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	07/30/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 1293524 Based on record review and interview, the facility failed to ensure a safe transfer and implement facility policy to prevent falls in 1 of 4 residents (Resident #2) reviewed for fall prevention, resulting in a fall during a lift transfer resulting in a right fractured humorous for Resident #2, which had impacted the resident's functional status and quality of life with the potential for further injury and falls due to unsafe transfers. Findings include: Resident #2Review of an admission Record revealed Resident #2 was a female with pertinent diagnoses which included fracture of right femur, dementia, quadriplegia (partial or total loss of function in all four limbs and the torso), and polyosteoarthritis (flexible tissue at the ends of the bones wear down). Review of a Minimum Data Set (MDS) assessment for Resident #2, with a reference date of 6/25/25 revealed, .Section GG: Mobility: Chair/bed-to-chair transfer. 01 - Dependent.Review of current Care Plan for Resident #2, revised on 6/30/25, revealed the focus, .SAFETY/FALLS: (Resident #2) has fallen related to balance problems as evidenced by cognitive deficits, with limited insight into risk, psychotropic medication use, incontinence . with the intervention .Dycem on top and bottom of wheelchair cushion .fall mat next to bedside when resident resting in bed .keep frequently used items within reach and cue to call light placement prior to leaving room .Low bed with mat . Review of N-ADV- Fall Risk Evaluation for Resident #2, dated 6/14/25 revealed, .History of falls (past 3 months): 1-2 falls in past 3 months. Fall Risk Score: 16.0 . Score of 16 indicated Resident #2 was a high fall risk. Review of Lift/Transfer Evaluation for Resident #2, dated 6/14/25, .Resident can bear full weight .Resident's right side is dominant/stronger .Resident is cooperative with transfers .Resident is cooperative with repositioning .Resident has upper extremity strength .Resident is not able or partially able to assist with transfers from bed to bed .Resident is partially able to assist with repositioning in bed .Resident is partially able to assist with repositioning in chair .During an observation on 07/28/2025 at 10:35 AM, Resident #2 was observed in her room seated in a low broda/scoot chair facing the TV. She wore a gown, pants, socks, and tennis shoes.During an observation on 07/28/2025 at 1:49 PM, on the closet door in Resident #2's room was a sign which indicated, .Her right arm sling to remain in place at all times, 1. hoyer 2 person transfers - keep right arm still and close to body.In an interview on 07/28/2025 at 1:51 PM, Family Member (FM) O reported Resident #2 was being transferred from the bathroom to bed at some point and the staff dropped her out of the dependent lift. FM O reported the staff called them and reported they did not think she was hurt at the time. Then one of the caretakers saw a bruise on her arm, x-rays were taken, and it was discovered Resident #2 had broken her humerus. Resident #2 was sent out to the emergency room (ER). FM O reported it was decided there would be no surgery and the ER placed Resident #2's arm in a sling to heal. FM O reported Resident #2 was not combative with cares.Review of Health Status Note for Resident #2, dated 7/12/2025 at 07:46 AM, revealed, .discoloration noted to right hip, both knees have light pink discoloration noted. Review of Telehealth - Asynchronous for Resident #2, date of service: 7/12/2025, revealed .Patient: (Resident #2).Situation: Had fall last night out of Sara lift (sit-to-stand lift) - is favoring her right arm. Can we order x-rays? please list what one you would like (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	done and if routine or STAT (immediately).Treatment: OK for STAT x ray of AP & lat shoulder, radius, elbow right arm.Review of Order for Resident #2, dated 7/12/2025 at 08:55 AM, revealed, .Order Note: ELBOW AP (x-ray beam enters from the front) & LAT (x-ray beam enters from the side) -RT (Right)| FOREARM AP&LAT-RT | HUMERUS MINIMUM 2V (views) -RT | SHOULDER COMPLETE, MIN 2V-RT | WRIST AP&LAT-RT.resident had a fall yesterday evening.get x-rays due to pain in right arm and favoring the arm.Review of Incident Report for Resident #2, dated 7/11/25 at 7:40 PM, revealed, .Type: Fall.Location: Resident room.Activity: Transfer.Sent to hospital: No.Immediate Actions Taken: Head to Toe Body Check.Neuro Assessment.Braden scale completed.Skin risk assessment completed.ROM within normal limits for resident.MD Notified.Fall Risk Assessment Completed. Note: Immediate Intervention put in place to ensure resident safety.Review of Incident Report for Resident #2, dated 7/11/25 at 7:40 PM, revealed, .Nurses Notes: At about 19:30 (7:30 PM) this nurse was called into the resident's room by the CNA (Certified Nursing Assistant). Resident was noted to be laying on the floor on her right side in between the open legs of the [NAME] (sit-to-stand) lift. Fall was witnessed and CNA stated that the resident slipped out of the sling and fell to the floor. Vitals stable, neuros WNL (within normal limits), no new skin issues noted, ROM (range of motion) WNL and no s/sx (sign/symptoms) of pain or discomfort noted at this time. Resident had a BM (bowel movement) on the floor prior to the fall, therefore was assisted into a shower chair by this nurse and the CNA via hoyer (dependent) lift and received a shower. Resident is resting comfortably in bed at this time. On call supervisor, on call NP (Nurse Practitioner) notified and message left with spouse to call back. Will continue to monitor.Resident Statement of what happened: I was transferring her from the toilet to the bed when she just slipped out of the sling and fell to the floor.Conclusion: CNA unbuckled resident causing to lose balance during transfer.Root Cause: Human error.Recommendation: 07/14/25: Changed transfer status to Hoyer (dependent) lift.Status: Implemented.Entered by: DON B.Review of a Witness Statement submitted and signed by LPN I revealed, .When I walked into the room (on 7/11/25), I witnessed (Resident #2) laying on the floor on her right side with her legs over one leg of the lift and her head resting on the other leg. BM (bowel movement) was observed on the floor when fall occurred witnessed by CNA. The arms of the lift were all the way up to a standing position and the sling was attached to the machine and the leg straps were not buckled. ROM (range of motion) was normal at that time and (Resident #2) was assisted into a shower chair via Hoyer lift with this nurse and CNA, and CNA assisted (Resident #2) to shower. Night maintenance was called to sanitize the floor. (Resident #2) was assessed post fall for pain and injury, and nothing was noted after time of fall.In an interview on 7/29/25 at 4:00 PM, Certified Nursing Assistant (CNA) C reported he was asked by third shift nurse to boost Resident #2 up in her wheelchair as she had slipped down, and then to get her ready for bed. CNA C reported he had noted she had a bowel movement (BM), and he placed her in the Sit to stand and sling and brought her to the bathroom. CNA C reported she had a bowel movement which was very loose. CNA C reported waited about 15 minutes and went to get her off of the toilet. CNA C reported he did not realize she was not finished yet, stood her up, and cleaned her up, lower sit to stand and seats, and pulled out into her room to clean her up some more and she had additional BM on the floor. CNA C reported he went to sit her down on her bed, removed the leg restraints, and then realized she was at the edge of bed, thought he would stand her up real quick and adjust her. CNA C reported she was noted to be a resident who could support her weight on the sit to stand when she was lifted. CNA C reported she went down and was between the legs on the Sara lift. CNA C reported there was BM all over the floor of her room when he had transferred her from bathroom to the bed she was not finished as he had thought. CNA C reported after she fell, he went to get LPN I to help get her up. CNA C reported the nurse checked to see if she was hurt, bleeding, blood pressure, and pupils before got her up off the floor. CNA C said I get it now.At the time it didn't seem like anything would happen if just stood her up real quick and sit her back further on the bed. CNA C reported after the nurse checked her out; she was taken to the shower room as she had BM all over her. CNA C reported she was taken off the shower chair, used the sit to stand again, and she did not (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	grimace or make any noise.This writer attempted to contact the nurse who was present during the incident but did not hear back from them prior to exit from the facility.In an interview on 07/30/2025 at 1:49 PM, Director of Nursing (DON) B reported (Resident #2) was transferred to her bed from the bathroom and CNA D had unbuckled the sling for the Sara lift at the time Resident #2 fell. DON B reported Resident #2 began grimacing and guarding her arm the next day, she was sent out and that was when the facture was found. DON B reported Resident #2 returned to the facility with a sling on her right arm. DON B reported the nurse conducted range of motion, skin assessment, vitals initially and one other time since she was unable to report any concerns. DON B reported then on the next day Resident #2 was observed pulling on her arm and was different, so we sent her out for evaluation.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record review, the facility failed to provide a Registered Nurse (RN) for 8 consecutive hours per day, 7 days per week, resulting in the potential for unmet care needs, resident change of condition to not be properly assessed and negative clinical outcomes. This deficient practice has the potential to impact all 29 residents currently residing in the facility. Findings include:Review of Nursing Schedules for 1/1-3/31/25 revealed the facility did not provide RN coverage for 8 consecutive hours per day, 7 days per week during 5 of 14 weekends included in this timeframe.Review of Nursing Schedules with a reference date of 5/1-7/27/25 revealed the facility did not provide RN coverage for 8 consecutive hours per day during any of the 13 weekends included in this timeframe. During 8 of the weekends in question, the facility had no scheduled RN coverage at all. Review of a Registered Nurse Job Description with a reference date of 2024 revealed POSITION SUMMARY: the Registered Nurse (RN) provides exceptional care.promoting their health.ensuring their safety and comfort.DUTIES AND RESPONSIBILITIES.conducts initial and ongoing assessments of residents' health status.collaborates with physicians, nurse practitioners, and other healthcare providers to develop and implement effective care plans tailored to the residents' unique needs.Review of a Licensed Practical Nurse Job Description with a reference date of 2024 revealed POSITION SUMMARY: the Licensed Practical Nurse (LPN) is responsible for providing resident care.under the direction of the Director of Nursing and the Nursing Supervisor.DUTIES AND RESPONSIBILITIES.makes routine rounds of assigned residents.ensures that medications are administered.observes and reports symptoms/conditions of residents to the treating physician.In an interview on 7/30/25 at 11:12am, Scheduler Z reported she began working at the facility approximately one month ago. Scheduler Z reported upon reviewing the nursing schedule, she recognized the facility had not provided its residents with at least 8 consecutive hours of RN coverage for several weekends. Scheduler Z reported the facility was aware of the situation. When further queried, Scheduler Z reported the facility currently did not have enough direct care RNs to provide the necessary coverage on the weekends.In an interview on 7/29/25 at 9:46am, Nursing Home Administrator (NHA) A reported she was unaware the facility had not provided RN coverage for at least 8 consecutive hours per day, 7 days a week, until she reviewed the nursing schedules that were requested during the survey. NHA A confirmed the facility did not have sufficient RN coverage for the days in question and thus, was not in compliance. NHA A reported the facility may have to consider having RNs on the management team cover some weekend shifts to ensure resident needs were met, but no steps had been taken as of this date.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to maintain best practices in accordance with professional standards of food service safety. The deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen.Findings include: On 07/28/25 at 9:40 AM, Observation of the clean utensil storage area found a mechanical scoop stored with stuck on food debris. Further observation found that the bins containing whisks and spoons were found with an increased accumulation of crumb debris. When asked how often this area gets cleaned, Dining Services Director (DSD) W stated they should get done every Tuesday. On 07/28/25 at 10:05 AM, An interview with DSD W found that the tabletop mixer and the slicer get used often. Observation of the mixer found dried stuck on food debris on the back shield and front grate of the mixing under arm. Observation of the slicer found stuck debris that looked like tomato seeds on the top backside of the blade. When asked Chef Y if tomatoes are used on the slicer he stated yes.According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. On 07/28/25 at 10:15 AM, Observation of the dish machine found that it requires 150F for the wash cycle and 180F from the rinse manifold (before it enters the machine) to ensure a contact of 160F or higher for utensils, pots, and pans in the machine. After running the dish machine through four full cycles, it was not able to achieve a contact of 160F or higher with the facility or surveyor dish plate thermometer. Both the facility thermometer and the surveyors read between 153F to 156F after each complete cycle.On 07/28/25 at 3:20 PM, a revisit to the kitchen found that the dish machine was still not achieving proper temperature for the rinse cycle. Further review found that the incoming hot water supply to the booster heater had an indicator on its temperature gauge showing it needed to be 130F or higher. At this time, the incoming hot water temperature for the booster heater was between 118F to 124F.A record review of the facility document entitled Dishmachine Temperature Record, dated July 2025, found multiple low temperatures listed below the requirement of 180F from the manifold and 160F from the surface contact temperature. According to the 2022 FDA Food Code section 4-703.11 Hot Water and Chemical. After being cleaned, equipment food-contact surfaces and utensils shall be sanitized in: (A) Hot water manual operations by immersion for at least 30 seconds and as specified under S 4-501.111; P (B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under SS 4-501.15, 4-501.112, and 4-501.113 and achieving a UTENSIL surface temperature of 71oC (160oF) as measured by an irreversible registering temperature indicator; On 07/28/25 at 10:18 AM, Observation of the floor in the dish machine area found heavy wear where grout was missing or worn down to the point it was allowing water to accumulate in crevices and stagnate. Under the dish machine, one complete tile was missing allowing the area to consistently accumulate water. The floor under the dish room hand sink was found with a beveled lip creating an uneven surface. When asked about the floor, DSD W stated that the facility is looking into renovating the floor and laying epoxy down but is unsure when.According to the 2022 FDA Food Code section 6-501.11 Repairing. PHYSICAL FACILITIES shall be maintained in good repair.On 07/28/25 at 10:31AM, Observation of the preparation table near the dining room door, found a half full container of less sodium soy sauce stored on the counter. Further review of the item found that it states to Refrigerate After Opening. Upon showing the item to Chef Y, he stated he would discard the item. According to the 2022 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less. On 07/28/25 at 3:26 PM, a revisit to the kitchen found a full six-quart container of pasta tightly covered in saran wrap sitting on a shelf inside walk-in cooler #7. At this time, condensation was observed accumulating at the top of the container and the temperature of the pasta was found to be 57F when measured with a digital rapid read thermometer. Observation of the cooling log outside of the walk-in cooler door, found numerous items actively being cooled, but the pasta was not listed. According to the 2022 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less. According to the 2022 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: (1) Placing the FOOD in shallow pans; (2) Separating the FOOD into smaller or thinner portions; (3)Using rapid cooling EQUIPMENT; (4) Stirring the FOOD in a container placed in an ice water bath; (5) Using containers that facilitate heat transfer; (6) Adding ice as an ingredient; or (7) Other effective methods. (B) When placed in cooling or cold holding EQUIPMENT, FOOD containers in which FOOD is being cooled shall be: (1) Arranged in the EQUIPMENT to provide maximum heat transfer through the container walls; and (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. Based on interview and record review, the facility failed to ensure that a qualified Infection Preventionist worked at least part-time at the facility, was provided sufficient time to perform the Infection Preventionist role, and to properly assess, implement, and manage the Infection Prevention and Control Program.Findings include:During an interview and record review on 7/29/25 at 10:00 AM, Infection Control Preventionist/Director of Nursing/Unit Manager (ICP/DON) B stated, I am the DON, ICP, and UM not only for the LTC side of the facility but also for AL (Assisted Living). I do MDS (Minimum Data Set) part-time as well. This all takes up a lot of time. I am interrupted by staff from my duties, and it is hard to get everything done with all I have to do.During an interview on 7/29/25 at 4:01 PM, ICP/DON B stated, There is a resident that has been here since sometime in June 2025 that requires the PCV20 vaccine, and I have not ordered it yet. I was going to get the other residents' immunization consent to know how many I needed but I just have not been able to get to them before now. Some resident immunization consent forms are still in my email, and I have not looked at them yet. Other newer residents do not have signed consents yet. I am supposed to do daily audits to check on infection control practices and if enhanced barrier precaution signage is on resident doors. I haven't been able to keep up with that. On an average week I can work about 4 or 5 hours on infection control out of 40-60 hours a week. That is 100% less than 1/2 of my hours dedicated to infection control. I do not know really what staff has been educated on for infection control.During an interview on 7/2925 at 4:01 PM, Nursing Home Administrator (NHA) A stated, (IPC/DON B) is to perform DON, ICP, Unit Manager duties along with overseeing the adjacent assisted living community. The facility is hoping some of the licensed nursing staff in the facility will offer to step up and take on some of the responsibilities the IPC/DON has.Review of the facility's Infection Prevention and Control Program revised 6/1/25, revealed, .Pneumococcal Immunization .Residents will be offered the pneumococcal vaccines recommended by the CDC (Centers for Disease Control) upon admission.Review of Facility Assessment reference date February 2025, revealed, Nursing Services.The Director of Nursing (DON) oversees, all nursing related functions and matters.Additional responsibilities of the DON include but are not limited to, oversight of the infection control process, audits, data gathering and reporting monthly to QAPI, wound management, and education to nursing staff as identified.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain a safe, functional, sanitary, and comfortable environment. This resulted in an increased potential for contamination and a possible decrease in residents' satisfaction of living. Findings include:On 07/28/25 at 1:25 PM, Observation of the 3500 Hall Spa room, with Maintenance Director (MD) X, found a stack of clean towels stored between the sink and the commode open and exposed for contamination. Further review of the shower room found multiple dime size pieces of dried bowel movement on the grate for the shower drain with a used glove and wash cloth found under the shower equipment. When asked if that is where clean linens are normally stored, MD X stated the linen is usually protected in a cabinet or covered cart. On 07/28/25 at 1:31 PM, Observation of the housekeeping closet, next to the pantry room, found that the cold-water line was turned off, indicating a stagnant water line. On 07/28/25 at 1:37 PM, Observation of the soiled utility room found brown and discolored water dispense from the cold-water line on the faucet over the hopper. Further review found that the foot pedals for the hopper spray were turned off, indicating a stagnant water line. On 07/28/25 at 1:39 PM, Observation of the Spa near the elevator, found water lines that were capped off near the floor. When asked about these water lines, MD X stated it was for a tub that was taken out awhile back. When asked if it's something that gets flushed, MD X was unsure.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to promote a dignified dining experience for 3 (Resident #21, Resident #4 and Resident #14) of 4 residents reviewed for dignity, resulting in a potential for a reduced quality of life, feelings of frustration, helplessness and a decreased sense of self-worth.Findings include: Resident #21: During an observation on 07/29/25 at 4:41 PM, Resident #21 was placed at the table with Resident #14 and the other female resident who was eating her meal. Resident #21 had a plate covered with a grey top in front of her, she had cooked cinnamon apples in a dessert dish on the table. During an observation on 07/29/25 at 4:45 PM, LPN “J” proceeded to assist Resident #21 by opening her napkin with silverware and removed the top to the plate. LPN “J” proceeded to sit down between Resident #21 and Resident #14 to assist with each with dinner. Review of an admission Record revealed Resident #21 was a female with pertinent diagnoses which included Alzheimer's disease, dysphagia oropharyngeal (swallowing disorder that involves difficulty moving food or liquid from the mouth into the esophagus), protein calorie malnutrition, and weakness. Review of a Minimum Data Set (MDS) assessment for Resident #21, with a reference date of 5/15/25 revealed, Section GG: Functional Abilities and Goals .Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident: 03 - Partial/moderate assistance…” Review of Care Plan dated 3/17/25, with the focus, .Resident #21 requires assistance with her ADLs due to severely impaired cognition due to Alzheimer's disease as well as weakness. She is receiving hospice care with decline anticipated .with the intervention .Resident performance: Eating - Limited assist / one-person physical assist Staff to feed [NAME], she will at times eat on her own . Review of Orders dated 4/21/2025 revealed, .Regular diet, Mechanical Soft texture, Nectar consistency Mechanical Soft meat only, supervision with all meals . Resident #4: Review of an admission Record revealed Resident #4 was a male with pertinent diagnoses which included dementia, hypoglycemia (body's blood sugar level goes below the standard range), diabetes, dysphagia oropharyngeal, and long-term use of insulin. Review of a Minimum Data Set (MDS) assessment for Resident #4, with a reference date of 5/15/25 revealed, Section GG: Functional Abilities and Goals .Eating: 03 - Partial/moderate assistance…” Review of Care Plan dated 7/22/25, with the focus, .Resident is at nutritional risk r/t (related to) dysphagia, diabetes, insulin dependent, low BMI, cognitive impairments . During an observation on 07/29/25 at 4:35 PM, Resident #4 was observed to be seated at the dining table. CNA “C” (continued on next page)

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	235401	A. Building B. Wing	07/30/2025

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was prompting him to take a bite of his grilled cheese, Resident #4 refused to take a bite. Licensed Practical Nurse (LPN) “J” spoke to Resident #4 inquired if he had a headache as he had rubbed his head. LPN “J” spoke to CNA “C” to determine if he had given Resident #4 anything to eat or if he had eaten anything. LPN “J” asked Resident #4 if it was okay to go to his room (to check his blood sugar and provide any necessary insulin) and they proceeded to his room and LPN “J” closed the door behind them. During an observation on 07/29/25 at 4:41 PM, Resident #4 was observed in his room and had been waiting for LPN “J” to return after she had taken him to his room to test his blood sugar. During an observation on 07/29/25 at 4:43 PM, LPN “J” proceeded back to Resident #4’s room to provide him with his insulin and she apologized to him for having to wait as she proceeded to close the door to his room. During an observation on 07/29/25 at 4:44 PM, Resident #4 self-ambulated out of his room back to the dining room table to eat his dinner. Note: 9 minutes had passed from when the nurse asked Resident #4 to go to his room until he returned back to the dining room. No staff offered to warm Resident #4's food upon his return. During an observation on 07/29/25 at 4:48 PM, Resident #4 had not begun to eat his meal. No staff prompted resident to eat or offered to warm his food. Using the reasonable person concept, though Resident #4 had decreased ability to verbally express his own thoughts due to her medical diagnoses, any reasonable person would likely feel a decreased desire to proceed with eating their dinner after it had sat for approximately 10 minutes without warming. Resident #14: During an observation on 07/29/25 at 4:38 PM, Resident #14 was observed seated at the table. She had a plate covered with saran wrap of pureed foods- grilled cheese and green beans. Resident #14 did not begin eating and it appeared she needed assistance with her meal. Resident #14 was seated at the table with another female resident who had her meal and was able to eat unassisted and she had begun her meal. During an observation on 07/29/25 at 4:45 PM, LPN “J” asked Resident #14 if she was ready to eat, proceeded to move over to assist Resident #21 by opening her napkin with silverware and removed the top to the plate. LPN “J” proceeded to sit down with Resident #14 and Resident #21 to assist with their meals. In an interview on 07/29/25 at 4:41 PM, CNA “C” reported those residents who came to the 3500 hallway to eat meals were residents who needed assistance with meals. CNA “C” reported there were two other CNAs on the shift but they were on the other hallways still. In an interview on 07/29/25 at 4:48 PM. Dining Services R reported the meal plate should be placed with the resident who needs assistance when a staff member was seated and ready to assist the resident. The staff should not place a meal in front of resident who needed assistance because otherwise the food would get cold. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an admission Record revealed Resident #14 was a female with pertinent diagnoses which included dementia, protein-calorie malnutrition, anemia, and muscle weakness. Review of a Minimum Data Set (MDS) assessment for Resident #14, with a reference date of 7/9/25 revealed, Section GG: Functional Abilities and Goals .Eating: 02 - Substantial/maximal assistance…” Review of Care Plan dated 3/12/25 revealed the focus, .The resident has an ADL self-care performance deficit r/t Dementia and impaired mobility EATING: Extensive assistance x1 staff. Upright for all meals. Alternate small bites/sips. Needs encouragement at times, may wander away from table if meal is not served to her quickly . Review of Order: dated 5/23/25, revealed, .ST Recertification order: treatment 9 times/period for 3 weeks for continued skilled dysphagia therapy to complete therapeutic diet trials, skilled diet texture analysis, patient/staff education and training on use of compensatory swallow strategies . Review of Order dated 5/3/25, revealed, .Upright for all meals. alternate small bites and sips, supervision at meals with assist feeding as needed . Review of Order dated 5/2/25, revealed, .Regular diet, Pureed texture, Thin consistency 1:1 assist as needed, small bites, alternate bites and sips, straws OK, mech soft snacks OK (Banana, soft chocolate chip cookies) . During an observation on 7/28/25 at 9:36am, Resident #14 sat at a table in the common area with 4 peers. Resident #14’s breakfast sat in front of her, untouched, as her peers fed themselves or were assisted by staff. Resident #14 did not initiate eating on her own and occasionally glanced down at the food then glanced at her peers. During an observation on 7/28/25 at 9:45am, Resident #14 continued to sit at the table with her breakfast untouched in front of her. Staff were assisting other residents at the table, another resident continued to feed himself. During an observation on 7/28/25 at 9:50am, Director of Nursing (DON) “B” began assisting Resident #14 with eating. Resident #14 had sat with her breakfast in front of her but was not assisted with eating for at least 14 minutes. During an observation on 7/28/25 at 10:12am CNA “E” assisted Resident #14 by loading the resident’s spoon and brining the food to the resident’s mouth. CNA “E” was noted to be looking downward and was observed using a cellphone that sat on her lap. In a confidential meeting on 7/29/25 at 11:00am, 2 of 5 residents in attendance reported they witnessed staff using their personal cell phones while providing cares to residents. 1 resident voiced frustration and a feeling of decreased self-worth when she had to wait for care because staff were on their cellphones. Review of a Promoting/Maintaining Resident Dignity policy with a reference date of 9/15/24 revealed Policy: It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life .1. All staff members are involved in providing care to (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents to promote and maintain resident dignity .5. When interacting with a resident, pay attention to the resident as an individual .

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents maintained their right to self-determination for 1 resident (Resident #32), of 1 reviewed for choices, resulting in feelings of anxiety when staff did not wear a surgical mask while caring for the resident, despite her preference for them to do so.Findings include:Resident #32Review of an admission Record revealed Resident #32 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: history of falls.Review of a Minimum Data Set (MDS) assessment for Resident #32 with a reference date of 7/25/25, revealed a Brief Interview for Mental Status (BIMS) score of 11/15 which indicated Resident #32 was moderately cognitively impaired.Review of a Care Plan for Resident #32 with a reference date of 7/29/25, revealed a focus/goal/interventions of: Focus: Resident and family encourage visitors to resident's room utilizing hand sanitizer and PPE (personal protective equipment) before entering residents room. Goal: Resident preferences will be honored until the next review date. Interventions.visitor will be encouraged to comply with residents wishes.During an observation on 7/28/25 at 10:38am, a handwritten 8x10 sign posted on Resident #32's door read Anyone entering this room, please use hand sanitizer and wear a mask. During the observation, a cart containing surgical masks was noted outside the door. In an interview on 7/28/25 at 10:38am, Resident #32 reported she did not want to hurt anyone's feelings, but she preferred to have anyone who entered her room, including staff, use hand sanitizer and wear a surgical mask prior to entering because she was concerned about exposure to possible illnesses. Resident #32 reported she chose to implement the same precautions at home, prior to being admitted to the facility, because she wanted to limit her exposure to potential illnesses. Resident #32 stated you never know where someone has been or what they've been exposed to and I'm already dealing with enough. Resident #32 reported she was at the facility recovering from a fall at home, wanted to return home as soon as possible, and was worried that if she contracted an illness, it could delay her recovery. Resident #32 reported she felt uncomfortable when staff members didn't abide by her wishes regarding masking. In an interview on 7/29/25, at 10:30am, Family Member (FM) M reported Resident #32 chose to ask caregivers and visitors to use hand sanitizer and to wear a mask when they visited her at her home prior to her admission to the facility. FM M reported Resident #32 had expressed a preference to follow the same precautions while at the facility, and as a result, Resident #32's daughter placed the sign on the resident's door a few days earlier.During an observation on 7/28/25 at 11:00am, an unknown Certified Nursing Assistant (CNA) assisted Resident #32 out of the bathroom and then exited her room. The CNA was not wearing a mask while caring for Resident #32.During an observation on 7/29/25 at 1:14pm, the sign that indicated Resident #32 wanted everyone to use hand sanitizer and don a mask before entering her room remained on her door.During an observation on 7/29/25 at 1:15pm, Housekeeping (HSK) F performed light housekeeping tasks in Resident #32's room, while the resident was present. HSK F did not wear a mask while in Resident #32's room.During an observation on 7/29/25 at 1:29pm, Licensed Practical Nurse (LPN) H completed the administration of Resident #32's medications in the resident's room. LPN H did not wear a mask.Review of a Resident Rights Policy with a reference date of 9/20/24 revealed .This policy affirms the facility's responsibility to provide care that respects the dignity, autonomy, safety, and legal protections of every resident.5. Residents have the right to.participate in decisions regarding their care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their policy and Centers for Disease Prevention and Control (CDC) guidance to administer pneumococcal vaccinations to residents who consented for immunization, screen and assess residents for eligibility of receiving pneumococcal vaccinations, and offer pneumococcal vaccinations to residents who were eligible to receive it, for 1 of 5 (R19) residents reviewed for pneumococcal vaccinations, resulting in the potential for contracting the virus. Finding include:Review of the facility's Pneumococcal Vaccine policy revision date October 2023, revealed, Policy statement: All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Policy Interpretation and Implementation.upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility.According to the Minimum Data Set (MDS) dated [DATE], R19 was admitted [DATE] and had diagnoses that included dementia, heart disease, and malignant neoplasm of the prostrate. Review of R19's immunization record indicated the resident received Prevnar 13 on 5/14/2015 and no other pneumococcal immunization.During an interview on 7/29/25 at 4:01 PM, Infection Control Preventionist/Director of Nursing (ICP/DON) B stated, There is a resident that has been here since sometime in June 2025 that requires the PCV20 vaccine, and I have not ordered it yet. He needs it and should have it. He is in a compromised health status and would benefit from it.According to Centers of Disease Control (CDC) at www.cdc.gov . Follow the recommended immunization schedule to ensure that your patients get the pneumococcal vaccines that they need. On October 23, 2024, the Advisory Committee on Immunization Practices recommended a single dose of PCV for all adults aged ˆ50 years who are PCV-naive or who have unknown vaccination history.