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	03/12/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure wheelchairs were kept clean and/or in good repair for 6 (Residents # 2, 52, 36, 6, 46, and 29) of 6 residents reviewed for environment resulting in dirty wheelchairs, wheelchairs with missing or broken parts, and the potential for injury. Findings include:Resident #2:Review of Resident #2's brief interview for mental status, dated 1/29/26, was scored 3 which reflected severely impaired cognition.During an observation and interview on 03/10/2026 at 11:27 AM, Resident #2 was seated in her wheelchair in the activity room. Her wheelchair was visibly soiled with an expansive dried-up splatter of brown/pink material. These stains/spills covered many parts of the wheelchair surface and were most prevalent on the right-hand side. Dried up spilled material was present on the wheelchair frame, seat, cushion, and front and back wheels. The 2 heavily soiled areas covering the surface on the wheelchair wheel that the hand would contact to move the wheelchair were approximately 6 inches long. Resident #2 was confused and unable to answer questions regarding the state of her wheelchair.During an observation on 03/11/2026 at 8:18 AM, Resident #2 was asleep with her wheelchair positioned near her bed. The wheelchair remained visibly soiled. In addition to the stains/spills observed on the right-hand side of the wheelchair previously, there were also more of the pink/brown stains/spills splattered on the left side of the wheelchair under the arm rest and front left tire.During an observation on 03/11/2026 at 12:35 PM, Resident #2 was seated upright in her wheelchair in the dining room for lunch. The stains/spills that were observed previously remained. Resident #2 was observed spilling food along her right-hand side on the wheelchair and on the floor. During an interview on 03/11/2026 at 4:01 PM, Director of Nursing (DON) B confirmed the facility's weekly wheelchair cleaning logs did not show that Resident #2's wheelchair was cleaned for the past 30 days.During an observation on 03/11/2026 at 4:12 PM, Resident #2 was in the activity room, and her wheelchair was still soiled with the stains/spills that were observed on 3/10/2026 and 3/11/2026.During an observation on 03/12/2026 at 8:15 AM, Resident #2 was in the dining room, seated in her wheelchair, and her wheelchair remained soiled as it had been on 3/10/2026 and 3/11/2026. Additionally, the front left inner wheel area was covered in a dried-up yellow material. Review of an email from DON B, dated 3/12/2026 at 7:16 AM, indicated Resident #2 was admitted on [DATE] and there was no documentation available to show when her wheelchair was last cleaned.Review of the facility's 4TH FLOOR .WHEELCHAIR/WALKER CLEANING SCHEDULE 2026, dated 2/9/26 through 3/11/2026, revealed no documentation that Resident #2's wheelchair was cleaned.Resident #52: Review of Resident #52's brief interview for mental status, dated 2/24/26, was scored 2 which reflected severely impaired cognition.During an observation and interview on 03/10/2026 at 11:28 AM, Resident #52 was seated upright in his wheelchair in the activity room. His right wheelchair foot pedal strap (intended to provide foot support and to prevent slipping) was only attached to the outer side of the foot pedal. The strap was not attached to the inner part of the foot pedal (making the strap non-functional), was not secured, and was resting on the floor. There was no heel strap present on the left wheelchair foot pedal. Resident #52 was confused and unable to answer (continued on next page)

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

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	03/12/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	questions regarding the state of his wheelchair.During an observation on 03/12/2026 at 8:46 AM, Resident #52 was seated upright in his wheelchair in the hallway near the nurses' station with his feet on the foot pedals. The wheelchair's left foot pedal strap was still missing. The right foot pedal's strap was still broken and hung off the outer right side and was resting on the floor.Resident #36:Review of Resident #36's brief interview for mental status, dated 1/6/26, was scored 0 which reflected severely impaired cognition.During an observation and interview on 03/10/2026 at 12:52 PM, Resident #36 was seated upright in his high back wheelchair near the nurses' station. His wheelchair seat was soiled with brown and white debris/stains and chunks of unknown brown material that appeared to be old food. There was debris on the wheelchair frame. The wheelchair had an anti-tip bar (prevents the wheelchair from tipping backwards) on the left side, but the anti-tip bar on the right side was missing. Resident #36 was confused and unable to answer questions regarding the state of his wheelchair. During an observation on 03/10/2026 at 4:10 PM, Resident #36 was seated in his wheelchair in the activity room. Resident #36's wheelchair seat was still soiled as it had been on 3/10/26 at 12:52 PM. The right anti-tip bar was still missing.During an observation on 03/11/2026 at 8:29 AM, Resident #36 was seated upright in his wheelchair and was speaking nonsensically. His wheelchair remained soiled as it had been on 3/10/2026 and some yellow debris was also present. The anti-tip bar on the right side of the wheelchair was still missing. During an observation on 03/11/2026 at 12:25 PM, Resident #36 was seated in his wheelchair near the dining room. The anti-tip bar on the right side of the wheelchair was still missing, and the wheelchair seat remained soiled. During an observation on 03/11/2026 at 2:25 PM, Resident #36 was asleep in bed with his wheelchair near the bed with the back reclined. The wheelchair's seat fabric remained soiled with stains observed previously and there were various pieces of debris on the seat. The debris on the seat included an approximately 1-inch-long piece of material that looked like a green bean. The anti-tip bar on the right side was still missing.During an observation on 03/11/2026 at 3:57 PM, Resident #36 was in his wheelchair near the nurses' station. The anti-tip bar on the right side was still missing, and the back of the wheelchair was slightly reclined. The wheelchair seat remained soiled and there was some white and yellow debris on the wheelchair's framing. The approximately 1-inch-long piece of what appeared to be a green bean was still present.During an interview on 03/12/2026 at 1:03 PM, Nursing Home Administrator (NHA) A confirmed Resident #36's wheelchair anti-tipper bars were discontinued on 3/11/26 and that was when the work order was submitted for maintenance to remove the one remaining anti-tip bar. NHA A confirmed the wheelchair should have had both anti-tip bars in place for the period prior to their removal.During an interview on 03/11/2026 at 4:01 PM, DON B confirmed the facility's weekly wheelchair cleaning logs did not show that Resident #36's wheelchair was cleaned for the past 30 days. DON B confirmed each resident's wheelchair should be cleaned weekly.During an observation on 03/12/2026 at 9:01 AM, Resident #36 was seated in his wheelchair near the dining room. The wheelchair seat on each side of the resident was dirty and soiled with spills/stains.Review of Resident #36's Interdisciplinary Notes, dated 10/17/2023, stated, OT (Occupational Therapy) provided a new wheelchair with anti-tipper.Review of the facility's 4TH FLOOOR .WHEELCHAIR/WALKER CLEANING SCHEDULE 2026, dated Week of 1/19/26, indicated the last time Resident #36's wheelchair was cleaned was documented on 1/21 (1/21/26). Review of an email from DON B, dated 3/12/2026 at 7:16 AM, confirmed that Resident #36's .wheelchair was last cleaned on 1/21/2026 .Resident #6:Review of Resident #6's brief interview for mental status, dated 1/9/26, was scored 2 which reflected severely impaired cognition.During an observation and interview on 03/11/2026 at 4:26 PM, Resident #6 was seated in a wheelchair at a table next to the nurses' station. There was brown and pink material built up on the resident's right wheelchair frame on the areas of the wheel lock, metal frame, and front wheel. The wheelchair cushion Resident #6 was sitting on had some brown staining. Resident #6 was confused and unable to answer questions about the state of her wheelchair.During an observation on 03/12/2026 at 8:20 AM, Resident #6 was observed sitting in her wheelchair eating in the dining room. The right side of the wheelchair was still (continued on next page)

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	03/12/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	soiled as it had been on 3/11/26 at 4:26 PM. Resident #46: Review of Resident #46's brief interview for mental status, dated 3/5/26, was scored 6 which reflected severely impaired cognition.During an observation on 03/12/2026 at 8:26 AM, Resident #46 was seated in her wheelchair and eating breakfast in the dining room. Resident #46's left wheelchair anti-tip bar was in disrepair/misaligned as it was angled inwards towards the center line of the wheelchair (instead of being positioned straight back and down). The position of the left anti-tip bar made it so if the wheelchair was to tip backwards, the left anti-tip bar wouldn't have been able to contact the floor as intended.Resident #29:Review of Resident #29's brief interview for mental status, dated 1/15/26, was scored 3 which reflected severely impaired cognition.During an observation and interview on 03/12/2026 at 8:56 AM, Resident #29 was seated in her wheelchair outside the activity room in the hallway. Her wheelchair's right foot pedal was in disrepair as the heel strap wasn't secured as intended. The heel strap was not secured to the foot pedal and was resting on the floor. There was no heel strap on the wheelchair's left foot pedal.Review of the facility's Cleaning environment, resident equipment, and medical devices policy, revised 7/2025, indicated wheelchairs were to be cleaned Weekly. Applying the reasonable person concept, one would desire a clean wheelchair in good repair (having all pieces secured and in place as intended) to be maintained. The residents addressed above, due to impaired cognition, were unable to share their feelings on how the state of their wheelchair made them feel or impacted them.