STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235736	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Terrace Senior Living	60 Veridian Drive Muskegon, MI 49440

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	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record reviews, the facility failed to effectively clean and maintain food service equipment effecting 29 out of 31 residents that receive food and beverages from the kitchen, resulting in the increased likelihood for cross-contamination and bacterial harborage.Findings include: During an initial kitchen tour on 3/09/26 at 9:10 AM, Certified Nurse's Aide (CNA) T revealed that the Dietary Manager was at a conference and the cook/Person in Charge was on a break. During the initial tour of the kitchen the following violations were observed: The flooring located throughout the kitchen was observed to have a build-up of debris, dust, dirt, and greasy food residue. Heavy build-up was observed under the cooking equipment, shelving, and along floor/wall junctures. 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. The oil in the fryer was observed to be black with a lot of crispy food debris floating over the surface of the oil. The oil in the fryer smelled and looked like it had not been cleaned/filtered and/or replaced recently. The inside of the microwave was observed to have multiple colors and layers of stuck on food debris and grime. The microwave had build-up the door, top, sides, and bottom of the unit. Observation of the cooking equipment (located beneath the hood system) had a visible build-up of grease, grime and food debris. Observation of the standing mixer had a build-up of stuck on food residue and debris on the guard/grate and underside of the unit. The can opener had a build-up of food debris and grime on the blade and on the housing unit. 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 cleaned 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. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2022 FDA Food Code section 4-602.12 Cooking and Baking Equipment. (B) The cavities and the door seals of the microwave ovens shall be cleaned at least every 24 hours by using the manufacturer's recommended cleaning procedure. The side boards on the well steamer unit/area were observed to be down. When lifted up (in order to place trays/pans/dishes on) the whole side/underside of this equipment was covered in food debris, grease, grime and drip marks. According to the 2022 FDA Food Code section 4-602.13 Nonfood-Contact Surfaces. NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues. The hand sinks and prep sinks located throughout the kitchen were observed to be soiled. The hand sink in the dishwashing area was being used as a dump sink and was observed to have yellow liquid eggs at the bottom of the sink's basin. According to the 2022 FDA Food Code section 4-601.11, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces of Utensils. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of accumulation of dust, dirt, FOOD residue, and other debris. According to the 2022 FDA Food Code section 5-205.11 Using a Handwashing Sink.(B) A HANDWASHING SINK may not be used for purposes other than handwashing. Further observation of the dishwashing area revealed an alarm going off on the dish machine. The dish machine was out of soap and the hot water during the sanitizing cycle only reached 158 degrees. The dish machine was being utilized by kitchen employees. When this surveyor questioned what the beeping was and why wasn't it sanitizing, the employee stated, I'm new, ask the cook. During an interview [NAME] U revealed she was in charge. However, when asked what the beeping on the dish machine meant she stated, I don't know, I'm the cook. [NAME] U then contacted maintenance for assistance. During an interview on 3/9/26 at approximately 9:45 AM, Director of Plant Operations (DOPO) P revealed the dish machine had been serviced earlier this morning. When asked why it wasn't sanitizing properly if it had just been serviced, DOPO P stated he wasn't sure, but would call them back out to service it again. When the alarm for soap/detergent was pointed out to DOPO P stated I will take care of it. Dish washing ceased at this time. According to the 2022 FDA Food Code section 4-501.17 Warewashing Equipment, Cleaning Agents. When used for WAREWASHING, the wash compartment of a sink, mechanical warewasher, or wash receptacle of alternative manual WAREWASHING EQUIPMENT as specified in 4-301.12 (C), shall contain a wash solution of soap, detergent, acid cleaner, alkaline cleaner, degreaser, abrasive cleaner, or other cleaning agent according to the cleaning agent manufacture's label instructions. According to the 2022 FDA Food Code section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitizing Temperatures (A) Except as in paragraph (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90 degrees C (194 degrees F) , or less than : (1) For a stationary rack, single temperature machine, 74 degrees C (165 degrees F) ; or (2) For all other machines, 82 degrees C (180 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	degrees F) . Further observation of the dishwashing area revealed a buildup of grime, slime and debris on both the clean and soiled drain boards. The shelving area where the soiled cups and bowls are stored (prior to being washed) had a build-up of black, brown and pink grime/slime. According to the 2022 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood Contact Surfaces, and Utensils. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, food residue, and other debris. On 03/10/2026 at 8:30AM, during a review of the dining services cleaning schedule with Dining Services Assistant Director (DSAD) O, DSAD O stated the Jolt system will produce a daily task list for dining services staff, staff will check off on the system when the task is completed and then the checklist is audited by management. The Jolt system is the dining services software for dining services tasks, and other kitchen related information such as food temperatures. On 03/10/2026 at 9:10AM, observed in dining area, exterior of cabinet that the beverage dispensers (pop, juice and coffee dispensers) sit on, had a heavy buildup of sticky brown residue on the top and bottom edge of the door for that cabinet and residue was on the doors closest to the pop dispenser. DSAD O confirmed that the residue was very sticky and seemed to come from the pop dispenser. According to the 2022 FDA Food Code section 4-602.13 Nonfood-Contact Surfaces. NonFOOD-CONTACT SURFACES of EQUIPMENT shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 03/10/2026 at 11:49AM, observed in the dishwash area, water leaking from the pipe connection of the overhead sprayer. DSAD O, stated there was a workorder for the overhead sprayer that was submitted around two weeks prior to 03/10/2026, for the leaking at the fixture. On 03/10/2026 at 2:00PM during interview with Director of Plant Operations (DPO) P regarding the leaking the connection, DPO P disclosed, plant operations had replaced the flexible arm of the overhead sprayer as that was determined to be the cause of leak for the workorder, DPO P was aware the fixture continued to leak but stated that was due to the backflow preventer that was installed on the pipe connection and would only stop when the water was turned off for the faucet. According to the 2022 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair.

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2732021. Based on interview and record review, the facility failed to follow discharge policies and procedures and provide a bed hold policy for one (R35), failed to notify the family in writing for one (R37) of four residents reviewed for transfers and discharges, and failed to notify the Ombudsman of all the other discharges in the facility for several months. Findings include:Resident (R37) Review of Face Sheet revealed Resident #37 admitted to the facility on [DATE] with pertinent diagnoses which included cerebral infarction, vascular dementia, major depressive disorder, anxiety disorder and encounter for palliative care. R37 originally entered the facility for a 5 day respite stay. A respite stay is a short-term, temporary arrangement where a person with care needs receives specialized care for a few days to several weeks. It provides relief for primary care givers. During the stay the family chose to extend R37's stay, facility agreed and resident's family paid out of pocket for his care. Review of the facility Admit/Discharge Report for 12/1/2025 to 12/31/2025 reflects that R37 entered the facility on 12/12/2025 for a 5-Day respite stay. Review of the facility Admit/Discharge Report for 1/1/2026- 1/30/2026 revealed that the resident was admitted on [DATE] and was discharged to another Skilled Nursing Facility (SNF) that was a Non (Name of Facility Owner) Campus on 1/30/2026. Further review of the report reflected the resident was private pay during his 49 days stay. During an interview on 3/10/26 at 2:54 PM, Complainant V stated, everything was going good as long as we were paying the out of pocket (charge of approximately $419 + a $60-dollar daily level of care charge.) We had told several people there that we were applying for Medicaid but were told they did not assist with that process. As a result, we went to a lawyer for assistance. The minute the facility found out we applied for Medicaid the facility called my mom (R37's wife) into a meeting with the business office on 1/27/26. I was on the phone with my mom during the meeting when they stated we did not tell them we were planning to file for Medicaid and that we would have to move out of the facility by Saturday 1/31/26 or pay $12,000 for the month of February. They told us they had no Medicaid beds available to put my dad into. On 1/28/26 (Name of NHA) called and stated they could not honor my dad's Medicaid status and that my dad would have to move out. Complainant V stated, I asked for a 30-day eviction notice and (Name of NHA) refused to provide it because he said my dad (R37) was not being evicted and he (R37) could stay as long as we paid $12,000. (Name of NHA) told me, that because my dad was not in a Long-Term Care (LTC) bed, the Medicaid rules did not apply. Review of Policy for Guidelines for Transfer and Discharge (Including AMA) last reviewed 12/08/2025 reflected, The resident has the right to refuse involuntary transfer out of, or discharge from, the facility under certain circumstances. Further review of policy/procedure reflected, 1. a. Notify The resident in writing, and if known, a family member or legal representative, 30 days in advance, of transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharged , and the reasons for the transfer or discharge, according to the criteria for the transfer or discharge. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R37's EMR failed to reflect that facility notified R37's family in writing he was being discharged . Resident (R35) Review of a Face Sheet revealed R35 admitted to the facility on [DATE] and discharged on 12/10/26. R35 had pertinent diagnoses of hemiplegia and hemiparesis (one-sided weakness). R35 was moderately cognitively impaired. In an interview on 3/10/26 at 1:59 PM, Registered Nurse (RN) E was questioned about resident transfers to the hospital and bed hold policies. RN E reported she had not seen a physical form that she provides the resident or has them sign anything but will get a verbal consent from the resident if they would like their bed held while they are out of the facility. In an interview and record review on 3/11/26 at 12:55 PM, RN J reported she was the nurse who sent R35 out to the hospital and did not recall providing R35 with a Bed Hold Policy prior to departure. RN J provided a copy of an Observation Detail List Report that was documented as given to the resident that revealed there was no option/documentation to show R35 wanted to reserve his bed while out at the hospital or that he could make that decision. Review of the admission Contract for R35 revealed information about the readmission Bed Hold Policy has different information regarding bed holds for Medicare and Medicaid than what was provided on the Observation Detail List Report for R35's transfer to the hospital on [DATE]. Neither document clearly defines the Bed Hold Policy and the option for the resident to accept or decline the bed hold and the associated cost of holding a bed while out of the facility. Review of a policy titled Bed Hold Notification last reviewed 1/8/25 revealed: Before transferring a resident to a hospital or allowing a resident to go on a therapeutic leave, the Nursing designee or other designated staff member should provide written information to the resident and a family member or legal representative of the bed hold and admission policies. Before transferring a resident to a hospital or allowing a resident to go on a therapeutic leave, the Nursing designee or other designated staff member should provide written information to the resident and a family member or legal representative of the bed hold and admission policies. In cases of emergency transfers, the notice of bed hold policy under the state plan and facility's bed hold policy should be provided to the resident or resident's representative within 24 hours of the transfer. This may be sent with other papers accompanying the resident to the hospital. Once a phone call is placed, BOM (business office manager) will make note of conversation and outcome in the Progress Notes section in [EMR] and complete Resident Bed Hold Authorization Form. Progress Note should be detailed and include person spoken with a notification of whether or not they elected to hold the bed. Resident Bed Hold Authorization form should be completed and Resident/Responsible Party signature obtained by fax, e-mail scan or mailed and returned. Bed Hold Policy should be sent with authorization form. When Resident Bed Hold authorization form is signed it should be scanned into Resident documents in [EMR] and filed in the resident AR file. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 3/11/26 at 2:17 PM, the Director of Nursing (DON) reported the facility acknowledged the Bed Hold Policy was not being sent with the residents when they are transferred to the hospital and will implement a new system. Ombudsman Notification of Discharges: During an interview on 3/11/26 at approximately 11:30 AM, NHA revealed they (the facility) had not been providing the Ombudsman with monthly Discharge Notifications. The NHA provided a form dated 3/11/26 revealing that he and (Name of) Interim Social Worker (ISW) I had been educated on this requirement. During an interview on 3/11/26 at approximately 11:45AM, ISW I revealed I was educated this morning that I had to notify the ombudsmen of admission/discharges in writing. ISW I further revealed she was not aware of the requirement prior to today.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation and interview, the facility failed to maintain and repair the premises, resulting in an increased potential for contamination and a possible decrease in satisfaction of living for residents. Findings Include: On 03/10/2026 at 9:11AM observed the wall area at the dining room handsink had a crack running horizontally along the wall. The crack was about four feet long and five feet off the floor. On 03/10/2025 at 9:15AM, observed in a conference room across from the kitchen, the outside wall had a four footlong crack on the wall area close to the ceiling. During this observation, Facilities Management Support (FMS) Q, said the cracks are due to settling of the building, it is currently being monitored by an engineering team for further movement or increase in cracks. On 03/10/2026 at 9:30AM, observed in the spa room on Angler Avenue hall, cracks at several locations in the room; a crack from ceiling to floor at the wall juncture that the spa tub is on (crack was one quarter to one half inch wide), horizontal running cracks on both sides above the entrance door to the spa, a vertical crack in the corner at wall juncture where the toilet is situated. There was monitoring tape on the crack above the entrance door (on the spa side) to measure movement in this area. On 03/10/2026 at 9:32AM, observed in the spa room, in the corner by the toilet, the flooring had a dip before meeting the wall, creating a space of about one quarter inch, where the wall coving is not in contact with flooring and would allow for water to pool and possibly seep under the tiling to the wall surface underneath. On 03/10/2026 at 2:00PM, FMS Q stated that the department has approved the construction team to patch up the cracks that are not being actively monitored for further movement or increase in size.

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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** Based on observation, interview, and record review, the facility failed to follow policies and procedures and pursue guardianship activation timely for one (R38) of one resident reviewed for guardianship who was severely cognitively impaired. Findings include:Review of a Guideline for Advanced Directive policy last reviewed 12/10/25 revealed: 1. Advanced Directives will be reviewed with resident and/or resident representative by the admission Representative or designee at the time of admission. A member of the IDT (interdisciplinary team) will review and/or updated quarterly and PRN (as needed) thereafter. Review of a Face Sheet for R38 revealed she was admitted to the facility on [DATE] with pertinent diagnoses of hemiplegia/hemiparesis (one-sided weakness), aphasia (communication disorder) following cerebral infarction (stroke), and dysphagia (swallowing disorder). R38 is listed as her own responsible party. Review of the Minimum Data Set (MDS) dated [DATE] for R38 revealed she was severely cognitively impaired. During an observation and an interview on 3/10/26 at 11:00 AM, R38 was observed at the end of the hallway sitting in a wheelchair crying. The maintenance staff was observed in R38's room touching up paint and cracks in the wall. R38 could not explain or convey what was wrong and just shook her head. R38's daughter came into the facility at this time and reported R38 had not been the same and does not communicate as well since R38 had a stroke prior to admission to the facility. R38's daughter reported that her sister would be the Power of Attorney (POA) for R38 and was not sure if it was activated. Review of the admission documentation with handwritten signatures for R38 revealed signatures throughout the documentation that shows illegible signatures not on the signature line. Some signatures are vertical and some are rounded off the signature line. In an interview on 3/10/26 at 1:08 PM, the Interim Social Worker (SW) I verified she saw the same information on the admission Contract for R38 and could not verify if the Power of Attorney Documentation was activated and verified a Do Not Resuscitate (DNR) document had an ineligible signature on it. During an observation and an interview on 3/11/26 at 9:53 AM, R38 was resting in bed and when questioned about her DNR status and communicated she didn't know. After explaining the difference of a DNR verses a Full Code status, R38 mumbled and could not communicate then waved her left-hand sideways mumbling no. When asked about her POA, R38 was getting frustrated she could not talk and nodded yes when asked about her daughter being the POA. R38 communicated she did not remember signing the admission Contracts and was indecisive with questions regarding her healthcare. R38 communicated she thought her daughter was already activated as the POA. When asked if it would be beneficial for her daughter to be able to make decisions for her, R38 nodded yes. All communication with R38 was a struggle for her to think and answer. In an interview on 3/11/26 at 10:00 AM, SW I reported to activate a POA would be a conversation during their first meeting which had already happened for R38. SW I verified that R38's POA was not activated and had not asked R38 if she wanted it activated yet or talked to the Physician about activating the POA. SW I reported she did not know how long it would take to activate the POA based on the cognitive decline of R38 and her inability to communicate, collaborate, and appropriately sign and acknowledge her own paperwork. In an interview on 3/11/26 at 2:41 PM, the Director of Nursing (DON) reported she expects the facility staff would recognize a resident with a low BIMS (Brief Interview for Mental status) indicating they are severely cognitively impaired and would look into deeming the resident incompetent and activating the POA timely. If the resident is a newer admission, the competency should be addressed the first week or so.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2732021.Based on interview and record review, the facility failed to ensure an appropriate Transfer and Discharge practice based on resident rights and medical needs for 1 Resident (R37) of 4 Residents reviewed for transfer and discharges, resulting in R37 being transferred/discharged solely due to financial status change rather than physical, mental, and psychosocial change. Findings include:Resident (R37) Review of Face Sheet revealed Resident #37 admitted to the facility on [DATE] with pertinent diagnoses which included cerebral infarction, vascular dementia, major depressive disorder, anxiety disorder and encounter for palliative care. Review of an email dated 12/11/25 at 5:16 PM, from Admissions Coordinator (AC) H revealed, (Name of R37) will be joining us from home tomorrow 12/12 in room [ROOM NUMBER] for an initial 5-day respite. Family will be paying privately for an additional 30 days. We will be partnering with family and their elder law attorney to confirm long term care eligibility from financial standpoint.Review of a Progress Note dated 12/16/25 at 5:01 PM, by Social Worker (SW) W reflected, Resident discharge plan is: To remain in campus for long term care. Progress note further revealed the resident's family participated in the discharge planning.Review of a Hospice IDG Comprehensive Assessment and Plan of Care Update Report dated 1/15/26 at 05:48:12 PM, reflects under a social worker note that, . Family is working with an Attorney to get patient Medicaid.During an interview on 03/11/2026 at 10:18 AM, admission Coordinator (AC) I revealed, We do not assist with Medicaid enrollment, we just gather information and pass it along. A respite stay is paid up front and if they want Long Term Care (LTC) we will inform them how many beds are available and will refer them to elder law attorney. If they are interested in Medicaid, we will discuss that prior to admission and will guide them to the Business Office Manager (BOM).Review of a letter sent from R37's family lawyers office on January 22, 2026, revealed the intent of the letter was to inform the facility that they had filed an Assets Declaration and Medicaid Application with (Name of County) of Health and Human Services on January 22, 2026. We requested Medicaid effective January 2026.During an interview on 03/11/2026 at 10:35 AM, Admissions G revealed, If we know the resident wants to stay for LTC (long term care) the (higher ups) say we can only take so many Medicaid (residents) whether we are at capacity or not. We only have 10 Medicaid beds; we have 12 right now because the other ones are hospice/Medicaid. We cannot take any more Medicaid because we are over budget. Admissions G further revealed, currently they have 58 beds (all dually certified) and census is 31. Out of 58 beds, 14 beds are being used by residents with Medicare, 12 beds are being used by residents that are on Medicaid/hospice, and 5 residents are private pay.Review of R37's Electronic Medical Record (EMR) revealed a letter from R37's lawyer's office that was attached to his record on 1/27/26.During an interview with the Complainant V on 3/10/26 at 2:54 PM stated, everything was going good as long as we were paying the out of pocket (charge of approximately $419 + a $60-dollar daily level of care charge.) We had told several people there that we were applying for Medicaid but were told they did not assist with that process. As a result, we went to a lawyer for assistance. The minute the facility found out we applied for Medicaid the facility called my mom (R37's wife) into a meeting with the business office on 1/27/26. I was on the phone with my mom during the meeting when they stated we did not tell them we were planning to file for Medicaid and that we would have to move out of the facility by Saturday 1/31/26 or pay $12,000 for the month of February. They told us they had no Medicaid beds available to put my dad into. On 1/28/26 (Name of NHA) called and stated they could not honor my dad's Medicaid status and that my dad would have to move out. Complainant V stated, I asked for a 30-day eviction notice and (Name of NHA) refused to provide it because he said my dad (R37) was not being evicted and he (R37) could stay as long as we paid $12,000. (Name of NHA) further stated, that because my dad was not in a Long-Term Care (LTC) bed, the Medicaid rules did (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235736	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Terrace Senior Living	60 Veridian Drive Muskegon, MI 49440

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not apply. Complainant V revealed, we did not want to move my dad, but felt we were not being given a choice. We moved him (R37) on 1/30/26 to (Name of LTC) Nursing Home that was close by and had accepted his Medicaid pending status. Complainant V further revealed, my dad passed away 8 days later.During an interview on 03/11/2026 at 10:57 AM, NHA stated, If a resident or resident's family stated they were applying for Medicaid, we may tell them we have limited beds pending on availability. NHA further stated, Myself and my boss look to see if they (a resident) can stay. We look to see if they qualify for Long Term Care. NHA revealed the facility has 58 dually licensed Medicaid/Medicare beds and their current census was 31. NHA further revealed the facility only has 10 Medicaid beds for the month, and it's based on historical data. This surveyor asked how that was possible given they had not been open long enough to have the data. NHA stated, we look at how we get admissions done at the corporate level.NHA was asked why he told (Name of R37's) family he had to leave because there weren't any Medicaid beds available. NHA stated he was not aware of Medicaid pending for (Name of R37.) This surveyor then stated, there was a letter from R37's lawyer dated 1/22/26 (Letter stated they had applied for Medicaid effective January 2026) The letter was placed in R37's Electronic Medical Record on 1/27/26. NHA revealed the resident relocated to (Name of) another LTC because it was closer to family. NHA was asked, Why a family would move a hospice resident less than 5 miles to a facility where he would need to share a room and community shower instead of having his own private room and shower that he had here? NHA replied, I'm not sure, that's what they agreed to.Review of R37's Transition of Care/Discharge Summary discharge date [DATE] reflected he was going to (Name of) Nursing Facility- Long Term Care. Further review revealed R37's Clinical Discharge and Narrative Goals of Stay reflected Resident ready to move to Long Term Care. Recapitulation of Stay reflected Resident ready to move to a higher level of care.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to provide appropriate wound care for one (R40) of one resident reviewed for wound care.Findings include:Review of a Face Sheet revealed R40 had pertinent diagnoses of necrotizing fasciitis (flesh eating disease), bacteremia (bacteria in blood), and morbid obesity. In an interview on 3/9/26 at 10:20 AM, R40 reported she had concerns about her wound care at the facility over the weekend. Review of the Orders for R40 revealed an order dated 3/3/26 - open ended date for Vashe (sodium chlor-hypochlorous acid) irrigation solution; 0.033%; Amount to Administer: Soak kerlix gauze; irrigation. Frequency: Twice A Day. Specialized Instructions: Necrotizing fasciitis debrided wound.-An order dated 3/3/26-3/9/26, to Cleanse and irrigate right gluteal wound with NS (normal saline). Apply layer of zinc barrier cream around wound. Pack vashe (wound solution) soaked kerlix gauze. Cover with ABD (type of wound pad) and secure with underwear. Avoid tape if possible. Frequency: Twice A Day.-An order dated 3/10/26-3/11/26 for Appointment [Wound Clinic]. Frequency: Twice a Day. During an observation on 3/10/26 at 9:00 AM, Licensed Practical Nurse (LPN) B and the Assistant Director of Nursing (ADON) A were in R40's room to provide wound care. LPN B removed the packing from wound and cleansed wound and the surrounding tissue with normal saline, then applied a zinc barrier cream around the wound. LPN B then continued to pack the wound with a kerlix gauze soaked with the ordered wound solution with a long cotton swab. During the packing, the kerlix gauze came in contact with the zinc barrier cream surrounding the wound and LPN B continued to pack the wound and covered the wound with an ABD pad. In an interview on 3/10/26 at 1:43 PM, LPN B was questioned about the dressing change for R40 when she applied the zinc barrier cream to the surrounding wound before packing with the soaked kerlix gauze, which became contaminated with the zinc barrier cream. LPN B reported she could understand how packing the wound before applying the zinc barrier cream could prevent it from getting into the wound. LPN B questioned surveyor on whether the orders should be written differently. In an interview on 3/10/26 at 3:10 PM, the Director of Nursing (DON) was questioned about applying a zinc barrier cream to the peri wound first before packing the wound with a soaked kerlix gauze. The DON reported she would not do that because if the kerlix gauze came in contact with the zinc barrier cream, it would be hard to get it out of the wound. The DON reported that the zinc barrier cream would be the last thing she would do.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to have a system for hospice communication and services provided for one (R27) of one resident reviewed for hospice services. Findings include:Resident #27 (R27)Review of the Electronic Medical Records (EMR) for R27 revealed she had pertinent diagnoses of Alzheimer's disease, dementia, and depression. Review of the Care plan revealed R27 was on Hospice. Review of a Physician Progress note dated 2/19/26 for R27 revealed she was receiving hospice services. Review of the EMR revealed no Hospice Services documentation for R27. In an interview on 3/11/26 at 2:19 PM, the Director of Nursing was questioned about R27 receiving Hospice services and the lack of communication and service provisions from Hospice in the EMR. The DON reported that Hospice does communicate verbally and acknowledged there is no hospice communication information in the EMR for R27.