resident's TAR to indicate if the treatment was completed or had been missed and the reasoning if it was missed. DON B reported facility leadership did not have anyone ensuring that nurses were completing all documentation for resident treatments. DON B confirmed that she was unaware that Resident #101 had multiple missing treatment records for April 2026. Resident #103Review of an admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included repeated falls and difficulty in walking. Review of Resident #103's TAR revealed, Order: Encourage Incentive Spirometer (handheld device designed to encourage deep breathing, increase lung capacity, and prevent lung complications), Use every 4 hours. KEEP in treatment cart. Nurse/CNA (Certified Nursing Assistant) to assist. four times a day for Respiratory Health. Start date: 4/23/26. Noted nursing staff had documented 07- Other/See Progress notes on the following dates: 4/23/26 at 1:00 PM, 5:00 PM, and 9:00 PM, On 4/24/26 at 9:00 PM, 4/25/25 at 9:00 AM, 1:00 PM, and 5:00 PM, On (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/26/26 and 4/27/26 at 9:00 AM and 9:00 PM, and 4/29/26 at 9:00 AM, 1:00 PM, 5:00 PM, and 9:00 PM. Noted no documentation in progress notes related to the treatment. Also noted that the treatment was documented as administered on 4/26/26 and 4/27/26 at 1:00 PM and 5:00 PM. During an interview on 4/29/26 at 9:57 AM, Family Member (FM) EE reported Resident #103 had an incentive spirometer that facility staff were supposed to assist him to use throughout the day. FM EE reported he didn't think facility staff were using Resident #103's incentive spirometer, and he thought they might have lost it. During an interview on 4/30/26 at 8:52 AM, Nurse Practitioner (NP) BB reported that the facility had placed an order for staff to offer Resident #103 his incentive spirometer 4 times daily per Resident #103's family request. NP BB reported she had tried to use the incentive spirometer on Resident #103, and he was not capable of using it. NP BB reported she thought that she had heard that staff had lost the incentive spirometer, so she was not even sure if the facility had a spirometer anymore. Noted that this interview conflicts with nursing documentation that Resident #103 had used his incentive spirometer on 4/26/26 and 4/27/26 at 1:00 PM and 5:00 PM. During an interview on 4/30/26 at 10:44 AM, Registered Nurse (RN) K reported that the facility did not have an incentive spirometer, and she did not think that Resident #103 had ever had one. RN K was unable to report why she had documented 07-Other/See Progress Notes on 4/29/26 without including a progress note to indicate that the facility did not have it. During an interview on 4/30/26 at 11:42 AM, DON B reported that Resident #103 was admitted to the facility with an incentive spirometer, and that the facility had placed an order for Resident #103 to use it 4 times daily per Resident #103's family request. DON B reported that she did not know if nursing staff were using the incentive spirometer or not. DON B confirmed that nurses were supposed to place a progress note in a resident record if they were to record 07-Other/See Progress Notes on a resident TAR. DON B was unable to report why some nurses had documented the treatment as administered, and other nurses were documenting 07-Other/See Progress Notes without including a reason in the progress note, so she was not able to confirm if staff had offered Resident #103 his incentive spirometer or not. DON B reported that the facility should have discontinued that order. Resident #105Review of an admission Record revealed Resident #105 was originally admitted to the facility on [DATE] with pertinent diagnoses which included sarcoidosis (inflammatory disease characterized by the growth of tiny, abnormal cell clusters called granulomas, most often affecting the lungs and lymph nodes) and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #105, with a reference date of 4/9/26 revealed a Brief Interview for Mental Status (BIMS) score of 14/15 which indicated Resident #105 was cognitively intact. Review of Resident #105's TAR revealed, Order: Ipratropium-Albuterol Solution (inhalation solution is a prescription medication used to treat wheezing, shortness of breath, and chest tightness) . inhale orally three times a day for asthma exacerbation for 3 Days. Start date: 4/13/26. Noted that this order was documented as administered twice on 4/13/26, 3 times on 4/14/26 and once on 4/15/126. The treatment was documented as 07-Other/See Progress Notes on 4/15/25 and 4/16/26 by Licensed Practical Nurse (LPN) D. Noted that there were no progress notes in Resident #105's record related to this order. Review of Resident #105's Progress Note dated 4/13/26 revealed, .(Resident #105) said she has been coughing for 10 or 11 days with wheezing and mild dyspnea (breathing discomfort, characterized as shortness of breath or labored breathing) . Assessment and plan: Wheezing *: DuoNeb treatments 3 times a day for 3 days. Follow-up with nurse practitioner in 2 days Review of Resident #105's Progress Note dated 4/20/26 revealed, .resident of skilled nursing facility, seen again for cough. I did see her for this problem on April 13.She had a fairly significant cough and wheezing at that time .Nebulizer treatments were ordered at the last visit, but patient says she never got any .Review of Resident #105's Progress Note dated 4/21/26 revealed, .seen today in follow-up after chest x-ray was completed last night for shortness of breath and cough. She was treated last week with nebulizer treatments ordered, but these were never administered because staff could not locate a nebulizer .During an interview on 4/29/26 at 2:30 PM, Resident #105 reported she had suffered from a severe cough and shortness of breath since the beginning of April. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #105 reported albuterol treatments were ordered for her, but the nursing staff never administered them. Resident #105 reported she had asked nursing staff about the medication, and informed NP BB that she was not getting the medication, but the facility still did not administer the medication, and she was not sure why. During an interview on 4/30/26 at 8:52 AM, NP BB confirmed that Resident #105 had reported to her that she had never received her albuterol treatments. NP BB reported that she had informed DON B that Resident #105 had not received the albuterol treatments, and she did not know why they were missed. During an interview on 4/30/26 at 11:34 AM, LPN D reported that she had documented 07-Other/See Progress Notes on 4/15/25 and 4/16/26 for Resident #105's albuterol treatment because the facility did not have a nebulizer for her, and she had to call and get it ordered. LPN D was unable to report why other nurses had administered the treatment as complete in between the dates that she had documented 07-Other/See Progress Notes on 4/15/25 and 4/16/26 as Resident #105 did not have a nebulizer for the medication to be administered. On 4/20/26 at 1:08 PM and 1:11PM, this writer attempted to contact the two other nurses (LPN HH and LPN II) that had documented Resident #105's albuterol treatments as administered. LPN HH and LPN II did not return this writer's call prior to survey exit. During an interview on 4/30/26 at 11:42 AM, DON B reported that the facility had a delay in getting Resident #105 a nebulizer, which caused a delay in Resident #105 receiving her ordered albuterol treatments. DON B was unable to report why nursing staff had documented that Resident #105 had the albuterol treatments administered when the facility had not yet received a nebulizer to administer the treatments. Review of the facility's Documentation in the Medical Record Policy last reviewed 2/3/26 revealed, Policy Overview: The purpose of this policy is to provide guidelines for documentation in the medical record. Guidelines: Principles of documentation include, but are not limited to: Documentation should be factual, objective, and resident centered.False information will not be documented. Record descriptive and objective information based on knowledge of the assessment, observation, or service provided .Documentation should be accurate, relevant, and complete .