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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This pertains to intake M100125723 and M100126630. Based on interview and record review, the facility failed to prevent neglect when systemic failures occured due to not following policies and procedures for new admissions, charting and documentation, and ordering medications and failed to provide necessary care and services including notifying the physician for missed treatment and medications for 2 residents (Resident #4 and Resident #10), resulting in residents not receiving medications, medical treatments or services including Activities of Daily Living (ADLs) and one resident readmitted back to the hospital 2 days after admission. Findings include: Review of a Policy titled Abuse and Neglect last revised on 10/14/20 revealed: The purpose of this policy/procedure is to articulate standards and/or processes for proper screening, training, prevention, identification, investigation protection and reporting relative to any form of abuse. It is the policy of this facility to provide professional care and services in an environment that is free from abuse, neglect, misappropriation of resident property, exploitation, and corporal punishment. Neglect: The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of a policy titled Admissions adopted 7/11/18 revealed: It is the policy of this facility to have well defined guidelines for processing the Resident's entry into the nursing facility and that the Resident's rights are protected under federal and state laws. Licensed Nurse Procedure: .1. Welcome Resident and family to Facility and inquire about any immediate special needs. 2. Initiate any required treatments (oxygen, intravenous) necessary at time of admission per transfer orders. 3. Do a complete assessment of body systems and complete admission assessment and nursing notes. Include a through skin check. 4. Inform physician of admission and verify transfer and admission orders. 5. Order medications from pharmacy. 6. Confirm diet order, complete diet slip and sent to dietary.9. Initiate Resident Care Plan. 10. Communicate immediate Resident special needs to CNA's, dietary, therapies, social services, ect. 11. Note and initiate physician order. Initiate mediations and treatment sheets.13. Note advance-directive information. 14. Ensure that admission forms are completed per policy and baseline plan of care initiated. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of a policy titled Charting and documentation adopted 7/11/18 revealed: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Review of a Guidelines for Medication Orders, Policy 2.1 revealed: Medications are dispensed by the Pharmacy only upon receipt of a clear, complete order, signed by an authorized licensed prescriber. facilities using an electronic order entry system and/or eMAR should refer to specific system. Resident #4 (R4) Review of a Face Sheet revealed R4 is an [AGE] year old female admitted to the facility on [DATE] with pertinent diagnoses of cardiac arrythmia, acute and chronic respiratory disease, and heart failure. Review of the Minimum Data Set (MDS) Discharge assessment dated [DATE] revealed R4 admitted to the facility on [DATE] and discharged on [DATE]. Section A2300 indicates R4 MDS Assessment Reference date is 1/16/22 and the resident was moderately cognitively impaired. In an interview on 2/1/22 at 1:20 p.m., Family Member (FM) A reported her mother (R4) admitted to the facility from the hospital on 1/14/22 around 3:30 p.m. and did not receive medications, oxygen, food, or water while at the facility. FM A reported she dropped off clothing for her mother around that time. The resident was cognitively intact until this incident. R4 was then admitted back to the hospital on 1/16/22. On 1/15/22 FM A reported she called the facility and complained to the nurse that her mother has not received any food, medications, or water and the facility did not connect R4 to 3 liters of oxygen. FM A reported she would call the facility and they would put her on hold and then hang up. FM A reported she talked to the nurse on 1/16/22 and insisted her mother (R4) goes back to the hospital after talking to R4 on the phone and noticed a change in her cognitive condition. The staff was reluctant to send R4 to the hospital and FM A reported she argued with the staff and insisted again that R4 goes to the hospital. They finally transferred the resident to the hospital and when she arrived, she was wearing the same clothes that she was admitted with on 1/14/22. When the resident arrived at the hospital, there was no discharge paperwork from the facility indicating who the resident was, so she was a [NAME] Doe for a few minutes. The resident was admitted to the hospital and FM A reported she was in a hepatic coma. Review of Hospital Records for R4 with an admitted [DATE] revealed Chief Complaint: Altered Mental Status pt (patient) present to ed (emergency department) c/o (complaints of) not feeling well. Pt coming from (Nursing Facility) and has been unable to take meds for 2 days. unable to take lactulose . pt normal on 2L NC (nasal cannula) . Pt is confused currently, able to follow commands, pt is normally AXO 4 (alert and oriented x4) per facility. She was discharged to a skilled nursing facility as the caregiver has COVID and to get over the quarantine period, the patient was staying in a nursing facility. Unfortunately the nursing facility did not have any of her medications and therefore has not received any medication since discharge from the hospital on Friday (1/14/22). It is difficult to ascertain the timing of the symptoms, but the patient is altered, able to tell me her name. EKG (electrocardiogram) demonstrates sinus tachycardia (fast heart rate) and elevated ammonia . Assessment/Plan: Altered mental status, Liver cirrhosis secondary to NASH (CMS/HCC), Hyperammonemia (metabolic disturbance characterized by an excess of ammonia in the blood). (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of an Internal Medicine History and Physical document dated 1/16/22 for R4 revealed: Patient presents from (Nursing Home) secondary to alteration of mental status. Reportedly the patient has not received her liver medications including lactulose, Aldactone, rifaximin, Lasix since she was discharged from (Hospital) on 1/14/2022. Unfortunately it appears that as previously mentioned there was an interruption in pharmacological administration of which is the likely culprit as the patient's ammonia level was elevated. Outpatient medications: . oxygen 3 liters nasal canula . 1. Hepatic Encephalopathy. Review of Hospital Discharge Therapy documentation dated 1/14/22 for R4 revealed she required some help with Activities of Daily Living (ADLs) and contact guard for toileting. At this time she demonstrated generalized weakness in upper extremities as well as requiring some continued assistance with activities of daily living. Review of the Electronic Medical Record revealed some of the Orders for R4 were documented to start on 1/15/22 at 2000 (8:00 p.m.) which included but not limited to Xifaxan 550 milligram (mg) tablet twice a day for encephalopathy, spironolactone 25 mg twice a day for high blood pressure, amiodarone 200 mg tablets- give 2 tablets by mouth every morning ad at bedtime for HF (heart failure), furosemide 40 mg once a day for edema, lactulose solution 20 grams twice a day for encephalopathy, and metoprolol 25 mg once a day for high blood pressure. All orders were dated to start on 1/15/22 and 1/16/22. Review of the Electronic Medication Administration Record (EMAR) revealed no medications were documented as given to R4 on 1/14/22. On 1/15/22 doses of apixaban, lactulose, spironolactone, and 3 liters of oxygen via nasal canula are documented as given. There is no documentation or resources available that verified lactulose was available or on hand to administer to R4. The other two medications are verified they came from the Cubex (on site medication dispenser) log on 1/15/22 at 8:32 p.m. Review of the Cubex transactions list from 1/1/22 to 2/7/22 revealed on 1/15/22 at 8:32 p.m. R4 had Eliquis and spironolactone as the only medications removed from the Cubex by Registered Nurse (RN) C. Review of the EMR (Electronic Medical Record) revealed no documentation of when R4 arrived at the facility, no admission assessment, no documentation the physician was notified, no pharmacy notification of medication needs until 1/15/22, no care plans, no skin assessments, no meals documented, and no ADL's documented. Review of a Late Entry General Progress Note backdated for 1/15/22 at 9:22 a.m. and created on 1/16/22 at 9:28 a.m. for R4 revealed: Resident received morning medications by paper MAR from nurse. Nothing documented in the EMR indicating where these medications came from, if the physician verified orders or is aware of missed doses of medications or if the pharmacy was contacted. Review of a General Progress note dated 1/15/22 at 11:51 p.m. for R4 revealed: Res resting with eyes closed at this time, O2 (oxygen) on as ordered. Meds available in back up pulled and given at (bedtime). Pharmacy contacted and STAT (fast as possible) delivery of all other meds requested. No documentation indicating the physician was notified of missed doses of medications or an assessment of the resident. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of a General Progress note dated 1/16/22 revealed R4 went to the hospital at approximately 9:20 a. m. Review of a Nursing Skilled Charting document for R4 dated 1/14/22 at 8:40 p.m. and locked on 1/15/22 at 7:45 p.m. revealed the resident was not assessed but her vital signs were documented. Review of the Task List for cares R4 received at the facility from 1/14/22 to 1/16/22 revealed the resident received no assistance with care and no meals were documented. In an interview on 2/3/22 at approximately 8:00 a.m., the Medical Records Clerk (MR) F reported she was caught up on any medical records needing to be scanned into the computer. When questioned if there were any records for R4 not scanned into the computer yet, MR F reported she was pretty sure all the records were in the computer and was going to make sure. About 30 minutes later MR F provided a soft file with a discharge summary/order from the hospital, a handwritten nursing admission assessment and a handwritten skilled charting document for R4. MR F reported the soft file was in the Administrator's office. During an interview on 2/3/22 at 10:22 a.m., RN D reported she took care of R4 on 1/15/22 during the day shift and did not verify the admission orders with the physician. RN D reported she got medications for R4 from the tackle box that had medications designated for the residents on the COVID unit. This was so they would not have to come out of the Covid unit to get medications out of the Cubex. In an interview on 2/3/22 at 10:45 a.m. The Director of Nursing (DON) reported RN E who worked the night of 1/14/22 did not do an initial assessment for R4 when she admitted to the facility. The facility was informed by the Attorney Generals (AG) Office on 1/20/22 that there was a concern regarding R4s care and they were instructed to freeze the electronic medical record for R4. So no documentation was to be added, removed, or altered at that point. When they became aware there was a concern with R4's care, the DON reported she had an assessment printed out and had the nurses fill them out by hand as a late entry, then put a file together to be put in the Administrator's office. The DON reported R4 did not get any medications on Friday 1/14/22 but reported RN D did put the medications in the computer that day. The DON reported once they were aware of the allegation, they reported it to the State Agency (SA). The DON confirmed there was a tackle box on the COVID unit with daily medications for the new admissions so they would not have to go out to the Cubex that was off of the COVID unit to get medications for the residents. The DON later provided a list of the medications that were in the tackle box designated to the COVID unit, but the list only included medications that were common to treat COVID, not regular routine medications or any medications that were given to R4. The DON then reported she could not exactly verify where the medications that the nurse signed as given on the hospital discharge orders fro R4 were obtained from. In an interview on 2/3/22 at 11:00, the Nursing Home Administrator (NHA) reported that the AG reached out to them on 1/20/22 and told her of the concern reported to their office, and so the NHA reported to the SA that there is an allegation of neglect. The AG office told them to not put any more documents into the computer for R4 because the records are being sequestered. That is why there was a soft file with handwritten assessments and hospital discharge medication list in her office signed by the nurses who were on duty when R4 was in the building. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	In an interview on 2/3/22 at 11:43 a.m. the DON still could not verify where the medications that were documented as given to R4 during her stay came from. During an Interview and Record review on 2/7/22 at 11:38 a.m., Pharmacist (PM) B revealed on 1/15/22 a New Admit place holder information was sent to them via EMR at the Nursing Facility. At 8:32 p.m., the nurse called the pharmacy for STAT medications and again at 9:32 p.m. No medications were delivered the night of 1/15/22 to the facility. Amiodarone and xifaxan was delivered to the facility on [DATE] at 8:40 a.m. PM B reported they had no record of R4 being charged for any medications received by the facility while she was there. If she did receive medications, she would have been charged for them or should have been. The pharmacy receives the information when a resident gets medications from the Cubex. PM B reported if the facility used the old tackle box approach to providing medications, then there should be a slip that would be written out with the residents' information and sent to the pharmacy for a charge. At the time of this interview, there were no medications charged to the resident or any proof provided to the Pharmacy that this resident received medications to be charged. In an interview on 2/7/22 at 4:15 p.m., Licensed Practical Nurse (LPN) M reported that she did not complete admission documentation for R4 who arrived to the facility on [DATE] because she was already admitting another resident who arrived 10 minutes before R4 arrived at the facility. LPN M reported she worked the day shift that day and started at 6:00 a.m. and worked until 9:30 p.m. to complete her other two admissions and their documentation. LPN M reported RN E worked the second shift this day and reported to him that R4 just recently arrived to the facility. Then about an hour later another new admission came in to the facility. LPN M reported R4 arrived around dinner time, and she just helped get her get settled into the room and made sure she had a meal tray and she was safe. There is no documentation in the EMR that this resident arrived or received services. In an interview on 2/8/22 at 8:49 a.m., RN D reported she did not get information during report the morning of 1/15/22 that R4 was in the facility. She became aware once she passed medications to her roommate and noticed R4 was in the room too. RN D reported her name was not on the report sheet or on the census list. RN D reported she filled out an assessment for R4 after the resident had discharged from the facility and signed it as a late entry for 1/20/22. This document was not part of the residents' medical records and was filled out by hand and put into a soft file in the Administrator's office. RN D reported the assessment she filled out reflected the date of 1/15/22 when she took care of her. RN D reported she only filled out part B and down and someone else completed the top portion. RN D reported that RN E told her he was going to come back to finish the admission documentation for R4 on 1/15/22. RN D reported the admission packet was on the desk for R4 and when she opened it, she was able to see what medications the resident needed. When queried about how R4 got her medications and why they were not charted in the EMR, RN D changed her story from earlier when she reported she got the medications out of the special tackle box that was for the COVID unit. She said she got the medications out of the Cubex. RN D could not explain why the medications she gave R4 did not show up in the Cubex log as a medication dispensed in R4s name. When queried why the medications were not documented in the EMAR, RN D reported is was because the timing would be off for the resident's next dose. So she signed the paper hospital medication discharge orders for R4 that she gave her amiodarone, apixaban, ferrous sulfate, furosemide, lactulose, loratadine, metoprolol, oxygen, protonix, and spironolactone at 9:30 a.m. on 1/15/22. When queried about the lactulose, RN D reported she took the lactulose from another resident to give to R4 None of these medications showed up as dispensed from the Cubex for R4, no documentation provided by the pharmacy to prove these medications were given, or any other paper trail indicating the resident received these medications from RN D. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	In an interview on 2/8/22 at 11:48 a.m., the DON reported the nurse did get medications out of the Cubex for R4 and got the lactulose from another resident by borrowing it. The facility replaced the medication taken from the other resident. The DON reported there should be a record of R4 in the Cubex if medications were taken out of it for her. The DON reported RN D told her 3 times that she pulled R4s medication from the Cubex. The DON did not know why the nurse took lactulose from another resident when the lactulose is also in the Cubex. The DON reported she is not involved in the investigation because the facility is trying to protect her since she is a witness per the AG. The DON did not know who the resident was that the medication was taken from. During an interview and record review on 2/9/22 at 11:00 a.m., RN E reported he worked the night of 1/14/22 and R4 was already in the building but he got another admission about an hour later. He introduced himself to the resident and did a quick assessment and made sure she had a call light but did not document anything in the computer. Could not recall if she had her oxygen in place or if she got a meal. Could not recall if he called the physician or left a message for the physician. RN E reported that night was busy and had another resident that occupied much of his time, and it was just a busy night. RN E reported the DON and the NHA had him fill out a handwritten assessment around 1/21/22 for R4 even though the date on one document showed 1/15/22, but verified it was not filled out until long after she was discharged and filled out what he could remember. These documents are not in the EMR and are in the soft file in the NHAs office. RN E reported he did not chart much that night because it was busy. In an interview on 2/15/22 at 12:00 p.m., RN C reported she worked the second shift on 1/15/22 and took care of R4 that day. RN C was not sure if R4 received medications earlier that day but was informed that the resident's daughter had called with concerns that R4 had not received any medication since she was admitted to the facility on [DATE]. RN C reviewed the chart and it looked like she was admitted that day (1/15/22) and was told that RN E was going to complete the admission documentation for the resident. RN E was there this night and thought he was completing the paperwork. RN C reported if the medications on the EMAR were documented as given, then she gave the medications. The medications documented are apixaban, lactulose, and spironolactone. Two of the medications were shown to be dispensed from the Cubex but not the lactulose. No other medications were documented as given and no documentation indicating the physician was notified. In an interview on 2/16/22 at 9:22 a.m., MDS Coordinator LPN N reported she completed the MDS assessment, and another Registered Nurse signed off on it. She reported she gathers information about the residents based on the information put into the computer. She reported the census line on this day still shows R4 admitted to the facility on [DATE] and not 1/14/22. LPN N reported she utilizes the admission nursing assessment as well to assist in filling out the MDS assessment while other disciplines will fill out their portions of the assessments. LPN N reported section A and G are a couple of the areas she fills out among other sections, but the social workers fill out section C for cognition. Review of several witness statements provided by the facility revealed a lack of documentation in R4's EMR backing up services and goods provided to the resident. There is no paper trail of events, assessments, physician contact, pharmacy contact, medication administration, pharmacy receipt and/or charges for medications or full physical assessment while R4 resided in the building. Resident #10 (R10) (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Some	Review of the MDS dated [DATE] for R10 revealed she admitted to the facility on [DATE] with pertinent diagnoses of Multiple sclerosis, contractures and pressure ulcers. She is severely cognitively impaired and requires extensive assistance of 2 staff for ADL's. Review of the January 2022 Medication Administration Record for R10 revealed orders to clean PEG (percutaneous endoscopic gastrostomy) site is to be cleansed every night shift and an new dressing to be applied and was not done for 8 days. The pressure ulcer dressing changes to the sacral wound was to be done twice a day and discontinued on 1/13/22, and missed 9 treatments. An order for dakins solution to be applied to the sacral wound twice a day missed 14 treatments. Another order for a sacral wound dressing to be cleansed with Dakins solution, pack wound bed with 4x4s, apply periguard, xeroform, and cover with an ABD dressing started 1/13/22 missed 6 treatments. An order to check the PEG tube placement missed 12 verifications. Orders to monitor and maintain the foley catheter missed 12 treatments. No orders to change foley catheter. Order for Prevalon boots to the bilateral lower extremities twice a day missed 10 treatments and no follow up documentation or physician notification noted. Review of an Incident Report titled Medication Error for R10 dated 1/7/22 revealed : Medication not given per scheduled date and time 1/7/2021 @ 0730: Baclofen 5 mg, Duloxetine DR 30 mg, Magnesium Ox 400 mg, Oxybutinin 5 mg, Vitamin D3, Zinc Gluconate 50 mg. 1/5/22 at 2000: Baclofen 5mg. No statements obtained from the incident from staff. No witnesses found. A copy of the packets these medications were attached to the report. The MAR for January 2022 revealed the medications were given. No further details to the investigation provided and the NHA reported this was all there was. In an interview on 2/14/22 at 10:25 a.m., the DON reported a State Agency staff member came to the facility to fill in for staffing. The facility found two packets of medications at the bottom of the medication cart that were not given to R10. (Indicated they found more residents that did not receive medications.) The facility tried to call the agency nurses who did not call back. So they assessed the resident and completed an incident form. During an observation and an interview on 2/2/22 at 2:05 p.m., R10 was in her room and the CNA finished cleaning her up and said her brief was soaked. Her dressing on her sacrum was heavily soaked with urine and barely attached to the skin. At this time LPN G entered the room to complete a dressing change. CNA O reported the therapist changed the residents brief about a half hour before lunch and alerted the nurse the foley catheter may not be working which is why her brief was soaked. The tubing of the catheter had cottage cheese like debri floating in the tubing. In an interview on 2/2/22 at 2:40 p.m., LPN G reported she had about 27 residents this day to care for and remembered the therapist came to tell her they changed the resident and reported the catheter may not be working but she did not have a chance to check on the residents catheter. Review of a Nurse Practitioner Progress Note dated 1/31/22 revealed: Patient seen for evaluation and management of multiple complex chronic medical problems that require frequent monitoring to maintain stability and prevent further decline. (R10) seen today for evaluation of Sacral /coccyx ulcer. Patient is bed bound dependent on staff for all ADL. She has a chronic sacral wound that is not improving as expected, although it has been without deterioration and infection.

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100125723 and M100126630. Based on interview and record review, the facility failed to follow policies and procedures for neglect, admissions, charting, and medications, for 2 (Resident #4 and Resident #10) resulting in gross negligence of residents not documented as receiving medications, treatments, services including Activities of Daily Living (ADLs) and one resident readmitted back to the hospital 2 days after admission. Findings include: Review of a Policy titled Abuse and Neglect last revised on 10/14/20 revealed: The purpose of this policy/procedure is to articulate standards and/or processes for proper screening, training, prevention, identification, investigation protection and reporting relative to any form of abuse. It is the policy of this facility to provide professional care and services in an environment that is free from abuse, neglect, misappropriation of resident property, exploitation, and corporal punishment. Neglect: The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. Review of a policy titled Admissions adopted 7/11/18 revealed: It is the policy of this facility to have well defined guidelines for processing the Resident's entry into the nursing facility and that the Resident's rights are protected under federal and state laws. Licensed Nurse Procedure: .1. Welcome Resident and family to Facility and inquire about any immediate special needs. 2. Initiate any required treatments (oxygen, intravenous) necessary at time of admission per transfer orders. 3. Do a complete assessment of body systems and complete admission assessment and nursing notes. Include a through skin check. 4. Inform physician of admission and verify transfer and admission orders. 5. Order medications from pharmacy. 6. Confirm diet order, complete diet slip and sent to dietary.9. Initiate Resident Care Plan. 10. Communicate immediate Resident special needs to CNA's, dietary, therapies, social services, ect. 11. Note and initiate physician order. Initiate mediations and treatment sheets.13. Note advance-directive information. 14. Ensure that admission forms are completed per policy and baseline plan of care initiated. Review of a policy titled Charting and documentation adopted 7/11/18 revealed: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Review of a Guidelines for Medication Orders, Policy 2.1 revealed: Medications are dispensed by the Pharmacy only upon receipt of a clear, complete order, signed by an authorized licensed prescriber. facilities using an electronic order entry system and/or eMAR should refer to specific system. Resident #4 (R4) (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Actual harm Residents Affected - Some	Review of a Face Sheet revealed R4 is an [AGE] year old female admitted to the facility on [DATE] with pertinent diagnoses of cardiac arrythmia, acute and chronic respiratory disease, and heart failure. Review of the Minimum Data Set (MDS) Discharge assessment dated [DATE] revealed R4 admitted to the facility on [DATE] and discharged on [DATE]. Section A2300 indicates R4 MDS Assessment Reference date is 1/16/22 and the resident was moderately cognitively impaired. In an interview on 2/1/22 at 1:20 p.m., Family Member (FM) A reported her mother (R4) admitted to the facility from the hospital on 1/14/22 around 3:30 p.m. and did not receive medications, oxygen, food, or water while at the facility. FM A reported she dropped off clothing for her mother around that time. The resident was cognitively intact until this incident. R4 was then admitted back to the hospital on 1/16/22. On 1/15/22 FM A reported she called the facility and complained to the nurse that her mother has not received any food, medications, or water and the facility did not connect R4 to 3 liters of oxygen. FM A reported would call the facility and they would put her on hold and then hang up. FM A reported she talked to the nurse on 1/16/22 and insisted her mother (R4) goes back to the hospital after talking to R4 on the phone and noticed a change in her cognitive condition. The staff was reluctant to send R4 to the hospital and FM A reported she argued with the staff and insisted again that R4 goes to the hospital. They finally transferred the resident to the hospital and when she arrived, she was wearing the same clothes that she was admitted with on 1/14/22. When the resident arrived at the hospital, there was no discharge paperwork from the facility indicating who the resident was, so she was a [NAME] Doe for a few minutes. The resident was admitted to the hospital and FM A reported she was in a hepatic coma. Review of Hospital Records for R4 with an admitted [DATE] revealed Chief Complaint: Altered Mental Status pt (patient) present to ed (emergency department) c/o (complaints of) not feeling well. Pt coming from (Nursing Facility) and has been unable to take meds for 2 days. unable to take lactulose . pt normal on 2L NC (nasal cannula) . Pt is confused currently, able to follow commands, pt is normally AXO 4 (alert and oriented x4) per facility. She was discharged to a skilled nursing facility as the caregiver has COVID and to get over the quarantine period, the patient was staying in a nursing facility. Unfortunately the nursing facility did not have any of her medications and therefore has not received any medication since discharge from the hospital on Friday (1/14/22). It is difficult to ascertain the timing of the symptoms, but the patient is altered, able to tell me her name. EKG (electrocardiogram) demonstrates sinus tachycardia (fast heart rate) and elevated ammonia . Assessment/Plan: Altered mental status, Liver cirrhosis secondary to NASH (CMS/HCC), Hyperammonemia (metabolic disturbance characterized by an excess of ammonia in the blood). Review of an Internal Medicine History and Physical document dated 1/16/22 for R4 revealed: Patient presents from (Nursing Home) secondary to alteration of mental status. Reportedly the patient has not received her liver medications including lactulose, Aldactone, rifaximin, Lasix since she was discharged from (Hospital) on 1/14/2022. Unfortunately it appears that as previously mentioned there was an interruption in pharmacological administration of which is the likely culprit as the patient's ammonia level was elevated. Outpatient medications: . oxygen 3 liters nasal canula . 1. Hepatic Encephalopathy. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Actual harm Residents Affected - Some	Review of Hospital Discharge Therapy documentation dated 1/14/22 for R4 revealed she required some help with Activities of Daily Living (ADLs) and contact guard for toileting. At this time she demonstrated generalized weakness in upper extremities as well as requiring some continued assistance with activities of daily living. Review of the Electronic Medical Record revealed some of the Orders for R4 were documented to start on 1/15/22 at 2000 (8:00 p.m.) which included but not limited to Xifaxan 550 milligram (mg) tablet twice a day for encephalopathy, spironolactone 25 mg twice a day for high blood pressure, amiodarone 200 mg tablets- give 2 tablets by mouth every morning ad at bedtime for HF (heart failure), furosemide 40 mg once a day for edema, lactulose solution 20 grams twice a day for encephalopathy, and metoprolol 25 mg once a day for high blood pressure. All orders were dated to start on 1/15/22 and 1/16/22. Review of the Electronic Medication Administration Record (EMAR) revealed no medications were documented as given to R4 on 1/14/22. On 1/15/22 doses of apixaban, lactulose, spironolactone, and 3 liters of oxygen via nasal canula are documented as given. There is no documentation or resources available that verified lactulose was available or on hand to administer to R4. The other two medications are verified they came from the Cubex (on site medication dispenser) log on 1/15/22 at 8:32 p.m. Review of the Cubex transactions list from 1/1/22 to 2/7/22 revealed on 1/15/22 at 8:32 p.m. R4 had Eliquis and spironolactone as the only medications removed from the Cubex by Registered Nurse (RN) C. Review of the EMR (Electronic Medical Record) revealed no documentation of when R4 arrived at the facility, no admission assessment, no documentation the physician was notified, no pharmacy notification of medication needs until 1/15/22, no care plans, no skin assessments, no meals documented, and no ADL's documented. Review of a Late Entry General Progress Note backdated for 1/15/22 at 9:22 a.m. and created on 1/16/22 at 9:28 a.m. for R4 revealed: Resident received morning medications by paper MAR from nurse. Nothing documented in the EMR indicating where these medications came from, if the physician verified orders or is aware of missed doses of medications or if the pharmacy was contacted. Review of a General Progress note dated 1/15/22 at 11:51 p.m. for R4 revealed: Res resting with eyes closed at this time, O2 (oxygen) on as ordered. Meds available in back up pulled and given at (bedtime). Pharmacy contacted and STAT (fast as possible) delivery of all other meds requested. No documentation indicating the physician was notified of missed doses of medications or an assessment of the resident. Review of a General Progress note dated 1/16/22 revealed R4 went to the hospital at approximately 9:20 a. m. Review of a Nursing Skilled Charting document for R4 dated 1/14/22 at 8:40 p.m. and locked on 1/15/22 at 7:45 p.m. revealed the resident was not assessed but her vital signs were documented. Review of the Task List for cares R4 received at the facility from 1/14/22 to 1/16/22 revealed the resident received no assistance with care and no meals were documented. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Actual harm Residents Affected - Some	In an interview on 2/3/22 at approximately 8:00 a.m., the Medical Records Clerk (MR) F reported she was caught up on any medical records needing to be scanned into the computer. When questioned if there were any records for R4 not scanned into the computer yet, MR F reported she was pretty sure all the records were in the computer and was going to make sure. About 30 minutes later MR F provided a soft file with a discharge summary/order from the hospital, a handwritten nursing admission assessment and a handwritten skilled charting document for R4. MR F reported the soft file was in the Administrator's office. During an interview on 2/3/22 at 10:22 a.m., RN D reported she took care of R4 on 1/15/22 during the day shift and did not verify the admission orders with the physician. RN D reported she got medications for R4 from the tackle box that had medications designated for the residents on the COVID unit. This was so they would not have to come out of the Covid unit to get medications out of the Cubex. In an interview on 2/3/22 at 10:45 a.m. The Director of Nursing (DON) reported RN E who worked the night of 1/14/22 did not do an initial assessment for R4 when she admitted to the facility. The facility was informed by the Attorney Generals (AG) Office on 1/20/22 that there was a concern regarding R4s care and they were instructed to freeze the electronic medical record for R4. So no documentation was to be added, removed, or altered at that point. When they became aware there was a concern with R4's care, the DON reported she had an assessment printed out and had the nurses fill them out by hand as a late entry, then put a file together to be put in the Administrator's office. The DON reported R4 did not get any medications on Friday 1/14/22 but reported RN D did put the medications in the computer that day. The DON reported once they were aware of the allegation, they reported it to the State Agency (SA). The DON confirmed there was a tackle box on the COVID unit with daily medications for the new admissions so they would not have to go out to the Cubex that was off of the COVID unit to get medications for the residents. The DON later provided a list of the medications that were in the tackle box designated to the COVID unit, but the list only included medications that were common to treat COVID, not regular routine medications or any medications that were given to R4. The DON then reported she could not exactly verify where the medications that the nurse signed as given on the hospital discharge orders fro R4 were obtained from. In an interview on 2/3/22 at 11:00, the Nursing Home Administrator (NHA) reported that the AG reached out to them on 1/20/22 and told her of the concern reported to their office, and so the NHA reported to the SA that there is an allegation of neglect. The AG office told them to not put any more documents into the computer for R4 because the records are being sequestered. That is why there was a soft file with handwritten assessments and hospital discharge medication list in her office signed by the nurses who were on duty when R4 was in the building. In an interview on 2/3/22 at 11:43 a.m. the DON still could not verify where the medications that were documented as given to R4 during her stay came from. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Actual harm Residents Affected - Some	During an Interview and Record review on 2/7/22 at 11:38 a.m., Pharmacist (PM) B revealed on 1/15/22 a New Admit place holder information was sent to them via EMR at the Nursing Facility. At 8:32 p.m., the nurse called the pharmacy for STAT medications and again at 9:32 p.m. No medications were delivered the night of 1/15/22 to the facility. Amiodarone and xifaxan was delivered to the facility on [DATE] at 8:40 a.m. PM B reported they had no record of R4 being charged for any medications received by the facility while she was there. If she did receive medications, she would have been charged for them or should have been. The pharmacy receives the information when a resident gets medications from the Cubex. PM B reported if the facility used the old tackle box approach to providing medications, then there should be a slip that would be written out with the residents' information and sent to the pharmacy for a charge. At the time of this interview, there were no medications charged to the resident or any proof provided to the Pharmacy that this resident received medications to be charged. In an interview on 2/7/22 at 4:15 p.m., Licensed Practical Nurse (LPN) M reported that she did not complete admission documentation for R4 who arrived to the facility on [DATE] because she was already admitting another resident who arrived 10 minutes before R4 arrived at the facility. LPN M reported she worked the day shift that day and started at 6:00 a.m. and worked until 9:30 p.m. to complete her other two admissions and their documentation. LPN M reported RN E worked the second shift this day and reported to him that R4 just recently arrived to the facility. Then about an hour later another new admission came in to the facility. LPN M reported R4 arrived around dinner time, and she just helped get her get settled into the room and made sure she had a meal tray and she was safe. There is no documentation in the EMR that this resident arrived or received services. In an interview on 2/8/22 at 8:49 a.m., RN D reported she did not get information during report the morning of 1/15/22 that R4 was in the facility. She became aware once she passed medications to her roommate and noticed R4 was in the room too. RN D reported her name was not on the report sheet or on the census list. RN D reported she filled out an assessment for R4 after the resident had discharged from the facility and signed it as a late entry for 1/20/22. This document was not part of the residents' medical records and was filled out by hand and put into a soft file in the Administrator's office. RN D reported the assessment she filled out reflected the date of 1/15/22 when she took care of her. RN D reported she only filled out part B and down and someone else completed the top portion. RN D reported that RN E told her he was going to come back to finish the admission documentation for R4 on 1/15/22. RN D reported the admission packet was on the desk for R4 and when she opened it, she was able to see what medications the resident needed. When queried about how R4 got her medications and why they were not charted in the EMR, RN D changed her story from earlier when she reported she got the medications out of the special tackle box that was for the COVID unit. She said she got the medications out of the Cubex. RN D could not explain why the medications she gave R4 did not show up in the Cubex log as a medication dispensed in R4s name. When queried why the medications were not documented in the EMAR, RN D reported is was because the timing would be off for the resident's next dose. So she signed the paper hospital medication discharge orders for R4 that she gave her amiodarone, apixaban, ferrous sulfate, furosemide, lactulose, loratadine, metoprolol, oxygen, protonix, and spironolactone at 9:30 a.m. on 1/15/22. When queried about the lactulose, RN D reported she took the lactulose from another resident to give to R4 None of these medications showed up as dispensed from the Cubex for R4, no documentation provided by the pharmacy to prove these medications were given, or any other paper trail indicating the resident received these medications from RN D. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Actual harm Residents Affected - Some	In an interview on 2/8/22 at 11:48 a.m., the DON reported the nurse did get medications out of the Cubex for R4 and got the lactulose from another resident by borrowing it. The facility replaced the medication taken from the other resident. The DON reported there should be a record of R4 in the Cubex if medications were taken out of it for her. The DON reported RN D told her 3 times that she pulled R4s medication from the Cubex. The DON did not know why the nurse took lactulose from another resident when the lactulose is also in the Cubex. The DON reported she is not involved in the investigation because the facility is trying to protect her since she is a witness per the AG. The DON did not know who the resident was that the medication was taken from. During an interview and record review on 2/9/22 at 11:00 a.m., RN E reported he worked the night of 1/14/22 and R4 was already in the building but he got another admission about an hour later. He introduced himself to the resident and did a quick assessment and made sure she had a call light but did not document anything in the computer. Could not recall if she had her oxygen in place or if she got a meal. Could not recall if he called the physician or left a message for the physician. RN E reported that night was busy and had another resident that occupied much of his time, and it was just a busy night. RN E reported the DON and the NHA had him fill out a handwritten assessment around 1/21/22 for R4 even though the date on one document showed 1/15/22, but verified it was not filled out until long after she was discharged and filled out what he could remember. These documents are not in the EMR and are in the soft file in the NHAs office. RN E reported he did not chart much that night because it was busy. In an interview on 2/15/22 at 12:00 p.m., RN C reported she worked the second shift on 1/15/22 and took care of R4 that day. RN C was not sure if R4 received medications earlier that day but was informed that the resident's daughter had called with concerns that R4 had not received any medication since she was admitted to the facility on [DATE]. RN C reviewed the chart and it looked like she was admitted that day (1/15/22) and was told that RN E was going to complete the admission documentation for the resident. RN E was there this night and thought he was completing the paperwork. RN C reported if the medications on the EMAR were documented as given, then she gave the medications. The medications documented are apixaban, lactulose, and spironolactone. Two of the medications were shown to be dispensed from the Cubex but not the lactulose. No other medications were documented as given and no documentation indicating the physician was notified. In an interview on 2/16/22 at 9:22 a.m., MDS Coordinator LPN N reported she completed the MDS assessment, and another Registered Nurse signed off on it. She reported she gathers information about the residents based on the information put into the computer. She reported the census line on this day still shows R4 admitted to the facility on [DATE] and not 1/14/22. LPN N reported she utilizes the admission nursing assessment as well to assist in filling out the MDS assessment while other disciplines will fill out their portions of the assessments. LPN N reported section A and G are a couple of the areas she fills out among other sections, but the social workers fill out section C for cognition. Review of several witness statements provided by the facility revealed a lack of documentation in R4's EMR backing up services and goods provided to the resident. There is no paper trail of events, assessments, physician contact, pharmacy contact, medication administration, pharmacy receipt and/or charges for medications or full physical assessment while R4 resided in the building.

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100125723 and M10026630. The facility failed to follow policies and procedures for a new admission and obtain physician orders for immediate care for 1 (Resident #4), resulting in the resident not having any orders for medications, dietary, routine care or a care plan that hastened a readmission to the hospital two days later. Findings include: Review of a policy titled Admissions adopted 7/11/18 revealed: It is the policy of this facility to have well defined guidelines for processing the Resident's entry into the nursing facility and that the Resident's rights are protected under federal and state laws. Licensed Nurse Procedure: .1. Welcome Resident and family to Facility and inquire about any immediate special needs. 2. Initiate any required treatments (oxygen, intravenous) necessary at time of admission per transfer orders. 3. Do a complete assessment of body systems and complete admission assessment and nursing notes. Include a through skin check. 4. Inform physician of admission and verify transfer and admission orders. 5. Order medications from pharmacy. 6. Confirm diet order, complete diet slip and sent to dietary.9. Initiate Resident Care Plan. 10. Communicate immediate Resident special needs to CNA's, dietary, therapies, social services, ect. 11. Note and initiate physician order. Initiate mediations and treatment sheets.13. Note advance-directive information. 14. Ensure that admission forms are completed per policy and baseline plan of care initiated. Review of a policy titled Charting and documentation adopted 7/11/18 revealed: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Review of a Guidelines for Medication Orders, Policy 2.1 revealed: Medications are dispensed by the Pharmacy only upon receipt of a clear, complete order, signed by an authorized licensed prescriber. facilities using an electronic order entry system and/or eMAR should refer to specific system. Resident #4 (R4) Review of a Face Sheet revealed R4 is an [AGE] year old female admitted to the facility on [DATE] with pertinent diagnoses of cardiac arrythmia, acute and chronic respiratory disease, and heart failure. Review of the Minimum Data Set (MDS) Discharge assessment dated [DATE] revealed R4 admitted to the facility on [DATE] and discharged on [DATE]. Section A2300 indicates R4 MDS Assessment Reference date is 1/16/22 and the resident was moderately cognitively impaired. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/1/22 at 1:20 p.m., Family Member (FM) A reported her mother (R4) admitted to the facility from the hospital on 1/14/22 around 3:30 p.m. and did not receive medications, oxygen, food, or water while at the facility. FM A reported she dropped off clothing for her mother around that time. The resident was cognitively intact until this incident. R4 was then admitted back to the hospital on 1/16/22. On 1/15/22 FM A reported she called the facility and complained to the nurse that her mother has not received any food, medications, or water and the facility did not connect R4 to 3 liters of oxygen. FM A reported would call the facility and they would put her on hold and then hang up. FM A reported she talked to the nurse on 1/16/22 and insisted her mother (R4) goes back to the hospital after talking to R4 on the phone and noticed a change in her cognitive condition. The staff was reluctant to send R4 to the hospital and FM A reported she argued with the staff and insisted again that R4 goes to the hospital. They finally transferred the resident to the hospital and when she arrived, she was wearing the same clothes that she was admitted with on 1/14/22. When the resident arrived at the hospital, there was no discharge paperwork from the facility indicating who the resident was, so she was a [NAME] Doe for a few minutes. The resident was admitted to the hospital and FM A reported she was in a hepatic coma. Review of Hospital Records for R4 with an admitted [DATE] revealed Chief Complaint: Altered Mental Status pt (patient) present to ed (emergency department) c/o (complaints of) not feeling well. Pt coming from (Nursing Facility) and has been unable to take meds for 2 days. unable to take lactulose . pt normal on 2L NC (nasal cannula) . Pt is confused currently, able to follow commands, pt is normally AXO 4 (alert and oriented x4) per facility. She was discharged to a skilled nursing facility as the caregiver has COVID and to get over the quarantine period, the patient was staying in a nursing facility. Unfortunately the nursing facility did not have any of her medications and therefore has not received any medication since discharge from the hospital on Friday (1/14/22). It is difficult to ascertain the timing of the symptoms, but the patient is altered, able to tell me her name. EKG (electrocardiogram) demonstrates sinus tachycardia (fast heart rate) and elevated ammonia . Assessment/Plan: Altered mental status, Liver cirrhosis secondary to NASH (CMS/HCC), Hyperammonemia (metabolic disturbance characterized by an excess of ammonia in the blood). Review of an Internal Medicine History and Physical document dated 1/16/22 for R4 revealed: Patient presents from (Nursing Home) secondary to alteration of mental status. Reportedly the patient has not received her liver medications including lactulose, Aldactone, rifaximin, Lasix since she was discharged from (Hospital) on 1/14/2022. Unfortunately it appears that as previously mentioned there was an interruption in pharmacological administration of which is the likely culprit as the patient's ammonia level was elevated. Outpatient medications: . oxygen 3 liters nasal canula . 1. Hepatic Encephalopathy. Review of Hospital Discharge Therapy documentation dated 1/14/22 for R4 revealed she required some help with Activities of Daily Living (ADLs) and contact guard for toileting. At this time she demonstrated generalized weakness in upper extremities as well as requiring some continued assistance with activities of daily living. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Actual harm Residents Affected - Few	Review of the Electronic Medical Record revealed some of the Orders for R4 were documented to start on 1/15/22 at 2000 (8:00 p.m.) which included but not limited to Xifaxan 550 milligram (mg) tablet twice a day for encephalopathy, spironolactone 25 mg twice a day for high blood pressure, amiodarone 200 mg tablets- give 2 tablets by mouth every morning ad at bedtime for HF (heart failure), furosemide 40 mg once a day for edema, lactulose solution 20 grams twice a day for encephalopathy, and metoprolol 25 mg once a day for high blood pressure. All orders were dated to start on 1/15/22 and 1/16/22. Review of the Electronic Medication Administration Record (EMAR) revealed no medications were documented as given to R4 on 1/14/22. On 1/15/22 doses of apixaban, lactulose, spironolactone, and 3 liters of oxygen via nasal canula are documented as given. There is no documentation or resources available that verified lactulose was available or on hand to administer to R4. The other two medications are verified they came from the Cubex (on site medication dispenser) log on 1/15/22 at 8:32 p.m. Review of the Cubex transactions list from 1/1/22 to 2/7/22 revealed on 1/15/22 at 8:32 p.m. R4 had Eliquis and spironolactone as the only medications removed from the Cubex by Registered Nurse (RN) C. Review of the EMR (Electronic Medical Record) revealed no documentation of when R4 arrived at the facility, no admission assessment, no documentation the physician was notified, no pharmacy notification of medication needs until 1/15/22, no care plans, no skin assessments, no meals documented, and no ADL's documented. Review of a Late Entry General Progress Note backdated for 1/15/22 at 9:22 a.m. and created on 1/16/22 at 9:28 a.m. for R4 revealed: Resident received morning medications by paper MAR from nurse. Nothing documented in the EMR indicating where these medications came from, if the physician verified orders or is aware of missed doses of medications or if the pharmacy was contacted. Review of a General Progress note dated 1/15/22 at 11:51 p.m. for R4 revealed: Res resting with eyes closed at this time, O2 (oxygen) on as ordered. Meds available in back up pulled and given at (bedtime). Pharmacy contacted and STAT (fast as possible) delivery of all other meds requested. No documentation indicating the physician was notified of missed doses of medications or an assessment of the resident. Review of a General Progress note dated 1/16/22 revealed R4 went to the hospital at approximately 9:20 a.m. Review of a Nursing Skilled Charting document for R4 dated 1/14/22 at 8:40 p.m. and locked on 1/15/22 at 7:45 p.m. revealed the resident was not assessed but her vital signs were documented. Review of the Task List for cares R4 received at the facility from 1/14/22 to 1/16/22 revealed the resident received no assistance with care and no meals were documented. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/3/22 at approximately 8:00 a.m., the Medical Records Clerk (MR) F reported she was caught up on any medical records needing to be scanned into the computer. When questioned if there were any records for R4 not scanned into the computer yet, MR F reported she was pretty sure all the records were in the computer and was going to make sure. About 30 minutes later MR F provided a soft file with a discharge summary/order from the hospital, a handwritten nursing admission assessment and a handwritten skilled charting document for R4. MR F reported the soft file was in the Administrator's office. During an interview on 2/3/22 at 10:22 a.m., RN D reported she took care of R4 on 1/15/22 during the day shift and did not verify the admission orders with the physician. RN D reported she got medications for R4 from the tackle box that had medications designated for the residents on the COVID unit. This was so they would not have to come out of the Covid unit to get medications out of the Cubex. In an interview on 2/3/22 at 10:45 a.m. The Director of Nursing (DON) reported RN E who worked the night of 1/14/22 did not do an initial assessment for R4 when she admitted to the facility. The facility was informed by the Attorney Generals (AG) Office on 1/20/22 that there was a concern regarding R4s care and they were instructed to freeze the electronic medical record for R4. So no documentation was to be added, removed, or altered at that point. When they became aware there was a concern with R4's care, the DON reported she had an assessment printed out and had the nurses fill them out by hand as a late entry, then put a file together to be put in the Administrator's office. The DON reported R4 did not get any medications on Friday 1/14/22 but reported RN D did put the medications in the computer that day. The DON reported once they were aware of the allegation, they reported it to the State Agency (SA). The DON confirmed there was a tackle box on the COVID unit with daily medications for the new admissions so they would not have to go out to the Cubex that was off of the COVID unit to get medications for the residents. The DON later provided a list of the medications that were in the tackle box designated to the COVID unit, but the list only included medications that were common to treat COVID, not regular routine medications or any medications that were given to R4. The DON then reported she could not exactly verify where the medications that the nurse signed as given on the hospital discharge orders fro R4 were obtained from. In an interview on 2/3/22 at 11:00, the Nursing Home Administrator (NHA) reported that the AG reached out to them on 1/20/22 and told her of the concern reported to their office, and so the NHA reported to the SA that there is an allegation of neglect. The AG office told them to not put any more documents into the computer for R4 because the records are being sequestered. That is why there was a soft file with handwritten assessments and hospital discharge medication list in her office signed by the nurses who were on duty when R4 was in the building. In an interview on 2/3/22 at 11:43 a.m. the DON still could not verify where the medications that were documented as given to R4 during her stay came from. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Actual harm Residents Affected - Few	During an Interview and Record review on 2/7/22 at 11:38 a.m., Pharmacist (PM) B revealed on 1/15/22 a New Admit place holder information was sent to them via EMR at the Nursing Facility. At 8:32 p.m., the nurse called the pharmacy for STAT medications and again at 9:32 p.m. No medications were delivered the night of 1/15/22 to the facility. Amiodarone and xifaxan was delivered to the facility on [DATE] at 8:40 a.m. PM B reported they had no record of R4 being charged for any medications received by the facility while she was there. If she did receive medications, she would have been charged for them or should have been. The pharmacy receives the information when a resident gets medications from the Cubex. PM B reported if the facility used the old tackle box approach to providing medications, then there should be a slip that would be written out with the residents' information and sent to the pharmacy for a charge. At the time of this interview, there were no medications charged to the resident or any proof provided to the Pharmacy that this resident received medications to be charged. In an interview on 2/7/22 at 4:15 p.m., Licensed Practical Nurse (LPN) M reported that she did not complete admission documentation for R4 who arrived to the facility on [DATE] because she was already admitting another resident who arrived 10 minutes before R4 arrived at the facility. LPN M reported she worked the day shift that day and started at 6:00 a.m. and worked until 9:30 p.m. to complete her other two admissions and their documentation. LPN M reported RN E worked the second shift this day and reported to him that R4 just recently arrived to the facility. Then about an hour later another new admission came in to the facility. LPN M reported R4 arrived around dinner time, and she just helped get her get settled into the room and made sure she had a meal tray and she was safe. There is no documentation in the EMR that this resident arrived or received services. In an interview on 2/8/22 at 8:49 a.m., RN D reported she did not get information during report the morning of 1/15/22 that R4 was in the facility. She became aware once she passed medications to her roommate and noticed R4 was in the room too. RN D reported her name was not on the report sheet or on the census list. RN D reported she filled out an assessment for R4 after the resident had discharged from the facility and signed it as a late entry for 1/20/22. This document was not part of the residents' medical records and was filled out by hand and put into a soft file in the Administrator's office. RN D reported the assessment she filled out reflected the date of 1/15/22 when she took care of her. RN D reported she only filled out part B and down and someone else completed the top portion. RN D reported that RN E told her he was going to come back to finish the admission documentation for R4 on 1/15/22. RN D reported the admission packet was on the desk for R4 and when she opened it, she was able to see what medications the resident needed. When queried about how R4 got her medications and why they were not charted in the EMR, RN D changed her story from earlier when she reported she got the medications out of the special tackle box that was for the COVID unit. She said she got the medications out of the Cubex. RN D could not explain why the medications she gave R4 did not show up in the Cubex log as a medication dispensed in R4s name. When queried why the medications were not documented in the EMAR, RN D reported is was because the timing would be off for the resident's next dose. So she signed the paper hospital medication discharge orders for R4 that she gave her amiodarone, apixaban, ferrous sulfate, furosemide, lactulose, loratadine, metoprolol, oxygen, protonix, and spironolactone at 9:30 a.m. on 1/15/22. When queried about the lactulose, RN D reported she took the lactulose from another resident to give to R4 None of these medications showed up as dispensed from the Cubex for R4, no documentation provided by the pharmacy to prove these medications were given, or any other paper trail indicating the resident received these medications from RN D. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0635 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/8/22 at 11:48 a.m., the DON reported the nurse did get medications out of the Cubex for R4 and got the lactulose from another resident by borrowing it. The facility replaced the medication taken from the other resident. The DON reported there should be a record of R4 in the Cubex if medications were taken out of it for her. The DON reported RN D told her 3 times that she pulled R4s medication from the Cubex. The DON did not know why the nurse took lactulose from another resident when the lactulose is also in the Cubex. The DON reported she is not involved in the investigation because the facility is trying to protect her since she is a witness per the AG. The DON did not know who the resident was that the medication was taken from. During an interview and record review on 2/9/22 at 11:00 a.m., RN E reported he worked the night of 1/14/22 and R4 was already in the building but he got another admission about an hour later. He introduced himself to the resident and did a quick assessment and made sure she had a call light but did not document anything in the computer. Could not recall if she had her oxygen in place or if she got a meal. Could not recall if he called the physician or left a message for the physician. RN E reported that night was busy and had another resident that occupied much of his time, and it was just a busy night. RN E reported the DON and the NHA had him fill out a handwritten assessment around 1/21/22 for R4 even though the date on one document showed 1/15/22, but verified it was not filled out until long after she was discharged and filled out what he could remember. These documents are not in the EMR and are in the soft file in the NHAs office. RN E reported he did not chart much that night because it was busy. In an interview on 2/15/22 at 12:00 p.m., RN C reported she worked the second shift on 1/15/22 and took care of R4 that day. RN C was not sure if R4 received medications earlier that day but was informed that the resident's daughter had called with concerns that R4 had not received any medication since she was admitted to the facility on [DATE]. RN C reviewed the chart and it looked like she was admitted that day (1/15/22) and was told that RN E was going to complete the admission documentation for the resident. RN E was there this night and thought he was completing the paperwork. RN C reported if the medications on the EMAR were documented as given, then she gave the medications. The medications documented are apixaban, lactulose, and spironolactone. Two of the medications were shown to be dispensed from the Cubex but not the lactulose. No other medications were documented as given and no documentation indicating the physician was notified. In an interview on 2/16/22 at 9:22 a.m., MDS Coordinator LPN N reported she completed the MDS assessment, and another Registered Nurse signed off on it. She reported she gathers information about the residents based on the information put into the computer. She reported the census line on this day still shows R4 admitted to the facility on [DATE] and not 1/14/22. LPN N reported she utilizes the admission nursing assessment as well to assist in filling out the MDS assessment while other disciplines will fill out their portions of the assessments. LPN N reported section A and G are a couple of the areas she fills out among other sections, but the social workers fill out section C for cognition. Review of several witness statements provided by the facility revealed a lack of documentation in R4's EMR backing up services and goods provided to the resident. There is no paper trail of events, assessments, physician contact, pharmacy contact, medication administration, pharmacy receipt and/or charges for medications or full physical assessment while R4 resided in the building.

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100125723 and M10026630. Based on interview and record review, the facilty failed to complete and submit and accurate Minimum Data Set (MDS) Assessment for 1 (Resident #4), resulting in the resident not reported as being admitted on the appropriate date and no assessment completed to accurately reflect the resident. Findings include: Review of a Face Sheet revealed R4 is an [AGE] year old female admitted to the facility on [DATE] with pertinent diagnoses of cardiac arrythmia, acute and chronic respiratory disease, and heart failure. Review of the Minimum Data Set (MDS) Discharge assessment dated [DATE] revealed R4 admitted to the facility on [DATE] and discharged on [DATE]. Section A2300 indicates R4 MDS Assessment Reference date is 1/16/22 and the resident was moderately cognitively impaired. In an interview on 2/1/22 at 1:20 p.m., Family Member (FM) A reported her mother (R4) admitted to the facility from the hospital on 1/14/22 around 3:30 p.m. and did not receive medications, oxygen, food, or water while at the facility. FM A reported she dropped off clothing for her mother around that time. The resident was cognitively intact until this incident. R4 was then admitted back to the hospital on 1/16/22. On 1/15/22 FM A reported she called the facility and complained to the nurse that her mother has not received any food, medications, or water and the facility did not connect R4 to 3 liters of oxygen. She would call the facility and they would put her on hold and then hang up. FM A reported she talked to the nurse and insisted her mother (R4) goes back to the hospital after talking to R4 on the phone and noticed a change in her cognitive condition. The staff was reluctant to send R4 to the hospital and FM A reported she argued with the staff and insisted again that R4 goes to the hospital. They finally transferred the resident to the hospital and when she arrived, she had the same clothes on that she was admitted to the Nursing Home on 1/14/22. When the resident arrived at the hospital, there was no discharge paperwork from the facility indicating who the resident was, so she was a [NAME] Doe for a few minutes. The resident was admitted to the hospital and FM A reported she was in a hepatic coma. Review of Hospital Records for R4 with an admitted [DATE] revealed Chief Complaint: Altered Mental Status (pt (patient) present to ed (emergency department) c/o (complaints of) not feeling well. Pt coming from (Nursing Facility) and has been unable to take meds for 2 days. unable to take lactulose . pt normal on 2L NC (nasal cannula), BS (blood sugar) 138. Pt is confused currently, able to follow commands, pt is normally AXO 4 (alert and oriented x4) per facility. She was discharged to a skilled nursing facility as the caregiver has COVID and to get over the quarantine period, the patient was staying in a nursing facility. Unfortunately the nursing facility did not have any of her medications and therefore has not received any medication since discharge from the hospital on Friday. It is difficult to ascertain the timing of the symptoms, but the patient is altered, able to tell me her name. EKG (electrocardiogram) demonstrates sinus tachycardia (fast heart rate) and elevated ammonia . Assessment/Plan: Altered mental status, Liver cirrhosis secondary to NASH (CMS/HCC), Hyperammonemia (metabolic disturbance characterized by an excess of ammonia in the blood). (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Internal Medicine History and Physical dated 1/16/22 for R4 revealed: Patient presents from (Nursing Home) secondary to alteration of mental status. Reportedly the patient has not received her liver medications including lactulose, Aldactone, rifaximin, Lasix since she was discharged from (Hospital) on 1/14/2022. Unfortunately it appears that as previously mentioned there was an interruption in pharmacological administration of which is the likely culprit as the patient's ammonia level was elevated. Outpatient medications: . oxygen 3 liters nasal canula . 1. Hepatic Encephalopathy. Review of Hospital Therapy documentation dated 1/14/22 for R4 revealed she required some help with Activities of Daily Living (ADLs) and contact guard for toileting. At this time she demonstrated generalized weakness in upper extremities as well as requiring some continued assistance with activities of daily living. Review of the Electronic Medical Record revealed some of the Orders for R4 were documented to start on 1/15/22 at 2000 (8:00 p.m.) which included but not limited to Xifaxan 550 milligram (mg) tablet twice a day for encephalopathy, spironolactone 25 mg twice a day for high blood pressure, amiodarone 200 mg tablets- give 2 tablets by mouth every morning ad at bedtime for HF (heart failure), furosemide 40 mg once a day for edema, lactulose solution 20 grams twice a day for encephalopathy, and metoprolol 25 mg once a day for high blood pressure. Orders were dated for 1/15/22 and 1/16/22. Review of a General Progress note dated 1/16/22 revealed R4 went to the hospital at approximately 9:20 a. m. Review of a Nursing Skilled Charting document for R4 dated 1/14/22 at 8:40 p.m. and locked on 1/15/22 at 7:45 p.m. revealed the resident was not and her vital signs were documented. In an interview on 2/7/22 at 4:15 p.m., Licensed Practical Nurse (LPN) M reported that she did not admit R4 to the facility on [DATE] because she was already admitting another resident when R4 arrived at the facility. LPN M reported she worked the day shift and started at 6:00 a.m. and worked until 9:30 p.m. to complete her other admission and documentation. LPN M reported RN E worked the second shift this day and reported to him of R4 admitting to the facility and about an hour later another new admission came to the facility. LPN M reported R4 arrived around dinner time, and she just helped get her settled into the room and made sure she had a meal tray and was safe. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/8/22 at 8:49 a.m., RN D reported she did not get in report that R4 was in the facility and became aware once she passed medications to her roommate and noticed R4 was in the room too. RN D reported her name was not on the report sheet or census either. RN D reported she filled out an assessment for R4 after the resident had discharged from the facility and signed it as a late entry for 1/20/22. This document was not part of the residents' medical records and was filled out by hand and put into a soft file in the administrator's office. RN D reported the assessment she did reflected the date of 1/15/22 when she took care of her. RN D reported she only filled out part B and down. RN D reported that RN E was going to come back to finish the admission documentation. RN D reported the admission packet was on the desk for R4 and she opened it to find out what medications the resident was on. When queried about how R4 got her medications and why they were not charted in the electronic medical record, RN D changed her story from earlier when she reported she got the medications out of the special tackle box that was for the COVID unit. She said she got the medications out of the Cubex. RN D could not explain why the medications she gave R4 did not show up in the Cubex log as a medication dispensed in R4s name. When queried why the medications were not documented in the computer MAR, RN D reported is was because the timing would be off for the resident's next dose. So she signed the paper hospital medication discharge orders for R4 that she gave her amiodarone, apixaban, ferrous sulfate, furosemide, lactulose, loratadine, metoprolol, oxygen, protonix, and spironolactone at 9:30 a.m. on 1/15/22. When queried about the lactulose, RN D reported she took the lactulose from another resident to give to R4. None of these medications showed up as dispensed from the Cubex for R4. During an interview and record review on 2/9/22 at 11:00 a.m., RN E reported he worked the night of 1/14/22 and R4 was already in the building but he got another admission about an hour later. He introduced himself to the resident and did a quick assessment and made sure she had a call light but did not document anything in the computer. Could not recall if she had her oxygen in place or if she got a meal. Could not recall if he called the physician or left a message for the physician. RN E reported that night was busy and had another resident that occupied much of his time, and it was just a busy night. RN E reported the DON and the NHA had him fill out a handwritten assessment around 1/21/22 for R4 even though the date on one document showed 1/15/22, but verified it was not filled out until long after she was discharged and filled out what he could remember. These documents are not in the EMR and in the soft file in the NHAs office. RN E reported he did not chart much that night because it was busy. In an interview on 2/15/22 at 12:00 p.m., RN C reported she worked the second shift on 1/15/22 and took care of R4 that day. RN C was not sure if R4 received medications earlier that day but was informed that the resident's daughter had called with concerns R4 had not received any medication since she was admitted to the facility. RN C reviewed the chart and it looked like she was admitted that day (1/15/22) and was told that RN E was going to complete the admission documentation for the resident. RN E was there this night and thought he was completing the paperwork. RN C reported if the medications on the MAR were documented as given, then she gave the medications. The medications documented are apixaban, lactulose, and spironolactone. Two of the medications were shown to be dispensed from the Cubex but not the lactulose. No other medications were documented as given. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 2/16/22 at 9:22 a.m., MDS Coordinator LPN N reported she completed the MDS assessment, and another Registered Nurse signed off on it. She reported she gathers information about the residents based on the information put into the computer. She reported the census line on this day still shows R4 admitted to the facility on [DATE] and not 1/14/22. LPN N reported she utilizes the admission nursing assessment as well to assist in filling out the MDS assessment while other disciplines will fill out their portions of the assessments. LPN N reported section A and G are a couple of the areas she fills out among other sections, but the social workers fill out section C for cognition.

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(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 - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100126050 and M100125909. Based on observation, interview and record review, the facility failed to adequately supervise 6 residents in the dining room and 2 (Resident #1 and Resident #2), resulting in an unsupervised dementia resident known to wander have unwanted/inappropriate contact with another resident and an unwitnessed fall with no investigation or appropriate interventions in place, and dependent residents in the dining room alone with unmet needs. Findings include: Resident #1 (R1) Review of a Face Sheet revealed R1 is a [AGE] year old female admitted to the facility on [DATE] with pertinent diagnoses of various psychological disorders, a hip fracture and cognitive communication deficit. Review of the Minimum Data Set (MDS) dated [DATE] revealed R1 is cognitively intact and required extensive assistance of 2 staff for cares and transfers. This resident is no longer at the facility. Resident #2 (R2) Review of a Face Sheet revealed R2 admitted to the facility on [DATE] with pertinent diagnoses of dementia, history of falling, and cognitive communication deficit. Review of the MDS dated [DATE] revealed R2 is moderately cognitively impaired and required supervision and oversight or cueing when ambulating. In an interview on 2/1/22, Family Member (FM) P reported a male resident entered her mothers' (R1) room and would not leave when she asked him to leave. Another day R1 told the male resident to leave 3-4 times while FM P was on the phone with R1. The male resident had been doing that for some time and her mother would repeatedly ask him to leave or try to ignore him, and he still would not leave her room. The male resident would ask her for food that is on her tray or start talking to her. FM P reported she talked to the NHA (Nursing Home Administrator) about her concerns and about the male resident sexually assaulting her mother. FM P reported she was not sure if staff would see him go into her mother's room because there is only 1 staff member per hall. FM P reported she talked to the police about the sexual assault incident. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(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 - Few	Review of a Facility Reported Incident dated 1/14/22 revealed R2 entered R1s room when R1 was in bed said she was calling out for help. R2 touched her foot then touched her leg. R1 asked if he was a doctor and he said he was a masseuse. R1 reported he touched her peritoneal area and he declined. The police were contacted, and a police report was filed. R1 declined to go to the hospital for an evaluation. R2 had some confusion and admitted he massaged R1s leg and said he was worried if she was okay. R1 reported to the police that she wanted to press charges. Review of staff statements revealed the resident was observed in the hallway and in his room ambulating without his walker and was unsteady. Review of other resident interviews revealed the facility did not ask other residents pertinent and meaningful questions to address if this resident or other residents wandered in and out of their rooms or touched them. Review of the Police report dated 1/14/22 revealed R1 and R2 had consistent stories that R2 entered R1s room and touched her ankles, leg and right thigh, but R2 denies touching R1's vaginal area. Disposition: Both (R1 and R2) statements were quite consistent. The only inconsistency was the (R1's) allegation that (R2) rubbed her vagina and area around it. (R2) denies this. (The Nursing Facility) is going to take the appropriate steps to keep (R2) separated from (R1), possibly by moving (R1) to a different room. R1 refused to go to the hospital or have a physician examine her, but is pursuing to press charges. In an interview on 2/14/22 at 10:25 a.m., the DON reported she did not remember R2 wandering in and out of other residents' rooms, just in the hall. In an interview on 2/14/22 at 12:30 p.m., Social Worker (SW) T reported R1 had a history of behaviors and would change her stories often. R1 just seemed unhappy overall. The facility has had a change in social workers, but SW U followed up with her after the sexual allegations. R2 was a very confused resident who was deemed incompetent. He was shaken up by the police after the sexual allegation incident and appeared timid during his support visits. After a few support visits he would talk about other things and not recall the incident. When R2 would walk out of his room he appeared to be lost but was easily redirected. SW T did not recall R2 wandering into other resident rooms', but he did wander. SW T reported she added it to his care plan. In an interview on 2/14/22 at 1:12 p.m., SW U reported he followed up with R1 post sexual allegation and tried to re enact the situation and concluded it was physically impossible for R2 to reach her vaginal area from where he was standing. SW U reported that R1 then changed her story. R2 was very distraught after the incident and told SW U he didn't do anything wrong. SW U reported when R1 complained of her feet hurting, both residents confirmed he said he was a therapist or something and R2 used to do that in the past. When R1 told R2 to stop, he did. SW U reported R1 had not made any allegations of this kind during her stay before. During an observation and an interview on 2/2/22 at 1:36 p.m., R2 was observed in bed in his room with 1:1 supervision. He could not recall the incident with R1 and made non sensical conversation. Certified Nursing Assistant (CNA) W reported the resident will make inappropriate comments to staff at times but does not realize he is doing it. CNA W reported he has been a 1:1 for cares for about a month now. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(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 - Few	Review of the Care Plan for R2 revealed no care plan for dementia noted. No care plan for supervision noted. R1 has a care plan initiated on 12/22/21 and revised on 1/19/22 with a focus that the resident has mood concern related to a history of auditory and visual hallucinations, wanders into other rooms. Increased supervision for safety implemented on 1/14/22. The resident is also care planned for assistance of one staff to walk with a two wheeled walker and gait belt. R2 is also care planned for increased risk for falls related to diuretic therapy. Resident #2 (R2) Review of an Incident Report dated 1/4/22 for R2 revealed the resident had an unwitnessed fall. Incident Description: upon arrival to resident room, patient visualized on floor laying flat on his back pillow was placed under head, reported from CNA while prepping to get resident cleaned up, they heard resident fall while attempting to get up from wheel chair, no injuries noted. Initiated neuro checks . No investigation to the root cause, no staff statements, no neuro checks available, and no meaningful interventions noted. In an interview on 2/14/22 at 10:25 a.m., when queried about the investigation related to R2 falling in his room on 1/4/22, the DON did not have an answer as to why there were no statements from the staff who worked that day and where they were. Review of a Care Plan revealed on 1/14/22 R2 had an intervention placed for Increased supervision for safety and on 12/22/21 a Care Plan initiated to address the resident wandering into other rooms and his confusion, but not meaningful interventions noted. Observations During an observation on 2/7/22 at 1:05 p.m., the dining room near station 2 had 6 residents unsupervised. One resident asked this surveyor if she could get assistance to go back to her room and find someone to assist another resident in a wheelchair who was sleeping and soiled herself. This resident was sitting at another table and had a pool of urine underneath her wheelchair. The other residents had their eyes closed sitting in their wheelchairs. At 1:11 p.m., a nurse entered the dining room to get some water and then left the room. During an observation on 2/7/22 at 1:17 p.m., a resident in room [ROOM NUMBER] was yelling out that he wanted to get up. He was sitting up in the wheelchair and there was no call light within reach. During an observation on 2/7/22 at 1:20 p.m. two CNAs came into the dining room near station 2 and took the resident who urinated through her clothes and on to the floor to her room and left the remaining 5 residents in the dining room unsupervised. At the same time, a resident in room [ROOM NUMBER] around the corner from the dining room was calling out for help and did not have a call light in reach. An Occupational Therapy Assistant (OTA) Q walked by and saw this surveyor in the room and assisted the resident to find her call light and assisted the resident. During an observation on 2/8/22 at 1:36 p.m., four residents observed in the dining room alone and 2 of the residents had food trays in front of them and appeared to be falling asleep with their eyes closing. At this time Physical Therapist (PT) S entered the room to talk with one of the residents for therapy. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(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 - Few	In an interview on 2/14/22 at 2:47 p.m., the DON reported staff did not need to be in the dining room with residents all the time and they can be in there alone. Informed the DON of observations.

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 This citation pertains to intake M100125723 and M10026630. Based on observation, interview and record review, the facility failed to follow policies and procedures for medication orders, obtain physician orders timely, provide and administer medications, and ensure a sufficient process for ordering medications to meet the needs for 1 (Resident #4), resulting in the Resident #4's admission to the hospital. Findings include: Review of a Guidelines for Medication Orders, Policy 2.1 revealed: Medications are dispensed by the Pharmacy only upon receipt of a clear, complete order, signed by an authorized licensed prescriber. facilities using an electronic order entry system and/or eMAR should refer to specific system. Review of a Medication Ordering and Receipt Policy 3.4-Delivery and Receipt of Medications revealed: The pharmacy will deliver Cycle Fill medications on a predetermined schedule. Nursing staff at the facility are responsible for verifying the accuracy of the delivery and notifying the pharmacy of any discrepancies within 4 hours of delivery.2. Orders received by the pharmacy before the designated fax cut-off time will be sent on the Facility's regular scheduled delivery. 3. Orders received by the pharmacy after the designated fax cut-off time and required the same night, must be called to the pharmacy and requested for same day delivery. Review of a policy titled Admissions adopted 7/11/18 revealed: It is the policy of this facility to have well defined guidelines for processing the Resident's entry into the nursing facility and that the Resident's rights are protected under federal and state laws. 2. Initiate any required treatments (oxygen, intravenous) necessary at time of admission per transfer orders. 5. Order medications from pharmacy. 6. Confirm diet order, complete diet slip and sent to dietary. 11. Note and initiate physician order. Initiate mediations and treatment sheets. Review of a policy titled Charting and documentation adopted 7/11/18 revealed: All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Resident #4 (R4) Review of a Face Sheet revealed R4 is an [AGE] year old female admitted to the facility on [DATE] with pertinent diagnoses of cardiac arrythmia, acute and chronic respiratory disease, and heart failure. Review of the Minimum Data Set (MDS) Discharge assessment dated [DATE] revealed R4 admitted to the facility on [DATE] and discharged on [DATE]. Section A2300 indicates R4 MDS Assessment Reference date is 1/16/22 and the resident was moderately cognitively impaired. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/1/22 at 1:20 p.m., Family Member (FM) A reported her mother (R4) admitted to the facility from the hospital on 1/14/22 around 3:30 p.m. and did not receive medications, oxygen, food, or water while at the facility. FM A reported she dropped off clothing for her mother around that time. The resident was cognitively intact until this incident. R4 was then admitted back to the hospital on 1/16/22. On 1/15/22 FM A reported she called the facility and complained to the nurse that her mother has not received any food, medications, or water and the facility did not connect R4 to 3 liters of oxygen. She would call the facility and they would put her on hold and then hang up. FM A reported she talked to the nurse and insisted her mother (R4) goes back to the hospital after talking to R4 on the phone and noticed a change in her cognitive condition. The staff was reluctant to send R4 to the hospital and FM A reported she argued with the staff and insisted again that R4 goes to the hospital. They finally transferred the resident to the hospital and when she arrived, she had the same clothes on that she was admitted to the Nursing Home on 1/14/22. When the resident arrived at the hospital, there was no discharge paperwork from the facility indicating who the resident was, so she was a [NAME] Doe for a few minutes. The resident was admitted to the hospital and FM A reported she was in a hepatic coma. Review of Hospital Records for R4 with an admitted [DATE] revealed Chief Complaint: Altered Mental Status (pt (patient) present to ed (emergency department) c/o (complaints of) not feeling well. Pt coming from (Nursing Facility) and has been unable to take meds for 2 days. unable to take lactulose . pt normal on 2L NC (nasal cannula), BS (blood sugar) 138. Pt is confused currently, able to follow commands, pt is normally AXO 4 (alert and oriented x4) per facility. She was discharged to a skilled nursing facility as the caregiver has COVID and to get over the quarantine period, the patient was staying in a nursing facility. Unfortunately the nursing facility did not have any of her medications and therefore has not received any medication since discharge from the hospital on Friday. It is difficult to ascertain the timing of the symptoms, but the patient is altered, able to tell me her name. EKG (electrocardiogram) demonstrates sinus tachycardia (fast heart rate) and elevated ammonia . Assessment/Plan: Altered mental status, Liver cirrhosis secondary to NASH (CMS/HCC), Hyperammonemia (metabolic disturbance characterized by an excess of ammonia in the blood). Review of an Internal Medicine History and Physical dated 1/16/22 for R4 revealed: Patient presents from (Nursing Home) secondary to alteration of mental status. Reportedly the patient has not received her liver medications including lactulose, Aldactone, rifaximin, Lasix since she was discharged from (Hospital) on 1/14/2022. Unfortunately it appears that as previously mentioned there was an interruption in pharmacological administration of which is the likely culprit as the patient's ammonia level was elevated. Outpatient medications: . oxygen 3 liters nasal canula . 1. Hepatic Encephalopathy. Review of the Electronic Medical Record revealed some of the Orders for R4 were documented to start on 1/15/22 at 2000 (8:00 p.m.) which included but not limited to Xifaxan 550 milligram (mg) tablet twice a day for encephalopathy, spironolactone 25 mg twice a day for high blood pressure, amiodarone 200 mg tablets- give 2 tablets by mouth every morning and at bedtime for HF (heart failure), furosemide 40 mg once a day for edema, lactulose solution 20 grams twice a day for encephalopathy, and metoprolol 25 mg once a day for high blood pressure. Orders were dated for 1/15/22 and 1/16/22. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	Review of the Electronic Medication Administration Record (EMAR) revealed no medications were given to R4 on 1/14/22 and on 1/15/22 she received evening doses of apixaban, lactulose, spironolactone, 3 liters of oxygen via nasal canula. There is no documentation or resource that verified lactulose was available or on hand to give to the resident but is signed as given to her. The other two medications are documented they came from the Cubex (on site medication dispenser) on 1/15/22 at 8:32 p.m. Review of the EMR revealed no documentation of when the R4 arrived at the facility, no admission assessment, no documentation the physician was notified, no care plans, no skin assessments, no meals documented, and no ADL's documented. Review of a Late Entry General Progress Note backdated 1/15/22 and created on 1/16/22 at 9:28 a.m. for R4 revealed: Resident received morning medications by paper MAR from nurse. Nothing documented in the EMR indicating the resident received these medications or where they came from. Review of a General Progress note dated 1/15/22 at 11:51 p.m. for R4 revealed: Res resting with eyes closed at this time, O2 (oxygen) on as ordered. Meds available in back up pulled and given at (bedtime). Pharmacy contacted and STAT (fast as possible) delivery of all other meds requested. Review of a Nursing Skilled Charting document for R4 dated 1/14/22 at 8:40 p.m. and locked on 1/15/22 at 7:45 p.m. revealed the resident had her vitals documented but was not assessed for ADL's. Review of the Cubex transactions list from 1/1/22 to 2/7/22 revealed on 1/15/22 at 8:32 p.m. R4 had Eliquis and spironolactone as the only medications removed from the Cubex by Registered Nurse (RN) C. In an interview on 2/3/22 at approximately 8:00 a.m., the Medical Records Clerk (MR) F reported she was caught up on any medical records needing to be scanned into the computer. When questioned if there were any records for R4 not scanned into the computer yet, MR F reported she was pretty sure all the records were in the computer and was going to make sure. About 30 minutes later MR F provided a soft file with a discharge summary/order from the hospital, a preprinted handwritten nursing admission assessment and a preprinted handwritten skilled charting documentation for R4. MR F reported the soft file was in the administrator's office. During an interview on 2/3/22 at 10:22 a.m., RN D reported she took care of R4 on 1/15/22 during the day shift and did not verify the admission orders with the physician. RN D reported she got medications for R4 from the tackle box that had medications for the residents on the COVID unit so they would not have to come out of the unit to go to the Cubex to get medications. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	During an interview and record review on 2/3/22 at 10:45 a.m. The Director of Nursing (DON) reported RN E did not do an initial assessment for R4 when she admitted to the facility on [DATE]. The facility was informed by the Attorney Generals (AG) Office on 1/20/22 that there was a concern regarding R4s care and instructed to freeze the electronic medical record for R4. So no documentation was to be added, removed, or altered at that point. When they became aware there was a concern, she had an assessment printed out and had the nurses fill them out as a late entry and put a file together to be put in the administrator's office. The DON reported R4 did not get any medications on Friday 1/14/22 but reported RN D put the medications in the computer that day. The DON reported once they were aware of the allegation, they reported it to the State Agency (SA). The DON later provided a list of medications that were in the tackle box designated to the COVID unit, but the list only included medications that were common to treat COVID, not regular routine medications or any medications that were given to R4. The DON then reported she could not exactly verify where the medications that the nurse signed on the hospital discharge orders summary as given to R4 were obtained from. In an interview on 2/3/22 at 11:00, the Nursing Home Administrator (NHA) reported that the AG reached out to them on 1/20/22 and told her of the concern reported to their office, and so the NHA reported to the SA that there is an allegation of neglect. The AG office told them to not put any more documents into the computer for R4 because the records are being sequestered. In an interview on 2/3/22 at 11:43 a.m. the DON still could not verify where the medications that were documented as given to R4 during her stay came from. During an Interview and Record review on 2/7/22 at 11:38 a.m., Pharmacist (PM) B revealed on 1/15/22 a New Admit place holder information was sent to them via EMR at the Nursing Facility. At 8:32 p.m., the nurse called the pharmacy for STAT medications and again at 9:32 p.m. No medications were delivered the night of 1/15/22 to the facility. Amiodarone and xifaxan was delivered to the facility on [DATE] at 8:40 a.m. PM B reported they had no record of R4 being charged for any medications at the facility while she was there. If she did receive medications, she would have been charged for them or should have been. The pharmacy receives the information when a resident gets medication. PM B reported if the facility used the old tackle box approach to providing medications, then there should be a slip that would be written out with the residents' information and sent to the pharmacy for a charge. At the time of this interview, there were no medications charged to the resident or any proof provided to the Pharmacy that this resident received medications to be charged. In an interview on 2/7/22 at 4:15 p.m., Licensed Practical Nurse (LPN) M reported that she did not admit R4 to the facility on [DATE] because she was already admitting another resident when R4 arrived at the facility. LPN M reported she worked the day shift and started at 6:00 a.m. and worked until 9:30 p.m. to complete her other admission and documentation. LPN M reported RN E worked the second shift this day and reported to him of R4 admitting to the facility and about an hour later another new admission came to the facility. LPN M reported R4 arrived around dinner time, and she just helped get her settled into the room and made sure she had a meal tray and was safe. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/8/22 at 8:49 a.m., RN D reported she did not get in report that R4 was in the facility and became aware once she passed medications to her roommate and noticed R4 was in the room too. RN D reported her name was not on the report sheet or census either. RN D reported she filled out an assessment for R4 after the resident had discharged from the facility and signed it as a late entry for 1/20/22. This document was not part of the residents' medical records and was filled out by hand and put into a soft file in the administrator's office. RN D reported the assessment she did reflected the date of 1/15/22 when she took care of her. RN D reported she only filled out part B and down. RN D reported that RN E was going to come back to finish the admission documentation. RN D reported the admission packet was on the desk for R4 and she opened it to find out what medications the resident was on. When queried about how R4 got her medications and why they were not charted in the electronic medical record, RN D changed her story from earlier when she reported she got the medications out of the special tackle box that was for the COVID unit. She said she got the medications out of the Cubex. RN D could not explain why the medications she gave R4 did not show up in the Cubex log as a medication dispensed in R4s name. When queried why the medications were not documented in the computer MAR, RN D reported is was because the timing would be off for the resident's next dose. So she signed the paper hospital medication discharge orders for R4 that she gave her amiodarone, apixaban, ferrous sulfate, furosemide, lactulose, loratadine, metoprolol, oxygen, protonix, and spironolactone at 9:30 a.m. on 1/15/22. When queried about the lactulose, RN D reported she took the lactulose from another resident to give to R4. None of these medications showed up as dispensed from the Cubex for R4, provided by the pharmacy, or any other paper trail indicating the resident received these medications from RN D. In an interview on 2/8/22 at 11:48 a.m., the DON reported the nurse did get medications out of the Cubex for R4 and got the lactulose from another resident by borrowing it. The facility replaced the medication taken from the other resident. The DON reported there should be a record of R4 in the Cubex if medications were taken out of it for her. The DON reported RN D told her 3 times that she pulled R4s medication from the Cubex. The DON did not know why the nurse took lactulose from another resident when the lactulose is also in the Cubex. The DON reported she is not involved in the investigation because the facility is trying to protect her since she is a witness per the AG. The DON did not know who the resident was that the medication was taken from. During an interview and record review on 2/9/22 at 11:00 a.m., RN E reported he worked the night of 1/14/22 and R4 was already in the building but he got another admission about an hour later. He introduced himself to the resident and did a quick assessment and made sure she had a call light but did not document anything in the computer. Could not recall if she had her oxygen in place or if she got a meal. Could not recall if he called the physician or left a message for the physician. RN E reported that night was busy and had another resident that occupied much of his time, and it was just a busy night. RN E reported the DON and the NHA had him fill out a handwritten assessment around 1/21/22 for R4 even though the date on one document showed 1/15/22, but verified it was not filled out until long after she was discharged and filled out what he could remember. These documents are not in the EMR and in the soft file in the NHAs office. RN E reported he did not chart much that night because it was busy. (continued on next page)

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	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skld 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0755 Level of Harm - Actual harm Residents Affected - Few	In an interview on 2/15/22 at 12:00 p.m., RN C reported she worked the second shift on 1/15/22 and took care of R4 that day. RN C was not sure if R4 received medications earlier that day but was informed that the resident's daughter had called with concerns R4 had not received any medication since she was admitted to the facility. RN C reviewed the chart and it looked like she was admitted that day (1/15/22) and was told that RN E was going to complete the admission documentation for the resident. RN E was there this night and thought he was completing the paperwork. RN C reported if the medications on the MAR were documented as given, then she gave the medications. The medications documented are apixaban, lactulose, and spironolactone. Two of the medications were shown to be dispensed from the Cubex but not the lactulose. No other medications were documented as given. Review of several witness statements provided by the facility revealed a lack of documentation in R4's EMR backing up services and goods provided to the resident. There is no paper trail of events, assessments, physician contact, pharmacy contact, medication administration, pharmacy receipt and/or charges for medications or full physical assessment while R4 resided in the building.