| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 366181 | A. Building<br>B. Wing | 09/30/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Grand Rapids Care Center | 24201 W 3rd St<br>Grand Rapids, OH 43522 |

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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY.Based on medical record review, review of a facility submitted Self-Reported Incident (SRI), review of the facility incident log, review of witness statements, staff and resident interview, and review of the facility policy, the facility failed to ensure residents were free from staff-to-resident verbal abuse. This affected one (#15) of three residents reviewed for abuse. The facility census was 30.Findings include:Review of the medical record for Resident #15 revealed an admission of 08/16/24. Diagnoses included vascular dementia, generalized anxiety disorder, and cerebral infarction (stroke).Review of the Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #15 had moderate cognitive impairment as evidence by a Brief Interview for Mental Status (BIMS) score of 9. Resident #15 was assessed to require total care for Activities of Daily Living (ADLs).Review of the care plan dated 11/19/24 revealed Resident #15 had behaviors of throwing (incontinence) briefs on floor, smearing stool on himself and/or the bed, unplugging the bed, disconnecting his feeding tube, anger, irritation, crawling on the floor, kicking/tipping over the bed table, throwing object(s) at others, restlessness, laying on the floor, attempting to sleep on the floor, impulsiveness, eating other people's food, putting himself on the floor for attention, attention seeking behaviors, and making himself-vomit. Interventions included encouraging Resident #15 to express concerns about care and the disease process, clarify misunderstandings, and maintain a calm environment and approach. Review of the facility incident log revealed an entry dated 09/11/25 at 8:45 P.M. related to an allegation of abuse against Resident #15.Review of Resident #26's family member's statement, dated 09/11/25, revealed she was in the dining room and Resident #15 attempted to leave. Certified Nursing Assistant (CNA) #133 was inappropriate, cussing, and saying stop being so stupid. The family member revealed Dietary Aide (DA) #131 was present in the dining room at the time of the incident.Review of the nursing progress note dated 09/12/25 revealed social services met with Resident #15 for follow up regarding allegations, and Resident #15 was in good spirits and denied any ill effects. Additional review of the nursing progress notes revealed on 09/12/25 at 10:37 A.M. the Certified Nurse Practitioner (CNP) was notified of the allegation.Review of the facility submitted SRI, initiated on 09/12/25, revealed a visitor reported an allegation of verbal abuse against Resident #15 that occurred on 09/09/25. The SRI stated Resident #15 was having behaviors of disconnecting his tube feeding multiple times and transferring himself in the room to different chairs without assistance. The visitor reported that CNA #133 used explicit language towards Resident #15. During the investigation, residents who were in the dining room were interviewed. Resident #24 stated that CNA #133 told Resident #15 he better behave and stop acting like a toddler. Resident #29 stated that CNA #133 talked to Resident #15 like an animal when he tried to leave the dining room and CNA #133 was making fun of Resident #15, stating If you want to act like a toddler, I will treat you like one. Interview with Dietary Aide (DA) #131 revealed CNA #133 directed an expletive word to Resident #15 to describe his behavior and told the resident he was acting like a fool and a toddler. CNA #103 stated CNA #133 told Resident #15 he was acting like a toddler, and that she would treat him that way. Review of the facility's investigation interview with CNA #103, dated 09/12/25, revealed Resident #15 was unplugging his feeding tube and was self-transferring. After Resident #15 unplugging the tube feeding multiple times, the staff left it unplugged and left him in the hallway. CNA #103 stated the staff told Resident #15 to stop unplugging the tube feeding and he would smile and say to call his family. CNA #103 stated that Resident #15 then tried to elope out of the front door. CNA #103 stated that CNA #133 asked Resident #15 if he felt stupid yet and then stated if the resident wanted to act like a kid, she would treat him like one and moved him by her. CNA #103 stated that Resident #15 went with CNA #133 to take the trash out and came back into the dining room and Resident #15 apologized to everyone in the dining room.Review of the facility's investigation interview with DA #131, dated 09/12/25, revealed she was serving dinner in the dining room and CNA #133 called Resident #15 stupid in front of everyone present. DA #131 reported that Resident #15 kept leaving the dining room and CNA #133 became frustrated with the resident. DA #131 stated CNA #133 coached Resident #15 into apologizing to everyone.Review of the facility's investigation interview with Resident #29, dated 09/12/25, revealed Resident #15 was being uncooperative with staff. The staff was saying bad things to Resident #15. Resident #29 stated CNA #133 was talking to Resident #15 like he was an animal when he tried to leave the dining room. Resident #29 stated the way CNA #133 was talking to |

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| F 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>(continued on next page) |

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The Administrator reported DA #131 and Resident #29 were also present at the time of the incident and confirmed the family member's report of what CNA #133 had stated to Resident #15. Interview on 09/30/25 at 2:08 P.M. with DA #131 revealed CNA #133 appeared frustrated with Resident #15. DA #131 stated that CNA #133 put Resident #15 across from the dining room and told him to stay put but the resident kept going back and forth from his room to the dining room. DA #131 stated CNA #131 was upset about Resident #15's behavior and confirmed CNA #133 called the resident stupid and made him apologize to the entire dining room. DA #131 stated she felt uncomfortable with the way CNA #133 was speaking to Resident #15. DA #131 verified she did not report the incident to facility management. Review of the facility policy titled, Ohio Resident Abuse Policy, revised 07/11/24, revealed it was the facility's policy to investigate all allegations, suspicions, and incidents of abuse, neglect, involuntary seclusion, exploitation of residents, misappropriation of resident property and injuries of unknown source. Facility staff must immediately report |