

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235549	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/02/2026
NAME OF PROVIDER OR SUPPLIER Roosevelt Park Nursing and Rehabilitation Communit		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide daily care for one (R14) of one resident reviewed for cares of a dependent resident. Findings include: Review of a Face Sheet revealed R14 originally admitted to the facility on [DATE] and had pertinent diagnoses of hemiplegia and hemiparesis (one-sided weakness), vascular dementia, and blindness in right eye. Review of the Care Plan revealed R14 is severely cognitively impaired. During an observation on 3/30/26 at 9:49 AM, R14 was lying in bed, and his hands appeared to be contracted. Hand splints were observed sitting across the room on a table. In an interview on 3/30/26 at 12:31 PM, the Guardian of R14 reported concerns of not having a care conference in a long time to review R14's care. The Guardian reported concerns of R14 not being provided oral care. The Guardian reported she had concerns of R14 being in bed all day and not attending activities. R14 liked religious activities like singing gospel songs and church activities. During an observation on 3/31/26 at 9:16 AM, R14 was observed sleeping in bed and no oral swabs were observed in the room. R14's left eye had a white discharge that was noticeable. Hand splints were observed on the bedside table. During an observation on 3/31/26 at 10:09 AM, R14 was lying in bed, and his left eye had a whitish discharge observed. During an observation on 3/31/26 at 11:40 AM, R14 was still in bed, and no oral swabs were observed in the room. R14 was friendly and talked but did not understand questions regarding his care. R14 had a white discharge in his left eye that was more obvious when he opened his eye. Hand splints were not placed on his hands. During an observation on 3/31/26 at 1:07 PM, R14 was still in bed, and no oral swabs were observed in the room. During an observation and an interview on 3/31/26 at 1:35 PM Certified Nursing Assistant (CNA) G reported she changed R14's brief right before lunch. When questioned about staff not observed in his room during that time frame, CNA G reported she entered his room through the joined bathroom from the room next door. At this time CNA G was asked to check R14's brief and it was saturated. CNA G reported R14 was to be checked and changed every 2 hours. When questioned about R14's oral care, CNA G reported they are to use glycerin swabs to swab his mouth and confirmed there were no oral glycerin swabs readily accessible in his room. CNA G reported she did not provide oral care this day. R14's toenails were very long and wrapped around the tip of his toes. CNA G confirmed there was a discharge in R14's left eye and reported it had been that way for a couple of weeks. CNA G reported she did clean his eyes this day and reported she told the nurse about the discharge. CNA G reported R14 only gets out of bed on Wednesdays and Saturdays. In an interview on 3/31/26 at approximately 4:00 PM, Registered Nurse (RN) reported that R14 does not like to get out of bed and is scheduled to be out of bed on Mondays, Wednesdays, and Fridays. RN Q reported R14 has normal saline eye drops for his eyes to treat his eyes. When questioned about the white discharge from R14's left eye, RN Q reported that is why he gets the eye drops. Review of the Care Plan for R14 revealed: -Urinary Incontinence [related to] severe cognitive impairment, dependent for all ADLs (activities of daily living) and mobility. 1/15/24- Incontinent of bowel and bladder and is a check and change. -Enhanced Barrier Precautions 6/10/24- (R14) has a visual deficit d/t (due to) blindness in the left eye. Wash eyes and face daily. (R14) tends to be passive or refuse group activities. If he is up in his Broda chair he is more likely to come down to an activity, but he (continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>does not always like getting out of bed. Staff will encourage (R14) to get up in his chair daily but will respect his wishes if he chooses to stay in bed to watch TV channel . This is not in the Approach section of the care plan.- ADL Functional Status 7/2/24- Goal- . will be clean/well-groomed daily and will participate in cares to his fullest ability. On 7/17/25 an Approach regarding palm protectors: Bilateral palm protectors on in AM and off in PM. Approach: Staff assist and encourage to get up in the broda chair daily. Approach: Use toothettes BID (twice a day)-Evaluation notes at the end of the care plan- Encourage res to get up daily out of bed.-No care plan indicating R14 gets out of bed on any specific days of the week. In an interview on 4/1/26 at 2:39 PM, the Director of Nursing (DON) reported he talked to the nurse the day before about R14's discharge in his eye and put a communication note in the physician's book. The DON reported he did not see any discharge in R14's eye this morning and suggested that maybe the CNA did not clean his eyes per the care plan.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation refers to Intake 2806247 in addition to the recertification survey. Based on observation, interview, and record review, the facility failed to prevent accidents and/or maintain an environment that was free from accident hazards for 2 of 4 residents (R2 and R14) reviewed for accidents and/or accident hazards, for the bathrooms in 6 of 9 resident rooms (room [ROOM NUMBER], room [ROOM NUMBER]/21, room [ROOM NUMBER]/24, room [ROOM NUMBER]/29, room [ROOM NUMBER], room [ROOM NUMBER]/33) reviewed for water temperatures, and 1 of 2 shower rooms (West Shower Room) reviewed for accident hazards. Findings include:An Environmental tour of the facility began on 4/01/26 at 12:05 PM with Director of Maintenance (DoM) K.</p> <p>During an observation of the [NAME] Shower Room on 04/01/2026 at 12:20 PM, the bathroom hand sink was noted to be missing the cold-water knob/handle and the water temperature coming out of the faucet was tempted at 130.3 degrees F. The hot water temperature coming out of the shower was 127.1 degrees F. Further observation of [NAME] Shower Room revealed call light switch located on the shower wall was not working. DoM K confirmed the shower call light switch was not activating the call lights located outside the shower room doors. DoM K stated, I will look into it.</p> <p>During the tour, the Resident in room [ROOM NUMBER] stated, Yes, I could come in check her room and water temperature, but the water gets really hot, be careful. The hot water temperature at the hand sink was 129.4 degrees F.</p> <p>Resident Rooms 19 & 21 share a bathroom, the hot water temperature coming out of their hand sink was 126.0 degrees F.</p> <p>Resident Rooms 22 & 24 share a bathroom, the hot water temperature coming out of their hand sink was 126.1 degrees F. Resident in room [ROOM NUMBER] stated, The water gets really hot, I always need to check the temperature before putting my hands in the water to wash them.</p> <p>Resident room [ROOM NUMBER] had a hand sink located in her room. The resident stated the water gets very hot. The hot water temperature coming out of the hand sink was 126.8 degrees F.</p> <p>Resident Rooms 27 & 29 share a bathroom, the hot water temperature coming out of their hand sink was 127.4 degrees F.</p> <p>Resident Rooms 31 & 33 share a bathroom, the hot water temperature coming out of their hand sink was 125.0 degrees F.</p> <p>Resident room [ROOM NUMBER] had hot water coming out of the hand sink at 120.7 degrees F.</p> <p>Observation of the boiler room reflected the temperature valve on the large holding tank was at 134 degrees. The temperature on the Mixing Valve was 130 degrees. DoM K stated he had last checked it on 3/26/26 and the recorded temperature on the log was 120 degrees. DoM K further stated that this was the temperature of the water that went out to the resident rooms.</p> <p>During an interview on 04/01/2026 at 1:26 PM, Regional Director of Operations (RDOO) U stated he understood that there are concerns with hot water temperatures. He revealed that staff are going (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>through checking temperatures and educating staff.</p> <p>During an interview on 4/01/2026 at 2:28 PM, DoM K stated, I turned the water down to 110 degrees and ran a bunch of water out of the tank to help bring down the temperature in the lines. DoM K revealed the water temperature is usually consistent with the mixing valve temperature.</p> <p>During an interview on 4/01/2026 at 3:48 PM, RDOO U revealed that they were having a plumber come out to check things over.</p> <p>During an observation and an interview on 3/31/26 at 10:08 AM, R14 was in his room lying in bed and an unsecured oxygen tank was standing alone at the foot of the bed under the window. The Regional Nurse Consultant (RN) A reported the oxygen tank should be secured.</p> <p>R2</p> <p>A review of R2's Face Sheet, dated 4/1/26, revealed they were a [AGE] year-old resident admitted to the facility on [DATE]. In addition, R2's Face Sheet revealed they had multiple diagnoses that included reduced mobility, generalized muscle weakness, morbid obesity, depression, and anxiety.</p> <p>A review of R2's Minimum Data Set (MDS) (a tool used for assessing a resident's care needs), dated 12/22/25, revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 14 which revealed R2 was cognitively intact. In addition, R2's MDS revealed they had physical impairment in both of their upper extremities (arms), and they were dependent on staff for bath/showers and transfers.</p> <p>A review of R2's Interdisciplinary Team note, dated 3/3/26, revealed, Summary of event: Resident was up in Bariatric shower chair, while adjusting resident shower chair leg broke and resident fell to floor hitting his head on floor. Post fall findings: Nurse assessed resident. No injuries noted at time of fall. Resident sent to ED for eval related to hitting head.</p> <p>A review of R2's Event Report, dated 3/4/26, revealed on 3/3/26 R2 was being transferred to the shower room for a shower. Certified Nursing Assistant (CNA) J was present and R2 fell when the bariatric shower chair leg broke when he was adjusted in the shower chair. R2 hit his head on the floor, but there were not any visible injuries. R2 complained of pain at a 5 of 10. He was transferred to the hospital for an evaluation.</p> <p>A review of R2's weight records revealed on 2/12/26 R2 weighed 419.1 pounds and the day of the incident (3/3/26) R2 weighed 415.4 pounds.</p> <p>During an interview on 04/01/2026 at 2:32 PM, Director of Maintenance (DOM) K stated he does not do preventive maintenance checks on the shower chairs. He stated that the leg of the bariatric shower chair broke, so there would be no way to check it to see if that would happen. DOM K stated the only moveable parts would be the screws that support the armrests and he would not know what to check on equipment that did not really have any moveable parts. DOM K further stated, I'm not even sure if the chair was rated high enough for him. He's over 500 pounds. DOM K stated he did not know what brand the shower chair that broke was so he could not reference the manufacturer's instructions to see what the maximum weight was for the shower chair that broke or call anyone to find out. DOM K stated he believed the broken chair was already disposed of, but he would check and see if it was (continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>still at the facility. He stated if it had not been disposed of, he may be able to find a brand name for it and reference the manufacturer's website to see what the maximum allowable weight for that chair was.</p> <p>During a second interview on 04/01/2026 at 2:45 PM, DOM K stated he looked and the broken shower chair was already disposed of. He stated he does not know what brand the broken shower chair was and he does not have another one like it at the facility. DOM K stated that the maximum weight allowed for each shower chair was not printed on the chairs themselves. He stated he was going to order another bariatric shower chair and when he receives it he will write somewhere on the chair the maximum allowable weight.</p> <p>During an interview on 04/01/2026 at 3:41 PM, R2 he remembered falling in the shower room on 3/3/26. He stated the aides were going to roll him down the hallway in the shower chair, but the chair did not look like it would easily roll down the hallway with him in it. R2 stated he was told that they could not use the shower bed because he was too big (heavy) for it. He stated they had the shower chair in the shower room, and they brought him in using a mechanical lift. R2 stated when the aides took him into the shower room and he saw the shower chair he was not sure if it would hold his weight. I'm a big guy and that chair looked like it was made out of flimsy, thin PVC piping. He also stated that the chair looked a little small considering I'm a bigger guy. R2 stated when the aides lowered him into the shower chair using the mechanical lift and as one of them was unhooking the sling, the chair collapsed. He stated he did not remember falling. He just remembered one minute being lowered into the chair and the next minute he was on the floor with an aide standing over him. R2 stated they called the fire department and EMS (Emergency Medical Services) to get him off the floor. He stated when they got him onto the EMS stretcher, he could see that the shower chair had splintered into a million pieces. R2 stated it looked like shattered glass on the floor, but it was the PVC material instead of glass. He stated he had been told that the shower chair was over [AGE] years old. R2 stated he did not have any injuries from the fall.</p> <p>During an interview on 04/01/2026 at 4:30 PM, CNA F stated she knew what the weight limit of a shower chair was based on the color of the chair. She stated she did not know the colors and weight limits off hand of each shower chair but there were multiple colors for multiple weights. For example, there was a specific color for chairs that can hold up to 200 pounds, one for 300 pounds, one for 400 pounds, and one for 500 pounds and up. CNA F stated the color scheme for the shower chairs was not the same as the color scheme for mechanical lift slings, but it was based on a similar idea.</p> <p>During an interview on 04/02/2026 at 8:15, Registered Nurse (RN) E stated the shower chairs are color coded based on maximum weight limits.</p> <p>During an observation in the [NAME] Shower Room on 04/02/2026 at 9:00 AM, RN E was shown two shower chairs (one looked like a standard shower chair, and one looked more heavy duty like a bariatric shower chair). RN E stated he could not tell by looking at the shower chairs what their weight limits were. RN E also stated that he would have to look it up the shower chairs on the manufacturer's website(s) to see the amount of weight each shower chair could hold because he normally does not give residents showers. However, he also stated he could not find the manufacturer's name on the shower chairs he looked at so he would need to contact DOM K to ask what brand they were in order to check the manufacturer's website(s). RN E further stated he doubted that an aide would take the time to look up the weight information on a manufacturer's website if they did not know the weight limit of a particular chair. (continued on next page)</p>		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During another observation on 04/02/2026 at 9:15 AM, CNA G stated she does give residents showers. CNA G was shown the same two shower chairs in the [NAME] Shower Room that RN E was shown. CNA G looked at the two shower chairs and stated she did not know the weight limit for them. She stated the weight limit should be listed on the chair or written on the chair, but it was not.		