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	02/27/2025

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39056 This citation pertains to intakes #'s: MI00149655 and MI00149651 Based on interview and record review, the facility failed to 1.) prevent misappropriation of residents narcotic medication and drug diversion for 4 residents (Resident #8, #7, #3, and #4) and 2.) monitor and investigate the potential/ongoing misappropriation of resident narcotic medication for 3 residents (Resident #3, #4, and #5) out of 7 residents reviewed for the misappropriation of narcotics. Findings: INCIDENT #1 Resident #8 (R8) Review of an Admission Record revealed R8 was a [AGE] year-old male, admitted to the facility on [DATE] and discharged on [DATE]. Review of a Facility Reported Incident (FRI) revealed, .On 1/4/2025 at approximately 4:45p, the (Name of police department arrived at the facility to inform (name of facility) that during a routine traffic stop, (RN E) [Registered Nurse (RN) E] was found to have medications belonging to resident, (R8) . In the police report it was listed that (RN E) was found in the procession of the following: 17 vials of Promethazine (antihistamine and sedative) 1 acetaminophen hydrocodone capsule and the white paper cup it had been concealed in. 1 brown prescription packaging ripped open, addressed to (R8) .It was confirmed that resident (R8) had an order for promethazine that was discontinued on 1/1/25. He did not have an order for oxycodone Acetaminophen .She was also found to be in possession of hydrocodone from unknown origin .Summary Based on the facts available, the facility finds that misappropriation of resident medication is substantiated. (RN E) was found to be in the possession of resident (R8's) discontinued medication (17 vials of Promethazine) off site. She was also found to be in possession of hydrocodone from unknown origin. The photograph of the hydrocodone in police evidence appears to have been concealed in a paper cup like the ones used at (Facility Name). It is not probable that a hydrocodone tablet that was meant to be destroyed would be in the possession of a RN off the facility property .In conclusion, based on the information available the facility finds that misappropriation is substantiated. (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Police Report dated 1/5/25 revealed, .I (Patrol Officer) made contact with the driver and informed her of the reason for the traffic stop. The driver was later identified as (RN E) .I recontacted (RN E) and informed her she had a revoked license. (RN E) advised she knew and was just on her way home from work. I had (RN E) step out of the vehicle and asked her if she had anything on her. (RN E) stated she might as she just left work and proceeded to reach into her left scrub top pocket. I observed her pull out a white object and throw it onto her driver seat. I placed (RN E) under arrest for operating a vehicle with a revoked license. (RN E) was placed into handcuffs and she was then placed into the back seat of my patrol car. Due to (RN E) not having a valid license, I was going to inventory the vehicle prior to it being impounded. I returned to the vehicle to conduct my inventory search. I observed the white object that (RN E) had thrown onto her seat to be a folded up small paper cup. I opened the cup and observed a white capsule imprinted with M365 on it. Further search of the vehicle was conducted by myself and I observed a purple [NAME] bag on the passenger side floor board. Inside the bag I located a plastic see through bag that had several prescription vials in it. The vials were all labeled Promethazine HCL injection. On the outside of the bag, I observed the medication to be prescribed to (R8) at (Name of Facility) nursing home. In total, I found 17 vials of 25 mg/ml of the Promethazine in the purple [NAME] bag. All vials appeared to be unopened and still had liquid inside of them. Inside the bag I also located a ripped open package that was also labeled as Promethazine 25 mg/ml vial that again had the name (R8) on it at the (Name of Facility) nursing home .The pill imprinted with M365 was searched on drugs.com. It returned as Acetaminophen and hydrocodone bitartrate, which is a prescription only schedule 2 controlled substance. Promethazine was also searched on drugs.com. It returned as a prescription only schedule 5 controlled substance . (Promethazine is abused/used recreationally to potentiate the effects of opioid medications.) During an interview on 02/27/2025 at 1:26 PM, Nursing Home Administrator (NHA) confirmed the narcotic medication and prescription medication diversion occurred and RN E's license had been reported to Licensing and Regulatory Affairs. INCIDENT #2 Review of a Facility Reported Incident revealed, .On 1/1/2025, RN E left the facility at approximately 8:30a and locked her med cart keys in the med cart. (RN E) sent a test (sic/text) message to the other nurse on duty-LPN (Licensed Practical Nurse) (LPN G) that said Hey, I left I threw up and I'm running a fever. Think my sugar is low. The keys are in the top right hand drawer. Pretty sure I locked the keys in the cart as well. (LPN G) did not have keys to get into the east end med cart. (LPN G) called the Director of Nursing (DON) and informed her. (DON) arrived at the building around 9:30a with the keys to the east end med cart. Med count was performed due to the fact that (RN E) left abruptly and did not count off properly. During the count between (LPN G) and (DON) RN it was identified that the count was off by one pill Norco for resident (R7), 1 pill of Norco for (R3) .1 lyrica, 1 lorazapam (sic) and 1 tramado (sic/tramadol) for (R4). (R7's) dose was missing. She was able to state she had not received her 08:00 meds and it was then given at 9:40a by (DON) upon discovery. (R3's) dose of Norco was missing from the narcotic card and was not signed out in the narc book or the EMAR (Electronic Medication Administration Record). Her dose was given to her by (LPN G) at the routine time. (R4's) Tramadol was not signed out on the narc log or the EMAR but it was missing from the card. This was a prn (as needed) medication and resident denied the need for it .no one had access to the medication cart until (DON) arrived and unlocked the cart and they (DON and LPN G) counted narcotics together .In an interview with (RN H) on 1/2/2025, (RN H) confirmed she reported off for her shift to (RN D) at 0600 on 1/1/25 and the narcotic count was correct . (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a Police Report dated 1/1/25-1/28/25 revealed, . (Nursing Home Administrator/NHA) reported one of his employees and (RN D) was observed leaving work this morning around 0830 hours (8:30 AM) without notice. (NHA) advised (RN D) had just started her shift for the day and hadn't mentioned leaving to anyone, nor clocked out of work .(NHA) advised per facility policies it is required that the nurse with last access to the medication cart perform a pill count and sign off on the count with the next nurse taking over the cart. (NHA) advised a pill count was completed at the beginning of (RN D's) shift, but not when she left work randomly. (NHA) advised at 0930 hours (9:30 AM) when nurses were able to access the locked cart a count was completed. (NHA) advised both (DON) and (LPN G) completed the count. (NHA) claims seven pills to be missing. (NHA) advised the pills were prescribed Scheduled medications . (LPN G) confirmed the cart was locked and could not enter it until (DON) arrived to work. The two completed their count and noticed pills to be missing which were not signed out .On 1/10/25 I also spoke with (DON) regarding the medication count. (DON) confirmed herself and (LPN G) were together during the count that showed a number of controlled and Scheduled medications missing .The Controlled Substance proof of Use documents indicate proper documentation of use prior to (RN D's) shift start. (RN D) fails to document use of the medications prior to leaving work without notice, nor was she seen providing medications to her patients . (RN D) has made obscene claims to why she could not come into work to conduct their investigation. (RN D) has not submitted to a drug test, ultimately advising (NHA) Just terminate my employment . Resident #7 (R7) Review of an Admission Record revealed R7 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: fibromyalgia. Review of a Minimum Data Set (MDS) assessment for R7, with a reference date of 11/1/24 and 1/28/25 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated R7 was cognitively intact. Review of R7's Order Summary dated 8/26/24 revealed, hydrocodone-acetaminophen (Norco)- Schedule II tablet; 5-325 mg; Amount to Administer: 1 tablet; oral; as needed TID (three times a day) PRN and hydrocodone-acetaminophen - Schedule II tablet; 5-325 mg; Amount to Administer: 5-325 mg; oral; Twice A Day. Review of R7's Controlled Substances Proof of Use form revealed on 1/1/25 a tablet of Norco 5/325mg was removed with the time crossed out and no corresponding signature to identify the nurse that administered the medication. Review of R7's January Medication Administration Record and Electronic Medical Record revealed no documentation that R7's Norco 5/325mg was administered on 1/1/25 between 6:00 AM-8:30 AM. Further review of the investigation revealed, .(R7) has a BIMS of 13 indicating that she is cognitively intact . (R7's) dose was missing. She was able to state she had not received her 08:00 meds and it was then given at 9:40a by (DON) upon discovery . On the back of R7's Controlled Substances Proof of Use form used for the investigation was a handwritten note which revealed, missing dose. given late. resident able to state did not receive. Resident #3 (R3) (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an Admission Record revealed R3 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: insomnia and need for assistance with personal care. Review of R3's Order Summary dated 12/14/23 revealed, hydrocodone-acetaminophen (Norco)- Schedule II tablet; 5-325 mg; Amount to Administer: 1 tablet; oral; As Needed; Give one tab PO (by mouth) every 4 hours PRN (as needed) . Review of R3's Order Summary dated 9/26/24 revealed, hydrocodone-acetaminophen (Norco)- Schedule II tablet; 5-325 mg; Amount to Administer: 1 tablet; oral; Every 6 Hours. Review of R3's Medication Administration Record (MAR) and Electronic Medical Record (EMR) revealed no documentation that R3's Norco was administered on 1/1/25 between 6:00 AM-8:30 AM. Review of a handwritten witness statement signed by LPN G revealed, .(R3) 12 (noon) norco missing (and) DON verified missing meds and administrator .pain assessment not need (sic) because medication was not to be administered until 12:00 PM . Confirming a medication not due to be administered at or around the time RN D abruptly exited the facility was unaccounted for. Resident #4 (R4) Review of an Admission Record revealed R4 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: chronic pain syndrome. Review of R4's Order Summary dated 10/5/23 revealed, tramadol - Schedule IV tablet; 50 mg; Amount to Administer: 1; oral; Every 6 Hours - PRN. Review of R4's Medication Administration Record and Electronic Medical Record revealed no documentation that R4's tramadol was administered on 1/1/25 between 6:00 AM-8:30 AM. Review of a handwritten witness statement signed by LPN G revealed, .(R4) .PRN Tramadol missing not signed out in EMAR or narcotic (Controlled Substances Proof of Use form) but not in card . During an interview on 02/27/2025 at 1:26 PM, NHA reported that the suspected diversion identified on 1/1/25 by RN D was deemed inconclusive due to RN D's refusal to cooperate with the facility investigation and provide a statement admitting to the diversion of the controlled medications. NHA stated, we didn't make a determination, we weren't able to conclude with the evidence we had that RN D diverted the controlled medications despite the statement provided by R7, RN D's refusal to submit to a drug screen, and the preponderance of evidence obtained during the facility investigation. In summary, it was confirmed that the narcotic count was completed with all controlled medications accounted for during shift-to-shift report on 1/1/25 at approximately 6:00 AM at the time RN D assumed responsibility for the medication cart/controlled medications. Following RN D's abrupt departure on 1/1/25 at approximately 8:30 AM the following discrepancies were discovered: (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*R7's dose of Norco was missing from the narcotic card and was not signed out on the Controlled Substances Proof of Use form or the Medication Administration Record. During the interview with R7, who is cognitively intact, it was confirmed that her dose of Norco was not administered. *R3's dose of Norco was missing from the narcotic card and was not signed out on the Controlled Substances Proof of Use form or the Medication Administration Record. *R4's dose of Tramadol was missing from the narcotic card and was not signed out on the Controlled Substances Proof of Use form or the Medication Administration Record. Additionally, RN D refused participate in the facility's drug diversion investigatory process. RN D failed to appear at her scheduled drug screen appointment at the local health clinic and refused to meet with the NHA and DON to provide her statement, ultimately texting NHA just terminate my employment. During the onsite investigation it was discovered that the facility had the following ongoing controlled/narcotic medication discrepancies and/or potential drug diversion, which were not promptly identified or reconciled. Resident #3 Review of R3's Order Summary dated 12/30/24 revealed, lorazepam (ativan) - Schedule IV tablet; 0.5 mg; Amount to Administer: 1 tablet; oral; Every 4 Hours - PRN for agitation/restlessness. Review of R3's Controlled Substances Proof of Use form revealed: *On 1/2/25 at 11:00 PM a lorazepam was documented as removed from the narcotic card. *On 2/23/25 at 7:30 AM a lorazepam was documented as removed from the narcotic card. Review of R3's January Medication Administration Record and Electronic Medical Record revealed no documentation that the lorazepam was administered on 1/2/25 at 11:00 PM. Review of R3's February Medication Administration Record and Electronic Medical Record revealed no documentation that the lorazepam was administered on 2/23/25 at 7:30 AM. Resident #4 Review of R4's Order Summary dated 10/5/23 revealed, tramadol - Schedule IV tablet; 50 mg; Amount to Administer: 1; oral; Every 6 Hours - PRN. Review of R4's Controlled Substances Proof of Use form revealed: *On 2/23/25 at 7:30 PM a tramadol was documented as removed from the narcotic card. *On 2/25/25 at 7:30 PM a tramadol was documented as removed from the narcotic card. *On 2/26/25 at 7:42 PM a tramadol was documented as removed from the narcotic card. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The removal of tramadol was signed out by the same nurse on all 3 days. Review of R4's February Medication Administration Record and Electronic Medical Record revealed no documentation that R4's tramadol was administered on 2/23/25, 2/25/25, or 2/26/25. Resident #5 (R5) Review of an Admission Record revealed R5 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: chronic pain syndrome. Review of R5's Order Summary dated 2/15/25 revealed, oxycodone-acetaminophen - Schedule II tablet; 5-325 mg; Amount to Administer: 1; oral; Every 6 Hours - PRN- Take one tablet every 6 hours if needed for severe pain. Review of R5's Controlled Substances Proof of Use form revealed: *On 2/21/25 at 3:03 PM an oxycodone-acetaminophen was documented as removed from the narcotic card. *On 2/25/25 at 10:23 AM an oxycodone-acetaminophen was documented as removed from the narcotic card. Review of R5's February Medication Administration Record and Electronic Medical Record revealed no documentation that R5's oxycodone-acetaminophen was administered on 2/21/25 or 2/25/25. During an interview on 02/27/2025 at 1:26 PM, NHA confirmed the controlled medication discrepancies for R3, R4, and R5. NHA was unable to provide documentation reflecting the administration of R3, R4, and R5's controlled medications/narcotics prior to survey exit. NHA was asked how the DON was ensuring controlled medications were not being diverted and residents were receiving those medications. NHA reported that DON had been reviewing the Controlled Substances Proof of Use forms daily, but he was unsure if a formal audit system had been implemented. NHA was asked to provide audit documentation for review. During an interview on 02/27/2025 at 1 2:22 PM, NHA reported there were no audits for review which he confirmed with the regional nurse. NHA stated the facility's regional nurse reported she never received audits to review. NHA was asked if controlled medication administration/reconciliation was reviewed during the monthly QAPI meeting, and reported his understanding was that the DON was looking for holes (medication not administered) and inaccurate medication counts on the Controlled Substances Proof of Use forms but had not been auditing PRN medication administration and ensuring residents were receiving the medications following the removal from the narcotic cards. NHA reported that DON had been out of office since 2/21/25 and RN F was responsible for auditing Controlled Substances Proof of Use forms until her return. NHA confirmed that RN F was told to watch for holes on the Controlled Substances Proof of Use forms and was not provided formal audit tools to use. NHA reported that RN F had not performed any controlled medication audits. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Abuse Prevention Program Policy & Procedure last reviewed 01/2025 revealed, INTENT: Each resident has the right to be free from abuse, neglect and corporal punishment of any type by staff or anyone. The facility will provide a safe resident environment and protect residents from abuse . POLICY: Atrium Centers has prevention programs in which policies and procedures safeguard our residents to be free from abuse, neglect, misappropriation of resident property, and exploitation .Exploitation, as defined taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion. Misappropriation of resident property, as defined the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the residents consent .Possible Indicators of Misappropriation . Resident Drug Diversion .Possible Indicators of Exploitation . The diversion of a residents' medication(s), including, but not limited to, controlled substances for staff use or personal gain . ABUSE PREVENTION PROGRAM 7 COMPONENTS .II. TRAINING The facility will ensure that all staff, new and existing are trained and knowledgeable of facility's Abuse Prevention Program, with additional in-service training for nursing assistants .Identifying what constitutes abuse, neglect, exploitation, and misappropriation of resident property; Recognizing signs of abuse, neglect, exploitation and misappropriation of resident property .NOTE: The provision of training on abuse prohibition alone does not relieve the facility of its responsibility to assure that the resident is free from abuse. The facility will provide ongoing oversight and supervision of staff in order to assure that its policies are implemented as written . V. INVESTIGATION 1. The Administrator and or Director of Nursing are to initiate and coordinate completion of a thorough investigation . Identify and interview (witness statements) all involved persons, including the alleged victim, alleged perpetrator, witnesses, and others who might have knowledge of the allegation(s) . Determining if abuse, neglect, exploitation, and/or mistreatment has occurred .Follow-up actions to correct and prevent potential reoccurrence .3. In order to complete the Resident Abuse Investigation, all information must be gathered and reviewed, with a final summary analysis with an action plan to prevent reoccurrence . 6. The Administrator will document the final disposition for each incident and will presented to and reviewed with the QAPI Committee 7. A file for all data obtained, will be retained with the Administrator's or Director of Nursing office . Per the International Journal of Drug Policy, We aimed to characterize how and why individuals use opioids in combination with these three psychoactive medications (PAMs) .There are numerous reasons why individuals with opioid use disorders (OUD) may use PAMs (psychoactive medications) .Gabapentin, clonidine, and promethazine are also used recreationally or to potentiate effects of other drugs . [NAME] D, [NAME] S, [NAME] K, [NAME] S, [NAME] C, [NAME] SE. Use of promethazine, gabapentin and clonidine in combination with opioids or opioid agonist therapies among individuals attending a syringe service program. Int J Drug Policy. 2020 [DATE];79:102752. doi: 10.1016/j.drugpo.2020.102752. Epub ahead of print. PMID: 32330837.