STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235279	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holt Senior Care and Rehab Center	5091 Willoughby Road Holt, MI 48842

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement care planned interventions to prevent falls in 1 of 3 sampled residents (Resident #69) assessed for falls, resulting in repeated falls during staff assisted transfers and the potential for continued falls and/or serious injury. Findings include:Review of the Face Sheet and Minimum Data Set (MDS) with Assessment Reference Date of 1/22/26, reflected R69 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included cerebral infarction with hemiparesis affecting left non-dominant side(left side paralyzed , vascular dementia, left above the knee amputation, atrial fibrillation(heart arrythmia with use of blood thinners), cognitive communication deficit, and major depressive disorder The MDS reflected R69 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for bed mobility, and all transfers.During an observation and interview on 4/07/2026 at 12:30 PM, R69 was in room sitting in wheelchair and appeared calm and pleasant with minimal difficulty answering questions. R69 had a above the knee left leg amputation and left arm was resting on padded arm rest of wheelchair. R69 reported was unable to use left side of body related to history of stroke and never used prostatic leg since admission. R69 reported had several falls at facility including when staff were assisting with transfers and was unsure of injuries. Review with the facility Matrix, dated 4/7/26, reflected R69 had history of fall with injury.Review of R69 Nurse Progress Note, dated 10/20/2025 at 11:23 a.m., reflected, CNA [Certified Nurse Aid] alerted this nurse that resident had fallen on the floor. This nurse entered resident's room to find resident laying on her right side, with arm beneath her. Left hand bleeding from skin tear. Resident reports that her left hand is painful at skin tear site, denies pain in wrist her left and arm. Reports slight pain in right shoulder, 2/10 on pain scale. ROM [range of motion] at baseline for this resident. VSS [vital signs stable], neuro check wnl [within normal limits], no other injuries noted, resident and CNA deny hitting head. With a gait belt, resident assisted off the floor and into her wheelchair by 2 staff members. CNA states she was transferring resident from her bed to wheelchair, wheelchair was not locked, when CNA attempted to sit resident in chair when w/c slipped from under her bottom and aid dropped resident onto the floor. 3cm x 4cm skin tear cleaned steri-strips applied, covered with adhesive bandage, order written to change bandage q 3 days until healed. Daughter notified via telephone, Dr. [named] notified, no changes or new orders at this time.Review of R69 Progress Note, dated 10/25/2025 at 4:15 p.m., reflected, Resident had a witnessed fall incident where her head did not hit anything. Resident was being transferred from bed to w/c [wheelchair] and slipped out of CNA's arms. Primary assessment showed no injuries. BP:124/64, P:57, R:18R, and O2Sats:94%. Assisted into w/c via 3 staff members. Resident denies discomforts, secondary assessment showed no injuries, Resident denies pain/discomfort. Dr. [named] notified of incident-no orders received, POA [power of attorney], [named], notified.Review of R69 Nurse Progress Note, dated 2/10/2026 at 6:00 a.m., reflected, Resident was being transferred from her bed to her wheelchair with the assistance of 2 staff members. The brakes had been applied to the wheelchair prior to the transfer, however, the brakes didn't completely stop the wheelchair (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	from moving backwards when staff attempted to transfer the resident into it. The wheelchair moved backwards as staff began to sit the resident in it and the resident was assisted to a sitting position on the floor. Upon inspection of her skin, it is noted that there is an abrasion to her left mid-back region. Resident reports that it is tender to the touch. Other than that she denies pain. No other obvious injury noted. Resident is able to move her right arm and leg without complaints of pain or discomfort. The left arm has been affected by her stroke, and she hasn't been able to use that arm since.Resident was assisted up onto her right leg and then into the wheelchair with the assistance of 2 staff members. She was then assisted to the toilet. Throughout the transfers from the wheelchair to the toilet then to the wheelchair and back into her bed, she maintained that she was only experiencing tenderness on her back. No report of any other pain. She was transferred to her bed with the assistance of the staff. She is able to verbalize her wants and needs.Review of R69 Nurse Progress Notes, dated 3/4/2026 at 2:43 a.m., reflected, Roommate yelled out to writer that she needs two people. Writer entered room and noted resident on floor. Resident was noted sitting on floor on buttock with feet pointed southwest facing southwest, with her back facing northeast wall, near toilet and w/c. Res.[resident] denied hitting head.Staff reported that resident was lowered to the floor.Intervention: Staff education.Review of R69 Fall Assessment Review, dated 8/25/25, reflected, Fall assessment in conjunction with MDS quarterly assessment. Resident had 3 falls including one fall with fracture to left wrist during look back period (5/12/25-8/5/25). Continues to need two-person extensive assistance with transfers. Remains at risk for falls secondary to impaired mobility, cognitive deficits, and poor safety awareness. Fall precautions and safety interventions are in place. Able to make needs known. Call light accessible and able to use appropriately.Review of R69 Fall Care Plan, revised 3/20/24, reflected, I have an actual ADL[activity of daily living] deficit related to weakness and impaired mobility due to left side weakness secondary to CVA [cerebral vascular accident], left AKA [above knee amputation], left humerus fracture, CKD-3 [chronic kidney disease], and cardiac conditions. I try to maintain my independence and will transfer myself to bed without using my call light or waiting for assistance. I have been educated on the importance of assistance with ADLS.TRANSFERS: 2 Person Assist. Date Initiated: 01/11/2024.SAFETY: I am at risk for falls related to impaired mobility secondary to left side weakness secondary to CVA, left above the knee amputation.Do not leave me in the restroom or on the toilet without staff present. Date Initiated: 01/11/2024.I will wear non-skid footwear for all transfers. Date Initiated: 01/11/2024.Make sure my brakes are locked before every transfer. Date Initiated: 01/11/2024.Email request was sent to facility on 3/8/26 at 1:38 p.m., that reflected, Can you please provide Incident/Accident reports with complete investigations for past six months for [named R69].Received four Incident/Accident reports for R69 on 3/8/26 at 1:53 p.m., dated 10/20/25, 10/25/25, 2/10/26 and 3/3/26 that involved staff assisted transfers that resulted in falls. Continued review reflected that R69 had a fall on 10/20/25 during a staff assisted transfer of one person and no gait belt. The notes reflected that the wheelchair brakes were not locked, staff transferred R69 with one person assist with no gait belt and staff education was provided. Continued review reflected that R69 had a fall on 10/25/25 during a staff assisted transfer of one person with no gait belt. (five days after R69 prior fall when staff failed to follow care planned safety interventions to prevent falls). The document reflected the Root Cause Analysis was staff did not follow care plan/Kardex. Continued review of reports reflected R69 had fall on 2/10/26 during a staff assisted transfer with two staff moving R69 from the bed to the wheelchair when the chair moved during the transfer and the R69 was lowered to the ground that resulted in tender bruised area to R69 left side that measured 11 cm by 7.5 cm. The report did not mention if gait belt or non-slip shoes were in place. Continued review of the reports reflected R69 had another fall on 3/3/26 during a staff assisted transfer with one person. The notes reflected the Root Cause Analysis was the staff did not follow Kardex for transfers and education was provided. (R69 had four falls in past six months that involved staff assisted transfers when staff failed to follow care planned interventions to prevent falls.) Continued review of the provided Incident/Accident reported for R69 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	reflected no staff names for staff involved and did not appear to be complete investigations as requested.During an interview on 4/8/2026 2:48 PM, Certified Nurse Aid (CNA) O reported routine worked with R69 on day shift and reported R69 required two-person extensive assist with transfers. CNA O reported that meant that two persons, one on each side of R69 with use of gait belt and reported know what each resident require by reviewing the Kardex prior to providing care. CNA O reported was not involved in any of R69 falls since October of 2025 and reported facility provided individual education to staff involved and verified did not received education related to falls after R69 falls. During a telephone interview on 4/08/2026 3:48 PM, R69's Daughter P had concerns because facility staff had dropped her mother R69 several times during transfers. R69's Daughter P reported was told had been new staff each time and stated, they dropped her a lot, too much, concerned for her safety. R69's Daughter P reported her mothers Kardex had always been two-person assist and one staff member was known to always only use one person. R69's Daughter P reported R69's Kardex also requires staff to remain in bathroom with R69 and witnessed nurse staff leave R69 in bathroom alone and immediately questioned staff because they make a choice to repeatedly not follow the Kardex interventions that are meant to keep R69 safe.During an interview on 4/08/2026 at 5:02 PM, Licensed Practical Nurse (LPN) F reported working at the facility for over two years and often worked with R69. LPN F reported R69 required two-person assist with transfer along with gait belt as long as she could remember. LPN F reported R69 was a very high risk for falls related to prior falls, left above the knee amputation, and history of stroke with left side paralysis. LPN F reported was not present for R69 falls and reported R69 had several falls with and without staff present. LPN F reported make her very angry when R69 had falls with staff assist when R69 Care Planned safely interventions were not being followed and reported no excuse for not following Kardex and reported most of R69's falls during staff assistance have happened on second and third shift. LPN F reported R69 Daughter was also very agree that staff have dropped R69 several times because Kardex was not followed. LPN F reported R69 had skin tear after one fall and recalled clearly after 2/10/26 fall had significant bruising to side and back the same day and verified R69 was taking blood thinners.Review of R69, SW- Skin Check Progress Note, dated 2/10/2026 9:00 p.m., reflected, Skin warm & dry, skin color WNL[within normal limits] and turgor is normal.No skin issues identified. (Incident reported reflected 11 cm x 7.5 cm abrasion and bruised area to R69 left side.) The note was completed LPN Q, who was unavailable for interview prior to survey exit. During an interview on 4/09/2026 at 8:15 AM, Certified Nurse Aid (CNA) R reported R69 required two-person assist with use of gait belt with transfers. CNA R reported new staff educated on first day that Kardex must be reviewed prior to care and to reviewed frequently and reported was not involved in R69 falls but had heard about them. CNA R reported facility provided individual education to staff involved in falls and all staff. During an interview on 4/09/2026 at 8:43 AM, Director of Nursing (DON) reported had only provided R69 incident/accidents for last six months not complete investigation and would provide. This surveyor verified email request was for complete investigation, including staff involved. DON reported had provided working schedules for the dates of R69 falls and verified had not provided correct schedule for the 2/10/26 fall that occurred on the evening of 2/9/26 schedule and would provide. DON reported staff involved were given one on one education and discipline and would provide as part of investigation.During an interview on 4/09/2026 at 9:17 AM, DON reported was currently working on gathering requested information. This Surveyor requested to review complete employee files for staff involved in R69 most recent four falls. DON reported had located three and still working on 4th staff. (should have been five in total)Review of provided employee files on 4/09/2026 at 9:45 AM, reflected four CNA files. According to Incident reports should be five staff directly involved with R69 past four falls. Review of working schedules, Incident reports and provided files reflected one missing employee file for CNA S. Continued Review of the employee files revealed three staff, CNA T (failed to follow Kardex on 10/20/25), and CNA U(failed to follow Kardex on 10/25/25) had completed, Employee Corrective Action for failure to follow Kardex interventions resulting in fall. Continued (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	review of CNA S file reflected no evidence of staff education provided for not following Kardex related to one person transfer resulting in fall on 3/3/26.During an interview on 4/09/2026 at 10:11 AM, Licensed Practical Nurse (LPN) V reported was R69 nurse at time of fall on 10/20/25. LPN V reported was notified by CNA T that R69 had fallen. LPN V reported was standing at medication cart outside R69 room and immediately entered R69 room and observed R69 was laying on floor next to the bed with left arm skin tear observed. LPN V reported after R69 was assessed was transferred to bed. LPN V reported CNA T reported she transferred R69 with alone because she could not find another staff and did not use gait belt because she did not have one. LPN V reported CNA T became very angry with LPN V and refused to work with LPN V after incident. LPN V reported had heard about R69 fall on 2/10/26 but was not present but reported R69 had large abrasion and bruised area to side. LPN V reported makes her so angry staff know R69 is very high risk fall and continue to transfer her with one assist instead of two-assist. LPN V reported was questioned by management yesterday if this surveyor had called about R69 fall During a telephone interview on 4/09/2026 at 11:21 AM, CNA S reported was R69 aid on 10/25/25 at time of fall. CNA S reported she transferred R69 alone with no gait belt and R69 fell. CNA S reported R69 was change to two-person assist after that and reported did not use gait belt because she could not find one and reported she should have used one. CNA S reported received education after incident.During an interview on 4/09/2026 at 11:40 AM, Clinical Care Coordinator (CCC) E reported was responsible for completing fall root cause analysis for cedar unit. CCC E reported would expect staff to follow Kardex and verified R69 falls for 10/20/25, 10/25/25 and 3/3/26 the staff failed to follow the care planned intervention on the Kardex to prevent falls. CCC E was queried what interventions were implemented after each of R69 falls? CCC E reported they performed one on one staff education for staff who did no follow Kardex. CCC E was queried if that intervention was effective and CCC E stated, No, [named R69] still fell. During an interview on 4/09/2026 at 12:10 PM, DON reported would expect staff to follow Kardex and care plan interventions. DON verified R69 falls on 10/20/25, 10/25/25 and 3/3/26 staff failed to follow Kardex and transferred R69 with one assist instead of two person assist and staff involved were provided one on one education. DON was queried of one on one education was effective DON stated, no and reported same staff not involved but intervention did not prevent additional falls for R69.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure accurate coding of a Minimum Data Set (MDS) assessment for one (R80) of 19 reviewed.Findings include: Review of the medical record reflected R80 admitted to the facility on [DATE] and readmitted [DATE], with diagnoses that included end stage renal disease and dependence on renal dialysis. The Annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/3/25, reflected R80 received dialysis. The Quarterly MDS, with an ARD of 1/27/26, reflected R80 was not coded as receiving dialysis. On 04/09/2026 at 11:40 AM, R80 was observed lying in bed. A Physician's Order, with a revision date of 4/16/25, reflected R80's scheduled dialysis days were Monday, Wednesday, Friday and as needed. In an interview on 04/08/2026 at 3:36 PM, MDS Nurse H acknowledged R80's Quarterly MDS, with an ARD of 1/27/26, should have been coded for receiving dialysis.

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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** Based on observation, interview and record review the facility failed to ensure comprehensive care plans were accurate and implemented for two out of 19 residents (Resident #8 & 69).Resident #8 (R8): Review of R8's electronic medical record (EMR) revealed R8 was admitted to the facility on [DATE] with a code status of full code by default. Review of a Code Status Form dated [DATE], revealed R8 was a full code by default and was signed by the Physician and two witnesses. Review of a Code Status Form dated [DATE], revealed R8 was a full code by default and was signed by the Physician and two witnesses. Review of a Code Status Form dated [DATE], revealed R8 was a full code by default and was signed by two witnesses, but no Physician. Review of a Code Status Form dated [DATE], revealed R8 was a DNR (do not resuscitate) and was signed by the Physician and two witnesses. Record review of R8's care plan revealed a care plan in place with a Focus of Advanced Directives:, Advance Directives have been discussed & the following has been decided (CPR [cardiopulmonary resuscitation] by default). The care plan was dated [DATE] and last revised on [DATE]. The care plan was not updated when R8 was changed to a DNR status. In an interview on [DATE] at 8:16 AM, Registered Nurse (RN) E stated R8's son had to get R8's Durable Power of Attorney (DPOA) paperwork to the facility so code status could be determined. RN E said Social Services is ultimately responsible for the updating of the care plan at the time of the change in the code status. In an interview on [DATE] at 8:36 AM, Social Worker (SW) D said R8's care plan should have been changed or updated when her code status changed. SW D said she did not know how or why R8's care plan was not updated to her current DNR code status. Review of the Face Sheet and Minimum Data Set (MDS) with Assessment Reference Date of [DATE], reflected R69 was a [AGE] year old female admitted to the facility on [DATE], with diagnoses that included cerebral infarction with hemiparesis affecting left non-dominant side(left side paralyzed , vascular dementia, left above the knee amputation, atrial fibrillation(heart arrythmia with use of blood thinners), cognitive communication deficit, and major depressive disorder The MDS reflected R69 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she was dependent on staff for bed mobility, and all transfers. During an observation and interview on [DATE] at 12:30 PM, R69 was in room sitting in wheelchair and appeared calm and pleasant with minimal difficulty answering questions. R69 had a above the knee left leg amputation and left arm was resting on padded arm rest of wheelchair. R69 reported was unable to use left side of body related to history of stroke and never used prostatic leg since admission. R69 reported had several falls at facility including when staff were assisting with (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfers and was unsure of injuries. Review with the facility Matrix, dated [DATE], reflected R69 had history of fall with injury. Review of R69 Nurse Progress Note, dated [DATE] at 11:23 a.m., reflected, CNA [Certified Nurse Aid] alerted this nurse that resident had fallen on the floor. This nurse entered resident's room to find resident laying on her right side, with arm beneath her. Left hand bleeding from skin tear. Resident reports that her left hand is painful at skin tear site, denies pain in wrist her left and arm. Reports slight pain in right shoulder, 2/10 on pain scale. ROM [range of motion] at baseline for this resident. VSS [vital signs stable], neuro check wnl [within normal limits], no other injuries noted, resident and CNA deny hitting head. With a gait belt, resident assisted off the floor and into her wheelchair by 2 staff members. CNA states she was transferring resident from her bed to wheelchair, wheelchair was not locked, when CNA attempted to sit resident in chair when w/c slipped from under her bottom and aid dropped resident onto the floor. 3cm x 4cm skin tear cleaned steri-strips applied, covered with adhesive bandage, order written to change bandage q 3 days until healed. Daughter notified via telephone, Dr. [named] notified, no changes or new orders at this time. Review of R69 Progress Note, dated [DATE] at 4:15 p.m., reflected, Resident had a witnessed fall incident where her head did not hit anything. Resident was being transferred from bed to w/c [wheelchair] and slipped out of CNA's arms. Primary assessment showed no injuries. BP:124/64, P:57, R:18R, and O2Sats:94%. Assisted into w/c via 3 staff members. Resident denies discomforts, secondary assessment showed no injuries, Resident denies pain/discomfort. Dr. [named] notified of incident-no orders received, POA [power of attorney], [named], notified. Review of R69 Nurse Progress Note, dated [DATE] at 6:00 a.m., reflected, Resident was being transferred from her bed to her wheelchair with the assistance of 2 staff members. The brakes had been applied to the wheelchair prior to the transfer, however, the brakes didn't completely stop the wheelchair from moving backwards when staff attempted to transfer the resident into it. The wheelchair moved backwards as staff began to sit the resident in it and the resident was assisted to a sitting position on the floor. Upon inspection of her skin, it is noted that there is an abrasion to her left mid-back region. Resident reports that it is tender to the touch. Other than that she denies pain. No other obvious injury noted. Resident is able to move her right arm and leg without complaints of pain or discomfort. The left arm has been affected by her stroke, and she hasn't been able to use that arm since.Resident was assisted up onto her right leg and then into the wheelchair with the assistance of 2 staff members. She was then assisted to the toilet. Throughout the transfers from the wheelchair to the toilet then to the wheelchair and back into her bed, she maintained that she was only experiencing tenderness on her back. No report of any other pain. She was transferred to her bed with the assistance of the staff. She is able to verbalize her wants and needs. Review of R69 Nurse Progress Notes, dated [DATE] at 2:43 a.m., reflected, Roommate yelled out to writer that she needs two people. Writer entered room and noted resident on floor. Resident was noted sitting on floor on buttock with feet pointed southwest facing southwest, with her back facing northeast wall, near toilet and w/c. Res.[resident] denied hitting head.Staff reported that resident was lowered to the floor.Intervention: Staff education. Review of R69 Fall Care Plan, revised [DATE], reflected, I have an actual ADL[activity of daily living] deficit related to weakness and impaired mobility due to left side weakness secondary to CVA [cerebral vascular accident], left AKA [above knee amputation], left humerus fracture, CKD-3 [chronic kidney disease], and cardiac conditions. I try to maintain my independence and will transfer (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	myself to bed without using my call light or waiting for assistance. I have been educated on the importance of assistance with ADLS.TRANSFERS: 2 Person Assist. Date Initiated: [DATE].SAFETY: I am at risk for falls related to impaired mobility secondary to left side weakness secondary to CVA, left above the knee amputation.Do not leave me in the restroom or on the toilet without staff present. Date Initiated: [DATE].I will wear non-skid footwear for all transfers. Date Initiated: [DATE].Make sure my brakes are locked before every transfer. Date Initiated: [DATE]. Received four Incident/Accident reports for R69 on [DATE] at 1:53 p.m., dated [DATE], [DATE], [DATE] and [DATE] that involved staff assisted transfers that resulted in falls. Continued review reflected that R69 had a fall on [DATE] during a staff assisted transfer of one person and no gait belt. The notes reflected that the wheelchair brakes were not locked, staff transferred R69 with one person assist with no gait belt and staff education was provided. Continued review reflected that R69 had a fall on [DATE] during a staff assisted transfer of one person with no gait belt. (five days after R69 prior fall when staff failed to follow care planned safety interventions to prevent falls). The document reflected the Root Cause Analysis was staff did not follow care plan/Kardex. Continued review of reports reflected R69 had fall on [DATE] during a staff assisted transfer with two staff moving R69 from the bed to the wheelchair when the chair moved during the transfer and the R69 was lowered to the ground that resulted in tender bruised area to R69 left side that measured 11 cm by 7.5 cm. The report did not mention if gait belt or non-slip shoes were in place. Continued review of the reports reflected R69 had another fall on [DATE] during a staff assisted transfer with one person. The notes reflected the Root Cause Analysis was the staff did not follow Kardex for transfers and education was provided. (R69 had four falls in past six months that involved staff assisted transfers when staff failed to follow care planned interventions to prevent falls.) Continued review of the provided Incident/Accident reported for R69 reflected no staff names for staff involved and did not appear to be complete investigations as requested. During an interview on [DATE] 2:48 PM, Certified Nurse Aid (CNA) O reported routine worked with R69 on day shift and reported R69 required two-person extensive assist with transfers. CNA O reported that meant that two persons, one on each side of R69 with use of gait belt and reported know what each resident require by reviewing the Kardex prior to providing care. CNA O reported was not involved in any of R69 falls since October of 2025 and reported facility provided individual education to staff involved and verified did not received education related to falls after R69 falls. During a telephone interview on [DATE] 3:48 PM, R69's Daughter P had concerns because facility staff had dropped her mother R69 several times during transfers. R69's Daughter P reported was told had been new staff each time and stated, they dropped her a lot, too much, concerned for her safety. R69's Daughter P reported her mothers Kardex had always been two-person assist and one staff member was known to always only use one person. R69's Daughter P reported R69's Kardex also requires staff to remain in bathroom with R69 and witnessed nurse staff leave R69 in bathroom alone and immediately questioned staff because they make a choice to repeatedly not follow the Kardex interventions that are meant to keep R69 safe. During an interview on [DATE] at 5:02 PM, Licensed Practical Nurse (LPN) F reported working at the facility for over two years and often worked with R69. LPN F reported R69 required two-person assist with transfer along with gait belt as long as she could remember. LPN F reported R69 was a very high risk for falls related to prior falls, left above the knee amputation, and history of stroke with left side paralysis. LPN F reported was not present for R69 falls and reported R69 had several falls with and without staff present. LPN F reported make her very angry when R69 has falls with staff assist when R69 Care Planned safely interventions were not being followed and reported no excuse for not (continued on next page)

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	235279	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holt Senior Care and Rehab Center	5091 Willoughby Road Holt, MI 48842

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	following Kardex and reported most of R69's falls during staff assistance have happened on second and third shift. LPN F reported R69 Daughter was also very agree that staff have dropped R69 several times because Kardex was not followed. LPN F reported R69 had skin tear after one fall and recalled clearly after [DATE] fall had significant bruising to side and back the same day and verified R69 was taking blood thinners. Review of provided employee files on [DATE] at 9:45 AM, reflected four CNA files. Continued Review of the employee files revealed three staff, CNA T (failed to follow Kardex on [DATE]), and CNA U(failed to follow Kardex on [DATE]) had completed, Employee Corrective Action for failure to follow Kardex interventions resulting in fall. Continued review of CNA S file reflected no evidence of staff education provided for not following Kardex related to one person transfer resulting in fall on [DATE]. During an interview on [DATE] at 10:11 AM, Licensed Practical Nurse (LPN) V reported was R69 nurse at time of fall on [DATE]. LPN V reported was notified by CNA T that R69 had fallen. LPN V reported was standing at medication cart outside R69 room and immediately entered R69 room and observed R69 was laying on floor next to the bed with left arm skin tear observed. LPN V reported after R69 was assessed was transferred to bed. LPN V reported CNA T reported she transferred R69 with alone because she could not find another staff and did not use gait belt because she did not have one. LPN V reported CNA T became very angry with LPN V and refused to work with LPN V after incident. LPN V reported had heard about R69 fall on [DATE] but was not present but reported R69 had large abrasion and bruised area to side. LPN V reported makes her so angry staff know R69 is very high risk fall and continue to transfer her with one assist instead of two-assist. LPN V reported was questioned by management yesterday if this surveyor had called about R69 fall During a telephone interview on [DATE] at 11:21 AM, CNA S reported was R69 aid on [DATE] at time of fall. CNA S reported she transferred R69 alone with no gait belt and R69 fell. CNA S reported R69 was change to two-person assist after that and reported did not use gait belt because she could not find one and reported she should have used one. CNA S reported received education after incident. During an interview on [DATE] at 11:40 AM, Clinical Care Coordinator (CCC) E reported was responsible for completing fall root cause analysis for cedar unit. CCC E reported would expect staff to follow Kardex and verified R69 falls for [DATE], [DATE] and [DATE] the staff failed to follow the care planned intervention on the Kardex to prevent falls. CCC E was queried what interventions were implemented after each of R69 falls? CCC E reported they performed one on one staff education for staff who did no follow Kardex. CCC E was queried if that intervention was effective and CCC E stated, No, [named R69] still fell. During an interview on [DATE] at 12:10 PM, DON reported would expect staff to follow Kardex and care plan interventions. DON verified R69 falls on [DATE], [DATE] and [DATE] staff failed to follow Kardex and transferred R69 with one assist instead of two person assist and staff involved were provided one on one education. DON was queried if one on one education was effective DON stated, no and reported same staff not involved but intervention did not prevent additional falls for R69.

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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** Based on observation, interview and record review, the facility failed to maintain complete and accurate medical records for one (R2) of 19 reviewed. Findings include:Review of the Face Sheet and Minimum Data Set (MDS) with an Assessment Reference Date 3/12/26, reflected R2 was a [AGE] year-old female admitted to the facility on [DATE], with diagnoses that included cirrhosis of the liver, kidney failure, heart failure, diabetic, anxiety and depression. The MDS reflected R2 had a BIM (assessment tool) score of 15 which indicated her ability to make daily decisions was cognitively intact, and she required staff assist with dressing, hygiene, bathing, transfers, and toileting.During an observation on 4/07/2026 at 11:47 AM, R2 was in bed with guest at bedside. R2 reported currently had Hospice services since December and often Hospice services want pain medication given according to there direction and facility staff do not agree and stated, seems like they do not speak to each other.Review of R2 Progress Note, dated 4/7/2026 at 11:08 a.m., reflected, Hospice collaboration meeting with [named hospice service]. Reviewed resident's current condition and hospice services provided.Continues to express pain, continues to decline pain medication secondary to increased sleepiness when taking medication. Continues to take ativan as needed secondary to anxiety.Review of R2 Electronic Medical Record(EMR), dated 12/12/25 through 4/8/26, reflected no evidence of Hospice visit notes since 1/14/26(two months ago). Unable to determine Hospice recommendations for changes with pain control.During an interview on 4/08/2026 at 11:15 AM, Clinical Care Coordinator (CCC) E verified R2 was seen by Hospice services since admission in December and reported had binder at Nurse Station. CCC E verified was unable to locate Hospice visit notes in R2 EMR or Hospice binder since 1/14/26 and had verified with Medical Record they did not have additional hospice visit notes for R2. CCC E reported R2 had recent pain medication changes yesterday.During an interview on 4/08/2026 at 11:35 AM, Medical Records W reported R2's most recent hospice documents, including visit notes, was from 1/14/26 and reported was not responsible for obtaining visit notes from hospice and advised to speak with MDS staffDuring an interview on 4/08/2026 at 11:55 AM, Director of Nursing (DON) reported would expect Hospice visit notes to be added to resident EMR within one month. DON reported would expect staff to verify at monthly hospice coordination meeting that visit notes were up to date in EMR and verified was unable to locate R2 hospice notes since 1/14/26 in EMR.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an antibiotic was administered as ordered for one (R4) of five reviewed. Findings include: Review of the medical record revealed R4 was admitted to the facility on [DATE] with diagnoses that included Parkinson's Disease, diabetes, and peripheral vascular disease. The Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 3/19/26 revealed R4 scored 15 out of 15 (cognitively intact) on the Brief Interview for Mental Status (BIMS-a cognitive screening tool). On 04/07/26 at 11:30 AM, R4 was observed sitting in her wheelchair in her room. R4 reported she was currently receiving an antibiotic for cellulitis in her right leg. R4's right leg was observed wrapped with a bandage. Review of the Physician's Order dated 3/4/26 and ordered to start on 3/4/36 at 2:00 PM, revealed an order for cephalexin (antibiotic) 500 milligrams (mg) three times a day for 7 days for cellulitis of the right lower extremity. Review of the Medication Administration Record (MAR), revealed R4's cephalexin was not signed out as administered on 3/4/26 at 2:00 PM, 3/6/26 at 9:00 PM, 3/7/26 at 2:00 PM, and 3/10/26 at 9:00 PM. Review of the Nurse's Note dated 3/11/2026 revealed Resident's last dose of abx [antibiotic] given, resident's right lower extremity noted with continued erythema and warm to touch, per [physician's name] extend keflex [cephalexin] x 1 more week. Review of the Physician's Order dated 3/11/26 and ordered to start on 3/11/26 at 2:00 PM, revealed an order for cephalexin 500 mg three times a day for 7 days for cellulitis of the right lower extremity. Review of the MAR revealed R4's cephalexin was not signed out as administered on 3/11/26 at 2:00 PM, 3/11/26 at 9:00 PM, 3/12/26 at 2:00 PM, 3/12/26 at 9:00 PM, and 3/14/26 at 9:00 PM. Review of the Physician's Order dated 4/6/26 and ordered to start on 4/6/26 at 9:00 PM, revealed an order for cephalexin 500 mg three times a day for 7 days for cellulitis of the right lower extremity. In an interview on 04/09/2026 at 10:25 AM, Infection Preventionist (IP) N reported they monitor antibiotic use multiple times per day. IP N reported R4's cellulitis has been complicated and seemed to have resolved last month, but then symptoms returned again on 4/6/26. When asked if R4 received all doses of cephalexin from 3/4/26 to 3/18/36, IP N reported it was unclear and she would have to look into it. In an interview on 04/09/2026 at 10:35 AM, Director of Nursing (DON) reported nothing was brought to her attention that R4 did not receive all antibiotic doses prescribed from 3/4/26 to 3/18/26. When asked if R4 received all their antibiotic doses between that timeframe, DON reported she could not say because there was missing documentation on the MAR. Review of the backup medication inventory available in the facility, revealed 15 capsules of cephalexin 500 mg were available. In an interview on 04/09/26 at 11:47 AM, IP N reported they did not locate any doses of R4's cephalexin that were left in the cart from the dates of 3/4/26 to 3/18/26. IP N reported any leftover doses would have been returned to pharmacy. IP N reported the facility contacted the pharmacy today and received an email that the pharmacy did not receive any leftover doses returned to them. The facility was able to provide documentation staff removed a dose of cephalexin 500 mg for R4 on 3/4/26 at 11:58 AM, however the first dose scheduled for 3/4/26 at 2:00 PM was not documented as administered on the MAR. Review of the Consolidated Delivery Sheets printed 3/4/25 at 10:35 PM, revealed the facility received 21 capsules of cephalexin 500 mg for R4. Review of the Consolidated Delivery Sheets revealed the facility received 21 capsules of cephalexin 500 mg for R4 on 3/12/26 at 12:40 AM. The facility provided documentation that they received 42 capsules of cephalexin 500 mg for R4 from pharmacy deliveries on 3/4/26 and 3/11/26 and also removed two capsules from the backup supply on 3/4/26. In total, the facility had 44 doses of cephalexin 500 mg for R4. The facility was not able to provide documentation that R4 received the other doses of cephalexin 500 mg that were not documented as administered. R4's MAR indicated 9 of the 42 doses from 3/4/26-3/18/26 were not documented as administered as ordered.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review the facility failed to safely transport portable oxygen tank, resulting in the increased likelihood of severe injury, potentially affecting all 92 residents in the facility, staff and visitors.Findings include:During an observation on 4/07/2026 at 12:07 PM, during the initial tour of the facility and screening process, Licensed Practical Nurse (LPN) F was observed carrying a portable oxygen tank down entire Hall C, past Hall C Nurse station and halfway down beginning of Hall C to the oxygen storage closet without oxygen transport cart. LPN F exited the oxygen storage room with portable oxygen tank in a transport cart and wheeled cart down both C Halls and entered room C23. Several Residents and staff were present in both C Halls at the time. During an interview on 4/08/2026 at 5:02 PM, Licensed Practical Nurse (LPN) F reported working at the facility for over two years and had been a nurse for over 30 years. LPN F was queried about how to safely transport portable oxygen tanks. LPN F reported was called to management office on 4/8/26, after this surveyor had observed staff transport oxygen tank without a cart and received education about safe transport of portable oxygen tanks. LPN F reported prior to that had not received education and did not know you could not carry a tank and stated she knows now. LPN F verified had carried empty tank from resident wheelchair to the oxygen storage room and returned full tank on transport cart. During an interview on 4/09/2026 at 11:40 AM, Clinical Care Coordinator E for Hall C reported would expect portable oxygen tanks to only be transported in wheeled oxygen cart. During an interview on 4/09/2026 at 12:10 PM, Director of Nursing (DON) reported would expect portable oxygen tanks to be transported in oxygen carts because if accidentally dropped they could become like a missile. DON reported LPN F was provided education on 4/8/26. Review of the facility, OXYGEN ADMINISTRATION & SAFETY, policy, dated 4/12/16, reflected, POLICY: Oxygen administration will be provided per physician's order observing appropriate safety measures .When using oxygen cylinders, secure oxygen cylinders in appropriate holder .