STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235656	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Christian Care Nursing Center	2053 South Sheridan Drive 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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were administered in accordance with physician orders and nursing professional standards of practice for 4 residents (Resident #2, #34, #23, and #53) out of 15 residents reviewed for medication administration.Findings:R53 Review of a Face Sheet revealed R53 admitted to the facility on [DATE] with pertinent diagnoses of hypertension (high blood pressure) and ventricular tachycardia (irregular heart rate in lower heart chamber). R53 is cognitively intact. During an interview on 4/27/26 at 9:02 AM, R53 was asked about the admission process to the facility and reported his medications were not available until very late. Review of R53's Medication Administration Record (MAR) showed that on 4/24/26 he had orders for the following medications: Atorvastatin 10 mg at bedtime — the dose was not given. Clonidine 0.1 mg twice a day for hypertension — the evening dose was not given. Pregabalin (Lyrica) 75 mg twice a day for pain management — the evening dose was not given. Review of R53's blood pressure readings showed the following: 4/24/26 at 4:20 PM – 154/75 4/25/26 at 7:13 PM – 171/98No blood pressure readings were documented between these times. During an interview on 4/28/26 at 10:04 AM, Registered Nurse (RN) A reported that many of R53's medications could have been pulled from the medication Pyxis if the pharmacy had not delivered them on time. RN A verified that the pharmacy delivered R53's medications before midnight, but staff did not administer them. RN 'A' stated there was sufficient time to give R53 his evening medications on 4/24/26 and stated the physician should have been notified if the medications were unavailable or not given. RN 'A' acknowledged the concern regarding R53's elevated blood pressure. In an interview on 4/28/26 at 10:30 AM, the Director of Nursing (DON) stated the nurse should have administered R53's medications on the night of his admission on [DATE] and confirmed that the pharmacy had delivered the medications. The DON explained that if the medications had not been delivered, the nurse could have obtained some of them from the medication Pyxis. She further stated that if any medications were unavailable or could not be given, the physician should have been (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	notified. Resident #2 (R2) Review of an admission Record revealed R2 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: hypertension. Review of R2's Order Summary dated 3/18/26 revealed, Toprol XL Oral Tablet Extended Release 24 Hour 50 MG Give 1 tablet by mouth two times.Hold if SBP less than 100 or HR (heartrate) less than 60. To be administered in the morning and evening. Review of R2's Blood Pressure Summary and Pulse Summary from 4/1/26 through 4/27/26 revealed: On 4/3/26 the morning blood pressure and pulse were not assessed. On 4/5/26 the morning and evening blood pressure and pulse were not assessed. On 4/7/26 the evening blood pressure and pulse were not assessed. On 4/9/26 the morning and evening blood pressure and pulse were not assessed. On 4/10/26 the morning and evening blood pressure and pulse were not assessed. On 4/13/26 the morning and evening blood pressure and pulse were not assessed. On 4/15/26 the morning and evening blood pressure and pulse were not assessed. From 4/18/26 through 4/27/26 there were no morning or evening blood pressures or pulses assessed. Review of R2's April Medication Administration Record revealed that all doses of R2's Toprol were administered from 4/1/26 through 4/27/26 despite assessments of her blood pressure and pulse to ensure it was within the parameters to safely administer. During an interview on 04/28/2026 7:35 AM, Registered Nurse (RN) A reported that when the provider orders medications with parameters the vitals are to be assessed and documented prior to the administration. RN A reported that on the electronic medication administration record (EMAR) screen there is a heart icon to prompt the nurse to obtain the required/ordered assessment. When the heart icon is clicked, an additional screen opens for the nurse to input the assessment data. During an interview on 04/29/2026 at 1:54 PM, the Director of Nursing (DON) confirmed the licensed nurses had not obtained a blood pressure or pulse assessment prior to the Toprol administration for the above dates. The DON reported that the facility provider transcribed his own order for R2's Toprol and did not include the prompt to input vital signs. DON reported that when the licensed nurses transcribed orders for the providers, they would include the prompt to input vital sign data in order to prevent missed assessments. Resident #34 (R34) Review of an admission Record revealed R34 was an [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R34's Order Summary dated 12/4/25 revealed, HYDROcodone-Acetaminophen (Norco) Oral Tablet 5-325 MG Give 1 tablet by mouth every 6 hours as needed for Moderate pain. Review of R34's Controlled Substance Proof of Use form revealed: On 4/16/26 at 3:30 AM a Norco tablet was dispensed. On 4/18/26 at 11:00 PM a Norco Tablet was dispensed. Review of R34's Medication Administration Record revealed no documentation that the Norco dispensed on 4/16/26 or 4/18/26 was administered. Resident #23 (R23) Review of an admission Record revealed R23 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: anxiety. Review of R23's Order Summary dated 3/30/26-4/8/26 revealed, LORazepam Oral Tablet 0.5 MG (Ativan) Give 1 tablet by mouth every 6 hours as needed for Anxiety or agitation. Review of R23's Controlled Substance Proof of Use form revealed that on 4/3/26 a dose of Ativan was dispensed at 6:50 AM. Review of R23's Medication Administration Record revealed no documentation that the Ativan dispensed on 4/3/26 was administered. During an interview on 04/28/2026 7:35 AM, RN A reported that signing out a controlled drug happens at the time the pill is dispensed from the medication cart, further reporting that the date, time, amount dispensed, and the signature were to be documented in the narcotic book (located on the medication cart). Following the administration of the controlled drug, it is to be signed out of the EMAR to ensure providers and other nurses are aware of when the medication was last administered (to prevent the as needed medications from being administered too soon and for the providers to assess for adequate pain control). During an interview on 04/29/2026 at 1:54 PM, the DON reported that the expectation was for the licensed nurses to follow nursing professional standards of practice with medication administration which included the documentation of the administration of controlled drugs in the EMAR as well as on the Controlled Substance Proof of Use form. The DON reported she would be immediately reeducating the licensed nurses on medication administration. Review of the facility policy, Medication Administration last reviewed/revised 4/29/26 revealed, .8. Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters.10. Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation.20. Sign MAR after administered. For those medications requiring vital signs, record vital signs onto the MAR. 21. If medication is a controlled substance, sign narcotic book.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2727057.Based on interview and record review, the facility failed implement dietary orders and care plan interventions to ensure safety with evening snacks for 5 residents (R52, 33, 34, 44, 45), of 5 residents reviewed for eating safety.Findings include:R52Review of a Face Sheet revealed R52 admitted to the facility on [DATE] with pertinent diagnoses of acute respiratory failure with hypoxia (low oxygen), dysphagia (difficulty swallowing), and pneumonitis due to inhalation of food and vomit. R52 was cognitively intact.Review of the Physician orders revealed on 12/18/25 R52's diet was to be NPO (nothing by mouth)- PEG tube (percutaneous endoscopic gastrostomy tube) diet.Review of the Facility Reported Incident (FRI) submitted to the State Agency on 12/23/25 revealed on 12/20/25 at approximately 8:00 PM, Licensed Practical Nurse (LPN) U entered R52's room and noticed brown all over resident from brief to face. First thought was that it was stool. After entering closer with the light on I saw the pudding cup in his groin. First question I asked was [R52], what are you doing? Then I noticed the pudding cup looked like a velociraptor ripped it open. Majority of pudding was in his groin, you could tell he ripped the top open any way he could. I then asked if he ate any of the pudding, he smiled and states yeah. He admits he was not supposed to eat. He was assisted to be cleaned up. After, I heard coughing. His through (sic) sounded wet and he was unable to clear it. At this time, order received for stat (immediate) chest Xray.This resident is alert and oriented X3 at the time of the incident per nursing assessment.Review of a statement from the Dietary Aide (DA) V revealed she was doing snack cart rounds and he (R52) stated he wanted a pudding and (DA V) gave it to him.Further review of the FRI for R52 revealed he was admitted to the facility 2 days prior to the incident and expressed dissatisfaction with the inability to eat and had a hard time with his new NPO status. Staff were educated about providing food to residents with an NPO status and steps were taken to ensure residents with an NPO status moving forward would not be provided. The interventions did not address residents who would require supervision or cueing by staff for eating to avoid aspiration was not identified or addressed.Review of a Hospital Emergency Department note dated 12/21/26 for R52 revealed he went to the hospital with concerns of aspiration and was diagnosed with Aspiration pneumonitis. In an interview on 4/29/26 at approximately 9:00 AM, the Dietary Manager (DM) M reported DA V who provided R52 with a pudding cup no longer worked at the facility. DM M reported the Dietary Aides pass out evening snacks using a list that identifies each resident and their dietary needs. They update this list frequently. If a newly admitted resident is not on the list, the Dietary Aides check with nursing staff to confirm that resident's dietary needs before giving them an evening snack. The Dietary Staff were educated to not pass out snacks to Residents who were NPO.Review of the Dietary Resident list provided by DM M showed that several residents required supervision, 1:1 assistance, and had conflicting dietary needs or assistance among the orders, Kardex, and Dietary Resident list.R33Review of a Face Sheet for R33 revealed he was admitted to the facility on [DATE] with pertinent diagnoses of dysphagia and pneumonia.Review of the Physician Orders dated 4/9/26 for R33 revealed an ordered for 1:1 feeding assistance with meals and to use a cup and a straw for liquids.Review of the Eating and Nutrition portion of the Kardex for R33 revealed: Eating: I need supervision. No mention of needing a cup and a straw for liquids.Review of the Dietary Resident list used for passing out evening snacks revealed R33 required a mechanical soft diet with liquids in a cup with a straw but does not mention he requires supervision.R34Review of a Face Sheet for R34 revealed she was admitted to the facility on [DATE] and had pertinent diagnoses of dysphagia, morbid obesity and spondylosis (degenerative changes to spine).Review of the Physician Orders for R34 revealed on 1/12/26 an order for a regular diet with regular texture, nectar consistency, for aspiration. No straws, sippy cups.Review of the Eating/Nutrition Kardex for R34 revealed to Provide, serve Regular, Puree, Nectar Thick liquids diet as ordered. Monitor intake and record [every] meal. Assist 1:1 with meals. Use divided plate at meals to increase ease of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	getting food on utensils. No mention of straws or sippy cups.Review of the Dietary Resident list for passing out evening snacks revealed R34 in on a regular diet (not pureed). No mention of straws, sippy cups, or 1:1 assistance.Review of a Face Sheet for R44 revealed he originally admitted to the facility on [DATE] with pertinent diagnoses of abnormal posture, epilepsy, and malnutrition.Review of a Physician Order for R44 revealed an order dated 3/13/26 for Carb consistent diet, regular texture, thin consistency. Offer/encourage fruit instead of dessert.Review of the Eating/Nutrition Kardex for R44 revealed Eating: I need supervision.Review of the Dietary Resident list for passing out evening snacks does not show he needed supervision while eating.R45Review of a Face Sheet for R45 revealed she originally admitted to the facility on [DATE] and had pertinent diagnoses of dysphagia, dementia, and hemiplegia and hemiparesis (one-sided weakness.)Review of the Physician Orders for R45 dated 11/16/25 revealed an order for Regular diet, regular texture, nectar consistency.Review of the Eating/Nutrition Kardex for R45 revealed: Eating: [R45] requires supervision for eating and should be encouraged to have meals in the dining room. Provide, serve Regular, thin liquids diet as ordered. Monitor intake and record every meal. Resident to use divided plate to help with self-feeding related to low vision and decreased activity tolerance.Review of the Dietary Resident list used for passing out evening snacks by the dietary staff does not mention the need for 1:1 supervision or thin liquids.In an interview on 4/29/26 at 11:30 AM, the DON agreed that the information in the Physician Orders, the Resident Kardex, and the Dietary Resident List conflicted or lacked necessary details for residents with special needs or who required supervision. The DON acknowledged that the dietary staff could not address residents' special eating needs or supervision requirements and stated she would re-evaluate the practice of having Dietary Aides pass out snacks.