STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235525	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Nursing and Rehabilitation Community	320 E Central Ave Zeeland, MI 49464

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on interview and record review, the facility failed to honor Advanced Directives for 1 resident (R2) out of 2 residents reviewed for Advanced Directives and ensure that the competent resident made their own Medical Treatment Decisions. Findings: Review of a Designation of Patient Advocate and Direction for Health Care (Durable Power of Attorney for Health Care) for (R2) dated 10/20/2020 reflected R2 appointed a Patient Advocate and Successor Patient Advocate(s). The document specified My Patient Advocate or Successor Patient Advocate may act only if I am unable to participate in making decisions regarding my medical, or as applicable, mental health treatment. Review of an admission Minimum Data Set (MDS) dated [DATE] indicated R2 admitted to the facility on [DATE] and was cognitively intact as evidenced by a Brief Interview for Mental Status (BIMS) score of 13/15 and did not exhibit problematic behavior or reject care. Review of a Medical Treatment Decisions of Resident dated 12/20/2022 reflected I have been informed in writing, in language that I understand, of my rights and all rules and regulations to make decisions concerning medical care, including the right to accept or refuse treatment and the right to formulate and to issue Advanced Directives to be followed if I become incapacitated. In the absence of an advanced directive I understand that any and all life sustaining measures may be used. I may revoke any and all of my decisions at any time. The form was signed by the patient advocate R2 specified could only act on their behalf when they were unable to participate in making decisions regarding medical and mental health treatment decisions. Review of a Do-Not-Resuscitate Order dated 12/21/22, included sections pertaining to consent: Declarant Consent (a person or party who makes a formal declaration) that included a space for the Declarant's signature as well as a line for Signature of person who signed for Declarant if applicable. The section pertaining to Patient Advocate Consent was signed by the patient advocate R2 specified could only act on their behalf when they were unable to participate in making decisions regarding medical and mental health treatment decisions. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Decision Making Capacity Determination reflected R2 was evaluated by 2 physicians and . Determined to lack capacity to make reasoned medical decisions . An individual, a de facto surrogate, resident advocate or durable power of attorney, will have the ability to make decisions on their behalf. The determination was effective as of the date the second physician signed the form on 2/27/2023, two months after R2 admitted to the facility. During an interview on 2/20/2025 at 9:57 AM, the Social Services (SS) staff F confirmed R2 had not been deemed incapacitated at the time the Medical Treatment Decisions of Resident form or Do-Not-Resuscitate Order were completed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on observation, interview, and record review, the facility failed to ensure medications were administered following nursing professional standards of practice, for 3 of 8 residents (R35, R11, and R30), resulting in medication errors and the withholding of medications without a physician order. Findings: Resident # 35 (R35) Review of an Admission Record revealed R35 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included type 2 diabetes mellitus. Review of R35's Order Summary dated 2/6/25 revealed, insulin aspart U-100 insulin pen; 100 unit/mL (3 mL); Amount to Administer: 3 units; subcutaneous; Before Meals. There were no parameters ordered to hold the insulin if the blood sugar was below a specific level. Review of R35's February Medication Administration Record revealed: *On 2/15/25 at 11:00 AM R35's aspart insulin was Not Administered: On Hold Comment: BS (blood sugar) 89. *On 2/17/25 at 11:00 AM R35's aspart insulin was Not Administered: Other Comment: glucose 75. Review of R35's Electronic Medical Record revealed no documentation that the licensed nurse received an order to hold the ordered insulin or that the provider was notified that the insulin was not administered. Resident # 11 (R11) Review of an Admission Record revealed R11 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included diabetes. Review of R11's Order Summary dated 8/28/24 revealed, Lantus Solostar U-100 Insulin (insulin glargine) insulin pen; 100 unit/mL (3 mL); Amount to Administer: 30 units; Subcutaneous; Once A Day. Review of R11's January Medication Administration Record revealed: *On 1/20/25 R11 was administered 15 Units of Lantus. *On 1/28/25 R11 was administered 15 Units of Lantus. Review of R11's Electronic Medical Record revealed no documentation that the provider had ordered a decreased dose of R11's Lantus on 1/20/25 or 1/28/25 or a rationale for the documentation/administration of 15 units of Lantus instead of the ordered 30 units of Lantus. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	29073 Resident #30 (R30) Review of an Admission Record revealed R30 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included hypertension (high blood pressure). Review of R30's Order Summary dated 2/9/24 revealed, metoprolol succinate tablet extended release 24 hr; 25 mg; Amount to Administer: 1 tablet; oral; Once A Day. There were no parameters ordered to hold the metoprolol if the blood pressure was below a specific level. Review of R30's January Medication Administration Record revealed that on 1/11/25 R30's metoprolol was Not Administered: Other Comment: outside parameters. Review of R30's Electronic Medical Record revealed no documentation that the provider had ordered the metoprolol to be held or that the provider was notified that the metoprolol had not been administered. During an observation on 2/19/25 at 8:57 AM, Registered Nurse (RN) A prepared medications for R30, including metoprolol succinate extended release 24 hr; 25 mg (milligram); Amount to Administer: 1 tablet; oral; Once a Day. RN A measured R30's blood pressure which was 126/51. RN A withheld R30's metoprolol, destroying it in a drug buster. When asked, RN A said she thought there were parameters to hold R30's metoprolol. RN A reviewed R30's order for the metoprolol and confirmed there were no parameters to hold the drug. RN A said there used to be parameters. Review of Resident Progress Notes dated 2/19/25 did not reflect RN A contacted the physician to inform them R30's ordered metoprolol had been held and/or that the order was clarified to include parameters. During an interview on 2/20/25 at 8:15 AM, the Director of Nursing (DON) confirmed that R35's aspart insulin did not have parameters to hold if the blood sugar was below a specific level at the time the medication was held. The DON reported that a new order was received to include blood sugar parameters. The DON reported confirmed R11's Lantus was documented as 15 units administered and not the ordered 30 units. The DON reported that she spoke with the nurse that administered the insulin, and the nurse reported she mixed them up with a different resident and it was a documentation error. The DON was unable to provide documentation ensuring R11 received the correct dose of Lantus. The DON confirmed there were no ordered parameters for R30's metoprolol and reported licensed nurses were not to make medication decisions (such as holding a medication) without first discussing or notifying the provider.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 Based on interview and record review, the facility failed to administer and accurately document administration of controlled substances for 3 of 6 residents (Resident #17, #16, and #239) reviewed for the administration of controlled medications, resulting in the potential for ineffective management of pain and the potential for diversion of controlled drugs. Resident #17 (R17) Review of an Admission Record revealed R17 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety, spinal stenosis, and severe osteopenia. Review of R17's Order Summary dated 7/20/24 revealed, hydrocodone-acetaminophen (Norco) tablet; 5-325 mg; Twice A Day to be administered between 06:00 AM-10:00 AM and 04:00 PM-07:00 PM Review of R17's Controlled Substances Proof of Use form revealed that on 2/15/25 R17's Norco was documented as being removed/administered 1 time at 8:00 AM. R17's evening dose of Norco was not documented as being administered. Review of R17's Medication Administration Record revealed R17's Norco was documented as administered 2 times on 2/15/25. Review of R17's Order Summary dated 9/28/24 revealed, lorazepam (Ativan) tablet; 0.5 mg; Amount to Administer: 1/2 tablet; oral Once A Day takes 1/2 tablet of 0.5mg =0.25mg. Review of R17's Controlled Substances Proof of Use form revealed that on 2/15/25 R17's dose of Ativan was not documented as being removed/administered. Review of R17's Medication Administration Record revealed R17's Ativan was documented as being administered on 2/15/25. Review of R17's Electronic Medical Record revealed no documentation and/or rationale for the withholding of R17's Norco or Ativan on 2/15/25. Resident #16 (R16) Review of an Admission Record revealed R16 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: a history of pelvic and rib fractures. Review of R16's Order Summary dated 1/21/25 revealed, oxycodone tablet; 5 mg; Amount to Administer: 1 tab; oral Every 6 Hours - PRN (as needed). Review of R16's Controlled Substances Proof of Use form revealed R16's oxycodone was documented as being pulled/administered on the following dates and time: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	*1/24/25 at 11:23 AM *1/25/25 at 9:00 PM *1/26/25 at 3:00 PM *1/26/25 at 9:00 PM *1/27/25 at 9:00 PM *1/30/25 at 7:45 PM *1/31/25 at 9:00 PM *2/14/25 at 8:00 PM Review of R16's Medication Administration Record revealed R16's oxycodone was not documented as being administered on the above listed dates. Resident #239 (R239) Review of an Admission Record revealed R239 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Review of R239's Order Summary dated 2/3/25 revealed, oxycodone tablet; 5 mg; Amount to Administer: 1 tab; oral Every 6 Hours - PRN (as needed). Review of R239's Controlled Substances Proof of Use form revealed R239's oxycodone was documented as being pulled/administered on 2/7/25 at 6:00 PM and on 2/8/25 at 3:15 AM. Review of R239's Medication Administration Record revealed R239's oxycodone was not documented as being administered on 2/7/25 or 2/8/25. During an interview on 2/20/25 at 8:15 AM, Director of Nursing (DON) confirmed the medication/documentation errors for R17, R16, and R239's controlled drug medications and reported licensed nurses are to document in the Medication Administration Record when a controlled drug is administered at the time it is administered. DON reported a medication error report would be completed for the withholding of R17's Norco and Ativan on 2/15/25. Review of the facility policy Controlled Substances Standards of Practice updated 09/2022 revealed, .Once the nurse completes the administration, then the nurse is to document on the MAR (Medication Administration Record) paper record or E-Mar electronic record. If PRN (as needed) medication is administered, additional documentation regarding reason, result, time and initials are required .Director of Nursing or Licensed Designee will conduct reviews in addition to above to ensure compliance in monitoring and be alert to any potential errors in accuracy .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intake # MI00146937 Based on interview and record review the facility failed to 1.) involve residents/resident representative in the medication management process and 2.) evaluate and track progress and/or decline towards the gradual dose reduction of a psychotropic medication for 2 of 5 residents (Resident #4 and #24) reviewed for psychotropic medication use. Findings: Resident #4 (R4) Review of an Admission Record revealed R4 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: Dementia with unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and major depressive disorder. R4 had a DPOA (Durable Power of Attorney) in place and did not make her own decisions. During an interview on 02/19/25 at 11:41 AM, DPOA G reported that R4 had been on Paxil (antidepressant) for approximately [AGE] years and was the medication used to treat her wild mood swings throughout the years. DPOA G reported that the facility staff notified him that R4's Paxil was to be reduced as part of a Gradual Dose Reduction (GDR) required by the State. DPOA G reported he didn't want them to (reduce R4's Paxil) because that was what worked with her for [AGE] years. DPOA G reported that because of the GDR of Paxil R4 had been swatting at other patients and they (facility) lost control (of her aggression/behaviors). During an interview on 02/20/2025 at 10:00 AM, Social Services (SS) F reported that the Behavior Management Team consisted of herself, the pharmacist, the facility provider, and a psychiatric consultant. SS F stated that if a resident didn't have a qualifying diagnosis of schizophrenia or bipolar (disorder) or if the resident didn't have qualifying documentation, we have to at some time attempt a GDR.SS F reiterated that a GDR attempt was required to be made on any psychotropic medications. During an interview on 02/20/2025 at 10:22 AM, Medical Doctor (MD) H reported that a GDR was attempted on psychotropic medications if a resident's behaviors and mood had been stable. If a GDR was determined to not be in the best interest of a resident a rationale was documented in the residents Electronic Medical Record. MD H reported he would defer to the psychiatric consultant and/or the pharmacist for their recommendations as it was not his area of expertise. During an interview on 02/20/25 at 12:18 PM, SS F reported that the pharmacist recommended the GDR of Paxil and had said it's not a medication that's good for the elderly. SS F reported that R4 had been doing well with the GDR then started having behaviors again. SS F reported that R4 was not followed by the psychiatric consultant. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/20/25 at 1:44 PM, Director of Nursing (DON) stated they had to get her off (of Paxil) per the pharmacist due to the side effects of the medications. Review of R4's Pharmacy Consultation Report dated 7/18/24 revealed the pharmacist recommended a decrease in R4's Paxil from 20mg once daily down to 10mg once daily. This recommendation was approved by the provider and signed on 7/24/24. A handwritten note at the bottom of the form revealed medication changed and was signed off by the Director of Nursing (DON) on 7/24/24. Review of R4's Order Summary dated 7/22/24 revealed, Paxil (paroxetine hcl) tablet; 10 mg; one tab .GDR per pharmacy recommendation telephone order from PA (physicians assistant) Once A Morning. Review of R4's Electronic Medical Record revealed no documentation that DPOA G had been consulted on further decreasing R4's Paxil and had not been notified of the medication change on 7/22/24. Review of R4's Progress Note dated 7/24/24 revealed, Resident medication change with Paxil from 20mg down to 10mg once daily. No adverse effects noted. Resident exhibiting some behaviors this am. Resident observed raising fist and yelling out at another resident in the dining room. Resident moved to a different table and behavior stopped. Indicating a change in behaviors with aggression towards other vulnerable residents. Review of R4's Progress Note dated 7/25/24 revealed, Aide noted resident to be somewhat aggressive in am when getting up into w/c via sit to stand with 2 assist. Aide reported resident pinching and poking at her breasts. No injuries note from aide. Otherwise, resident sitting in dining room quietly for lunch. Indicating new physically aggressive behaviors. Review of R4's Progress Note dated 7/28/24 revealed, Resident medication change with Paxil from 20mg down to 10mg once daily. No adverse effects noted. Resident exhibiting some behaviors this am. Resident making faces at staff while providing care. Resident unable to sit next to certain resident when in dining room due to getting angry and waving fists when sitting near them. Will continue to note changes. Indicating ongoing aggression towards other residents. Review of R4's Progress Notes revealed the last behavior note was documented on 8/3/24. There was an Activities quarterly assessment completed on 8/9/24 and a Covid progress note completed on 8/23/24. Review of R4's Progress Note dated 8/27/24 revealed, refused to get up this am stated no wouldn't hold onto bars of sit to stand, refused to remain seated upright, spit out am meds at first attempt accepted on second noted glaring at staff, slept most of day resistive to care stiffening up and pushing staff away, noted sticking out tongue and growling at staff. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R4's Progress Note dated 9/1/24 revealed, during lunch in dinning (sic) room, kitchen staff overheard another resident yelling stop it stop it. to this resident. this resident became agitated and slapped at other residents right arm striking right forearm/wrist area, on top side with open palm. then this resident began screaming out nonsensically. residents immediately separated with investigation showing no injury to other resident, this resident placed at nurses station where began yelling at staff stating i need it i need it. once tray delivered from dining room resident calmed but continues to glare harshly and pint at staff who removed from dinning room whenever passed saying you you you. for next 10 minutes. This incident was reported to the State Agency due to R4 assaulting another resident. (All incidences of resident to resident abuse are to be reported to the State Agency for review/investigation as all residents have the right to be free from abuse). Review of R4's Progress Note dated 9/15/24 revealed, resident became agitated i dining room when another resident was tearful, and began spitting noises while making face at other resident from across the dinning room . Review of R4's Progress Note dated 9/16/24 revealed, making faces and pointing at other residents at times easily redirected with conversation, combative with AM care, pulling away and slapping with open palm at times. Review of R4's Psychotropic Monthly Review forms revealed no reviews were completed in August 2024 or September 2024. (Confirmed with Nursing Home Administrator via email on 2/20/25 at 3:20 PM.) . Indicating the Behavior Management Team did not evaluate and track progress and/or decline towards the GDR of R4's Paxil since previous GDR on 7/22/24. There was no documentation that the Behavior Management Team reviewed/discussed the increased behaviors/aggression towards staff and residents as documented in the Progress Notes or that the resident to resident abuse, where R4 had been the perpetrator on 9/1/24 was reviewed/discussed. Documentation that R4 failed the Paxil GDR despite the change in behaviors was not reviewed/discussed. Review of R4's Physician Progress Note dated 9/19/24 revealed, .Following up at the request of the nursing and social services to consider discontinuation of the patient's Paxil and start the patient on Zoloft. The nursing staff otherwise do not report any other acute concerns .I have DC'd (discontinued) the patient's Paxil and start the patient on Zoloft 25 mg . Indicating the provider had not been made aware of the increased behaviors/aggression towards staff and residents as documented in the Progress Notes from the previous GDR on 7/22/24. Review of R4's Electronic Medical Record revealed no documentation that DPOA G had been consulted on discontinuing R4's Paxil and had not been notified of the discontinuation on 9/19/24. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 02/20/25 at 11:31 AM, Consultant Pharmacist (CP) I reported that an attempt to GDR R4's Paxil was made due to the high risk of side effects noted in the geriatric population. CP I reported that medication reviews are completed monthly, and he completes them either remotely or in person. CP I reported that he reviews behavior logs as well as psychiatric consultant notes. If the psychiatric consultant identifies that a GDR of a medication is contraindicated, he follows their lead. If a patient has been stable for a long period of time it indicates that a GDR could be attempted. CP I reported that the recommendation would have been to have go back up on the Paxil if R4 was displaying increased behaviors during the GDR process and the benefits of the medication would have outweighed the risk. CP I reported they could revisit the GDR of Paxil at a later date if she was experiencing side effects from the medication. CP I reported that the GDR process for R4's Paxil revealed she required the medication, and it was restarted on 1/22/25. During an interview on 02/21/25 at 11:40 AM, CP I reported he could not recall if he was notified of R4's resident to resident abuse identified on 9/1/25. Resident #24 (R24) Review of an Admission Record revealed R24 was an [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: Vascular dementia, unspecified severity, with psychotic disturbance, Delirium due to known physiological condition, and Unspecified dementia, unspecified severity, with agitation. R24 had a DPOA in place and did not make his own decisions. Review of R24's Psychiatric Consultation Report dated 1/2/25 revealed, .Patient continues to experience hallucinations per his report approximately twice a week Continue .Depakote ER 500 mg daily . Review of R24's Pharmacy Consultation Report dated 1/2/25 revealed, (R24) has experienced a recent fall in [DATE], and is at moderate to high risk of falls due to medications which may contribute to fall risk . Recommendation: Please consider the following actions to reduce the future risk of falls .2. Trial decrease to depakote ER 250 mg po HS (by mouth at night) . Indicating the depakote GDR was initiated due to a fall and not due to long term stability with behaviors/moods. During an interview on 02/19/25 at 12:00 PM, DPOA E reported that she had not been notified of a GDR for R24's Depakote. DPOA E stated she was told the GDR process was dictated by the state. They have to try to lower it and see if it works. DPOA E stated unless he actually needs to be reduced, I don't prefer that further stating that R24 tends to be unstable and has a lot of hallucinations. DPOA E reported she was not aware that she had a say in the GDR process or that a GDR could be deemed contraindicated if the benefits of the medication outweighed the risks due to his history of aggression and the fact that R24's reductions in the past did not go well. A request was made to Nursing Home Administrator (NHA) for documentation that DPOA E was consulted/notified of an attempt to GDR R24's Depakote on 2/21/25 at 9:42 AM via email. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	NHA provided an email sent by SS F on 1/15/25 which revealed, Pharmacy gave a recommendation for a trail (sic) GDR (Gradual dose reduction) for (R24's) Depakote, which is his mood stabilizer medication. We have to attempt reductions with all medications, and we have not tried one yet for this medication. (Psychiatric consultant name omitted) that follow's (sic) (R24) is in agreement that we need to trail (sic) a GDR, if it does not go well, then we will put it back. I wanted to update you on this, so we can get this order in and signed by the doctor. This notification email did not include risk versus benefit documentation or the rationale for the initiation of the Depkote GDR. On 2/21/25 at 9:49 AM NHA was asked to provide documentation that DPOA E agreed to R24's Depakote GDR via email. At 2/21/25 at 10:00 AM NHA stated, Unfortunately, (SS F) is unable to find a response email. Confirming DPOA E did not consent to the GDR of R24's Depakote. Review of the facility policy Psychotropic Medication Use last reviewed 01/2024 revealed, .3. Residents and/or representatives will be educated on the risks and benefits of psychotropic medication use, as well as alternative treatments/non-pharmacological interventions. 4. Residents who use psychotropic medications will receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue the medication if possible . 9. The effects of psychotropic medications on residents will be evaluated. This may be through physician evaluation, pharmacist routine medication review, nurse assessments and medication monitoring, and the plan of care 10. The resident response to the medication will be documented in the resident's medical record . Review of the State Operations Manual revealed, When selecting medications and non-pharmacological approaches, members of the IDT, including the resident, his or her family, and/or representative(s), participate in the care process to identify, assess, address, advocate for, monitor, and communicate the resident's needs and changes in condition . o Involvement of the resident, his or her family, and/or the resident representative in the medication management process. o Selection of medications(s) based on assessing relative benefits and risks to the individual resident . o Selection and use of medications in doses and for the duration appropriate to each resident's clinical conditions, age, and underlying causes of symptoms and based on assessing relative benefit and risks to, and preferences and goals of, the individual resident . o Resident Choice -If a resident declines treatment, the facility staff and physician should inform the resident about the risks related to the lack of the medication, and discuss appropriate alternatives such as offering the medication at another time or in another dosage form, or offer an alternative medication or non-pharmacological approach . Track progress and/or decline towards the therapeutic goal .Determining the frequency of monitoring-- The frequency and duration of monitoring needed to identify therapeutic effectiveness, achievement of resident goals, and adverse consequences will depend on factors such as clinical standards of practice, facility policies and procedures, manufacturer's specifications, and the resident's clinical condition and choices . Periodic planned evaluation of progress toward the therapeutic goals.

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Heritage Nursing and Rehabilitation Community	320 E Central Ave Zeeland, MI 49464

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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. 29073 Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food in the kitchen. Findings include: During an initial tour of the kitchen on 2/19/2025 beginning at 9:45 AM, it was observed that the handwashing sink next to the dish machine was obscured with a gallon size container of an unknown chemical. Further observation found a large, sealed, zippered plastic bag in the walk-in cooler containing scrambled eggs that had been served at breakfast. The bag was found warm to the touch. During an interview on 2/19/2025 at 10:00 AM, Dietary Manager (DM) L reported foods that are cooled for reuse are documented on a cooling log. There was no documentation pertaining to the leftover foods that had been discovered in the walk-in cooler. The leftover scrambled eggs were retrieved from the walk-in cooler and an analog temperature probe indicated the eggs were 100 degrees Fahrenheit. DM L reported cooling had started at 9:15 AM at 135 degrees Fahrenheit. It was noted at this time there was a plastic zippered bag containing sausage links. The sausage links temperature was 50 degrees Fahrenheit. DM L said the sausage links also began cooling at 9:15 AM at 135 degrees Fahrenheit. DM L then added the leftover eggs and sausage to a cooling log. According to the 2022 FDA Food Code section 3-501.15 Cooling Methods. (A) Cooling shall be accomplished in accordance with the time and temperature criteria specified under S 3-501.14 by using one or more of the following methods based on the type of FOOD being cooled: . (2) Loosely covered, or uncovered if protected from overhead contamination as specified under Subparagraph 3-305.11(A)(2), during the cooling period to facilitate heat transfer from the surface of the FOOD. During an observation and interview on 2/18/25 at 10:15 AM, DM L said the facility had a low temperature dish machine. A cycle was run, and chemical sanitizer concentration was measured with a test strip indicating the chemical concentration was 100 ppm (parts per million). DM L said the dish machine had to reach 120 degrees Fahrenheit. The temperature gauge outside of the machine did not indicate the cycle reached 120 degrees as required. The surveyor requested the water temperature be manually measured. The temperature was approximately 105 degrees. When asked, DM L reported the analog thermometer probes are calibrated monthly. DM L prepared ice water to calibrate two thermometers. Each thermometer required calibration from 40 degrees to 32 degrees and indicated a high likelihood food temperature measured before the breakfast meal were not accurate. The dish machine water was again temped. The wash cycle was 90 degrees, and the rinse cycle was 100 degrees. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of a Dish Machine Temperature Log for February 2025 specified Check and record temperatures and test strip results before washing dishes. Plz (sic) notify yur (sic) Director/Manager with any identified issues. NOTE: For low temperature machines, if sanitize is less than 50 ppm or if the temperature is less than 120 degrees Fahrenheit or above 150 degrees Fahrenheit, Plz (sic) notify your director. The log reflected the rinse cycle did not meet the minimum required 120 degrees during the breakfast service every day except 2/2/25, 2/3/25 and 2/8/25. The rinse cycle did not reach 120 degrees during the lunch service on any day except 2/3/25. The rinse cycle did not meet the required 120-degree rinse during the dinner service on 2/15/25, 2/16/25 or 2/17/25. According to the 2022 FDA Food Code section 4-501.15 Warewashing Machines, Manufacturers' Operating Instructions. (A) A WAREWASHING machine and its auxiliary components shall be operated in accordance with the machine's data plate and other manufacturer's instructions. (B) A WAREWASHING machine's conveyor speed or automatic cycle times shall be maintained accurately timed in accordance with manufacturer's specifications. 38905 During a follow up tour of the kitchen, at 9:32 AM on 2/19/25, an interview with DM L found that staff cool down food frequently. Review of the facility log entitled Cooling Down Foods - Tracking Chart, contained items that cooled down between 2/2/25 and 2/10. The log states the foods need to cool from 135F to 70F within two hours and from 70F to 41F in four hours. A review of the log found Chicken Gravy cooled on 2/2/25 went from 135F at 1:00 PM to 76F at 3:00 PM, Chicken and Rice soup on 2/4 started cooling at 135F at 2:00 PM and was documented at 81F two hours later at 4:00 PM. When asked if these items were served to residents after improperly cooling, DM L was unsure. According to the 2017 FDA Food Code section 3-501.14 Cooling. (A) Cooked TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be cooled: (1) Within 2 hours from 57 C (135 F) to 21 C (70 F); and (2) Within a total of 6 hours from 57 C (135 F) to 5 C (41 F) or less . During a follow up tour of the kitchen, at 9:40 AM on 2/19/2025, observation of the tabletop mixer found increased accumulation of brown dried debris on the underside arm of the unit and in and around nuts / bolts on the surface. Follow up observation of sheet pans and one saucepan, at 10:06 AM on 2/19/25, found that the surfaces of equipment had increased amount of encrusted black grease deposits. Accumulation was evident on the sides and corners of the pans. An interview with [NAME] J found that she tries hard to scrub the surfaces, but some don't come clean. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. During a follow up tour of the dry storage room, at 10:20 AM on 2/19/25, it was observed that an open container of Teriyaki marinade was found on the dry storage shelf. A review of the manufacture label found that the item states Refrigerate After Opening. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less.

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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** 29073 Based on interview and record review, the facility failed to ensure a complete and accurate medical record for one resident (R29) out of 9 residents reviewed when the physician did not document an assessment or date mark a signature on an assessment of capacity. Findings: Review of a Face Sheet reflected R29 admitted to the facility from a hospital on 1/09/2025 with pertinent diagnoses that included metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic imbalance). Review of an admission Minimum Data Set (MDS) assessment dated [DATE] reflected R29 was moderately cognitively impaired as evidenced by a Brief Interview for Mental Status (BIMS) assessment score of 10/15. Review of a Hospitalist Progress Note dated 1/09/2025 reflected Assessment of capacity-Based on my evaluation of the patient (R29) on the morning of 1/9 patient lacks capacity to make informed decisions regarding complex medical decision making. Patient was interviewed at bedside and is unable to state where she was, current month or year, any underlying/chronic medical conditions or reason she was hospitalized . It is readily apparent that patient lacks capacity for advanced medical decision making and therefore would advise activation of MDPOA (medical durable power of attorney). The assessment was electronically signed by a hospital physician on 1/09/2025 at 1:32 PM EST (eastern standard time). Below the documented assessment, a handwritten X and signature line with the handwritten name of the facility Medical Director (MD) H. MD H signed the line. The signature is not dated and there is not a documented assessment or statement of agreement with the hospital physician's assessment. During an interview on 2/20/2025 at 9:48 AM, MD H was shown the Hospitalist Progress Note. MD H said he had no idea when he signed the document and intended to indicate agreement with the assessment of capacity.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29073 Based on interview and record review, the facility failed explain terms of an Agreement to Resolve Legal Disputes Through Arbitration and ensure the validity of understanding/consent to enter into the agreement was witnessed for one resident's (R29's) Health Care Power of Attorney (HCPOA) out of 3 residents reviewed for Arbitration agreements. Findings: Review of a Face Sheet reflected R29 admitted to the facility from a hospital on 1/09/2025 with pertinent diagnoses that included metabolic encephalopathy (a condition where the brain does not function properly due to an underlying metabolic imbalance). Review of the facility Agreement to Resolve Legal Disputes Through Arbitration reflected This Agreement to Resolve Legal Disputes Through Arbitration (the Agreement) is made and entered into on 1/10/2025 by and between (name of facility) ('name of facility' or the facility), and _____ (Resident) and HCPOA N (Representative), collectively, the Parties. The space reserved for the resident's name was left blank. The Agreement was signed by HCPOA N and the Nursing Home Administrator (NHA) on 1/10/2025. The signature line for a Witness was blank. During an interview on 2/20/2025 at 10:31 AM, HCPOA N was asked if he recalled signing a binding arbitration agreement. According to HCPOA N, he recalled signing the agreement but did not like arbitration in general due to his understanding of arbitration being overall lacking in transparency, preferred arbitrators and the lack of appeal rights. HCPOA reported a family member was an attorney and used to talk about preferred arbitrators often favoring an entity rather than the complainant. HCPOA N was asked if he understood that the agreement meant that any dispute arising from care and/or services provided at the facility could not be heard in a court of law. HCPOA N was also asked if he understood that when he signed the agreement, he had 30 days to inform the facility in writing to cancel the agreement. HCPOA N said he did not understand what he was signing and was overwhelmed with the admission process and that upon review it sounds like a ridiculous arrangement. HCPOA N said he did not know that he could have cancelled the agreement within 30 days of signing the document if he submitted the cancellation request in writing. HCPOA said it was a [NAME] point now, because the 30 days have elapsed. During an interview on 2/21/2025 at 10:45 AM, the NHA reported she was surprised to hear that HCPOA N did not understand the binding arbitration agreement. According to the NHA, she had emailed with HCPOA N about the admission contract which included the binding arbitration agreement. The NHA was asked for the email communication at this time. Review of an e-mail sent by the NHA to the surveyor on 2/21/2025 at 12:08 PM reflected Here is the history of that contract. It states that it was sent to (HCPOA N) email and that he signed and sent it back. Attached to the email was a document labeled (R29's last name) Contract.pdf (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of (R29's last name) Contract.pdf reflected on 1/10/2025 at 11:02 AM, the NHA created an envelope and sent the envelope to herself at 11:04 AM. At 11:05, the NHA opened and viewed the envelope. At 11:10 AM the NHA signed the envelope and sent an invitation to HCPOA N. At 2:31 PM on 1/10/2025, HCPOA N opened and viewed the envelope which contained the following: -Adult Admission.pdf -Admit consent-(name of facility).pdf -Coronavirus (COVID-19) Statement.pdf -NOTICE OF AVAILABILITY OF HOSPICE CAR.pdf -Advanced Directive Information.pdf -Stop and Watch.pdf -Authorization for Professional Services.pdf -Professionals - Contact List - (name of facility).pdf -Resident Authorization & Release for Photographs.pdf -Understanding Regarding Services Provided.pdf -Bed Holds & Leaves of Absence.pdf -Medicare Secondary Payer Questionnaire.pdf -Resident Personal Funds.pdf -NEMB-SNF.pdf -Assignment of Benefits.pdf -Private Pay Methods - (name of facility).pdf -Designation of Medicaid Authorized Representative.pdf -AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION.pdf -PRIVACY ACT STATEMENT.pdf -Bed Rail Authorization.pdf -Sex Offender Verification Form.pdf -Non-Discrimination and Accessibility Notice-(name of facility).pdf (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Consent Form for Vaccines in LTC-Residents.pdf -Admission Policy.pdf -Notice of Privacy Practices.pdf -Notice of Acknowledgements.pdf -Authorization Form and Supplier Standards.pdf -Resident Rights.pdf -Resident Handbook.pdf -(name of facility), new arbit.pdf HCPOA N signed the envelope containing 30 attachments, the last of which was the binding arbitration agreement, 13 minutes after he opened it on 1/10/24 at 2:44 PM. HCPOA N would have had 43 seconds to review each attachment, making it highly unlikely the documents were reviewed thrououghly. The signed documents were received by the NHA who immediately sent the documents to the facility Business Office Manager. No evidence additional signing was completed by the NHA, indicating the electronic signature of the NHA on the arbitration agreement was present before HCPOA N was assessed for understanding of the agreement. A follow-up email was sent by the surveyor to the NHA on 2/25/24 at 8:32 AM asking who reviewed any and all of the documents with HCPOA N. The NHA replied via email at 9:17 AM, I had contacted him via phone and asked if he would like to come in. He stated he had crazy hours and asked if it could be sent to him. I discussed with him that I could, but I wanted him to call if he had any questions. I sent it to him and he sent it back. He had my email and the SW (social worker) email. We had seen him after this and he never indicated that he had any questions. He stated he had a family member that was an attorney and so he was familiar with these contracts.