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	09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roosevelt Park Nursing and Rehabilitation Communit	1300 West Broadway Avenue 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # 2614154Based on interview and record review, the facility failed to prevent misappropriation of residents narcotic medication for 2 residents (Resident #1 and #2) and monitor and investigate the potential/ongoing misappropriation of resident narcotic medication for 4 residents (Resident #2, #3, #4, and #6) out of 7 residents reviewed for the misappropriation of narcotics, resulting in the diversion of narcotic medications and the potential for ongoing diversion of narcotic medications. Findings:Resident #1 (R1)Review of an admission Record revealed R1 was a [AGE] year-old male, admitted to the facility on [DATE].Review of R1's Order Summary dated 3/3/22 revealed, Norco (hydrocodone-acetaminophen) tablet; 10-325 mg; amt: 1; oral Three Times A Day; 07:00 AM, 01:00 PM, 07:00 PM.Review of R1's Controlled Substances Proof of Use sheet in the column Quantity Remaining revealed:*On 8/22/25 at 7:20 AM there were 19 tabs of Norco remaining.*On 8/22/25 at 11:42 AM (the next entry) there were 17 tabs of Norco remaining. Indicating 2 tabs of Norco were dispensed instead of the ordered 1 tab. The handwritten entry of 17 was written bold and appeared to haven been written repeatedly as to obscure the previous documentation. Upon closer review, 18 was legible under the bold 17.*On 8/22/25 at 6:47 PM the handwritten 16 was repeatedly/boldly written. Beneath the 16, 17 was legible.*On 8/23/25 at 7:00 AM the handwritten 15 was repeatedly/boldly written. Beneath the 15, 16 was legible.*On 8/23/25 at 1:40 PM the handwritten 14 was repeatedly/boldly written.*On 8/23/25 at 6:00 PM the handwritten 12 was repeatedly/boldly written. Beneath the 12, 14 was legible. This entry indicated 2 tabs of Norco were dispensed instead of the ordered 1 tab.The falsification/modification of these entries left 2 tabs of Norco unaccounted for.Resident #2 (R2)Review of an admission Record revealed R2 was a [AGE] year-old female, admitted to the facility on [DATE].Review of R2's Order Summary dated 4/29/24 revealed, alprazolam (Xanax) - Schedule IV tablet; 0.5 mg; amt: 0.5 mg; oral Twice A Day; 06:00 AM - 10:00 AM, 06:00 PM - 10:00 PM.Review of R2's Controlled Substances Proof of Use sheet revealed an additional dose of Xanax was dispensed on 8/24/25, outside of the ordered times.Review of R2's August Medication Administration Record revealed no corresponding entry for the Xanax administration.Review of R2's Electronic Medical Record (EMR) revealed no entry related to the additional dose of Xanax.Review of the Facility Reported Incident (FRI) revealed: .Reported Incident On 8/23/2025, during a routine audit of controlled substances, an inaccuracy was discovered on the Controlled Substances Proof of Use sheet. Entries in the Quantity Remaining column had been altered, suggesting that the narcotic count was manipulated (for R1). Interviews with staff identified Agency Nurse (Licensed Practical Nurse [LPN] C) as the individual responsible for altering the documentation of counts entered by other nurses.During medication audits conducted by licensed nursing staff, it was discovered that a dose of Xanax for (R2) was signed out on the Controlled Substances Proof of Use sheet by (LPN C). No corresponding entry existed in the eMAR (electronic medication administration record) as medication was not scheduled at that time. It was determined that tablet was missing with no adverse physical impact on patient.Audits of both east and west medication carts were completed, revealing no additional discrepancies beyond the Xanax entry noted above.Medication Audits: Licensed nursing staff completed audits of both east and west medication carts. No additional discrepancies found except for the Xanax dose for resident (R2), which was signed out on the Controlled Substances Proof of Use sheet (by LPN C) without corresponding eMAR documentation. Review determined this medication is not scheduled to be administered during third shift, the shift (LPN C) worked. Consultant pharmacist completed audits of both east and west carts no further discrepancies identified. Staff & Policy Actions: Education to be provided to RN and LPN staff regarding controlled substances policy and proper medication count procedures.Summary Based on the facility's investigation, documentation review, staff interviews, and medication audits, it has been determined that misappropriation of controlled substances is substantiated. Evidence supports that Agency Nurse (LPN C) altered the narcotic count on the Controlled Substances Proof of Use sheet and that a Xanax dose for resident (R2) was documented as given without corresponding eMAR entry, during a shift when it was not prescribed to be administered.However, the alteration of records, missing documentation, and potential diversion meet criteria for misappropriation of medication. The facility has taken corrective actions, notified appropriate regulatory and law enforcement agencies, and implemented staff education to prevent recurrence.Review of LPN F's witness statement dated 8/28/25 revealed, On Friday August 22nd, 2025 this nurse (LPN F) passed the second med pass. The resident (R1)