STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235378	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resthaven Care Center	280 W 40th St Holland, MI 49423

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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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed provide a dignified environment and assist residents with care needs in 1 (Resident #52) of 2 residents reviewed for dignity, resulting in feelings of frustration and the potential for depression, loss of self-worth, and an overall deterioration of psychological well-being.Findings include:Resident #52 Review of an admission Record revealed Resident #52 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dysphagia (difficulty swallowing) and depression. Review of a Minimum Data Set (MDS) assessment for Resident #52, with a reference date of 5/23/25 revealed a Brief Interview for Mental Status (BIMS) score of 7/15 which indicated Resident #7 was severely cognitively impaired. Review of Resident #52's Orders revealed, Aspiration precautions: Sit upright for all PO(by mouth) intake and 30 minutes after, check for oral residue, excellent oral care including denture cleaning, encourage small bites, slow rate, drink to follow every 2-3 bites. every shift . Start date: 4/26/25. Review of Resident #52's Care Plan revealed, I have an ADL (Activities of Daily Living) self-care performance deficit r/t (related to) activity intolerance, deconditioning. Date initiated: 4/22/25. Interventions: Eating: I require feed assist. Date initiated: 4/22/25 .In an interview on 6/23/25 at 11:29 AM Resident #52 was lying in her bed. Resident #52 reported that she felt like staff at the facility did not want to help her, and that they did not like to take care of her. Resident #52 reported that she needed help with eating, and that staff would tell her that she could feed herself, and refuse to help her. Resident #52 reported that she felt like some of the staff did not like her. It was noted that Resident #52 was tearful during the interview. In an observation on 6/24/25 at 8:32 AM, Resident #52's breakfast tray was sitting on her table next to her bed untouched. Resident #52 was noted to be lying in bed flat on her back. It was noted that Resident #52's breakfast tray had not been set up for Resident #52. In an observation on 6/24/25 at 9:13 AM, Certified Nursing Assistant (CNA) P entered Resident #52's room and asked Resident #52 if she was going to eat her breakfast. CNA P set up Resident #52's food tray and said All right (Resident #52) here you go, you can do it. As CNA P began to walk out of Resident #52's room, Licensed Practical Nurse (LPN) FF told CNA P that Resident #52 needed help with eating her breakfast. CNA P said loudly in front of Resident #52 (Resident #52) can do it herself, I know she can. She does not need help. CNA P then turned to Resident #52 and said to her again You can do it yourself. CNA P then exited Resident #52's room. Resident #52 was noted to be sitting up in bed staring at her breakfast tray. In an interview on 6/24/25 at 9:19 AM, LPN FF confirmed that Resident #52 required assistance with eating, and that staff were supposed to assist Resident #52 with eating. During an interview on 6/24/25 at 11:44 AM, CNA P reported that sometimes Resident #52 required assistance with feeding, and sometimes she did not. CNA P reported that staff followed the Resident care plan to determine if the resident required assistance with feeding. CNA P confirmed that Resident #52's care plan indicated that she needed assistance with feeding. CNA P then reported that even though Resident #52's care plan noted that she required assistance with feeding, that she felt that Resident #52 could feed herself. CNA P was unable to report on why she felt that Resident #52 could feed herself. In an interview and observation on 6/25/25 at 9:07 AM, Resident #52 was sitting up in her bed with her breakfast tray in front of her. When this writer entered her room, Resident #52 asked this writer to please help me with my breakfast. Resident #52 reported that she wanted to eat, but that she needed help. Resident #52 was trying to take a drink from her cup, and was struggling to bring the cup to her mouth. This writer found CNA P in the hallway and informed her that Resident #52 was asking for assistance with eating her breakfast. CNA P then entered the room and began to assist Resident #52 with her meal. After Resident #52 took a few bites of her food, she told CNA P that she was having a hard time swallowing. CNA P began asking her over and over, Well do you want to be done then, do you want to be done then? Resident #52 told CNA P that she wanted to eat, but that she was struggling to swallow. CNA P replied to Resident #52 and said Well, I would have a hard time eating too if I was swallowing the way you are. You need to put your head in the right alignment. Do you want to be done then? Resident #52 again said that she wanted to eat, and CNA P assisted Resident #52 to a better position to swallow more easily. CNA P continued to assist Resident #52 with her meal and frequently asked her if she wanted to be done every few bites. In an interview on 6/25/25 at 9:21 AM, CNA P reported that she was assisting Resident #52 with her meal prior to when this writer entered her room, but she had to leave to pick up trays and keep up with the tasks on the floor. CNA P confirmed that Resident #52 was having trouble swallowing because of the way

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. Based on interview and record review, the facility failed to provide quarterly resident trust fund financial statements to 8 of 8 residents utilizing resident trust accounts resulting in the residents not being systematically informed about personal funds. Findings include: Review of electronic correspondence received from Nursing Home Administrator (NHA) A on 6/25/25 at 1:36 PM revealed, We currently have 8 residents utilizing resident trust. In an interview on 6/25/25 at 10:27 AM, Accounting Associate (AA) ZZ reported that resident trust fund financial statements were provided annually and upon request to the residents utilizing resident trust accounts. AA ZZ reported she did not provide quarterly trust fund financial statements but thought Resident Services Coordinator (RSC) V might send them. In an interview on 6/25/25 at 10:46 AM, RSC V reported she did not provide quarterly trust fund financial statements to the residents utilizing resident trust accounts but could let the resident know the balance of their account if they inquired about it. In an interview on 6/25/25 at 1:04 PM, NHA A reported the facility did not currently provide quarterly trust fund financial statements to the residents utilizing resident trust accounts but could provide a statement upon request at any time.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure accurate documentation of advance directives - code status (resident wishes for life sustaining interventions an emergency) for 1 (Resident #389) of 28 residents reviewed for advance directive - code status documentation resulting in the lack of an order or other documentation for the first 5 days of Resident #389's stay. Findings include:Review of an admission Record revealed Resident #389 was a female who admitted to the facility on [DATE] and had pertinent diagnoses which included: vascular dementia (dementia related to blood flow through narrowed blood vessels) and Alzheimer's disease. Review of a Minimum Data Set (MDS) assessment for Resident #389, with a reference date of [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 6/15 which indicated Resident #389 was severely cognitively impaired. (BIMS score 0-7 indicates severe cognitive impairment).Review of Order Summary for Resident #389 on [DATE] revealed no noted order in place regarding the resident's code status. In an interview on [DATE] at 3:41 pm, Resident #389 reported that she wished to be a Do Not Resuscitate (DNR), (no cardiopulmonary resuscitation to be done in the facility if her heart stopped or she stopped breathing). Review of Resident #389 medical record revealed she had an appointed guardian and was not able to sign or speak for herself regarding her medical choices. In an interview on [DATE] at 12:12 pm, Social Worker (SW) QQ reported that the admitting nurse was who should complete advance directive forms. SW QQ reported that an order was required for every resident related to code status. SW QQ reported if a resident was to be a DNR then the resident or their representative and the doctor needed to sign the DNR form; once the DNR form was signed then the order could be placed for code status of DNR. SW QQ reported while waiting for the DNR form to be signed then nurse needed to ensure that here was an order for full code in place in the resident's record. SW QQ at this time reviewed Resident #389's record and confirmed that there was no order in place for a code status. In an interview on [DATE] at 12:21 pm, Clinical Manager (CM) O reviewed Resident #389's record and confirmed that there was no order for code status and CM O asked can I add it now? CM O then added an order for full code to Resident #389's record. In an interview on [DATE] at 12:23 pm, Licensed Practical Nurse (LPN) C reported that the admitting nurse was responsible for inputting code status orders into a resident's record. LPN C reported that a resident was a full code until the DNR form was signed by the resident and the doctor. LPN C reported that once the form was signed then the order could be changed to DNR. LPN C reported that a physician order was required for code status. In an interview on [DATE] at 12:34 pm, LPN X reported that a physician order was required code status and that every resident needed a code status in their record. LPN X reported that all resident who wanted to be a DNR had to have a DNR form signed by the physician before the order could be changed and that the resident was a full code until the form was signed. Review of Order Summary for Resident #389 revealed .Full code (Attempt CPR) with a start date of [DATE] and a discontinue date of [DATE] authored by CM O . Code status DNR (NO CPR) . with a start date of [DATE] authored by CM O . Review of Michigan Physician Orders For Scope of Treatment for Resident #389 revealed signatures from the resident representative and the physician and a date of [DATE]. Review of facility policy Code Status with a review date of [DATE] revealed . as part of the admission process, each resident/elder/responsible part will be asked to complete (Name Omitted) code status form . once the resident/elder/responsible party has completed the code status form, it will be reviewed and signed by the physician .The code status will be found in the resident's/elder's medical record .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to maintain a comfortable ambient temperature between 71-81 degrees for 20 residents within a memory care unit (Rooms 401-415), resulting in resident's experiencing ambient room temperatures higher than 81 degrees and a potential for overheating and dehydration.Findings include: Review of Heat and Older Adults published by the Centers for Disease Control and Prevention, 6/25/24 revealed People aged 65 years or older are more prone to heat-related health problems .older adults .are more likely to have a chronic medical condition that changes normal body responses to heat .they are more likely to take prescription medicines that affect the body's ability to control its temperature or sweat .During an observation on 6/23/25 at 10:21am, a wall mounted oscillating fan was blowing in the common area of the memory care unit but could not be felt in the area where several residents sat.During an observation on 6/23/25 at 11:01am, Resident #112 in his bed with a comforter wrapped around his body and covering the back of his head. The ambient temperature in his room was 81.1 degrees. The resident's cheeks were mildly reddened. In an interview on 6/23/25 at 11:02am, Resident #112 reported he felt a little too warm in his room and that the air conditioning was not working well. In an interview on 6/23/25 at 1:42pm, Family Member (FM) TT reported she was concerned for Resident #112 when she visited him over the weekend of 6/21-6/22/25 because it was very hot on the memory care unit. FM TT reported Resident #112 was not able to recognize how hot or cold he was due to his type of dementia, and she was concerned he would overheat, especially since he usually kept himself wrapped up in a comforter in his room most of the time.In interview on 6/23/25 at 11:07am, Certified Nursing Assistant (CNA) BBBB reported she worked on the memory care unit over the weekend (6/21-6/22/25) and the air conditioning system stopped working. CNA BBBB reported some residents complained that they were too hot, and several family members voiced concern for their loved ones when they came to visit. CNA BBBB reported the nurse had asked for extra fans from the facility but when they weren't provided, staff moved some resident's personal fans into the common areas to try to keep residents cooler. CNA BBBB reported the facility's wall mounted falls were on but couldn't be felt where the resident's sat in the lounge. CNA BBBB reported the facility installed portable air conditioning units in the common areas at approximately 10:30am on 6/23/25, following entry by the State Agency. During an observation on 6/23/25 at 12:30pm, residents ate their lunch in the dining area. The ambient temperature registered at 81.3 degrees. A portable air conditioning unit was present in the dining area and running at that time. In an interview on 6/23/25 at 2:06pm, FM UU reported she visited Resident #104 on the afternoon of 6/22/25 and was concerned for the resident's well-being because it was extremely warm back there. FM UU reported she assisted Resident #104 with eating dinner and there was no portable air conditioning unit in the dining room at that time. FM UU reported the resident was sweating a lot and his arms felt warm and moist. FM UU reported she decided if it was as hot in the dining room when she arrived on 6/23/25, she was going to insist Resident #104 ate in his room, next to his fan. During an observation on 6/23/25 at 2:32pm in room [ROOM NUMBER]-1 the ambient temperature measured at 82 degrees. During an observation on 6/23/25 at 2:35pm, in room [ROOM NUMBER]-2 the ambient temperature measured at 81.3 degrees. During an observation on 6/23/25 at 2:37pm, the ambient temperature in Resident #112's room measured 82 degrees.In an interview on 6/24/25 at 9:40am, FM SS reported she assisted Resident #27 with his evening meal on 6/22/25 and when she arrived, his shirt was soaked with sweat. FM SS reported Resident #27 looked like he'd gone swimming because his shirt was so wet. FM SS reported she was concerned about Resident #27 becoming overheated and reported her concern to the nurse. In an interview on 6/24/25 at 10:10am, Licensed Practical Nurse (LPN) HH reported she called and reported the hot temperature on the unit to Building Services Specialist (BSS) PP on 6/21/25. LPN HH reported she was concerned for the residents and the staff because the unit was uncomfortably warm.In an interview on 6/24/25 at 10:23am, LPN C reported the air conditioning on the unit was not working on 6/21 or 6/22/25. LPN C reported she informed the on-call maintenance on 6/21/25 that the memory care unit was hot and was told they were working on the system. LPN C reported she was concerned for the resident's wellbeing due to the excessive level of heat and asked the on-call maintenance staff to bring extra fans to the unit. LPN C reported the facility did not provide any extra fans or portable air conditioning units over the weekend. LPN C reported the CNA's told her some residents felt sweaty and family members voiced concern about the temperature level/safety of the residents. LPN C reported she felt the facility should

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure a Preadmission Screening (PAS) / Annual Resident Review (ARR) Level I Screening Form DCH-3877 was completed annually for 1 (Resident #37) of 2 residents reviewed for preadmission screening / annual resident review screening, resulting in the potential for unmet mental health care needs. Findings include: Review of an admission Record revealed Resident #37 was a male, with pertinent diagnoses which included: anxiety disorder, unspecified; dementia in other diseases classified elsewhere, unspecified severity, with psychotic disturbance; and delusional disorders. Review of a Minimum Data Set (MDS) assessment for Resident #37, with a reference date of 3/14/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #37 was cognitively intact. Review of an OBRA (Omnibus Budget Reconciliation Act) PASARR Correspondence letter for Resident #37 dated 3/7/23 revealed, .The recipient may be admitted to or remain in the nursing facility and receive mental health services. Further PASARR Level II Evaluations (Annual Resident Reviews) are not required unless a significant change has been reported by the nursing facility. This does not alter the nursing facility's requirement for completing the annual Level I (DCH-3877) or reporting significant changes .A copy of this notice is required to remain in the recipient's medical record along with the current Level I (DCH 3877) . A review of Resident #37's electronic medical record on 6/24/25 at 9:07 AM revealed the most recent Level I (DCH-3877) Form had been completed for Resident #37 on 11/20/23. No subsequent Level I (DCH-3877) Forms for Resident #37 were found. In an interview on 6/24/25 at 12:30 PM, Social Services Technician (SST) HHH reported the last Level I (DCH-3877) Form that had been completed for Resident #37 was done in 2023 (referring to the form completed on 11/20/23). SST HHH reported Resident #37 should have had another Level I (DCH-3877) Form completed in 2024. SST HHH reported Social Worker (SW) Y was the social worker responsible for completing this form for Resident #37. In an interview on 6/24/25 at 1:37 PM, SW Y reported Resident #37 should have had a Level I (DCH-3877) Form completed in 2024 and they had it marked in their system as being completed but they couldn't find it. In a subsequent interview on 6/25/25 at 9:43 AM, SW Y reported she had contacted the OBRA coordinator who also could not locate a more recent Level I (DCH-3877) Form since the one completed in 2023.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure professional standards of nursing were followed for treatment of a skin tear for 1 (Resident #43) of 1 resident reviewed for professional standards of nursing practice. Findings include: Review of an admission Record revealed Resident #43 was a female with pertinent diagnoses which included Alzheimer's disease, dementia with behavioral disturbance, and pressure inducted deep tissue damage of right heel. Review of Care Plan for Resident #43 revised on 6/8/25 revealed the focus, .The resident has potential impairment to skin integrity due to limited mobility and incontinence. She can be resistant and refuse care and toileting at times with combativeness - hitting, kicking - that could cause skin injury and delay in care . with the intervention .Derma Sleeves- to bilateral arms when up . Review of Treatment Administration Record (TAR) for June 2025 revealed, documentation of Resident #43 with bilateral derma sleeves noted as on for day, evening, and night shifts. Review of Order for Resident #43 revealed, .Monitor skin tear to left outer forearm, steri-strips in place, clean and reapply if needed, every shift .Start Date: 05/23/2025 . Review of TAR for June 2025 for Resident #43 revealed, .Complete wound UDA-skin tear to outer left forearm every evening shift every Fri .Start Date: 05/30/2025 . During an observation on 06/23/25 at 11:01 AM, Resident #43 was seated in the atrium, and she had a bandage on her left forearm with no date or initials. No derma sleeves were observed on resident's arms. During an observation on 06/23/25 at 12:27 PM, Resident #43 was seated in her wheelchair in the dining room, and she had a bandage on her left forearm with no date or initials noted on it. No derma sleeves were observed on resident's arms. During an observation on 06/23/25 at 12:41 PM, Resident #43 was seated in her wheelchair in the dining room and was observed to have a bandage on her left forearm with no date or initials noted on it. Review of Skin Assessment dated 6/17/2025 at 5:12 PM for Resident #43, revealed, .Reason for Assessment: Weekly/Biweekly skin Observation .Notes: Skin assessment, Skin warm and dry, See wound UDA for Right forearm, left dorsal palm/hand, Left forearm, right heel, Treatments done per order .Uses a high back wheelchair for mobility, does not self-propel in wheelchair .Unit Director was previously notified of the skin impairment .Interventions: Pressure reducing device for chair in place .Pressure reducing device for bed in place .Nutritional supplements in place. Ointment applied to the area of skin impairment . Review of orders revealed no order for a dressing for Resident #43's left forearm skin tear. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/25/25 at 11:12 AM, Licensed Practical Nurse (LPN) HH reported when a resident had a skin tear, the floor nurses were the ones who completed the wound assessment and took the photos, type of treatments discussed with the provider on what they would like for the floor nurses to do. LPN HH reported if the resident had a pressure ulcer then the wound nurse would be consulted to review. LPN HH reported the nurse would contact the provider to obtain an order for any changes in treatment. LPN HH reported the bandage should have had initials and a date written on it. In an interview on 06/25/25 at 11:18 AM, Wound Nurse (WN) SSS reported she would not be involved in the care of the skin tears unless there was a flap of skin missing or it was a significant skin tear. WN SSS reported for residents with fragile skin an intervention used was application of extra cream to help prevent skin tears. In an interview on 06/25/25 at 01:31 PM Director of Nursing (DON) B reported Resident #43 had fragile skin with lots of risk reports. DON B reported she had multiple interventions such as protective sleeves, or at least long sleeves to protect her skin.

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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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to prevent, treat, and promote healing of pressure ulcers in 1 of 2 residents (Resident #126) reviewed for pressure ulcers, resulting in the lack of repositioning and implementation of care planned interventions, delayed healing of pressure ulcers for the resident, and the potential for infection and the development of new ulcers.Findings include: Review of an admission Record revealed Resident #126 was a female with pertinent diagnoses which included pressure ulcer of right buttock, stage 3, dementia, diabetes and adult failure to thrive. Review of Care Plan for Resident #126 revised on 06/09/2025, revealed the focus, .The resident has open area to right buttocks. Healing complicated by poor intake, incontinence and diabetes . with the interventions .Administer treatments as ordered and monitor for effectiveness . Assess/record/monitor wound healing Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed, drainage and healing progress. Report improvements and declines to the MD (Medical Doctor) .Educate the resident/family/caregivers as to causes of skin breakdown; including: transfer/positioning requirements; importance of taking care during ambulating/mobility, good nutrition and frequent repositioning .Instruct/assist to shift weight in chairs/recliner chair regularly .Pressure Relief- cushion in her recliner and wheelchair . Review of Kardex dated 06/23/2025 for Resident #126, revealed, .Bed Mobility: I need minimal assistance to turn and reposition in bed .Encourage resident to stay in common areas when awake .Skin Health: Apply a sheer layer of barrier cream with each incontinence . INCONTINENT: Check regularly and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinence episodes .Instruct/assist to shift weight in chairs/recliner chair regularly .Pressure Relief- cushion in her recliner and wheelchair .Reposition after meals, with toileting, with cares in bed and in chair/recliner chair .Review of Order dated 04/28/2025 for Resident #126, revealed, . Wound Care to see patient for area on right buttocks . Review of Order dated 05/14/2025 for Resident #126, revealed, .Monitor open areas to right inner gluteal cleft (groove or crease located between the buttocks) w/ (with) ordered border gauze dressing in place every shift . Review of Order dated 06/04/2025 for Resident #126, revealed, .Right buttock wound - cleanse and flush with NS (normal saline)/wound cleanser. Lightly Pack with collagen. Cover with silicone bordered foam dressing. every day shift every other day for Wound care . Review of Order dated 06/04/2025 for Resident #126, revealed, .Right buttock wound - cleanse and flush with NS/wound cleanser. Lightly Pack with collagen. Cover with silicone bordered foam dressing. as needed for dressing disruption/soilage . Review of Minimum Data Set (MDS) Significant Change dated 03/31/2025, revealed, .(Resident #126) is at risk for pressure ulcers because she has incontinence, fluctuating intake of food and fluids (however this has improved within the last several months) her blood sugars fluctuate, and she has assistance with bed mobility at times. (Resident #126)'s overall mobility and time spent in bed has changed in the last months showing improvement in her ability to change positions and she makes position changes now in bed and chairs independently most often and she is spending much of her day out in the common area as well. (Resident #126) remains at risk for skin breakdown however therefore has a care plan for risk for impaired skin integrity with interventions to help prevent pressure ulcers. (Resident #126) does not have any pressure ulcers, see care plan .Review of Nursing Progress Note dated 4/26/2025 23:15 for Resident #126 revealed, .Resident noted to have superficial open area to intergluteal cleft, cleaned affected area with normal saline wipe and applied dermaseptin. Notified NP (Nurse Practitioner) (Name) .Wound UDA (assessment) completed, no new orders at this time. Resident resting in bed with even and unlabored respirations, pressure reducing interventions implemented .Review of Skin & Wound assessment dated [DATE] for Resident #126 , revealed, .Pressure ulcer, Stage 2, In house acquired . Discovered 4/25/25 .0.2 x 0.5 x 0.5 CM, treatment - Dermaseptin applied per orders, no dressing and no cleansing .interventions: turning / repositioning, and other .Review of Skin & Wound assessment dated [DATE] at 1:03 PM for Resident #126, revealed, .0.3 x 0.9 x 0.5 depth 0.9 and undermining 0.7 CM .Review of Skin & Wound assessment dated [DATE] at 11:56 AM for Resident #126, revealed, .0.3 CM x 0.7 CM x 0. 6 CM depth 0.3 CM .undermining 0.2 CM . Review of Skin & Wound assessment dated [DATE] at 11:01 AM for Resident #126, revealed, .Pressure Stage 3 intergluteal cleft, medial, superior 1-3 months <0.1 CM Area x 0.5 CM Length x 0.3 CM Width x 0.3 CM Depth x 0.4 Undermining .Granulation 100% of wound filled . Moderate exudate , Serosanguineous Discoloration - black/blue, Extent: 1.5 CM, Review of Skin & Wound

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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** Based on observation, interview, and record review, the facility failed to provide adequate supervision and ensure appropriate transfer techniques were implemented for 2 (Resident #96 and Resident #102) of 9 residents reviewed for accidents resulting in an increased risk for falls and injuries. Findings include: Resident #96Review of an admission Record revealed Resident #96 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia (general term for loss of memory, language, problem-solving and thinking abilities that are severe enough to interfere with daily life). Review of a Minimum Data Set (MDS) assessment for Resident #96 with a reference date of 4/21/25, revealed a Brief Interview for Mental Status (BIMS) score of 0/15 which indicated Resident #96 was severely cognitively impaired. Section GG revealed Resident #96 needed supervision or light touching to transfer from sitting to standing. Review of a Care Plan for Resident #96 with a reference date of 2/25/21, revealed a focus/goal/interventions of: Focus: (Resident #96) needs assistance with her ADL's (activities of daily living) because she has dementia. Goal: Resident will accept assistance with care he/she is not able to do for her/himself . Interventions: TRANSFER: .Assist as needed, may need assist getting up from low or soft furniture. During an observation on 6/24/25 at 12:22pm, Resident #96 sat in a small recliner in the common area of the facility's memory care unit. Certified Nursing Assistant's (CNA) J and BB stood facing Resident #96, on either side of the recliner, placed their flexed forearms under Resident #96's armpits and simultaneously lifted the resident from the low seated position to a standing position. The CNA's held on to the waistband of Resident #96's pants with their opposite hands as they lifted the resident. No gait belt was in place on Resident #96; however, CNA BB had a gait belt looped across her own body from shoulder to waist. CNA J then turned to the surveyor and stated Sorry, our little lady (Resident #96) needed help getting up from that low chair. In an interview on 6/24/25 at 12:24pm, CNA J confirmed that she and CNA BB completed a sit to stand transfer of Resident #96 without the use of a gait belt and instead, hooked their arms under the resident's and held on to the resident's waistband as they lifted her from the chair. In an interview on 6/24/25 at 1:02pm, Physical Therapist (PT) EEE reported a gait belt should always be used by staff when assisting residents with transferring from one position to another. PT 'EEE reported it was the expectation that any time a staff member is providing physical support of a resident, the safest way to do so was with the use of a gait belt. PT EEE reported staff that transfer residents by hooking their arms under the residents could easily result in injuring the resident's should joint. In an interview on 6/25/25 at 1:57pm, Nursing Home Administrator (NHA) A confirmed it was the expectation that staff members use a gait belt to assist resident's with transfers. (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 facility Gait Belt policy with a reference date of 2025 revealed Purpose: To ensure the safe ambulation and transfer of residents through the standardized use of gait belts, thereby reducing the risk of injury to residents and staff. Policy Statement: Gait belts will be used by all direct care staff when assisting resident with transfers .Proper use of gait belts enhances resident stability, supports mobility, and minimizes the risk of falls and injury. Procedures .Residents refusing gait belt use will have that preference addressed and documented . Resident #102:Review of an admission Record revealed Resident #102 was a male with pertinent diagnoses which included dementia, Parkinson's disease with dyskinesia with fluctuations (dyskinesia symptoms are jerky movements they can't control such as swaying, wriggling around, [NAME] your head and can spread to the whole body), muscle wasting and atrophy (decrease in size or wasting away of a body part or tissue), dysphagia (damage to the brain responsible for production and comprehension of speech), anxiety, cerebellar ataxia (the cerebellum that coordinates voluntary movements is damaged) and osteoarthritis (the protective cartilage that cushions the ends of the bones wears down). Review of admission summary dated [DATE] at 6:52 PM, revealed, .Not processing well for new information, hx (history) of falls, will try to get out of bed .has confusion .unable to ambulate .has hx of frequency urinating .continent of bowels . Review of Nursing Progress Note dated 4/20/25 at 7:53 PM, revealed, .Daughter called to this nurse that guest was on the floor. Upon arrival, guest was on his hands and knees facing the bed, wheelchair behind him. Call light was on, alarm was not sounding. Guest stated I fell, as you can see .with x3 assist pt assisted to wheelchair. Guest reported he needed to use the restroom, guest toileted, Large BM result . Note: No incident or risk management report was provided to this writer when requested all reports for Resident #102. Review of Incident Report - Unwitnessed Fall dated 4/22/25 at 10:40 PM, revealed, .Nursing Description: This nurse was alerted by staff that the resident had fallen and was on the floor. This nurse went to the resident's room and noted him lying on his right side with his right arm underneath him in front of his recliner clutching an incontinence pad that staff stated was in the recliner under him originally. The resident's alarm pad was noted in the recliner seat and was on, but staff stated that it was not sounding when they noted the resident on the floor .Resident was toileted after the incident and staff believes that was his initial goal due to the resident having an incontinence episode of BM at the time .Injury: Right shoulder (rear) .This nurse noted a reddened area to his right should blade .Predisposing Environmental Factors: Alarm not Functioning . Predisposing Situation Factors: Attempting to toilet self .Ambulating without assist .Fall Investigation: Date of Last Fall: 4/20/25 .This is resident's 2nd fall r/t (related to) need for toileting .New intervention to implement toileting schedule and do bowel and bladder log to establish patterns . Review of Nursing Progress Note dated 4/23/25 at 06:33 AM, revealed, .Replaced guest alarm and it appears to be functioning properly without issue . Review of Nursing Progress Note dated 4/23/25 at 3:18 PM, revealed, .Guest's alarm started beeping and this nurse got up to check on guest. Guest was observed on floor crawling to bed from his recliner .Guest brought to common area . (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 - Un-Witnessed Fall dated 4/23/25 at 3:00 PM, revealed, .Guest's alarm started beeping and this nurse got up to check on guest. Guest was observed on floor crawling to bed from his recliner .Guest brought to common area .Notes: 4/23/25: Guest last seen by Nurse an hour ago .Last fall was night prior .New intervention for q2h (every 2 hours) toileting .4/25/25: New intervention to encourage resident to sit in common area to increase supervision . Review of Secure Conversations dated 4/24/25 at 07:02 AM, revealed, .Guest had another unwitnessed fall. Walked in and guest was on hands and knees crawling to bed . Review of Incident Report - Unwitnessed Fall dated 4/24/25 at 8:45 PM, revealed, .The nurse was alert to resident being on hands and knees in common area by the tv. Resident observed on hands and knees by chair near tv .resident stated he was going to grab his iPad, unable to give more of a description . Predisposing Physiological Factors: Gait imbalance, impaired memory, poor standing balance, confused, antidepressants .Other info: is on alarms currently .Immediate Intervention: keep iPad close to the resident . Review of Order dated 5/1/25 for Resident #102 revealed, .Check chair alarm for function and placement q shift. every shift for fall .Start date: 5/1/25 . Review of Social Work admission assessment dated [DATE] at 11:11 AM, revealed, .Resident is deemed incapacitated. Current level of cognitive functioning: Resident had a diagnosis of dementia. He presents with disorientation and confusion. His cognition has the potential to fluctuate. His executive functioning is impaired .History of attempting to self-transfer and stand, rummaging, wandering, delusions, and agitation . Review of Nursing Progress Notes dated 5/15/25 at 2:48 PM, revealed, .Required 1 person assist with pivot transfer/sit to stand 2 assist as needed. Requires sensor alarm when in bed and chair alarm when in chair or wheelchair . (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 Concern Form - Cares dated 5/15/25 at 9:00 PM, revealed, .Nursing Description: (First Name), Daughter, expressed concern after returning to visit (Resident #102) at around 9pm just before the storm. Family expressed concern that no staff nearby. Resident was almost out of recliner. Back of knees were still in contact with foot area of recliner. Family assisted resident back in recliner and observed what appeared to be blood on nose (later discovered it was chocolate ice cream). Daughter then went to seek out CNA (Certified Nursing Assistant). Family expressed concern with CNA ' s responses once found .Resident Description: Resident Unable to give Description .Immediate Action Taken: CNA supervisor was notified of situation by on shift nurse. CNA supervisor assisted resident with cares and repositioning from recliner to bed. Nurse administered medications 9:30pm. Resident alarms in place and functioning properly . Statements: .(Licensed Practical Nurse (LPN) YYY): Family was upset with resident sliding down out of recliner, and they came to get me. The family was upset because they didn't like their interaction with the CNA. The family relayed to me that CNA seemed dismissive. I reached out to unit manager on phone and CNA supervisor .(Certified Nursing Assistant (CNA) ZZZ): I was getting towels and helping 110 to go to bed. I went to get her linen and, on my way, back to her room, A lady came up to me and approached me. She said, what happened to my dad ' s nose, do you know what happened? I didn't know who she was or who her dad was. Then she told me who her dad was. I said I'm not sure if you want to talk to the nurse she is probably in the office. I went in there 2-3 times, and I went in to take his tray and never saw anything. She thought he was injured. The new nurse came over and she has been giving me a hard time. I overheard her talking about me to the family. Saying I hadn't checked on him. They found that it was chocolate ice cream on his nose. After the nurse talked with family, she called someone else to come do his cares. The nurse came up to me and told me she wasn't in the office.(R102 Family Member (FM) AAAA: We were visiting my dad in the afternoon and then left to get dinner. When we came back around 9pm we saw my dad with his knees down to recliner. He had slid down, and he would normally be in bed at this time. He had what looked like blood on his nose. I walked out of room to find assistance and found a CNA. I asked the aide, who had my dad and why did it look like blood was on his nose? The aide was dismissive towards me and when I asked for some assistance, the aide said, I don't know, go ask the nurse. I asked her where the nurse was. The aide said, Probably in the office sitting down. I went to the office to find the nurse and she was not in the office. I found her coming out of a room and then she helped me. We went to room to see what happened to my dad ' s nose and discovered it was chocolate. The CNA supervisor came around to assist my dad into bed and get washed up. I do not want that aide taking care of my dad . Notes: Reviewed statements from nurse, family, and CNA. Reviewed times in (Medical Record System) that staff was documented in room. Resident was assisted with toileting at 1700 (5:00 PM) by CNA. Nurse administered medications at 1742 (5:42 PM). Resident had meal and dinner tray removed .At the time the resident was slipping out of recliner, CNA was giving cares to another resident. Implemented Dycem to recliner and wheelchair . This writer attempted to contact FM AAAA prior to exit and was unable to speak with them. Review of Order Note dated 5/21/25 at 11:23 PM, revealed, .Re-added Motion sensor alarm to alert staff of resident attempting to move out of bed. Resident was reported attempting to get up during the night 5/20 via 3rd shift staff Start Date: 5/22/2025 . (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 Nursing Progress Note dated 5/21/25 at 11:45 PM, revealed, .the resident was restless after supper. The staff transferred him into his chair to watch TV .He continued to press his call light five different times after 7pm but could not tell the staff what was needed. He appeared confused. He asked the CNA to help him call his wife. She did and the resident was left talking to his wife in hopes to calm the resident. Soon after the resident was found on the floor by another staff member. She notified this nurse and the CNA that was taking care of him. He was found on the floor on his hands and knees .When the resident was hoyered off the floor, he c/o (complained of) back pain but denied pain when in bed . Note: No incident or risk management report was provided to this writer when requested all reports for Resident #102. Review of Order dated 5/22/25 for Resident #102 revealed, .Ensure motion sensor is on and working when guest in room .Start date: 5/22/25 . Review of Nursing Progress Note dated 5/24/25 at 3:06 PM, revealed, .Staff responding to chair alarm. Upon entry to room resident was observed crawling on hands and knees. Resident stated he was looking for wife and needed his transportation(wheelchair) which was located in the bathroom . Note: No incident or risk management report was provided to this writer when requested all reports for Resident #102. Review of Nursing Progress Note dated 5/24/25 at 11:53 PM, revealed, .Resident was found on his knees in front of the chair at 1935 (7:35 PM). He had his medicine and an ice-cream previously. Note: No incident or risk management report was provided to this writer when requested all reports for Resident #102. Review of Nursing Progress Note dated 6/5/25 at 00:29 AM, revealed, .Resident was agitated after supper. He was given ice-cream but wondered where his wife was and waited for her to return. After 2000, he was trying to get out of his chair. The CNA was able to get him out of the chair into bed. HS meds were given. However, the resident was restless, trying to get out of his bed. The alarms went off and the staff had to put his legs in bed many times. Finally, it didn't seem he could relax from his high anxiety . Review of Incident/Accident/Unusual Occurrence Progress Note dated 6/6/25 at 11:08 AM, revealed, .Direct care staff reports responding to sounding alarm. Upon entering room resident was observed lying on his right side .Resident assisted back into recliner via two assist and gait belt. Assessment noted an abrasion to the right temple measuring 0.7cm x 0.1cm . During an observation on 06/24/25 at 3:01 PM, observed Resident #102 was seated at the edge of his recliner in his room, no alarm was sounding, call light was pressed. This writer observed no staff supervising residents during this time as there were no staff in the common area/dining area. This writer went to the front office and informed Recreation Therapy Aide (RTA) UUU of Resident #102's current situation. RTA UUU appeared bothered in body language and tone, she reported can't move him, maybe distract him until staff comes and headed to Resident #102's room. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 06/24/25 at 3:06 PM, CNA KKK exited a resident's room with soiled linen in her hands. She was informed of the current situation for Resident #102 and appeared agitated and reported she was responsible for 10 residents over here, and 3 of them had alarms. CNA KKK proceeded to dispose of soiled linen and returned to the area and obtained her call light/bed alarm tablet from the counter. (Note: CNA KKK did not have her tablet on her person while in a room with another resident). CNA KKK went into Resident #102's room and scooted him back in the recliner. Resident #102's chair alarm was not alerting as the resident was still providing pressure on half the pad as it had slid down when the resident scooted forward in the chair with Dycem on the top and alarm on the bottom. CNA KKK asked Resident #102 if he wanted to get into his bed, Resident #102 indicated her did want to get in bed. CNA KKK informed Resident #102 she had to obtain the sit to stand to transfer Resident #102 to his bed. CNA KKK proceeded to obtain the sit to stand and went into Resident #102's room and closed the door. Note: CNA KKK transferred resident #102 by herself into his bed. On 06/24/25 at 3:09 PM, This writer went to other attached cottage and observed three staff members in the front office and second CNA exited from a resident's room with soiled linen. Clinical Manager E and Licensed Practical Nurse (LPN) LLL were seated in the front office. LPN LLL was speaking with another staff member and indicated he was giving report to additional staff member. This writer asked if they were able to hear an alarm while in the office, they reported they did not hear an alarm alert. This writer requested if they would set off the alarm for the resident for the cottage they were currently located on, this writer walked to the other side to determine if able to hear the alarm on the other cottage. This writer was unable to hear the alarm in the common/tv/dining room area. This writer informed them Resident #102 had attempted to get up out of his recliner and was seated on the edge of the seat, leaning forward and was currently being assisted by CNA KKK. LPN LLL and this writer went to Resident #102's room, and he indicated the resident had a chair alarm which was a pressure alarm and was not connected to a motion sensor alarm which alerted to the sensors plugged in to the outlets at the counter as well as the tablet carried by the CNAs. There were two sensors plugged in, and they were numbered as 106 and 108 to indicate the room it was connected to. LPN LLL reported Resident #102 was restless and confused and previously had attempted to get up or slide out of his recliner to the floor. In an interview on 06/24/25 at 3:12 PM, CNA NNN reported the chair pressure pad alarm was not able to be heard when she was on the other attached cottage where she was assigned. CNA NNN was noted to not have her tablet on at the time. In an interview on 06/24/25 at 3:11 PM, Clinical Manager (CM) E reported the pressure pad alarm would not alert to anyone in the other cottage, where she was located at, only the alarms that were motion sensored. CM E reported the alarms were not a guarantee to keep a resident safe, the alarms were a tool to assist staff, not all falls can be prevented but the hope was staff would hear the alarm prior to the resident falling. CM E reported she did not believe there was a supervision requirement for residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 06/25/25 at 01:44 PM, Director of Nursing (DON) B reported supervision for the residents on the cottages the facility does not have a constant intervention for one to one supervision. DON B reported typically there would always be staff there and available to intervene for a resident. DON B reported the facility does use other interventions to help notify the staff such as chair and motion alarms. DON B reported for a resident who was impulsive and/or a fall risk the staff would conduct frequent rounds and investigate for the root cause of the fall(s). DON B reported there were interventions the facility could attempt such as if it was determined to be a toileting concern, then could schedule toileting for the resident. DON B reported she hoped that when the staff would hear a resident's alarm, they would be able to reach the resident in time. DON B reported it was proven that alarms do not prevent falls and could also be cause more agitation or distress for a resident especially for one with dementia. In an interview on 06/25/25 at 2:00 PM, Nursing Home Administrator A reported the facility had implemented multiple alarms for Resident #102 and he was unsure of what else could possibly be done for Resident #102's situation other than to provide a one to one for the resident and his situation did not warrant a one to one. NHA A reported the facility had the appropriate number of staff in the cottages based on the resident numbers. NHA A reported he did not think the facility was able to provide constant supervision of the residents as staff have to provide resident cares for all residents. Review of policy Fall Intervention Review Procedure implemented on 4/2025, revealed, .5. Supervision Enhancements: o Consider supplemental remote monitoring (sensor alarms and motion detectors) .o Consider increasing intermittent supervision (staff nearby or periodic check ins) .o Consider implementing more frequent observations at set intervals (hourly safety checks) .o Consider temporary direct supervision (1 :1 supervision) when unsafe to self or others while root cause of fall can be further evaluated and alternative interventions can be implemented .o Encourage participation in group activities to increase supervision .o A recreational therapy assessment may help identify appropriate engagement strategies .

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents received food items within their preferences for 1 (Resident #27) of 2 residents reviewed for food, resulting in dissatisfaction and the potential for nutritional decline and gastrointestinal upset. Findings include: Review of Choice on the menu in residential aged care: An underrated tool for maintaining resident autonomy [NAME] PhD, APD, [NAME] L. [NAME] PhD, APD, [NAME] M. [NAME] PhD, Adv APD First published: 25 February 2025, revealed Food and mealtimes are areas where residents want to express their autonomy. In the community, individuals make decisions about food based on preferences, which have been shaped by a lifetime of experiences. Being able to choose foods that align with these preferences is a sign of normality and a continuation of self-identity. Resident #27 Review of an admission Record revealed Resident #27 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia (type of dementia caused by reduced blood flow to the brain, leading to damage and impaired cognitive function), barrett's esophagus with dysplasia (cells within the throat have undergone abnormal changes due to chronic acid reflux), diabetes mellitus (chronic condition in which the body doesn't produce enough insulin causing abnormal blood sugar levels), and dysphagia (difficulty swallowing). Review of a Minimum Data Set (MDS) assessment for Resident #27 with a reference date of 4/28//25, revealed a Brief Interview for Mental Status (BIMS) score of 00/15 which indicated Resident #27 was severely cognitively impaired. Review of a Care Plan for Resident #27 with a reference date of 5/20/24, revealed a focus/goal/interventions of: Focus: I am at risk for malnutrition as evidenced by Dx (diagnosis) of dementia, Barrett's esophagus, hx (history) of dysphagia DM (diabetes) receives insulin, hx diverticulitis with GI (gastrointestinal) bleed. Goal: Weight without consistent, ongoing significant change while tolerating diet and consistency without difficulty. Interventions: .Likes seafood, dislikes mac n cheese, likes tomato juice at meals .monitor and report to nurse s/sx (signs and symptoms) of GERD (gastroesophageal reflux disease) (condition in which stomach contents leak backward from stomach into esophagus that can be triggered by spicy foods). Review of a Kardex care guide for Resident #27 revealed Nutrition: Diet Per Physician Order .Likes seafood, dislikes mac n cheese, Likes tomato juice at meals. (continued on next page)

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	235378	A. Building B. Wing	06/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Resthaven Care Center	280 W 40th St Holland, MI 49423

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/24/25, at 9:40am, Durable Power of Attorney (DPOA) SS reported she visited Resident #27 daily to assist him with his evening meal. DPOA SS reported she repeatedly told staff Resident #27 preferred foods that were prepared without spices, but he continued to receive spicy foods. DPOA SS reported she told staff who worked on Resident #27's unit and the staff who attended his most recent care conference, but the problem continued. DPOA SS reported Resident #27 had avoided spicy foods for many years because they caused him to have heartburn. DPOA SS stated some of the foods he's given would really bother his stomach if he ate them. DPOA SS reported one of the foods that he would not eat were the potatoes wedges the facility provided because they were spicy. DPOA SS reported Resident #27 put a bite of a potato wedge recently and promptly spit it back out. DPOA SS reported she was concerned because she was only present for 1 meal per day and Resident #27 would not voice why he wasn't eating if he was served certain foods and staff might assume he was not hungry. During an observation on 6/25/25 at 9:32am, Dietary Aide (DA) Q prepared breakfast plates for Resident #27's unit in the satellite kitchen. DA Q reviewed the meal ticket for each resident and then selected foods from a serving cart. In an interview on 6/25/25 at 9:37am, DA Q reported the meal tickets for each resident included their diet, likes, dislikes, and beverages of choice. DA Q reported she normally worked on Resident #27's unit and was responsible for setting up meals on each resident's plate. DA Q reported on Resident #27's unit, every resident received the meal listed on the facility menu because the residents did not have the cognitive ability to choose foods. DA Q reported she referred to the likes and dislikes on the meal ticket to ensure preferences for those residents were honored. When queried about Resident #27's preferences, DA Q reported I know his family does not want him to have tomato juice but other than that, I don't know of any food preferences for him. DA Q reported the facility's dietician was responsible for obtaining each resident's food preferences and the information was then placed on the meal tickets. In an interview on 6/25/25 at 11:57am, Dietary Services Director (DSD) RR reported food preferences were gathered by the dietician at the time of a resident's admission. In an interview on 6/25/25 at 1:11pm, Registered Dietician (RD) S reported she recorded a resident's preferences at the time of their admission and again as things come up. RD S reported Resident #27 had a diagnosis of barrett's esophagus, but she did not know if he had any issues with increased acid reflux related to the foods he consumed. RD S reported she relied on floor staff or members of the IDT (Interdisciplinary Team) to communicate additional food preferences to her and only reached out to family members for additional food preference information if the resident experienced weight loss, ongoing gastrointestinal upset or other food related issues. RD S reported Resident #27 was not able to tell her his food preferences. RD S reported she was not able to attend all care conference meetings because of her large caseload and was not aware Resident #27's DPOA had food concerns related to his preferences. RD S stated I don't know about any food preferences for him other than what's on his meal ticket. RD S appeared dismissive when told Resident #27's DPOA had a concern regarding the food he received, and stated You have to remember that when a family member tells you something, it might be something that was taken care of 20 years ago. We honor food preferences much better than most other places. Review of Resident #27's meal tickets for 6/25/25 revealed Lunch: dislikes: none, prefers: NO PREFERENCE meal: american chop suey .Dinner: dislikes: none, prefers: NO PREFERENCE meal: Salisbury steak .seasoned brussels sprouts. DO NOT GIVE TOMATO JUICE PER RESIDENT FAMILY REQUEST. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Week at a Glance menu with a reference date of 6/22-6/28/25 revealed 6/25/25 Dinner: Salisbury Steak .potato wedges . Review of a Meal Preference-Prescreen assessment for Resident #27 with a reference date of 5/20/24 revealed A. Meal Preference .Resident able to make meal preferences known: yes .3. Any Food Allergies/Intolerances: No .7. Are there food items you like to have at meals: 7a. seafood .8. Are there food items you dislike and do not want to receive: 8a. Mac n cheese . Review of a Nutritional admission Assessment for Resident #27 with a reference date of 6/3/25 revealed .C. Nutrition Related Functional and Cognitive Issues: .5a. Dementia .6a. Aphasia (language disorder that affects a person's ability to communicate) .D. Estimated Nutritional Needs and Intake: .6. Food Allergies/Intolerance (Digestive problems that occur after a certain food is eaten) b) No .E. Details of Nutrition Summary .reviewed with IDT no concerns voiced . Review of a Nutrition Screening/preferences policy with a reference date of 1/23/25 revealed Policy: Dietary Supervisors, RDN (Registered Dietitian Nutritionist) or other designated associate with (sic) visit each resident within approximately 72 hours .following admission and complete .meal preference assessment. PROCEDURE .2. Obtain food preferences, allergies or intolerances .5. The frequency of subsequent visitations will depend on the nutritional status of the resident and as requested by the interdisciplinary team and/or family. 6. Selective menus are used with meal and beverage preferences obtained on a daily basis.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to properly sanitized resident shared equipment, specifically a glucometer between uses during medication administration for 1 (Resident #129) of 5 residents observed for medication administration, resulting in the potential for the spread of infection, cross-contamination, and disease transmission. Findings include: Resident #129 Review of an admission Record revealed Resident #129 was a female who admitted to the facility on [DATE] and had pertinent diagnoses which included: Type 1 diabetes (a chronic condition where the pancreas produces little to no insulin for the body). Review of Order Summary for Resident #129 revealed .blood glucose scans QAC (before every meal) and HS (bedtime). Notify physician if blood glucose is less than 60 or over 400 unless individual parameters dictate otherwise four times a day for Type 1 Diabetes with a start date of 3/14/2025. On 6/24/25 at 11:45 am, Licensed Practical Nurse (LPN) C was observed completing a blood sugar check (obtaining a sample of blood from the tip of a finger that was then placed onto a test strip in a glucometer (a machine that measures sugar levels of the blood) and the machine resulted a value) on Resident #129. Once LPN C exited Resident #129's room, he returned to the medication cart and deposited the glucometer into a box for alcohol wipes in the bottom drawer of the medication cart. LPN C then opened the top drawer and proceeded to prep Resident #129's medications. LPN C did not clean or sanitized the glucometer after using it to check Resident #129's blood sugar and returning it to the cart. In an interview and observation on 6/24/25 at 11:55 pm, LPN C reported the glucometer should be cleaned after each use and LPN C confirmed he returned the glucometer to the medication cart after he checked Resident #129's blood sugar and he did not clean it. LPN C reported everything in the drawer that the glucometer touched was now contaminated. LPN C then retrieved the glucometer from the bottom drawer of the medication cart and immediately cleaned it. In an interview on 6/24/25 at 9:32 am LPN G reported the glucometer should be cleaned after every use and before being stored in the medication cart. In an interview on 6/24/25 at 9:40 am LPN T reported the glucometer should be cleaned after every use and before being stored in the medication cart. In an interview on 6/24/25 at 10:59 am, Education and Infection Control Nurse (EICN) OO reported her expectations were that the glucometer should be cleaned after every use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy titled Blood Glucose Monitoring with a revised date of 3/2024 revealed .the nurse will abide by the infection control practices of cleaning and disinfection of the glucometer as per the manufacture's instructions and in accordance with the facility's glucometer disinfection policy The nurse is responsible for cleaning and disinfection of the machine between residents following the manufacturer's instructions and in accordance with the facility's glucometer disinfection policy .