STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235401	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clark Retirement Community	1551 Franklin Street, SE Grand Rapids, MI 49506

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 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** 41027 This citation pertains to intake #MI00146821. Based on observation, interview, and record review, the facility failed to effectively develop and implement comprehensive, person centered care plans for 2 residents (Resident #106 and #107), of 8 residents reviewed, resulting in unmet care needs and the potential for negative physical, mental and psychosocial outcomes. Findings include: Resident #106 Review of an Admission Record revealed Resident #106 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dysphagia (swallowing disorder) and urinary retention (inability to empty bladder). Review of Resident #106's Orders revealed, Meals: upright in chair, at table. Feeding assist needed. Small bites and sips. Oral care before meals. Would benefit from sippy cup. every day shift for SLP (speech language pathologist: a person who helps with swallowing problems) recommendations. Active 9/21/2024. Review of Resident #106's Nutritional Risk Care Plan revealed, .at nutritional risk r/t (related to) parkinson's disease, tremors, decreased ADLs (activities of daily living). date initiated: 8/15/24. Interventions: Assistance with feeding meals and join with others and res (resident) should not have meals in room unless being assisted, sippy cup, small bites and sips, sitting upright at table for meals. date initiated 8/15/24, revision on 11/14/24. Review of Resident #106's Current Functional Performance Care Plan revealed, .Resident performance: Eating-Independent/set-up only. dated initiated 8/15/24 . The care plan intervention was revised on 9/19/24 and revealed, .Resident performance: Eating-Independent/set-up only needs feeding assistance, sit up at table for meals. There was an additional intervention in place which indicated, .Resident performance: Eating-limited assist/one-person physical assist. date initiated 8/15/24. The interventions were ambiguous (more than one possible interpretation). (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #106's ADL Care Plan revealed, .Eating: The resident is able to eat with set-up, however, resident does have intermittent confusion at times and will require assistance eating. date initiated 8/12/24. This was not consistent with the revised care plans above. During an observation on 2/19/25 at 11:55 AM in the dining room, Resident #106 was in his wheelchair at a table. Resident #106 and the other resident at the table were the only ones without a lunch tray. Director of Nursing (DON) B, Certified Nursing Assistant (CNA) L and CNA G were in the dining room assisting other residents. At 11:59 AM staff placed Resident #106's lunch in front of him, and walked away. Resident #106 began eating his pudding using the spoon and then he switched to using his fingers to eat. Resident #106 then used the spoon to eat his mashed potatoes, taking 2 large bites, that mostly fell off the spoon before he could get them to his mouth. At 12:06 AM DON B asked Licensed Practical Nurse (LPN) E to retrieve a meal replacement drink for a different resident in the dining room, to which LPN E responded that she would in a few minutes after she finished a task on the unit. At 12:10 PM LPN E sat down between Resident #106 and the other resident that was at the table. Until that time there was no staff assisting or actively supervising Resident #106 with his meal. LPN E prompted Resident #106 to pick up his breadstick and take a bite instead of trying to cut it with his knife. Resident #106 took a bite of his breadstick and then LPN E began loading his spoon with food and cueing him to feed himself. In an interview on 2/19/25 at 1:41 PM, DON B reported that it was his understanding that Resident #106 was independent with eating, but may require assistance if he was having trouble feeding himself. In an interview on 2/19/25 at 12:26 PM, CNA J reported that Resident #106 coughed a lot when he ate, and that someone usually fed Resident #106. Review of Resident #106's Braden Scale for predicting pressure sore risk dated 2/12/25 indicated that the resident was at moderate risk to develop pressure sores. Review of Resident #106's Pressure Ulcer Care Plan revealed, .has potential for pressure ulcer development r/t end-stage parkinson's, immobility, incontinence. date initiated 8/25/24. Interventions: APM (alternating pressure mattress) in place (hospice provided). date initiated 8/25/24. There were no other interventions developed for pressure ulcers. Review of Resident #106's Incontinence Care Plan revealed, .bladder incontinence r/t dementia, parkinson's, impaired mobility. date initiated 8/25/24. Interventions: .Check every 2-3 hours and as required for incontinence. Wash, rinse and dry perineum .date initiated 8/25/24. In an interview on 2/19/25 at 9:00 AM, Family Member (FM) M reported that Resident #106 sat in his chair from about 7:00 AM until after lunch everyday, unless the resident had a bowel movement, and then FM M had to press the call light and request for incontinence care to be done. FM M reported that she thought staff was supposed to check Resident #106 for a wet or soiled brief every 2 hours, but they only check on him from the doorway. FM M reported that Resident #106 was not able to move or offload his buttocks when he is in the chair. At 9:56 AM FM M left the facility for the day. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/19/25 at 12:26 PM, CNA J reported that Resident #106 had gotten up early to eat breakfast, and would be laid down after lunch, for a total of about 6 hours in his chair without incontinence care. CNA J reported that FM M notified the staff when Resident #106 had a bowel movement and needed to be changed, otherwise incontinence care was not provided until after lunch when Resident #106 was in bed. CNA J reported that staff was not able to provide incontinence care more frequently due to having to help other CNA's with their assignments but when hospice staff visited, then Resident #106 received more frequent care. During an observation on 2/19/25 at 12:37 PM, CNA J prepared to transfer Resident #106 into bed. Resident #106 was observed with a wet and soiled brief. In an interview on 2/19/25 at 1:41 PM, DON B reported that Resident #106 was at risk for pressure ulcer development and should be repositioned and have incontinence care every 2 hours. DON B reported that Resident #106 had a roho cushion in his wheelchair and an air mattress to reduce pressure. Review of the facility policy Skin Care Program dated 7/7/22 revealed, .Preventative Interventions: .The Clinical Care Coordinators and/or Licensed Nurses along with the interdisciplinary team will create and revise care plans and CNA instruction to include as appropriate: a) Directions for repositioning . c) special and routine skin care. d) nutrition/hydration interventions. e) Resident toileting preferences or programs. f) use of incontinent products. g) Directives for use of pressure relieving devices. Care plan interventions will be developed based on results of the assessments, determined risk factors and overall needs of the resident . Resident #107 Review of an Admission Record revealed Resident #107 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: bilateral hearing loss. Review of Resident #107's Orders revealed, Hearing aids on and off two times a day place hearing aids in AM and remove at HS (bedtime). start date 7/13/23. Review of Resident #107's Care Plan revealed, .impaired communication related to hearing loss as evidenced by hearing aids. date initiated 3/29/23. Interventions: .Ensure hearing aids bilateral hearing aids are in place. date initiated 3/29/23 . During an observation on 2/19/25 at 11:00 AM Resident #107 was in his wheelchair in the common area. Resident #107 was not wearing hearing aids. In an interview on 2/19/25 at 11:07 AM, LPN E reported that Resident #107's hearing aids are kept in his room, and the nurse was supposed to ensure he has the hearing aids in place when morning medication administration is completed. LPN E reported that Resident #107 had received his morning medication, but that she did not check his hearing aids. During an observation and interview on 2/19/25 at 11:11 AM in the hall outside of Resident #107's room, the resident was observed by this surveyor and LPN E without hearing aids in place. Resident #107 reported that he would like his hearing aids in, but was not able to do it himself. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to Fundamentals of Nursing ([NAME] and [NAME]) 9th edition, The care plan (see Chapter 18) is a map for nursing care and demonstrates your accountability for patient care.A well-planned, comprehensive nursing care plan reduces the risk for incomplete, incorrect, or inaccurate care. As a patient's problems and status change, so does the plan. A nursing care plan is a guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used later in evaluation (see Chapter 20). The plan of care communicates nursing care priorities to nurses and other health care providers.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake #MI00146821 Based on observation, interview, and record review, the facility failed to ensure timely, effective incontinence care was provided for 1 resident (Resident #106) of 3 residents reviewed for bowel and bladder incontinence, resulting in an increased risk for UTI (urinary tract infection) and the potential for skin breakdown. Findings include: Review of an Admission Record revealed Resident #106 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: urinary retention (inability to empty bladder). Review of Resident #106's Incontinence Care Plan revealed, .bladder incontinence r/t (related to) dementia, parkinson's (a disorder that effects movement), impaired mobility. date initiated 8/25/24. Interventions: . Check every 2-3 hours and as required for incontinence. Wash, rinse and dry perineum (genitals and anus) . date initiated 8/25/24. In an interview on 2/19/25 at 9:00 AM, Family Member (FM) M reported that Resident #106 sat in his chair from about 7:00 AM until after lunch everyday, unless the resident had a bowel movement, and then FM M had to press the call light and request for incontinence care to be done. FM M reported that she thought staff was supposed to check Resident #106 for a wet or soiled brief every 2 hours, but they only check on him from the doorway. FM M reported that Resident #106 was not able to move or offload his buttocks when he is in the chair. At 9:56 AM FM M left the facility for the day. In an interview on 2/19/25 at 12:26 PM, CNA J reported that Resident #106 had gotten up early to eat breakfast, and would be laid down after lunch, for a total of about 6 hours in his chair without incontinence care. CNA J reported that FM M notified the staff when Resident #106 had a bowel movement and needed to be changed, otherwise incontinence care was not provided until after lunch when Resident #106 was in bed. CNA J reported that staff was not able to provide incontinence care more frequently due to having to help other CNA's with their assignments but when hospice staff visited, then Resident #106 received more frequent care. During an observation on 2/19/25 at 12:37 PM, CNA J and Registered Nurse (RN) K prepared to transfer Resident #106 into bed. Both staff donned gloves and CNA J was designated to do the incontinence care washing, and RN K would assist. Resident #106 was observed with a wet and soiled brief. CNA J used disposable wipes to remove the feces from the resident's groin and between the legs. CNA J did not wash the resident's penis. CNA J continued washing the resident's buttocks and retrieved multiple wipes out of the package during the care. CNA J continued washing the resident's buttocks and then applied a clean incontinence brief to Resident #106. With the same soiled gloves, CNA J handled the bed controls, straightened the resident's clothing, adjusted the pillow, pulled the blankets over the resident, and clipped the call light on the bedding. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/19/25 at 12:54 PM, CNA J reported that she forgot to change gloves and was trying to get the incontinence care done quickly during the previous observation. CNA J reported that during morning cares there is more time to provide thorough care. In an interview on 2/19/25 at 1:41 PM, Director of Nursing (DON) B reported that Resident #106 should have incontinence care every 2 hours.