STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235440	A. Building B. Wing	12/23/2025

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2700015Based on interview and record review, the facility failed to protect the resident's right to be free from staff to resident verbal and threat of physical abuse in 1 (Resident #105) of 4 residents reviewed for abuse, resulting in Resident #105 being verbally abused by a staff member and the potential for a decline in mental and psychosocial well-being. Findings include: Resident #105 Review of an admission Record revealed Resident #105 was originally admitted to the facility on [DATE] with pertinent diagnoses which included unspecified dementia and major depressive disorder. Review of Resident #105's Care Plan revealed, I (Resident #105) have a diagnosis of senile dementia, depression, anxiety, and insomnia. Because of this I have a history of behaviors including touching others. I will rub others arms, legs, hands, and chest. This is not thought to be sexual in nature. I will also go into other's rooms, touch other belongings and food .kick at doors and attempt to repeatedly get into locked doors and will eat others food. Date initiated: 12/9/25. Interventions: Assess for contributing causes, such as, infection, electrolyte imbalance. Date Initiated: 12/19/2025. Behavior monitoring program to assist in determining cause and triggers. Date Initiated: 12/19/2025. Divert attention from stimulus and attempt to redirect me if I start to talk negatively about things. Date Initiated: 12/19/2025. Encourage verbalization of any fears or concerns I may have. Date Initiated: 12/19/2025 . Review of the Facility Reported Incident (FRI) dated 11/22/25 revealed, . Allegation: At approximately 6:00 PM on 11/22/25 Certified Nursing Assistant (CNA) F and W reported to Registered Nurse (RN) Y that they witnessed RN K potentially verbally abuse (Resident #105). CNA F and W reported that RN K had stated to Resident #105 that I'm going to kick your a** and When I quit or get fired, I'm going to kick your a**. This was in response to Resident #105 wandering and approaching the medication cart and another resident's room .Conclusion: Due to 4 eyewitness accounts corroborating the statement, I am going to kick your a** was made to Resident #105 by RN K; verbal abuse is substantiated . During an interview on 12/22/25 at 12:49 PM, CNA F reported he had observed Resident #105 trying to open RN K's medication cart and RN K told Resident #105 I am going to kick your as*, and When I quit or get fired, I'm going to kick your a**. CNA F reported the statements made by RN K were inappropriate and could be a form of abuse, so he reported RN K right away. During an interview on 12/23/25 at 9:50 AM, CNA W reported she observed Resident #105 attempting to get into RN K's medication cart and she stated to Resident #105, I am going to kick your a**. CNA W reported that a few minutes later she heard RN K tell Resident #105 that I cannot wait to quit, on my last day I am going to kick your a**. CNA W reported the statements made by RN K immediately. During an interview on 12/22/25 at 12:58 PM, Licensed Practical Nurse (LPN) P reported Resident #105 often wandered through the unit and often required redirection due to Resident #105's dementia diagnosis. LPN P reported she was given report from RN K the day she was suspended for the allegations of verbal abuse towards Resident #105. LPN P reported she did not witness the verbal (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 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse towards Resident #105, but that RN K told her that she was being investigated for allegations of verbal abuse. LPN P reported RN K told her that she would never actually do that; she was just joking around. This writer attempted to contact RN K on 12/22/25 at 12:59 PM. RN K did not return this writer's call at time of survey exit. During an interview on 12/22/25 at 11:28 AM, Nursing Home Administrator (NHA) A reported he had conducted the investigation for the allegations of verbal abuse from RN K towards Resident #105. NHA A confirmed that he had substantiated that Resident #105 was verbally abused by RN K. NHA A reported that RN K resigned during the investigation. Review of the facility's Abuse Policy last revised 9/2022 revealed, POLICY: Each resident has the right to be free from abuse and neglect. To provide a safe environment for residents, to promote respect, and to set standards of care, the facility will monitor for abuse and investigate all allegations of resident abuse . Definitions: . Verbal Abuse refers to any use of oral, written or gestured language that includes disparaging and/or derogatory terms to residents or their families, or within their hearing distance, to describe residents, regardless of their age, ability to comprehend, or disability .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2693805 and 2707404.Based on interview, and record review, the facility failed to properly store and dispose of medications for 1 (Resident #103) of 7 residents reviewed for medication storage resulting in the potential compromise of medications and/or misappropriation of medications, accidental ingestion, medication errors, and decreased efficacy of medications. Findings include: Resident #103Review of an admission Record revealed Resident #103 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease with late onset (disease characterized as progressive memory loss and cognitive decline) and type 2 diabetes (condition where body cannot use insulin correctly and sugar builds up in the blood.)Review of Resident #103's Emergency Medical Services (EMS) report dated 12/13/25 revealed, . Chief complaint: Unresponsive. Secondary complaint: Possible medication overdose . POSITION PT (patient) FOUND/INITIAL SCENE FINDINGS: upon EMS arrival pt was being held upright in a wheelchair . Facility staff reports that patient may have been given his medication as well as another patient's medication. Facility staff is unable to confirm for sure if a medication error occurred and facility staff is unable to say what medications the patient may have been administered. Pt was last seen normal at approximately 1800 (6:00 PM) tonight when his evening medications were administered . Review of the facility's Near Miss report dated 12/13/25 and documented by Nurse Manager (NM) L revealed, Incident Description: Suspected different medications given to Resident #105. Assigned nurse stated that the resident was not available for medications and left the medications in the med cup on top drawer of the med cart . Other info: There was another resident medication cup next to the resident's medication cup on top drawer of the med cart . In an interview on 12/23/25 at 8:29 AM, Nurse Manager I reported she had received a phone call from Licensed Practical Nurse (LPN) C on 12/13/25 that he had to send Resident #103 to the hospital because he was not responsive, and he was worried that he might have given Resident #103 the wrong medication. NM I reported that LPN C told her that he had prepped Resident #103's night medications and realized he was not in his room to take the medications, so he placed the medications in the top drawer of the medication cart and started passing medications to other residents. NM I reported LPN C reported he did not know if he gave Resident #103 the wrong medications, so she started an investigation to determine if Resident #103 was given the wrong medications. NM I reported that she was unable to confirm if LPN C had given Resident #103 the wrong medications. NM I reported that nurses should discard any medications that they are unable to administer, and that LPN C should have discarded Resident #103's pulled medications if he was unable to administer them. NM I reported pre setting medications and preparing more than one resident medications at a time is against the rights of medication administration. In an interview on 12/22/25 at 10:46 AM, LPN C reported that he was the nurse caring for Resident #103 when he had a change in condition and was sent to the hospital. LPN C reported that around 6:00 pm, He had pulled Resident #103's night medications, and he discovered that Resident #103 was not on the unit when he went to his room, so he was not able to administer Resident #103 his medications. LPN C reported he took the pulled medications for Resident #103 back to his medication cart and placed them in the top drawer of his cart, and he began to pull medications for a different resident. LPN C reported that he gave Resident #103 the medications he had pulled earlier when he returned to the unit, and shortly after that, Resident #103 became unresponsive and needed to be sent to the hospital. LPN C reported that he did tell Resident #103's family member and Nurse Manager I that he could have given the wrong (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications to Resident #103. LPN C confirmed that he should have discarded Resident #103's medications, and that he knew that he was not supposed to pull medications for more than one resident at a time. LPN C reported that he was busy, overwhelmed, and trying to get ahead, and he knew he was not storing or passing medications correctly, and his likelihood for causing a medication error were increased due to this. During an interview on 12/22/25 at 1:50 PM, Director of Nursing (DON) B reported she had been made aware that LPN C reported that he could have given Resident #103 the wrong medications. DON B confirmed that the facility conducted an investigation into the potential medication error, but that they could not confirm if Resident #103 had been given the wrong medications. DON B confirmed that LPN C was not following the rights of medication administration and he should have discarded Resident #103's medication instead of storing them in the medication cart. Review of the facility's Medication Administration Policy last revised April 2024 revealed, POLICY: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the medication management system in the facility. The facility has sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions . Procedures: . Administration: 14. If medications are unable to be administered after preparation, the nurse will discard those medications and contact the pharmacy for replacement doses .