STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2024
NAME OF PROVIDER OR SUPPLIER Resthaven Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 280 W 40th St Holland, MI 49423	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. 41424 This citation pertains to intake: MI00136097, MI00136440, MI00137896, MI00139274 Based on observation, interview, and record review, the facility failed to provide an environment that promoted a dignified experience and respond to resident call lights timely for 2 residents (Resident #100, Resident #103) of 8 residents, resulting in the feelings of humiliation, embarrassment, concern about receiving a timely response in the event of a medical emergency and a negative psychosocial outcome for the residents impacting their quality of life. Findings include: Resident #100: Review of an Admission Record revealed Resident #100 was a male with pertinent diagnoses which included muscle wasting and atrophy, pain in left shoulder, dementia, acquired absence of right leg above knee, diabetes, depression, heart failure, kidney disease, and abdominal pain. Review of current Care Plan for Resident #100, revised on 1/29/24, revealed the focus, .I am at risk for falls r/t (related to) neuropathy, recent above the knee amputation .I do attempt to get up independently at times . with the intervention .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed .Re-Educate to use call light to ask for help to get up (4/2/24) . In an interview on 4/18/24 at 9:23 AM, Resident #100 reported he felt no one seems to care for him and he felt bad and mad the staff didn't give a da** as he could have had a heart attack or had been throwing up and needed assistance. Resident #100 reported he had reported to the administration and felt that no one cares how long the call lights took and what could be happening to the resident. Resident #100 reported he had a loose bowel movement and asked for assistance and was told the staff member had to go to the dining room and would take care of him when they came back and let me stay like that. Resident #100 reported if the staff do not treat him with care and respect, he did not want them assigned to take care of him. Resident #100 became tearful and reported he did not feel like some staff treated him like a man, with dignity, who wants to be left like that? (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/17/24 at 4:20 PM, Family Member (FM) M reported if (Resident #100) reported he waited long periods of time for the call lights to be answered that was what it was. FM M reported he was pretty good at measuring the time, if he said it was 30 minutes, it was 30 minutes. The facility does have staffing issues at times. FM M reported Resident #100 reported to her he was tired of staff not coming in to see him or check on him. Review of Call Light Reports for Resident #100 for the time period of 2/12/23 - 2/18/23, 5/17/23 - 5/24/23, 6/19/24 - 6/24/23, 9/5/23 - 9/12/23. There were multiple incidents where Resident #100's call light was on for 30 minutes or greater. In an interview on 4/18/24 at 10:08 AM, Nursing Home Administrator (NHA) A reported last Thursday or possibly Friday, Resident #100 had reported to him he had concerns with a staff member returning timely to provide assistance to him and the frustration Resident #100 felt about that. NHA A reported when he had inquired of the date or day when the incident occurred the resident could not remember the date and wanted to speak to a staff member who was present when the incident occurred to get the date of the incident. NHA A reported he had checked in with Resident #100 on 4/16/24 to see if he had any additional information on the date the incident occurred and the resident reported he had not obtained the exact date. NHA A did not elaborate on why the call light logs for Resident #100 were not reviewed to determine probable cause. Resident #103: Review of an Admission Record revealed Resident #103 was a female with pertinent diagnoses which included cerebral palsy, pain, anxiety, embolism (blood clot), abnormal posture, anemia (blood doesn't have enough red blood cells), and osteoporosis (disease that weakness bones, making them thinner). Review of current Care Plan for Resident #103, revised on 10/27/22, revealed the focus, .The resident is at risk for falls r/t (related to) diagnosis of cerebral palsy and scoliosis. Resident is unable to use her legs and she does not try to get up on her own . with the intervention .Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed .Ensure that resident can reach her push pad call light and turn it on . In an interview on 4/198/24 at 11:29 AM, Resident #103 reported when she had to wait for the call light her anxiety would increase, and she would worry if and when they would come to assist her. Resident #103 reported the staff could have come and told her that they would be there soon as that was common decency to let her know so she was not waiting and unsure of what was happening. Review of Call Light Reports for Resident #103 for the time period of 9/5/23 - 9/12/23 revealed, Resident #103 had call light requests for assistance greater than 30 minutes on multiple occassions. During an observation on 4/18/24 at 9:03 AM, where the halls meet in the back corner by the activity/tv room area on the wall was a small monitor that shows which room had their call lights activated. In an interview on 4/18/24 at 9:14 AM, CNA L reported the staff could turn their phone on vibrate or turn it up so can hear it instead of having to pull the phone out and look at the phone or see if it alerted you. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/18/24 at 11:15 AM, CNA J reported the staff did set up the phones for your assignment on the unit. The phones always vocalized the room and bed. CNA J reported the phone could get turned down in volume and you can set it up to choose where you get notified from. CNA J reported can set up for your side of the unit and the phones always vocalize the room and bed but the volume could be turned down. CNA J reported if the call light was not answered within 3 minutes, the charge nurse would be notified, then the unit manager and the Director of Nursing would be notified. CNA J reported when a staff member pulled the pin in the wall the alert would flash red and sound would repeat. CNA J reported sometimes when the phone was in their pockets it would be turned down or shut off. In an interview on 4/18/24 at 11:15 AM, CNA I reported the staff could set up the cell phone system to tell them of who needed assistance from their unit assigned to them. CNA I demonstrated there was a menu to select where staff would get alerts from while in possession of the phone. CNA I reported there were screens located across from the tv/activity room by the entrance to the rehab unit and one back in the corner across from the tv/activity room. CNA I reported the cell phone would vocalize the room, bed, station, and if it was the toilet or the spa. In an interview on 4/18/24 at 12:18 PM, Unit Manager (UM) E reported the acceptable time for call lights to be answered was up to 15 minutes. UM E reported the managers were able to see when the call lights were illuminated as they were notified by their phones as it would alert them after a number of minutes of the call light going unanswered. UM E reported we switched offices and indicated she was not getting the alerts. UM E reported all staff should assist with call lights but not all have phones and would need to look at the screens located at the end of the hallways to see which rooms had call lights illuminated. In an interview on 4/18/24 at 3:01 PM, Assistant Director of Nursing (ADON) B reported call lights should be responded to within a 7 minute timeframe. The CNAs had the phones which alerts them to the call lights, the Interdisciplinary team (IDT) had access to pull the call lights up on the laptops. ADON B reported she did have the capability to review call lights on her phone as well as the Unit managers. ADON B reported there were screens set up so the call lights would be triaged and prioritized based on the indicated need and all staff could respond to the call lights. There were screens located throughout the building for staff to visualize the call lights locations. Review of policy, Call Lights revised on 5/12/2023, revealed, .The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance .Call lights will directly relay to a staff member or centralized location to ensure appropriate response .5. Staff will ensure the call light is within reach of resident and secured, as needed .6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room .10. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified . (continued on next page)

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Resthaven Care Center	280 W 40th St Holland, MI 49423

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC71 48550/, dated March 27, 2020, .In conclusion, the call light system is critical for interactions between the nursing home staff and residents. Research conducted in other health care settings has demonstrated that the call light system not only significantly improves the communication between staff and patients together but also helps ensure the safety of patients .In this study, it has been observed that the call light system is perceived to be an important factor affecting the outcomes of the care process and the satisfaction of both residents and staff as well in addition to the staffs performance . According to https://journals.lww.com/ regarding call light use, It is one of the few means by which patients can exercise control over their care on the unit. When patients use the call light, it is usually to summon the nurse .Patients expect that when they push the call light button, a nursing staff member will answer or come to them.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on interview and record review, the facility failed to ensure resident safety during a Hoyer (mechanical life) transfer in 1 of 8 residents (Resident #103), resulting in a fall with minor injury. Findings include: Review of an Admission Record revealed Resident #103 was a female with pertinent diagnoses which included cerebral palsy, pain, anxiety, embolism (blood clot), abnormal posture, anemia (blood doesn't have enough red blood cells), and osteoporosis (disease that weakness bones, making them thinner). Review of current Care Plan for Resident #103, revised on 10/27/22, revealed the focus, .Transfer 2A (2 assist) . Note: Care Plan does not indicate Resident #103 required a Hoyer for transfers. Review of Minimum Data Set (MDS) Section GG - Functional Abilities and Goals dated 1/17/24, revealed, .E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) .1. Dependent: Helper does ALL the effort. Resident does none of the effort to complete the activity . In an interview on 4/18/24 at 10:03 AM, Resident #102 who was Resident #103's spouse reported a few weeks ago she was dropped out of the Hoyer onto her head. Resident #102 reported Resident #103 was on concussion watch for three days, he stated, .I was so worried about her having a concussion and I am so concerned for her safety, wish the staff were more careful . Review of Incident/Accident/Unusual Occurrence Progress Note dated 1/20/24 at 12:40 PM, revealed, .On 1/19/24 resident slipped out of Hoyer lift onto floor. Hoyer loop came off the hook during transfer . Review of Secure Conversations dated 120/24 at 12:47 PM, Clinical Manager F documented, .She fell last night 1/19/2024. Hit head and Neuro checks implemented . Review of Skin assessment dated [DATE] at 9:30 PM, revealed, .Reason for Assessment: Unusual Occurrence Notes: skin warm and dry. red abrasion noted to mid and upper portion of back. no open skin. lump on posterior back of head which was tender to touch. no other areas of concern. Unit Director was not notified as there is no impairment. Wound UDA was not completed Interventions: Other pertinent information: . (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 Incident Report dated 1/19/2024, revealed, .Incident Description: Nursing Description: around 2120, this nurse was notified by a CNA that the resident slipped out of Hoyer lift onto the floor. 2 CNAs were assisting resident from her wheelchair to her bed when the Hoyer loop came off the hook during transfer. Resident Description: was transferring from my chair to my bed via Hoyer lift with my aide and landed on the floor .Immediate Action Taken: Nursing intervention: reviewed Hoyer safety policies with CNAs .Injuries Observed at Time of Incident: Abrasion .Vertebrae (upper-mid) .Other .Back of head .lump on posterior of head, tender to touch .Predisposing Environmental Factors: Uses Mechanical Lift .Witnesses: (Certified Nursing Assistant (CNA) C) . Review of Incident Report dated 1/19/24 on 4/18/24 at 12:27 PM, Clinical Manager (CM) E provided this writer with incident report reviewed during when queried, revealed, .(CNA C) date 1/2124 .Around nine twenty, myself and (CNA D) were lifting a resident up in a Hoyer, after the resident was up and (sic) of the wheelchair the top right loop slipped off and the resident fell out and onto the floor .I asked (CNA D) to (sic) and get the nurse .1/22/2024: Root Cause: Hoyer sling strap came off machine hook .New intervention: reviewed Hoyer transfer policy with staff . In an interview on 4/18/24 at 1:39 PM, Licensed Practical Nurse (LPN) G reported there were two aides there were assisting Resident #103 back to bed, LPN G reported she was not in the room during the transfer. LPN G reported CNA C came to her and reported Resident #103 was on the floor. LPN G reported she was told the loop slipped out or did not get on hanger all the way. LPN G reported the CNAs reported Resident #103 was barely up and out of her wheelchair, not very high, and she then ended up on the floor. LPN G reported Resident #103 had hit her head and had a bump on the back of her head. LPN G reported she provided some education to the two aides to ensure the loops were attached or to have two loops attached in case one were to come off then there was an additional loop. Also, to double check they had the loops on the Hoyer before pushing the button before raising the resident up. In an interview on 4/18/24 at 11:29 AM, Resident #103 reported the staff were hooking up the pad, the hook/pad let loose, and she fell to the floor and bumped her head. Resident #103 reported she had fallen by my room door and the staff had to come in the bathroom door to come and assist the other staff after the fall. Review of policy, Safe Handling/Transfers received on 4/18/24, revealed, .It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident . 8. Two staff members must be utilized when transferring residents with all full-body lifts and as indicated for sit- to-stand lifts .11. Staff members are expected to maintain compliance with safe handling/transfer practices. Failure to maintain compliance may lead to disciplinary action up to and including termination of employment .12. Resident lifting and transferring will be performed according to the resident's individual plan of care .13. Staff will perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device . (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 procedure, Transferring Clients with a Mechanical Lift received on 4/18/24, revealed, .This checklist identifies the steps needed to transfer a person using a mechanical lift .Operate the Lift To operate the lift for transfer from a chair/wheelchair to a bed: o Follow the manufacturer's instructions to operate the lift .o Raise the person about 2 inches above the height of the chair .o Check on the person and ensure they are well balanced .o Check that all hooks remain secure .o Unlock lift wheels and move the lift toward the bed .o Help the person straighten their legs .Rationale: Promotes safety .