STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235549	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Park Nursing and Rehabilitation Communit	1300 W Broadway Ave Muskegon, MI 49441

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 30120 This citation refers to MI00147558. Based on interview and record review, the facility failed to maintain complete and accurate medical records for 2 of 4 residents (R2 and R4), resulting in the potential for providers not having an accurate and complete picture of the resident's stay at the facility. Findings include: R2 A review of R2's Face Sheet, dated 11/25/24, revealed R2 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 2's Admission Record revealed multiple diagnoses that included delusional disorders, severe depression with psychotic symptoms, post-traumatic stress disorder (PTSD), and personality disorder. A review of R2's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 11/21/24, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 7 which revealed R2 was severely cognitively impaired. A review of the facility's investigation summary documentation (an internal document that was not a part of R2's medical record), undated, revealed on 10/9/24 at approximately 7:45 a.m., R2 reported to Registered Nurse (RN) E that certified nursing assistant (CNA) D had pushed her. A review of R2's electronic medical records, dated 9/9/24 to 11/25/24, failed to reveal any documentation that R2 had accused staff of pushing and/or abusing her. In addition, R2's electronic medical record failed to reveal any documentation that physical and/or psychosocial assessments had been made related to the allegation. A review of R2's Social Services note, dated 10/10/24, revealed, Psychosocial wellness visits completed with the resident and no adverse effects were noted. Resident still participated in activities today as normal. However, the note did not give the reason for the visit (i.e., post allegation evaluation, post incident evaluation (R2 had a fall 2 days prior), routine visit). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235549	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Park Nursing and Rehabilitation Communit	1300 W Broadway Ave Muskegon, MI 49441

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R2's Social Services note, dated 10/11/24, revealed, Psychosocial wellness visits completed with the resident and no adverse effects were noted. Resident was up and visited with family today. Resident stated she is feeling good today and doing well. However, the note did not give the reason for the visit (i.e., post allegation evaluation, post incident evaluation, routine visit). A review of R2's Skin Body Assessment, dated 10/9/24, revealed R2 had Various healing bruises and on body from frequent falls. No bruising to back or shoulder regions. However, the skin assessment was listed as a weekly assessment and there was no indication that it was performed as a result of R2's accusation. A review of R2's Pain Assessment, dated 10/9/24, revealed R2 had moderate aching pain rated at a 5-6 (moderate pain) to her legs and lower back. However, the pain assessment was only listed as an unscheduled assessment and did not indicate the reason for the assessment (i.e., post allegation assessment, post incident assessment, increase in pain symptoms, etc.). During an interview on 11/25/24 at 2:00 PM, the Nursing Home Administrator (NHA) was informed that the surveyor could not locate any documentation in R2's electronic medical record specifically related to the allegation on 10/9/24. The NHA stated he would see if he could find any documentation in R2's electronic medical record and stated he would provide copies of anything that he can find. During an interview on 11/25/24 at 2:30 PM, R2 stated there was a CNA that pushed her. R2 stated she wanted to wear a particular outfit one day and the CNA told her that she needed to wear the one that she had pulled out of her closet for her. R2 stated they argued and the CNA pushed her. R2 stated she did not remember the CNA's name or exactly when the incident occurred because she loses track of time since she has been at the facility. She stated it could have occurred a year ago or sooner. R2 further stated this incident was the only time she has had issues with staff. R4 A review of R4's Face Sheet, dated 11/25/24, revealed R4 was a [AGE] year-old resident admitted to the facility on [DATE]. In addition, Resident 4's Admission Record revealed multiple diagnoses that included weakness. A review of 4's MDS, dated [DATE], revealed a BIMS score of 9 which revealed R4 was moderately cognitively intact. A review of the facility's investigation summary documentation (an internal document that was not a part of R4's medical record), undated, revealed on 10/9/24 at approximately 8:45 a.m., R4 reported to RN E that someone had hit her. A review of R4's electronic medical records, dated 9/9/24 to 11/25/24, failed to reveal any documentation that R4 had accused someone of hitting her. In addition, R4's electronic medical record failed to reveal any documentation that physical and/or psychosocial assessments had been made related to the allegation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235549	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Park Nursing and Rehabilitation Communit	1300 W Broadway Ave Muskegon, MI 49441

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of R4's Social Services note, dated 10/10/24, revealed, Psychosocial wellness visits completed with the resident and no adverse effects were noted. Resident was up and visited with family today. However, the note did not give the reason for the visit (i.e., post allegation evaluation, post incident evaluation (R4 had a fall 4 days prior), routine visit). A review of R4's Social Services note, dated 10/11/24, revealed, Psychosocial wellness visits completed with the resident and no adverse effects were noted. Resident was up sitting in her wheelchair today. However, the note did not give the reason for the visit (i.e., post allegation evaluation, post incident evaluation, routine visit). A review of R4's Skin Body Assessment, dated 10/9/24, revealed small faint old bruise to rt (right) shin, sacral area red and painful. However, the skin assessment was only listed as an unscheduled assessment and did not indicate the reason for the assessment (i.e., post allegation assessment, post incident assessment, etc.). A review of R4's Pain Assessment, dated 10/9/24, revealed R4 had moderate aching pain rated at a 5 to 6. However, the pain assessment was only listed as an unscheduled assessment and did not indicate the reason for the assessment (i.e., post allegation assessment, post incident assessment, increase in pain symptoms, etc.). During an interview on 11/25/24 at 2:20 PM, the Director of Nursing (DON) was informed that the surveyor could not locate any documentation in R2's or R4's electronic medical records specifically related to their allegations on 10/9/24. The DON stated she would expect the nurses to write a note in the resident's progress notes that they made an accusation against staff or an allegation of abuse or neglect. The DON reviewed R2's and R4's electronic medical records with the surveyor and stated she did not see a note in R2's or R4's progress notes related to their allegations. She also stated, I guess I'll have to have my nurses improve on that. The surveyor informed the DON that if she should further review R2's and/or R4's electronic medical records and find any documentation related to their allegations on 10/9/24 to please provide copies to the surveyor. As of the completion of the survey and exit from the facility, the facility failed to provide any further documentation that R2's and/or R4's allegations were documented in their electronic medical records. Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice . Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care . Documentation is sometimes viewed as burdensome and even as a distraction from patient care. High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings . (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235549	A. Building B. Wing	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Park Nursing and Rehabilitation Communit	1300 W Broadway Ave Muskegon, MI 49441

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely documentation of the following types of information should be made and maintained in a patient's EHR (electronic health record) to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care- Assessments; Clinical problems; Communications with other health care professionals regarding the patient; Communication with and education of the patient, family, and the patient's designated support person and other third parties . Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. (ANA's (American Nursing Association) Principles for Nursing Documentation- Guidance for Registered Nurses, 2010, www.nursingworld.org).