Printed: 11/24/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0656 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS IN Sased on interview and record reviresidents (R6, R7, R8, R10, and R for the development of serious con and resulting in R6 having significat choking hazards due to lack of feedule to pain. Findings include: R7 A review of R7's Admission Record the facility on [DATE]. In addition, Indiabetes, difficulty walking, and pair A review of R7's Minimum Data Se 10/21/21, revealed R7 had a Brief cognitive status) assessment which addition, R7's MDS revealed R7 had review of R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020). R7's impaired skin interelated to decreased mobility, resis 09/02/2020).	iew, the facility failed to implement and 11), resulting in R7 and R8 developing in R8 developing supports and R6, R10, R11 being ding support. R8 having poor pain contact of R7 was an R7's Admission Record revealed R7 has raplegia (paralysis of lower body and left (MDS) (a tool used for assessing a result of Interview for Mental Status (BIMS) (a set in revealed R7 had short-term and longed moderately impaired cognitive decis sure ulcers or sores. Grity care plan, revised 1/25/21, revealed stance to repositioning, incontinence of tegrity care plan also revealed an interview for P1 and R8 developing incontinence of tegrity care plan also revealed an interview for sores.	operationalize care plans for 5 pressure ulcers and the potential alth status) from the pressure ulcers, grat risk for future weight loss and arol and poor tolerance to activity 87 -year-old resident admitted to admultiple diagnoses that included egs). esident's care needs), dated cale used to determine a resident's term memory problems. In ion-making skills. R7's MDS also ed R7 had impaired skin integrity bowel and bladder (Date Initiated: vention of Elevate heels off bed e following: and may extend into the

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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 235004

If continuation sheet Page 1 of 49

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
		CTREET ADDRESS SITV STATE 7	ID CODE
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	IP CODE
Skld Muskegon 1061 W Hackley Ave Muskegon, MI 49441			
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		ion)
F 0656	- 11/11/21= 4.1 cm (centimeters) x	(by) 3.6 cm (length by width). Area= 1	1 cm2 (centimeters squared).
Level of Harm - Actual harm	- Right heel- unstageable pressure	ulcer (Full thickness tissue loss in wh	ich the actual depth of the ulcer is
Residents Affected - Few		llow, tan, gray, green or brown) and/or	
	-11/11/21= 3.2 cm x 2.6 cm. Area=	= 6.1 cm2.	
	A review of R7's General Progress Note, dated 11/12/21, revealed, observed resident to have bilateral he elevated up on pillows, heels had lotion on them, they were cracked open and tender to the touch left her measured at - 5.3 cm x 4.4 cm x .2 cm deep, right heel measured at 5.6 cm x 4.3 cm x 1.4 cm deep, no drainage present, surrounding tissue dry and cracked, 70% pink, 30% eschar, treatment started, notificatic completed, wound care to follow weekly on wound rounds, encourage resident to use heel bridge, and will have his bed length extended to help prevent his heels from resting on the foot board. A review of R7's Skin Observation Tools, dated 10/11/21 to 11/10/21, failed to reveal any skin alterations wounds. R7's Skin Observation Tools revealed R7 had normal appearing skin and no new alterations in s integrity including open areas of any type.		
		2:45 PM, R7 stated he developed sore the staff were made aware of his pressws now.	
	nursing assistant filled out a skin al measurements on 11/10/21. She st stated R7 was non-compliant with p towards the foot board. UM N state each heel. He told her he did not. L because he would slide down in be foot boards. UM N stated on 11/10/Pressure Ulcer/Injury form for R7's cm x 4.4 cm x 0.2 cm (left heel) and (completed) R7's Focused Incident	11:10 AM, Registered Nurse Unit Man ert note. She stated she (UM N) evaluated R7 had wounds on his right heel positioning, including being boosted up d she asked R7 if he knew how he dead of the stated R7 probably developed the dynamic of the stated R7 probably dynamic	ated R7's wound and did and left heel (one each). UM N in bed when he slides down veloped the pressure ulcers on e bilateral heel pressure ulcers bed, and his feet would rest on the it Review for New or Worsened is wound measurements were 5.3 . UM N stated that she locked the Ulcer/Injury form on 11/12/21 and
	38659		
	(continued on next page)		
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FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 235004

If continuation sheet Page 2 of 49

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skid Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0656 Level of Harm - Actual harm Residents Affected - Few	is defined as: significant weight los months). should be addressed in tongoing search for the cause(s) of decisions are made and document procedure includes the resident be by the 7th day of each month and it thereafter any resident weight that days and 10% in 180 days will be every weight gain/loss and the intervention weighed weekly, with the weight error Review of the facility policy with the date of 7/11/18 revealed a purpose interventions for maintaining or imprecognized standards of practice in the interventions. Dietary evaluation following a change in condition. R6 Review of R6's face sheet revealed admitted on [DATE] with diagnosis vitamins, weakness, lack of coordin Review of R6's kardex revealed un meal for pocketed foods and debrist to eat slowly, and to chew each bit able to eat independently. Under the monthly. Review of R6's care plan revealed to) weakness, confusion, impaired eat independently with an initiation AEB (as evidenced by) Dx (diagnouplace; chronic variable po (by mouplinterventions that included: 1:1 feed Monitor/document/report PRN (as weights, and weigh resident per fact to) dysphagia, poor dentition interventionstruct, assist and/or encourage rethoroughly, and Monitor for achokin Review of physician note from 11/2	bject Weight Management with adopte s (5% in one (1) month, 7.5% in three (he care plan. Facility approaches to adweight loss once the cause(s) is/are ided. Ongoing interventions are evaluate ing weighed monthly and as needed. Neviewed by the Nutrition Committee with varies from the previous reporting periodal and the previous reporting periodal and the resident meeting the intered in the resident's medical record in the record in the resident in the record	dress weight loss may include an dentified, relevant care plan d and modified as needed. The Monthly weights are to be completed thin a reasonable period of time ind by 5% in 30 days, 7.5% in 90 to determine the cause of the exciteria for weight loss will be determine the cause of the exciteria for weight loss will be determine the cause of the exciteria for weight loss will be determine the cause of the exciteria for weight loss will be determine the cause of the exciteria for weight loss will be determine the cause of the exciteria for weight loss will be determine the cause of the exciteria for weight loss will be determined and the second of the exciteria for weight loss will be determined to the exciteria for weight loss will be determined to the exciteria for weight loss will be determined to the exciteria for the exciteri

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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0656 Level of Harm - Actual harm Residents Affected - Few	in resident rooms and residents we her meal. One of her roommates habout half complete in consuming I clear red honey thick liquid to her masleep with the glass to her mouthminute. R6's shoulder was rubbed to her lips briefly and then slowly lorom with confusion, not making ethat usually someone will come hel someone may come back to help homeone may come homeone ma	AM, no staff other than a housekeeper are eating breakfast. R6 was observed and completely finished their meal at this ner meal. R6 was viewed to have her formouth with her eyes closed. R6 was ap She did not respond to verbal attempt when speaking to her and she slowly obvered it. R6 continued to not respond ye contact. A discussion was completely p R6 at with her meal, but they don't user. Conversation was attempted again eye contact. Upon exiting the room and ed on the hall or in resident rooms. R6 a limited amount of very small bites, nortified nursing assistant) entered the hall are resident and delivered it to their room exited R10's room with their meal tray as with their meal tray and then entered to away as she was viewed to be very slow as, I am the only one on the hall, it's like an assistance and she said at least 3 an inicially about R6 and her needs. CNA X go on her to make sure she's not chokin she managed to assist 3 residents at a just has to keep going back and forth by the staff usuall acceptance logs for R6 were reviewed as was to add supplements to meals as well herself at times, but that staff usuall acceptance logs for R6 were reviewed as when she has staff assistance. Dietic mentation and stated she would expect on weekly weights as of 11/23/21, this weights were ordered to be completed ekly dietary evaluations of R 6 due to the and weights. Dietician Y was asked herself weight was missed on 12/13/21 (Note to be completed. Dietician Y was informing the property of the pr	in her room, not being assisted with a time and the other roommate was bod untouched and had a glass of proached and appeared to be as to get her attention for about a pened her eyes, but kept the glass verbally and looked around the divith R6's roommate, who stated sually assist her until later, so with R 6 and she was not walking the hall again, no staff was watched from the hall noving very slowly. At all and appeared to have gotten ms. At 8:52 AM CNA X entered the not then went into R 11's room. At the room of R 6. CNA X was viewed why feeding herself. CNA X was in as the only aide assigned to the extra the seems to be doing good grounded to the rooms of R6, R10, stated she seems to be doing good grounded to the rooms of R6, R10, stated she seems to be doing good grounded to the rooms of R6, R10, stated she seems to be doing good grounded to the rooms of R6, R10, stated she seems to be doing good grounded to the rooms of R6, R10, stated she seems to be doing good grounded to the rooms of R6, R10, stated she seems to be doing good grounded to the rooms of R6, R10, stated she seems to be doing good grounded to the rooms of R6, R10, stated she seems to be doing good grounded to the rooms of R6, R10, stated she seems to be doing good grounded to the rooms of R6, R10, stated she seems to be doing good grounded feeding setween them. Garding R6's nutritional status. In had a downgrade in her well as provide feeding and with Dietician Y and she stated it ian Y agreed there were some each meal to be documented. Was discontinued for some reason, on Mondays for 4 weeks. Dietician he significant weight loss, which we she completed her review of R6 Monday). Dietician Y stated it does ned missing the weekly weight was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235004	A. Building B. Wing	12/21/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Skld Muskegon	Skld Muskegon		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0656 Level of Harm - Actual harm Residents Affected - Few	viewed to be asleep in bed. There meal trays to residents in their roor elevated R 6 in bed, set up her meabegin eating. At 12:21 PM, R6 had she was today and how her meal wof ice cream. Upon exiting R6's roowas completing medication pass. Tresident with their meal. At 12:28 Pfood. At 12:31 PM Nurse Z entered time the resident took one more vemember and came across CNA X lunch. CNA X stated she could not overheard saying she [R6] did not onursing staff on the hall for about 3 assist her with eating at approxima On 12/16/21 at 12:03 PM, an email administrator (NHA) requesting the schedule appeared to be unclear. To one nurse were assigned to the hall DON and NHA were informed of the concerning with there being at leas choking hazards and/or weight loss level of immediate jeopardy with R6 On 12/17/21 at 9:05 AM, R6 was viewed to be attached to a bag on 12/17/21 at 9:55 AM Unit Mana IV in her arm. The Surveyor asked eyes wide open and was watching On 12/21/21 at 9:00 AM, UM Z was running. UM Z was giving R6 spoor verbal cues to open her mouth whe tasted, and she responded good. Review of R6's weights revealed the pounds, 10/1/21 125.6 pounds, 11/12/16/21 106.3 pounds, 12/20/21 weight loss. Between 11/17/21 and 9/2/21 and 12/1/21 (3 months) R6 completed late during a time period.	eal trays were observed to begin to be were between 2 to 3 CNA staff on the ham. At 12:13 PM a CNA entered R6's roal and then exited the room by 12:17 Pyet to take a bit and the surveyor enters. R6 stared blankly at the surveyor at at 12:23 PM, it was viewed that no so there were 2 staff in the dining room are M, Nurse Z returned to the hall. R6 wat R6's room with medications and askerry slow bite of ice cream. Nurse Z appointelly exiting the dining room, Nurse Z because she was assisting residents in do great at breakfast. Nurse Z then left minutes. Nurse Z then returned to the tely 12:35 PM. It request was made to the director of not staff covering the 400 hall for the more the DON responded by email on 12/16 ll for that shift. During a follow up intervel elack of staff viewed on the hall during to 3 identified residents who required 1: so the DON and NHA were informed of 8's weight loss and lack of interventions are wed being transported to the dining reg of IV fluids and was smilling and makinger (UM) Z was observed feeding R6 in R6 how her food tasted, and she responded by the more than the spoon reached her lips. The Survey of the sustained a 14.5% weight loss continued to lose we will also the response of the sustained a significant weight where R6 sustained a significant weight 2/13/21 where R6 continued to lose we will also to lose weight where R6 continued to lose weight a significant weight 2/13/21 where R6 continued to lose weight a significant weight 2/13/21 where R6 continued to lose weight a significant weight 2/13/21 where R6 continued to lose weight 2/13/21 where R6 continued to lo	nall at various times delivering the com to deliver her tray. They M without assisting the resident to red the room. R6 was asked how and then slowly took one small bite staff were in the hall and a nurse ea and 1 staff was assisting a s not eating any further bites of d R6 if she needed help. At this eared to be looking for another staff asked CNA X to assist R6 with a the dining room and was the hall and there was not any hall and to R6's room and began to cursing (DON) and nursing home ning of 12/16/21, since the was not all 2/16/21, since the was not all 2/16/21 at 3:20 PM, the great service that day, which was a assistance with meals due to the extensive concerns rising to a sebeing implemented. Soom in her wheelchair by staff. She are she in the main dining room. R6 had an conded, I do not know. R6's had her outh, she opened it without cueing. The groom. R6 did not have an IV lad her eyes open and did not need veyor asked R6 how her food. The control of the control of the control of the eyes open and did not need veyor asked R6 how her food. The control of the control of the control of the eyes open and did not need veyor asked R6 how her food. The control of the control of the control of the eyes open and did not need veyor asked R6 how her food.
	(continued on next page)		

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED
	235004	B. Wing	12/21/2021
NAME OF PROVIDER OR SUPPLIE	NAME OF PROVIDER OR SUPPLIER		P CODE
Skld Muskegon		1061 W Hackley Ave Muskegon, MI 49441	
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F 0656		ealed no dietary progress notes from 5/ led: Resident triggered a 8.6% significa	
Level of Harm - Actual harm	(current body weight) at 117# (11/1	7) and BMI 22.0. Wt hx reviewed: 126 ins fair, consuming 60% on average ov	# (10/1), 127# (8/3), and 125# (5/2)
Residents Affected - Few	is supplemented with House Shake notified of significant wt loss as we Resident's meal intake remains fair House Shake supplement TID (threintake. Noted orders for weekly wts place and continue to monitor residence week. She continues to have good pro each) for increased kcal and nuongoing wt loss. Will continue with PRN (as needed) for changes. An and is triggering a 7.6% significant 6. Wt hx reviewed: 117# (11/17), 1 intake. Will continue with all other rx4wks and PRN (as needed) for fure means of nutrition vs. comfort care alert with confusion. Not engaged will reed to pook while feeding in up right position of honey thick. Provider notified. Resident's diet has been feeding assistance at all meals per Treat TID (3 times a day) (300kcals and increased kcal intake. A nutrificonsuming only 35% on average of throughout the day. She is provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake. Supplement up Noted referral for hospice care in provide and nutrient intake.	e. Will increase her supplement to TID II. A nutrition progress note for 11/23/2°, consuming 56% on average over the set times a day) (200kcals, 6g pro each; to monitor trends. Will continue with a lent weekly and PRN for changes A nut's meal intake remains fair, consuming acceptance of her House Shake supplutrient intake. Goal po (by mouth) intake current nutrition interventions in place autrition progress note from 12/2/21 revent loss x2wk. Her CBW (current body w28# (9/2) and 123# (6/3). Recommend nutrition interventions in place and contributer changes. If decline continues, res. A behavior progress note from 12/7/2 with staff today. Resisted am cares and intake, as seen by recent weight loss 45+ degrees. Speech therapist in with dent staying in bed today per her choic downgraded to Honey-thickened liquid SLP (speech-language pathology). Sus, 11g pro each) in place of House Shapen note from 12/14/21 revealed: Reside wer the past week. She is accepting of did with Nutritional Treat TID (300kcals, addated from House Shake d/t downgraded	to support wt maintenance. MD 1 revealed: Weekly Review: past week. She is provided with) for increased kcal and nutrient III other nutrition interventions in trition progress note for 11/30/21 g 55% on average over the past ement provided TID (200kcals, 6g e is >60% average and prevent and monitor resident weekly and ealed Resident's weight obtained weight) is 109# (12/1) and BMI 20. Enhanced foods to maximize kcal inue to monitor trends weekly ident may benefit from alternative 1 revealed Note Text: Resident I refused medications this morning. Noted drooling and coughing resident and downgrading fluids to e. A nutrition note for 12/7/21 els with recommendations for 1:1 pplement updated to Nutritional kes for appropriate consistency ent's meal intake remains fair/poor, most supplements and fluids 11g pro each) for increased kcal ele to HTL (honey thick liquids). to remain variable given overall changes. A general progress note esident. She presented with dry [name of physician] notified. Order and in resident's left forearm. Site is 12/16/21) revealed 11 days when the entries did not indicate what meal dent was independent with eating 17/21 even though she was care 16/21- one at 1:46 PM with 25%

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NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0656 Level of Harm - Actual harm Residents Affected - Few	Review of R10's face sheet revealed admitted on [DATE] with diagnosis (muscle weakness or partial paraly dementia, lack of coordination and Review of R10's kardex revealed uncheck mouth after meals for pocked upright position, to eat slowly, and review of R10's care plan revealed deficit r/t (related to) Dementia, Hemotion), Stroke) interventions inclust focus area [R 10] has a potential fobites and sips. check mouth after resident to eat in an upright position PRN (as needed) and s/sx (signs a Holding food in mouth, Several atteres Report to nurse and/or MD and adj. Review of R10's progress notes for to keep food on his utensil. Assiste (Speech-Language Pathology) for R11 Review of R11's face sheet revealed included: obstructive hydrocephalus dysphagia and cognitive communical Review of R11's care plan revealed unallows; encourage self-feeding. The Review of R11's care plan revealed (diagnosis) of .cognitive communical blindness and tremors; need for feeresident to consume food/fluids as (signs and symptoms) of dysphagia Several attempts at swallowing, ReMD and adjust plan of care as indicated.	ed he originally admitted to the facility of that included: acute respiratory failure, sis on one side of the body), dysphagia convulsions. Inder food/fluids: 1:1 feeding assistance at ded food and debris .instruct, assist, and to chew eat bite thoroughly. In a focus area of ADL (activities of daily miplegia, Impaired balance, Limited Mode: EATING: 1:1 feeding assistance at a swallowing problems r/t Dysphagia in meals for pocketed food and debris . in n., to eat slowly, and to chew eat bite thand symptoms) of dysphagia: Pocketing empts at swallowing, Refusing to eat, A just plan of care as indicated. In 10/3/21 revealed: .Resident prefers be down with lunch today, he ate 100%. Will repossible evaluation. In the focus area ADL self-care performance at the facility and the facility action deficiency. In a focus area ADL self-care performance at the focus area Nutritional status risk A faction deficit .h/o (history of) dysphagia; edding assistance and adaptive equipmer resident allows . Monitor/document/reparatesident allows . Monitor/document/	on [DATE] and most recently hemiplegia and hemiparesis a (difficulty swallowing), vascular at all meals as resident allows dor encourage resident to eat in an vilving) self-care performance obility, Limited ROM (range of all meals as resident allows. Under sterventions include: Alternate small struct, assist, and/or encourage foroughly. Monitor/document/report g, Choking, Coughing, Drooling, appears concerned during meals. Seing fed his meals as he struggles sotify UM (unit manager) and SLP district to thrive, weakness, assume food/fluids as resident e by 1 staff to eat ance deficit r/t Confusion, Fatigue, the resident requires extensive as elf-feeding deficits r/t (related to) ent. interventions include assist bort PRN (as needed) and s/sx ling, Holding food in mouth, and meals. Report to nurse and/or

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235004	B. Wing	12/21/2021	
NAME OF PROVIDER OR SUPPLIER		P CODE	
Skld Muskegon			
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SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
28101			
Review of R8's face sheet dated 12/16/21 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Schizophrenia, obsessive compulsive disorder, blindness, anxiety disorder, major depressive disorder, and need for assistance with personal care. R8 was his own responsibility party.			
Review of R8's Brief Interview of M (normal cognition).	lental Status (BIMS) score dated 11/18	/21 revealed he scored 15/15	
Review of R8's physician progress note dated 11/15/21 at 6:50 PM revealed, R8 was treated at the hospital for a right hip fracture. When R 8 returned to the facility he complained of persistent pain and a repeat x-ray showed an addition femur fracture. He returned to the hospital for a revision of his Open Reduction Internal Fixation (ORIF), surgical repair of the right femur. Under Assessment/Plan revealed, Change Norco to 5/32 TID (narcotic pain medication three times a day) as patients pain is not well controlled. He has mental illnes and is not remembering to ask for pain medication. After skin revealed, Inspection and palpation (touch): warm and dry. No indication of skin break down. After musculoskeletal revealed, Right leg swelling greater than left leg.			
skilled follow-up evaluation. The pa	tient recently had a right femur fracture	e. He is motivated, cooperative and	
Review of R8's physician progress noted dated 11/29/21 at 3:00 PM revealed, R8 is seen today for evaluation of the patient at the request of nursing for lower extremity swelling and also abrasion over the right lower extremity. The patient had a dressing on and he had a recent hip fracture. Incision is very well approximated. Sutures are still in place. The patient thinks that his pain is much better than before. After pla revealed, 1. encourage pt (patient) to limit his time in chair to 2 hours. 2. Pain in right hip joint- externally rotated. Patient instructions. Continue current treatment.			
patient for complaints of pain. He h is still externally rotated. We are at lower extremity in an anatomical pot to reduce the effect of narcotic pair PT and OT to work with the patient confused, in no acute distress. He	physician note dated 12/6/21 at 2:10 PM revealed, R8 is seen today for evaluation of the plaints of pain. He had a femur fracture. The patient has less pain when he is in bed. His leg or rotated. We are attempting to procure specialized shoes that he is able to maintain his right in an anatomical position. At this time, I would like to start him on Lidoderm patch in an effort fect of narcotic pain medicine and also start him on muscle relaxant in an effort to improve work with the patient. His lower extremity edema is much improved. He is alert, awake, acute distress. He denies any acute problem. He is painful when he is able to bear weight.		
(continued on next page)			
	plan to correct this deficiency, please con SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by 28101 Review of R8's face sheet dated 12 [DATE] and had diagnoses that inc disorder, major depressive disorde responsibility party. Review of R8's Brief Interview of M (normal cognition). Review of R8's physician progress for a right hip fracture. When R 8 re showed an addition femur fracture. Fixation (ORIF), surgical repair of t TID (narcotic pain medication three and is not remembering to ask for a warm and dry. No indication of skir than left leg. Review of R8's physician progress skilled follow-up evaluation. The pai is making good progress with there well. Review of R8's physician progress evaluation of the patient at the requ right lower extremity. The patient h approximated. Sutures are still in p revealed, 1. encourage pt (patient) rotated. Patient instructions. Contir Review of R8's physician note date patient for complaints of pain. He at lower extremity in an anatomical pai to reduce the effect of narcotic pair PT and OT to work with the patient confused, in no acute distress. He No mention of pressure ulcer on rig	IDENTIFICATION NUMBER: 235004 A. Building B. Wing STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441 plan to correct this deficiency, please contact the nursing home or the state survey SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying informati 28101 Review of R8's face sheet dated 12/16/21 revealed he was a [AGE] year- [DATE] and had diagnoses that included: Schizophrenia, obsessive comp disorder, major depressive disorder, and need for assistance with person responsibility party. Review of R8's Brief Interview of Mental Status (BIMS) score dated 11/18 (normal cognition). Review of R8's physician progress note dated 11/15/21 at 6:50 PM reveal for a right hip fracture. When R 8 returned to the facility he complained of showed an addition femur fracture. He returned to the hospital for a revisi Fixation (ORIF), surgical repair of the right femur. Under Assessment/Plat TID (narcotic pain medication three times a day) as patients pain is not we and is not remembering to ask for pain medication. After skin revealed, In warm and dry. No indication of skin break down. After musculoskeletal re- than left leg. Review of R8's physician progress note dated 11/24/21 at 2:00 PM reveal skilled follow-up evaluation. The patient recently had a right femur fracture is making good progress with therapy. He denies any pain, has no acute of well. Review of R8's physician progress noted dated 11/29/21 at 3:00 PM reveal skilled follow-up evaluation. The patient recently had a right femur fracture is making good progress with therapy. He denies any pain, has no acute of well. Review of R8's physician progress noted dated 11/29/21 at 3:00 PM reveal skilled follow-up evaluation. The patient recently had a right femur fracture is making good progress with therapy. He denies any pain, has no acute of serview of R8's physician note dated 12/6/21 at 2:10 PM revealed, R8 is s patient for complaints of pain. He had a femur fracture. The patient has le is	

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0656 Level of Harm - Actual harm Residents Affected - Few	evaluation of right hip pain. I have the Patient has a history of right femuritimes a day). Patient is seen lying is mention that he experiences occas reports that the patient was exhibiting he has just receive a pain pill prior is mentions that the patients right hip patch for the patients right knee. Review of R8's Skin & Wound Evalulcer on his right lateral malleolus to the right lateral malleolus to the patients right was expected and the correcting this position. Resident wound nurse to examine to determine the surger with external rotation noted. Edema to lower leg noted to devices in place. Ordered positionis recommendations. Review of R8's care plan revealed in skin integrity, multiple incision sit Date initiated was 10/26/21 and last to be place mid back when lying on tolerated, 12/17/21 resident needs side lying and while turning resident Review of R8's care plan for limited date initiated 5/28/19 and last revis BEARING TO RLE (right lower extra 10/28/21 Bed Mobility: resident req 12/21/21 R 8 required the assistant two wheeled walker for locomotion leg). Review of R8's care plan for chronical Administer analgesia per physician cause increased pain or discomfort Review of R8's Kardex dated 12/19 However, all observations of care for movement in bed as his right leg was a side legal.	I physical mobility related to weakness ion on 12/16/21 revealed, 9/17/21 The remity) and FULL WEIGHT BEARING tuires assistance of one staff member. See of 2 staff for bed mobility). 12/22/20 (R 8 was not able to stand and was not pain dated initiated 1/14/21 and revisorders. Anticipate and treat before, du	ncreased pain and discomfort. TID (narcotic pain medication 3 denies hip pain however does knee pain at this moment. Nursing epositioning however, nurse says at at that time. Nursing also patch and is requesting a lidocaine led, he had a new unstageable in and was 0.1 cm deep. Taled, Therapist reported to this in width. Some serosanguino (sp) ernally rotated with no tolerance of e. After notes revealed, 11/29/21 Cause: Related to resident having or any sharp surfaces and none llowing. Boot and positioning in seess for any further positioning in seess for any further positioning sin integrity related to current break source injury to his right lateral ankle. Is included, 12/17/21 position pillow in wedge to right foot when in bed as ioning pillow between knees when and history of right fibula fracture resident is NON WEIGHT to LLE (left lower extremity). (All observations 12/17/21 to Locomotion: The resident uses a at able to bear weight on his right fone person for bed mobility. and 2 people assisting him with move his right leg without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0656 Level of Harm - Actual harm Residents Affected - Few	AMP (alternating pressure mattress Review of R8's wound timeline pro- 11/27/21 - 4.5 cm x 5 x 5 cm 12/2/21 - 7.3 cm x 4.1 cm x 2.5 cm 12/9/21 3.2 cm x 2.5 cm x 1.7 cm 12/17/21 2.8 cm x 3.2 cm x UTD (u The last Skin & Wound evaluation)	indermined depth). located in R8's record and provided by eable pressure ulcer on R8's right later	these changes. ing measurements: the facility was dated 12/9/21 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)
F 0686	Provide appropriate pressure ulcer	care and prevent new ulcers from dev	eloping.
Level of Harm - Actual harm	**NOTE- TERMS IN BRACKETS H	HAVE BEEN EDITED TO PROTECT C	ONFIDENTIALITY** 30120
Residents Affected - Few	This citation refers to MI00124948.		
	Based on interview and record review, the facility failed to prevent, assess, and monitor pressure ulcers for 2 of 3 residents (R7 and 8), resulting in R7and R8 developing pressure ulcers and R7's and R8's pressure ulcers not being timely assessed and monitored and the potential for the facility not being aware of a worsening of R7's and R8's pressure ulcers and wounds, should it occur, and a delay in the implementation of new interventions, if warranted, in a timely manner.		
	Findings include:		
	A review of R7's Admission Record, dated 12/15/21, revealed R7 was an 87 -year-old resident admitted to the facility on [DATE]. In addition, R7's Admission Record revealed R7 had multiple diagnoses that included diabetes, difficulty walking, and paraplegia (paralysis of lower body and legs).		
	A review of R7's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 10/21/21, revealed R7 had a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) assessment which revealed R7 had short-term and long-term memory problems. In addition, R7's MDS revealed R7 had moderately impaired cognitive decision-making skills. R7's MDS also revealed R7 did not have any pressure ulcers or sores.		
	A review of R7's impaired skin integrity care plan, revised 1/25/21, revealed R7 had impaired skin integrity related to decreased mobility, resistance to repositioning, incontinence of bowel and bladder (Date Initiated: 09/02/2020). R7's impaired skin integrity care plan also revealed an intervention of Elevate heels off bed surface while at rest in bed (Date Initiated: 10/26/2020).		
	A review of R7's Skin & Wound Eva	aluations, dated 11/10/21 to 12/16/21,	revealed the following:
		(involves the full thickness of the skin tion tissue and epibole (rolled wound e	
	- 11/11/21= 4.1 cm (centimeters) x	(by) 3.6 cm (length by width). Area= 1	1 cm2 (centimeters squared).
	- 11/18/21= 2.8 cm x 1.8 cm x 0.2	cm (length by width by depth). Area= 3	3.9 cm2.
	- 12/2/21= 0.9 cm x 0.3 cm x 0.1 cm. Area= 0.2 cm2. This measurement was done 14 days after the previous one.		
	- 12/16/21= No open area. This me	easurement was done 14 days after the	e previous one.
	- Right heel- unstageable pressure ulcer (Full thickness tissue loss in which the actual depth of the ulcer is completely obscured by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed).		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
Skld Muskegon	Skld Muskegon		
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.		agency.	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying inf			on)
F 0686	-11/11/21= 3.2 cm x 2.6 cm. Area=	= 6.1 cm2.	
Level of Harm - Actual harm	- 11/18/21 at 8:57 AM= 2.4 cm x 0	.8 cm. Area= 1.2 cm2.	
Residents Affected - Few	- 11/18/21 at 8:59 AM= 2 cm x 1.2	cm. Area= 1.9 cm2.	
	- 12/2/21= 0.6 cm x 0.4 cm x 0.2 c previous one.	m. Area= 0.1 cm2. This measurement	was done 14 days after the
	- 12/16/21= 1.1 cm x 0.7 cm. Area	= 0.6 cm2. This measurement was don	ne 14 days after the previous one.
		ated 11/1/21 to 12/16/21, revealed the addition to the following note and mea	
	- General Progress Note, dated 11/12/21, revealed, observed resident to have bilateral heels elevated up on pillows, heels had lotion on them, they were cracked open and tender to the touch left heel measured at - 5. 3 cm x 4.4 cm x .2 cm deep, right heel measured at 5.6 cm x 4.3 cm x 1.4 cm deep, no drainage present, surrounding tissue dry and cracked, 70% pink, 30% eschar, treatment started, notifications completed, wound care to follow weekly on wound rounds, encourage resident to use heel bridge, and will have his bed length extended to help prevent his heels from resting on the foot board.		
		Tools, dated 10/11/21 to 11/10/21, faile ols revealed R7 had normal appearing y type.	•
	During an interview on 12/15/21 at 2:45 PM, R7 stated he developed sores on his heels because they were laying on the bed. He stated when the staff were made aware of his pressure sores, they put them up on pillows. They keep them up on pillows now.		
	During an interview on 12/16/21 at 11:10 AM, Registered Nurse Unit Manager (UM) N stated on 11 nursing assistant filled out a skin alert note. She stated she (UM N) evaluated R7's wound and did measurements on 11/10/21. She stated R7 had wounds on his right heel and left heel (one each). I stated R7 was non-compliant with positioning, including being boosted up in be when he slides dow towards the foot board. UM N stated she asked R7 if he knew how he developed the pressure ulce each heel. He told her he did not. UM N stated R7 probably developed the bilateral heel pressure ubecause he would slide down in bed, refuse to be boosted/pulled up in bed, and his feet would rest foot boards. UM N stated on 11/10/21, she completed a Focused Incident Review for New or Wors Pressure Ulcer/Injury form for R7's bilateral heel pressure ulcers and R7's wound measurements w cm x 4.4 cm x 0.2 cm (left heel) and 5.6 cm x 4.3 cm x 1.4 cm (right heel). UM N stated that she loc (completed) R7's Focused Incident Review for New or Worsened Pressure Ulcer/Injury form on 11/ on that date the progress note was entered with the measurements she did.		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021	
NAME OF DROVIDED OR SUDDIL	NAME OF PROVIDER OR SUPPLIER		P CODE	
		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave	FCODE	
Skia Maskegori	Skld Muskegon			
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)	
F 0686	During an interview on 12/16/21 at	11:10 AM, UM N stated on 11/11/21, tl	ne wound team looked at R7's	
Level of Harm - Actual harm		owever, prior to the wound team evaluated a heel bridge (a pillow-like object)		
Residents Affected - Few		extend R7's bed another three inches in		
Residents Allected - Few	the bed extension piece because R7 refused to be boosted up in bed when he slides down and the extension will give him more feet room. She stated the bed extension piece was not a result of R7 being too tall for the bed. UM N also stated residents with pressure ulcers are assessed and measurements are done weekly.			
		t 11:10 AM, UM N stated all of R7's wo not any other wound measurements a		
	A review of the facility's Documentation of Wounds policy and procedure, revised on 2/1/21, revealed, 1. Wound assessments are documented upon admission, weekly, and as needed . 4. Additional documentation shall include, but is not limited to: a. Date and time of wound management treatments b. Weekly progress towards healing and/or effectiveness of current intervention .			
	28101			
	Review of R8's face sheet dated 12/16/21 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Schizophrenia, obsessive compulsive disorder, blindness, anxiety disorder, major depressive disorder, and need for assistance with personal care. R8 was his own responsibility party.			
	Review of R8's Brief Interview of Mental Status (BIMS) score dated 11/18/21 revealed he scored 15/15 (normal cognition).			
	Review of R8's physician progress note dated 11/15/21 at 6:50 PM revealed, R8 was treated at the hospital for a right hip fracture. When R8 returned to the facility he complained of persistent pain and a repeat x-ray showed an addition femur fracture. He returned to the hospital for a revision of his Open Reduction Internal Fixation (ORIF), surgical repair of the right femur. Under Assessment/Plan revealed, Change Norco to 5/325 TID (narcotic pain medication three times a day) as patients pain is not well controlled. He has mental illness and is not remembering to ask for pain medication. After skin revealed, Inspection and palpation (touch): warm and dry. No indication of skin break down. After musculoskeletal revealed, Right leg swelling greater than left leg.			
	Review of R8's physician progress note dated 11/24/21 at 2:00 PM revealed, The patient is seen today for skilled follow-up evaluation. The patient recently had a right femur fracture. He is motivated, cooperative and is making good progress with therapy. He denies any pain, has no acute concerns. He is eating and sleeping well.			
	(continued on next page)			

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.		agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0686 Level of Harm - Actual harm Residents Affected - Few	evaluation of the patient at the requiright lower extremity. The patient happroximated. Sutures are still in prevealed, 1. encourage pt (patient) rotated. Patient instructions. Continuated. Patient instructions. Continuated. Patient for complaints of pain. He has is still externally rotated. We are at lower extremity in an anatomical pot to reduce the effect of narcotic pair PT and OT to work with the patient confused, in no acute distress. He No mention of pressure ulcer on right Review of R8's physician progress evaluation of right hip pain. I have a Patient has a history of right femuratimes a day). Patient is seen lying in mention that he experiences occas reports that the patient was exhibit he has just receive a pain pill prior mentions that the patients right hip patch for the patients right knee. Review of R8's Skin & Wound Evalulcer on his right lateral malleolus to Review of a pressure ulcer report from the patients right would correcting this position. Resident would have to examine to determ recent surgery with external rotation noted. Edema to lower leg noted to devices in place. Ordered positioni recommendations. Review of R8's care plan revealed in skin integrity, multiple incision sit Date initiated was 10/26/21 and last to be place mid back when lying or	and 12/6/21 at 2:10 PM revealed, R8 is a sad a femur fracture. The patient has le tempting to procure specialized shoes it is sition. At this time, I would like to start in medicine and also start him on muscle. His lower extremity edema is much in denies any acute problem. He is painfught lower extremity. Inote dated 12/20/21 at 1:40 PM reveal open asked to evaluate the patient for it fracture and is currently on Norco 3-32 in bed. He denies any current pain. He ional pain in his right knee. He denies ing pain this morning during care and reto care and it may not have taken affect pain is well controlled with a lidocaine utation dated 12/2/21 at 9:17 AM reveal hat measured 7.3 cm x 4.1 cm x 2.5 cm or R8 dated 11/27/21 at 10:05 AM reveal hat measured 7.3 cm x 4.1 cm x 2.5 cm ainage noted on linen. Right leg is extend a sunaware of open area on right ankle in the information of the pressure related. 12/10/21 Root on noted. Bed and wheelchair checked in the contributing factor. Wound team for an device for positioning. Therapy to as a care plan for actual impairment to skips to his right lower extremity and pressure reduction interventions: positioning positions in patient reduction interventions: positioning positions.	ling and also abrasion over the hip fracture. Incision is very well much better than before. After plan Pain in right hip joint- externally seen today for evaluation of the ss pain when he is in bed. His leg that he is able to maintain his right him on Lidoderm patch in an effort e relaxant in an effort to improve approved. He is alert, awake, all when he is able to bear weight. Ided, Patient is seen today for noreased pain and discomfort. The following pain however does knee pain at this moment. Nursing epositioning however, nurse says at at that time. Nursing also patch and is requesting a lidocaine seled, Therapist reported to this an in width. Some serosanguino (sp) emally rotated with no tolerance of a fafter notes revealed, 11/29/21 Cause: Related to resident having for any sharp surfaces and none llowing. Boot and positioning in seess for any further positioning win integrity related to current break is included, 12/17/21 position pillow revedge to right foot when in bed as

			NO. 0936-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021	
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE	
For information on the nursing home's plan to correct this deficiency, please contact the		tact 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 0686 Level of Harm - Actual harm Residents Affected - Few	Review of R8's care plan for limited physical mobility related to weakness and history of right fibula fracture date initiated 5/28/19 and last revision on 12/16/21 revealed, 9/17/21 The resident is NON WEIGHT BEARING TO RLE (right lower extremity) and FULL WEIGHT BEARING to LLE (left lower extremity). 10/28/21 Bed Mobility: resident requires assistance of one staff member. (All observations 12/17/21 to 12/21/21 R8 required the assistance of 2 staff for bed mobility). 12/22/20 Locomotion: The resident uses a two wheeled walker for locomotion (R8 was not able to stand and was not able to bear weight on his right leg).			
	Review of R8's care plan for chronic pain dated initiated 1/14/21 and revision on 11/12/21 revealed, 5/29/19 Administer analgesia per physician orders. Anticipate and treat before, during, and after treatment tat may cause increased pain or discomfort.			
	Review of R8's Kardex dated 12/19/21 revealed he required assistance of one person for bed mobility. However, all observations of care for R8 from 12/17/21 to 12/21/21 R8's had 2 people assisting him with movement in bed as his right leg was very painful and he was not able to move his right leg without assistance. R8 also required physical assistance to roll and two people to pull him up in bed.			
		ry note) dated 12/20/21 revealed, Heal s) in place now. Care plan did not reflec		
	Review of R8's wound timeline pro	vided by the facility revealed the following	ing measurements:	
	11/27/21 - 4.5 cm x 5 x 5 cm			
	12/2/21 - 7.3 cm x 4.1 cm x 2.5 cm			
	12/9/21 3.2 cm x 2.5 cm x 1.7 cm			
	12/17/21 2.8 cm x 3.2 cm x UTD (u	indermined depth).		
	revealed a facility acquired, unstag	located in R8's record and provided by eable pressure ulcer on R8's right later th. Assessments did not indicate any d	al malleolus that measured 3.2 cm	
		bserved eating in bed. The head of his his food in bed. His body was covered worning. He was feeding himself.		
	On 12/17/21 at 10:09 AM CNA AA said she was assigned to R8 today and started work at 6:00 AM. CN said the only care she had provided for R8 this morning was to reposition him around 6:00 AM. CNA AA she was also responsible for residents on another hall. CNA AA said she was caring for 11 residents ar was on a split hall. CNA AA said there was one on other CNA working with her that morning.			
	R8. CNA AA was assigned to care	ger Z on 12/17/21 at 10:15 AM, she co for 11 residents on the unit and 6 of the The other CNA on the unit this morning	e residents on the unit were care	
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN OF CORRECTION	235004	A. Building	12/21/2021	
	233004	B. Wing	12/21/2021	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE	
Skld Muskegon		1061 W Hackley Ave		
Muskegon, MI 49441				
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0686	During an interview with CNA X on 12/17/21 at 10:18 AM, CNA X said she had not provided any care for R8 this morning.			
Level of Harm - Actual harm		21 at 10:20 AM DO had a dragging and	his right his aver his averical	
Residents Affected - Few		21 at 10:20 AM, R8 had a dressing on l nad a lidocaine patch on his right thigh		
		o date or initials. The dressings did not		
	areas on the boarder and an inden	the dressing on his right hip and the inc tation about approximately .5 cm in len	gth at the distal end of the incision.	
		R8's incision on his right hip. No draina nit Manager Z rolled R8 in bed to remove		
	grimaced and hit his fisted hands of	n the mattress with movement. R8 did	not yell out in pain or ask staff to	
	, ,	nrough to his sheet. R8 did yell out in p and positioning. During care R 10 said		
	when he was asked. When pulling	back the boot on R8's foot a 1-inch ind	entation was noted in his skin	
		was fastened with a Velcro strap (1 inc ped they did not support his right leg. R		
	•	in at 6:00 AM R8 was positioned toward k for breakfast. CNA AA and Unit Mana	•	
	R8's right hip and kept the boot fas		ager z piaced wedge custilon under	
		0 AM, Physical Therapist Assistant (PT		
		room. The Surveyor asked PTA BB if a ent, how she would instruct staff to do p		
	circulation was being impaired by t	he boot on his right leg. PTA BB confirm	med the boot was causing the	
		ed to be replaced by some other devic a device on order, but it had not arrived		
	placed a pillow under R8 calf. PTA	BB demonstrated and instructed Unit N	Manager Z to use a pillow between	
		 PTA BB instructed Unit Manager Z to oning him to his side. (avoid bony areas 		
	complained of less pain with this m	ovement than he did during the observ	ration at 10:20 AM. R8 was able to	
	a lot of pain with movement.	n he was log rolled in bed and his right	t leg was supported but ne still nad	
	On 12/17/21 at 11:25 AM the Surve	eyor emailed the Director of Nursing (D	ON) to inform her R8's boot on his	
	right foot caused 1 inch pitting ede	ma, he was complaining of pain at a 10	on 1-10 scale with movement,	
	, ,	viding pressure relief due to pillows pla s and was not provided any pressure re	· · · · · · · · · · · · · · · · · · ·	
	12/17/21 the DON acknowledged r	eceiving the email about R8 and said sor provide any different information.		
	· ·			
		served up in a wheelchair in the main that foot was on the floor. R8 had grippe		
	on his right lower leg was visibly so	oiled. R8 said he had been up in his wh d ankle hurt. R8 was served breakfast a	eelchair since around 6 or 7 this	
		a annie nurt. Ne was serveu breaklast a	at O.O I AIVI.	
	(continued on next page)			

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZIP CODE 1061 W Hackley Ave Muskegon, MI 49441	
For information on the nursing home's plan to correct this deficiency, please contact		tact 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)		on)
F 0686 Level of Harm - Actual harm Residents Affected - Few	chair. When PTA BB moved R8's le over his dressing on the right lower R8's wheelchair at 9:29 AM and R8 arms to the door of the main dining PTA BB was planning on doing the checked with LPN CC to see if R8 had his lidocaine patch so he did n nurse would need to contact the do On 12/21/21 at 10:21 AM, the Direct he now had a order for prn (as need on 12/21/21 at approximately 11:0 R8 grimaced with pain during the this pain was 5 when he was not meaning the saturated all the way through. Their removed. The wound was facing the having too much pain to change his pointed out that R8 had a dressing did not know anything about that did the dressing should not be on R8's saturated area was noted on the did the undated dressing was removed documentation that showed when I right ankle started having drainage right hip. During an interview with the DON or right hip was draining, she was not for all documentation on R8's wour that showed they were aware the right ankle started hip, they had	ctor of Nursing (DON) informed staff sh d) Norco and they could give it now. 0 AM CNA B and CNA DD used an ele ransfer. He made fists with both hands ransfer. He again reported a 10 with pa	his leg with her bare hand right turned to put a leg rest back on ushed his wheelchair with both t out the door and back to his room. As an was 10 out of 1 - 10. PTA BB and R8 had Norco at 8:08 AM and the this time. LPN CC said R8's he had contacted R8's doctor and contacted R8's doctor and contacted R8's doctor and contacted R8's doctor and her initials. The dressing was been done of the dressing was his ankle wound. The Surveyor time or initials. LPN EE said she ger Z arrive at R8's room and said and on R8's right hip and a 1/2 that had an indentation in it when er Z was not able to locate any lining, or when the wound on his lew orders for a dressing over R8's anot aware R8's incision on his was saturated. The DON was asked in odocumentation of who put the less on the full condition of R8's right

			No. 0936-0391
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For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accidents. **NOTE- TERMS IN BRACKETS IN This citation refers to MI00124983: Based on observation, interview are supervision for 3 residents (R6, R1 and choking risk, resulting in the posupervision and assistance. Findings include: Review of facility policy with the suis defined as: significant weight los months). should be addressed in tongoing search for the cause(s) of decisions are made and document procedure includes the resident beby the 7th day of each month and intereafter any resident weight that days and 10% in 180 days will be weight gain/loss and the intervention weighed weekly, with the weight errecognized weekly, with the weight errecognized standards of practice in the interventions. Dietary evaluation following a change in condition. R6 Review of R6's face sheet revealed admitted on [DATE] with diagnosis vitamins, weakness, lack of coordinate of procketed foods and debrist of eat slowly, and to chew each bit to eat slowly, and to chew each bit.	AVE BEEN EDITED TO PROTECT Condition of the care planned for 1:1 fotential for choking, aspiration, and ser bject Weight Management with adoptes (5% in one (1) month, 7.5% in three of the care plan. Facility approaches to act weight loss once the cause(s) is/are ided. Ongoing interventions are evaluated in grey weighed monthly and as needed. Neviewed by the Nutrition Committee we evaluated by the Interdisciplinary Team on(s) required any resident meeting the intered in the resident's medical record in the resident in the res	ovide feeding assistance and seeding assistance due to dysphagia ious injury due to lack of d date 9/11/20 revealed weight loss (3) months, oR10% in six (6) Idress weight loss may include an dentified, relevant care plan and modified as needed. The Monthly weights are to be completed ithin a reasonable period of time iod by 5% in 30 days, 7.5% in 90 to determine the cause of the ecriteria for weight loss will be ement Program with the adopted ag defining and implementing stent with resident needs, goals and as response or lack of response to least quarterly thereafter, and lity on [DATE] and most recently fficulty swallowing), deficiency of efficit. at all meals . check mouth after sident to eat in an upright position, ry in the kardex, which stated R6 is

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

			10. 0736-0371
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Skld Muskegon		1061 W Hackley Ave Muskegon, MI 49441	
For information on the nursing home's	plan to correct this deficiency, please conf	tact 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)		on)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R6's care plan revealed to) weakness, confusion, impaired leat independently with an initiation AEB (as evidenced by) Dx (diagnos place; chronic variable po (by mout interventions that included: 1:1 feed Monitor/document/report PRN (as rweights, and weigh resident per facto) dysphagia, poor dentition interveinstruct, assist and/or encourage rethoroughly, and Monitor for .choking Review of physician note from 11/2 work, dietary evaluation and weekly On 12/16/21 at approximately 8:35 in resident rooms and residents we her meal. One of her roommates hawas about half complete in consum of clear red honey thick liquid to he asleep with the glass to her mouth, minute. R6's shoulder was rubbed to her lips briefly and then slowly lo room with confusion, not making ey that usually someone will come hel someone may come back to help h communicative and did not make expense of the room with confusion to the help h communicative and did not make expense of R10. At 8:55 AM CNA (cerus additional food from the kitchen for room of R10. At 8:55 AM CNA X ex 8:58 AM CNA X exited R11's room to briefly check on R6 and walked at the room with R6 for approximately hall the morning and she stated yes if anyone on the hall needed feedin and R11. CNA X was asked specifinow, but you have to keep checking own today. CNA X was asked how	under the focus ADL (activities of daily balance, limited mobility an intervention date of 4/27/20. Under the focus area: sis) of .dementia . dysphagia w/ need feh) intake; h/o (history of) wt (weight) fluding assistance at all meals with an init needed) any s/sx (signs or symptoms) cility protocol . Under the focus area ha entions included: check mouth after mesident to eat in an upright position, to existence.	living) self-care deficit r/t (related in that states The resident is able to: [R6] has a Nutritional status risk or altered textured diet/fluids in inctuations; and advanced age with lated date of 12/7/21, of dysphagia ., review routine is a swallowing problem r/t (related eal for pocketed food and debris ., eat slowly, and to chew each bite in complaint of weight loss. Lab that loss were ordered. If were observed on the 400 hall or in her room, not being assisted with its time, and the other roommate interest food untouched and had a glass approached and appeared to be is to get her attention for about a pened her eyes, but kept the glass werbally and looked around the did with R6's roommate, who stated sually assist her until later, so with R6 and she was not walking the hall again, no staff was watched from the hall loving very slowly. At all and appeared to have gotten ins. At 8:52 AM CNA X entered the did then went into R11's room. At her room of R6. CNA X was viewed why feeding herself. CNA X was in as the only aide assigned to the this every day. CNA X was asked and pointed to the rooms of R6, R10 stated she seems to be doing good go, but she is doing good on her once who needed feeding

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 235004

If continuation sheet Page 19 of 49

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skid Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dietician Y stated R6 has had weig swallowing ability. The dietary plan to R6. Dietician Y stated R6 can fe provide encouragement. The food appears R6's acceptance increase holes in the food acceptance docur Dietician Ys stated R6 was placed but reordered on 12/6/21. Weekly Y stated she is also completing we would include reviewing her intake on 12/14/21 (a Tuesday) if R6's we appear R6 needed another weight concerning and also informed R6 v On 12/16/21 at 12:08 PM, lunch moviewed to be asleep in bed. There meal trays to resident in their room elevated R6 in bed, set up her meal begin eating. At 12:21 PM, R6 had she was today and how her meal w of ice cream. Upon exiting R6's roow was completing medication pass. The resident with their meal. At 12:28 Pf food. At 12:31 PM Nurse Z entered time the resident took one more verified to the resident took one more verified to the hall for about 3 minutes her with eating at approximately 12 On 12/16/21 at 12:03 PM email recadinistrator (NHA) requesting the schedule appeared to be unclear. One nurse were assigned to the hall DON and NHA were informed of the concerning with there being at leas choking hazards and/or weight loss level of immediate jeopardy with R6 on 12/17/21 at 9:05 AM, R6 was verified to the set of the property of the property with R6 on 12/17/21 at 9:05 AM, R6 was verified to the provide the property with R6 on 12/17/21 at 9:05 AM, R6 was verified to the provide the property with R6 on 12/17/21 at 9:05 AM, R6 was verified to the provide the provid	view was completed with Dietician Y regit loss recently and overall a decline at was to add supplements to meals as wed herself at times, but that staff usuall acceptance logs for R6 were reviewed as when she has staff assistance. Dietic mentation and stated she would expect on weekly weights as of 11/23/21, this weights were ordered to be completed ekly dietary evaluations of R6 due to the and weights. Dietician Y was asked hotely weight was missed on 12/13/21 (It to be completed. Dietician Y was inform vas not viewed to be getting assistance as a trays were observed to begin to be were between 2-3 CNA staff on the half is. At 12:13 PM a CNA entered R6's rotal and then exited the room by 12:17 P1 yet to take a bit and the surveyor entervas. R6 stared blankly at the surveyor at the was 2 staff in the dining room are part of the half. R6 was 1 R6's room with medications and asked PN, Nurse Z returned to the half. R6 was 1 R6's room with medications and asked priefly exiting the dining room, Nurse Z because she was assisting residents in do great at breakfast. Nurse Z then left is. Nurse Z then returned to the half and the staff covering the 400 half for the more thank that the sidentified residents who required 1: is. The DON responded by email on 12/16 if for that shift. During a follow up interval as identified residents who required 1: is. The DON and NHA were informed of 6's weight loss and lack of interventions are got IV fluids and was smiling and making of	and had a downgrade in her well as provide feeding assistance by need to initiate feeding and with Dietician Y and she stated it it ian Y agreed there were some at each meal to be documented. It was discontinued for some reason, on Mondays for 4 weeks. Dietician the significant weight loss, which we she completed her review of R6 Monday). Dietician Y stated it does med missing the weekly weight was a with her breakfast meal. I at various times delivering the form to deliver her tray. They will without assisting the resident to red the room. R6 was asked how and then slowly took one small bite staff were in the hall and a nurse that and 1 staff was assisting a so not eating any further bites of the R6 if she needed help, at this eared to be looking for another staff asked CNA X to assist R6 with the dining room and was the hall and there was no nursing to R6's room and began to assist the hall and there was no nursing to R6's room and began to assist the significant with the dining service that day, which was a assistance with meals due to the extensive concerns rising to a service implemented.

			10.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, Z 1061 W Hackley Ave Muskegon, MI 49441	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact 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)		ion)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV in her arm. The Surveyor asked eyes wide open and was watching On 12/21/21 at 9:00 AM, UM Z was running. UM Z was giving R6 spoor verbal cues to open her mouth whe tasted, and she responded good. Review of R6's weights revealed the pounds, 10/1/21 125.6 pounds, 11/12/16/21 106.3 pounds, 12/20/21 weight loss. Between 11/17/21 and 9/2/21 and 12/1/21 (3 months) R6 completed late during a time period.	ager (UM) Z was observed feeding R6 R6 how her food tasted, and she resp UM Z. When the spoon came to her m is observed feeding R6 in the main dininfuls of thickened cranberry juice. R6 her the spoon reached her lips. The Sur its following weights in the last approxing the following weights in the last approxing 17/21 116.6 pounds, 12/1/21 109.0 pot 05.1 pounds. Between 10/1/21 and 11 12/1/21 (2 weeks) R6 sustained and 11 12/1/21 (2 weeks) R6 sustained and where R6 sustained a significant weig 2/13/21 where R6 continued to lose with the sustained and the sustained	onded, I do not know. R6's had she touth, she opened it without cueing. Ing room. R6 did not have an IV had her eyes open and did not need veyor asked R6 how her food mately 3 months: 9/2/21 127.6 hunds, 12/6/21 109.0 pounds, /17/21 (1 month) sustained a 7.1 % her 6.5% weight loss. Between bothly weight in November was ght loss and weekly weights were

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

			No. 0938-0391
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R6 progress notes revea progress note from 11/18/21 reveal (current body weight) at 117# (11/1 . Meal intake reviewed which remai is supplemented with House Shake notified of significant wt loss as wel Resident's meal intake remains fair House Shake supplement TID (thre intake. Noted orders for weekly wts place and continue to monitor resid revealed: Weekly Review: Resident week. She continues to have good pro each) for increased kcal and nongoing wt loss. Will continue with PRN (as needed) for changes. A nuand is triggering a 7.6% significant 6. Wt hx reviewed: 117# (11/17), 12 intake. Will continue with all other nx4wks and PRN (as needed) for fur means of nutrition vs. comfort carealert with confusion. Not engaged vxesident is now a 'feed' due to poo while feeding in up right position of honey thick. Provider notified. Resident revealed: Resident's diet has been feeding assistance at all meals per Treat TID (3 times a day) (300kcals and increased kcal intake. A nutritic consuming only 35% on average of throughout the day. She is provided and nutrient intake. Supplement up Noted referral for hospice care in pl decline. Will continue to monitor we from 12/16/21 revealed: A hydration mucus membranes. Her skin turgor received for one liter of NS (normal patent and is infusing well. Review of R6's meal intake records meals were charted and 6 days who being charted. Approximately 37 of no staff oversight or help at any tim for 1:1 assistance at that time. 2 me	led no dietary progress notes from 5/1 ed: Resident triggered a 8.6% significa 7) and BMI 22.0. Wth x reviewed: 126; ns fair, consuming 60% on average over the signification of the triggered a 8.6% signification of the triggered at the triggered	7/21 until 11/18/21. A nutrition ant wt loss x 1.5mo with her CBW (10/1), 127# (8/3), and 125# (5/2) er a 14-day lookback period. She to support wt maintenance. MD 21 revealed: Weekly Review: past week. She is provided with of or increased kcal and nutrient ll other nutrition interventions in trition progress note for R11/30/21 (9.55% on average over the past ement provided TID (200kcals, 6g et is >60% average and prevent and monitor resident weekly and ealed Resident's weight obtained weight) is 109# (12/1) and BMI 20. Enhanced foods to maximize kcal inue to monitor trends weekly ident may benefit from alternative 1 revealed Note Text: Resident refused medications this morning. Noted drooling and coughing resident and downgrading fluids to be A nutrition note for 12/7/21 (as with recommendations for 1:1 pplement updated to Nutritional kes for appropriate consistency ent's meal intake remains fair/poor, most supplements and fluids 1:1g pro each) for increased kcal le to HTL (honey thick liquids). To remain variable given overall changes. A general progress note esident. She presented with dry [name of physician] notified. Order in resident's left forearm. Site is 4/21) revealed 11 days when only 2 as did not indicate what meal was was independent with eating with even though she was care planned 1:46 PM with 25% eaten and one

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 235004

If continuation sheet Page 22 of 49

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R10's face sheet revealed he originally admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnosis that included: acute respiratory failure, hemiplegia and hemiparesis (muscle weakness or partial paralysis on one side of the body), dysphagia (difficulty swallowing), vascular dementia, lack of coordination and convulsions. Review of R10's kardex revealed under food/fluids: 1:1 feeding assistance at all meals as resident allows. check mouth after meals for pocketed food and debris .instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew eat bite thoroughly. Review of R10's care plan revealed a focus area of ADL (activities of daily living) self-care performance deficit r/t (related to) Dementia, Hemiplegia, Impaired balance, Limited Mobility, Limited ROM (range of motion), Stroke) interventions include: EATING: 1:1 feeding assistance at all meals as resident allows. Under focus area [R10] has a potential for swallowing problems r/t Dysphagia interventions include: Alternate small bites and sips . check mouth after meals for pocketed food and debris . instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew eat bite thoroughly . Monitor/document/report PRN (as needed) and s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals.		
	Review of R10's progress notes for R10/3/21 revealed: Resident prefers being fed his meals as he struggles to keep food on his utensil. Assisted with lunch today, he ate 100%. Will notify UM (unit manager) and SLP (Speech-Language Pathology) for possible evaluation. R11 Review of R11's face sheet revealed she was initially admitted to the facility on [DATE] with diagnosis that included: obstructive hydrocephalus (blockage of fluid in the brain), adult failure to thrive, weakness, dysphagia and cognitive communication deficiency. Review of R11's kardex revealed under Food/fluids: Assist resident to consume food/fluids as resident allows; encourage self-feeding .The resident requires extensive assistance by 1 staff to eat Review of R11's care plan revealed a focus area ADL self-care performance deficit r/t Confusion, Fatigue, Impaired balance, Limited Mobility with interventions including EATING: The resident requires extensive assistance by 1 staff to eat . Under the focus area Nutritional status risk AEB (as evidenced by) dx (diagnosis) of .cognitive communication deficit .h/o (history of) dysphagia; self-feeding deficits r/t (related to) blindness and tremors; need for feeding assistance and adaptive equipment . interventions include assist resident to consume food/fluids as resident allows . Monitor/document/report PRN (as needed) and s/sx (signs and symptoms) of dysphagia: Pocketing, Choking, Coughing, Drooling, Holding food in mouth, Several attempts at swallowing, Refusing to eat, Appears concerned during meals. Report to nurse and/or MD and adjust plan of care as indicated. Review of R11's progress notes for R10/8/21 revealed: CNA reported to the the (sic) writer that resident has been noted holding food in her mouth, appetite has decreased .		

		1	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
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Skid Muskegon			r CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0692	Provide enough food/fluids to main	tain a resident's health.	
Level of Harm - Immediate jeopardy to resident health or	**NOTE- TERMS IN BRACKETS F	AVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 38659
safety	This citation refers to MI00124429:		
Residents Affected - Few	Based on observation, interview and record review the facility failed to provide adequate nutrition monitoring and interventions for 3 residents (R6, R10, R11) of 7 residents reviewed for nutrition/hydration resulting in an Immediate Jeopardy (IJ) that began on 12/13/2021 when R6 experienced a significant weight loss and the facility failed to implement identified interventions to prevent weight loss and R6 continued to lose weight. This deficient practice has the high likelihood to affect all residents in this facility potentially resulting in harm, serious injury or death.		
	Findings include:		
	Review of facility policy with the subject Weight Management with adopted date 9/11/20 revealed weight loss is defined as: significant weight loss (5% in one (1) month, 7.5% in three (3) months, oR10% in six (6) months). should be addressed in the care plan. Facility approaches to address weight loss may include an ongoing search for the cause(s) of weight loss .once the cause(s) is/are identified, relevant care plan decisions are made and documented. Ongoing interventions are evaluated and modified as needed. The procedure includes the resident being weighed monthly and as needed .Monthly weights are to be completed by the 7th day of each month and reviewed by the Nutrition Committee within a reasonable period of time thereafter .any resident weight that varies from the previous reporting period by 5% in 30 days, 7.5% in 90 days and 10% in 180 days will be evaluated by the Interdisciplinary Team to determine the cause of the weight gain/loss and the intervention(s) required .any resident meeting the criteria for weight loss .will be weighed weekly, with the weight entered in the resident's medical record .		
	Review of the facility policy with the subject Nutrition Monitoring & Management Program with the adopted date of 7/11/18 revealed a purpose: To provide care and services including .defining and implementing interventions for maintaining or improving nutritional status that are consistent with resident needs, goals and recognized standards of practice .monitoring and evaluating the resident's response or lack of response to the interventions . Dietary evaluations are assessed on admission and at least quarterly thereafter, and following a change in condition.		
	R6		
	admitted on [DATE] with diagnosis	d she had originally admitted to the facil that included: dementia, dysphagia (dit nation, and cognitive communication de	fficulty swallowing), deficiency of
	Review of R6's kardex revealed under food/fluids: 1:1 feeding assistance at all meals . check mouth after meal for pocketed foods and debris . instruct, assist, and/or encourage resident to eat in an upright position, to eat slowly, and to chew each bite thoroughly . There is a conflicting entry in the kardex, which stated R6 i able to eat independently. Under the section special needs weight is noted to be taken weekly as well as monthly.		
	(continued on next page)		

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	<u> </u>	
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	to) weakness, confusion, impaired eat independently with an initiation AEB (as evidenced by) Dx (diagnost place; chronic variable po (by mout interventions that included: 1:1 feet Monitor/document/report PRN (as weights, and weigh resident per fact to) dysphagia, poor dentition interventionstruct, assist and/or encourage rethoroughly, and Monitor for .chokin	under the focus ADL (activities of daily balance, limited mobility an intervention date of 4/27/20. Under the focus area: sis) of .dementia . dysphagia w/ need fith) intake; h/o (history of) wt (weight) fluding assistance at all meals with an init needed) any s/sx (signs or symptoms) cility protocol . Under the focus area ha entions included: check mouth after measident to eat in an upright position, to eg .	In that states The resident is able to: [R6] has a Nutritional status risk or altered textured diet/fluids in actuations; and advanced age with itated date of 12/7/21, of dysphagia ., review routine as a swallowing problem r/t (related eal for pocketed food and debris ., eat slowly, and to chew each bite
	On 12/16/21 at approximately 8:35 in resident rooms and residents we her meal. One of her roommates have as about half complete in consum of clear red honey thick liquid to he asleep with the glass to her mouth, minute. R6's shoulder was rubbed to her lips briefly and then slowly lo room with confusion, not making ey that usually someone will come hel someone may come back to help h communicative and did not make e other than housekeeping was view consuming her breakfast. She took approximately 8:47 AM, a CNA (ce additional food from the kitchen for room of R10. At 8:55 AM CNA X ex 8:58 AM, CNA X exited R11's room to briefly check on R6 and walked at the room with R6 for approximately hall that morning and she stated ye if anyone on the hall needed feedin and R11. CNA X was asked specifinow, but you have to keep checking own today. CNA X was asked how	AM, no staff other than a housekeeper and completely finished their meal at this aing her meal. R6 was viewed to have it mouth with her eyes closed. R6 was she did not respond to verbal attempts when speaking to her and she slowly of the contact. A discussion was completely p R6 at with her meal, but they don't uster. Conversation was attempted again ye contact. Upon exiting the room and ed on the hall or in resident rooms. R6 a limited amount of very small bites, mortified nursing assistant) entered the had a resident and delivered it to their room with their meal tray and then entered away as she was viewed to be very slow as as the was viewed to be very slow as as the only one on the hall, it's like an assistance and she said at least 3 and cally about R6 and her needs. CNA X gon her to make sure she's not chokin she managed to assist 3 residents at conjust has to keep going back and forth the sure and she said at least 3 and cally about R6 and her needs. CNA X gon her to make sure she's not chokin she managed to assist 3 residents at conjust has to keep going back and forth the contact of the co	r were observed on the 400 hall or in her room, not being assisted with in her room, not being assisted with it is time, and the other roommate her food untouched and had a glass approached and appeared to be is to get her attention for about a spened her eyes, but kept the glass verbally and looked around the divide with R6's roommate, who stated sually assist her until later, so with R6 and she was not walking the hall again, no staff was watched from the hall moving very slowly. At all and appeared to have gotten mis. At 8:52 AM, CNA X entered the not then went into R11's room. At the room of R6. CNA X was viewed why feeding herself. CNA X was viewed will be eather only aide assigned to the eather the tother of the rooms of R6, R10 stated she seems to be doing good g, but she is doing good on her once who needed feeding

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 235004

If continuation sheet Page 25 of 49

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
Evel of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Dietician Y stated R6 has had weigswallowing ability. The dietary plan to R6. Dietician Y stated R6 can fe provide encouragement. The food appears R6's acceptance increase holes in the food acceptance docur Dietician Ys stated R6 was placed but reordered on 12/6/21. Weekly of Y stated she is also completing we would include reviewing her intake on 12/14/21 (a Tuesday) if R6's we appear R6 needed another weight concerning and also informed R6 of the viewed to be asleep in bed. There is meal trays to resident in their room elevated R6 in bed, set up her meal begin eating. At 12:21 PM, R6 had she was today and how her meal of ice cream. Upon exiting R6's root was completing medication pass. The resident with their meal. At 12:28 Pfood. At 12:31 PM Nurse Z entered time the resident took one more over member and came across CNA X I lunch. CNA X stated she could not overheard saying she [R6] did not overheard saying	view was completed with Dietician Y regit loss recently and overall a decline a was to add supplements to meals as wed herself at times, but that staff usuall acceptance logs for R6 were reviewed so when she has staff assistance. Dieticinentation and stated she would expect on weekly weights as of 11/23/21, this weights were ordered to be completed ekly dietary evaluations of R6 due to the and weights. Dietician Y was asked herely weight was missed on 12/13/21 (In to be completed. Dietician Y was information of the weekly weight was missed on 12/13/21 (In to be completed. Dietician Y was information of the were between 2 to 3 CNA staff on the loss. At 12:13 PM a CNA entered R6's rotal and then exited the room by 12:17 P1 yet to take a bit and the surveyor at was. R6 stared blankly at the surveyor at was. R6 stared blankly at the surveyor at PM, Nurse Z returned to the hall. R6 was a R6's room with medications and asker by slow bite of ice cream. Nurse Z appeared by exiting the dining room, Nurse Z because she was assisting residents in do great at breakfast. Nurse Z then left minutes. Nurse Z then returned to the tely 12:35 PM. It request was made to the director of note that shift. During a follow up interversidate that shift is a dientified residents who required 1: so The DON and NHA were informed of 6's weight loss and lack of interventions are staff covering that was smilling and making of IV fluids and was smilling and ma	nd had a downgrade in her well as provide feeding assistance y need to initiate feeding and with Dietician Y and she stated it ian Y agreed there were some a each meal to be documented. Was discontinued for some reason, on Mondays for 4 weeks. Dietician we significant weight loss, which we she completed her review of R6 Monday). Dietician Y stated it does med missing the weekly weight was a with her breakfast meal. delivered to the 400 hall. R6 was nall at various times delivering the form to deliver her tray. They without assisting the resident to red the room. R6 was asked how and then slowly took one small bite staff were in the hall and a nurse ea and 1 staff was assisting a s not eating any further bites of d R6 if she needed help. At this eared to be looking for another staff asked CNA X to assist R6 with a the dining room and was the hall and there were not any hall and to R6's room and began to cursing (DON) and nursing home ming of 12/16/21, since the indicated the service that day, which was a sistance with meals due to the extensive concerns rising to a service implemented.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave	P CODE
		Muskegon, MI 49441	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	IV in her arm. The Surveyor asked eyes wide open and was watching On 12/21/21 at 9:00 AM, UM Z was running. UM Z was giving R6 spoot verbal cues to open her mouth whe tasted, and she responded good. Review of R6's weights revealed th pounds, 10/1/21 125.6 pounds, 11/12/16/21 106.3 pounds, 12/20/21 weight loss. Between 11/17/21 and 9/2/21 and 12/1/21 (3 months) R6 completed late during a time period	ager (UM) Z was observed feeding R6 R6 how her food tasted, and she respond LM Z. When the spoon came to her management of the spoon reached from the spoon reached her lips. The Surface following weights in the last approximal 17/21 116.6 pounds, 12/1/21 109.0 pounds. Between 10/1/21 and 11.12/1/21 (2 weeks) R6 sustained anothe sustained a 14.5% weight loss. The most where R6 sustained a significant weigh 2/13/21 where R6 continued to lose were sustained to lose were sustained as the sustained to lose were sustained to los	anded, I do not know. R6's had she buth, she opened it without cueing. Ing room. R6 did not have an IV and her eyes open and did not need veyor asked R6 how her food Inately 3 months: 9/2/21 127.6 ands, 12/6/21 109.0 pounds, 117/21 (1 month) sustained a 7.1 % er 6.5% weight loss. Between anthly weight in November was ht loss and weekly weights were

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIE Skld Muskegon	ER	STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the pureing home's	plan to correct this deficiency places con		ogonov
(X4) ID PREFIX TAG	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)		
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	progress note from 11/18/21 revea (current body weight) at 117# (11/1 . Meal intake reviewed which rema is supplemented with House Shake notified of significant wt loss as wel Resident's meal intake remains fair House Shake supplement TID (thre intake. Noted orders for weekly wts place and continue to monitor reside revealed: Weekly Review: Residen week. She continues to have good pro each) for increased kcal and nu ongoing wt loss. Will continue with PRN (as needed) for changes. A mand is triggering a 7.6% significant 6. Wt hx reviewed: 117# (11/17), 1: intake. Will continue with all other rx4wks and PRN (as needed) for furmeans of nutrition vs. comfort care alert with confusion. Not engaged verside the solution of honey thick. Provider notified. Resirevealed: Resident's diet has been feeding assistance at all meals per Treat TID (3 times a day) (300kcals and increased kcal intake. A nutritic consuming only 35% on average of throughout the day. She is provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted referral for hospice care in provider and nutrient intake. Supplement up Noted re	aled no dietary progress notes from 5/1 led: Resident triggered a 8.6% significa 7) and BMI 22.0. Wt hx reviewed: 126i ins fair, consuming 60% on average over the 2. Will increase her supplement to TID II. A nutrition progress note for R11/23/5, consuming 56% on average over the 2. Et important to the et times a day) (200kcals, 6g pro each 2. To monitor trends. Will continue with a 2. It is meal intake remains fair, consuming acceptance of her House Shake supplutrient intake. Goal po (by mouth) intake current nutrition interventions in place a 2. It is meal intake remains fair, consuming acceptance of her House Shake supplutrient intake. Goal po (by mouth) intake current nutrition interventions in place and contribution of the continues, respectively and 123# (6/3). Recommend autrition interventions in place and contributer changes. If decline continues, respectively and the folial of the folial contribution of the folial con	ant wt loss x 1.5mo with her CBW (10/1), 127# (8/3), and 125# (5/2) er a 14-day lookback period. She to support wt maintenance. MD 21 revealed: Weekly Review: past week. She is provided with of or increased kcal and nutrient life of the nutrition interventions in trition progress note for R11/30/21 of 55% on average over the past ement provided TID (200kcals, 6g exis >60% average and prevent and monitor resident weekly and ealed Resident's weight obtained weight) is 109# (12/1) and BMI 20. Enhanced foods to maximize kcal inue to monitor trends weekly ident may benefit from alternative 1 revealed Note Text: Resident refused medications this morning. Noted drooling and coughing resident and downgrading fluids to be. A nutrition note for 12/7/21 s with recommendations for 1:1 pplement updated to Nutritional kes for appropriate consistency ent's meal intake remains fair/poor, most supplements and fluids 1:1 ppro each) for increased kcal le to HTL (honey thick liquids). to remain variable given overall changes. A general progress note esident. She presented with dry [name of physician] notified. Order and in resident's left forearm. Site is 1:46 PM with 25% eaten and 1:46 PM with 25% eaten and

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 235004

If continuation sheet Page 28 of 49

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

			110. 0700 0071
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please conf	l tact 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 0692	R10		
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admitted on [DATE] with diagnosis (muscle weakness or partial paralyst dementia, lack of coordination and Review of R10's kardex revealed upon the check mouth after meals for pocket upright position, to eat slowly, and the Review of R10's care plan revealed deficit r/t (related to) Dementia, Hermotion), Stroke) interventions inclured focus area [R10] has a potential for bites and sips. check mouth after resident to eat in an upright position PRN (as needed) and s/sx (signs a Holding food in mouth, Several atteres Report to nurse and/or MD and adjured Review of R10's progress notes for to keep food on his utensil. Assister (Speech-Language Pathology) for particulated: obstructive hydrocephalus dysphagia and cognitive communical Review of R11's kardex revealed upon allows; encourage self-feeding. The Review of R11's care plan revealed limpaired balance, Limited Mobility assistance by 1 staff to eat. Under (diagnosis) of .cognitive communication blindness and tremors; need for feeresident to consume food/fluids as (signs and symptoms) of dysphagia Several attempts at swallowing, Re MD and adjust plan of care as indicated.	nder food/fluids: 1:1 feeding assistance and food and debris instruct, assist, and to chew eat bite thoroughly. If a focus area of ADL (activities of daily miplegia, Impaired balance, Limited Mode: EATING: 1:1 feeding assistance at swallowing problems r/t Dysphagia intereals for pocketed food and debris in notice, to eat slowly, and to chew eat bite thind symptoms) of dysphagia: Pocketing empts at swallowing, Refusing to eat, Aust plan of care as indicated. If R10/3/21 revealed: Resident prefers did with lunch today, he ate 100%. Will repossible evaluation. If the focus area ADL self-care performance at a focus area ADL self-care performance at the focus area Nutritional status risk A attion deficit in ho (history of) dysphagia; eding assistance and adaptive equipmeresident allows. Monitor/document/regatered. Pocketing, Choking, Coughing, Droofusied. If R10/8/21 revealed: CNA reported to the self-care performed during the self-care and during the self-care and deficit in the self-care and adaptive equipmeresident allows. Monitor/document/regatered.	hemiplegia and hemiparesis a (difficulty swallowing), vascular at all meals as resident allows. d/or encourage resident to eat in an a living) self-care performance obility, Limited ROM (range of all meals as resident allows. Under terventions include: Alternate small struct, assist, and/or encourage enroughly. Monitor/document/report of the control

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 235004

If continuation sheet Page 29 of 49

Printed: 11/24/2024 Form Approved OMB No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLII		STREET ADDRESS, CITY, STATE, ZI	P CODE
	ER .	1061 W Hackley Ave	PCODE
Skld Muskegon		Muskegon, MI 49441	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 12/16/21 at 3:20 PM, the NHA when the facility failed to assist R6 doctor's orders which include: perferisk (dysphagia) and nutritional neetimely per standards of practice. The death was evidenced by: R6 had a weeks. Surveyor observations reverown. R6 is likely to incur further were loss continues without monitoring a action was: The facility interdiscipling weight loss and decline, and ensurensure nutrition and hydration need practice. On 12/17/2021, the facility plan to reagency began to validate the removed 1. Response to Cited Areas: - Resiresident, a nutrition assessment has appropriate interventions are in plated. A review has been completed on - A review of current residents that ensure nutritional needs are met and - A review of current resident's nutrochanges in nutritional status. - Residents that have been identified reviewed to ensure appropriate interviewed to ensure appropriate interviewed to ensure appropriate interviewed to ensure appropriate interviewed to ensure at risk for hydrochem identified as at risk for hydrochem identified ident	was informed of an Immediate (IJ) relative (who weighs 109 pounds) with nutrition forming weekly weights, providing 1:1 and significant of the identified risk of serious injury, serious 14.5% weight loss in 3 months and a distance or supervisition or little assistance or supervisition in the identified risk of serious injury, serious 14.5% weight loss in 3 months and a distance or supervisition in the identified risk of serious injury, serious has a led no or little assistance or supervisitions, and interventions to prevent weight loss many team must immediately review and ethat all residents at risk for nutrition and sare being met per plan of care, docton emove the Immediate Jeopardy was an eval plan which included: Illowing information to demonstrate that it. Independent of had a current weight obtained. It is been completed and plan of care had ce. Independent of had a current weight obtained. It is been completed and plan of care had ce. Independent of had a current weight obtained. It is been completed and plan of care had ce. Independent of had a current weight obtained. It is been completed and plan of care had ce. Independent of had a current weight obtained. It is been completed and plan of care review and inhydration and/or nutritional interventions and inhydration or nutritional status and a plan of care review and update as near the further incidence: In the form of the stress of the form or nutritional status and a plan of care review and update as near the further incidence: In the form of the stress of the stress of the form of the stress of the st	ted to F 600 that began on 12/13/21 hal needs per the plan of care and sistance or supervision for choking ring nutritional and hydration status us harm, serious impairment or 6.5% weight loss in the last 2 on for R6 who could not eat on her arm and/or hastened death if weight in place. The need for immediate d monitor R6 for her significant und/or hydration are assessed to or's orders, and standards of ccepted and the state survey It the immediacy of the cited The physician has assessed the seen reviewed to ensure reight is documented. The feeding have been reviewed to ensure reight or nutritional status have been esiding in the facility to identify d monitoring 10 residents have had a nutritional leded.
	(continued on next page)		

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 235004

If continuation sheet Page 30 of 49

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skid Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	o Weekly weight process o Providing proper assistance with o Documenting intake o Notification of changes in nutrition On December 16th, 2021, 1 out of management program. - Any staff member that has not be 4. Monitoring: - The DON/designee then monthly thereafter times 3 monutrition monitoring and management interventions, weekly weights, intaked applicable The facility alleges that the immediate Jeopardy of the service of the ser	oral intake nal status timely f 1 registered dietician has been educatent en educated will be educated prior to the will complete 5 random audits on resident program is being followed including the documentation and proper assistance acy with the deficient practice has been was removed on 12/16/2021, the facility actual harm that is not immediate jeopa	nted on the nutrition monitoring and the start of their shift. Idents, weekly times 4 weeks and sheen maintained to ensure the appropriate nutritional the being provided during meals, as the removed on December 16th,

		1	1		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED		
	235004	B. Wing	12/21/2021		
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE		
Skld Muskegon		1061 W Hackley Ave Muskegon, MI 49441			
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0697	Provide safe, appropriate pain mar	nagement for a resident who requires s	uch services.		
Level of Harm - Minimal harm or potential for actual harm	**NOTE- TERMS IN BRACKETS H	HAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 28101		
Residents Affected - Few	This citation pertains to MI0012494				
		nd record review the facility failed to add to address pain for 1 Resident (R8) res n.			
	Findings include:				
	Review of R8's face sheet dated 12/16/21 revealed he was a [AGE] year-old male admitted to the facility [DATE] and had diagnoses that included: Schizophrenia, obsessive compulsive disorder, blindness, and disorder, major depressive disorder, and need for assistance with personal care. R8 was his own responsibility party.				
	Review of R8's Brief Interview of M (normal cognition).	lental Status (BIMS) score dated 11/18	/21 revealed he scored 15/15		
	for a right hip fracture. When R8 re showed an addition femur fracture. Fixation (ORIF), surgical repair of t TID (narcotic pain medication three and is not remembering to ask for pair to the street and the street an	ysician progress note dated 11/15/21 at 6:50 PM revealed, R8 was treated at the hospit ure. When R8 returned to the facility he complained of persistent pain and a repeat x-ran femur fracture. He returned to the hospital for a revision of his Open Reduction Internurgical repair of the right femur. Under Assessment/Plan revealed, Change Norco to 5/3 medication three times a day) as patients pain is not well controlled. He has mental illustering to ask for pain medication. After skin revealed, Inspection and palpation (touch): indication of skin break down. After musculorskeletal revealed, Right leg swelling greaters.			
	led, The patient is seen today for e. He is motivated, cooperative and concerns. He is eating and sleeping				
	Review of R8's physician progress noted dated 11/29/21 at 3:00 PM revealed, R8 is seen today for evaluation of the patient at the request of nursing for lower extremity swelling and also abrasion over the right lower extremity. The patient had a dressing on and he had a recent hip fracture. Incision is very well approximated. Sutures are still in place. The patient thinks that his pain is much better than before. After plan revealed, 1. encourage pt (patient) to limit his time in chair to 2 hours. 2. Pain in right hip joint- externally rotated. Patient instructions. Continue current treatment.				
	(continued on next page)				

			NO. 0936-0391
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NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Skld Muskegon		1061 W Hackley Ave Muskegon, MI 49441	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	patient for complaints of pain. He h is still externally rotated. We are att lower extremity in an anatomical pot to reduce the effect of narcotic pain PT and OT to work with the patient confused, in no acute distress. He is No mention of pressure ulcer on rig Review of R8's physician progress evaluation of right hip pain. I have the Patient has a history of right femuritimes a day). Patient is seen lying in mention that he experiences occas reports that the patient was exhibiting he has just receive a pain pill prior mentions that the patients right hip patch for the patients right knee. Review of R8's Skin & Wound Evalulcer on his right lateral malleolus to the patients right knee. Review of a pressure ulcer report for nurse, an open area on the outer right ariange (fluid containing blood) dracorrecting this position. Resident wound nurse to examine to determ recent surgery with external rotation noted. Edema to lower leg noted to devices in place. Ordered positioning recommendations. Review of R8's care plan revealed in skin integrity, multiple incision sitt Date initiated was 10/26/21 and last to be place mid back when lying on tolerated, 12/17/21 resident needs side lying and while turning resident Review of R8's care plan for limited date initiated 5/28/19 and last revis BEARING TO RLE (right lower extra 10/28/21 Bed Mobility: resident req 12/21/21 R8 required the assistance.	note dated 12/20/21 at 1:40 PM reveal been asked to evaluate the patient for i fracture and is currently on Norco 3-32 n bed. He denies any current pain. He ional pain in his right knee. He denies Ing pain this morning during care and reto care and it may not have taken affect pain is well controlled with a lidocaine uation dated 12/2/21 at 9:17 AM revea that measured 7.3 cm x 4.1 cm x 2.5 cm or R8 dated 11/27/21 at 10:05 AM revea ght ankle area. 4.5 cm in length 5.5 cm ainage noted on linen. Right leg is exteas unaware of open area on right ankle ine if pressure related. 12/10/21 Root on noted. Bed and wheelchair checked in the contributing factor. Wound team for ged evice for positioning. Therapy to as a care plan for actual impairment to skies to his right lower extremity and prest revision was on 12/2/21. Interventions side. 12/2/21 Prevalon boot with outer pressure reduction interventions: positi	as pain when he is in bed. His leg that he is able to maintain his right him on Lidoderm patch in an effort to relaxant in an effort to improve aproved. He is alert, awake, I when he is able to bear weight. The ed, Patient is seen today for necreased pain and discomfort. The TID (narcotic pain medication 3 denies hip pain however does knee pain at this moment. Nursing apositioning however, nurse says at at that time. Nursing also patch and is requesting a lidocaine and was 0.1 cm deep. The time the time is aled, the had a new unstageable in and was 0.1 cm deep. The time the time is aled, 11/29/21 cause: Related to resident having for any sharp surfaces and none allowing. Boot and positioning in the seess for any further positioning in the seess for any further positioning in the seess for any further position pillow wedge to right foot when in bed as oning pillow between knees when and history of right fibula fracture resident is NON WEIGHT of LLE (left lower extremity). All observations 12/17/21 to be comotion: The resident uses a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION 235004 IDENTIFICATION NUMBER: 235004 STREET ADDRESS, CITY, STATE, ZIP CODE 1021/2021 STREET ADDRESS, CITY, STATE, ZIP CODE 1061 W Hackley Ave Muskegon, MI 49441 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. (XA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) Review of R8's care plan for chronic pain dated initiated 1/14/21 and revision on 11/1/2/21 revealed, 5/29/1 Administer analgesia per physician orders. Anticipate and treat before, during, and after treatment that macuse increased pain or discomfort. Review of R8's Kardex dated 12/19/21 revealed he required assistance of one person for bed mobility. However, all observations of care for R8 from 12/17/21 to 12/21/21 R8 in all 2 people assisting him with movement in bed as his right leg was very paintful and he was not able to move his right leg without assistance. R8 also required hypixical assistance bro fol and two people to pull him up hed. Review of R8's EDT (intendisciplinary note) dated 12/20/21 revealed, Heal suspension boot discontinued, AMP (alternating pressure mattress) in place now. Care plan did not reflect these changes. Review of R8's wound timeline provided by the facility revealed the following measurements: 11/27/21 - 4.5 cm x 5 x 5 cm 12/2/21 - 7.3 cm x 4.1 cm x 2.5 cm 12/2/21 - 7.3 cm x 4.1 cm x 2.5 cm x 1.7 cm 12/11/21 2.8 cm x 3.2 cm x UTD (undermined depth). The last Skin & Wound evaluation located in R8's record and provided by the facility was dated 12/20/21 and revealed a facility acquired, unstageable pressure ucler on R8's right lateral mallicolus that measured 3.2 cm x 2.5 cm x 1.7 cm and was 0.2 depth. Assessments did not indicate any drainage. On 12/11/21 at 10:09 AM CNA As as als have sas segreted to R8 to May as addition to the file of the facility was called 12/20/21 and the entire of the fac				NO. 0936-0391
Skid Muskegon 1061 W Hackley Ave Muskegon, MI 49441 For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. (XA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) Review of R8's care plan for chronic pain dated initiated 1/14/21 and revision on 11/12/21 revealed, 5/29/1 Administer analgesia per physician orders. Anticipate and treat before, during, and after treatment that ma cause increased pain or discomfort. Review of R8's Kardex dated 12/19/21 revealed he required assistance of one person for bed mobility. However, all observations of care for R8 from 12/17/21 to 12/21/12 R8's had 2 people assisting him with movement in bed as his right leg was very painful and he was not able to move his right leg without assistance. R8 also required physical assistance to roll and two people to pull him up in bed. Review of R8's BDT (interdisciplimary note) dated 12/20/21 revealed, Heal suspension boot discontinued, AMP (alternating pressure maltress) in place now. Care plan did not reflect these changes. Review of R8's wound timeline provided by the facility revealed the following measurements: 11/27/21 - 4.5 cm x 5.x 5 cm 12/2/21 - 7.3 cm x 4.1 cm x 2.5 cm 12/9/21 3.2 cm x 2.5 cm x 1.7 cm 12/17/21 2.8 cm x 3.2 cm x UTD (undermined depth). The last Skin & Wound evaluation located in R8's record and provided by the facility was dated 12/9/21 are revealed a facility acquired, unstageable pressure uicer on R8's right lateral malleolus that measured 3.2 c x 2.5 cm x 1.7 cm and was 0.2 depth. Assessments did not indicate any drainage. On 12/17/21 at 9.55 AM, R8 was observed eating in bed. The head of his bed was elevated about 20 to 30 degrees. R8 was dropping a lot of his food in bed. His body was covered with a sheet. R8 said he had not been provided any care yet this morning. He was feeding himself. On 12/17/21 at 10:09 AM CNA AA said she was assigned		IDENTIFICATION NUMBER:	A. Building	COMPLETED
SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) Review of R8's care plan for chronic pain dated initiated 1/14/21 and revision on 11/12/21 revealed, 5/29/1 Administer analgesia per physician orders. Anticipate and treat before, during, and after treatment that ma cause increased pain or discomfort. Residents Affected - Few Residents			1061 W Hackley Ave	P CODE
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Residents Affected - Few Review of R8's care plan for chronic pain dated initiated 1/14/21 and revision on 11/12/21 revealed, 5/29/1 Administer analgesia per physician orders. Anticipate and treat before, during, and after treatment that ma cause increased pain or discomfort. Review of R8's Kardex dated 12/19/21 revealed he required assistance of one person for bed mobility. However, all observations of care for R8 from 12/17/21 to 12/21/21 R8's had 2 people assisting him with movement in bed as his right leg was very painful and he was not able to move his right leg without assistance. R8 also required physical assistance to roll and two people to pull him up in bed. Review of R8's IDT (interdisciplinary note) dated 12/20/21 revealed, Heal suspension boot discontinued, AMP (alternating pressure mattress) in place now. Care plan did not reflect these changes. Review of R8's wound timeline provided by the facility revealed the following measurements: 11/27/21 - 4.5 cm x 5 x 5 cm 12/9/21 3.2 cm x 2.5 cm x 1.7 cm 12/17/21 2.8 cm x 3.2 cm x UTD (undermined depth). The last Skin & Wound evaluation located in R8's record and provided by the facility was dated 12/9/21 an revealed a facility acquired, unstageable pressure ulcer on R8's right lateral malleolus that measured 3.2 c x 2.5 cm x 1.7 cm and was 0.2 depth. Assessments did not indicate any drainage. On 12/17/21 at 9:55 AM, R8 was observed eating in bed. The head of his bed was elevated about 20 to 3′d degrees. R8 was dropping a lot of his food in bed. His body was covered with a sheet. R8 said he had not been provided any care yet this morning. He was feeding himself. On 12/17/21 at 10:09 AM CNA AA said she was assigned to R8 today and started work at 6:00 AM, CNA As said the only care she had provided for R8 this morning was to reposition him around 6:00 AM, CNA AA said the only care she had provided for R8 this morning was to was caring for 11 residents and wa	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
Administer analgesia per physician orders. Anticipate and treat before, during, and after treatment that ma cause increased pain or discomfort. Residents Affected - Few Review of R8's Kardex dated 12/19/21 revealed he required assistance of one person for bed mobility. However, all observations of care for R8 from 12/17/21 to 12/21/21 R8's had 2 people assisting him with movement in bed as his right leg was very painful and he was not able to move his right leg without assistance. R8 also required physical assistance to roll and two people to pull him up in bed. Review of R8's IDT (interdisciplinary note) dated 12/20/21 revealed, Heal suspension boot discontinued, AMP (alternating pressure mattress) in place now. Care plan did not reflect these changes. Review of R8's wound timeline provided by the facility revealed the following measurements: 11/27/21 - 4.5 cm x 5.5 cm 12/9/21 3.2 cm x 2.5 cm x 1.7 cm 12/17/21 2.8 cm x 3.2 cm x UTD (undermined depth). The last Skin & Wound evaluation located in R8's record and provided by the facility was dated 12/9/21 ar revealed a facility acquired, unstageable pressure ulcer on R8's right lateral malleolus that measured 3.2 c x 2.5 cm x 1.7 cm and was 0.2 depth. Assessments did not indicate any drainage. On 12/17/21 at 9:55 AM, R8 was observed eating in bed. The head of his bed was elevated about 20 to 3/d degrees. R8 was dropping a lot of his food in bed. His body was covered with a sheet. R8 said he had not been provided any care yet this morning, He was feeding himself. On 12/17/21 at 10:09 AM CNA As aid she was assigned to R8 today and started work at 6:00 AM. CNA as a she was also responsible for residents on another hall. CNA As asid she was assigned to R8 today and started work at 6:00 AM. CNA as he was also responsible for residents on another hall. CNA As asid she was caring for 11 residents and was on	(X4) ID PREFIX TAG			on)
(continued on next page)	Level of Harm - Minimal harm or potential for actual harm	Review of R8's care plan for chroni Administer analgesia per physician cause increased pain or discomford Review of R8's Kardex dated 12/18 However, all observations of care for movement in bed as his right leg wassistance. R8 also required physical Review of R8's IDT (interdisciplinar AMP (alternating pressure mattress Review of R8's wound timeline profund 11/27/21 - 4.5 cm x 5 x 5 cm 12/2/21 - 7.3 cm x 4.1 cm x 2.5 cm 12/9/21 3.2 cm x 2.5 cm x 1.7 cm 12/17/21 2.8 cm x 3.2 cm x UTD (under the context of the co	ic pain dated initiated 1/14/21 and revision orders. Anticipate and treat before, duit. 2/21 revealed he required assistance of or R8 from 12/17/21 to 12/21/21 R8's has very painful and he was not able to cal assistance to roll and two people to call assistance to roll and the follow wided by the facility revealed the follow eable pressure ulcer on R8's right later th. Assessments did not indicate any dispersion in the call of the call th	sion on 11/12/21 revealed, 5/29/19 ring, and after treatment that may for one person for bed mobility. It and 2 people assisting him with move his right leg without pull him up in bed. Suspension boot discontinued, cot these changes. It the facility was dated 12/9/21 and ral malleolus that measured 3.2 cm rainage. It bed was elevated about 20 to 30 with a sheet. R8 said he had not distanted work at 6:00 AM. CNA AA him around 6:00 AM. CNA AA him around 6:00 AM. CNA AA said was caring for 11 residents and her that morning. Infirmed CNA AA was assigned to be residents on the unit were care grant was considered as a considered and the considered and t

			NO. 0936-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021	
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	OF DEFICIENCIES receded by full regulatory or LSC identifying information)		
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incision with no date or initials, he had leg just above his malleolus with no through. Unit Manager Z removed that was removed. CNA AA and Ur grimaced and hit his fisted hands of stop moving him. Urine had soak the moving his right leg to provide care when he was asked. When pulling below the top of the boot. The boot and the unit manager rolled R8 in beleg. CNA AA said when she came in pillow to allow him to be on his bace R8's right hip and kept the boot fas. On 10/17/21 at approximately 11:00 R8. Unit Manager Z was still in the pain in the right leg during moveme circulation was being impaired by the indentation on the right foot and ne positioning. PTA BB said they had placed a pillow under R8 calf. PTA R8's legs when rolling him (log roll) R8's back (not his hip) when positic complained of less pain with this material let staff know he had less pain where a lot of pain with movement. On 12/17/21 at 11:25 AM, the Surveright foot caused 1 inch pitting eder staff were having difficulty with provider soaked in urine for over 4 hours 12/17/21 the DON acknowledged material control of the pool of the poo	21 at 10:20 AM, R8 had a dressing on India a lidocaine patch on his right thigh to date or initials. The dressings did not the dressing on his right hip and the inclusion about approximately .5 cm in len R8's incision on his right hip. No drainabit Manager Z rolled R8 in bed to remove the mattress with movement. R8 did prough to his sheet. R8 did yell out in parand positioning. During care R 10 said back the boot on R8's foot a 1-inch individual was fastened with a Velcro strap (1 incided they did not support his right leg. R nat 6:00 AM R8 was positioned toward k for breakfast. CNA AA and Unit Manager and the sum of the control	and a dressing on his right lower have any drainage showing cision under the dressing had red gth at the distal end of the incision. age was observed on the dressing ve his saturated brief and sheet. R8 not yell out in pain or ask staff to ain at times when staff were d his pain was at 10 on a 1-10 scale entation was noted in his skin ch pitting edema). When CNA AA 8 indicated his pain was in his right d his right side, and she moved the ager Z placed wedge cushion under anything could be done to decrease bressure relief in bed and if R8's med the boot was causing the eto provide pressure relief and d. PTA BB removed the boot and Manager Z to use a pillow between place the pillow or wedge behind with positioning devices). R8 ration at 10:20 AM. R8 was able to the gwas supported but he still had book to it leg was supported but he still had book to it leg was supported but he still had book to it is a hours. Around noon on he would address the issues. The	

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		P CODE
plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
		ion)
chair. When PTA BB moved R8's le over his dressing on the right lower R8's wheelchair at 9:29 AM and R8 arms to the door of the main dining PTA BB was planning on doing the checked with LPN CC to see if R8 had his lidocaine patch so he did n nurse would need to contact the do On 12/21/21 at 10:21 AM, the Direct he now had a order for prn (as need on 12/21/21 at approximately 11:0 R8 grimaced with pain during the trout in pain or complain during the this pain was 5 when he was not more on 12/21/21 at 11: 35 AM, LPN EE LPN EE showed where she had wr saturated all the way through. Ther removed. The wound was facing the having too much pain to change his pointed out that R8 had a dressing did not know anything about that did the dressing should not be on R8's saturated area was noted on the dressing should not be on R8's saturated area was noted on the dressing thip. During an interview with the DON oright hip was draining, she was not for all documentation on R8's wour that showed they were aware the ridressing on the right hip, they had	eg to remove the leg rest she grabbed of leg that was visible soiled. PTA BB refers's said it this leg rest felt better. R8's pur room than requested assistance to ge trapy at this time but R8 reported his parcould get anything for pain. LPN CC said have any thing else she could give a potor. Cotor of Nursing (DON) informed staff shid) Norco and they could give it now. O AM, CNA B and CNA DD used an elegansfer. He made fists with both hands ransfer. He again reported a 10 with paroving in bed. Esaid she put the dressing on R8's right itten with a light ink pen the date, time re was a large letter C shape in the block as position to allow the Surveyor was not able to position to allow the Surveyor to view over his right hip incision with no date, ressing. A few minutes later Unit Managright hip. LPN EE removed the dressing R8's incision on his right hip started drawn and the country of the dressing on his right and get no country of the dressing on his right ankler was a ware the dressing on his right ankler was a ware the dressing on his right ankler was a sessing. The distal area of the incision to the dressing on his right ankler was a ware the dressing on his right ankler was a ware the dressing on his right ankler was a session.	his leg with her bare hand right turned to put a leg rest back on ushed his wheelchair with both at out the door and back to his room. As ain was 10 out of 1 - 10. PTA BB aid R8 had Norco at 8:08 AM and at this time. LPN CC said R8's he had contacted R8's doctor and he had shook his arms but did not yell ain during movement but reported had an her initials. The dressing was be his ankle wound. The Surveyor time or initials. LPN EE said she ger Z arrive at R8's room and said and on R8's right hip and a 1/2 that had an indentation in it when her Z was not able to locate any sining, or when the wound on his new orders for a dressing over R8's hours asked lid not provide any documentation no documentation of Who put the les on the full condition of R8's right
	DENTIFICATION NUMBER: 235004 R Dalan to correct this deficiency, please con SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by) On 12/21/21 at 9:17 AM, PTA BB of chair. When PTA BB moved R8's like over his dressing on the right lower R8's wheelchair at 9:29 AM and R8 arms to the door of the main dining PTA BB was planning on doing the checked with LPN CC to see if R8 had his lidocaine patch so he did nourse would need to contact the document of the nown had a order for prometic for prometi	DENTIFICATION NUMBER: 235004 A. Building B. Wing STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441 Dana to correct this deficiency, please contact the nursing home or the state survey SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying informatic On 12/21/21 at 9:17 AM, PTA BB came in the Main Dining room and remethair. When PTA BB moved R8's leg to remove the leg rest she grabbed over his dressing on the right lower leg that was visible soiled. PTA BB rearms to the door of the main dining room than requested assistance to ge PTA BB was planning on doing therapy at this time but R8 reported his perchecked with LPN CC to see if R8 could get anything for pain. LPN CC schedibility and a order for prn (as need) Norco and they could give a nurse would need to contact the doctor. On 12/21/21 at 10:21 AM, the Director of Nursing (DON) informed staff she now had a order for prn (as need) Norco and they could give it now. On 12/21/21 at approximately 11:00 AM, CNA B and CNA DD used an el R8 grimaced with pain during the transfer. He made fists with both hands out in pain or complain during the transfer. He again reported a 10 with pain pain was 5 when he was not moving in bed. On 12/21/21 at 11: 35 AM, LPN EE said she put the dressing on R8's right LPN EE showed where she had written with a light ink pen the date, time saturated all the way through. There was a large letter C shape in the blo removed. The wound was facing the mattress so the Surveyor was not at having too much pain to change his position to allow the Surveyor to view pointed out that R8 had a dressing over his right hip incision with no date, did not know anything about that dressing. A few minutes later Unit Mana the dressing should not be on R8's right hip. LPN EE removed the dressin saturated area was noted on the dressing. The distal area of the incision in the undated dressing should not be on R8's incision on his right hip started dright ankle started having drainag

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 235004	A. Building	COMPLETED 12/21/2021	
		B. Wing		
	NAME OF PROVIDER OR SUPPLIER		P CODE	
Skld Muskegon		1061 W Hackley Ave Muskegon, MI 49441		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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)		on)	
F 0725	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.			
Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS H	NAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 38659	
	This citation refers to MI00124429:			
	This citation has two deficient pract	tice statements		
	DPS #1			
	Based on observation, interview and record review the facility failed to provide adequate staff for weight monitoring, feeding assistance and supervision for 3 residents (R6, R10, and R11), resulting in significant weight loss for R6 and the potential for future weight loss, as well as the potential for choking, aspiration, and serious injury due to lack of supervision and meal assistance for R6, R10 and R11.			
	Findings include:			
	Review of facility policy with the subject Weight Management with adopted date 9/11/20 revealed weight los is defined as: significant weight loss (5% in one (1) month, 7.5% in three (3) months, oR10% in six (6) months). should be addressed in the care plan. Facility approaches to address weight loss may include an ongoing search for the cause(s) of weight loss .once the cause(s) is/are identified, relevant care plan decisions are made and documented. Ongoing interventions are evaluated and modified as needed. The procedure includes the resident being weighed monthly and as needed. Monthly weights are to be complete by the 7th day of each month and reviewed by the Nutrition Committee within a reasonable period of time thereafter .any resident weight that varies from the previous reporting period by 5% in 30 days, 7.5% in 90 days and 10% in 180 days will be evaluated by the Interdisciplinary Team to determine the cause of the weight gain/loss and the intervention(s) required .any resident meeting the criteria for weight loss .will be weighed weekly, with the weight entered in the resident's medical record .			
	Review of the facility policy with the subject Nutrition Monitoring & Management Program with the adopted date of 7/11/18 revealed a purpose: To provide care and services including .defining and implementing interventions for maintaining or improving nutritional status that are consistent with resident needs, goals and recognized standards of practice .monitoring and evaluating the resident's response or lack of response to the interventions . Dietary evaluations are assessed on admission and at least quarterly thereafter, and following a change in condition.			
	R6			
	Review of R6's face sheet revealed she had originally admitted to the facility on [DATE] and most recently admitted on [DATE] with diagnosis that included: dementia, dysphagia (difficulty swallowing), deficiency of vitamins, weakness, lack of coordination, and cognitive communication deficit.			
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's r	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	<u> </u>	
F 0725 Level of Harm - Actual harm Residents Affected - Few	meal for pocketed foods and debris to eat slowly, and to chew each bite able to eat independently. Under the monthly. Review of R6's care plan revealed to) weakness, confusion, impaired leat independently with an initiation AEB (as evidenced by) Dx (diagnos place; chronic variable po (by mout interventions that included: 1:1 feed Monitor/document/report PRN (as reveights, and weigh resident per fact to) dysphagia, poor dentition interveinstruct, assist and/or encourage rethoroughly, and Monitor for .choking Review of physician note from 11/2	der food/fluids: 1:1 feeding assistance in instruct, assist, and/or encourage resist thoroughly. There is a conflicting entile election special needs weight is noted under the focus ADL (activities of daily balance, limited mobility an intervention date of 4/27/20. Under the focus area: sis) of .dementia. dysphagia w/ need find in the mean of the focus area at all meals with an initial needed) any s/sx (signs or symptoms) is dility protocol. Under the focus area has entitions included: check mouth after means included: check mouth after means included and in an upright position, to be greatly as a significant of the focus area for a form of the focus area in the focus area.	sident to eat in an upright position, ry in the kardex, which stated R6 is d to be taken weekly as well as living) self-care deficit r/t (related in that states The resident is able to: [R6] has a Nutritional status risk or altered textured diet/fluids in actuations; and advanced age with isted date of 12/7/21, of dysphagia., review routine is a swallowing problem r/t (related that for pocketed food and debris., that slowly, and to chew each bite in complaint of weight loss. Lab

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDED OR CURRULED		STREET ADDRESS CITY STATE 71	D CODE
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave	PCODE
Skld Muskegon		Muskegon, MI 49441	
For information on the nursing home's plan to correct this deficiency, please con		tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by the state of		CIENCIES full regulatory or LSC identifying informati	on)
F 0725		AM, no staff other than a housekeeper	
Level of Harm - Actual harm		ere eating breakfast. R6 was observed it ad completely finished their meal at this	
Residents Affected - Few	· ·	ning her meal. R6 was viewed to have h	· · · · · · · · · · · · · · · · · · ·
Trestactitis Affected - Few	asleep with the glass to her mouth, minute. R6's shoulder was rubbed to her lips briefly and then slowly lo room with confusion, not making ethat usually someone will come hel someone may come back to help homeomeore communicative and did not make e other than housekeeping was view consuming her breakfast. She took approximately 8:47 AM, a CNA (ce additional food from the kitchen for room of R10. At 8:55 AM CNA X ex 8:58 AM CNA X exited R11's room to briefly check on R6 and walked at the room with R6 for approximately hall the morning and she stated ye if anyone on the hall needed feeding and R11. CNA X was asked specifinow, but you have to keep checkin own today. CNA X was asked how assistance and she stated that she	or mouth with her eyes closed. R6 was a she did not respond to verbal attempts when speaking to her and she slowly of owered it. R6 continued to not respond ye contact. A discussion was completed p R6 at with her meal, but they don't user. Conversation was attempted again ye contact. Upon exiting the room and ed on the hall or in resident rooms. R6 a limited amount of very small bites, mortified nursing assistant) entered the hall are resident and delivered it to their room with their meal tray and with their meal tray and with their meal tray and then entered to away as she was viewed to be very slow as she was viewed to be very slow as a mortified R10's room with their meal tray and then entered to away as she was viewed to be very slow as a sked if she were a minutes. CNA X was asked if she were a said at least 3 and ically about R6 and her needs. CNA X g on her to make sure she's not chokin she managed to assist 3 residents at a continuous survey as a sample of the provision of the literature of the provision of the provisi	s to get her attention for about a spened her eyes, but kept the glass verbally and looked around the d with R6's roommate, who stated sually assist her until later, so with R6 and she was not walking the hall again, no staff was watched from the hall noving very slowly. At all and appeared to have gotten ms. At 8:52 AM CNA X entered the not then went into R11's room. At he room of R6. CNA X was viewed wly feeding herself. CNA X was in as the only aide assigned to the this every day. CNA X was asked and pointed to the rooms of R6, R10 stated she seems to be doing good g, but she is doing good on her once who needed feeding between them.
	Dietician Y stated R6 has had weig swallowing ability. The dietary plan to R6. Dietician Y stated R6 can fe provide encouragement. The food appears R6's acceptance increase holes in the food acceptance docur Dietician Ys stated R6 was placed but reordered on 12/6/21. Weekly of Y stated she is also completing we would include reviewing her intake on 12/14/21 (a Tuesday) if R6's we appear R6 needed another weight concerning and also informed R6 v	view was completed with Dietician Y regist loss recently and overall a decline a was to add supplements to meals as wed herself at times, but that staff usuall acceptance logs for R6 were reviewed so when she has staff assistance. Dietic mentation and stated she would expect on weekly weights as of 11/23/21, this weights were ordered to be completed ekly dietary evaluations of R6 due to the and weights. Dietician Y was asked how the weight was missed on 12/13/21 (Note to be completed. Dietician Y was inform was not viewed to be getting assistance.	nd had a downgrade in her well as provide feeding assistance y need to initiate feeding and with Dietician Y and she stated it ian Y agreed there were some each meal to be documented. was discontinued for some reason, on Mondays for 4 weeks. Dietician he significant weight loss, which low she completed her review of R6 Monday). Dietician Y stated it does med missing the weekly weight was
	(continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	For information on the nursing home's plan to correct this deficiency, please con		agency
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC		<u>- </u>
F 0725 Level of Harm - Actual harm Residents Affected - Few	viewed to be asleep in bed. There meal trays to resident in their room elevated R6 in bed, set up her meal begin eating. At 12:21 PM, R6 had she was today and how her meal wof ice cream. Upon exiting R6's roow was completing medication pass. Tresident with their meal. At 12:28 P food. At 12:31 PM Nurse 2 entered time the resident took one more veremember and came across CNA X lunch. CNA X stated she could not overheard saying she [R6] did not o	eal trays were observed to begin to be were between 2-3 CNA staff on the hall s. At 12:13 PM a CNA entered R6's roal and then exited the room by 12:17 PI yet to take a bit and the surveyor enterwas. R6 stared blankly at the surveyor at the was 2 staff in the dining room are the was 2 staff in the dining room are the was 2 staff in the dining room are the was 2 staff in the dining room are the was 2 returned to the hall. R6 was 1 R6's room with medications and asker yelow bite of ice cream. Nurse Z appeariefly exiting the dining room, Nurse Z because she was assisting residents in do great at breakfast. Nurse Z then left is. Nurse Z then returned to the hall and the was 1 R6's room with medications and asker yelow between the was assisting residents in do great at breakfast. Nurse Z then left is. Nurse Z then returned to the hall and the was 1 R6's room with medication and yellow up interversions and was made to the director of nursing a staff covering the 400 hall for the month of the book responded by email on 12/16. If for that shift. During a follow up interversion at the property of the wellow up interversion and the was smilling and making it is in the property of the was a smilling and making of IV fluids and was smilling and IV fluids and was smilling and IV fluids	I at various times delivering the om to deliver her tray. They without assisting the resident to red the room. R6 was asked how and then slowly took one small bite staff were in the hall and a nurse as and 1 staff was assisting a so not eating any further bites of the R6 if she needed help, at this eared to be looking for another staff asked CNA X to assist R6 with a the dining room and was the hall and there was no nursing to R6's room and began to assist the hall and there was no nursing to R6's room and began to assist the properties of the pr

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0725 Level of Harm - Actual harm Residents Affected - Few	progress note from 11/18/21 revea (current body weight) at 117# (11/17). Meal intake reviewed which rema is supplemented with House Shake notified of significant wt loss as we Resident's meal intake remains fair House Shake supplement TID (threintake. Noted orders for weekly wts place and continue to monitor resic revealed: Weekly Review: Residen week. She continues to have good pro each) for increased kcal and nu ongoing wt loss. Will continue with PRN (as needed) for changes. An and is triggering a 7.6% significant 6. Wt hx reviewed: 117# (11/17), 1 intake. Will continue with all other rx4wks and PRN (as needed) for fu means of nutrition vs. comfort care alert with confusion. Not engaged Resident is now a 'feed' due to pook while feeding in up right position of honey thick. Provider notified. Resi revealed: Resident's diet has been feeding assistance at all meals per Treat TID (3 times a day) (300kcals and increased kcal intake. A nutritic consuming only 35% on average of throughout the day. She is provide and nutrient intake. Supplement up Noted referral for hospice care in provided and nutrient intake. Supplement up Noted referral for hospice care in provided and nutrient intake. Supplement up Noted referral for hospice care in provided and nutrient intake. Supplement up Noted referral for hospice care in provided and supplement and is infusing well. Review of R6's meal intake records meals were charted and 6 days where the supplement and is infusing well. Review of R6's meal intake records meals were charted and 6 days where the supplement and is infusing well.	aled no dietary progress notes from 5/1 led: Resident triggered a 8.6% significa 7) and BMI 22.0. Wt hx reviewed: 126; ins fair, consuming 60% on average over the least 30 days (from 11/17-12/16 en only 1 meal was charted the resident being totally a for the last 30 days (from 11/17-12/16 en only 1 meal was charted. The entries is por and tenting. Physician on-call estable to the past week. She is accepting of development of the resident has a fair to the past week. She is accepting of development of the past week. She is accepting the past wee	ant wt loss x 1.5mo with her CBW # (10/1), 127# (8/3), and 125# (5/2) are a 14-day lookback period. She to support wt maintenance. MD 21 revealed: Weekly Review: past week. She is provided with of for increased kcal and nutrient ll other nutrition interventions in trition progress note for R11/30/21 g 55% on average over the past ement provided TID (200kcals, 6g e is >60% average and prevent and monitor resident weekly and ealed Resident's weight obtained weight) is 109# (12/1) and BMI 20. Enhanced foods to maximize kcal inue to monitor trends weekly ident may benefit from alternative 1 refused medications this morning. Noted drooling and coughing resident and downgrading fluids to be. A nutrition note for 12/7/21 sls with recommendations for 1:1 pplement updated to Nutritional kes for appropriate consistency ent's meal intake remains fair/poor, most supplements and fluids 11g pro each) for increased kcal de to HTL (honey thick liquids). to remain variable given overall changes. A general progress note esident. She presented with dry [name of physician] notified. Order and in resident's left forearm. Site is

			NO. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's plan to correct this deficiency, please con		tact 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)		on)
F 0725 Level of Harm - Actual harm Residents Affected - Few	Review of R10's face sheet revealed admitted on [DATE] with diagnosis (muscle weakness or partial paraly dementia, lack of coordination and Review of R10's kardex revealed uncheck mouth after meals for pocked upright position, to eat slowly, and review of R10's care plan revealed deficit r/t (related to) Dementia, Hemotion), Stroke) interventions inclust focus area [R10] has a potential for bites and sips. check mouth after resident to eat in an upright position PRN (as needed) and s/sx (signs a Holding food in mouth, Several atteres Report to nurse and/or MD and adj. Review of R10's progress notes for to keep food on his utensil. Assiste (Speech-Language Pathology) for R11 Review of R11's face sheet revealed included: obstructive hydrocephalus dysphagia and cognitive communical Review of R11's care plan revealed unallows; encourage self-feeding. The Review of R11's care plan revealed (diagnosis) of .cognitive communical blindness and tremors; need for feeresident to consume food/fluids as (signs and symptoms) of dysphagia Several attempts at swallowing, ReMD and adjust plan of care as indicated.	ed he originally admitted to the facility of that included: acute respiratory failure, sis on one side of the body), dysphagia convulsions. Inder food/fluids: 1:1 feeding assistance at ded food and debris .instruct, assist, and to chew eat bite thoroughly. In a focus area of ADL (activities of daily miplegia, Impaired balance, Limited Mode: EATING: 1:1 feeding assistance at swallowing problems r/t Dysphagia intereals for pocketed food and debris . in n., to eat slowly, and to chew eat bite thand symptoms) of dysphagia: Pocketing empts at swallowing, Refusing to eat, A ust plan of care as indicated. In R10/3/21 revealed: Resident prefers d with lunch today, he ate 100%. Will repossible evaluation. In the focus area ADL self-care performant with interventions including EATING: The focus area Nutritional status risk A ation deficit .h/o (history of) dysphagia; edding assistance and adaptive equipmer resident allows . Monitor/document/repair Pocketing, Choking, Coughing, Drooffusing to eat, Appears concerned during attention of the cated. In R10/8/21 revealed: CNA reported to the R10/8/21 rev	on [DATE] and most recently hemiplegia and hemiparesis a (difficulty swallowing), vascular at all meals as resident allows dor encourage resident to eat in an vilving) self-care performance obility, Limited ROM (range of all meals as resident allows. Under terventions include: Alternate small struct, assist, and/or encourage foroughly. Monitor/document/report groughly. Monitor/

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021	
NAME OF PROMPTS OF SUPPLIES		CEDEET ADDRESS CITY STATE 71	D CODE	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	PCODE	
Skld Muskegon		1061 W Hackley Ave Muskegon, MI 49441		
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
F 0725	28101			
Level of Harm - Actual harm	DPS #2			
Residents Affected - Few	Based on observation interview and record review the facility failed to provide adequate staffing for 1 Resident (R8) to provided timely repositioning and incontinence care, resulting in R8 not being repositioned in over 2 hours and left soiled for over 4 hours. Findings include:			
	Review of R8's face sheet dated 12/16/21 revealed he was a [AGE] year-old male admitted to the facility on [DATE] and had diagnoses that included: Schizophrenia, obsessive compulsive disorder, blindness, anxiety disorder, major depressive disorder, and need for assistance with personal care. R8 was his own responsibility party.			
	Review of R8's Brief Interview of M (normal cognition).	lental Status (BIMS) score dated 11/18	/21 revealed he scored 15/15	
		bserved eating in bed. The head of his his food in bed. His body was covered orning. He was feeding himself.		
	On 12/17/21 at 10:09 AM, CNA AA said she was assigned to R8 today and started work at 6:00 AM. CNA AA said the only care she had provided for R8 this morning was to reposition him around 6:00 AM. CNA AA said she was also responsible for residents on another hall. CNA AA said she was caring for 11 residents and was on a split hall. CNA AA said there was one on other CNA working with her that morning.			
	During an interview with Unit Manager Z on 12/17/21 at 10:15 AM, she confirmed CNA AA was assigned to R8. CNA AA was assigned to care for 11 residents on the unit and 6 of the residents on the unit were care planned to need 2 people for care. The other CNA on the unit this morning was CNA X.			
	During an interview with CNA X on this morning.	12/17/21 at 10:18 AM, CNA X said she	e had not provided any care for R8	
	R8 was observed in bed on 12/17/21 at 10:20 AM, CNA AA and Unit Manager Z rolled R8 in bed to remove his saturated brief and sheet.			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		ion)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS IN This citation refers to MI00124948. Based on interview and record revives in the residents (R7), resulting in inaccura and complete picture of the resident Findings include: A review of R7's Admission Record the facility on [DATE]. In addition, Fincluded diabetes, difficulty walking A review of R7's Minimum Data Se 10/21/21, revealed R7 had a Brief I cognitive status) assessment which addition, R7's MDS revealed R7 had review of R7's impaired skin integretated to decreased mobility, resis 09/02/2020). R7's impaired skin integrelated to decreased mobility, resis 09/02/2020). R7's impaired skin integretated to decreased mobility, resis 09/02/2020). R7's Skin & Wound Evaluation of R7's Skin & Woun	ew, the facility failed to maintain accurate medical records and the potential fut's medical condition and/or stay at the decision of the medical condition and/or stay at the decision of the medical condition and/or stay at the decision of the medical condition and/or stay at the decision of the medical condition and/or stay at the decision of the medical condition and/or stay at the decision of the medical condition	ate medical records for 1 of 11 or providers not having an accurate e facility. [AGE] year-old resident admitted to ed R7 had multiple diagnoses that ody and legs). esident's care needs), dated scale used to determine a resident's -term memory problems. In ion-making skills. R7's MDS also ed R7 had impaired skin integrity bowel and bladder (Date Initiated: vention of Elevate heels off bed revealed the following: and may extend into the edges) are often present). 11 cm2 (centimeters squared). 3.9 cm2. was done 14 days after the

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	on)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completely obscured by slough (ye wound bed). -11/11/21= 3.2 cm x 2.6 cm. Area= -11/18/21 at 8:57 AM= 2.4 cm x 0 -11/18/21 at 8:59 AM= 2 cm x 1.2 -12/2/21= 0.6 cm x 0.4 cm x 0.2 c previous one12/16/21= 1.1 cm x 0.7 cm. Area A review of R7's progress notes, d were also in the progress notes. In - General Progress Note, dated 11 pillows , heels had lotion on them, t 3 cm x 4.4 cm x .2 cm deep, right h surrounding tissue dry and cracked wound care to follow weekly on wo length extended to help prevent his A review of R7's Skin Observation alterations or wounds. R7's Skin Ol alterations in skin integrity including discovered on 11/10/21 noted on R Incident Review for New or Worser completed on 11/10/21. She st stated on 11/10/21, she completed form for R7's bilateral heel pressure (left heel) and 5.6 cm x 4.3 cm x 1. Incident Review for New or Worser note was entered with the measure	.8 cm. Area= 1.2 cm2.	was done 14 days after the the 14 days after the previous one. above mentioned measurements surement: thave bilateral heels elevated up on the touch left heel measured at - 5. cm deep, no drainage present, rted, notifications completed, heel bridge, and will have his bed d 11/17/21, failed to reveal any skin hal appearing skin and no new did have pressure ulcers that were 1/11/21 and on R7's Focused 1/10/21 (at 4:16 PM) and ager (UM) N stated on 11/10/21, a lated R7's wound and did and left heel (one each). UM N or Worsened Pressure Ulcer/Injury is were 5.3 cm x 4.4 cm x 0.2 cm locked (completed) R7's Focused 2/21 and on that date the progress though she did do R7's

			No. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	Y STATEMENT OF DEFICIENCIES ciency must be preceded by full regulatory or LSC identifying information)	
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 12/16/21 at notes, dated 11/18/21 at 8:57 AM a AM and 8:59 AM . UM N appeared notes and on the wound evaluation AM, and R7's Skin & Wound Evalu made in error. However, there were addition, UM N stated the system to may have accidentally entered the	11:10 AM, UM N was shown R7's Skir and 8:59 AM and R7's Skin & Wound E to be surprised that there were two en forms. She stated R7's Skin & Wound ations progress note, dated 11/18/21 are not any notes or annotations in R7's hey use to do wound measurements a data. She stated she did not know whees she actually did. UM N stated, It might a stated in the stated of t	n & Wound Evaluations progress Evaluations, dated 11/18/21 at 8:57 at tries for that date in the progress of Evaluation, dated 11/18/21 at 8:57 at 8:57 AM, were inaccurate and medical record reflecting this. In and enter them into the computer or how it happened since the

			NO. 0936-0391
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection 30120 Based on observation, interview, a practices in the facility and residen and disease. Findings include: A review of the facility's Infection P document is designed to provide gremain in place whether or not the facility will implement source controuse of well-fitting cloth masks, face spread of respiratory secretions whether or not the control of the	revention Control policy and procedure uidance to the facility regarding the CO facility is experiencing outbreaks of SA of measures and physical distancing measures and sides of the face), gloves, and gowles Control and Prevention (CDC) Use of the Confirmed or Suspected COVID-19 e and be worn correctly for the duration cemask should be extended under chir espirator/facemask under your chin or aps should be placed on crown of head	replement proper infection control or the spread of infection, illness, vID19 core practices that should RS-CoV-2 (COVID-19) . 6. The easures. Source control refers to n's mouth and nose to prevent the g, or coughing . Staff members ator, eye protection (eye goggles or n. and the spread of the sp

GTATEMENT OF THE CO. T. C. T.	(X1) PROVIDER/SUPPLIER/CLIA	(20)	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/21/2021
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	her mask under her chin. She state throughout the facility because she During an observation on 12/15/21 respirator tucked into her respirator are required to wear gowns and glo are supposed to wear KN95's throu a white N95 respirator that resemble During an observation on 12/15/21 the bottom strap of her N95 tucked During an interview on 12/15/21 at respirators when they are in the fact respirators when they are in the fact respirator in the halls and face shie shields are not required in the halls During an interview on 12/16/21 at their N95 respirators on. She stated During an observation on 12/16/21 with only her top strap of her N95 respirators on the COVII was observed coming out of a residuance and then closing the medic with the same gown still on. 38659 On 12/15/21 at 9:13 AM, CNA A was mask hanging loose underneath her on 12/15/21 at 9:27 AM, CNA B was within a quarter inch on each other.	at 3:25 PM, CNA T was observed walk into her respirator under her chin. 4:15 PM, the Director of Nursing (DON cility. She stated on the COVID unit and Ids, gowns, and gloves in the individual of the COVID unit and 500 Hall (obser 8:00 AM, Receptionist O stated staff at they should not be wearing N95 respirated at 8:25 AM, DA U was observed pushiespirator on. The bottom strap was dared unit on 12/16/21 from 10:45 AM to 10 dent's room with a gown on, walking to eation cart and leaving the resident care as viewed assisting a resident out of the or chin.	ctive equipment (PPE) requirement ack to work. In the bottom strap of her N95 all was an observation hall and staff in the COVID unit. She stated staff wearing (the surveyor was wearing sting up and down the 400 Hall with the stated staff are to wear N95 at 500 Hall, staff are to wear the N95 at 1 resident rooms. She stated face reation unit). It is supposed to wear both straps of rators with only one strap secured. In ga food cart down the 300 Hall angling below her chin. D:55 AM, Registered Nurse (RN) V medication cart and rummaging area through the double doors It is bottom with one strap of her N95 area through the straps of her N95 mask low and their N95 low under their ears.

		12/21/2021	
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZIP CODE 1061 W Hackley Ave Muskegon, MI 49441	
o correct this deficiency, please cont		agency.	
		on)	
in 12/15/21 at 2:30 PM Nurse E werlapping. 3 CNA staff were view be bottom part of their mask. CNA in. This staff member later spoke ose and neither corrected CNA I. in 12/17/21 at 8:49 AM a staff mer wer strap of her N95 mask loose at 12/17/21 at 8:52 AM CNA B was 55 mask low and within a quarter in 12/21/21 at 8:42 AM a CNA was 55 low and overlapping. in 12/21/21 at 8:49 AM a CNA was d overlapping.	as viewed at the 400 hall nurses stationed on the unit with one of their N95 str. I was viewed entering a resident room to a Nurse E as well as Nurse J on the mber was viewed walking down the 300 and under her chin. Is viewed on a resident unit delivering the inch on each other. Is viewed speaking to a nurse at the nurse viewed exiting the employee lounge of the street was viewed on a resident unit with both street as viewed on a resident unit with both street and on the street was viewed on a resident unit with both street.	n with the straps on their N95 aps below their chin or tucked into with one N95 strap below their a 300 hall with the strap dangling the hall with a cart of linens with the the meal cart with both straps of her rses station with both straps of their with both straps of their N95 low	
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