STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER Skid Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Some	<ul> <li>and neglect by anybody.</li> <li>**NOTE- TERMS IN BRACKETS F</li> <li>This pertains to intake M10012572</li> <li>Based on interview and record revidue to not following policies and pr</li> <li>medications and failed to provide n</li> <li>treatment and medications for 2 rearesident readmitted back to the host</li> <li>Findings include:</li> <li>Review of a Policy titled Abuse and policy/procedure is to articulate statidentification, investigation protection to provide professional care and see misappropriation of resident proper facility, its employees or service pravoid physical harm, pain, mental and Review of a policy titled Admission defined guidelines for processing the are protected under federal and states and complete admission and verify the Confirm diet order, complete diet si immediate Resident special needs physician order. Initiate mediations</li> </ul>	ew, the facility failed to prevent neglec ocedures for new admissions, charting recessary care and services including r sidents (Resident #4 and Resident #10 atments or services including Activities spital 2 days after admission. d Neglect last revised on 10/14/20 reve indards and/or processes for proper sc on and reporting relative to any form of ervices in an environment that is free fr rty, exploitation, and corporal punishme oviders to provide goods and services	ONFIDENTIALITY** 37573 t when systemic failures occured and documentation, and ordering notifying the physician for missed b), resulting in residents not of Daily Living (ADLs) and one ealed: The purpose of this reening, training, prevention, abuse. It is the policy of this facility om abuse, neglect, ent. Neglect: The failure of the to a resident that are necessary to policy of this facility to have well sility and that the Resident's rights . Welcome Resident and family to pured treatments (oxygen, complete assessment of body a through skin check. 4. Inform medications from pharmacy. 6. ent Care Plan. 10. Communicate vices, ect. 11. Note and initiate ce-directive information. 14. Ensure

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Facility ID: 235004

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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, function or psychosocial condition, shall be documented in the resident's medical record. The medical record show facilitate communication between the interdisciplinary team regarding the resident's condition and response		
	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.		
	facility from the hospital on 1/14/22 while at the facility. FM A reported s was cognitively intact until this incid FM A reported she called the facility medications, or water and the facilit the facility and they would put her of 1/16/22 and insisted her mother (R- change in her cognitive condition. T argued with the staff and insisted at the hospital and when she arrived, When the resident arrived at the hospital	m., Family Member (FM) A reported he around 3:30 p.m. and did not receive r she dropped off clothing for her mother lent. R4 was then admitted back to the y and complained to the nurse that her ty did not connect R4 to 3 liters of oxyg n hold and then hang up. FM A report 4) goes back to the hospital after talkin The staff was reluctant to send R4 to th gain that R4 goes to the hospital. They she was wearing the same clothes tha ospital, there was no discharge paperwor ME] Doe for a few minutes. The reside c coma.	nedications, oxygen, food, or wate around that time. The resident hospital on 1/16/22. On 1/15/22 mother has not received any food en. FM A reported she would call ed she talked to the nurse on g to R4 on the phone and noticed e hospital and FM A reported she finally transferred the resident to t she was admitted with on 1/14/2 ork from the facility indicating who
	pt (patient) present to ed (emergen (Nursing Facility) and has been una NC (nasal cannula) . Pt is confused oriented x4) per facility. She was di get over the quarantine period, the did not have any of her medications hospital on Friday (1/14/22). It is dif able to tell me her name. EKG (elec elevated ammonia . Assessment/Pl	with an admitted [DATE] revealed Chie cy department) c/o (complaints of) not able to take meds for 2 days. unable to d currently, able to follow commands, p scharged to a skilled nursing facility as patient was staying in a nursing facility s and therefore has not received any m fficult to ascertain the timing of the sym ctrocardiogram) demonstrates sinus ta- lan: Altered mental status, Liver cirrhos etabolic disturbance characterized by a	feeling well. Pt coming from take lactulose . pt normal on 2L t is normally AXO 4 (alert and the caregiver has COVID and to . Unfortunately the nursing facility edication since discharge from th ptoms, but the patient is altered, chycardia (fast heart rate) and is secondary to NASH
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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: Patier presents from (Nursing Home) secondary to alteration of mental status. Reportedly the patient has n received her liver medications including lactulose, Aldactone, rifaximin, Lasix since she was discharg (Hospital) on 1/14/2022. Unfortunately it appears that as previously mentioned there was an interrup pharmacological administration of which is the likely culprit as the patient's ammonia level was eleva 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.		
	1/15/22 at 2000 (8:00 p.m.) which i encephalopathy, spironolactone 25 2 tablets by mouth every morning a edema, lactulose solution 20 grams	ecord revealed some of the Orders for ncluded but not limited to Xifaxan 550 i i mg twice a day for high blood pressur ad at bedtime for HF (heart failure), furc s twice a day for encephalopathy, and i re dated to start on 1/15/22 and 1/16/22	milligram (mg) tablet twice a day for e, amiodarone 200 mg tablets- give osemide 40 mg once a day for metoprolol 25 mg once a day for
	documented as given to R4 on 1/14 of oxygen via nasal canula are doc verified lactulose was available or o	n Administration Record (EMAR) revea 4/22. On 1/15/22 doses of apixaban, la umented as given. There is no docume on hand to administer to R4. The other ication dispenser) log on 1/15/22 at 8:3	ctulose, spironolactone, and 3 liters entation or resources available that two medications are verified they
		ist from 1/1/22 to 2/7/22 revealed on 1/ dications removed from the Cubex by F	
	facility, no admission assessment,	dical Record) revealed no documentation of documentation the physician was no care plans, no skin assessments, no m	otified, no pharmacy notification of
	9:28 a.m. for R4 revealed: Residen documented in the EMR indicating	ogress Note backdated for 1/15/22 at 9 t received morning medications by pap where these medications came from, it ons or if the pharmacy was contacted.	per MAR from nurse. Nothing
	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)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	<ul> <li>m.</li> <li>Review of a Nursing Skilled Chartin 7:45 p.m. revealed the resident was</li> <li>Review of the Task List for cares R received no assistance with care ar</li> <li>In an interview on 2/3/22 at approxic caught up on any medical records r any records for R4 not scanned into were in the computer and was goin discharge summary/order from the skilled charting document for R4. M</li> <li>During an interview on 2/3/22 at 10 shift and did not verify the admission from the tackle box that had medica would not have to come out of the 0</li> <li>In an interview on 2/3/22 at 10:45 a of 1/14/22 did not do an initial assee by the Attorney Generals (AG) Offici instructed to freeze the electronic m altered at that point. When they bee had an assessment printed out and together to be put in the Administra 1/14/22 but reported RN D did put t were aware of the allegation, they may tackle box on the COVID unit with of to the Cubex that was off of the CO list of the medications that were in the medications that were in the discussion of the tackle box on the covid unit with of the themedication that were common to the given to R4. The DON then reported signed as given on the hospital discussion of neglect computer for R4 because the recording the record of the record the record of the record the record of the record the re</li></ul>	imately 8:00 a.m., the Medical Records beeding to be scanned into the compute of the computer yet, MR F reported she g to make sure. About 30 minutes later hospital, a handwritten nursing admiss IR F reported the soft file was in the Ad- :22 a.m., RN D reported she took care on orders with the physician. RN D report ations designated for the residents on to Covid unit to get medications out of the the Director of Nursing (DON) reports ssment for R4 when she admitted to the e on 1/20/22 that there was a concern hedical record for R4. So no document came aware there was a concern with I had the nurses fill them out by hand a tor's office. The DON reported R4 did the medications in the computer that da eported it to the State Agency (SA). The faily medications for the new admission VID unit to get medications for the resist the tackle box designated to the COVIII reat COVID, not regular routine medicat d she could not exactly verify where the charge orders fro R4 were obtained fro the Nursing Home Administrator (NHA) the concern reported to their office, and t. The AG office told them to not put ar ds are being sequestered. That is why bital discharge medication list in her office	40 p.m. and locked on 1/15/22 at documented. o 1/16/22 revealed the resident c Clerk (MR) F reported she was er. When questioned if there were was pretty sure all the records r MR F provided a soft file with a ion assessment and a handwritter ministrator's office. of R4 on 1/15/22 during the day orted she got medications for R4 he COVID unit. This was so they c Cubex. orted RN E who worked the night re facility. The facility was informed ation was to be added, removed, o R4's care, the DON reported she is a late entry, then put a file not get any medications on Friday ay. The DON reported once they he DON confirmed there was a ns so they would not have to go ou dents. The DON later provided a D unit, but the list only included ations or any medications that were e medications that the nurse m.

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F 0600 Level of Harm - Actual harm Residents Affected - Some	documented as given to R4 during During an Interview and Record rev New Admit place holder information nurse called the pharmacy for STA night of 1/15/22 to the facility. Amic PM B reported they had no record was there. If she did receive medic pharmacy receives the information facility used the old tackle box appr written out with the residents' inform there were no medications charged received medications to be charged In an interview on 2/7/22 at 4:15 p.1 admission documentation for R4 wi another resident who arrived 10 mit day shift that day and started at 6:0 and their documentation. LPN M re- just recently arrived to the facility. T LPN M reported R4 arrived around made sure she had a meal tray and arrived or received services. In an interview on 2/8/22 at 8:49 a.1 1/15/22 that R4 was in the facility. S noticed R4 was in the room too. RN RN D reported she filled out an ass signed it as a late entry for 1/20/22 filled out by hand and put into a sof out reflected the date of 1/15/22 wit down and someone else completed back to finish the admission document the desk for R4 and when she oper queried about how R4 got her med story from earlier when she reporte COVID unit. She said she got the m she gave R4 did not show up in the the medications were not document for the resident's next dose. So she gave her amiodarone, apixaban, fe protonix, and spironolactone at 9:3 took the lactulose from another res from the Cubex for R4, no docume	view on 2/7/22 at 11:38 a.m., Pharmac n was sent to them via EMR at the Nur T medications and again at 9:32 p.m. N darone and xifaxan was delivered to the of R4 being charged for any medication ations, she would have been charged f when a resident gets medications from roach to providing medications, then the nation and sent to the pharmacy for a d I to the resident or any proof provided the second	ist (PM) B revealed on 1/15/22 a sing Facility. At 8:32 p.m., the No medications were delivered the he facility on [DATE] at 8:40 a.m. hs received by the facility while she for them or should have been. The n the Cubex. PM B reported if the ere should be a slip that would be charge. At the time of this interview to the Pharmacy that this resident reported that she did not complete ause she was already admitting _PN M reported she worked the omplete her other two admissions his day and reported to him that R- admission came in to the facility. er get settled into the room and ation in the EMR that this resident mation during report the morning of hedications to her roommate and report sheet or on the census list. discharged from the facility and sidents' medical records and was 0 reported the assessment she filled d she only filled out part B and N E told her he was going to come rted the admission packet was on ations the resident needed. When d in the EMR, RN D changed her becial tackle box that was for the uld not explain why the medication l in R4s name. When queried why s because the timing would be off discharge orders for R4 that she ratadine, metoprolol, oxygen, t the lactulose, RN D reported she cations showed up as dispensed ove these medications were given

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F 0600 Level of Harm - Actual harm Residents Affected - Some	R4 and got the lactulose from anoth from the other resident. The DON rep Cubex. The DON did not know why in the Cubex. The DON reported sh protect her since she is a witness p medication was taken from. During an interview and record revi and R4 was already in the building to the resident and did a quick asset in the computer. Could not recall if called the physician or left a messa resident that occupied much of his had him fill out a handwritten asses showed 1/15/22, but verified it was could remember. These documents reported he did not chart much that In an interview on 2/15/22 at 12:00 care of R4 that day. RN C was not resident's daughter had called with admitted to the facility on [DATE]. F (1/15/22) and was told that RN E w was there this night and thought he EMAR were documented as given, apixaban, lactulose, and spironolac Cubex but not the lactulose. No oth indicating the physician was notified In an interview on 2/16/22 at 9:22 at assessment, and another Registere residents based on the information shows R4 admitted to the facility or nursing assessment as well to assis portions of the assessments. LPN N other sections, but the social worket Review of several witness statement backing up services and goods pro physician contact, pharmacy contact	p.m., RN C reported she worked the s sure if R4 received medications earlier concerns that R4 had not received any RN C reviewed the chart and it looked if as going to complete the admission do was completing the paperwork. RN C then she gave the medications. The metications. The metications were sho the medications were documented as g d. m.m., MDS Coordinator LPN N reported ad Nurse signed off on it. She reported put into the computer. She reported the [DATE] and not 1/14/22. LPN N reported st in filling out the MDS assessment with reported section A and G are a coupling and the computer of the metication of the metication of the section A and G are a coupling the section of the metication of the metication of the the section of the metication of the metic	replaced the medication taken in the Cubex if medications were ulled R4s medication from the resident when the lactulose is als ecause the facility is trying to the resident was that the rted he worked the night of 1/14/2 hour later. He introduced himself light but did not document anythin of a meal. Could not recall if he at night was busy and had another Ereported the DON and the NHA ugh the date on one document scharged and filled out what he if file in the NHAs office. RN E econd shift on 1/15/22 and took that day but was informed that the <i>r</i> medication since she was like she was admitted that day cumentation for the resident. RN If reported if the medications on the redications documented are own to be dispensed from the iven and no documentation she completed the MDS she gathers information about the e census line on this day still ted she utilizes the admission nile other disciplines will fill out the e of the areas she fills out among ack of documentation in R4's EMF r trail of events, assessments,

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F 0600 Level of Harm - Actual harm		or R10 revealed she admitted to the fa tractures and pressure ulcers. She is staff for ADL's.	
Residents Affected - Some	<ul> <li>(percutaneous endoscopic gastrost applied and was not done for 8 day done twice a day and discontinued applied to the sacral wound twice a be cleansed with Dakins solution, p ABD dressing started 1/13/22 missiverifications. Orders to monitor and foley catheter. Order for Prevalon b and no follow up documentation or Review of an Incident Report titled scheduled date and time 1/7/2021 (Oxybutinin 5 mg, Vitamin D3, Zince) from the incident from staff. No witr the report. The MAR for January 20 investigation provided and the NHA In an interview on 2/14/22 at 10:25 to fill in for staffing. The facility four were not given to R10. (Indicated the tried to call the agency nurses who incident form.</li> <li>During an observation and an interview on date to the skin. At a reported the therapist changed the foley catheter may not be working were not given to 2/2/22 at 2:40 p.1 remembered the therapist came to</li> </ul>	Medication Error for R10 dated 1/7/22 @ 0730: Baclofen 5 mg, Duloxetine DF Gluconate 50 mg. 1/5/22 at 2000: Bacl resses found. A copy of the packets th 22 revealed the medications were give reported this was all there was. a.m., the DON reported a State Agence d two packets of medications at the bo- ney found more residents that did not r did not call back. So they assessed the view on 2/2/22 at 2:05 p.m., R10 was in vas soaked. Her dressing on her sacru this time LPN G entered the room to co residents brief about a half hour before which is why her brief was soaked. The ing. m., LPN G reported she had about 27 in tell her they changed the resident and nce to check on the residents catheter	shift and an new dressing to be as to the sacral wound was to be An order for dakins solution to be der for a sacral wound dressing to uard, xeroform, and cover with an PEG tube placement missed 12 treatments. No orders to change wice a day missed 10 treatments revealed : Medication not given por 30 mg, Magnesium Ox 400 mg, ofen 5mg. No statements obtained ese medications were attached to en. No further details to the cy staff member came to the facility teresident and completed an in her room and the CNA finished m was heavily soaked with urine omplete a dressing change. CNA of a lunch and alerted the nurse the e tubing of the catheter had cottag residents this day to care for and reported the catheter may not be

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F 0607	Develop and implement policies an	d procedures to prevent abuse, negled	et, and theft.
Level of Harm - Actual harm	**NOTE- TERMS IN BRACKETS H	AVE BEEN EDITED TO PROTECT C	ONFIDENTIALITY** 37573
Residents Affected - Some	This citation pertains to intake M10	0125723 and M100126630.	
	Based on interview and record review, the facility failed to follow policies and procedures for r admissions, charting, and medications, for 2 (Resident #4 and Resident #10) resulting in gros residents not documented as receiving medications, treatments, services including Activities (ADLs) and one resident readmitted back to the hospital 2 days after admission.		
	Findings include:		
	policy/procedure is to articulate sta identification, investigation protection to provide professional care and se misappropriation of resident proper	A Neglect last revised on 10/14/20 revendards and/or processes for proper scion and reporting relative to any form of ervices in an environment that is free from the ty, exploitation, and corporal punishme bounders to provide goods and services the anguish, or emotional distress.	reening, training, prevention, abuse. It is the policy of this facili om abuse, neglect, ant. Neglect: The failure of the
	defined guidelines for processing the are protected under federal and state Facility and inquire about any imme- intravenous) necessary at time of a systems and complete admission and physician of admission and verify the Confirm diet order, complete diet state immediate Resident special needs physician order. Initiate mediations	s adopted 7/11/18 revealed: It is the po- ne Resident's entry into the nursing fac ate laws. Licensed Nurse Procedure: .1 ediate special needs. 2. Initiate any req admission per transfer orders. 3. Do a c assessment and nursing notes. Include ransfer and admission orders. 5. Order ip and sent to dietary.9. Initiate Reside to CNA's, dietary, therapies, social ser and treatment sheets.13. Note advance d per policy and baseline plan of care i	ility and that the Resident's rights . Welcome Resident and family to uired treatments (oxygen, complete assessment of body a through skin check. 4. Inform medications from pharmacy. 6. ent Care Plan. 10. Communicate vices, ect. 11. Note and initiate ce-directive information. 14. Ensur
	resident, progress toward the care or psychosocial condition, shall be	nd documentation adopted 7/11/18 rev plan goals, or any changes in the resic documented in the resident's medical r he interdisciplinary team regarding the	lent's medical, physical, functional ecord. The medical record should
	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)		

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	235004	B. Wing	02/17/2022
NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE
Skld Muskegon		1061 W Hackley Ave Muskegon, MI 49441	
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F 0607		84 is an [AGE] year old female admitter thmia, acute and chronic respiratory dis	
Level of Harm - Actual harm Residents Affected - Some	Review of the Minimum Data Set (MDS) Discharge assessment dated [DATE] revealed R4 admitted to facility on [DATE] and discharged on [DATE]. Section A2300 indicates R4 MDS Assessment Reference is 1/16/22 and the resident was moderately cognitively impaired.		
	facility from the hospital on 1/14/22 while at the facility. FM A reported a was cognitively intact until this incic FM A reported she called the facilit medications, or water and the facilit facility and they would put her on h and insisted her mother (R4) goes in her cognitive condition. The staff with the staff and insisted again that hospital and when she arrived, she When the resident arrived at the hospital	m., Family Member (FM) A reported he around 3:30 p.m. and did not receive is she dropped off clothing for her mother lent. R4 was then admitted back to the y and complained to the nurse that her ty did not connect R4 to 3 liters of oxyg old and then hang up. FM A reported s back to the hospital after talking to R4 was reluctant to send R4 to the hospit tt R4 goes to the hospital. They finally to was wearing the same clothes that sh spital, there was no discharge paperw .ME] Doe for a few minutes. The reside c coma.	medications, oxygen, food, or water r around that time. The resident hospital on 1/16/22. On 1/15/22 mother has not received any food, gen. FM A reported would call the she talked to the nurse on 1/16/22 on the phone and noticed a change cal and FM A reported she argued transferred the resident to the e was admitted with on 1/14/22. ork from the facility indicating who
	pt (patient) present to ed (emergen (Nursing Facility) and has been una NC (nasal cannula) . Pt is confused oriented x4) per facility. She was di get over the quarantine period, the did not have any of her medications hospital on Friday (1/14/22). It is di able to tell me her name. EKG (elev elevated ammonia . Assessment/P	with an admitted [DATE] revealed Chie cy department) c/o (complaints of) not able to take meds for 2 days. unable to I currently, able to follow commands, p scharged to a skilled nursing facility as patient was staying in a nursing facility s and therefore has not received any m fficult to ascertain the timing of the sym ctrocardiogram) demonstrates sinus ta lan: Altered mental status, Liver cirrhos etabolic disturbance characterized by	feeling well. Pt coming from take lactulose . pt normal on 2L t is normally AXO 4 (alert and the caregiver has COVID and to v. Unfortunately the nursing facility nedication since discharge from the aptoms, but the patient is altered, chycardia (fast heart rate) and sis secondary to NASH
	presents from (Nursing Home) second received her liver medications inclu (Hospital) on 1/14/2022. Unfortunal pharmacological administration of v	tory and Physical document dated 1/16 ondary to alteration of mental status. R ding lactulose, Aldactone, rifaximin, La tely it appears that as previously menti which is the likely culprit as the patient! liters nasal canula . 1. Hepatic Encept	eportedly the patient has not asix since she was discharged from oned there was an interruption in s ammonia level was elevated.

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 SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Skld Muskegon		1061 W Hackley Ave Muskegon, MI 49441		
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)	
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 hel 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.			
Residents Allected - Solile	Review of the Electronic Medical Record revealed some of the Orders for R4 were docum 1/15/22 at 2000 (8:00 p.m.) which included but not limited to Xifaxan 550 milligram (mg) ta encephalopathy, spironolactone 25 mg twice a day for high blood pressure, amiodarone 2 2 tablets by mouth every morning ad at bedtime for HF (heart failure), furosemide 40 mg or edema, lactulose solution 20 grams twice a day for encephalopathy, and metoprolol 25 mg 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.			
	facility, no admission assessment,	dical Record) revealed no documentation o documentation the physician was no care plans, no skin assessments, no m	otified, no pharmacy notification of	
	9:28 a.m. for R4 revealed: Residen documented in the EMR indicating	ogress Note backdated for 1/15/22 at 9 t received morning medications by pap where these medications came from, it ons or if the pharmacy was contacted.	er MAR from nurse. Nothing	
	closed at this time, O2 (oxygen) on Pharmacy contacted and STAT (fa	e dated 1/15/22 at 11:51 p.m. for R4 rev as ordered. Meds available in back up st as possible) delivery of all other med d of missed doses of medications or ar	pulled and given at (bedtime). Is requested. No documentation	
	Review of a General Progress note m.	e dated 1/16/22 revealed R4 went to the	e hospital at approximately 9:20 a.	
	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 R received no assistance with care a	4 received at the facility from 1/14/22 t nd no meals were documented.	o 1/16/22 revealed the resident	
	(continued on next page)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0607 Level of Harm - Actual harm Residents Affected - Some	caught up on any medical records in any records for R4 not scanned into were in the computer and was goin discharge summary/order from the skilled charting document for R4. M During an interview on 2/3/22 at 10 shift and did not verify the admission from the tackle box that had medica would not have to come out of the 0 In an interview on 2/3/22 at 10:45 at of 1/14/22 did not do an initial assee by the Attorney Generals (AG) Office instructed to freeze the electronic in altered at that point. When they been had an assessment printed out and together to be put in the Administrat 1/14/22 but reported RN D did put to were aware of the allegation, they no tackle box on the COVID unit with of to the Cubex that was off of the CC list of the medications that were in the medications that were common to the given to R4. The DON then reported signed as given on the hospital disc In an interview on 2/3/22 at 11:00, to them on 1/20/22 and told her of the that there is an allegation of neglect computer for R4 because the recorn handwritten assessments and hosp on duty when R4 was in the buildin	a.m. the DON still could not verify where	er. When questioned if there were was pretty sure all the records MR F provided a soft file with a ion assessment and a handwritten lministrator's office. of R4 on 1/15/22 during the day orted she got medications for R4 he COVID unit. This was so they Cubex. orted RN E who worked the night e facility. The facility was informed regarding R4s care and they were ation was to be added, removed, or R4's care, the DON reported she s a late entry, then put a file not get any medications on Friday ay. The DON reported once they he DON confirmed there was a hs so they would not have to go out dents. The DON later provided a D unit, but the list only included ations or any medications that were e medications that the nurse m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2022
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For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0607 Level of Harm - Actual harm Residents Affected - Some	New Admit place holder information nurse called the pharmacy for STA' night of 1/15/22 to the facility. Amio PM B reported they had no record of was there. If she did receive medic pharmacy receives the information facility used the old tackle box appr written out with the residents' inform there were no medications charged received medications to be charged In an interview on 2/7/22 at 4:15 p.1 admission documentation for R4 wl another resident who arrived 10 mii day shift that day and started at 6:0 and their documentation. LPN M re just recently arrived to the facility. T LPN M reported R4 arrived around made sure she had a meal tray and arrived or received services. In an interview on 2/8/22 at 8:49 a.1 1/15/22 that R4 was in the facility. S noticed R4 was in the room too. RN RN D reported she filled out an ass signed it as a late entry for 1/20/22. filled out by hand and put into a sof out reflected the date of 1/15/22 wf down and someone else completed back to finish the admission docum the desk for R4 and when she oper queried about how R4 got her med story from earlier when she reporte COVID unit. She said she got the m she gave R4 did not show up in the the medications were not documen for the resident's next dose. So she gave her amiodarone, apixaban, fe protonix, and spironolactone at 9:30 took the lactulose from another resi from the Cubex for R4, no documen	view on 2/7/22 at 11:38 a.m., Pharmacian was sent to them via EMR at the Nurr T medications and again at 9:32 p.m. N darone and xifaxan was delivered to the of R4 being charged for any medication ations, she would have been charged for when a resident gets medications, then the nation and sent to the pharmacy for a con- to providing medications, then the nation and sent to the pharmacy for a con- to the resident or any proof provided to d. m., Licensed Practical Nurse (LPN) M in the arrived to the facility on [DATE] bec- nutes before R4 arrived at the facility. I 00 a.m. and worked until 9:30 p.m. to co- ported RN E worked the second shift the then about an hour later another new a dinner time, and she just helped get the d she was safe. There is no documenta m., RN D reported she did not get infor She became aware once she passed in N D reported her name was not on the in- essment for R4 after the resident had or the top portion. RN D reported that Ri- entation for R4 on 1/15/22. RN D repor- ted it, she was able to see what medic ications and why they were not charted d she got the medications out of the spin edications out of the Cubex. RN D con- e Cubex log as a medication dispensed ted in the EMAR, RN D reported is war e signed the paper hospital medication rrous sulfate, furosemide, lactulose, lou 0 a.m. on 1/15/22. When queried about intation provided by the pharmacy to pri- the resident received these medications in the provided by the pharmacy to pri- the resident received these medications	sing Facility. At 8:32 p.m., the No medications were delivered the the facility on [DATE] at 8:40 a.m. hs received by the facility while she or them or should have been. The the Cubex. PM B reported if the ere should be a slip that would be charge. At the time of this interview to the Pharmacy that this resident reported that she did not complete ause she was already admitting PN M reported she worked the omplete her other two admissions his day and reported to him that R- idmission came in to the facility. ar get settled into the room and tion in the EMR that this resident mation during report the morning of hedications to her roommate and report sheet or on the census list. discharged from the facility and idents' medical records and was reported the assessment she fille d she only filled out part B and N E told her he was going to come rted the admission packet was on ations the resident needed. When the EMR, RN D changed her becial tackle box that was for the uld not explain why the medication in R4s name. When queried why is because the timing would be off discharge orders for R4 that she ratadine, metoprolol, oxygen, t the lactulose, RN D reported she cations showed up as dispensed ove these medications were given

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NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0607 Level of Harm - Actual harm Residents Affected - Some	R4 and got the lactulose from anoth from the other resident. The DON rep Cubex. The DON did not know why in the Cubex. The DON reported sh protect her since she is a witness p medication was taken from. During an interview and record revi and R4 was already in the building to the resident and did a quick asse in the computer. Could not recall if called the physician or left a messa resident that occupied much of his had him fill out a handwritten asses showed 1/15/22, but verified it was could remember. These documents reported he did not chart much that In an interview on 2/15/22 at 12:00 care of R4 that day. RN C was not resident's daughter had called with admitted to the facility on [DATE]. F (1/15/22) and was told that RN E w was there this night and thought he EMAR were documented as given, apixaban, lactulose, and spironolad Cubex but not the lactulose. No oth indicating the physician was notified In an interview on 2/16/22 at 9:22 a assessment, and another Registerer residents based on the information shows R4 admitted to the facility or nursing assessment as well to assis portions of the assessments. LPN N other sections, but the social worker Review of several witness statement backing up services and goods pro physician contact, pharmacy contact	p.m., RN C reported she worked the sesure if R4 received medications earlier concerns that R4 had not received any RN C reviewed the chart and it looked I ras going to complete the admission do a was completing the paperwork. RN C then she gave the medications. The metone. Two of the medications were shown medications were documented as g d.	replaced the medication taken in the Cubex if medications were ulled R4s medication from the resident when the lactulose is also ecause the facility is trying to the resident was that the rted he worked the night of 1/14/22 hour later. He introduced himself light but did not document anything of a meal. Could not recall if he at night was busy and had another reported the DON and the NHA ugh the date on one document scharged and filled out what he if file in the NHAs office. RN E econd shift on 1/15/22 and took that day but was informed that the <i>y</i> medication since she was ike she was admitted that day cumentation for the resident. RN E reported if the medications on the edications documented are own to be dispensed from the iven and no documentation she completed the MDS she gathers information about the e census line on this day still ted she utilizes the admission nile other disciplines will fill out thei e of the areas she fills out among ack of documentation in R4's EMR r trail of events, assessments,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informat	ion)
F 0635	Provide doctor's orders for the resid	dent's immediate care at the time the r	esident was admitted.
Level of Harm - Actual harm	**NOTE- TERMS IN BRACKETS H	AVE BEEN EDITED TO PROTECT C	ONFIDENTIALITY** 37573
Residents Affected - Few	This citation pertains to intake M10	0125723 and M10026630.	
	immediate care for 1 (Resident #4)	and procedures for a new admission a , resulting in the resident not having ar tened a readmission to the hospital tw	ny orders for medications, dietary,
	Findings include:		
	Facility and inquire about any imme- intravenous) necessary at time of a systems and complete admission a physician of admission and verify tr Confirm diet order, complete diet sl immediate Resident special needs physician order. Initiate mediations that admission forms are completed	tte laws. Licensed Nurse Procedure: .1 adiate special needs. 2. Initiate any rec dmission per transfer orders. 3. Do a d ssessment and nursing notes. Include ansfer and admission orders. 5. Order ip and sent to dietary.9. Initiate Reside to CNA's, dietary, therapies, social ser and treatment sheets.13. Note advand d per policy and baseline plan of care i	uired treatments (oxygen, complete assessment of body a through skin check. 4. Inform medications from pharmacy. 6. ent Care Plan. 10. Communicate vices, ect. 11. Note and initiate ce-directive information. 14. Ensure nitiated.
	resident, progress toward the care or psychosocial condition, shall be	nd documentation adopted 7/11/18 rev plan goals, or any changes in the resid documented in the resident's medical in he interdisciplinary team regarding the	lent's medical, physical, functional, record. The medical record should
	Pharmacy only upon receipt of a cle	ion Orders, Policy 2.1 revealed: Medic ear, complete order, signed by an auth em and/or eMAR should refer to speci	orized licensed prescriber. facilities
	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)		

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	235004	A. Building B. Wing	02/17/2022
NAME OF PROVIDER OR SUPPLIE	R	STREET ADDRESS, CITY, STATE, ZI	P CODE
Skld Muskegon		1061 W Hackley Ave Muskegon, MI 49441	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying informati	on)
F 0635 Level of Harm - Actual harm Residents Affected - Few	facility from the hospital on 1/14/22 while at the facility. FM A reported a was cognitively intact until this incic FM A reported she called the facilit medications, or water and the facilit facility and they would put her on h and insisted her mother (R4) goes l in her cognitive condition. The staff with the staff and insisted again tha hospital and when she arrived, she When the resident arrived at the ho the resident was, so she was a [NA FM A reported she was in a hepatic Review of Hospital Records for R4 pt (patient) present to ed (emergen (Nursing Facility) and has been una NC (nasal cannula) . Pt is confused oriented x4) per facility. She was di get over the quarantine period, the did not have any of her medications hospital on Friday (1/14/22). It is dit able to tell me her name. EKG (eler elevated ammonia . Assessment/PI (CMS/HCC), Hyperammonemia (m Review of an Internal Medicine Hist presents from (Nursing Home) seco received her liver medications inclu (Hospital) on 1/14/2022. Unfortunal pharmacological administration of w Outpatient medications: . oxygen 3 Review of Hospital Discharge Ther- with Activities of Daily Living (ADLs	m., Family Member (FM) A reported he around 3:30 p.m. and did not receive r she dropped off clothing for her mother lent. R4 was then admitted back to the y and complained to the nurse that her ty did not connect R4 to 3 liters of oxyg old and then hang up. FM A reported s back to the hospital after talking to R4 of was reluctant to send R4 to the hospit t R4 goes to the hospital. They finally t was wearing the same clothes that shi spital, there was no discharge paperwi. ME] Doe for a few minutes. The reside c corna. with an admitted [DATE] revealed Chie cy department) c/o (complaints of) not able to take meds for 2 days. unable to a currently, able to follow commands, p scharged to a skilled nursing facility as patient was staying in a nursing facility as and therefore has not received any m ficult to ascertain the timing of the sym ctrocardiogram) demonstrates sinus tar lan: Altered mental status, Liver cirrhos etabolic disturbance characterized by a tory and Physical document dated 1/16 ondary to alteration of mental status. R ding lactulose, Aldactone, rifaximin, La lely it appears that as previously mentity which is the likely culprit as the patient's liters nasal canula . 1. Hepatic Enceph apy documentation dated 1/14/22 for R a) and contact guard for toileting. At this remities as well as requiring some cont	nedications, oxygen, food, or water around that time. The resident hospital on 1/16/22. On 1/15/22 mother has not received any food, en. FM A reported would call the he talked to the nurse on 1/16/22 on the phone and noticed a change al and FM A reported she argued ransferred the resident to the e was admitted with on 1/14/22. ork from the facility indicating who ent was admitted to the hospital and ef Complaint: Altered Mental Status feeling well. Pt coming from take lactulose . pt normal on 2L t is normally AXO 4 (alert and the caregiver has COVID and to . Unfortunately the nursing facility edication since discharge from the ptoms, but the patient is altered, chycardia (fast heart rate) and is secondary to NASH an excess of ammonia in the blood). #/22 for R4 revealed: Patient eportedly the patient has not six since she was discharged from oned there was an interruption in a ammonia level was elevated. ialopathy.

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	ER	STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave	P CODE	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)	
F 0635 Level of Harm - Actual harm Residents Affected - Few	1/15/22 at 2000 (8:00 p.m.) which i encephalopathy, spironolactone 25 2 tablets by mouth every morning a edema, lactulose solution 20 grams	the Electronic Medical Record revealed some of the Orders for R4 were documented to start on 2000 (8:00 p.m.) which included but not limited to Xifaxan 550 milligram (mg) tablet twice a day for pathy, spironolactone 25 mg twice a day for high blood pressure, amiodarone 200 mg tablets- giv y mouth every morning ad at bedtime for HF (heart failure), furosemide 40 mg once a day for stulose solution 20 grams twice a day for encephalopathy, and metoprolol 25 mg once a day for pressure. All orders were dated to start on 1/15/22 and 1/16/22.		
	documented as given to R4 on 1/14 of oxygen via nasal canula are doc verified lactulose was available or o	n Administration Record (EMAR) revea 4/22. On 1/15/22 doses of apixaban, la umented as given. There is no docume on hand to administer to R4. The other ication dispenser) log on 1/15/22 at 8:3	ctulose, spironolactone, and 3 liters entation or resources available that two medications are verified they	
	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.			
	9:28 a.m. for R4 revealed: Residen documented in the EMR indicating	ogress Note backdated for 1/15/22 at 9 t received morning medications by pap where these medications came from, it ons or if the pharmacy was contacted.	er MAR from nurse. Nothing	
	closed at this time, O2 (oxygen) on Pharmacy contacted and STAT (fa:	e dated 1/15/22 at 11:51 p.m. for R4 rev as ordered. Meds available in back up st as possible) delivery of all other med d of missed doses of medications or ar	pulled and given at (bedtime). Is requested. No documentation	
	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)			
	1			

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NAME OF PROVIDER OR SUPPLIER Skild Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey a	agency.
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F 0635 Level of Harm - Actual harm Residents Affected - Few	caught up on any medical records i any records for R4 not scanned inti- were in the computer and was goin discharge summary/order from the skilled charting document for R4. M During an interview on 2/3/22 at 10 shift and did not verify the admission from the tackle box that had medical would not have to come out of the 4 In an interview on 2/3/22 at 10:45 at of 1/14/22 did not do an initial assee by the Attorney Generals (AG) Offic instructed to freeze the electronic in altered at that point. When they be had an assessment printed out and together to be put in the Administra 1/14/22 but reported RN D did put were aware of the allegation, they be tackle box on the COVID unit with of to the Cubex that was off of the CC list of the medications that were in medications that were common to the given to R4. The DON then reported signed as given on the hospital disc In an interview on 2/3/22 at 11:00, to them on 1/20/22 and told her of that there is an allegation of negled computer for R4 because the recor handwritten assessments and hosp on duty when R4 was in the buildin	a.m. the DON still could not verify where	er. When questioned if there were was pretty sure all the records MR F provided a soft file with a ion assessment and a handwritten lministrator's office. of R4 on 1/15/22 during the day orted she got medications for R4 he COVID unit. This was so they Cubex. orted RN E who worked the night e facility. The facility was informed regarding R4s care and they were ation was to be added, removed, or R4's care, the DON reported she s a late entry, then put a file not get any medications on Friday ay. The DON reported once they he DON confirmed there was a hs so they would not have to go out dents. The DON later provided a D unit, but the list only included ations or any medications that were e medications that the nurse m.

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For information on the nursing home's	plan to correct this deficiency, please con	l tact the nursing home or the state survey	agency.
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F 0635 Level of Harm - Actual harm Residents Affected - Few	New Admit place holder information nurse called the pharmacy for STA' night of 1/15/22 to the facility. Amio PM B reported they had no record of was there. If she did receive medic pharmacy receives the information facility used the old tackle box appr written out with the residents' inform there were no medications charged received medications to be charged In an interview on 2/7/22 at 4:15 p.1 admission documentation for R4 will another resident who arrived 10 mii day shift that day and started at 6:0 and their documentation. LPN M re just recently arrived to the facility. T LPN M reported R4 arrived around made sure she had a meal tray and arrived or received services. In an interview on 2/8/22 at 8:49 a.1 1/15/22 that R4 was in the facility. S noticed R4 was in the room too. RN RN D reported she filled out an ass signed it as a late entry for 1/20/22. filled out by hand and put into a sof out reflected the date of 1/15/22 wf down and someone else completed back to finish the admission docum the desk for R4 and when she oper queried about how R4 got her medi story from earlier when she reporte COVID unit. She said she got the m she gave R4 did not show up in the the medications were not documen for the resident's next dose. So she gave her amiodarone, apixaban, fe protonix, and spironolactone at 9:30 took the lactulose from another resi from the Cubex for R4, no documen	view on 2/7/22 at 11:38 a.m., Pharmacian was sent to them via EMR at the Nur- T medications and again at 9:32 p.m. N adarone and xifaxan was delivered to the of R4 being charged for any medication ations, she would have been charged for when a resident gets medications, then the nation and sent to the pharmacy for a con- to the resident or any proof provided to d. m., Licensed Practical Nurse (LPN) M if ho arrived to the facility on [DATE] bec- nutes before R4 arrived at the facility. If 00 a.m. and worked until 9:30 p.m. to co- ported RN E worked the second shift to "hen about an hour later another new a dinner time, and she just helped get he d she was safe. There is no documenta m., RN D reported she did not get infor She became aware once she passed in N D reported her name was not on the essment for R4 after the resident had of the top portion. RN D reported that R leensthor for R4 on 1/15/22. RN D repor- ted the top portion. RN D reported that R leentation for R4 on 1/15/22. RN D repor- ied it, she was able to see what medic ications and why they were not charted d she got the medications out of the sp nedications out of the Cubex. RN D cop- ned it, she was able to see what medic ications and why they were not charted d she got the medication dispensed ted in the EMAR, RN D reported is was a signed the paper hospital medication rrous sulfate, furosemide, lactulose, lou 0 a.m. on 1/15/22. When queried abou ident to give to R4 None of these medi- intation provided by the pharmacy to pr he resident received these medications	sing Facility. At 8:32 p.m., the No medications were delivered the he facility on [DATE] at 8:40 a.m. hs received by the facility while she or them or should have been. The he the Cubex. PM B reported if the ere should be a slip that would be charge. At the time of this interview to the Pharmacy that this resident reported that she did not complete ause she was already admitting _PN M reported she worked the omplete her other two admissions his day and reported to him that R- idmission came in to the facility. er get settled into the room and tion in the EMR that this resident mation during report the morning of hedications to her roommate and report sheet or on the census list. discharged from the facility and sidents' medical records and was preported the assessment she fille d she only filled out part B and N E told her he was going to come rted the admission packet was on ations the resident needed. When d in the EMR, RN D changed her becial tackle box that was for the uld not explain why the medication in R4s name. When queried why s because the timing would be off discharge orders for R4 that she ratadine, metoprolol, oxygen, t the lactulose, RN D reported she cations showed up as dispensed ove these medications were given.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)
F 0635 Level of Harm - Actual harm Residents Affected - Few	R4 and got the lactulose from anoth from the other resident. The DON rep Cubex. The DON did not know why in the Cubex. The DON reported sh protect her since she is a witness p medication was taken from. During an interview and record revi and R4 was already in the building to the resident and did a quick asse in the computer. Could not recall if called the physician or left a messa resident that occupied much of his had him fill out a handwritten asses showed 1/15/22, but verified it was could remember. These documents reported he did not chart much that In an interview on 2/15/22 at 12:00 care of R4 that day. RN C was not resident's daughter had called with admitted to the facility on [DATE]. F (1/15/22) and was told that RN E w was there this night and thought he EMAR were documented as given, apixaban, lactulose, and spironolad Cubex but not the lactulose. No oth indicating the physician was notified In an interview on 2/16/22 at 9:22 at assessment, and another Registerer residents based on the information shows R4 admitted to the facility or nursing assessment as well to assi portions of the assessments. LPN I other sections, but the social worker Review of several witness statements backing up services and goods pro physician contact, pharmacy contact	p.m., RN C reported she worked the s sure if R4 received medications earlier concerns that R4 had not received any RN C reviewed the chart and it looked if as going to complete the admission do was completing the paperwork. RN C then she gave the medications. The m tone. Two of the medications were sho ner medications were documented as g d. m.m., MDS Coordinator LPN N reported ad Nurse signed off on it. She reported put into the computer. She reported the IDATE] and not 1/14/22. LPN N reported st in filling out the MDS assessment with reported section A and G are a coupl	replaced the medication taken in the Cubex if medications were ulled R4s medication from the resident when the lactulose is also ecause the facility is trying to the resident was that the rted he worked the night of 1/14/22 hour later. He introduced himself light but did not document anythin jot a meal. Could not recall if he at night was busy and had another reported the DON and the NHA ugh the date on one document scharged and filled out what he if file in the NHAs office. RN E econd shift on 1/15/22 and took that day but was informed that the <i>y</i> medication since she was like she was admitted that day cumentation for the resident. RN E reported if the medications on the redications documented are own to be dispensed from the iven and no documentation she completed the MDS she gathers information about the e census line on this day still ted she utilizes the admission nile other disciplines will fill out theil e of the areas she fills out among ack of documentation in R4's EMR r trail of events, assessments,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2022
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		on)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an a **NOTE- TERMS IN BRACKETS H This citation pertains to intake M100 Based on interview and record revis Set (MDS) Assessment for 1 (Resid appropriate date and no assessment Findings include: Review of a Face Sheet revealed R pertinent diagnoses of cardiac arryf Review of the Minimum Data Set (N facility on [DATE] and discharged of is 1/16/22 and the resident was mo In an interview on 2/1/22 at 1:20 p.1 facility from the hospital on 1/14/22 while at the facility. FM A reported she was cognitively intact until this incide FM A reported she called the facility medications, or water and the facility they would put her on hold and then (R4) goes back to the hospital after condition. The staff was reluctant to insisted again that R4 goes to the h arrived, she had the same clothes of resident arrived at the hospital, then resident was, so she was a [NAME] A reported she was in a hepatic cor Review of Hospital Records for R4 (pt (patient) present to ed (emerger (Nursing Facility) and has been una NC (nasal cannula), BS (blood sug AXO 4 (alert and oriented x4) per fa has COVID and to get over the qua the nursing facility did not have any discharge from the hospital on Frida altered, able to tell me her name. E	AVE BEEN EDITED TO PROTECT CO 0125723 and M10026630. ew, the facilty failed to complete and su dent #4), resulting in the resident not re- int completed to accurately reflect the re- the completed to accurately reflect the re- around 3:30 p.m. and did not receive re- she dropped off clothing for her mother lent. R4 was then admitted back to the y and complained to the nurse that her ty did not connect R4 to 3 liters of oxygon in hang up. FM A reported she talked to to talking to R4 on the phone and notice- to send R4 to the hospital and FM A rep- pospital. They finally transferred the res- on that she was admitted to the Nursing re was no discharge paperwork from the l Doe for a few minutes. The resident v ma. with an admitted [DATE] revealed Chies accility. She was discharged to a skilled rantine period, the patient was staying of her medications and therefore has ay. It is difficult to ascertain the timing of KG (electrocardiogram) demonstrates nt/Plan: Altered mental status, Liver ci	DNFIDENTIALITY** 37573 ubmit and accurate Minimum Data aported as being admitted on the esident. d to the facility on [DATE] with sease, and heart failure. ATE] revealed R4 admitted to the MDS Assessment Reference data r mother (R4) admitted to the medications, oxygen, food, or water around that time. The resident hospital on 1/16/22. On 1/15/22 mother has not received any food en. She would call the facility and o the nurse and insisted her mother d a change in her cognitive orted she argued with the staff and ident to the hospital and when she g Home on 1/14/22. When the e facility indicating who the vas admitted to the hospital and FN ef Complaint: Altered Mental Status feeling well. Pt coming from take lactulose . pt normal on 2L o follow commands, pt is normally nursing facility as the caregiver in a nursing facility. Unfortunately not received any medication since of the symptoms, but the patient is sinus tachycardia (fast heart rate) rhosis secondary to NASH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIE Skid Muskegon		(X2) MULTIPLE CONSTRUCTION       (X3) DATE SURVEY         A. Building       COMPLETED         B. Wing       02/17/2022         STREET ADDRESS, CITY, STATE, ZIP CODE         1061 W Hackley Ave         Muskegon, MI 49441	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	tact the nursing home or the state survey a EIENCIES 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 His (Nursing Home) secondary to altera medications including lactulose, Alo 1/14/2022. Unfortunately it appears pharmacological administration of v Outpatient medications: . oxygen 3 Review of Hospital Therapy docum Activities of Daily Living (ADLs) and weakness in upper extremities as v Review of the Electronic Medical R 1/15/22 at 2000 (8:00 p.m.) which it encephalopathy, spironolactone 25 2 tablets by mouth every morning a edema, lactulose solution 20 grams high blood pressure. Orders were c Review of a General Progress note m. Review of a Nursing Skilled Chartin 7:45 p.m. revealed the resident was In an interview on 2/7/22 at 4:15 p.1 to the facility on [DATE] because sh LPN M reported she worked the da other admission and documentation him of R4 admitting to the facility an	tory and Physical dated 1/16/22 for R4 ation of mental status. Reportedly the p dactone, rifaximin, Lasix since she was that as previously mentioned there wa which is the likely culprit as the patient's liters nasal canula . 1. Hepatic Enceph entation dated 1/14/22 for R4 revealed d contact guard for toileting. At this time well as requiring some continued assistance ecord revealed some of the Orders for included but not limited to Xifaxan 550 r mg twice a day for high blood pressure d at bedtime for HF (heart failure), furo is twice a day for encephalopathy, and r	revealed: Patient presents from batient has not received her liver discharged from (Hospital) on as an interruption in a sammonia level was elevated. halopathy. If she required some help with e she demonstrated generalized ance with activities of daily living. R4 were documented to start on milligram (mg) tablet twice a day for e, amiodarone 200 mg tablets- give bsemide 40 mg once a day for metoprolol 25 mg once a day for e hospital at approximately 9:20 a. 40 p.m. and locked on 1/15/22 at tted. reported that she did not admit R4 ent when R4 arrived at the facility. rked until 9:30 p.m. to complete her econd shift this day and reported to mission came to the facility. LPN M

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. Building	(X3) DATE SURVEY COMPLETED
	235004	B. Wing	02/17/2022
NAME OF PROVIDER OR SUPPLIE Skid Muskegon	R	STREET ADDRESS, CITY, STATE, ZI 1061 W Hackley Ave Muskegon, MI 49441	P CODE
For information on the nursing home's	plan to correct this deficiency, please cont	act the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying information	on)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	became aware once she passed m reported her name was not on the r for R4 after the resident had discha document was not part of the reside the administrator's office. RN D rep care of her. RN D reported she only back to finish the admission docum and she opened it to find out what r medications and why they were not earlier when she reported she got t She said she got the medications o R4 did not show up in the Cubex lo medications were not documented off for the resident's next dose. So a gave her amiodarone, apixaban, fe protonix, and spironolactone at 9:30 took the lactulose from another resi from the Cubex for R4. During an interview and record revi and R4 was already in the building to the resident and did a quick asses in the computer. Could not recall if called the physician or left a messa resident that occupied much of his had him fill out a handwritten assess showed 1/15/22, but verified it was could remember. These documents he did not chart much that night bear In an interview on 2/15/22 at 12:00 care of R4 that day. RN C was not resident's daughter had called with the facility. RN C reviewed the char RN E was going to complete the ac thought he was completing the pap as given, then she gave the medica	p.m., RN C reported she worked the se sure if R4 received medications earlier concerns R4 had not received any mer t and it looked like she was admitted th mission documentation for the residen erwork. RN C reported if the medicatio tions. The medications documented ar ions were shown to be dispensed from	d R4 was in the room too. RN D ported she filled out an assessment a late entry for 1/20/22. This t by hand and put into a soft file in I the date of 1/15/22 when she took rted that RN E was going to come packet was on the desk for R4 in queried about how R4 got her rd, RN D changed her story from e box that was for the COVID unit. In why the medications she gave ume. When queried why the s was because the timing would be on discharge orders for R4 that she ratadine, metoprolol, oxygen, t the lactulose, RN D reported she ications showed up as dispensed rted he worked the night of 1/14/22 hour later. He introduced himself light but did not document anything jot a meal. Could not recall if he at night was busy and had another E reported the DON and the NHA ugh the date on one document scharged and filled out what he in the NHAs office. RN E reported econd shift on 1/15/22 and took that day but was informed that the dication since she was admitted to nat day (1/15/22) and was told that t. RN E was there this night and ns on the MAR were documented re apixaban, lactulose, and

NAME OF PROVIDER OR SUPPLIER         STREET ADDRESS, CITV, STATE, ZIP CODE           Skid Muskegon         1001 W Hackley Ave           Tor information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.         (X4) ID PREFIX TAC           SUMMAPY STATEMENT OF DEFICIENCES         Each deficiency must be preceeded by full regulatory or LS0 identifying information)           F 0641         Level of Harm - Minimal harm or potential for actual harm         In an interview on 2/16/22 at 9/22 a.m., MDS Coordinator LPN N reported she completed the MDS assessment as well assign finging out the MDS assessment while aber utilizes the admitted to the facility on [UATE] and not 1/14/22. LPN N reported she completes the cansus line on this day still shows R4 admitted to the facility on [UATE] and not 1/14/22. LPN N reported she utilizes the admitsion nursing assessment as well on the MDS assessment while aber utilizes the admitsion of the assessment while aber and the profess assessment while aber and the profess assessment while aber altings on the MDS assessment while aber altings on the MDS assessment while aber altings on the must assessment while aber altings on the MDS assessment while aber altings on the must assessment while aber altings on the MDS assessment while aber altings on the MDS assessment while aber altings on the MDS assessment while aber altings on the assessment while aber altings on the must assessment while aber altings on the must assessment while aber altings and the information profess the actions. Such as exercises the fills out among other sections. Dut the social workers fill out section C for cognition.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2022
(X4) ID PREFIX TAG       SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)         F 0641       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 Affected - Few         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		R	1061 W Hackley Ave	P CODE
F 0641       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	For information on the nursing home's	plan to correct this deficiency, please cont	act the nursing home or the state survey a	agency.
Level of Harm - Minimal harm or potential for actual harmassessment, 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	(X4) ID PREFIX TAG			on)
	Level of Harm - Minimal harm or potential for actual harm	In an interview on 2/16/22 at 9:22 a assessment, and another Registerer residents based on the information shows R4 admitted to the facility on nursing assessment as well to assis portions of the assessments. LPN N	.m., MDS Coordinator LPN N reported ad Nurse signed off on it. She reported put into the computer. She reported the [DATE] and not 1/14/22. LPN N repor st in filling out the MDS assessment wh I reported section A and G are a coupl	she completed the MDS she gathers information about the e census line on this day still ted she utilizes the admission hile other disciplines will fill out their

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235004	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/17/2022
NAME OF PROVIDER OR SUPPLI	FR	STREET ADDRESS, CITY, STATE, ZI	P CODF
Skld Muskegon		1061 W Hackley Ave Muskegon, MI 49441	
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	ion)
F 0689 Level of Harm - Minimal harm or potential for actual harm	accidents.	Free from accident hazards and provid	
Residents Affected - Few	This citation pertains to intake M100126050 and M100125909. Based on observation, interview and record review, the facility failed to adequately supervise the dining room and 2 (Resident #1 and Resident #2), resulting in an unsupervised dementi- to wander have unwanted/inappropriate contact with another resident and an unwitnessed fa investigation or appropriate interventions in place, and dependent residents in the dining roo 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.		
		MDS) dated [DATE] revealed R1 is cog cares and transfers. This resident is no	
	Resident #2 (R2)		
	Review of a Face Sheet revealed F history of falling, and cognitive com	R2 admitted to the facility on [DATE] wi munication deficit.	th pertinent diagnoses of dementia
	Review of the MDS dated [DATE] revealed R2 is moderately cognitively impaired and required supervision and oversight or cueing when ambulating.		
	and would not leave when she ask while FM P was on the phone with would repeatedly ask him to leave resident would ask her for food tha (Nursing Home Administrator) abou mother. FM P reported she was no	lember (FM) P reported a male resider ed him to leave. Another day R1 told th R1. The male resident had been doing or try to ignore him, and he still would n t is on her tray or start talking to her. Fl ut her concerns and about the male res t sure if staff would see him go into her reported she talked to the police about	he male resident to leave 3-4 times that for some time and her mother not leave her room. The male M P reported she talked to the NHA sident sexually assaulting her mother's room because there is
	(continued on next page)		

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	235004	B. Wing	02/17/2022
NAME OF PROVIDER OR SUPPLIER Skid Muskegon		STREET ADDRESS, CITY, STATE, ZIP CODE 1061 W Hackley Ave Muskegon, MI 49441	
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		I <b>ENCIES</b> full regulatory or LSC identifying information)	
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<ul> <li>said she was calling out for help. R he said he was a masseuse. R1 rep contacted, and a police report was confusion and admitted he massag police that she wanted to press cha the hallway and in his room ambula interviews revealed the facility did r this resident or other residents wan</li> <li>Review of the Police report dated 1 room and touched her ankles, leg a Both (R1 and R2) statements were (R2) rubbed her vagina and area an appropriate steps to keep (R2) sept to go to the hospital or have a phys</li> <li>In an interview on 2/14/22 at 10:25 of other residents' rooms, just in the In an interview on 2/14/22 at 12:30 would change her stories often. R1 workers, but SW U followed up with was deemed incompetent. He was timid during his support visits. After incident. When R2 would walk out or recall R2 wandering into other reside plan.</li> <li>In an interview on 2/14/22 at 1:12 p tried to re enact the situation and cr from where he was standing. SW L the incident and told SW U he didn' hurting, both residents confirmed he When R1 told R2 to stop, he did. S' before.</li> <li>During an observation and an inter- supervision. He could not recall the Assistant (CNA) W reported the residents</li> </ul>	ent dated 1/14/22 revealed R2 entered 2 touched her foot then touched her leg ported he touched her peritoneal area a filed. R1 declined to go to the hospital ed R1s leg and said he was worried if s arges. Review of staff statements revea ting without his walker and was unstea tot ask other residents pertinent and m dered in and out of their rooms or touc /14/22 revealed R1 and R2 had consis and right thigh, but R2 denies touching quite consistent. The only inconsistence round it. (R2) denies this. (The Nursing arated from (R1), possibly by moving (f ician examine her, but is pursuing to pr a.m., the DON reported she did not rere hall. p.m., Social Worker (SW) T reported F just seemed unhappy overall. The faci in her after the sexual allegations. R2 w shaken up by the police after the sexual a few support visits he would talk about of his room he appeared to be lost but vi- lent rooms', but he did wander. SW T r m., SW U reported he followed up witt poncluded it was physically impossible for reported that R1 then changed her sto t do anything wrong. SW U reported w e said he was a therapist or something W U reported R1 had not made any all view on 2/2/22 at 1:36 p.m., R2 was ob incident with R1 and made non sensio ident will make inappropriate comment and he has been a 1:1 for cares for about	g. R1 asked if he was a doctor and and he declined. The police were for an evaluation. R2 had some she was okay. R1 reported to the led the resident was observed in ady. Review of other resident eaningful questions to address if hed them. tent stories that R2 entered R1s R1's vaginal area. Disposition: cy was the (R1's) allegation that Facility) is going to take the R1) to a different room. R1 refused ress charges. member R2 wandering in and out R1 had a history of behaviors and lity has had a change in social as a very confused resident who al allegation incident and appeared ut other things and not recall the was easily redirected. SW T did not eported she added it to his care h R1 post sexual allegation and or R2 to reach her vaginal area ory. R2 was very distraught after hen R1 complained of her feet and R2 used to do that in the past. egations of this kind during her stay eserved in bed in his room with 1:1 cal conversation. Certified Nursing ts to staff at times but does not

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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICE (Each deficiency must be preceded by f		CIENCIES full regulatory or LSC identifying informati	on)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	noted. R1 has a care plan initiated mood concern related to a history of supervision for safety implemented	ealed no care plan for dementia noted. on 12/22/21 and revised on 1/19/22 wi of auditory and visual hallucinations, wa on 1/14/22. The resident is also care p and gait belt. R2 is also care planned for	th a focus that the resident has anders into other rooms. Increased planned for assistance of one staff
	Description: upon arrival to residen under head, reported from CNA wh attempting to get up from wheel cha cause, no staff statements, no neur In an interview on 2/14/22 at 10:25	I 1/4/22 for R2 revealed the resident hat t room, patient visualized on floor layin ille prepping to get resident cleaned up air, no injuries noted. Initiated neuro ch ro checks available, and no meaningful a.m., when queried about the investiga ave an answer as to why there were no ere.	g flat on his back pillow was place , they heard resident fall while lecks . No investigation to the root interventions noted. ation related to R2 falling in his
		1/14/22 R2 had an intervention placed n initiated to address the resident wand ventions noted.	
Observations			
	One resident asked this surveyor if assist another resident in a wheelch another table and had a pool of urin	1:05 p.m., the dining room near station she could get assistance to go back to hair who was sleeping and soiled herse ne underneath her wheelchair. The oth p.m., a nurse entered the dining room	her room and find someone to elf. This resident was sitting at er residents had their eyes closed
	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.		
	the resident who urinated through h residents in the dining room unsupe the corner from the dining room wa	1:20 p.m. two CNAs came into the din ner clothes and on to the floor to her ro ervised. At the same time, a resident in is calling out for help and did not have TA) Q walked by and saw this surveyo sisted the resident.	om and left the remaining 5 room [ROOM NUMBER] around a call light in reach. An
	residents had food trays in front of	1:36 p.m., four residents observed in t them and appeared to be falling asleep ered the room to talk with one of the res	with their eyes closing. At this
	(continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Skid Muskegon		STREET ADDRESS, CITY, STATE, ZIP CODE 1061 W Hackley Ave Muskegon, MI 49441	
For information on the nursing home's	plan to correct this deficiency, please cont	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by the second		on)
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 nee be in there alone. Informed the DON of	ed to be in the dining room with

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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by f		IENCIES iull regulatory or LSC identifying informati	on)
F 0755 Level of Harm - Actual harm Residents Affected - Few	licensed pharmacist. ***NOTE- TERMS IN BRACKETS H This citation pertains to intake M100 Based on observation, interview an medication orders, obtain physician sufficient process for ordering medi #4's admission to the hospital. Findings include: Review of a Guidelines for Medicati Pharmacy only upon receipt of a cle using an electronic order entry syst Review of a Medication Ordering ar pharmacy will deliver Cycle Fill med responsible for verifying the accura 4 hours of delivery.2. Orders receiv the Facility's regular scheduled deli time and required the same night, m Review of a policy titled Admissions defined guidelines for processing th are protected under federal and sta necessary at time of admission per order, complete diet slip and sent to treatment sheets. Review of a policy titled Charting ar resident, progress toward the care for or psychosocial condition, shall be of facilitate communication between the to care. Resident #4 (R4) Review of a Face Sheet revealed R pertinent diagnoses of cardiac arryter Review of the Minimum Data Set (N	d record review, the facility failed to fol orders timely, provide and administer cations to meet the needs for 1 (Resid on Orders, Policy 2.1 revealed: Medic: ear, complete order, signed by an auth em and/or eMAR should refer to specif ad Receipt Policy 3.4-Delivery and Rec lications on a predetermined schedule cy of the delivery and notifying the pha- ed by the pharmacy before the design very. 3. Orders received by the pharma- nust be called to the pharmacy and rec e Resident's entry into the nursing fac te laws. 2. Initiate any required treatme transfer orders. 5. Order medications i o dietary. 11. Note and initiate physicia and documentation adopted 7/11/18 rev olan goals, or any changes in the resid documented in the resident's medical r te interdisciplinary team regarding the 4 is an [AGE] year old female admittee hmia, acute and chronic respiratory dis IDS) Discharge assessment dated [D/ n [DATE]. Section A2300 indicates R4	ONFIDENTIALITY** 37573 Now policies and procedures for medications, and ensure a ent #4), resulting in the Resident ations are dispensed by the orized licensed prescriber. facilities fic system. ceipt of Medications revealed: The . Nursing staff at the facility are irmacy of any discrepancies within ated fax cut-off time will be sent on acy after the designated fax cut-off quested for same day delivery. Nicy of this facility to have well lility and that the Resident's rights ents (oxygen, intravenous) from pharmacy. 6. Confirm diet n order. Initiate mediations and ealed: All services provided to the lent's medical, physical, functional, record. The medical record should resident's condition and response

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For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey a	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	IENCIES full regulatory or LSC identifying information)	
F 0755 Level of Harm - Actual harm Residents Affected - Few	facility from the hospital on 1/14/22 while at the facility. FM A reported a was cognitively intact until this incic FM A reported she called the facilit medications, or water and the facilit they would put her on hold and then (R4) goes back to the hospital after condition. The staff was reluctant to insisted again that R4 goes to the h arrived, she had the same clothes of resident arrived at the hospital, then resident arrived at the hospital, then resident arrived at the hospital for Review of Hospital Records for R4 (pt (patient) present to ed (emerger (Nursing Facility) and has been una NC (nasal cannula), BS (blood sug AXO 4 (alert and oriented x4) per fa has COVID and to get over the qua the nursing facility did not have any discharge from the hospital on Frid- altered, able to tell me her name. E and elevated ammonia . Assessme (CMS/HCC), Hyperammonemia (m Review of an Internal Medicine Hist (Nursing Home) secondary to altera medications including lactulose, At 1/14/2022. Unfortunately it appears pharmacological administration of v Outpatient medications: . oxygen 3 Review of the Electronic Medical R 1/15/22 at 2000 (8:00 p.m.) which i encephalopathy, spironolactone 25 2 tablets by mouth every morning a	with an admitted [DATE] revealed Chie acy department) c/o (complaints of) not able to take meds for 2 days. unable to ar) 138. Pt is confused currently, able t acility. She was discharged to a skilled rantine period, the patient was staying of her medications and therefore has ay. It is difficult to ascertain the timing of KG (electrocardiogram) demonstrates nt/Plan: Altered mental status, Liver cir etabolic disturbance characterized by a tory and Physical dated 1/16/22 for R4 ation of mental status. Reportedly the p lactone, rifaximin, Lasix since she was that as previously mentioned there way which is the likely culprit as the patient's liters nasal canula . 1. Hepatic Enceph ecord revealed some of the Orders for ncluded but not limited to Xifaxan 550 n mg twice a day for high blood pressure nd at bedtime for HF (heart failure), fur s twice a day for encephalopathy, and n	medications, oxygen, food, or water around that time. The resident hospital on 1/16/22. On 1/15/22 mother has not received any food, en. She would call the facility and othe nurse and insisted her mother d a change in her cognitive orted she argued with the staff and ident to the hospital and when she g Home on 1/14/22. When the le facility indicating who the vas admitted to the hospital and FM ef Complaint: Altered Mental Status feeling well. Pt coming from take lactulose . pt normal on 2L o follow commands, pt is normally nursing facility as the caregiver in a nursing facility. Unfortunately not received any medication since of the symptoms, but the patient is sinus tachycardia (fast heart rate) rrhosis secondary to NASH an excess of ammonia in the blood). revealed: Patient presents from vatient has not received her liver discharged from (Hospital) on as an interruption in s ammonia level was elevated. halopathy. R4 were documented to start on milligram (mg) tablet twice a day for e, amiodarone 200 mg tablets- give rosemide 40 mg once a day for

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NAME OF PROVIDER OR SUPPLIER Skld Muskegon		STREET ADDRESS, CITY, STATE, ZIP CODE 1061 W Hackley Ave Muskegon, MI 49441	
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(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by		IENCIES full regulatory or LSC identifying informati	on)
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		
	revealed: Resident received morning	ogress Note backdated 1/15/22 and creating medications by paper MAR from nured these medications or where they cal	se. Nothing documented in the
	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.		
		ist from 1/1/22 to 2/7/22 revealed on 1/ dications removed from the Cubex by F	
	caught up on any medical records r any records for R4 not scanned into were in the computer and was goin discharge summary/order from the	imately 8:00 a.m., the Medical Records needing to be scanned into the compute o the computer yet, MR F reported she g to make sure. About 30 minutes later hospital, a preprinted handwritten nurs ing documentation for R4. MR F report	ter. When questioned if there were was pretty sure all the records r MR F provided a soft file with a sing admission assessment and a
	shift and did not verify the admission	:22 a.m., RN D reported she took care on orders with the physician. RN D report ations for the residents on the COVID us orget medications.	orted she got medications for R4
	(continued on next page)		

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X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICI (Each deficiency must be preceded by f		CIENCIES full regulatory or LSC identifying informati	on)
F 0755 Level of Harm - Actual harm Residents Affected - Few	<ul> <li>did not do an initial assessment for by the Attorney Generals (AG) Offic to freeze the electronic medical rec that point. When they became awa nurses fill them out as a late entry a reported R4 did not get any medica computer that day. The DON repor Agency (SA). The DON later provic COVID unit, but the list only include medications or any medications that where the medications that the nur- obtained from.</li> <li>In an interview on 2/3/22 at 11:00, i to them on 1/20/22 and told her of that there is an allegation of neglec computer for R4 because the recor</li> <li>In an interview on 2/3/22 at 11:43 a documented as given to R4 during</li> <li>During an Interview and Record rev New Admit place holder information nurse called the pharmacy for STA night of 1/15/22 to the facility. Amic PM B reported they had no record of there. If she did receive medication pharmacy receives the information tackle box approach to providing m residents' information and sent to th medications to be charged.</li> <li>In an interview on 2/7/22 at 4:15 p. to the facility on [DATE] because sl LPN M reported she worked the da other admission and documentation him of R4 admitting to the facility and</li> </ul>	a.m. the DON still could not verify where	n [DATE]. The facility was informed regarding R4s care and instructed to be added, removed, or altered at sessment printed out and had the idministrator's office. The DON N D put the medications in the titon, they reported it to the State e tackle box designated to the eat COVID, not regular routine orted she could not exactly verify ders summary as given to R4 were of reported that the AG reached out d so the NHA reported to the SA hy more documents into the e the medications that were as to (PM) B revealed on 1/15/22 a sing Facility. At 8:32 p.m., the No medications were delivered the facility on [DATE] at 8:40 a.m. hs at the facility while she was em or should have been. The B reported if the facility used the old that would be written out with the of this interview, there were no by that this resident received reported that she did not admit R4 ent when R4 arrived at the facility. rked until 9:30 p.m. to complete here econd shift this day and reported to mission came to the facility. LPN M

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		5. mily	
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZI	P CODE
Skld Muskegon		1061 W Hackley Ave Muskegon, MI 49441	
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F 0755			
Level of Harm - Actual harm	reported her name was not on the r	eport sheet or census either. RN D rep	oorted she filled out an assessment
Residents Affected - Few	document was not part of the reside	ents' medical records and was filled out	t by hand and put into a soft file in
	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) 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 became aware once she passed medications to her roommate and noticed R4 was in the room too. R1 reported her name was not on the report sheet or census either. RN D reported she filled out an assess for R4 after the resident had discharged from the facility and signed the date of 1/15/22. This document was not part of the residents' medical records and was filled out by hand and put into a soft the administrator's office. RN D reported the assessment she did reflected the date of 1/15/22. This document was not part of the residents' medical records and was filled out by hand and put into a soft the administrator's office. RN D reported the admission packet was on the desk for 1 and she opened it to find out what medications the resident was on. When queried about how R4 gdh the medications and why they were not charted in the electronic medical record, RN D changed her story f earlier when she reported she got the medications out of the special tack box that was for the COVLD She said she got the medications out of the Cubex. RN D could not explain why the medications she g R4 did not show up in the Cubex (pa 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 wo off for the resident's next dose. So she signed the paper hospital medication discharge orders for R4 it gave her amiodarone, apixaban, ferroux sulfate, furcesmide, lactubes, loratadine, metoprolol, oxygen, protonix, and spironolactone at 9:30 a.m. on 1/15/22. When queried about the lactubes, RN D reported took the lactubes from another resident to givto R14. None of these medications out of the Cube K4 and got the lactubes from another resident of a in the Cubex. The DON reported the numer aniodarone, apixeban, f		I the date of 1/15/22 when she took rted that RN E was going to come packet was on the desk for R4 in queried about how R4 got her rd, RN D changed her story from a box that was for the COVID unit. In why the medications she gave ime. When queried why the is was because the timing would be on discharge orders for R4 that she ratadine, metoprolol, oxygen, it the lactulose, RN D reported she ications showed up as dispensed indicating the resident received et medications out of the Cubex for replaced the medication taken in the Cubex if medications were ulled R4s medication from the resident when the lactulose is also accuse the facility is trying to the resident was that the rted he worked the night of 1/14/22 hour later. He introduced himself light but did not document anything ot a meal. Could not recall if he at night was busy and had another Ereported the DON and the NHA ugh the date on one document scharged and filled out what he

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	235004	B. Wing	02/17/2022	
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(X4) ID PREFIX TAG			IENCIES full regulatory or LSC identifying information)	
F 0755 Level of Harm - Actual harm Residents Affected - Few	care of R4 that day. RN C was not resident's daughter had called with the facility. RN C reviewed the char RN E was going to complete the ac thought he was completing the pap as given, then she gave the medicat spironolactone. Two of the medicat No other medications were docume Review of several witness statement backing up services and goods pro physician contact, pharmacy contact	p.m., RN C reported she worked the sesure if R4 received medications earlier concerns R4 had not received any met and it looked like she was admitted the imission documentation for the resident erwork. RN C reported if the medication to the medications documented as given. The medications documented as given. The resident. There is no pape ct, medication administration, pharmac, ment while R4 resided in the building.	that day but was informed that the dication since she was admitted to hat day (1/15/22) and was told that t. RN E was there this night and ns on the MAR were documented re apixaban, lactulose, and the Cubex but not the lactulose.	