STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	614010	A. BUILDING _____ B. WING _____	5/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHRISTIAN CARE NURSING CENTER	2053 S SHERIDAN DRIVE MUSKEGON, MI 49442

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMMENTS Christian Care Nursing Center was surveyed for a re-visit survey on 5/14/25. Census= 44	F0000		
F0550 SS= D	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required	F0550	F550 1. Residents #401 and #10 still currently reside in the facility, the cited residents did not sustain harm from the deficient practice and are at their psychosocial baseline. Their call lights have been evaluated and are working appropriately. 2. Current residents have the potential to be affected by this deficient practice; a sweep was completed on both units to assess the working order of every resident's call light on 6/6/2025. Residents were interviewed regarding observing staff on cell phones in resident rooms on 6/6/2025. Any resident with a concern had a resident concern form filled out on their behalf. 3. Policies on Call lights and use of Personal cell phones were reviewed and deemed appropriate. Clinical staff have been educated on these policies by 6/6/2025 by the DON/designee. Facility charge nurses were provided with call light receivers to ensure proper notification of call lights. 4. The QAPI committee has directed the DON/designee to perform random weekly audits to ensure call lights are answered timely and staff are not utilizing their personal cell phones in care areas. The Admin/designee will perform a 3x weekly audit on call light receivers to ensure receivers are functioning and audible. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The	4/25/2025

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

Electronically Signed | 06/03/2025

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.

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	under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide care in a dignified manner for 2 residents (R401 and R10) of 6 residents reviewed for dignity. Findings include: R401 Review of an "Admission Record" revealed R401 admitted to the facility on 3/13/2023 with pertinent diagnoses which included congestive heart failure and muscle weakness. Review of a "Minimum Data Set" (MDS) (a tool used for assessing a resident's care needs) assessment for R401, with a reference date of 3/11/2025 revealed a "Brief Interview for Mental Status" (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R401 was cognitively intact. Review of a current activities of daily living (ADL) "Care Plan" intervention for R401, initiated 3/13/2025, revealed R401 used briefs for dignity rather than the toilet. In an observation on 5/13/2025 at 8:31 AM on Love Unit, the nursing station call light monitor displayed R401's call had been on since 7:49 AM. Upon entering room 9, R401 reported her brief was wet and she needed staff assistance to have it changed. R401 reported her call light had been on as the monitor indicated and that she frequently waited for a long time for her call light to be answered.		results will be provided to the QAPI Committee for further follow-up and review.	

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	In an interview on 5/13/2025 at 8:45 AM, Certified Evaluated Nursing Assistant (CENA) "H" reported call lights alarm to electronic tablets that the CENA's carry on their person. CENA "H" reported the only other way to tell that a call light is activated was by checking the call light monitor at the nursing station. CENA "H" reported call lights did not audibly alarm and there were no lights or indicators above the resident's doors to verify whether the call light in the room was activated. CENA "H" reported nurses did not carry the electronic tablets and were required to check the monitor at the nursing station to see if any call lights were activated. In an interview on 5/13/2025 at 8:52 AM, R401 reported call lights often took 40 to 60 minutes to be answered. R401 stated "Sometimes I wonder if my call light works. You get sore when you wait so long to be changed. Sometimes I get ticked off, sometimes it is embarrassing." In an observation and interview on 5/13/2025 at 10:35 AM on Love Unit, CENA "I" reported the only way to know if a call light was going off was by using the electronic tablet or checking the monitor at the nursing station. CENA "I" did not have an electronic tablet on her person at that time. CENA "I" reported she was required to carry the electronic tablet while working but did not always do this as they were bulky and difficult to carry. Review of R401's call light report revealed the following: 5/13/2025- Call light pushed at 7:49 AM and answered 42 minutes later 5/12/2025- Call light pushed at 2:41 PM and answered 53 minutes later			

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	5/12/2025- Call light pushed at 9:09 AM and answered 33 minutes later 5/10/2025- Call light pushed at 9:07 AM and answered 38 minutes later 5/8/2025- Call light pushed at 8:39 AM and answered 57 minutes later 5/5/2025- Call light pushed at 6:57 PM and answered 29 minutes later 5/4/2025- Call light pushed at 10:08 AM and answered 38 minutes later 5/2/2025- Call light pushed at 4:28 PM and answered 35 minutes later 5/2/2025- Call light pushed at 10:30 AM and answered 44 minutes later 4/30/2025- Call light pushed at 7:37 AM and answered 37 minutes later 4/29/2025- Call light pushed at 1:22 PM and answered 43 minutes later 4/29/2025- Call light pushed at 10:18 AM and answered 33 minutes later 4/27/2025- Call light pushed at 8:44 AM and answered 41 minutes later R10 Review of the Admission Record reflected R10 was originally admitted to the facility 1/13/16 with current diagnoses that include muscle weakness and Chronic Obstructive Pulmonary Disease (difficulty in breathing) Review of the Minimum Data Set (MDS) dated 2/17/25			

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	reflected a Brief Interview for Mental Status (BIMS) score of 15 out 15 which indicated the Resident was cognitively intact. On 5/13/25 at 10:52 AM an interview was conducted with R10 in her room. R10 reported that often when staff are in her room to provide care the staff will text on their personal phones. R10 clarified that sometimes staff use the facility-provided electronic work pad but most often staff are texting on their personal phones. R10 reported that when staff are in her room at her request "they should pay attention to me" and "it makes me feel like I have to wait on them". On 5/14/25 at 3:05 PM an interview was conducted with the Director of Nursing (DON) in her office. The DON was informed of the complaint of R10 of staff texting on their personal phone when in her room to provide care. The DON indicated that it is against facility policy for staff to use personal phones in resident rooms. The policy provided by the facility titled "Personal Cell Phones" last revised 10/28/22, was reviewed. The policy reflected "1. The facility prohibits employees from using personal cell phones for any reason on the nursing units or in working areas of the facility" And "2. This includes calls texts, social media or any other use of cell phones".			
F0585 SS= D	Grievances §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished,	F0585	F585 1. Resident #29 still currently resides in the facility. The cited resident did not sustain harm from the deficient practice and is at their psychosocial baseline. Resident #29's grievances were resolved. 2. All residents were interviewed during guardian angel rounds to ensure for potential resident concerns by 6/6/2025. Those	4/25/2025

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	the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for		residents with concerns were provided with a resident concern form and resolved according to the facility grievance policy. 3. The facility IDT was reeducated on the facility grievance policy including grievance documentation, follow up, and resolution by 6/6/2025. Facility grievance monitoring was added to the morning meeting template for follow up. 4. The QAPI committee has directed the NHA/designee to perform random weekly audits of the facility grievance log to ensure grievance is resolved according the grievance policy. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	

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	example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by:			

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	Based on interview and record review, the facility failed to act in accordance with facility policy on two documented grievances for one facility resident (R29) of three residents reviewed for grievances. Findings include: Review of the Admission Record reflected R29 was admitted to the facility 2/9/24 with diagnoses that included weakness and Parkinson's disease. The medical record reflected R29 was cognitively intact. Review of the Plan of Correction (POC) binder provided by the facility revealed two "Grievance/ Complaint Report" forms dated 4/22/25 that identified R29 as the resident of concern. The first form reflected that the "grievance/complaint" of R29 as follows "Resident states that "during mealtimes nursing staff will stand around talking and laughing rather than paying attention to the residents". Also "nurses are sometimes rude or too forceful when trying to get residents to eat"." This document reflected it was "assigned" on 4/23/25 at 10:30 AM to the Director of Nursing (DON) and "Date to be resolved by 4/25/25". The second form reflected the "grievance/complaint" of R29 as follows "Resident states that "when they ask for condiments after receiving a meal tray in their room they are told they will have to wait until after all trays are passed often times they never receive the condiments or their food becomes cold before it comes"". This document, as the first, reflected it was "assigned" on 4/23/25 at 10:30 AM to the DON and "Date to be resolved			

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	by 4/25/25". On 5/14/25 at 11:42 AM an interview was conducted with R29 in her room. R29 was asked about the two Grievance/Complaint forms dated 4/22/25. R29 reported no one had talked with her about these concerns since she raised them more than three weeks prior. R29 reported she has "come to expect that nothing is going to be done" about issues she raises. Review of the policy provided by the facility titled "Resident and Family Grievances" last revised 4/24/25 was reviewed. The policy reflected, "It is the policy of this facility to support each resident's and family member's right to voice grievances ...". And "Definitions" "Prompt efforts to resolve" include facility acknowledgement of a complaint/grievance ad actively working toward resolution of that complaint/grievance". "2 The Grievance Official is responsible for overseeing the grievance process ..." The policy outlined the grievance "Procedure" which included staff initiating a record of "the nature and the specifics on the designated grievance form", forwarding the grievance form to the "Grievance Official, implementing "prompt efforts" to resolve the grievance keeping the resident "apprised of progress of resolution" and "will issue a written decision on the grievance to the resident ...". On 5/14/25 at 2:39 PM an interview was conducted with the DON in her office. The DON reported that the Nursing Home Administrator (NHA) takes care of the resident grievances. On 5/14/25 at 2:46 PM an interview was conducted with the NHA in his office. The NHA indicated that he is the current Grievance Official and addresses resident grievances with "the team" at every morning meeting. The NHA was			

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	presented with the two grievances found in the POC binder and asked the status of this Resident's concerns. The NHA reported he had not seen this grievance paperwork before and reported he was diligent about addressing resident concerns brought to his attention. This indicated that staff are not following the procedure outlined in the "Resident and Family Grievances" policy to ensure resident concerns are addressed.			
F0761 SS= D	Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to appropriately and securely maintain medication storage in 2 of 2 medication rooms and 1 of 2 medication carts.	F0761	F761 1. No specific residents were identified in this citation, both undated TB vaccine vials were discarded immediately upon discovery and the nurse who left the med cart unlocked and unattended was provided on the spot education. 2. The facility provided a sweep of the medication rooms and medication carts by 6/6/2025 to identify improperly dated medications, any found were immediately discarded. 3. The policy on labeling, dating and storage of medications was reviewed and deemed appropriate. Licensed nurses were educated by the DON/designee on proper procedure, including the importance of securing unattended medication carts by 6/6/2025. Labels were requested from pharmacy for the purpose of ensuring vials are dated appropriately. 4. The QAPI committee has directed the DON/designee to perform random weekly audits of medication rooms and carts to ensure appropriate labeling is done and unattended carts are properly secured. The Administrator is responsible for ensuring that substantial compliance is attained through the Plan of Correction and is maintained thereafter. The results will be provided to the QAPI Committee for further follow-up and review.	4/25/2025

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	Findings include: Faith Unit Medication Room In an observation and interview on 5/13/2025 at 8:15 AM in the Faith Unit medication room with Registered Nurse (RN) Unit Manager "J", a multidose vial of opened tuberculin solution did not have an opened date on the vial, box, or packaging. RN Unit Manager "J" reported staff were required to date multidose vials when they were opened so that it could be discarded at the appropriate time. In an observation and interview on 5/13/2025 at 8:40 AM in the Faith Unit medication room with Registered Nurse (RN) Unit Manager "J", a multidose vial of opened tuberculin solution did not have an opened date on the vial. The box was dated. RN Unit Manager "J" reported staff were required to date the vial in addition to the box in case the box became separated from the vial. Review of the Manufacturer's Product Information Sheet (package insert) reflected, "Storage ... A vial of (PPD solution) which has been entered and in use for 30 days should be discarded ..." Love Unit Medication Room On 5/13/25 at 11:18 AM at the Love Unit an unlocked and unattended medication cart was observed. At 11:21 Licensed Practical Nurse (LPN) "G" returned to the medication cart from a front common area. LPN "G" reported she had intended to lock the cart but got distracted at the nurse's station and left the area without locking the cart. Review of facility policy/procedure "Medication			

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	Storage in the Facility", dated November 2021, revealed " ...Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications ... Expiration Dating ... Certain medications ... such as ... multiple dose injectable vials ... require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency ..."			