

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Holland Home - Raybrook Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 Raybrook SE Grand Rapids, MI 49546	
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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2808946. Based on interview and record review the facility failed to notify the physician/designee and resident's responsible party in a timely manner of significant changes in condition for 2 residents (Resident #101 and #103) out of 6 residents reviewed, resulting in a delay in care for an acute basal ganglia hemorrhagic (bleeding in brain) stroke for Resident #101 when the physician was not notified immediately of an acute change in condition and delay in care for Resident #103 when his responsible party was not notified of a fall and an acute change in condition until the resident was being sent to the hospital 2 days later. Findings include: Resident #101 Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: hypertensive heart disease (heart condition caused by long-term high blood pressure). Review of Resident #101's Progress Note dated 3/1/26 at 9:07 AM written by Registered Nurse (RN) E revealed, CNA notified nurse that resident was lethargic, minimally responsive, and unable to sit on side of the bed. Resident opened eyes when name called but did not respond, unable to take AM medications. BS (blood sugar) 117, BP (blood pressure) 197/77, 102 (heart rate), 20 (respirations), 91% (blood oxygen level) on RA (room air), 101.2 (temperature). Notified on call physician (name redacted). Send to ER (emergency room) for evaluation. Review of Resident #101's Progress Note dated 2/28/26 at 10:03 PM written by RN I revealed, I spoke to resident's daughter (Family Member (FM) L). She was very concerned about resident's increased fatigue and low blood sugar; she had many questions and concerns about her care. She requested that resident's care plan be updated because resident is no longer as independent as she used to be and she will need someone to toilet her and help her get out of bed to keep her from falling. I reassured (FM L) that resident does receive help and staff is present to help with her needs. I told her to call (Nurse Manager (NM) C) if she had additional concerns. It was noted that the physician was not notified. Review of Resident #101's Progress Note dated 2/28/26 at 9:39 PM written by RN I revealed, per previous nurse, resident has been sleeping and did not have lunch. During shift, (FM L) visited and called me in to resident's room; she was trying to get resident out of bed, but resident was not following commands. I checked VS (vital signs) which were stable, BS (blood sugar) 101. I gave resident orange juice and stayed with her and daughter. She slowly became more responsive, she said she was feeling tired and wanted to sleep. BS increased to 145. Denied pain or discomfort. (FM L) was very concerned about resident; she called other family members (FM K), and they visited for a while. (Resident #101) ate supper but continued to be very sleepy. Review of Resident #101's Progress Note dated 2/28/26 at 1:47 PM written by Licensed Practical Nurse (LPN) G revealed, Lethargic this shift; did not wake up for lunch; BS of 96 in AM, 136 before lunch; VS are WNL (within normal limits) for her; has been sleeping in bed with both eyes closed; did come down for breakfast; poor appetite; did drink 50% of Glucerna (supplement); drank orange juice and had doughnut with hard-boiled egg; went to sleep shortly after; negative for Covid-19; will continue to monitor; will pass on to oncoming shift. It was noted that the physician was not notified. In an interview on 6/16/26 at 1:46 PM, LPN G reported that during first shift on 2/28/26 Resident #101 was lethargic, not speaking, (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	not eating well and would not get out of bed in the afternoon. LPN G reported that he had not worked with Resident #101 recently but normally the resident would walk to the dining room and fed herself. LPN G had received report from the previous shift that Resident #101 had not been feeling well. LPN G could not remember Resident #101's assessment and/or if the physician had been notified. In an interview on 6/16/26 at 4:21 PM, RN I reported that on 2/28/26 Family Member (FM) L reported that Resident #101 was not her usually self, was very tired, would not get out of bed and did not want to eat. RN I reported that she did a quick assessment and determined that Resident #101 was more tired than usual but RN I did not believe the resident's condition warranted contacting the physician. RN I reported that normally Resident #101 walked to the dining room for meals and fed herself, but that RN I had heard in report from the first shift nurse that Resident #101 was lethargic and did not get up for meals that day. RN I reported that she checked Resident #101's vital signs and they were normal and further explained that she only recorded vital sign results if they were abnormal. In an interview on 6/16/26 at 2:14 PM, RN E reported that she was told in report on 3/1/26 that Resident #101 was not doing well and needed assistance with care. RN E reported that she was notified by staff that Resident #101 was super weak, wouldn't talk, and wasn't able to stand. RN E reported that she assessed Resident #101 and the resident was not at her baseline; she was not responsive, had food in her mouth, and could only partially open her eyes. RN E reported that she checked Resident #101's vital signs and then sent the resident to the hospital. In an interview on 6/17/26 at 11:30 AM, Nurse Manager (NM) C reported that she was not aware of any changes to Resident #101's health prior to the resident's hospitalization on 3/1/26; NM C had heard that Resident #101 had passed away but had not reviewed the hospitalization any further. NM C reported that the nurse and/or CNA should have contacted the manager on call and the physician when they noticed Resident #101 change of condition on the morning of 2/28/26. In an interview on 6/17/26 at 3:21 PM, Primary Care Physician (PCP) J reported that the last he knew, Resident #101 was doing fine and was her normal self. PCP J reported that he was not notified when Resident #101 became lethargic, wouldn't eat, talk and/or walk on 2/28/26. PCP J reported that he would have expected staff to notify him to get further recommendations. In an interview on 6/18/26 at 9:01 AM, FM K reported that on 2/28/26 FM L talked to a nurse and tried to relay her concerns about Resident #101's condition and the nurse did not take it seriously. Therefore, FM K called the facility later that evening and explained to RN I herself, that the family thought something was seriously wrong with Resident #101; FM K reported the nurse blew her off. Resident #103 Review of an admission Record revealed Resident #103 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: parkinson's (a brain disorder that causes problems with movement) and dementia (abnormal changes in the brain that causes loss of memory, language, problem solving, etc). Review of Resident #103's Progress Note dated 5/12/26 at 3:25 PM written by RN E revealed, CNA notified nurse upon arrival that resident was vomiting and didn't look well. VS (vital signs) 155/70, 99.8 (temperature), 107 (heart rate), 26 (respirations), 87% (oxygen saturation in blood) on RA, BS 118. Resident clammy, applied 2L of oxygen via nasal cannula. Resident bladder scanned for >700 (milliliters). Cathed (catheterized: draining urine from bladder) for 800 ml. Urine dark amber, no odor. Resident denies frequency, urgency or dysuria. Resident no void throughout the night. Notified (on call provider) with ok to send to ER. Review of Resident #103's relevant Progress Notes prior to hospitalization: 5/12/26 at 6:37 AM: No void this shift. Bladder scan for 733 ml. Unable to st (straight) cath (blockage). Waiting for doctor to call back. 5/12/26 at 5:26 AM: Resident had a medium emesis this shift. 5/12/26 at 5:24 AM: Unable to obtain CBC (complete blood count blood draw), resident moving around a lot, then said no. Incontinent this shift. 5/12/26 at 1:40 AM: Continues on UTI monitoring. No complaints at this time. Fall vitals wnl (within normal limits). Right eye slightly dilated. Dr aware. 5/11/26 at 11:06 PM: Received call from (Medical Director (MD) Q), I went over resident's new symptoms of emesis, abnormal pupillary response, recent unwitnessed fall and elevated WBC count. Per provider continue monitoring, repeat vital signs q (every) shift, repeat CBC in the morning. 5/11/26 at 10:56 PM: Shortly after speaking to on call provider, CNA (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	notified me that resident had vomited. As we were sitting resident up to get him changed, he threw up a large amount of brownish liquid. BP 170/80, pulse 100, pulse ox 95% on room air, temperature 99.0. Pupils sluggish and right greater than left. I called on call again and reported new findings to (NP). She will notify provider and he will return call with further direction.5/11/26 at 10:14 PM: Elevated WBC of 17.1, paged on call provider and spoke to (NP). Resident does not have any clear symptoms of UTI but due to elevated WBC we'll need to place order for UA reflex culture. Continue monitoring resident and call again with any s/s (signs and symptoms) of infection.5/11/26 at 10:03 PM: Resident on UTI monitor for lethargy, decreased appetite, and suprapubic pain. VS WNL, no fever. Resident denies pain yet groans when he readjusts in bed. He also had an episode of emesis earlier today after receiving medications. No further episodes witnessed. He continues on fall charting after unwitnessed fall yesterday. CBC results still pending.5/11/26 at 6:57 PM: Resident started on UTI monitor. VSS (vital signs stable) Temperature 99.1, lethargic and c/o (complaint of) suprapubic pain when touched. Poor appetite. Urine dark yellow no c/o urgency, frequency or dysuria (painful urination) noted. CBC drawn, results pending.5/10/26 at 3:00 AM: Post Fall Evaluation. Fall was not witnessed. Fall occurred in the resident's room. Resident was attempting to self toilet at the time of fall. Resident was using incontinence supplies at time of fall. In an interview on 6/16/26 at 2:09 PM, RN E reported that the day before Resident #103 was sent to the hospital he was lethargic, did not get up for lunch, had vomited in the afternoon, and was started on a UTI (urinary tract infection) watch. RN E reported that when she came in the next day she was told in report that Resident #103 had not urinated during the night and that his bladder scan showed urine in the bladder. In an interview on 6/17/26 at 9:28 AM, LPN P that on 5/12/26 very early in the morning (third shift) the CNA's had reported Resident #103 had not voided during the night. LPN P reported that she used the bladder scan and saw there was urine in the bladder, but she wasn't able to catheterize Resident #103 to drain the bladder. LPN P reported that she knew something was going on with Resident #103 but she would have to look at her documentation because it was too long ago. This surveyor read the documentation to LPN P and she replied that must be what happened then. In an interview on 6/17/26 at 12:10 PM, NM C reported that Resident #103 had an unwitnessed fall during the night on 5/10/26 which is a sign of UTI. NM C continued by saying that the next day Resident #103 had a low grade fever, vomiting, was lethargic and refusing to walk therefore, a UTI monitoring was ordered which included a blood draw. NM C reported that the WBC (white blood cell, which is an indicator for infection) was high. NM C reported that from the documentation, the nurse contacted the doctor a couple times to update about symptoms and Medical Director (MD) Q recommended to continue monitoring the resident and recheck blood work in the morning. In an interview on 6/18/26 at 2:18 PM, Family Member (FM) M reported that she was never contacted about Resident #103's fall on 5/10/26 and was not aware that he was being monitored or tested for a UTI, until 5/12/26 when NM C called to report they would be sending Resident #103 to the hospital because they thought he was septic (systemic life threatening condition due to infection) due to a UTI. In an interview on 6/18/26 at 2:49 PM, NM C reported that it did not appear from documentation that Resident #103's responsible party FM M had been notified about the resident becoming ill, having emesis and getting his blood drawn. Review of the facility policy Change in resident's condition dated March 2023 revealed, .The resident and/or resident representative and attending physician/designee are notified when the resident's condition, treatment, or status changes, in accordance with regulatory requirements. PROCEDURES: 1. Immediate and Prompt Notifications: a. The nurse/designee will immediately inform the resident, resident's physician and resident representative-consistent with his/her authority-when there is: .ii. a significant change in the resident's physical, mental, or psychosocial status that is a deterioration in the health, mental, or psychosocial status in either life-threatening conditions or clinical complication . c. The nurse/designee will notify the resident, resident's physician and the resident representative for non-immediate changes of condition. d. The nurse will document the notification and record any new orders in the resident's medical record .		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2808946. Based on interview and record review, the facility failed to ensure residents received care in accordance with professional standards in 3 residents (Resident #101, #103 & #106) of 6 residents reviewed for quality of care, resulting in an immediate jeopardy for 1 resident (Resident #101) when, beginning on 2/28/26 at approximately 8:00 AM, Resident #101 had an acute change of condition and staff failed to accurately assess, monitor and notify the physician, resulting in Resident #101 being transported to the hospital on 3/1/26 (approximately 24 hours later) due to unresponsiveness, hypertensive (high blood pressure) and fever. Resident #101 was evaluated and diagnosed with an acute basal ganglia hemorrhagic (bleeding in brain) stroke, admitted to the hospital and died on 3/8/26. This deficient practice placed all residents at risk for serious harm, injury and/or death. The facility also failed to identify symptoms of a UTI (urinary tract infection) for Resident #103 resulting in harm when Resident #103 did not receive prompt treatment leading to death from severe sepsis and acute kidney failure. The facility failed to adequately monitor and assess Resident #106 after an acute change in condition was identified on 6/18/26. Findings include: The immediate jeopardy began on 2/28/26 and was identified on 6/17/26 due to the facility's failure to accurately assess and identify an acute change in condition for Resident #101 and notify the physician, resulting in a delay in medical treatment and death due to an acute hemorrhagic stroke. On 6/17/26 at 4:35 PM, the Director of Nursing (DON) B was verbally notified and the Nursing Home Administrator (NHA) A received written notification of the Immediate Jeopardy. The surveyor confirmed that the immediate Jeopardy was removed on 6/18/26 but noncompliance remains at the scope of isolated and severity of actual harm due to not all staff had received the education and sustained compliance has not been verified by the State Agency. Resident #101 Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: hypertensive heart disease (heart condition caused by long-term high blood pressure). Review of Resident #101's Care Plan last revised 11/9/25 revealed, .I require assistance to maintain my self-care related to my cognitive deficits, poor safety insight with need for assistance with dressing, transfers, toileting, and ambulation. Interventions: Bed mobility (rolling from side to side in bed): supervision. Dressing: one person assistance, Eating: set up & supervision. Showers: one assist with bathing. Ambulate to/from the gym using 4 WW (wheeled walker). Review of Resident #101's Hospital Records revealed, History of Present Illness: .presents with altered mental status. Her family saw her on Friday (2/27/26) and they say she was in her normal state of health. On Saturday, they felt she was more tired than normal. They expressed concern to the staff and requested she be watched more closely. This morning the facility called as she was difficult to wake up. She has also been experiencing fevers since yesterday. Her blood pressure upon arrival to ED (emergency department was 230/88. CT (detailed x-ray) imaging showed acute basal ganglia hemorrhage (a life threatening type of stroke where a blood vessel ruptures inside the brain most commonly caused by high blood pressure) .Discussed level of disability she will likely have due to the IPH (Intraparenchymal hemorrhage is a type of stroke that involves bleeding directly into the functional tissue of the brain) and that she will likely have a new cognitive baseline. Also discussed increased morbidity and mortality with IPH. Hospital Course: .On the morning of 3/7 patient was noted to have posturing (stiffness and jerking of the body) after multiple episodes of vomiting overnight, tube feeds were held at that time and repeat head CT without contrast was obtained which showed new intraparenchymal hemorrhage with possible active bleed. She was transferred back to the ICU and neurosurgery was reengaged however there was no surgical intervention indicated at that time. After this event family wished to proceed with comfort and hospice measures and she was subsequently transferred out of the ICU to the general floor. Patient was pronounced expired at 0129 on 3/8/20/2026. Review of EMS report dated 3/1/26 revealed, .Call received: 9:28 AM. On scene: 9:47 (continued on next page)		

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Reason for transfer: Unresponsive.Usual Functional status before the acute change of condition: ambulates with assistive device.Usual mental status/Cognitive Function before the acute change of condition: Alert, disoriented, but can follow simple instructions.Review of Resident #101's Progress Note dated 3/1/26 at 9:07 AM written by RN E revealed, CNA notified nurse that resident was lethargic, minimally responsive, and unable to sit on side of the bed. Resident opened eyes when name called but did not respond, unable to take AM medications. BS (blood sugar) 117, BP (blood pressure) 197/77, 102 (heart rate), 20 (respirations), 91% (blood oxygen level) on RA (room air), 101.2 (temperature).Notified on call physician (name redacted). Send to ER (emergency room) for evaluation.Review of Resident #101's Progress Note dated 2/28/26 at 10:03 PM written by RN I revealed, I spoke to resident's daughter (Family Member (FM) L). She was very concerned about resident's increased fatigue and low blood sugar; she had many questions and concerns about her care. She requested that resident's care plan be updated because resident is no longer as independent as she used to be and she will need someone to toilet her and help her get out of bed to keep her from falling. I reassured (FM L) that resident does receive help and staff is present to help with her needs. I told her to call (Nurse Manager (NM) C) if she had additional concerns. It was noted that the physician was not notified.Review of Resident #101's Vital Signs Record revealed the last documented blood pressure, heart rate, respirations or O2 saturation documented was on 2/22/26.Review of Resident #101's Progress Note dated 2/28/26 at 9:39 PM written by RN I revealed, per previous nurse, resident has been sleeping and did not have lunch. During shift, (FM L) visited and called me in to resident's room; she was trying to get resident out of bed, but resident was not following commands. I checked VS (vital signs) which were stable, BS (blood sugar) 101. I gave resident orange juice and stayed with her and daughter. She slowly became more responsive, she said she was feeling tired and wanted to sleep. BS increased to 145. Denied pain or discomfort. (FM L) was very concerned about resident; she called other family members (FM K), and they visited for a while. (Resident #101) ate supper but continued to be very sleepy.Review of Resident #101's Progress Note dated 2/28/26 at 1:47 PM written by Licensed Practical Nurse (LPN) G revealed, Lethargic this shift; did not wake up for lunch; BS of 96 in AM, 136 before lunch; VS are WNL (within normal limits) for her; has been sleeping in bed with both eyes closed; did come down for breakfast; poor appetite; did drink 50% of Glucerna (supplement); drank orange juice and had doughnut with hard-boiled egg; went to sleep shortly after; negative for Covid-19; will continue to monitor; will pass on to oncoming shift. It was noted that the physician was not notified.In an interview on 6/16/26 at 1:46 PM, LPN G reported that during first shift on 2/28/26 Resident #101 was lethargic, not speaking, not eating well and would not get out of bed in the afternoon. LPN G reported that he had not worked with Resident #101 recently but normally the resident would walk to the dining room and fed herself. LPN G had received report from the previous shift that Resident #101 had not been feeling well. LPN G could not remember Resident #101's assessment and/or if the physician had been notified.In an interview on 6/16/26 at 4:21 PM, RN I reported that on 2/28/26 Family Member (FM) L reported that Resident #101 was not her usually self, was very tired, would not get out of bed and did not want to eat. RN I reported that she did a quick assessment and determined that Resident #101 was more tired than usual but RN I did not believe the resident's condition warranted contacting the physician. RN I reported that normally Resident #101 walked to the dining room for meals and fed herself, but that RN I had heard in report from the first shift nurse that Resident #101 was lethargic and did not get up for meals that day. RN I reported that she checked Resident #101's vital signs and they were normal and further explained that she only recorded vital sign results if they were abnormal.In an interview on 6/17/26 at 3:00 PM, RN D reported that she had worked third shift the night before Resident #101 was (continued on next page)		

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In an interview on 6/16/26 at 2:24 PM, Certified Nursing Assistant (CNA) N reported that staff had been talking about Resident #101 not acting like herself for a couple days; she was not smiling, not walking, not talking and the nurses did not take it seriously. In an interview on 6/17/26 at 2:33 PM, CNA F reported that he had worked with Resident #101 the day before she went to the hospital; she was slouched at the table, would not eat and slept all day. CNA F notified LPN G that Resident #101 did not seem like herself; normally the resident walked, talked, smiled and gave hugs. CNA F reported that he did not see anyone take vitals signs on Resident #101. In an interview on 6/17/26 at 2:22 PM, Restorative CNA (R-CNA) H reported that on 2/28/26 she did not even attempt to work with Resident #101 because staff had informed her that the resident had not gotten out of bed and had not eaten breakfast. R-CNA H reported that just a few days before that, Resident #101 was constantly walking and wanting to be up and around; it was unusual for the resident to be in bed during the day. In an interview on 6/17/26 at 11:30 AM, Nurse Manager (NM) C reported that she was not aware of any changes to Resident #101's health prior to the resident's hospitalization on 3/1/26; NM C had heard that Resident #101 had passed away but had not reviewed the hospitalization any further. NM C reported that Resident #101 had fallen in early February but last she knew, the resident was still walking around and at baseline. NM C reported that Resident #101 was taking a lot of medications for her heart and blood pressure and ideally would have been having her vital signs checked daily. NM C reported that the most recent vital signs documented prior to her hospitalization, were on 2/22/26; NM C noted that vital sign results should always be documented and not written as within normal limits. NM C reported that the Intradisciplinary Team reviewed Resident #101 on 2/24/26 and did not find any changes in her condition; documentation by staff did not reflect any changes to Resident #101 prior to 2/28/26. NM C reported that the nurse and/or CNA should have contacted the manager on call and the physician when they noticed Resident #101 change of condition on the morning of 2/28/26. In an interview on 6/17/26 at 3:21 PM, Primary Care Physician (PCP) J reported that the last he knew, Resident #101 was doing fine and was her normal self. PCP J reported that he was not notified when Resident #101 became lethargic, wouldn't eat, talk and/or walk on 2/28/26. PCP J reported that he would have expected staff to notify him to get further recommendations; adding that Resident #101's blood pressure would be an important assessment due to her history of heart problems. In an interview on 6/18/26 at 9:01 AM, FM K reported that on 2/28/26 FM L talked to a nurse and tried to relay her concerns about Resident #101's condition and the nurse did not take it seriously. Therefore, FM K called the facility later that evening and explained to RN I herself, that the family thought something was seriously wrong with Resident #101; FM K reported the nurse blew her off. On 6/18/26, this surveyor verified the facility completed the following to remove the Immediate Jeopardy: 1) Resident #101 no longer resides at the facility. 2) On June 17 and June 18 the Director of Nursing and the IDT reviewed current residents for any significant change identified. Physicians are to be notified, and orders received to be implemented for any changes of condition. 3) A. Director of Nursing initiated an in-service on 6-18-2026 for licensed nurses and certified nurse aides. Licensed nurses call Nurse Manager and the On Call Physician for any resident demonstrating a change of condition including lethargy, increased fatigue, s/s of stroke, and changes to activities of daily living. Certified nurse aides to utilize the chain of command in reporting change of condition to licensed nurse, nurse manager, then director of nursing. This in-service will continue for (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Holland Home - Raybrook Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 Raybrook SE Grand Rapids, MI 49546	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	each shift until all nurses and certified nurse aides are in-serviced. As of 6-18-2026, 26 of 128 licensed nurses and/or certified nurse aides have been educated. No staff will be allowed to work without having received education.B. On June 17 the Executive Director reviewed the Change of Condition policy. No changes were needed for the Change in Condition Policy.C. On 6-18-2026 interviews with nurses to determine that licensed nurses a) understand the Change of Condition policy and b) can list the symptoms of changes of condition requiring notification. These interviews will be conducted randomly at least 5X each week by the Director of Nursing or Designee until substantial compliance is achieved.D. The interdisciplinary team will continue to review resident changes of condition in morning meeting to determine if appropriate notifications and interventions were implemented for any significant changes in condition.The facility alleges the immediacy with the deficient practice has been removed on June 18, 2026. Although the immediate jeopardy was removed on 6/18/2026, the facility remained out of compliance with a scope of isolated and severity of no actual harm with the potential for more than minimal harm that is not immediate jeopardy due to all staff had not received the in-service education and sustained compliance had not yet been verified by the state agency. Resident #103Review of an admission Record revealed Resident #103 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: parkinson's (a brain disorder that causes problems with movement) and dementia (abnormal changes in the brain that causes loss of memory, language, problem solving, etc). Review of Resident #103's Hospital Records revealed, .Arrival Date/Time: 5/12/26 at 11:01AM. Hospital Course: .concerns for UTI/Sepsis. Brought in by EMS from his nursing home with concerns for decreased alertness and concern for sepsis. Nursing home staff were concerned that he was dealing with a urinary tract infection and was becoming less alert. On route, he went into ventricular tachycardia (fast abnormal heart rhythm) and was unresponsive but still had a pulse. WBC 25.1. Urine Culture: >=100,000 CFU/mL Enterococcus faecalis (an abnormal bacteria found in the urine). Hyperkalemia (condition where potassium level is too high in the blood), V-tach (ventricular tachycardia), Uremia (a life threatening condition where kidneys fail to filter waste from the body), Altered mental status, Pneumonia (an infection in the lungs) of right lower lobe (a part of the lung) due to infectious organism, Sepsis with acute organ dysfunction and septic shock (dangerously low blood pressure and widespread organ failure due to an infection), due to unspecified organism. date of death : 5/16/26.Review of Resident #103's Progress Note dated 5/12/26 at 3:25 PM written by RN E revealed, CNA notified nurse upon arrival that resident was vomiting and didn't look well. VS (vital signs) 155/70, 99.8 (temperature), 107 (heart rate), 26 (respirations), 87% (oxygen saturation in blood) on RA, BS 118. Resident clammy, applied 2L of oxygen via nasal cannula. Resident bladder scanned for >700 (milliliters). Cathed (catheterized: draining urine from bladder) for 800 ml. Urine dark amber, no odor. Resident denies frequency, urgency or dysuria. Resident no void throughout the night. Notified (on call provider) with ok to send to ER.Review of Resident #103's Transfer to the Hospital document revealed, .Date of Transfer: 5/12/26 at 9:44 AM.Reason for transfer: abnormal white blood cell count (high). HR (heart rate) 107, RR (respiratory rate) 26, Temp 99.8, O2 sat 87.Pain location: abdomen.Usual functional status before the acute change in condition: ambulates with human assistance.Usual mental status/cognitive function before the acute change in condition: Alert, disoriented, but can follow simple instructions.Review of Resident #103's Change of Condition Evaluation dated 5/12/26 at 9:34 AM revealed, .continued vomiting, low O2 (oxygen), increased pulse, urinary retention (not able to urinate).Review of Resident #103's relevant Progress Notes prior to hospitalization: 5/12/26 at 6:37 AM: No void this shift. Bladder scan for 733 ml. Unable to st (straight) cath (blockage). Waiting for doctor to call back.5/12/26 at 5:26 AM: Resident had a medium emesis this shift.5/12/26 at 5:24 AM: Unable to obtain CBC (complete blood count blood draw), resident moving around a lot, then said no. Incontinent this shift.5/12/26 at 1:40 AM: Continues on UTI monitoring. No complaints at this time. Fall vitals wnl (within normal limits). Right eye slightly dilated. Dr aware.5/11/26 at 11:06 PM: Received call from (MD Q), I went over resident's new symptoms of emesis, abnormal pupillary response, recent (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	unwitnessed fall and elevated WBC count. Per provider continue monitoring, repeat vital signs q (every) shift, repeat CBC in the morning.5/11/26 at 10:56 PM: Shortly after speaking to on call provider, CNA notified me that resident had vomited. As we were sitting resident up to get him changed, he threw up a large amount of brownish liquid. BP 170/80, pulse 100, pulse ox 95% on room air, temperature 99.0. Pupils sluggish and right greater than left. I called on call again and reported new findings to (NP). She will notify provider and he will return call with further direction.5/11/26 at 10:14 PM: Elevated WBC of 17.1, paged on call provider and spoke to (NP). Resident does not have any clear symptoms of UTI but due to elevated WBC we'll need to place order for UA reflex culture. Continue monitoring resident and call again with any s/s (signs and symptoms) of infection.5/11/26 at 10:03 PM: Resident on UTI monitor for lethargy, decreased appetite, and suprapubic pain. VS WNL, no fever. Resident denies pain yet groans when he readjusts in bed. He also had an episode of emesis earlier today after receiving medications. No further episodes witnessed. He continues on fall charting after unwitnessed fall yesterday. CBC results still pending.5/11/26 at 6:57 PM: Resident started on UTI monitor. VSS (vital signs stable) Temperature 99.1, lethargic and c/o (complaint of) suprapubic pain when touched. Poor appetite. Urine dark yellow no c/o urgency, frequency or dysuria (painful urination) noted. CBC drawn, results pending.5/10/26 at 3:00 AM: Post Fall Evaluation. Fall was not witnessed. Fall occurred in the resident's room. Resident was attempting to self toilet at the time of fall. Resident was using incontinence supplies at time of fall. In an interview on 6/17/26 at 1:37 PM, MD Q reported that Resident #103 was on UTI monitoring prior to hospitalization, which consists of drawing blood, checking vital signs, pushing fluids, and looking for specific symptoms such as dysuria, frequent urination, urgent urination, and urine odor. MD Q reported that Resident #103's blood work clearly met the criteria for a UTI, he had abdominal pain, but he did not have any other criteria to indicate he needed treatment for a UTI. MD Q reported that the staff would need to closely watch behaviors for toileting and incontinence for a resident with dementia to determine if that would meet the UTI measure of frequent or urgent urination. MD Q reported that Resident #103's fall was unspecific and did not point to a UTI or head injury concern. MD Q reported that Resident #103's symptoms were not concerning enough to warrant further evaluation, until he was not able to void and was short of breath. In an interview on 6/16/26 at 2:09 PM, RN E reported that the day before Resident #103 was sent to the hospital he was lethargic, did not get up for lunch, had vomited in the afternoon, and was started on a UTI (urinary tract infection) watch. RN E reported that when she came in the next day she was told in report that Resident #103 had not urinated during the night and that his bladder scan showed urine in the bladder. RN E reported that the CNA's were doing morning rounds and reported that he was not doing well. RN E said that Resident #103's skin was pale, he was shaking and had vomited in bed. RN E reported that the in-house Nurse Practitioner (NP) assessed Resident #103 and sent him to the hospital. In an interview on 6/16/26 at 2:20 PM, CNA N reported that when she went in to check on Resident #103 during morning rounds on 5/12/26; he was breathing hard, sweaty and his face, neck and behind his head was covered in black emesis. CNA N notified RN E and started to clean Resident #103. In an interview on 6/17/26 on 3:10 PM, RN D reported that Resident #103 was very prideful; he always denied needing assistance and/or having pain. RN D reported that staff had to assess his pain in other physical ways because he did not ever complain. In an interview on 6/17/26 at 8:20 PM, CNA O reported that Resident #103 had black vomit on him and was having trouble breathing when they entered his room at approximately 7:30 AM on 5/12/26. CNA O said that the third shift CNA's did not mention any concerns about Resident #103 during report and CNA O was not aware that Resident #103 was being monitored for a UTI. CNA O had noticed for about a week that Resident #103 was more irritable, refusing care, got angry with staff; normally Resident #103 was very sweet and kind to staff. CNA O reported that Resident #103 was in the bathroom a lot and constantly removing his incontinence brief. In an interview on 6/17/26 at 9:28 AM, LPN P that on 5/12/26 very early in the morning (third shift) the CNA's had reported Resident #103 had not voided during the night. LPN P reported that she used the bladder scan and saw there was urine in the (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	bladder, but she wasn't able to catheterize Resident #103 to drain the bladder. LPN P reported that she knew something was going on with Resident #103 but she would have to look at her documentation because it was too long ago. This surveyor read the documentation to LPN P and she replied that must be what happened then. In an interview on 6/17/26 at 12:10 PM, NM C reported that Resident #103 had an unwitnessed fall during the night on 5/10/26 which is a sign of UTI. NM C continued by saying that the next day Resident #103 had a low grade fever, vomiting, was lethargic and refusing to walk therefore, a UTI monitoring was ordered which included a blood draw. NM C reported that the WBC (white blood cell, which is an indicator for infection) was high. NM C reported that from the documentation, the nurse contacted the doctor a couple times to update about symptoms and Medical Director (MD) Q recommended to continue monitoring the resident and recheck blood work in the morning. In an interview on 6/17/26 at 2:37 PM, CNA F reported that Resident #103 frequently changed his own incontinence brief and took himself to the bathroom. CNA F reported that staff would have to monitor Resident #103 for appropriate incontinence hygiene and assist him to the bathroom due to his gait being unsteady. In an interview on 6/17/26 at 3:39 PM, PCP J reported that Resident #103's fall on 5/10/26, his low grade fever, complaints of suprapubic (area of abdomen near bladder) pain, emesis (vomit), abnormal pupils (part of the eye that is assessed to ensure the nervous system is functioning properly) and WBC indicating infection are all indicative of a UTI. PCP J reported that and even when specific criteria for UTI is not met, treatment could still be started, and then documentation that the benefits of treating the resident outweighed the risks of not treating would be completed by the physician. PCP J was not the provider that was on-call and contacted regarding Resident #103's symptoms. In an interview on 6/18/26 at 2:18 PM, FM M reported that she was never contacted about Resident #103's fall on 5/10/26 and was not aware that he was being monitored or tested for a UTI, until 5/12/26 when NM C called to report they would be sending Resident #103 to the hospital because they thought he was septic (systemic life threatening condition due to infection) due to a UTI. FM M reported that she waited 90 minutes for Resident #103 at the hospital and when she called back, NM C reported that they were still doing the paperwork. FM M reported that Resident #103 went into cardiac arrest on the way to the hospital and never recovered; he passed away on 5/16/26. FM M reported that Resident #103 did not have a history of frequent UTI's and did not complain about anything, adding that the staff would have to be paying attention to other cues to identify a UTI. In an interview on 6/18/26 at 2:49 PM, NM C reported that it did not appear from documentation that Resident #103's responsible party FM M had been notified about the resident becoming ill, having emesis and getting his blood drawn. Resident #106 Review of an admission Record revealed Resident #106 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: severe dementia. In an interview on 6/18/26 at 11:45 AM, RN E reported that she had just observed Resident #106 breathing hard and wheezing, so she notified the provider and family; the provider gave an order to send Resident #106 to the hospital for evaluation but the family would like her to stay in the facility and be treated first before going to the hospital. RN E reported that she had given Resident #106 a breathing treatment and the provider ordered lab work to be completed right away. Review of Resident #106's Progress Note dated 6/18/26 at 12:07 PM revealed, Resident in living area near TV, heard breathing noises. Observed resident who was tachypneic (rapid and shallow breathing). VS (vital signs) BP 186/74, 90 (heart rate), 36 (respirations), 92% (oxygen in blood) on RA (room air), temperature 98.2. Applied 2 L (liters) O2 (oxygen) via nasal cannula (tubing placed at base on nose) for comfort and administered Duoneb (a breathing treatment to open airway and reduce mucus) treatment via mask. Notified (NP) with N.O. (new order) to send to ER to eval. CBC (complete blood count lab order) and CMP (comprehensive blood test) stat (immediately) as well as STAT 2 view x-ray ordered. Son called back and stated that resident was sent out to a dermatologist appointment and it went really badly for her and doesn't think sending her out is the best option. (RN E) Stated we are able to do testing and treatment here while keeping her comfortable. Son stated he wanted to start with that and see what comes from the (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	CXR (chest x-ray) and labs. Review of Resident #106's Progress Note dated 6/18/26 at 3:59 PM revealed, order note: .Azithromycin Tablet 250 mg. for infection. Review of Resident #106's Progress Note dated 6/18/26 at 7:01 PM revealed, CXR and lab results back. Labs WNL, CXR with pneumonia. (NP) notified. Resident 92% on RA. Son notified. It was noted that Resident #106 did not have any progress notes or vital signs recorded for approximately 24 hours, between 7:01 PM on 6/18/26 and 6:07 PM on 6/19/26. Review of Resident #106's Progress Note dated 6/19/26 at 6:07 PM revealed, Resident continues on (antibiotic) for PNA (pneumonia). No adverse side effects noted at this time. VSS. LS (lung sounds) diminished throughout. No crackles or wheezing heard. O2 sat 92% via RA. Resting in bed at this time. Review of Resident #106's Progress Note dated 6/20/26 at 1:54 PM revealed, Resident continues on oral antibiotics with no adverse effects noted. Resident remains afebrile with stable VS. It was noted that Resident #106 did not have any progress notes and or vital signs recorded for greater than 24 hours, between 1:54 PM on 6/20/26 to 7:08 PM on 6/21/26. Review of Resident #106's Progress Note dated 6/21/26 at 7:08 PM written by LPN G revealed, (Resident #106) during dinner started wheezing and blowing snot out of nose. Vitals taken that were as follows: BP 134/75, P (heart rate) 74, T (temperature) 97. RR 22, SpO2 74% RA; started to break out in sweats, put on O2 at 2L per PRN order, put in bed, called on-call (MD Q) with symptoms that ordered VS q (every) shift x 3 days, chest x-ray 2 views, and CBC with CMP for tomorrow. Called DPOA/Son to update on change of condition, stated to send her to hospital if needed, retook VS that were as follows: BP 128/72, P 71, T 97.2, RR 18, SpO2 91% 2L via nasal cannula, will continue to monitor and pass on to oncoming shift. Review of Resident #106's Progress Note dated 6/21/26 at 10:30 PM written by LPN G revealed, (Resident #106) was diaphoretic, cold to touch, lethargic, VS were as follows: BP 135/74, P 71, RR 24, BS 328, T 96 forehead, SpO2 74% 2L O2 via nasal cannula, called 911 for pick up, notified son earlier in night that she may be sent out and he said to send if she needs to be sent, notified on-call (MD Q) that she is being sent out D/T (due to) symptoms present, he stated to send out, notified manager on-call (NM R). Review of Resident #106's Vital Signs Record revealed results from 6/21/26 at 10:40 PM; 6/20/26 at 4:07 PM, 12:46 PM and 12:17 AM; and 6/19/26 at 4:05 PM. There were no results entered for 6/18/26. Review of Resident #106's Hospital Records revealed, .Arrival date/time: 6/21/26 at 11:32 PM. Discharge Summary note: .Sepsis (life threatening response to infection). On arrival she was found to be hypoxic (lack of oxygen to tissue and cells), hypertensive (high blood pressure), and severely hypothermic (low body temperature that can cause vital organs to fail), with unresponsiveness to voice and pain. Initial evaluation revealed leukocytosis (a sign the body is responding to an underlying infection), lactic acidosis (high acidity in the bloodstream due to inadequate oxygen), severe respiratory acidosis (lungs cannot remove carbon dioxide from your body causing body fluids to become too acidic), and acute kidney injury (sudden kidney failure). Chest x-ray. concerning for edema (fluid accumulation in the lungs) versus pneumonia (infection		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document vital signs during acute changes in condition for 2 residents (Resident #101 and #106) of 6 residents reviewed for complete and accurate medical record documentation, resulting in the potential for staff and providers mismanaging care for residents. Findings include: Resident #101 Review of an admission Record revealed Resident #101 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: hypertensive heart disease (heart condition caused by long-term high blood pressure). Review of Resident #101's Progress Note dated 3/1/26 at 9:07 AM written by Registered Nurse (RN) E revealed, CNA notified nurse that resident was lethargic, minimally responsive, and unable to sit on side of the bed. Resident opened eyes when name called but did not respond, unable to take AM medications. BS (blood sugar) 117, BP (blood pressure) 197/77, 102 (heart rate), 20 (respirations), 91% (blood oxygen level) on RA (room air), 101.2 (temperature). Notified on call physician (name redacted). Send to ER (emergency room) for evaluation. Review of Resident #101's Progress Note dated 2/28/26 at 10:03 PM written by RN I revealed, I spoke to resident's daughter (Family Member (FM) L). She was very concerned about resident's increased fatigue and low blood sugar; she had many questions and concerns about her care. She requested that resident's care plan be updated because resident is no longer as independent as she used to be and she will need someone to toilet her and help her get out of bed to keep her from falling. I reassured (FM L) that resident does receive help and staff is present to help with her needs. I told her to call (Nurse Manager (NM) C) if she had additional concerns. Review of Resident #101's Vital Signs Record revealed the last documented blood pressure, heart rate, respirations or O2 saturation documented was on 2/22/26. Review of Resident #101's Progress Note dated 2/28/26 at 9:39 PM written by RN I revealed, per previous nurse, resident has been sleeping and did not have lunch. During shift, (FM L) visited and called me in to resident's room; she was trying to get resident out of bed, but resident was not following commands. I checked VS (vital signs) which were stable, BS (blood sugar) 101. I gave resident orange juice and stayed with her and daughter. She slowly became more responsive, she said she was feeling tired and wanted to sleep. BS increased to 145. Denied pain or discomfort. (FM L) was very concerned about resident; she called other family members (FM K), and they visited for a while. (Resident #101) ate supper but continued to be very sleepy. Review of Resident #101's Progress Note dated 2/28/26 at 1:47 PM written by Licensed Practical Nurse (LPN) G revealed, Lethargic this shift; did not wake up for lunch; BS of 96 in AM, 136 before lunch; VS are WNL (within normal limits) for her. In an interview on 6/16/26 at 4:21 PM, RN I reported that on 2/28/26 Family Member (FM) L reported that Resident #101 was not her usually self, was very tired, would not get out of bed and did not want to eat. RN I reported that she did a quick assessment and determined that Resident #101 was more tired than usual but RN I did not believe the resident's condition warranted contacting the physician. RN I reported that she checked Resident #101's vital signs and they were normal and further explained that she only recorded vital sign results if they were abnormal. In an interview on 6/17/26 at 11:30 AM, Nurse Manager (NM) C reported that she was not aware of any changes to Resident #101's health prior to the resident's hospitalization on 3/1/26; NM C had heard that Resident #101 had passed away but had not reviewed the hospitalization any further. NM C reported that Resident #101 had fallen in early February but last she knew, the resident was still walking around and at baseline. NM C reported that Resident #101 was taking a lot of medications for her heart and blood pressure and ideally would have been having her vital signs checked daily. NM C reported that the most recent vital signs documented prior to her hospitalization, were on 2/22/26; NM C noted that vital sign results should always be documented and not written as within normal limits. NM C reported that the Intradisciplinary Team reviewed Resident #101 on 2/24/26 and did not find any changes in her condition; documentation by staff did not reflect any (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes to Resident #101 prior to 2/28/26. NM C reported that the nurse and/or CNA should have contacted the manager on call and the physician when they noticed Resident #101 change of condition on the morning of 2/28/26. In an interview on 6/17/26 at 3:21 PM, Primary Care Physician (PCP) J reported that the last he knew, Resident #101 was doing fine and was her normal self. PCP J reported that he was not notified when Resident #101 became lethargic, wouldn't eat, talk and/or walk on 2/28/26. PCP J reported that he would have expected staff to notify him to get further recommendations; adding that Resident #101's blood pressure would be an important assessment due to her history of heart problems. Resident #106 Review of an admission Record revealed Resident #106 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: severe dementia. Review of Resident #106's Progress Note dated 6/18/26 at 12:07 PM revealed, Resident in living area near TV, heard breathing noises. Observed resident who was tachypneic (rapid and shallow breathing). VS (vital signs) BP 186/74, 90 (heart rate), 36 (respirations), 92% (oxygen in blood) on RA (room air), temperature 98.2. Applied 2 L (liters) O2 (oxygen) via nasal cannula (tubing placed at base on nose) for comfort and administered Duoneb (a breathing treatment to open airway and reduce mucus) treatment via mask. Notified (NP) with N.O. (new order) to send to ER (emergency room) to eval. CBC (complete blood count lab order) and CMP (comprehensive blood test) stat (immediately) as well as STAT 2 view x-ray ordered. Son called back and stated that resident was sent out to a dermatologist appointment and it went really badly for her and doesn't think sending her out is the best option. (RN E) Stated we are able to do testing and treatment here while keeping her comfortable. Son stated he wanted to start with that and see what comes from the CXR (chest x-ray) and labs. Review of Resident #106's Progress Note dated 6/18/26 at 3:59 PM revealed, order note: .Azithromycin Tablet 250 mg. for infection. Review of Resident #106's Progress Note dated 6/18/26 at 7:01 PM revealed, CXR and lab results back. Labs WNL, CXR with pneumonia. (NP) notified. Resident 92% (level of oxygen in blood) on RA. Son notified. It was noted that Resident #106 did not have any progress notes or vital signs recorded for approximately 24 hours, between 7:01 PM on 6/18/26 and 6:07 PM on 6/19/26. Review of Resident #106's Progress Note dated 6/19/26 at 6:07 PM revealed, Resident continues on (antibiotic) for PNA (pneumonia). No adverse side effects noted at this time. VSS. LS (lung sounds) diminished throughout. No crackles or wheezing heard. O2 sat 92% via RA. Resting in bed at this time. Review of Resident #106's Progress Note dated 6/20/26 at 1:54 PM revealed, Resident continues on oral antibiotics with no adverse effects noted. Resident remains afebrile with stable VS. It was noted that Resident #106 did not have any progress notes and or vital signs recorded for greater than 24 hours, between 1:54 PM on 6/20/26 to 7:08 PM on 6/21/26. Review of Resident #106's Progress Note dated 6/21/26 at 7:08 PM written by LPN G revealed, (Resident #106) during dinner started wheezing and blowing snot out of nose. Vitals taken that were as follows: BP 134/75, P (heart rate) 74, T (temperature) 97. RR 22, SpO2 74% RA; started to break out in sweats, put on O2 at 2L per PRN order, put in bed, called on-call (MD Q) with symptoms that ordered VS q (every) shift x 3 days, chest x-ray 2 views, and CBC with CMP for tomorrow. Called DPOA/Son to update on change of condition, stated to send her to hospital if needed, retook VS that were as follows: BP 128/72, P 71, T 97.2, RR 18, SpO2 91% 2L via nasal cannula, will continue to monitor and pass on to oncoming shift. Review of Resident #106's Progress Note dated 6/21/26 at 10:30 PM written by LPN G revealed, (Resident #106) was diaphoretic, cold to touch, lethargic, VS were as follows: BP 135/74, P 71, RR 24, BS 328, T 96 forehead, SpO2 74% 2L O2 via nasal cannula, called 911 for pick up, notified son earlier in night that she may be sent out and he said to send if she needs to be sent, notified on-call (MD Q) that she is being sent out D/T (due to) symptoms present, he stated to send out, notified manager on-call (NM R). Review of Resident #106's Vital Signs Record revealed results from 6/21/26 at 10:40 PM; 6/20/26 at 4:07 PM, 12:46 PM and 12:17 AM; and 6/19/26 at 4:05 PM. There were no results entered for 6/18/26. In an interview on 6/23/26 at 9:40 AM, NM C reported that Resident #106 was positive for pneumonia and started oral antibiotics on 6/18/26; when a resident is on antibiotic it is expected that vitals signs are checked and record every shift and as (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235440	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Holland Home - Raybrook Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 2121 Raybrook SE Grand Rapids, MI 49546	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed. NM C reported that for Resident #106 staff would have been expected to also check lung sounds during the assessment of vital signs. Review of Resident #106's record with NM C and she concluded that vital signs and assessments were documented on 6/18/26 when the concern started, then once on 6/19/26 (nearly 24 hours later), three times on 6/20/26 (with the last time being at approximately 4:00 PM) and then no further assessments until 6/21/26 at approximately 7:00 PM (>24 hours later) when Resident #106 had another episode of shortness of breath. In an interview on 6/23/26 at 12:56 PM, MD Q reported that once a resident was placed on an antibiotic, then vital signs should be checked every shift and as needed.		