STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235116	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Woods Nursing & Rehabilitation Center	1684 Vulcan St Muskegon, MI 49442

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37872 This citation pertains to intake MI00146846. Based on interview and record review, the facility failed to 1.) Notify the Resident and Resident Representative in writing with the reason for a transfer out of the facility 2.) Send a discharge notice to a representative of the Office of the State Long Term Care (LTC) Ombudsman for a facility-initiated discharge, 3) Send discharge papers to the receiving hospital for 1 resident, Resident #1 (R1) of three residents reviewed for transfers and discharges, resulting in R1 receiving an involuntary discharge with no notice or place to live. Findings: Review of the Notice of Transfer or Discharge Policy and Procedure revised in July of 2023 reflects . 2. Facility -Initiated Transfer (FIT) a. The FIT-100 form, and process will be used when there is a transfer of a resident from the federally certified nursing home to another facility, such as acute care hospital, with the expectation that the resident will return to the federally certified nursing home. i. Prepare the Facility-Initiated Transfer and Appeal Form (FIT-100) ii. Provide the FIT-100 form to the resident and/or authorized representative along with an envelope and postage for an appeal request, iii. A copy of this notice will be placed in the resident's medical record iv. A monthly list of all facility-initiated transfers is provided to the Michigan Long Term Care Ombudsman at MLTCOP@meij.org. Further review of the Policy and Procedure reflected, 3. Involuntary Transfer or Discharge (ITD) and Facility-Initiated Discharge a. Prepare the ITD-100 form - Have an initial discussion with the resident and/ or authorized representative to assist in identification of transfer or discharge location b. If the destination changes and this change was initiated by the facility, and updated notice with the new destination will be issues. This change restarts the 30-day timeline for transfer or discharge. Resident #1 (R1) Review of Admission Record revealed R1 was a [AGE] year-old male, readmitted to the facility on [DATE], with pertinent diagnoses which included: Dementia, Bipolar II Disorder, psychotic disorder with delusions, major depressive disorder, anxiety disorder. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for R1 with a reference date of 7/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 99 and was unable to participate in the cognitive interview. Further review of R1's MDS history reflected 5 discharge assessments between 6/5/24 to 9/7/24 and 4 Entry Tracking Records between 6/05/24 to 10/23/24. During an interview on 10/23/24 at 8:58 AM, R1's Guardian L revealed that the facility notified her by phone that the facility was sending R1 to the hospital because he was having behaviors and had hit staff. Guardian L stated the facility later informed her in a telephone call that they would not take him back. Guardian L stated she never received any discharge paperwork and the poor guy has now been in the hospital for almost 2 months because they cannot find placement for him. Guardian L revealed further frustration because (Name of Local Agency that provides social work and counseling) dropped R1 as a client and Neuropsych will not take him either. During an interview on 10/23/24 at 4:10 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were not able to provide the 9/7/24 transfer paperwork for R1 because they stated they had not completed any. The NHA and DON were not able to provide evidence of initiating Involuntary Discharge paperwork for the resident and/or resident's Guardian because the NHA stated they had not started one. The NHA and DON confirmed that they talked to Guardian L and informed her on the telephone that the facility sent R1 to the hospital and that they were not accepting him back to the facility. Review of R1's Medical Record revealed there was no paperwork for R1's hospital transfer/discharge on 9/7/24 located. The facility was not able to provide a copy of any paperwork prior to survey completion. Review of the facility Admission/Discharge To/From Report from 8/22/24-10/22/24 reflected that the facility discharged R1 to (Name of Local Hospital) on 9/7/24. During an interview on 10/23/24 at approximately 4:14PM, local Ombudsman O stated she was unaware R1 had an involuntary discharge to the hospital and that the resident was still there. Ombudsman O revealed the information the facility provided to their offices reflected, they sent the resident for acute care and did not check the box on if he was returning or not returning to the facility. If they (the facility) are not allowing the residents to return they are supposed to fill out the involuntary discharge paperwork. They did not follow the process or procedures. They are supposed to send a monthly list of discharges to the state. During an interview on 10/23/24 at 11:51 AM, Registered Nurse (RN) P said that R1 was not longer at the facility because the facility sent R1 to the hospital due to hitting a staff member. RN P said R1 would become combative and agitated. RN P said R1's behaviors would come on abruptly and he could walk down the hall and without warning hit or lash out at someone. RN P also stated that R1 had been at the facility for a long time and the behaviors have escalated over the last year. She stated not knowing why the behaviors had escalated and thought it could be due to disease progression. (continued on next page)

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R1's Care Plan initiated on 10/24/23 reflected R1 had a history of being physically and verbally aggressive with peers and staff and had behaviors since admitting to the facility. Interventions initiated on 10/23/24 included Psychoactive medication is being administered for the diagnosis of anxiety and major depression with psychotic symptoms.Identify behavioral precipitants, if possible, to assist with further defining effective dementia care and trauma informed care.With presentation of behavioral and psychological symptoms of dementia, attempt use of social interventions such as tactile stimulation, sorting objects, appropriate touch, music and sounds, etc., to increase stimulation of the senses and to decrease negative behaviors. Review of a progress note dated 9/7/24 at 10:18 AM revealed that on 9/7/24 at 0755 Registered Nurse (RN K) gave R1 his meds while Certified Nursing Assistant (CNA K) was providing 1:1 supervision and he spit them out. R1 was pushing CNA K and punched her in the stomach twice. CNA K then threw a glass of water she was holding at R1 getting the water on his face. R1 called CNA K a b*tch as he laid down and dried off his face. RN K had CNA K leave the situation and Licensed Practice Nurse (LPN M) stayed with R1 while RN K called DON. The Administration notified the corporate office, the guardian, and called the police and EMS to have R1 taken to the ER. Review of progress note dated 09/07/2024 at 10:22 AM, reflected, Police and EMS arrived at 0830 to transport R1 to the ER. Review of a progress note dated 9/7/24 at 12:47 PM reflected that RN K was notified by the DON that R1 would not be allowed to return to the facility per direction of herself, the NHA, and [NAME] President (VP) of the company. RN K called the ER and informed the hospital staff that the facility would not allow R1 to return to the facility. Further review of progress note dated 09/07/2024 at 13:28 reflected that RN K received a call from the hospital physician caring for R1 in the ER with an update and stated that he would speak with social services at the hospital regarding the facility refusal to take resident back. RN K notified the DON of the conversation, and the DON stated that the administration was aware of the situation and would deal with the ramifications of not accepting R1 back to the facility.

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37872 This citation pertains to intake MI00146846. Based on interview and record review, the facility failed to allow a resident to return to the facility after being sent to the hospital for aggressive behavioral issues for one resident, Resident #1 (R1), of three residents reviewed for facility-initiated transfers, resulting in R1 being involuntary discharged to the hospital without a home to return to. Findings: Resident #1 (R1) Review of Admission Record revealed R1 was a [AGE] year-old male, readmitted to the facility on [DATE], with pertinent diagnoses which included: Dementia, Bipolar II Disorder, psychotic disorder with delusions, major depressive disorder, anxiety disorder, and obstructive sleep apnea. Review of a Minimum Data Set (MDS) assessment for R1 with a reference date of 7/29/24 revealed a Brief Interview for Mental Status (BIMS) score of 99 and was unable to participate in the cognitive interview. Further review of R1's MDS history reflected 5 discharge assessments between 6/5/24 to 9/7/24 and 4 Entry Tracking Records between 6/05/24 to 10/23/24. During an interview on 10/23/24 at 8:58 AM, R1's Guardian L revealed that the facility notified her by phone that the facility was sending R1 to the hospital because he was having behaviors and had hit staff. Guardian L stated the facility later informed her in a telephone call that they would not take him back. Guardian L stated she never received any discharge paperwork and the poor guy has now been in the hospital for almost 2 months because they cannot find placement for him. Guardian L revealed further frustration because (Name of Local Agency that provides social work and counseling) dropped R1 as a client and Neuropsych will not take him either. Review of a progress note dated 9/7/24 at 10:18 AM revealed that on 9/7/24 at 0755 Registered Nurse (RN K) gave R1 his meds while Certified Nursing Assistant (CNA K) was providing 1:1 supervision and he spit them out. R1 was pushing CNA K and punched her in the stomach twice. CNA K then threw a glass of water she was holding at R1 getting the water on his face. R1 called CNA K a b*tch as he laid down and dried off his face. RN K had CNA K leave the situation and Licensed Practice Nurse (LPN M) stayed with R1 while RN K called DON. The Administration notified the corporate office, the guardian, and called the police and EMS to have R1 taken to the ER. Review of progress note dated 09/07/2024 at 10:22 AM, reflected, Police and EMS arrived at 0830 to transport R1 to the ER. Review of a progress note dated 9/7/24 at 12:47 PM reflected that RN K was notified by the DON that R1 would not be allowed to return to the facility per direction of herself, the NHA, and [NAME] President (VP) of the company. RN K called the ER and informed the hospital staff that the facility would not allow R1 to return to the facility. (continued on next page)

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F 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of progress note dated 09/07/2024 at 13:28 reflected that RN K received a call from the hospital physician caring for R1 in the ER with an update and stated that he would speak with social services at the hospital regarding the facility refusal to take resident back. RN K notified the DON of the conversation, and the DON stated that the administration was aware of the situation and would deal with the ramifications of not accepting R1 back to the facility. During an interview on 10/23/24 at 4:10 PM, the Nursing Home Administrator (NHA) and Director of Nursing (DON) were not able to provide the 9/7/24 transfer paperwork for R1 because they stated they had not completed any. The NHA and DON were not able to provide evidence of initiating Involuntary Discharge paperwork for the resident and/or resident's Guardian because the NHA stated they had not started one. The NHA and DON confirmed that they talked to Guardian L and informed her on the telephone that the facility sent R1 to the hospital and that they were not accepting him back to the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 30120 This citation refers to MI00147470. Based on observation, interview, and record review, the facility failed to secure 1 of 3 medication carts (Harbor Medication Cart), resulting in the potential for misappropriation of resident medications. Findings include: During an observation on 10/22/24 at 07:55 AM, the Harbor Medication Cart was left unlocked (the lock was in a pulled-out position and the red/orange dot- which would indicate the cart was unlocked- was clearly visible) and unattended in the hallway outside of a resident room. In addition, because the medication cart was left unlocked, the controlled substances that were stored in the medication cart were only under a single lock vs. the requirement that controlled substances are secured by a double lock system. There were not any staff within visual range of the medication cart. Residents were also observed in the hallway at the time of the observation. During the observation on 10/22/24 at 07:55 AM, Agency Registered Nurse (RN) A returned to the Harbor Medication Cart while the surveyor was writing down information for that cart. RN A stated, uh oh and then proceeded to tell the surveyor the oncoming nurse was running late. RN A stated she was just helping out and trying to administer some medications to the residents before the next nurse came on shift. During an interview on 10/22/24 at 2:30 PM, Licensed Practical Nurse (LPN) C stated she always locks her medication cart before she walks away from it. She stated the only time she would leave her medication cart and not lock it would be if there was an emergency situation, such as a resident fell or was in imminent danger. She stated if that happened, she would ask someone to lock it for her as she responded to the emergency situation. During an interview on 10/23/24 at 11:40 AM, RN B stated she always locks her medication cart when she walks away from it. She stated she does this to prevent people from wandering by and opening it. During an interview on 10/23/24 at 12:45 PM, the Director of Nursing (DON) stated the nurses should lock their medication carts when they walk away from them. A review of the facility's Medication Storage & Stability policy and procedure, revised April 2021, revealed, 2. Only licensed nurses, consultant pharmacist, and those lawfully authorized to administer medications are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Controlled Medication Storage, Security & Disposition policy and procedure, revised December 2016, revealed, Medications listed in Schedules II, III, IV, and V are stored under double lock separated from other medications .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 30120 This citation refers to MI00147470. Based on observation, interview, and record review, the facility failed to safeguard the confidentiality of medical records for 1 of 83 facility residents (R9), resulting in the potential for unauthorized access to resident medical records and the potential for the loss of resident privacy and confidentiality of their personal health information. Findings include: During an observation on 10/22/24 at 7:55 AM, the computer screen on top of the Harbor Medication Cart was observed open to R9's electronic Medication Administration Record, (e-MAR). R9's personal and health identifying information (e.g., picture, name, room number, physician's name, and allergies) and medications were visible to anyone walking by the medication cart. No staff were visible within sight of the medication cart. During the observation on 10/22/24 at 7:55 AM, Agency Registered Nurse (RN) A returned to the Harbor Medication Cart while the surveyor was taking notes. RN A stated, uh oh and then proceeded to tell the surveyor the oncoming nurse was running late. RN A stated she was just helping out and trying to administer some medications to the residents before the next nurse came on shift. During an interview on 10/22/24 at 2:30 PM, Licensed Practical Nurse (LPN) C stated she will close her computer screen when she walks away from the medication cart by allowing it to go to sleep. LPN C stated, But it does not really hide it. If a resident walks by the med (medication) cart and touches the mouse or bumps the cart, the screen will pop back up. LPN C further stated there was not a way for the staff to hide or lock the computer screen to keep unauthorized people from seeing it when the nurse is away from the cart. LPN C stated the only way she really knows of to keep someone from using the mouse to re-open an e-MAR was to minimize the screen. She stated however the minimized screen would log her out of the computer system if it was left open for too long and she would have to completely log back in. During an interview on 10/23/24 at 11:40 AM, RN B stated she hides her computer screen (pushes a button that displays a message that the screen was hidden if someone moves the mouse) when she walks away from her medication cart. She stated she does this to prevent people from reading it as they walk by. RN B also stated she also does this to protect resident privacy. During an interview on 10/23/24 at 12:45 PM, the Director of Nursing (DON) stated the nurses should hide their computer screens when they walk away from the medication carts. A review of the facility's HIPAA (Health Insurance Portability and Accountability Act): Compliance, Confidentiality Statement & Employee Use of Protected Health Information (PHI) policy and procedure, revised January 2024, revealed, Close computer programs before leaving desktop or laptop computers.