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	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Grand Rapids	1950 32nd St S E 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to ensure residents were cared for with dignity and respect for 3 (Resident #14, #16 and #61) of 5 residents reviewed for dignity, resulting in the potential for feelings of embarrassment, frustration, depression, and loss of self-worth and an overall deterioration of psychological well-being. Findings include: Resident #14 Review of an Admission Record revealed Resident #14 was originally admitted to the facility on [DATE] with pertinent diagnoses which included major depressive disorder and anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #14, with a reference date of 3/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident #14 was moderately cognitively impaired. Resident #16 Review of an Admission Record revealed Resident #16 was originally admitted to the facility on [DATE] with pertinent diagnoses which included alzheimer's disease with late onset. Review of a Minimum Data Set (MDS) assessment for Resident #16 with a reference date of 3/13/25 revealed a Brief Interview for Mental Status (BIMS) score of 10/15 which indicated Resident #16 was moderately cognitively impaired. Resident #61 Review of an Admission Record revealed Resident #61 was originally admitted to the facility on [DATE] with pertinent diagnoses which included alzheimer's disease with late onset and major depressive disorder and dementia. Review of a Minimum Data Set (MDS) assessment for Resident #61, with a reference date of 5/7/25 revealed that a Brief Interview for Mental Status (BIMS) assessment should not be completed because Resident #61 had a memory problem, and cognitive skills for decision making were severely impaired. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 5/6/25 at 8:35 AM, a staff member was assisting Resident #61 from an activity towards the nursing station. Certified Nursing Assistant (CNA) RR yelled in the hallway to the staff member You can put her(Resident #61) right over here with the other lay backs, as she pointed to Resident #14 and Resident #16 who were sitting across the nurses station in their geri chairs (a chair with wheels designed to assist individuals with limited mobility). In an interview on 5/7/25 at 12:38 PM, Director of Nursing (DON) B confirmed that staff should not refer to residents with labels such as lay backs. This writer attempted to reach CNA RR on 5/8/25 at 12:50 PM for interview. CNA RR did not return this writer's call prior to survey exit. Resident #15, Resident #16, and Resident #61 were unable to be interviewed. Using the reasonable person concept, though Resident #61 had decreased ability to verbally express their own thoughts due to medical diagnoses, any reasonable person would likely feel a decreased sense of self-worth and frustration in the situation observed. Review of the facility's Dignity Policy dated 9/21/23 revealed, Policy Overview: It is the policy of this facility that each resident will be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem. General Guidelines: Residents will be treated with dignity and respect at all times .Staff will speak respectfully to residents, including addressing residents by his or her name of choice .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview and record review the facility failed to obtain psychotropic medication consent prior to administration of psychotropic medication per facility policy for 1 resident (Resident #15) of 5 residents reviewed for unnecessary medications, resulting in the resident and/or representative not being fully informed and the potential for resident decision makers not having an accurate picture of resident condition. Findings include: Review of an Admission Record revealed Resident #15 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia, depression and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #15, with a reference date of 3/3/2025 revealed a Brief Interview for Mental Status (BIMS) score of 00, out of a total possible score of 15, which indicated Resident #15 was cognitively severely impaired. In an interview on 5/07/25 at 07:33 AM, Certified Nursing Assistant (CNA) O reported that Resident #15 was not able to clearly verbalize her needs and frequently would call out for help. CNA O reported that Resident #15 would frequently refuse care and get angry when staff tried to encourage her to get out of bed. Review of Resident #15's Physician Orders as of 5/5/25 revealed the following psychotropic medications: Lexapro Oral Tablet 20 MG (milligrams) for depression with an order date of 12/2/24, Risperidone Oral Tablet 0.25 MG for Dementia with agitation/behaviors with a re-order date of 3/16/25, Trazodone Oral Tablet 50 MG for Depression with an order date of 9/21/24, and Ativan Oral Tablet 0.5 MG for Anxiety with an order date of 3/13/25. Review of Resident #15's Consent for Psychotropic Medication documents, revealed no record of consents being signed or verbally discussed. In an interview on 05/08/25 at 10:41 AM, Regional Nurse Consultant (RNC) C reported that Resident #15 did not have any medication consents on file prior to 5/6/25. RNC C reported that all medication consents will be obtained upon admission going forward. Attempts were made to contact Medical Director (MD) ZZ on 5/7/25 at 12:35 PM and 5/8/25 at 10:02 AM, with no return call received prior to exit. Review of Resident #15's Care Plan revealed, .At risk for adverse effects r/t (related to) Use of antidepressant medication and use of antipsychotic medication related to Major Depressive Disorder and Anxiety. Date Initiated: 11/21/2024 Revision on: 01/31/2025, Interventions: .Provide resident teaching of risks and benefits of medications as needed. Date Initiated: 11/21/2024 .

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 This citation pertains to intake #MI00152454 Based on interview and record review the facility failed to notify a resident durable power of attorney(DPOA)/emergency contact of a fall and transfer to hospital for 1 (Resident #337) of 2 residents reviewed for notification, resulting in the potential for a delay in required medical treatment. Findings include: Review of an Admission Record revealed Resident #337 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness on one side). Review of Resident #337's Progress Note dated 4/21/25 and documented by Licensed Practical Nurse (LPN) P revealed, Resident found laying (sic) in prone position next to bed started neuros (neurological assessments), vitals (vital signs) slightly elevated, no c/o (complaint of) pain, large bruise on right knee, bump and bruise on left side of forehead, contact on-call (provider) authorized to send resident to hospital, called (local ambulance) arrived 02:40 transport to the hospital In an interview on 5/1/25 at 4:48 PM, Family Member (FM) EEE reported that she was contacted by the hospital on 4/21/25 around 7:00 AM and learned that Resident #337 had been sent to the hospital after a fall around 2:00 AM. FM EEE reported that the facility had not contacted her to notify her that Resident #337 had fallen and was sent to the hospital. In an interview on 5/6/25 at 3:02 PM, LPN P confirmed that she was the nurse that was caring for Resident #337 when she fell . LPN P reported that Resident #337 had an unwitnessed fall out of her bed, and that she had a large bump on her forehead. LPN P reported that she had contacted the physician and asked to send Resident #337 to the hospital because she was concerned about a possible head injury since the fall was unwitnessed, and she already looked really bad. LPN P reported that if she had contacted Resident #337's guardian, she would have documented it in the incident report, but she could not recall speaking to Resident #337's DPOA. Review of Resident #337's Incident Report dated 4/21/25 did not reveal documentation that Resident #337's DPOA had been contacted regarding Resident #337 being sent to the hospital. In an interview on 5/7/25 at 12:38 PM, Director of Nursing (DON) B and Regional Nurse Consultant (RNC) C confirmed that LPN EEE did not contact Resident #337's DPOA to notify her of the fall and that Resident #337 was sent to the hospital. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Change in Condition Notification policy dated 8/9/23 revealed, It is the policy of the facility to notify the resident, his or her attending physician/practitioner, and the resident's designated representative of changes in the resident's medical/mental condition and/or status. Guidelines: The nurse will notify the resident, the resident's physician/practitioner, and the resident's designated representative when there is: An accident or incident involving the resident which results in an injury and has the potential for requiring physician/practitioner intervention .a need to transfer or discharge the resident from the facility, including discharge against medical advice .

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 41027 Based on interview and record review, the facility failed to issue a Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) for non-covered services in 1 resident (Resident #188) of 3 residents reviewed for timely provision of notifications, resulting in the potential for unforeseen financial obligation and hardship. Findings include: Review of Resident #188's SNF Beneficiary Notification Review worksheet completed by the facility indicated after her last covered day (9/17/24), the resident paid privately from 9/18/24 to 9/23/24. The supporting documentation included a Beneficiary Notification dated and signed on 9/17/24, and indicated the resident's last covered day would be 9/17/24. There was no Skilled Nursing Facility Advance Beneficiary Notice (SNF ABN) included with the supporting documentation provided by the facility. Review of Resident #188's Progress Note dated 9/17/2024 at 08:31 AM revealed, .Spoke with (Resident #188) regarding her request to be discharged from therapy services and to end her skilled stay. Pt (patient) reporting she is not feeling well enough to continue to participate and would like today, 9/17/24, to be her LCD (last covered day). Plan is to transition to LTC (long term care) at this time. Pt verbalized understanding that her payer source will change as of 9/18 to private pay . In an interview on 05/07/25 at 10:37 AM, Business Office Manager (BOM) HHH reported that Resident #188 should have received an ABN when she decided to reside in the facility after her last covered day. BOM HHH reported that there was no record of the resident being informed of the cost to pay privately.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview and record review, the facility failed to ensure proper discharge notifications were completed in 2 residents (Resident #85 & #337) of 2 residents reviewed for discharge process, resulting in the State Long-Term Care (LTC) Ombudsman not receiving notification of Resident #85's discharge to the hospital and DPOA (Durable Power of Attorney) not receiving written notice of bed hold for Resident #337. Findings include: In an email correspondence on 5/1/25 at 10:04 AM, LTC Ombudsman reported that the facility had not been sending notifications for emergency/hospital transfer and discharge notifications. In an interview on 05/07/25 at 10:44 AM, Nursing Home Administrator (NHA) A reported that to her knowledge, notices to the ombudsman regarding discharges were being done at the corporate level. NHA A provided 4 log sheets for January, February, March and April of 2025. NHA A reported that she did not know why Resident #85 was not listed on the April 2025 log of discharges. NHA A was not able to provide any supporting documentation that any notifications were being sent to the ombudsman's office. Resident #85 Review of an Admission Record revealed Resident #85 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety and depression. In an interview on 05/07/25 at 02:42 PM, Licensed Practical Nurse (LPN) FF reported Resident #85 was petitioned for discharge, and recently returned from a two week stay at the psychiatric hospital, and seemed to be doing better. Review of Resident #85's Census Report (indication for dates of admission and discharge) in the electronic health record, indicated the resident went to the hospital on 4/17/25, returned on 4/17/25, was discharged on [DATE], and returned on 4/30/25. Review of Resident #85's Progress Note dated 4/30/25 at 7:14 PM revealed, Resident arrived via wheelchair at (5:15 PM) . Review of Resident #85's Progress Note dated 4/18/25 at 10:11 AM revealed, Resident has been accepted for a psychiatric stay at (hospital name omitted) .transported by: (transport company name omitted) at 11 AM . Review of Resident #85's Provider Note dated 4/18/25 revealed, .Seen for return from ER 47659 Resident #337 (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #337 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness on one side). Review of Resident #337's Progress Note dated 4/21/25 and documented by Licensed Practical Nurse (LPN) P revealed. Resident found laying (sic) in prone position next to bed .contact on-call (provider) authorized to send resident to hospital, called (local ambulance) arrived 02:40 transport to the hospital On 5/7/25 at 1:41 PM, This writer requested verification from the facility that Resident #337's Durable Power of Attorney (DPOA) had been provided with the notice of bed-hold notice for Resident #337's transfer to the hospital on 4/21/25. In an interview on 5/7/25 at 1:46 PM, Nursing Home Administrator (NHA) A reported that she did not know if the bed-hold policy had been provided to Resident #337's DPOA, and that she would check into it. In an email on 5/7/25 at 2:26 PM, NHA A confirmed that the facility had not provided the bed hold notice.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to implement care plan interventions for 1 (Resident #5) of 18 Residents reviewed for care planning, resulting in a potential for unmet care needs. Findings include: Review of an Admission Record revealed Resident #5 was originally admitted to the facility on [DATE] with pertinent diagnoses which included weakness and need for assistance with personal care. Review of Resident #5's Care Plan revealed, (Resident #5) is at risk fort risk for falls due to side effects of medication, behaviors, debility, poor PO (by mouth) intake, history of ataxia (lack of muscle coordination), impaired safety awareness, visual impairment, osteoporosis (skeletal disorder).Date Initiated: 08/13/2024. Interventions: Call light within reach. Date Initiated: 08/13/2024 .Fall mat next bed. Date Initiated: 08/13/2024 . In an observation on 5/5/25 at 4:12 PM, Resident #5's was noted to be lying in bed. It was noted that there was no fall mat next to Resident #5's bed. In an observation on 5/6/25 at 1:03 PM, Resident #5 was observed lying in her bed. Resident #5's fall mat was not next to her bed, and the rolling bedside table was on top of it. It was noted that the mat was angled away from the side of the bed and if Resident #5 were to fall out of bed she would land directly on the floor, and not on the mat. In an observation on 5/8/25 at 10:26 AM, Resident #5 was sitting up in her bed. Resident #5's touch pad call light was noted to be attached to left side of her bed out of her reach, and the fall mat was noted to be folded up against the wall. In an interview on 5/8/25 at 10:34 AM, Certified Nursing Assistant (CNA) FFF reported that she had provided care for Resident #5 and had recently been in Resident #5's room. CNA FFF confirmed that Resident #5 was supposed to have a fall mat next to her bed, and that staff would move it when Resident #5 would eat meals in her room to accommodate her bedside table. CNA FFF reported that staff often forgot to return Resident #5's fall mat to the floor when Resident #5 was done eating. CNA FFF went into Resident #5's room and confirmed that staff missed putting Resident #5's fall mat back after she ate breakfast.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview and record review, the facility failed to ensure residents received the necessary care and services, consistent with professional standards of practice to prevent and promote healing of pressure ulcers in 1 resident (Resident #45) of 3 residents reviewed for pressure ulcers, resulting in the development of an unstageable pressure injury to the right heel, and the potential for additional new, worsening and/or reoccurrence of pressure injuries due to the resident's bed being too short and his feet pressing against the footboard for extended periods. Findings include: Resident #45 Review of an Admission Record revealed Resident #45 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: unstageable pressure ulcer left heel. Review of Resident #45's most recent Braden Scale for Predicting Pressure Sore Risk dated 12/5/24 indicated that the resident was 14, at a moderate risk. During an observation and interview on 05/05/25 at 09:56 AM Resident #45 was lying in bed with his feet pressed firmly against the footboard, wearing a blue boot on only his left foot. Resident #45 reported that he had wounds on both of his heels and on his toes from the footboard. Resident #45 reported that the facility told him that they would clean up his feet but they never did. Resident #45 reported that he would like to get up into his chair, but his feet hurt when they laid on the wheelchair pedals. During an observation and interview on 05/06/25 at 01:57 PM in Resident #45's room, observed Agency Registered Nurse (RN) SS performing wound care and dressing change to the resident's left heel. Observed RN SS removing the old dressing; it was stuck to the wound. Observed the wound on Resident #45's left heel open, with red and dark brown areas in the wound. Resident #45's left second toe knuckle was open and bleeding, and his right foot had bleeding and scabs across the top of his toes. Observed the resident's right heel with a wound that was about 50% open and the rest was scabbed; the right heel did not have a dressing in place. In an interview on 05/06/25 at 03:48 PM, Rehab Director (RD) XX reported that she had ensured that Resident #45 had a bed extender in place, so that his feet were no longer pressed against the footboard. During an observation on 05/07/25 01:11 PM Resident #45 was lying in his bed. Observed a bed extender in place at the end of his bed. The resident's bed near his feet was soiled with skin and old blood. Resident #45's toes had several blood crusted scabs on them and had dried blood on the bottom of his feet. Resident #45 reported that he was not able to move his feet and that no one had cleaned up his toes for about a week. Resident #45 was wearing blue pressure-relieving boots, and they were soiled with brown and yellow dried substances. Observed Resident #45's left heel with a wrap bandage, and the right heel was not covered, but there was a gauze pad laying on the bed next to his right foot. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/07/25 at 01:43 PM, Agency Unit Manager (UM) E reported that Resident #45 had a pressure wound on his left heel, and that she spoke to the provider about a new wound on Resident #45's right heel. UM E reported that the provider recommended a consult with the wound doctor. UM E reported that the wound was in about the same location as a previous healed wound, but it was not clear if it was a re-opening or a newly formed. UM E reported that the cause of the pressure wound was not determined but that the wound doctor would see him next week. UM E reported that she was not aware of wounds on Resident #45's toes. In an interview on 05/07/25 at 01:53 PM, Agency Registered Nurse (RN) UU reported that Resident #45 had orders for wound care of both heels, but that there were no orders in place for wounds on his toes. Observed RN UU preparing to complete wound care and dressing change for Resident #45. Resident #45's left heel was wrapped with gauze and covered with a thick gauze pad. The gauze pad was dry and stuck to the wound. Observed an open wound on the resident's left heel, with red and yellow wound bed. The resident's feet were dirty and had very dry flaky skin covering them. Observed a wound on the resident's right heel, covered with a brown scab; the wound was not covered and was stuck to the blue boot. Resident #45 reported that his feet always used to hit the footboard, until a couple days ago when they gave him a longer bed. Review of Resident #45's Physician Orders revealed, .Foam heel suspension boots to be worn while in bed as tolerated every shift for pressure ulcers. Active 12/10/2024 . Review of Resident #45's Wound Evaluation dated 5/7/25 at 12:01 PM revealed, .blister .right medial malleolus (heel) .In-house acquired .New .2.3 CM x 1.7 CM (centimeters) .Exudate (drainage) light . Review of Resident #45's Skin Check dated 5/6/25 at 2:53 PM revealed, .Abnormalities: .left heel open area, right heel new open area ., right toes all 5 toes have scabs on them, left toes big toe has a scab on it . Review of Resident #45's Wound Visit dated 5/1/2025 revealed, .Wound #2 Left Heel, Pressure, unstageable of at least a stage 3 .history of cognitive impairment and unstageable pressure injuries to bilateral heels .on 12/5/24 presents with unstageable pressure ulcers found to bilateral heels and toes upon admission .5/1/25 No new wound-related changes per nursing staff .WOUND ASSESSMENT: Wound: #2 Location: Left Heel, Primary Etiology: Pressure, Stage/Severity: unstageable of at least a stage 3 .Wound Base: , 90% granulation , 10% slough .Exudate (drainage): Moderate amount of Sanguineous .RECOMMENDATIONS: Continue standard offloading and repositioning recommendations per facility guidelines, including the use of a pressure reduction wheelchair cushion, offloading heel boots, and APM (alternating pressure mattress) . This visit did not note a wound on the right heel and/or on the toes. Review of Resident #45's Wound Visit Note dated 4/24/2025 revealed, .Wound #2 Left Heel, Pressure, unstageable of at least a stage 3 .4/24/25 No new wound-related changes per nursing staff . WOUND ASSESSMENT: .Primary Etiology: Pressure .Size: 2.2 cm x 3.3 cm x 0.1 cm. Calculated area is 7.26 sq cm. Wound Base: , 80% granulation , 20% slough .Exudate (drainage): Moderate amount of Sanguineous . PROCEDURE(S): Surgical Wound Debridement (surgical removal of dead skin and tissue) . Pre-Debridement Measurement: 2.2 x 3.3 x 0.1 cm .Post-Debridement Measurement: 2.2 x 3.3 x 0.2 cm. Percent of Wound Debrided: 20% Indications: Removal of necrotic tissue and removal of biofilm (a layer of microorganisms that form over wound) for wound healing . This visit did not note a wound on the right heel and or the toes. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #45's Wound Visit Note dated 2/27/2025 revealed, .Wound #1 Right Heel, Pressure, Stage 3, Wound #2 Left Heel, Pressure, unstageable of at least a stage 3, Wound #3 Right 2nd Toe Dorsal, Pressure, Unstageable .history of cognitive impairment and unstageable pressure injuries to bilateral heels . 2/27/25 Nursing staff report that a layer of eschar (crusted dead tissue) has reformed over wound to left heel following debridement last week .WOUND ASSESSMENT: Wound: #1 Location: Right Heel, Primary Etiology: Pressure, Stage/Severity: Stage 3 .Size: 0.4 cm x 0.5 cm x 0.1 cm ., 100% granulation .Exudate: Moderate amount of Serous .Wound: #2 Location: Left Heel, Primary Etiology: Pressure, Stage/Severity: unstageable of at least a stage 3, Size: 3.4 cm x 4.2 cm x 0.2 cm .Wound Base: , 10% granulation , 90% eschar .Exudate: Moderate amount of Serous .Wound: #3 Location: Right 2nd Toe Dorsal, Primary Etiology: Pressure, Stage/Severity: Unstageable, Wound Status: Resolved . Use sponge boots for heel offloading, use pillows for repositioning and offloading, Continue to use group 2 mattress, continue routine offloading and repositioning per facility protocol . The visit note indicated that the resident had wounds at that time on the left heel, right heel and right 2nd toe.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41982 Based on interview and record review, the facility failed to implement care planned interventions for bed mobility to to prevent a fall in 1 of 4 residents (Resident #45) reviewed for falls, resulting in a fall with injury. Findings include: Resident #45 Review of an Admission Record revealed Resident #45 was a male, with pertinent diagnoses which included: muscle weakness and repeated falls. Review of an Incident Report for Resident #45 dated 4/26/25 at 8:20 PM revealed, .Nursing Description: CNA (certified nurse aide) reported to RN (registered nurse) that resident was on the floor. RN entered resident room to find (Resident #45) on the floor next to his bed, his position was partially underneath bed #1, his head and shoulders were under the head of the bed side and his BLE's (bilateral (both) lower extremities) were positioned diagonally with bilateral feet on the foot of bed side between bed #1 and bed #2. Resident was found face down .RN then rolled resident over on his back and found resident to have abrasions on his face x 3 (forehead, nose, chin), abrasions on bilateral knees, and an abrasion on this (sic) left 2nd toe which was an existing wound and is currently receiving treatments but is now actively bleeding a small amount of frank blood .Resident Description: After resident was assessed by RN and transferred into his bed, he stated the following: I was on the side of my bed receiving care from the nurses aid when something was pulled or picked up from behind me causing me to fall forward off of my bed . Review of Resident #45's Care Plan at the time of the fall on 4/26/25 revealed ADL (Activities of Daily Living) interventions which included ADL Assist of one staff (Date Revised 12/6/24) and Bed mobility assist x 2 (2 person) assist (Date Initiated 12/6/24). In an interview on 5/7/25 at 2:05 PM, Director of Nursing (DON) B reported that at the time of Resident #45's fall on 4/26/25, Agency CNA AAA had been providing ADL cares to Resident #45 in his bed and was moving him in the bed when he fell . DON B reported Agency CNA AAA was the only one in the room at the time and that there should have been 2 people moving Resident #45 in his bed. This surveyor attempted to contact Agency CNA AAA on 5/7/25 at 2:32 PM via phone to no avail as the number was not in service and no other contact information was provided. In an interview on 5/7/25 at 2:57 PM, Regional Nurse Consultant (RNC) C reported the facility had completed a Past Non-Compliance (PNC) corrective action plan for the deficient practice resulting in Resident #45's fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Past Non-Compliance document provided by the facility revealed, .Event (Description of what occurred) Agency CNA did not follow the care plan/Kardex (an individualized guide with specific instructions on how to care for a resident) for 2x assist with patient care resulting in a fall r/t (related to) rolling resident away from caregiver. Root Cause Analysis (Reason the event occurred) Agency CNA did not review the Kardex to determine the correct way to provide care. CNA did not ask nurse or any other staff prior to providing care . During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included: staff education (including agency) on ADL cares and following resident plan of care for bed mobility; Resident #45's care plan was updated to reflect ADL assist of 2 staff; Resident #45 was reassessed by therapy to increase strengthening. The facility was able to demonstrate monitoring of the corrective action and maintained compliance.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review the facility failed ensure post dialysis assessment and monitoring for 1 (Resident #42) of 1 resident reviewed for dialysis care, resulting in the potential for the resident to not meet his highest practicable physical, mental, and psychosocial well-being. Findings include: Review of an Admission Record revealed Resident #42 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: chronic kidney disease and dependence on renal dialysis. Review of Resident #42's Care Plan revealed, The resident needs dialysis: Hemodialysis r/t (related to) ESRD (end stage renal disease) and Renal Osteodystrophy (weakening of bones). Date Initiated: 11/21/2024. Revision on: 04/17/2025. Interventions: Do not draw blood or take B/P in arm with graft. Date Initiated: 11/21/2024 . Monitor/document/report PRN (as needed) any s/sx (signs and symptoms) of infection to access site: Redness, Swelling, warmth or drainage. Date Initiated: 11/21/2024. Monitor/document/report PRN for s/sx of renal insufficiency: changes in level of consciousness, changes in skin turgor (hydration), oral mucosa, changes in heart and lung sounds. Date Initiated: 11/21/2024. Monitor/document/report PRN for s/sx of the following: Bleeding, Hemorrhage, Bacteremia (infection), septic shock. Date Initiated: 11/21/2024 . Review of Resident #42's Physician Orders revealed, Dialysis treatment center (name omitted) treatment days: Tues, Thurs, Sat. Treatment chair time: 6:00 AM p/u (pick up) time: 5:00 AM .Order date 4/28/25. In an interview and observation on 05/06/25 at 12:14 PM Resident #42 was eating lunch in the dining room, and reported that he had just returned from dialysis, and had not spoken to the nurse yet. In an interview on 05/06/25 at 12:20 PM, Registered Nurse (RN) QQ reported that she was an agency employee and was not familiar with Resident #42. RN QQ was assigned to Resident #42's care that day. Review of Resident #42's Vital Signs revealed that the most recent record was from 4/6/25. 4/6/2025 BP (blood pressure) 121/60 mmHg, 2/20/2025 BP 128/64 mmHg, 1/26/2025 BP 138/62 mmHg . Vital signs were not being recorded regularly. In an interview on 05/06/25 at 03:24 PM, Unit Manager (UM) E reported that when a resident returns from dialysis, the nurse should intercept the dialysis communication form from the dialysis facility immediately and ensure the resident is stable. UM E reported that Resident #42 had dialysis that morning; his dialysis communication form was not in the file, and the floor nurse said that she did not receive a dialysis communication form. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 05/07/25 at 07:57 AM, Director of Nursing (DON) B reported that Resident #42's dialysis communication from 5/6/25 form was found in the pocket of his wheelchair. DON B reported that the facility nurse did not monitor Resident #42 when he returned from dialysis, and did not retrieve the form to review the dialysis facility's report and ensure any changes to the resident's orders were addressed immediately. DON B was not sure what the facility policy was for monitoring residents when they return from dialysis, and/or how often vital signs should be obtained, but that she would review the policy. In a subsequent interview on 05/08/25 at 10:27 AM, DON B reported that the facility policy was that the nurse assigned to Resident #42's hall should retrieve the dialysis communication form immediately when the resident returned to the facility, ensure the resident is stable, and write a progress note in the resident's record. DON B reported that the resident went to dialysis on 5/1/25 (Thursday), 5/3/25 (Saturday) and 5/6/25 (Tuesday) that week. Review of Resident #42's Progress Notes revealed no documentation for 5/3/25 and 5/6/25.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41982 Based on interview and record review, the facility failed to ensure a prompt response to the registered pharmacist's monthly medication regimen review (MRR) recommendations for 3 (Resident #40, #15, #35) of 5 residents reviewed for unnecessary medications, resulting in the registered pharmacist's recommendations not being addressed in a timely fashion and the potential for negative medication side effects as a result of unaddressed recommendations. Findings include: Resident #40 Review of an Admission Record revealed Resident #40 was a female, with pertinent diagnoses which included: dysphagia, oral phase (swallowing difficulty) and unspecified dementia, unspecified severity, with other behavioral disturbance. Review of a Minimum Data Set (MDS) assessment for Resident #40, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 2, out of a total possible score of 15, which indicated Resident #40 was severely cognitively impaired. Nystatin-Triamcinolone cream Review of a Consultant Pharmacist Recommendation to Prescriber for MRR dated [DATE] revealed, (Resident #40) has been receiving a topical anti-infective/corticosteroid combination, Nystatin-Triamcinolone cream, indicated for rash, since [DATE]. Recommendation: Please evaluate continued use of Nystatin-Triamcinolone cream, as long term use of an anti-infective and corticosteroid is not recommended. The provider agreed with the recommendation and signed the form on [DATE]. Review of a Recommendation Summary Report (DON (Director of Nursing)/Medical Director Copy) for MRR dated [DATE] revealed, (Resident #40) has been receiving a topical anti-infective/corticosteroid combination, Nystatin-Triamcinolone cream, indicated for rash, since [DATE]. Recommendation: Please evaluate continued use of Nystatin-Triamcinolone cream, as long term use of an anti-infective and corticosteroid is not recommended. There was no documentation of any follow-up completed; there was no documentation from physician indicating review of the recommendation. Review of a Consultant Pharmacist Recommendation to Prescriber for MRR dated [DATE] revealed, (Resident #40) has been receiving a topical anti-infective/corticosteroid combination, Nystatin-Triamcinolone cream, indicated for rash, since [DATE]. Recommendation: Please evaluate continued use of Nystatin-Triamcinolone cream, as long term use of an anti-infective and corticosteroid is not recommended. There was no documentation of any follow-up completed; there was no documentation from physician indicating review of the recommendation. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Consultant Pharmacist Recommendation to Prescriber for MRR dated [DATE] revealed, (Resident #40) has been receiving a topical anti-infective/corticosteroid combination, Nystatin-Triamcinolone cream, indicated for rash, since [DATE]. Recommendation: Please evaluate continued use of Nystatin-Triamcinolone cream, as long term use of an anti-infective and corticosteroid is not recommended. There was no documentation of any follow-up completed; there was no documentation from physician indicating review of the recommendation. Review of a Physician's Order history for Resident #40 revealed, Nystatin-Triamcinolone External Cream , d+[DATE].1 UNIT/GM (Gram)-% (Nystatin-Triamcinolone) Apply to Bilateral feet topically two times a day for rash . with a start date of [DATE] and a discontinued date of [DATE]. Acidophilus Review of a Recommendation Summary Report (DON (Director of Nursing)/Medical Director Copy for MRR dated [DATE] revealed, (Resident #40) receives Acidophilus and is NOT receiving antibiotic therapy. Current studies do not support continued use of probiotics for improvement of gut health. Recommendation: Please evaluate continued use of Acidophilus. The provider signed the recommendation and responded discontinue dated [DATE]. Review of a Consultant Pharmacist Recommendation to Prescriber for MRR dated [DATE] revealed, (Resident #40) receives Acidophilus and is NOT receiving antibiotic therapy. Current studies do not support continued use of probiotics for improvement of gut health. Recommendation: Please evaluate continued use of Acidophilus. There was no documentation of any follow-up completed; there was no documentation from physician indicating review of the recommendation. Review of a Physician's Order history for Resident #40 revealed, Acidophilus/Pectin Oral Capsule 100 MG (Lactobacillus) Give 2 capsule by mouth one time a day for supplement . with a start date of [DATE] and a discontinued date of [DATE]. In an interview on [DATE] at 9:13 AM, Regional Nurse Consultant (RNC) C reported Resident #40's Nystatin was not discontinued until [DATE] but that it should have been discontinued when the provider signed agreement to the recommendation on [DATE]. RNC C reported Resident #40's Acidophilus was not discontinued until [DATE] but that it should have been discontinued when the provider signed the recommendation to discontinue on [DATE]. RNC C and DON B reported the process for pharmacy recommendations for the physician was that the physician should review and sign the recommendation and give it to the DON to verify the changes were addressed and then scanned into the medical record. RNC C and DON B confirmed that process had not occurred for Resident #40's Nystatin and Acidophilus. 41027 Resident #15 Review of an Admission Record revealed Resident #15 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia, depression and anxiety. Review of a Minimum Data Set (MDS) assessment for Resident #15, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, out of a total possible score of 15, which indicated Resident #15 was cognitively severely impaired. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #15's Physician Orders as of [DATE] revealed the following psychotropic medications: Lexapro Oral Tablet 20 MG (milligrams) for depression with an order date of [DATE], Risperidone Oral Tablet 0.25 MG for Dementia with agitation/behaviors with a re-order date of [DATE], Trazodone Oral Tablet 50 MG for Depression with an order date of [DATE], and Ativan Oral Tablet 0.5 MG for Anxiety with an order date of [DATE]. Review of Resident #15's Abnormal Involuntary Movement Scale (AIMS) (used to assess level of abnormal movements in residents taking antipsychotic medications) revealed no record of AIMS completed. Review of Resident #15's Monthly Medication Regimen Reviews (MRR) revealed on [DATE] and [DATE] that the pharmacist reviewed the resident's medications and noted see report for any noted irregularities and/or recommendations. There was no report found in the resident's medical record. In an interview on [DATE] at 03:15 PM with Nursing Home Administrator (NHA) A request made to review Resident #15's AIMS and MRR irregularity reports. In an interview on [DATE] at 07:33 AM, Certified Nursing Assistant (CNA) O reported that Resident #15 was not able to clearly verbalize her needs and frequently would call out for help. CNA O reported that Resident #15 would frequently refuse care and get angry when staff tried to encourage her to get out of bed. In an interview on [DATE] at 09:01 AM, Regional Nurse Consultant (RNC) C reported that the MRR irregularity reports with pharmacy recommendations for medications had not been reviewed by the facility for March and/or April of 2025. RNC C reported that the facility's policy was the Director of Nursing (DON) B received the reports via email from the pharmacist and should ensure the providers acknowledge the recommendations and implement the changes as necessary. RNC C reported that it was unknown when the process that had been in place failed, but that all reports for all residents from March and April were printed and sent to the physician on [DATE]. RNC C also reported that Resident #15 had not received an AIMS assessment since she had been admitted until [DATE]. In an interview on [DATE] at 10:41 AM, Regional Nurse Consultant (RNC) C reported that Resident #15 did not have any medication consents on file prior to [DATE]. RNC C reported that all medication consents will be obtained upon admission going forward. Attempts were made to contact Medical Director (MD) ZZ on [DATE] at 12:35 PM and [DATE] at 10:02 AM, with no return call received prior to exit. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #15's Care Plan revealed, .At risk for adverse effects r/t (related to) Use of antidepressant medication and use of antipsychotic medication related to Major Depressive Disorder and Anxiety. Date Initiated: [DATE] Revision on: [DATE], Interventions: .AIMS testing per facility guidelines. Date Initiated: [DATE], ANTIDEPRESSANTS - Monitor for possible side effects such as: Anxiety, Blurred vision, Constipation, Dizziness, Dry mouth, Fatigue, Insomnia, Nausea, Weight gain, Confusion, Agitation, Muscle twitching, Sweating, Shivering, Diarrhea, Fever, Seizures, Irregular heartbeat, and Unconsciousness. Date Initiated: [DATE], ANTIPSYCHOTIC MEDICATIONS --Monitor for possible side effects: Muscle rigidity, Bradykinesia, Dystonia, Muscle tremor, Akathisia, Tardive dyskinesia, Sedation, Dizziness, Weight gain, Cardiac effects, Hypotension, Dry mouth, Constipation, extrapyramidal side effects, Nausea, Vomiting, Headache, Insomnia, and Constipation. Date Initiated: [DATE], Evaluate effectiveness and side effects of medications for possible decease/elimination of psychotropic drugs Date Initiated: [DATE], .Monitor resident's mental status functioning on an ongoing basis. Monitor/document/report any side effects/adverse reactions of psychotropic medication: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the resident. Date Initiated: [DATE], Provide resident teaching of risks and benefits of medications as needed. Date Initiated: [DATE] . 47659 Resident #35 Review of an Admission Record revealed Resident #35 was originally admitted to the facility on [DATE] with pertinent diagnoses which included alzeimer's disease with early onset and major depressive disorder. Review of Resident #35's Consultant Pharmacist Recommendation to Prescriber dated [DATE] revealed, Recommendation: Please evaluate continued need for Vitamin B-12 and Lipitor (medication that lowers cholesterol) secondary to patient's terminal status . Physician/Provider response: this was not completed or signed by physician/provider. In an interview on [DATE] at 2:42 PM, Nurse Practitioner (NP) CCC reported that the monthly medication reviews were assigned to whoever was on call the day the pharmacy sent them in, and she did not know anything about Resident #35's monthly recommendations from the pharmacy. In an interview on [DATE] at 3:29 PM, Regional Nurse Consultant (RNC) C reported that she did not know why the facility's provider had not responded to Resident #35's January Consultant Pharmacist Recommendation to Prescriber. Review of the facility's Medication Regimen Review policy last revised [DATE] revealed, Policy Overview: The purpose of this policy is to provide guidelines for a Medication Regimen Review. A Medication Regimen Review (MRR) is a thorough evaluation is a thorough evaluation of medication regimen of a resident with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. Guidelines: A Medication Regimen Review (MRR) applies to all residents, whether short or long stay . The physician documents in the medical record that any irregularity identified by the pharmacist has been reviewed, and what (if any) action was taken to address it by their next mandatory visit

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on observation, interview, and record review, the facility failed to properly label, date, and store medications in 2 out of 6 medication carts resulting in the potential for decreased efficacy of medications and the exacerbation of medical conditions. Findings include: In an observation of the 400 hall medication cart on [DATE] at 8:22 AM, One bottle of a resident nitroglycerin medication was noted in the cart with a label on the bottle that stated Discard after [DATE]. Two opened insulin pens (lantus and humalog) were found without dates to indicate what day they had been opened. One lidocaine cream was noted to be opened without a resident name or open date on the package. In an interview on [DATE] at 8:30 AM, Registered Nurse (RN) SS reported that nurses were supposed to ensure that they labeled all medications when they opened them to ensure that the medications were getting disposed of when they were expired. RN SS confirmed that all medications should be labeled with a resident name as well, to ensure medications were not being used for multiple residents. RN SS confirmed that the nitroglycerin that was in the cart should have discarded from the cart in [DATE] when it was expired. In an observation of the 300 hall cart on [DATE] at 8:56 AM, two opened bottles of Genteal tears eye drops were noted without resident names or open dates. There was also one opened insulin latrine pen with a resident name, but no open date noted on the pen. In an interview on [DATE] at 9:00 AM, RN QQ reported that she did not know which residents the bottles of opened eye drops belonged to. RN QQ confirmed that nurses were supposed to ensure that all medications were labeled with resident names and an open date. RN QQ confirmed that the insulin pen was also missing an open date, and therefore, she did not know if the insulin pen was safe to use. 36221 In an observation on [DATE] at 1:35 PM, noted an unlocked medication cart in the hallway near the beginning of the 300 Hall (outside the Unit Manager's office). Observed the narcotic drawer was pulled open (sticking out) from the medication cart. No staff were present within direct supervision of the unlocked medication cart at the time of the observation. In an observation on [DATE] at 1:41 PM, Agency Registered Nurse (RN) Unit Manager F approached the unlocked medication cart at the beginning of the 300 Hall, closed the narcotic drawer, and locked the cart. In an interview on [DATE] at 1:46 PM, Agency RN Unit Manager E reported medication carts should be locked when not in use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy/procedure Medication and Treatment Storage, dated [DATE], revealed .It is the policy of this facility to ensure .safe and secure storage (including proper temperature controls, appropriate humidity and light controls, limited access, and mechanisms to minimize loss or diversion) of all medications and treatments .All medications and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 This citation contains two deficient practice statements, A & B. Deficient Practice Statement A Based on observation, interview, and record review, the facility failed to effectively implement Enhanced Barrier Precautions (EBP) per facility policy and Centers for Disease Control and Prevention (CDC) guidance, in 3 of 4 residents (Resident #2, #42, & #45) reviewed for EBP, resulting in the potential for cross-contamination and the development and spread of infection to a vulnerable population. Findings include: Resident #2 Review of an Admission Record revealed Resident #2 was a female, with pertinent diagnoses which included obstructive and reflux uropathy (a blockage in the urinary tract that prevents urine from flowing properly), anemia, diabetes, heart disease, and high blood pressure. Review of a Minimum Data Set (MDS) assessment for Resident #2, with a reference date of 3/20/25, revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated she was cognitively intact. Review of an Order Summary Report for Resident #2 revealed the active physician order .Enhanced Barrier Precautions: Wound and Nephrostomy tubes . with a start date of 3/18/25. Review of a current Care Plan for Resident #2 revealed the focus .(Resident #2) requires enhanced barrier precautions related to: nephrostomy tubes. Indwelling medical device, Wound . revised 4/14/25, with interventions which included .Enhanced Barrier Precautions . and .Staff will wear a gown and gloves during high contact resident activities . both initiated 3/18/25. In an observation and interview on 5/6/25 at 12:17 PM, Agency Registered Nurse (RN) QQ entered Resident #2's room to complete nephrostomy care and flush Resident #2's bilateral nephrostomy tubes. Observed Agency RN QQ prepare the supplies on Resident #2's bedside table and don gloves. Agency RN QQ removed Resident #2's old dressings and performed nephrostomy site care. Once new dressings were applied, observed Agency RN QQ flush each of Resident #2's bilateral nephrostomy tubes with normal saline. Noted Agency RN QQ did not utilize a gown while completing nephrostomy site care or while flushing Resident #2's bilateral nephrostomy tubes. Once care was complete and Agency RN QQ exited the room, Resident #2 reported staff should be wearing gowns when completing nephrostomy care, and stated .but half of them don't . wear the protective gowns. In an interview on 5/6/25 at 12:40 PM, Agency RN QQ reported they did not feel that a gown would be indicated for Resident #2's nephrostomy care because there was .no splashing . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 5/7/25 at 12:28 PM, Agency RN Unit Manager E reported residents on Enhanced Barrier Precautions require staff to utilize gowns and gloves for high contact care, including wound care, indwelling device care, and ADL (Activities of Daily Living) care. 41027 Resident #42 Review of an Admission Record revealed Resident #42 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: chronic kidney disease and dependence on renal dialysis. During an observation and interview on 05/05/25 at 03:00 PM Resident #42 was lying in bed, yelling out for help. Certified Nursing Assistant (CNA) U reported that she was aware Resident #42 had an unmet need; he was waiting for pain medication. Observed CNA U don gloves, reposition Resident #42, and then remove his incontinence brief. CNA U was checking Resident #42's buttocks for open areas, due to the resident's complaint of pain on his bottom side. CNA U was not wearing a gown. CNA U reported that the EBP signage on Resident #42's door was old, and he was no longer on precautions. Review of Resident #42's Physician Orders revealed, Enhanced Barrier Precautions r/t (related to) AV (arteriovenous fistula: a connection made between an artery and a vein to receive dialysis) and perma-cath (catheter) shunts for HD (hemodialysis) In an interview on 5/8/25 at 10:27 AM, Regional Nurse Consultant (RNC) C reported that Resident #42 had orders for EBP due to having a hemodialysis catheter, and not just the typical dialysis port that is fully embedded in the body. Resident #45 Review of an Admission Record revealed Resident #45 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer. During an observation and interview on 05/07/25 at 01:53 PM Resident #45 room was observed with an EBP sign near the door, and the resident was lying in bed. Registered Nurse (RN) UU was preparing to complete wound care and dressing changes for Resident #45's pressure wounds on both heels. Observed RN UU set up the wound supplies at the bedside and don gloves. RN UU was not wearing a gown. RN UU reported that she did not know that she was supposed to be wearing a gown and was not familiar with EBP. RN UU reported that day was her first time in the facility, her previous experience was not in long term care, and she had not received any education from the facility related to EBP. Review of Resident #45 Wound assessment dated [DATE] indicated a stage 3 pressure wound on left heel, with moderate drainage, and present on admission. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the policy/procedure Enhanced Barrier Precautions, dated 3/28/24, revealed .The purpose of this policy is to provide guidelines for the use of enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs) .Enhanced barrier precautions are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs). Enhanced barrier precautions involve gown and glove use during high-contact resident activities for residents known to be colonized with a CDC targeted MDRO (where contact precautions do not apply) as well as those residents at increased risk of MDRO acquisition, such as chronic wounds or indwelling medical devices .Indwelling medical devices include but are not limited to .Central vascular lines .Indwelling urinary catheters .Other indwelling devices/lines that exit the body .High contact resident activities include (for all residents on Enhanced Barrier Precautions) Dressing .Bathing/Showering .Transferring .Providing hygiene .Changing linens .Changing briefs or assisting with toileting .Care and use of indwelling medical devices .Wound care . PPE (Personal Protective Equipment) (gown, gloves, and any other PPE required per standard precautions) are applied prior to performing the high contact resident care activity . 38905 Deficient Practice Statement B Based on observation, interview, and record review, the facility failed to have an active and ongoing plan for reducing the risk of Legionella and other opportunistic pathogens of premise plumbing (OPPP). This deficient practice has the increased potential to result in waterborne pathogens to exist and spread in the facility's plumbing system and an increased risk of respiratory infection among any or all the residents in the facility. Findings include: During a tour of the facility, at 1:45 PM on 5/5/25, observation of the main janitors sink, in the dining / gathering area, found brown and discolored water dispense momentarily from the hot and cold water handles before turning clear. When asked if this sink was on a flushing schedule for stagnant lines, Director of Facilities (DOF) DDD stated it was not flushed. An interview with DOF DDD, at 1:54 PM on 5/5/25, found that there is a flushing schedule for vacant rooms and a policy to flush after repairs. An observation of the 100 Hall janitors closet, at 2:11 PM on 5/5/25, it was found that the cold water handle did not dispense water, indicating a stagnant line. When asked if he knew why or if the line was inactive, DOF DDD, was unsure. An observation of the 200 Hall janitors closet, at 2:27 PM on 5/5/25, found items stored in the basin of the sink and the sink dry and with an accumulation of dirt and debris. When the hot water handle was turned on only a small stream was able to dispense. No cold water was able to be dispensed, indicating a stagnant line. During a tour of the 300 Hall spa room, at 2:38 PM on 5/5/25, it was observed that the tub was dusty on the inside. When asked if it was used, DOF DDD, stated he didn't think it was used often. When asked if it was on a flushing schedule, DOF DDD, stated he would add all the tubs to the list. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation of the 300 Hall janitors closet, at 2:44 PM on 5/5/25, found that the cold water handle did not dispense water, indicating a stagnant line. An observation of the 400 Hall janitors closet, at 3:05 PM on 5/5/25, found that the cold water handle did not dispense water, indicating a stagnant line. An interview with DOF DDD, at 3:35 PM on 5/5/25, found that the facility does not take any samples for residual disinfectants in the domestic water supply, such as free chlorine, but he has the test kit. A record review of the facility provide policy entitled Water Management Program Policy, revised 10/22, found that Control measures will be applied to address potential hazards at each control point. A variety of measures may be used, including physical controls, temperature management, disinfectant level control, visual inspections, or environmental testing for pathogens. The measures shall be specified in the water management program action plan. The document goes on to state that Testing protocols and control limits will be established for each control measure. a. Individuals responsible for testing or visual inspections will document findings. b. When control limits are not maintained, corrective actions will be taken and documented accordingly.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 Based on interview, and record review, the facility failed to ensure residents were screened for eligibility to receive pneumococcal vaccinations and receive the vaccination if eligible in 1 of 5 residents (Resident #60) reviewed for vaccinations, resulting in the potential of acquiring, transmitting, or experiencing complications from pneumococcal pneumonia. Findings include: Review of the policy/procedure Vaccination - Pneumococcal Vaccine, dated 11/22/24, revealed .Residents will be offered a pneumococcal vaccine unless it is medically contraindicated, or the resident is up to date on their pneumococcal vaccinations .The type of pneumococcal vaccine .offered will depend upon the recipient's age and susceptibility to pneumonia and previous pneumococcal vaccinations given in accordance with current CDC (Centers for Disease Control and Prevention) guidelines and recommendations .A pneumococcal vaccination is recommended for all adults [AGE] years and older and based on the following recommendations .For adults [AGE] years or older who have only received a PPSV23 .Give 1 dose PCV20 or PCV21 or PCV15 at least one year after the PPSV23 vaccine . Resident #60 Review of an Admission Record revealed Resident #60 was a female, with pertinent diagnoses which included Alzheimer's disease, dementia, and high blood pressure. Noted Resident #60 was greater than [AGE] years old. Review of the Immunizations section of Resident #60's electronic medical record revealed no documentation regarding administration of a pneumococcal vaccination, and no documentation that Resident #60 had been screened for eligibility to receive the vaccination. In an interview on 5/7/25 at 10:19 AM, Infection Preventionist C reviewed Resident #60's electronic medical record and reported there was a consent for Resident #60 to receive a pneumococcal vaccination which was signed in 2022. Infection Preventionist C reported they would have to look further in the medical record to determine when the vaccination was administered. At this time, requested documentation to verify that Resident #60 had been screened for eligibility to receive the vaccination and offered pneumococcal immunizations as recommended by the CDC. Review of Resident #60's September 2023 Medication Administration Record (MAR) revealed she received a pneumococcal polysaccharide vaccine (PPSV23) while at the facility on 9/6/23. No documentation noted related to any additional screening completed by the facility to determine eligibility to receive additional doses of a pneumococcal vaccination. In an interview on 5/7/25 at 2:42 PM, Infection Preventionist C reported they reviewed Resident #60's electronic medical record and identified that the PPSV23 vaccine was administered on 8/3/22 and again on 9/6/23 (same vaccine). Infection Preventionist C reported that per the CDC, Resident #60 should be offered the Prevnar 20 (PCV20) vaccination. Infection Preventionist C reported since Resident #60 previously received two doses of the same vaccine they were going to check with the Health Department for guidance prior to offering the PCV20 to Resident #60. (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/7/25 at 3:53 PM, Infection Preventionist C reported they were able to contact the Health Department and it was recommended to offer Resident #60 the PCV20 vaccination. Infection Preventionist C reported the resident representative consented to the vaccine and a physician order was obtained for administration.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 36221 Based on interview, and record review, the facility failed to ensure COVID-19 vaccinations were offered to eligible residents in 3 of 5 residents (Resident #16, #18, & #60) reviewed for COVID-19 vaccinations, resulting in the potential for development and transmission of COVID-19 within a vulnerable population. Findings include: Review of the policy/procedure Covid-19, dated 10/26/23, revealed .The facility has developed and implemented written policies and procedures that include .Covid-19 Vaccination for Residents .Residents will be screened for current suspected or confirmed cases of Covid-19, previous allergic reactions, and administration of therapeutic treatments and services to determine if they are an appropriate candidate for vaccination .Residents will be offered the Covid-19 vaccination per CDC (Centers for Disease Control and Prevention) and/or FDA (Food & Drug Administration) guidelines unless such immunization is medically contraindicated, they have already been immunized during the time period, or they refuse to receive the vaccine .The resident's medical record will include documentation that indicates, at a minimum, that the resident or resident representative was provided education regarding the benefits and potential side effects of the Covid-19 vaccine, and that the resident (or representative) either accepted and received the Covid-19 vaccine or did not receive the vaccine due to medical contraindications, prior vaccination, or refusal . Resident #16 Review of an Admission Record revealed Resident #16 was a female, with pertinent diagnoses which included stroke, Alzheimer's disease, anemia, and high blood pressure. Review of the Immunizations section of Resident #16's electronic medical record revealed her most recent COVID-19 vaccination was administered on 10/3/22. No information noted in regard to whether or not any additional COVID-19 vaccinations were offered or administered beyond that date. Resident #18 Review of an Admission Record revealed Resident #18 was a male, with pertinent diagnoses which included diabetes and high blood pressure. Review of the Immunizations section of Resident #18's electronic medical record revealed no documentation that a COVID-19 vaccination was offered or administered. Resident #60 Review of an Admission Record revealed Resident #60 was a female, with pertinent diagnoses which included Alzheimer's disease, dementia, and high blood pressure. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Immunizations section of Resident #60's electronic medical record revealed her most recent COVID-19 vaccination was administered on 3/31/22. No information noted in regard to whether or not any additional COVID-19 vaccinations were offered or administered beyond that date. In an interview on 5/7/25 at 10:19 AM, Infection Preventionist C reported COVID-19 vaccinations are offered upon admission and annually as the vaccination changes. Infection Preventionist C reported Resident #18 last received a COVID-19 vaccination on 11/17/22. Requested any additional documentation to verify Resident #16, #18, and #60 were offered COVID-19 vaccinations beyond 2022. In an interview on 5/7/25 at 2:42 PM, Infection Preventionist C reported no additional information was noted in Resident #16, #18, and #60's electronic medical records to indicate if COVID-19 vaccinations were offered/administered beyond 2022. Infection Preventionist C reported all three residents (Resident #16, #18, and #60) were currently eligible to receive a COVID-19 vaccination.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake #MI00152454 Based on observation, interview and record review, the facility failed to ensure a functioning call light was in place for 4 residents (Resident #85, #63, #57 & #337) of 18 residents reviewed for supervision, and have a fully operational call system in place for all 89 residents residing in the facility resulting in the potential for unmet needs, harm or serious injury. Findings include: Resident #85 Review of a Minimum Data Set (MDS) assessment for Resident #85, with a reference date of 3/3/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #85 was cognitively intact. In an interview on 05/05/25 at 10:32 AM, Resident #187 reported that he had been waiting for staff to answer his call light for about 2 hours. Observed Resident #187's call light lit up on the wall in the room, but the light in the hall was not on. Reported to Licensed Practical Nurse (LPN) FF who said that he would tell the aide when he saw her. Resident #63 Review of a Minimum Data Set (MDS) assessment for Resident #63, with a reference date of 3/15/25 revealed a Brief Interview for Mental Status (BIMS) score of 14, out of a total possible score of 15, which indicated Resident #63 was cognitively intact. In an interview on 05/05/25 at 10:39 AM, Resident #63 reported that when she pressed her call light, it took a long time and sometimes no one would come at all. Resident #57 Review of a Minimum Data Set (MDS) assessment for Resident #57, with a reference date of 3/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #57 was cognitively intact. In an interview on 05/06/25 at 04:23 PM, Resident # 57 reported her call light was not working the day before. Resident #57 reported that when she pressed the light, it would not show up in the hallway, and sometimes it stays on even after the staff turned it off. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 05/07/25 at 09:40 AM, Director of Facilities (DOF) DDD reported that the company that provided maintenance for the call light system was in the facility about 6 weeks ago. DOF DDD reported that they are aware that the call lights haven't been working perfectly and have been fixing them as they are made aware. DOF DDD was not aware of any issues with Resident #63's call light. DOF DDD reported that staff are supposed to be monitoring the screen at the nurse's station that alerts them, in addition to visually monitoring the hallway lights. DOF DDD reported that the screen monitor had been located in an office, until just recently; staff were not able to see the screen from the nurse's station. DOF DDD reported that the system also included cell phones, but those had not been working properly, so they were not being used. During an observation on 05/07/25 at 9:45 AM in Resident #63's room observed DOF DDD testing the call light, and it was not functioning properly. The call light would sometimes come on and other times did not. The call light was registering inside the room, but not in the hallway to alert staff. In an interview on 05/08/25 at 11:12 AM, Director of Nursing (DON) B reported that staff should be using the call light screen and the hallway lights to monitor residents. DON B reported that staff used to have cell phones, but they hadn't been able to get them programmed to work properly with the rest of the system. DON B reported that the facility had used the phones for about a week in January, and since then had only been using the call light screen and the hallway lights. DON B reported that the screen monitor had been placed in the nursing office for an unknown length of time and was moved out to the nurse's station a couple days ago. 47659 Resident #337 Review of an Admission Record revealed Resident #337 was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side (paralysis and weakness on one side). Review of Resident #337's Care Plan revealed, (Resident #337) At risk for falls due to hemiplegia and hemiparesis following CVA . Date Initiated: 03/29/2025. Interventions: Call light within reach. Date Initiated: 03/29/2025 . In an interview on 5/1/25 at 4:48 PM, Family Member (FM) EEE reported that Resident #337's call light was often placed out of her reach, and the call light system in resident's room frequently did not work. In an interview on 5/6/25 at 1:02 PM, Resident #63 (who had shared a room with Resident #337) confirmed she frequently saw Resident #337's call light out of reach. Resident #63 reported that Resident #337 would call out for help and she would tell her to use her call light and she would tell her that I can't, I don't have it. Resident #63 reported that the room had issues with the call light system, and sometimes when she and Resident #337 would turn on their call lights, the light would not go off in the hallway to alert staff that they needed help. Resident #63 reported that the facility had fixed the call light a few times, but it wouldn't last long. (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	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Optalis Health and Rehabilitation of Grand Rapids	1950 32nd St S E 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.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an observation on 5/06/25 at 4:41 PM, this writer turned on the call light for the room where Resident #337 was in the facility. It was noted that the call light had turned on in the room, but the light was not activated in the hallway to alert staff. Review of Resident #337's Work Orders noted that Resident #337's room call light had orders placed three times between 3/1/25-5/6/25 for the call light not working. In an interview on 5/8/25 at 11:23 AM, Licensed Practical Nurse (LPN) GGG reported that staff knew that a resident needed assistance by the light outside of the resident's room being activated. LPN GGG confirmed that the facility had ongoing issues with the call lights not working.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 36221 Based on interview, and record review, the facility failed to implement an effective training program in regard to infection prevention and control and Enhanced Barrier Precautions (EBP) in 4 of 5 staff members reviewed for infection control/EBP education, resulting in the potential for cross-contamination and the spread of infection to a vulnerable population. Findings include: On 5/7/25 at 3:53 PM, requested information from Infection Preventionist C to verify that Agency Registered Nurse (RN) QQ and Agency RN UU completed education in regard to EBP prior to working a shift at the facility. In an interview and record review on 5/8/25 at 10:43 AM, Infection Preventionist C reported there is a binder of information at the front entrance to the facility that Agency staff are required to review prior to the start of their shift. Infection Preventionist C reported this was not something that previously required signatures for verification of completion, but that process will be implemented going forward. Infection Preventionist C reported the staffing agency informs the Agency nursing staff of the need to review the binder. Review of the Agency binder revealed information regarding the facility policy for EBP, along with a copy of the EBP signage posted outside pertinent resident rooms. In an interview on 5/8/25 at 11:11 AM, Agency RN QQ reported the Agency phone application contains information regarding the facility and a list of requirements, like where to park and what to wear. Agency RN QQ stated .I did not get any book to review when I came in, but there are procedural books on the counter (at each nursing station) if you need it . When asked about any education provided by the facility specific to EBP, Agency RN QQ stated .No one has ever mentioned anything about that to me . In an interview on 5/8/25 at 11:19 AM, Agency RN VVreported the only binder they were asked to review prior to working a shift at the facility was the narcotic binder which had information about the narcotic count procedure. Agency RN VV reported they could not recall receiving any education related to EBP. In an interview on 5/8/25 at 11:22 AM, Agency Certified Nursing Assistant (CNA) NN reported no education was provided regarding EBP prior to working at the facility. Agency CNA NN reported they were never asked to review a binder of information/education at the front desk. 41027 During an interview on 05/07/25 at 01:53 PM, Agency Registered Nurse (RN) UU was preparing to complete wound care and dressing changes for a resident's pressure wounds. RN UU reported that she did not know that she was supposed to be wearing a gown, and was not familiar with EBP. RN UU reported that day was her first time in the facility, her previous experience was not in long term care, and she had not received any education from the facility related to EBP. (continued on next page)

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	For additional information see F880.