STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235440	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Home - Raybrook Manor	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 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. 41982 Based on interview and record review, the facility failed to maintain dignity and respond to a resident's call light in a timely manner in 1 (Resident #76) of 3 residents reviewed for dignity, resulting in feelings of frustration and the potential for overall decline in quality of life. Findings include: Resident #76 Review of an Admission Record revealed Resident #76 was a female, with pertinent diagnoses which included: anxiety disorder and depression. Review of a Minimum Data Set (MDS) assessment for Resident #76, with a reference date of 1/6/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #76 was cognitively intact. Further review of said MDS revealed Resident #76 was dependent on staff for toilet transfer (the ability to get on and off a toilet or commode). Review of Resident #76's current Care Plan revealed a focus of I am experiencing occasional urinary incontinence w/ (with) need for assistance to reach toilet, manage incontinent product & (and) LE (lower extremity) weakness associated w/Sciatica (nerve pain in sciatic nerve that runs down one or both legs) with a start date of 1/9/25. In an interview on 2/3/25 at 11:49 AM, Resident #76 reported at times, it had taken up to about an hour for staff to respond to her call light. Resident #76 reported it was frustrating because she often had to use the bathroom, and she could hear staff out in the hallway talking amongst themselves. Review of Resident #76's Alarm History Report revealed the following findings: On 1/2/25, Resident #76's alarm was activated at 7:49:08 AM and completed at 8:20:39 AM, indicating a response time of approximately 31 minutes. On 1/5/25, Resident #76's alarm was activated at 3:38:23 AM and completed at 4:06:01 AM, indicating a response time of approximately 27 minutes. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/9/25, Resident #76's alarm was activated at 12:50:39 PM and completed at 1:37:13 PM, indicating a response time of approximately 46 minutes. On 1/12/25, Resident #76's alarm was activated at 10:16:52 AM and completed at 10:44:28 AM, indicating a response time of approximately 27 minutes. On 1/20/25, Resident #76's alarm was activated at 2:16:11 PM and completed at 3:00:39 PM, indicating a response time of approximately 44 minutes. On 1/22/25, Resident #76's alarm was activated at 12:47:56 PM and completed at 1:50:00 PM, indicating a response time of approximately 62 minutes. On 1/27/25, Resident #76's alarm was activated at 6:00:10 PM and completed at 6:51:31 PM, indicating a response time of approximately 51 minutes. In an interview on 2/5/25 at 12:07 PM, Registered Nurse (RN) GG reported the goal for call light response time was less than 10 minutes, but we hope for better. In an interview on 2/5/25 at 12:13 PM, Director of Nursing (DON) B reported call light wait time should be 5 minutes or less but no later than 10 minutes.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview and record review, the facility failed to 1.) protect the residents right to privacy for 1 (Resident #50) of 1 resident reviewed for privacy when staff entered the resident's room without knocking or asking for permission, 2). maintain the confidentiality of the Protected Health Information (PHI) when the Electronic Medical Record (EMR) was left open and unattended in a common area of the facility, resulting in 1.) feelings of frustration and embarrassment (Resident #50) and 2.) potential for unauthorized access to unsecured resident protected health information. Findings include: Review of Nursing Home Resident Rights and Responsibilities, Leading Age Michigan, November 30, 2021, provided by the facility, revealed: This community is dedicated to meeting the highest standards of care and protecting the individual dignity of residents H. Privacy and Dignity: The resident has a right to personal privacy and confidentiality of his or her personal and medical records. During an observation on 2/4/25, at 9:02am, a laptop computer sat on top of a medication cart in the hallway outside room [ROOM NUMBER]. No staff were present in the hallway. The laptop screen was visible from passerby's and displayed the protected health information of an unidentified facility resident. The laptop remained unattended for 6 minutes as several individuals passed by. In an interview on 2/4/25, at 9:08am, Registered Nurse (RN) H reported she was responsible for the unsecured laptop on the medication cart outside room [ROOM NUMBER]. RN H reported the laptop was open with a resident's medical information displayed and should have been closed and locked before it was left unattended. RN H reported she had been busy and must have forgotten to close the laptop when she stepped away. In an interview on 2/5/25 at 11:59 AM, Director of Nursing (DON) B confirmed that an unattended laptop, with resident protected health information displayed in the hallway, was a breach of resident privacy and that staff were expected to ensure laptops were closed before leaving them unattended. 41982 Resident #50 Review of an Admission Record revealed Resident #50 was a female, with pertinent diagnoses which included: major depressive disorder and generalized anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #50 with a reference date of 12/5/24 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #50 was cognitively intact. (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 2/3/25 at 12:31 PM, Resident #50 reported sometimes when she was in her room getting dressed, staff didn't always knock on the door prior to entering her room and had walked in on her while she was naked. Resident #50 described herself as a [NAME] when she was naked and didn't like people to see her. Resident #50 also reported over the past weekend, Licensed Practical Nurse (LPN) DDD had rushed in to give her insulin while she was on the toilet. Resident #50 reported LPN DDD did end up giving her the insulin while she was on the toilet, and she felt it was very disrespectful to her privacy. Resident #50 reported she had complained to the social worker in the past about staff not always knocking on the door prior to entering her room, and had a meeting scheduled with the social worker to covey her concern about the nurse giving her insulin while she was on the toilet. Attempts were made on 2/4/25 at 2:26 PM and 2/5/25 at 11:41 AM to contact LPN DDD to no avail. In an interview on 2/5/25 at 12:16 PM, Social Worker (SW) Z reported Resident #50 had complained to her in the past that staff were coming into her room without knocking and the facility had put a sign up at one time. SW Z reported was not sure if the sign was still up and that Resident #50 may have taken it down. SW Z reported she had spoken with Resident #50 the day before and that Resident #50 had complained that a nurse had gone into her room to offer her insulin while she was in the bathroom. SW Z reported she did not know that the nurse gave the insulin to Resident #50 but that she assured Resident #50 that they would speak to LPN DDD.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to resolve resident concerns for 1 (Resident #34) of 1 sampled resident reviewed for resolution of concerns resulting in feelings of frustration and a potential decline in psychosocial and mental well-being. Findings include: Resident #34 Review of Admission Record revealed Resident #34 was originally admitted to the facility on [DATE] with pertinent diagnosis which included functional urinary incontinence (a condition in which the bladder functions normally, but the individual is unable to reach the toilet in time due to physical or cognitive limitations.) Review of a Minimum Data Set (MDS) assessment for Resident #34, with a reference date of 12/6/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #34 was cognitively intact. Review of Resident #34's Care Plan revealed, Problem (Resident #34) had urinary incontinence related to decreased mobility, pain, requires staff to assist with transfers and toileting. Interventions: Change/peri care Q2H (every two hours) w (with) rounds during night. WAKE HER UP! . Start date 2/15/24 . During an interview on 2/3/25 at 11:24 AM, Resident #34 reported that she had concerns with the way that some of the staff at the facility treated and cared for her. Resident #34 reported staff would often not change her and she would have to lay in a wet brief for hours at a time. Resident #34 was tearful and reported that some of the staff made her feel bad about herself. Resident #34 stated I can't help it that I need help with these things, I wish I could do them by myself. Resident #34 reported that she had voiced her concerns to management before, and she had no idea if they had done anything about it. Resident #34 confirmed that she was still frequently being left wet and soiled overnight. On 2/4/2025 at 10:52 AM, This writer requested all concern/grievance forms for Resident #34. Nursing Home Administrator (NHA) A did not have any concern/grievance forms for Resident #34, but did upload a copy of an email that NHA A had sent to the facility's Interdisciplinary Team (IDT). Review of the email that NHA A sent to the facility's IDT team dated 11/20/24 revealed, Hello all : (Resident #34) family (Names redacted) had a meeting [NAME] President of Operations (VPO) K to discuss care concerns not resolved . (Resident #34) stating she has been left 50 times soiled in bed for 3 to 5 hours, usually on night shift, just happened last weekend . (Staff that do not do a good job) Licensed Practical Nurse (LPN) F and Former Certified Nursing Assistant (CNA) AAA . (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/25 at 1:05 PM, NHA A reported that he was made aware of Resident #34's concerns via email from VPO K. NHA A reported that he had forwarded the concerns that were reported to the IDT team and he believed that they addressed Resident #34's concerns during Resident #34's care conference. NHA A reported that Social Worker (SW) Z and Unit Manager (UM) GG were responsible for following up and resolving the concerns Resident #34 had. During an interview on 2/4/25 at 1:57 PM, SW Z reported that she had been made aware of Resident #34's concerns in November 2024. SW Z reported that she thought that she had met with Resident #34, but she was not able to provide documentation of her meeting with Resident #34, or documentation that she had worked to resolve Resident #34's concerns. During an interview on 2/4/25 at 2:05 PM, UM GG reported that she was responsible for following up on Resident #34's concerns. UM GG was not able to provide any documentation or examples of what she had done to resolve Resident #34's concerns. UM GG was unaware that Resident #34 still had concerns with being left wet and soiled. UM GG confirmed that the facility had the ability to review cameras to confirm how often staff were entering into Resident #34's room, but that she had not reviewed the cameras. UM GG reported that she had not investigated Resident #34's allegations of being left wet and soiled for 3-4 hours at a time. UM GG was unable to report why she had not documented Resident #34's concerns on a grievance form. When queried by this writer about Resident #34's concerns with LPN F and Former CNA AAA, UM GG reported that she thought that LPN F and Resident #34 had personality conflicts. UM GG reported that Former CNA AAA no longer worked at the facility, and that she had received disciplinary action, but she could not recall if it was related to Resident #34's concerns. UM GG reported that she had not followed up with Resident #34 to ensure that her concerns had been resolved. Review of CNA AAA's employee file revealed that on 12/2/24, CNA AAA received a Coaching Conversation for Attempting to leave mid cares. When a resident told her to come back CNA AAA told her to talk more nicely because I am helping out of the kindness of my heart . During an interview on 2/5/25 at 11:59 AM, Director of Nursing (DON) B reported that she was not involved in following up on Resident #34's concerns, and that she thought that NHA A had addressed Resident #34's concerns. During a follow up interview on 2/5/25 at 12:11 pm NHA A reported that he had shared Resident #34's concerns with UM GG and asked that Resident #34's concerns be addressed with a care conference. NHA A confirmed that no documentation was present in the medical record regarding a care conference to address the issues. NHA A reported he also had no documentation regarding any staff education or disciplinary action. NHA A confirmed that the staff members listed in the grievance continue to work at the facility . NHA A stated I'm not seeing that any of this was addressed. This writer attempted to contact Former CNA AAA and VPO K during the survey. Former CNA AAA and VPO K were unable to be reached prior to survey exit. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's Complaint-Grievance Policy dated 12/2018 revealed, POLICY Residents have the right to voice complaints and grievances to the facility or other agency (as identified in #3 below) without discrimination or reprisal and without fear of discrimination or reprisal. Complaints and grievances can address care and treatment that has or has not been provided; the behavior of staff and of other residents; and other concerns regarding their skilled nursing facility (SNF) stay. DEFINITIONS Voice grievances are not limited to a formal, written grievance process but may include a resident's verbalized complaint to facility staff. Prompt efforts .to resolve includes the facility's acknowledgement of complaint/grievances and active working toward resolution of that complaint/grievance. Procedures: .4. All staff members are responsible for taking immediate action to prevent further potential violations of any resident while an investigation is taking place a. communicating complaints and grievances, either verbal or written, to their supervisor, including immediate reporting of all alleged violations involving neglect, abuse, injuries of unknown source, and/or misappropriation of resident property. (A Registry of Complaint Form may be used for this purpose. See Complaint_Registry of form.)b.maintaining confidentiality of all information associated with the grievance, including the identity of resident for those grievances submitted anonymously . 6. The grievance official of each facility will be the executive director/designee who is responsible for: a. overseeing the grievance process b. receiving and tracking grievances through to their conclusions c. leading and completing any necessary investigations by the facility d. maintaining the confidentiality of all information associated with grievances e. providing a written report if requested by the complainant f. coordinating with state and federal agencies as necessary in light of specific requirements. 7. Follow-up investigation and documentation will be completed as directed by the executive director/designee including: a. completion of investigation b. written submission of the investigative report or status thereof to the complainant, if requested 8. Written decisions must include: a. the date the grievance was received b. a summary statement of the resident's grievance c. steps taken to investigate the grievance d. a summary of pertinent findings or conclusions e. a statement as to whether grievance was confirmed or not confirmed f. any corrective action taken g. the date the written decision was issued 9. If the complainant is not satisfied with the investigation or action taken, the executive director/designee will arrange a meeting with the complainant. 10. Written complaint records and documentation of investigation evidence will be maintained for three (3) years .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659 Based on interview and record review, the facility failed to report allegations of neglect to the State Agency in a timely manner for 1 (Resident #34) of 1 resident reviewed for neglect, resulting in the potential for continued violations involving neglect going undetected, unreported, or without thorough investigation. Findings include: Resident #34 Review of Admission Record revealed Resident #34 was originally admitted to the facility on [DATE] with pertinent diagnosis which included functional urinary incontinence (a condition in which the bladder functions normally, but the individual is unable to reach the toilet in time due to physical or cognitive limitations.) Review of a Minimum Data Set (MDS) assessment for Resident #34, with a reference date of 12/6/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #34 was cognitively intact. Review of Resident #34's Care Plan revealed, Problem (Resident #34) had urinary incontinence related to decreased mobility, pain, requires staff to assist with transfers and toileting. Interventions: Change/peri care Q2H (every two hours) w (with) rounds during night. WAKE HER UP! . Start date 2/15/24 . During an interview on 2/3/25 at 11:24 AM, Resident #34 reported that she had concerns with the way that some of the staff at the facility treated and cared for her. Resident #34 reported staff would often not change her and she would have to lay in a wet brief for hours at a time. Resident #34 was tearful and reported that some of the staff made her feel bad about herself. Resident #34 stated I can't help it that I need help with these things, I wish I could do them by myself. Resident #34 reported that she had voiced her concerns to management before, and she had no idea if they had done anything about it. Resident #34 confirmed that she was still frequently being left wet and soiled overnight. On 2/4/2025 at 10:52 AM, this writer requested all concern/grievance forms for Resident #34. Nursing Home Administrator (NHA) A did not have any concern/grievance forms for Resident #34, but did upload a copy of an email that NHA A had sent to the facility's Interdisciplinary Team (IDT). Review of the email that NHA A sent to the facility's IDT team dated 11/20/24 revealed, Hello all : (Resident #34) family (Names redacted) had a meeting with [NAME] President of Operations (VPO) K to discuss care concerns not resolved . (Resident #34) stating she has been left 50 times soiled in bed for 3 to 5 hours, usually on night shift, just happened last weekend . (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/25 at 1:05 PM, NHA A reported that he did not report Resident #34's concern of being left wet and soiled for hours at a time to the State Agency. NHA A reported that he had thought that Resident #34's concerns were more care related, and not considered neglect, so he did not think that he needed to get involved with reporting and investigating the concerns. NHA A reported that he could have missed what Resident #34's concerns were, because the concerns had gone through several lines of communication before reaching him. On 2/05/25 at 10:24 AM, this writer attempted to contact VPO K. VPO K was not able to be reached prior to survey exit. In a follow up interview on 2/5/25 at 12:11 pm, NHA A reported he did not consider an allegation as potential neglect unless there was an injury, another type of negative outcome, or if the resident voiced a feeling of being neglected. NHA A reported no investigation was completed regarding the concerns Resident #34 voiced. Review of the facility's Abuse and Neglect Policy dated 9/2022, revealed, POLICY Each resident has the right to be free from abuse and neglect. To provide a safe environment for residents, to promote respect, and to set standards of care, .will monitor for abuse and investigate all allegations of resident abuse, neglect, mistreatment, exploitation, and misappropriation of property.Definitions: Neglect - failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress . 3. All alleged violations involving mistreatment, abuse, exploitation, neglect or misappropriation of property will be thoroughly investigated by the facility under the direction of the executive director / designee and in accordance with state law. 4.will adhere to State of Michigan reporting requirements as follows: a. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the executive director/designee and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview and record review, the facility failed to revise a person-centered care plan to reflect resident care needs for 1 (Resident #60) of 18 residents reviewed for care planning, resulting in an inaccurate reflection of resident care needs, and a potential for further injury and avoidable pain. Findings include: Review of the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, v1.16, Chapter 2: Assessments for the Resident Assessment Instrument (RAI), revealed .the resident ' s care plan must be reviewed after each assessment .and revised based on changing goals, preferences and needs of the resident and in response to current interventions .Residents' preferences and goals may change throughout their stay, so facilities should have ongoing discussions with the resident and resident representative, if applicable, so that changes can be reflected in the comprehensive care plan . Resident #60 Review of an Admission Record revealed Resident #60, was originally admitted to the facility on [DATE] with a pertinent diagnosis which included: dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement). Review of a Minimum Data Set (MDS) assessment for Resident #60, with a reference date of 1/17/25 revealed a Brief Interview for Mental Status (BIMS) score of 2/15 which indicated Resident #60 was severely cognitively impaired. Review of a Care Plan for Resident # 60, with a reference date of 10/17/23, revealed a problem/goal/interventions of: Problem: Need for restorative nursing plan related to potential functional decline. Goal: Resident will maintain functional abilities; will actively participate in restorative program. Interventions: 3x week (3 times per week) ambulate with 4ww (4 wheeled walker, requiring use of both hands) x 80 feet, (exercise equipment name omitted) with BUE (both upper extremities) x 10min). During an observation on 2/3/25 at 9:48am, Resident #60 sat in a wheelchair, in the doorway of her room, a blue sling was noted on her right arm. In an interview on 2/3/25 at 11:27am Case Manager (CM) FFF reported Resident #60 had a recent right humerus (upper arm) fracture and should not exercise or bear weight on her right arm at this time. CM FFF reported the sling was to be used for comfort as the resident tolerated. In an interview on 2/3/25, at 2:45pm, Certified Nursing Assistant (CNA) CC reported she cared for Resident #60 on this date. CNA CC reporte the resident appeared apprehensive about doing anything that might cause pain in her right upper arm, and stated don't hurt me, don't hurt me during cares. CNA CC reported she was not sure if staff were supposed to provide any care that involved moving the resident's right arm, donning or doffing (putting on or taking off) Resident #60's sling. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/4/25 at 3:03pm, Unit Manager (UM) T reported Resident #60 suffered a right humerus fracture on 1/31/25 and per physician orders a sling was applied. UM T reported when a resident has an acute injury, and the physician orders an intervention, the floor nurse should update the care plan at that time. The care plan contained no guidance for staff regarding Resident #60's use of the sling or physical restrictions related to her fracture. UM T reported the Interdisciplinary Team (IDT) met to discuss Resident #60's needs due to her recent fracture and developed a plan for range of motion exercises, but the care plan was not updated. UM T reported it was her responsibility to update a resident's plan of care after the IDT met. UM T confirmed that the interventions listed in Resident #60's plan of care were no longer appropriate and could result in further injury and avoidable pain if they were carried out.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Home - Raybrook Manor	2121 Raybrook SE Grand Rapids, MI 49546

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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** 41982 Based on observation, interview, and record review, the facility failed to 1.) implement documented intervention and provide adequate supervision to prevent a fall for 1 (Resident #8) resident and 2.) safely transport 2 (Resident #27 and #42) residents in their wheelchairs with foot pedals of 5 residents reviewed for accidents/hazards/falls, resulting in a fall with fracture and a significant change in health status (Resident #8) and the potential for falls for Resident #27 and #42. Findings include: Resident #8 Review of an Admission Record revealed Resident #8 was a female, with pertinent diagnoses which included: fracture of nasal bones (1/23/25), other fracture of third [NAME] (lumbar) vertebra (1/23/25). Review of an Minimum Data Set (MDS) dated [DATE] revealed Resident #8 had a BIMS score of 10/15 indicating mild cognitive impairement and required supervision when transfering to the toilet, was occassionally incontinent of urine, and had late onset Alzheimer's disase. Review of the Significant Change in Status Minimum Data Set (MDS) assessment for Resident #8, with a reference date of 1/27/25 (conducted after Resident #8's fall) revealed a Brief Interview for Mental Status (BIMS) score of 2, out of a total possible score of 15, which indicated Resident #8 was severely cognitively impaired. Review of Resident #8's Incident Report dated 12/27/24 revealed, Describe the Incident .What was the resident trying to DO? Transferred without staff assistance .Resident's Description: Resident stated I just needed to go to the bathroom .Root Cause: Resident uses items with wheels as walker Was Care plan reviewed: yes Care plan revisions: Remove items with wheels . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #8's Care Plan for the period beginning 10/7/24 revealed the focus of (Resident #8) is at a risk for falls and injury related to impaired mobility, hx (history) of falls, opioids, incontinence & (and) is high risk for falls & OK if I fall & die but does not desire to spend any time out of room on unit with a start date of 7/18/23 with the entirety of care planned interventions which included Be sure call light is within reach and encourage to use it for assistance as needed. Respond promptly to all requests for assistance (start 7/18/23), Keep personal items within reach (start 7/18/23), Keep room and environment free of barriers and clutter (start 7/18/23), Offer toileting with AM/PM (day/evening) care, before and after meals and at (Resident #8's) request (start 7/18/23), Encourage resident to find the O2 (oxygen) line manually, as her vision is limited (start 7/21/23), Ambulate & transfer w/one moderate assist for upper body support using 4ww (4-wheeled walker) & GB (gait belt) (start 10/10/23), Red Dot: Remind visitors to let staff know when they leave if visiting a resident in a resident's room (start 10/10/23), Sign to call for assistance placed on walker (start 11/27/23), Assist to bathroom around 1:00 p.m. daily (start 1/19/24), Non-skin strips to floor in front of toilet (start 2/12/24), Dycem (anti-slip mat) added to recliner to prevent slipping out of chair (start 5/17/24), Anti-rollbacks placed on WC (wheelchair) (Start 7/8/24), Clip placed on call light so that call light can be clipped to front of resident clothing when in bed or recliner (start 7/24/24), Functional activity level is Green. Please refer to Activities Care Plan for non-pharmacological interventions (start 10/30/24). The care plan did not reflect the documented intervention of remove items with wheels. Review of Resident #8's Incident Report dated 1/23/25 at 12:00pm revealed, Describe the Incident: Describe the environment of the incident: Resident lying on face down in front of recliner, tray table pushed forward. Resident wearing blanket. How was staff alerted to the fall? Alarm notified staff, manager ran into resident's room. Where/what was resident doing prior to fall? Resident in recliner eating lunch. What was the resident trying to DO? Attempted to ambulate without assistive device .Resident's Description: Resident unable to describe at this time .If applicable, please describe any abnormalities: Bruising along forehead and down nose, residentalso (sic) bleeding from nose .Resident transferred to hospital: Yes .OTHERS INVOLVED Staff (Registered Nurse (RN) II) Staff (RN-MDS MM) Staff (Certified Nurse Aide (CNA) EE) Was Care plan reviewed: yes Care plan revisions: Resident to be placed in area of Higher Visibility at all times when awake and offer functional activity . Review of Resident #8's History & Physical from (hospital name omitted) dated 1/23/25 at 4:33 PM revealed, .(Resident #8) is a [AGE] year-old female .presented to the ER (emergency room) after an unwitnessed GLF (ground level fall), with head injury but unclear if she had LOC (loss of consciousness). She was noted to have altered mental status, Baseline A&O (alert and oriented) x 2. On examination patient with obvious facial trauma with raccoon eyes, dried blood in both mouth and nose, no postnasal bloody drip .Imaging studies showed RLL (right lower lobe) atelectasis (collapsed lung) versus pneumonia. Also traumatic L1-3 (parts of the vertebra of the spine) transverse process (a bony projection on the side of the vertebrae) fractures, nasal bone fractures with deviation to right . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #8's Physician Office Visit note dated 1/31/25 revealed, History and Physical Recent fall, nasal fracture and lumbar transverse process fractures, general weakness, status post hospitalization Subjective Patient is a very pleasant [AGE] year-old female with multiple medical problems .Patient recently did experience an unwitnessed fall. Due to injuries, she was transferred to the hospital for further evaluation . CT (computed tomography scan - a type of x-ray imaging) of spine did indicate displaced right L1-L3 transverse process fracture .CT maxillofacial (face, mouth, jaws, head, and neck) also showed .bilateral (both sides) nasal fractures with mild rightward displacement .Her DURABLE POWER OF ATTORNEY for healthcare was consulted, and she was admitted to hospice. She has now been discharged back to nursing facility under hospice care with goal of comfort care. Patient is now bed dependent, dependent on nursing staff for all of her ADLs (activities of daily living). She is unable to engage in any kind of conversation. She remains on oxygen . In an interview on 2/4/25 at 12:16 PM, RN-MDS MM reported when Resident #8 fell , she was sitting in her office and heard Resident #8's alarm activate. RN-MDS MM reported when she reached her office door, she heard a thud. RN-MDS MM reported when she got to Resident #8's room (which is located next to RN-MDS MM's office) Resident #8 was lying beside her recliner with her face on the floor on her right side with her right hand under her head and positioned on her right shoulder. RN-MDS MM reported Resident #8 was moaning and was trying to roll over. RN-MDS MM reported she asked an aide to get the nurse who then assessed the resident and got her up into her recliner chair. RN-MDS MM reported the nurse and the CNA took over from there. Review of the Urinary Incontinence care plan with a start date of 2/12/24 revealed Resident #8 was to be offererd toileting with morning/evening care and before and after meals. In an interview on 2/4/25 at 1:37 PM, CNA EE reported she had last seen Resident #8 approximately 20 minutes prior to her fall in her recliner chair when she delivered her lunch meal tray to her on her bedside table. CNA EE did not report having offered Resident #8 to go to the toilet prior to leaving the room after delivering her lunch. CNA EE reported Resident #8 was known to attempt to get up on her own. CNA EE reported at the time of Resident #8's fall, she was on the A hall delivering meal trays. CNA EE reported Resident #8 resided on the B Hall. CNA EE reported at the time of Resident #8's fall, the nurse assigned to B Hall was in the dining room assisting residents to eat. CNA EE reported neither the assigned CNAs nor the nurse were on B Hall at the time of Resident #8's fall and that RN-MDS MM had been in her office and heard Resident #8's alarm and responded. In an interview on 2/5/25 at 9:24 AM, RN II reported she had been in the dining room at the time of Resident #8's fall. RN II reported Resident #8 had been in her room and her lunch tray had just been delivered to her in her recliner chair. In an observation/interview on 2/5/25 at 9:30 AM, Registered Nurse Manager (RNM) DD was queried about Resident #8's 12/27/24 Incident Report with the root cause of Resident uses items with wheels as walker and the care plan revision to Remove items with wheels . RNM DD reported she had been on vacation at the time of the fall but that it was her understanding that Resident #8 had had her bedside table by her and had used that to basically get up and transport herself. At 2/5/25 at 9:40 AM, this surveyor accompanied RNM DD to Resident #8's room to observe her bedside table. The bedside table had wheels, without locks, and a foam lining around the tray portion of the bedside table. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	In a follow-up interview on 2/5/25 at 9:42 AM, RN-MDS MM reported she could not recall if Resident #8's tray table had wheels when she was found after her fall on 1/23/25 but that there was foam on the tray portion of the bedside table. In a follow-up interview on 2/5/25 at 10:10 AM, RNM DD reported Resident #8 preferred to eat in her room and would get mad when they encouraged her to come out of her room to eat. RNM DD reported because of Resident #8's history of falls, they had initiated an intervention to have her be in higher visibility areas, but that Resident #8 had been adamant about staying in her room. When queried about staff supervision at the time of Resident #8's fall, RNM DD reported CNA EE had been passing trays on the A Hall, the other CNA on duty on that hall had been in the dining room and RN II had been in the dining room, but that RN-MDS MM had been in her office which was next to Resident #8's room. 46999 Resident #27 Review of an Admission Record revealed Resident #27, was originally admitted to the facility on [DATE], with pertinent diagnoses which included: unspecified dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement) and repeated falls. Review of a Minimum Data Set (MDS) assessment for Resident #27, with a reference date of 1/3/25, revealed the resident could not complete a Brief Interview for Mental Status and his decision making was severely impaired. Section GG revealed Resident #27 used a wheelchair for all mobility. Review of a Care Plan for Resident # 27, with a reference date of 5/2/23, revealed problem/goal/interventions of: Problem: I am at a risk for falls and injury related to impaired mobility .chronic pain .confusion. Goal: I will remain free of injury .Interventions: wheelchair for mobility. During an observation on 2/3/25 at 11:47am, Resident #27 was seated in a wheelchair with his legs extended in front of him, no foot pedals were attached to his chair. CNA CC stated put your feet up as she began to push the resident's wheelchair. Certified Nursing Assistant (CNA) CC pushed him from his room to his seat in the dining room. Resident #27, while holding his legs outward, was maneuvered through 2 steel doorways, and around a group of tables, before he and his wheelchair were placed at table by the windows in the dining room. The distance from Resident #27's room to the table in the dining room was 50'. In an interview on 02/05/25 at 09:42am, Registered Nurse (RN) II reported Resident #27 should have his foot pedals on his wheelchair when staff push him to maintain his safety. RN II reported Resident #27 did not consistently follow directions and did not recognize potentially dangerous situations. During an observation on 2/5/25 at 9:48am, Resident #27 was seated in his wheelchair outside his room, no foot pedals were in place as Licensed Practical Nurse (LPN) CCC pulled the resident's wheelchair backwards approximately 6' before turning the wheelchair around. LPN CCC then pushed Resident #27 into his room, at which time the resident planted his feet on the floor to stop the movement of his wheelchair, and pushed his wheelchair backwards, back into the hallway. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an observation on 2/5/25 at 9:52am, Resident #27 sat in his wheelchair, faced the door of the dining room, and fidgeted with the doorknob. No foot pedals were in place on his wheelchair. CNA J approached the resident, instructed him to lift his feet, as the resident lifted his feet, CNA J turned Resident #27's wheelchair around, and pushed him from the far dining room door to his room with no foot pedals in place. Resident #42 Review of an Admission Record revealed Resident #42, was originally admitted to the facility on [DATE], with pertinent diagnoses which included: dementia (a group of conditions characterized by impairment of at least two brain functions, such as memory loss and judgement) and localized edema (swelling caused by fluid buildup that causes a feeling of heaviness). Review of a Minimum Data Set (MDS) assessment for Resident #42, with a reference date of 1/24/25, revealed a Brief Interview for Mental Status (BIMS) score of 6/15 which indicated Resident #42 was severely cognitively impaired. Section GG revealed Resident #42 relied on a wheelchair for all mobility. Review of a Care Plan for Resident #42, with a reference date of 4/9/24, revealed a problem/goal/interventions of: (Resident #42) is at a risk for falls and injury related to impaired mobility, hx (sic)(history) of falls .depression. Goal: (Resident #42) will be remain free of injury secondary to falls. Interventions: .WC (wheelchair) for long distance. During an observation on 2/3/25 at 2:00pm, Resident #42 was seated in her wheelchair as CNA L pushed the resident from her room at the end of the hall, to the common area of the unit, a total distance of 75'. Resident #42's footrests were attached to her wheelchair, but the actual foot plates (platforms on which the user rests their feet) were folded up, perpendicular to the floor. Resident #42's feet hovered above the floor between the folded-up foot pedals as CNA L pushed her quickly down the hall. In an interview on 2/5/25 at 11:33am, Unit Manager (UM) T reported staff were expected to use foot pedals on resident wheelchairs any time they pushed a resident. UM T reported pushing a resident without proper foot pedals/proper use of foot plates was unsafe and could leave a resident at risk for falling from the chair or having other injuries. In an interview on 2/5/25 at 12:01pm, Director of Nursing (DON) B confirmed for safety purposes, staff should always use foot pedals on resident wheelchairs any time a resident is being pushed. Review of a Wheelchair Foot Pedal, Use of facility policy, with a reference date of 5/2023 revealed: Policy: To promote a safe environment, staff will use foot pedals when propelling residents in wheelchairs. Procedures: 1. Foot pedals must be used at all times when propelling a resident in a wheelchair, regardless of functional abilities. Review of Mosby's Textbook for Long-Term Care Nursing Assistants - E-Book by [NAME] A. [NAME], 6th Edition 2013 titled 'Wheelchair Safety revealed .Make sure the person's feet are on the footplates (foot pedals/rests) before moving the chair. The person's feet must not touch or drag on the floor when the chair is moving .

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36221 Based on observation, interview, and record review, the facility failed to ensure special eating utensils were provided during meal times in 2 of 2 residents (Resident #55 & #30) reviewed for adaptive equipment, resulting in impaired ability to eat independently and the potential for weight loss. Findings include: Review of the policy/procedure Meal Delivery, revised November 2010, revealed .A defined meal delivery service is followed to ensure delivery of appropriate diet, a dignified dining atmosphere and necessary assistance to promote nutritional health .Nursing staff delivers the food trays to each resident and .Ensures that food items served match meal ticket .Assists with meal set-up .Assists resident as needed with eating, according to his or her Plan of Care .The (Registered Dietitian) or designee arranges and includes in the resident's Plan of Care specific variables to meal delivery to ensure that individualized dietary needs, meal services preferences, and special requests are provided . Resident #55 Review of a Profile Face Sheet revealed Resident #55 was a male, with pertinent diagnoses which included arthritis, depression, and dementia. Review of a current Care Plan for Resident #55 revealed the problem .I am at risk for alteration in nutrition and hydration status r/t (related to) multiple medical problems . with approaches which include .Diet: General, thin liquids .Built up silverware / cup w/ (with) lid for hot liquids . with a start date of 4/28/22. Review of a Quarterly Nutrition Assessment for Resident #55, dated 1/24/25, revealed .Adaptive equipment: cup w/ (with) lid for hot liquids and gray built up utensils .Feeds self w/ meal setup at lunch but staff do provide more assistance w/ dinner . Review of a Quarterly Nursing Note for Resident #55, dated 1/24/25, revealed .He needs set up and adaptive equipment for meals, spouse will assist at times when visiting . Review of a Quarterly Care Conference Note for Resident #55, dated 1/30/25, revealed .(Resident #55) has been eating well. (Registered Dietitian) ordered new built-up silverware for him .Plastic throwaway (utensils) have been put in place r/t an outbreak (of illness) on the floor. Wife voiced she does not like the plastic silverware but does help feed him as best she can . In an observation and interview on 2/3/25 at 12:51 PM, Resident #55 was noted in his recliner in his room with Family Member BBB sitting in a chair beside him. Observed Resident #55's lunch tray on the table nearby, which had been served in a foam container with disposable cutlery. Family Member BBB reported all food items are currently being served with disposable containers and cutlery due to an illness outbreak on the unit. Family Member BBB reported the dietary department has not been sending Resident #55's built-up silverware with his meals. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an observation on 2/4/25 at 11:57 AM, Resident #55 was noted in his recliner in his room. Noted Resident #55's lunch tray had just been delivered. Observed all food items were served in disposable containers, with only disposable plastic utensils provided. No built up utensils were provided to Resident #55 for his lunch meal. In an interview on 2/4/25 at 12:04 PM, Dietitian EEE reported due to the gastrointestinal illness outbreak within the facility, all residents are provided with disposable utensils only. Dietitian EEE reported no special eating utensils/adaptive equipment for meals are being provided at this time. In an observation on 2/5/25 at 8:19 AM, Resident #55 was noted in his recliner in his room. Noted no staff or family present in room at this time. Observed Resident #55's breakfast meal had been served in a foam container with disposable plastic utensils. No built up utensils were provided to Resident #55 for his breakfast meal. In an interview on 2/5/25 at 8:44 AM, Director of Nursing (DON) B reported the purpose of the disposable containers/utensils for meals was to minimize the risk for transmission of gastrointestinal illness. DON B reported residents should still receive special eating utensils/adaptive equipment as ordered or indicated in the care plan. 47659 Resident #30 Review of Admission Record revealed Resident #30 was originally admitted to the facility on [DATE] with pertinent diagnoses which included dysphagia (difficulty swallowing foods) and parkisons disease. Review of a Minimum Data Set (MDS) assessment for Resident #30, with a reference date of 11/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #30 was cognitively intact. Review of Resident #30's Care Plan revealed, Nutritional Status. (Resident #30) is at risk for alteration in nutrition/hydration status r/t (related to) multiple problems including Parkinson . Interventions: Diet: mech(mechanical) soft gluten and lactose free diet with nectar thick liquids. Cut up food. Supervision, recommended to eat in dining room or high traffic areas. No gravy on my foods. Suction divided plate, red foam on silverware . start date 6/20/24 . During an observation on 2/3/25 at 12:17 PM, Resident #30 was sitting in his wheelchair with his tray table in front of him eating lunch. Resident #30 was struggling to eat as food slipped off of his silverware before he could get the food to his mouth multiple times. Resident #30 also struggled to put more spoonfuls of food in his mouth. It was noted that Resident #30 did not have red foam (adaptive equipment) on his silverware. During an observation on 2/4/25 at 11:58 AM, Resident #30 was sitting in his wheelchair with his tray table in front of him eating lunch. It was noted that Resident #30 did not have red foam on his silverware. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/4/25 at 2:21 PM, Resident #30 reported that the facility had not been providing him with the red foam for on his silverware over the past week. Resident #30 confirmed that the red foam on his silverware made it easier for him to feed himself, and he had been struggling to eat without it. During an interview on 2/4/25 at 2:31 PM, Registered Nurse (RN) H reported that she had delivered Resident #30's lunch tray, and he did not have his red foam on his silverware. During an interview on 2/4/25 at 1:30 PM, Speech Language Pathologist (SLP) QQ reported that Resident #30 should always have the red foam on his, as it was what worked best for Resident #30 to assist him with eating. During an observation on 2/5/25 at 8:35 AM, was sitting in his wheelchair with his tray table in front of him eating breakfast. It was noted that Resident #30 did not have the red foam on his silverware. Resident #30 was struggling to use a spoon to eat cereal and was spilling food off of his spoon frequently.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the dry storage area and ensure proper labeling and dating of foods in the resident refrigerator in 2 dining rooms resulting in the potential to spread food borne illness to all residents that consume food from the kitchen and residents that store food in the dining room refrigerators. Findings include: During a kitchen tour on 2/04/2025 at 9:24 AM, the following items were observed: The dry storage area: 64 fluid ounce of white vinegar in a plastic bottle on the shelf was dripping by the cap onto the side of the container onto the shelf. A box of grape juice concentrate on the shelf was dripping outside of the container onto the box of apple juice concentrate on the shelf below. During a tour of the resident refrigerators in the main dining rooms on 2/04/2025 at 10:24 AM, the following was observed: The 3rd floor resident refrigerator: A plastic bag had room [ROOM NUMBER] written on it and had the following food items in it without a label that indicated the open date and use by date: bag of open baby carrots, open bag of lettuce, a small styrofoam cup half full of sweet potatoes. The 4th floor resident refrigerator: Blueberries were in a small styrofoam cup which was not covered. During the kitchen tour on 2/4/2025 in the morning, Dining Services Manager (DSM) W stated that the items in the dry storage area should have been thrown out. He also indicated that the items in the resident refrigerators in the main dining rooms should have been labeled and dated or thrown out if there wasn't a label and date on it. DSM W said that the nursing staff should be labeling and dating resident food items when putting it in the refrigerator but it's the kitchen's responsibility ultimately. According to the 2022 FDA Food Code section 6-501.12 Cleaning, Frequency and Restrictions. (A)PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean . (continued on next page)

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	235440	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Holland Home - Raybrook Manor	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . According to the 2022 FDA Food Code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by . (4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the FOOD in packages, covered containers, or wrappings . Review of the facility policy: Date Marking for Food Safety with a revision date of July 2019 revealed Procedures: Policy Explanation and Compliance Guidelines for Staffing: 2. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 3. The individual opening or preparing a food shall be responsible for date marking the food at the time the food is opened or prepared. 4. The marking system shall consist of a color-coded label, the day/date of opening, and the day/date the item must be consumed or discarded. Review of the facility policy: Sanitation Inspection with a revision date of July 2019 revealed Policy: It is the policy of this facility, as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. Procedures: Policy Explanation and Compliance Guidelines:1. All food service areas shall be kept clean, sanitary . 3. Inspections will be conducted but not limited to the following areas: a. Dry storage.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview and record review, the facility failed to successfully implement the use of personal protective equipment (PPE) and hand hygiene practices in resident rooms that were under transmission-based precautions (TBP), resulting in a potential for cross contamination and the spread of infectious diseases. This deficient practice has the potential to impact all residents of the facility. Findings include: Review of a facility policy Categories of Transmission Based Precautions(TBP) with a reference date of 7/2024, revealed: Policy: Transmission-based precautions .are used for residents who are known or suspected to have communicable diseases .C. Implement Contact Precautions for residents known or suspected to be infected with microorganisms .don (put on) gloves, gown prior to entering the room .remove and discard gloves and gown before leaving room; perform hand hygiene(if microorganism is known or suspected to be .norovirus, perform hand hygiene with soap and water only). During an observation on 2/3/25 at 11:04am, Unit Manager (UM) T placed a sign on the door frame of room [ROOM NUMBER] that stated: , VISITORS: PLEASE REPORT TO A NURSE BEFORE ENTERING THE ROOM Gloves - Wear gloves when entering the room. Remove gloves and discard before leaving the room. Gown - Wear a gown when you anticipate that your clothing will have substantial contact with resident or environmental surfaces, or when you are unable to contain the infective material. Handwashing- Wash hands before and after each resident encounter. These precautions are in addition to Standard Precautions which are always to be used. UM T also pulled a PPE cart closer to the door of room [ROOM NUMBER] at this time. During an observation on 2/3/25 at 11:02am, Certified Nursing Assistant (CNA) L entered room [ROOM NUMBER] without donning (putting on) a gown or gloves. CNA L placed her bare hands on a lift device the resident had used during toileting and brought the device to the hallway for disinfecting. In an interview on 2/3/25 at 11:15am, UM T reported she found the contact precautions sign for room [ROOM NUMBER] on the floor. UM T reported the resident in room [ROOM NUMBER] was placed in contact precautions for suspected norovirus on 2/1/25. UM T reported staff relied on the signs to tell them what precautions to use when providing cares to residents, but the signs were not staying affixed to the door frames. In an interview on 2/3/25 at 11:21am, CNA L confirmed she did not know the resident in room [ROOM NUMBER] was on contact precautions when she entered the room without the proper PPE. CNA L confirmed there was no sign on the doorframe of room [ROOM NUMBER] when she entered, and that UM T found the sign on the floor. In an interview on 2/3/25 at 11:41am, Licensed Practical Nurse (LPN) XX reported staff share information about resident's who are on precautions with oncoming staff based on the report sheet. LPN XX reported the report sheet for 2/3/25 did not indicate room [ROOM NUMBER] was under contact precautions. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 2/3/25 at 2:14pm, CNA HH entered room [ROOM NUMBER] using only a surgical mask for PPE. CNA HH assisted the resident of 440 to the restroom. CNA HH exited the restroom and transferred the resident back to his recliner at 2:21pm. At that time, CNA L walked to the doorway of room [ROOM NUMBER] and told CNA HH she needed to use a gown and gloves when caring for the resident of that room. In an interview on 2/3/25 at 3:01pm, CNA HH reported she did not know the resident of room [ROOM NUMBER] was in contact isolation precautions until she was told by CNA L. CNA HH reported she started her shift early on this date and did not receive report from the off going staff. When further queried, CNA HH reported she did not notice the small isolation sign on the door frame of room [ROOM NUMBER] and was confused because the PPE cart was next to his door. CNA HH reported several more residents had been placed in isolation precautions for suspected norovirus since the last time she worked, and she was shocked at how many residents had symptoms. CNA HH reported the facility had not provided any recent education about PPE use and hand hygiene during the facility's norovirus outbreak, but she knew from personal experience that it was necessary to use soap and water to cleanse her hands after caring for a resident with norovirus. In an interview on 2/3/25 at 2:45pm, CNA CC reported the facility had not provided any recent training regarding proper PPE use and hand hygiene when caring for residents with norovirus. When further queried regarding what method of hand hygiene was necessary after caring for a resident with suspected norovirus, CNA CC reported using hand sanitizer was sufficient if the staff member's hands were not visibly soiled. 41982 During an observation on 2/3/25 at 11:49 AM, it was noted that room [ROOM NUMBER] had a Contact Precautions (a set of practices used to prevent the spread of infectious diseases through direct or indirect contact) sign posted on the door. There was no Personal Protective Equipment (PPE) noted outside the door. Review of the posted sign on the door outside room [ROOM NUMBER] revealed, During an observation and interview on 2/3/25 at 12:05 PM, Certified Nurse Aide (CNA) X entered room [ROOM NUMBER] to deliver a meal tray. CNA X was wearing a surgical mask but did not don (put on) gloves nor a gown prior to entering the room. From the hallway, this surveyor overhead CNA X speaking to one of the residents in the room asking the resident if they were sick to which the resident reported that they were. CNA X looked outside the room for PPE and then exited the room. This surveyor queried CNA X if the resident was on Contact Precautions to which CNA X reported she had not seen PPE outside her room, but now saw from the sign that Contact Precautions were in place. When queried as to whether CNA X should have donned gloves and a gown prior to entering the room, CNA X reported she had only gone in the room to deliver a tray and then deferred to Licensed Practical Nurse (LPN) LL. In an interview on 2/3/25 at 12:15 PM, LPN LL was queried as to whether CNA X should have donned gloves and a gown prior to entering a room with Contact Precautions, LPN LL simply stated, I always wear a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/3/25 at 12:28 PM, Registered Nurse (RN) GG reported when delivering a meal tray in a room where Contact Precautions were in place, the expectation was that a surgical mask, gloves, and gown were worn. In an interview on 2/4/25 at 12:02 PM, LPN F reported staff should be gowning up and wearing gloves when delivering a tray to a room with Contact Precautions. In an interview on 2/5/25 at 8:57 AM, Director of Nursing (DON) B reported when staff delivered a tray to a resident in Contact Precautions, staff needed to wear PPE which included a surgical mask, a gown, and gloves. 48637 During an interview on 2/05/2025 at 9:02 AM, Infection Preventionist (IP) N stated that when a resident was on Transmission Based Precautions (TBP), which included contact precautions (set of practices used to prevent the spread of infectious diseases through direct or indirect contact), Personal Protective Equipment (PPE) such as a gown and gloves should be worn by staff when going into the room whether it was to provide care, to deliver meal trays or just to talk to the resident. IP N said if a resident has gastrointestinal issues and was vomiting then staff should wear a mask too. She reported that with TBP rooms, PPE should be put on prior to entering the room and should be taken off prior to exiting the resident room. IP N stated that when staff was in a TBP room, they needed to wash their hands with soap and water before they exited the room. If staff was in a room that wasn't under TBP, IP N said hand sanitizer was acceptable to use unless the hands were visibly soiled and then soap and water must be used.