STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235729	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Michigan Veteran Homes at Grand Rapids	**2950 Monroe NE , Grand Rapids, Michigan, 49505**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Michigan Veteran Homes at Grand Rapids was surveyed for a Recertification survey on 6/11/26. Intakes: 2978594, 3038613, 3040983 Census= 121	F0000		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure the kitchen/kitchenettes' food-contact and/or nonfood-contact surfaces were consistently maintained in a clean and sanitary manner or good repair with the potential to affect any resident out of the census of 121 who consumed food/beverages from the kitchen resulting in the	F0812		

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 reverse for further 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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F0812 SS = F	Continued from page 1 potential for foodborne illness and/or physical food contamination. Findings include: Slicer: During an observation and interview on 06/9/26 at 10:31 AM, the slicer (meat/deli slicer) in the main kitchen had dried brown food debris in several areas between the blade and metal plate surrounding it. Nutrition Services Director (NSD) “V” confirmed it was soiled and instructed staff to address it. During an interview on 06/11/2026 at 10:24 AM, Nutrition Services Supervisor (NSS) “W” reported the slicer was newer. NSS “W” reported last month they held a slicer training, but some staff were not present at the time, and he was still in the process of educating staff on it. NSS “W” reported the slicer’s cleaning instructions were posted on the wall near the slicer. Review of the facility’s “Meat Slicer Cleaning Instructions”, undated, stated, “…Proper cleaning and maintenance of a meat slicer is crucial to ensure food safety…Meat Slicer Problem Areas…Accumulated food: Food particles can accumulate in and around certain parts of your slicer, allowing bacteria to breed (grow and multiply).” Review of the facility’s “Cook’s Cleaning List” indicated the “Slicer Machine” was last cleaned on 6/6/26 and the scheduled frequency of cleaning was “after use”. Utensils: During an observation and interview on 06/10/26 at 11:04 AM, 13 of 13 storage bins on the shelving rack near the grill in the main kitchen had debris of various sizes and colors (blue, green, white, and brown) accumulated on the insides. These bins contained food storage lids, scoops, tongs, and other food-contact items that were in direct contact with the debris. Inside the bins, 5 scoops had debris stuck to their scooping surface. There were 13 light brown colored plastic food storage container lids that had burned/melted edges/areas that were no longer smooth and had lost their original form. NSD “V” reported the facility would clean the storage bins and items within them. During an interview on 06/11/2026 at 10:24 AM, NSS “W” reported he recently had been addressing with	F0812		

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F0812 SS = F	Continued from page 2 staff to keep the kitchen's utensil storage bins clean. Review of the 2022 Food and Drug Administration's Food Code, stated, "4-202.11 Food-Contact Surfaces…shall be:…smooth…Free of breaks, open seams, cracks, chips, inclusions (flaws in the material), pits, and similar imperfections…Cleanability…Food-contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms (capable of causing illness)." Review of the 2022 Food and Drug Administration's Food Code, stated, "4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils…Equipment food-contact surfaces and utensils shall be clean to sight and touch…Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris." Air-drying: During an observation and interview on 06/11/2026 at 9:47 AM, in the 500 unit's kitchenette cupboard, 10 insulated drinking mugs with lids on were found to have water inside. Dietary Services Aide (DSA) "X" confirmed that morning she had put the mugs in the kitchenette's cupboard. DSA "X" confirmed the mugs were normally air-dried, facing down to drain, and to be put away dry. During an observation on 06/11/2026 at 9:58 AM, in the 600 unit's kitchenette cupboard, labeled "hydration cups", 16 insulated drinking mugs with lids on had water inside. During an observation on 06/11/2026 at 10:10 AM, in the 700 unit's kitchenette cupboard, 8 insulated drinking mugs with lids on had water inside. During an observation on 06/11/2026 at 10:10 AM, in the 800 unit's kitchenette cupboard, 4 insulated drinking mugs with lids on had water inside. During an interview on 06/11/2026 at 10:24 AM, NSS "W" reported the mugs needed to be air-dried before being put into the cupboards. Review of the 2022 Food and Drug Administration's Food Code, stated, "4-901.11 Equipment and Utensils, Air-Drying Required. Items must be allowed to drain and to air-dry before being stacked or stored..."Review of the facility's "Food Safety	F0812		

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F0812 SS = F	Continued from page 3 Requirements" policy, dated 2/3/26, stated, "Food safety practices shall be followed throughout the Home's entire food handling process…All equipment used in the handling of food shall be cleaned and sanitized…All utensils…and equipment are kept clean, maintained in good repair…Food preparation equipment and utensils that are manually washed are allowed to air dry…"	F0812		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to review and revise a comprehensive, individualized plan of care for 4 (Resident #13, #86, and #111) of 24 residents reviewed for care plans, resulting in the potential for further falls to occur. Findings include:	F0657		

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F0657 SS = D	Continued from page 4 Resident #13 Review of an "Admission Record" revealed Resident #13 was originally admitted to the facility on 6/8/23 with pertinent diagnoses which included difficulty in talking and limitation of activities due to disability. Review of Resident #13's "Incident Report" dated 6/2/26 and documented by Licensed Practical Nurse (LPN) "II" revealed, " Witnessed Fall: Incident Description: Nursing Description: (Resident #13) was in the dining room, attempted to stand partially up to reach for a straw, wheelchair locks were not engaged, wheelchair rolled out from under (Resident #13) and he went to the ground on his bottom..." Review of Resident #13's "Care Plan" revealed, " (Resident #13) is at risk for falls r/t psychoactive drug use, diabetes... Date initiated: 12/6/22. Interventions: (Resident #13) needs a safe environment with even floors free from spills and/or clutter; adequate, glare free light; a working and reachable call light, the bed at appropriate height for ease of self-transfer in and out of bed; handrails on the walls, personal items within reach. Date initiated: 12/6/22. Ensure (Resident #13) is wearing appropriate footwear when ambulating. Date initiated: 12/6/22." Noted that Resident #13's care plan had not been revised after Resident #13's fall on 6/2/26. During an interview on 6/11/2026 at 2:00 PM, LPN "II" reported she was caring for Resident #13 when he slipped out of his wheelchair on 6/2/26. LPN "II" reported that every time a resident fell in the facility, the nurse caring for the resident would complete an incident report and that the facility interdisciplinary team (IDT) would investigate the fall to determine a root cause and update the resident care plan with new interventions to prevent further falls from occurring. LPN "II" reported that updating care plans after a fall was a "team effort" but that nurses would update the care plan if they implemented an intervention immediately after a fall. During an interview on 6/11/2026 at 2:18 PM, Assistant Director of Nursing (ADON) "JJ" reported the nurses and the facility IDT were both responsible for updating a resident's care plan after falls. ADON "JJ" reviewed Resident #13's care plan with this writer and confirmed that Resident #13's care plan	F0657		

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F0657 SS = D	Continued from page 5 was not revised with a new intervention after his fall on 6/2/26. Resident #86: Review of an "Admission Record" revealed Resident #86 was a male with pertinent diagnoses which included Alzheimer's disease (progressive and irreversible brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks), dementia (decline in mental ability severe enough to interfere with daily life), abnormalities of gait and mobility, Parkinson's disease (progressive nervous system disorder that primarily affects movement), hearing loss, and muscle weakness. Review of the Care Plan for Resident #86, revised on 3/5/26, revealed the focus, "…(Resident #86) was independent with ambulation, bed mobility, and transfers. Offer 4ww (wheeled walker) with ambulation…(Resident #86) is High risk for falls r/t (related to) Unaware of safety needs d/t (due to) Dementia and Parkinsons…" with the interventions "…Anticipate and meet (Resident #86)'s needs…Be sure call light is within reach and encourage him to use it for assistance as needed, needs prompt response to all requests for assistance…Ensure that (Resident #86) is wearing appropriate footwear such as non-skin socks and walkable shoes when ambulating… Follow facility fall protocol… If (Resident #86) is awake during 30-minute location checks, have him use the bathroom Initiated: 5/11/26… known to kneel on the floor and try to pick up trash or anything that's he sees on the floor. If found kneeling on the floor and picking up stuff without any skin issues noted, this is not considered a fall… (Resident #86)'s wife brought a set of random keys, ask the nurse about the keys. Give the set of keys to Mike so he can work on the cabinets in his room, to keep him busy or have something to do for him. Wife reported that because (Resident #86) picks on the locks at home, she gave him set of keys to keep him busy Initiated: 3/24/26… PT (Physical Therapy) evaluate and treat as ordered or PRN (as needed)…Review information on past falls and attempt to determine cause of falls. Record possible root causes. Alter remove any potential causes if possible. Educate resident/family/caregivers/IDT (Interdisciplinary Team) as to causes Initiated: 3/4/26…When (Resident #86) sits in the recliners, make sure foot rests are not up, He will climb out of recliner with footrest up Initiated: 3/8/26…"	F0657		

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F0657 SS = D	Continued from page 6 Review of “Incident” dated 3/8/26 at 1:30 AM, revealed, “…Attempted to climb out of recliner with footrest up. Slid onto the floor…Confused, ambulating without assist, active exit seeker, impaired memory, confused…Root cause: Foot rest up on recliner chair…Have him not use the recliner function…” No immediate intervention was implemented at the time of the incident. Review of “Incident” dated 3/22/26 at 4:15 PM, revealed, “…RN (Registered Nurse) was reported that member had a fall in his bedroom. Caregiver reported while she was helping member to change their shirt, member slipped down to the floor from the bed while sitting with back of shoulders against the bed. RN went in the room to check. Member was sitting in the bed with the caregiver on the side….Immediate intervention was to remind member to slow down and take steps to have ADLs (Activities of Daily Living) with caregiver’s help while maintaining current capability…” Review of Resident #86’s care plan did not reveal an intervention for caregivers to provide reminders to resident to slow down. Review of “Incident” dated 3/24/26 at 11:15 AM, Had a fall at the Bistro area…his foot got trapped in one of the wheels on his walker. Lost his balance and fell backwards. Came back to the unit in a wheelchair with wife. A bruise noted on his right hand, 1.5 CM x 2 CM…fell backwards on his back, his feet got trapped in the walker, when he stood up from sitting…” Resident #86 was to be continuously monitored every 30 minutes for safety and wandering behaviors but resident was off the unit and no education or intervention was implemented to ensure his safety while off the unit. Review of “Health Status Note” dated 5/7/2026 at 2:06 PM, revealed, “…This nurse returning from lunch…had a fall in bistro while with wife. Nurse stating while she was down there for lunch she had observed wife sitting in chair, member had walker nearby, but when attempting to sit down it appeared member had tripped over his feet while backing up into chair and had fallen. …alert charting for 3 days to monitor vitals and any increased pain…” Review of incident revealed no immediate intervention was implemented for Resident #86. On	F0657		

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F0657 SS = D	Continued from page 7 5/8/26, wife was reminded to have Resident #86 use his walker for ambulation and transfers which was not added to the care plan for a reminder when resident left the unit. Resident #111: Review of "Admission Record" revealed Resident #111 was a male with pertinent diagnoses which included dementia, anxiety, and history of falls. Review of "Care Plan" for Resident #111, revealed the focus revised on 10/2/25, "…(Resident #111) is at risk for falls r/t (related to) dementia, urine dribbling, occasional bowel incontinence. Psychoactive drug use, and h/o (history of) falls while at home…" with the intervention "…According to his wife (Resident #111) has urinary urgency and dribbling in the morning upon awakening. (Resident #111) typically gets up in the morning and will hurry to use the bathroom because of this. Offer urinal as needed. Bowel incontinence secondary to foods he eats…Anticipate and meet (Resident #111)'s needs…Encourage (Resident #111) to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: Ball tossing, group exercise…Ensure that (Resident #111) is wearing appropriate footwear when ambulating. Have grippy socks on when he goes to bed. Check to ensure his socks are dry and provide him a new pair if wet…Ensure (Resident #111)'s touch pad light is at the bathroom side of his bed. He needs prompt response when he gets up due to being HIGH FALL RISK…Follow facility fall protocol…Pt evaluate and treat as ordered or PRN (as needed)…" Review of "Incident" dated 5/29/26 at 6:00 PM, revealed, "…Member attempting to self-transfer from wheelchair to recliner in household common area. CNA (Certified Nursing Assistant) assisted lowering member to the floor…Intervention: Frequent checks…" In an interview on 6/11/26 at 10:52 AM, Licensed Practical Nurse (LPN) "CC" reported the floor nurse would create immediate interventions following a resident fall or incident. LPN "CC" reported the interventions were created to help prevent another fall or incident in the near future. LPN "CC" reported the floor nurses were able to edit the care plan and revise it with the new intervention(s), if it was a task it was placed on the kardex (care guide) for the CNA	F0657		

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F0657 SS = D	Continued from page 8 (Certified Nursing Assistants) and verbally notify the current staff of the changes to the resident's care as well. In an interview on 06/11/2026 at 2:17 PM, RN (Registered Nurse) Case Manager (RNCM) "E" reported the nurses were to implement an immediate intervention to keep the resident safe following an incident and/or fall. RNCM "E" reported the interventions implemented following the incident and/or a fall were reviewed by the interdisciplinary team (IDT) including her as well to determine if a different intervention would have been more appropriate due to type and frequency of incident/fall events and the level of assistance needed by a resident. In an interview on 6/11/26 at 3:16 PM, Nursing Home Administrator (NHA) "A" reported staff were frequently reminded and educated on updating a resident's care plan following a change in resident condition as well as following an incident and/or falls.	F0657		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to provide adequate supervision and implement appropriate care planned interventions for 1 (Resident #16) of 10 residents reviewed for falls, resulting in the potential for residents to sustain a fall with injury. Findings include: Resident #16:	F0689		

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F0689 SS = D	Continued from page 9 Review of “Admission Record” revealed Resident #16 was a female with pertinent diagnoses which included anxiety disorder, diabetes, Alzheimer’s disease, wandering, dementia (decline in mental abilities severe enough to interfere with daily life), lack of coordination, adjustment disorder (emotional or behavioral responses to a stressor is prolonged, causing disruption to your life), cognitive communication deficit (impairment in communication from underlying brain changes), and need for assistance with personal care. Review of "Care Plan" for Resident #16, revised on 6/9/26, revealed the focus, "...(Resident #16) is High risk for falls r/t (related to) Unaware of safety needs, visual agnosia (neurological disorder where the person’s eyes see clearly but their brain struggles to process and assign meaning to what they are looking at) and use psychotropic medications…” with the intervention “…Anticipate and meet (Resident #16)'s needs…(Resident #16) needs hand in hand guidance with locations (especially of an item), and directions. For example, walk side by side with (Resident #16) if she wants to go to the bathroom or sit on a chair as she is unable to recognize familiar objects, shapes or people…Date Initiated: 02/22/2026…” Fall on 3/12/26: Review of “Incident Note” dated 3/12/2026 at 1:35 PM, revealed, “…(Resident #16) was sitting on the couch in the living room. She got up from the couch and took a couple of steps and then went to sit back down. She misjudged the location and sat on the side of the couch, causing her to fall on her bottom…” Review of “Incident” for Resident #16 dated 3/12/26, revealed, “…Confused…Impaired memory…vision is impaired r/t (related to) issues with her brain…She frequently says she needs to go to the bathroom but is not able to urinate. UA (Urinalysis) was obtained r/t frequency and urgency which could cause increased anxiety and restlessness (Resident #16 did not have a urinary tract infection)…OT (Occupational therapy) to work with (Resident #16) r/t vision agnosia and visual changes…” Fall on 3/29/26: Review of “Incident” dated 3/29/26 at 9:55 AM, revealed, “…(Resident #16) in living room area, going to sit down in chair and misses the seat of the chair…Immediate Action Taken: Chair moved from	F0689		

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F0689 SS = D	Continued from page 10 living room area…Body Language: Tensed, Distressed Pacing…Facial Expression: Sad, Frightened, Frown…Confused, Gait Imbalance, Impaired Memory…Having increased visual decline r/t cognition…" Review of "Fall Risk Evaluation" dated 3/29/2026 at 1:45 PM, revealed, "…History of falls (past 3 months): 1-2 falls in past 3 months…Vision status: Poor (with or without glasses). Predisposing disease: 1-2 present. Resident had a change in condition in the last 14 days…Gait / balance: Balance problem while walking. Gait / balance: Change in gait pattern when walking through doorway. Gait / balance: Jerking or unstable when making turns. Gait / balance: Balance problem while standing. Medication: Takes 3-4 these medications (or medication classes) currently and/or within last 7 days…" Fall on 3/30/26: Review of "Incident" dated 3/30/26 at 5:50 PM, revealed, "…LPN (Licensed Practical Nurse) called RN (Registered Nurse) and said member had a witnessed fall in member's bedroom. RN went into the bedroom to check on member found member had two spots of redness on the right side of forehead. Caregiver said member stood up from lying in the bed suddenly, tripped by the blanket she was carrying and fell to the floor and hit her head on the floor…sent out to the ER (Emergency Room)…Bruise on the right side of forehead above eyebrow…Confused…Pain level of 3 on the Pain scale with 1 being none to 10 being the worst…" Review of "Fall" dated 3/30/2026 at 9:36 PM, "…Was called by RN on the floor stating that (Resident #16) fell…Noted a red spot above her right eyebrow and a small area which is lighter brown on her right periorbital bone area. (Resident #16) was complaining of pain and holding her right forehead…Ordered to send to (Local Hospital) ED (emergency department) for eval (evaluation) and treat…" Review of Resident #16's Care Plan revealed the care plan was not noted as reviewed and/or revised following her falls on 3/12/26, 3/29/26 and 3/30/26. In an interview on 06/11/2026 at 2:17 PM, RN (Registered Nurse) Case Manager (RNCM) "E" reported the nurses were to implement an immediate intervention to keep the resident safe following an incident and/or fall. RNCM "E" reported Resident	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235729	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0689 SS = D	Continued from page 11 #16 was ambulatory and had visual deficits which were at varying degree of impairment at various times, and the facility discovered the visual deficit was due to the deficits in her brain. RNCM “E” reviewed Resident #16’s care plan and reported Resident #16 needed hand in hand guidance to walk which was not noted as implemented when the falls happened on 3/12/26 and 3/29/26. RNCM “E” reported the hand in hand assistance was when Resident #16 went to the bathroom, and when she sat in a chair as she was unable to recognize familiar objects, shapes or people. RNCM “E” reported with the addition of another fall where Resident #16 had attempted to sit down and had a fall, staff should have recognized there was a beginning pattern and implement interventions to address her increased risk of falls. RNCM “E” reported following the fall on 3/30/26 and the removal of the chair from the living room was perplexing as there were other chairs in the living room for Resident #16 to attempt to sit on. RNCM “E” reported staff proceeded with care of Resident #16 based on her mobility status alone and inadvertently overlooked her documented cognitive and visual deficits. RNCM “E” reported the interventions implemented following the fall were reviewed by the interdisciplinary team (IDT) including her as well to determine if a different intervention would have been more appropriate due to type and frequency of fall events.	F0689		