STATEMENT OF O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CON	ISTRUCTION		ATE SURVEY LETED
		614010	B. WING			5/12/2	2022
NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, ST	ATE, ZIP CO	DE
CHRISTIAN C	ARE NURSING C	CENTER			2053 S SHERIDAN DRIVE MUSKEGON, MI 49442	I.	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	ATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTIC RECTIVE ACTION SHOULD BE EFERENCED TO THE APPROP DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
F0000 SS=	INITIAL COMME	INTS	F0000				
33=	Christian Care Nu Recertification sur	rsing Center was surveyed for a vey on 5/12/22.					
	Intakes: MI001259 MI00127960, and						
	Census= 25.						
F0656 SS= D	Plan §483.21(b) §483.21(b)(1) The implement a correct care plan for eact the resident right and §483.10(c)(3) objectives and the resident's medical psychosocial neet comprehensive at following - (i) The furnished to attai highest practical psychosocial we §483.24, §483.24 services that woot under §483.24, § not provided due rights under §483.24 refuse treatment Any specialized at recommendation the findings of the its rationale in the (iv)In consultation resident's repress resident's goals for	care plan must describe the e services that are to be n or maintain the resident's ble physical, mental, and II-being as required under 5 or §483.40; and (ii) Any uld otherwise be required §483.25 or §483.40 but are to the resident's exercise of 3.10, including the right to under §483.10(c)(6). (iii) services or specialized vices the nursing facility will ult of PASARR is. If a facility disagrees with e PASARR, it must indicate e resident's medical record. n with the resident and the entative(s)- (A) The for admission and desired	F0656				
LABORATORY	DIRECTOR'S OR PI	ROVIDER/SUPPLIER REPRESENT	ATIVE'S SIGNATI	JRE	TITLE	(X6) DA	TE

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.

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 614010		À. BUILDING	3	ISTRUCTION	ĊOMF	(X3) DATE SURVEY COMPLETED <b>5/12/2022</b>	
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE NURSING CENTER				STREET ADDRESS, 2053 S SHERIDAN MUSKEGON, MI 4			DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORRECT RECTIVE ACTION SHOULD I FERENCED TO THE APPRO DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	potential for futu document wheth return to the con any referrals to 1 other appropriate (C) Discharge pl care plan, as ap the requirements this section. This REQUIREM evidenced by: Based on observat review, the facility interventions to pr of 1 Resident revi- having 6 unwitness the potential for so Findings: Review of R22's f revealed she was a the facility on 3/2: included: Atrial fi irritable bowel syr unsteady on feet, or mobility, history of weakness. Review of R22's M nursing assessment she required limited transfers, walking Review of R22's concern dated 3/2; admitted here fron living independen	ace sheet dated 5/12/22 a 96-year-old female admitted to 3/22 and had diagnoses that brillation, anxiety disorder, ndrome, overactive bladder, other abnormalities of gait and of a traumatic brain injury, and Minimum Data Set (MDS) at tool, dated 3/30/22, revealed ed assistance of one person for						

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 614010		À. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 5/12/2022	
	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST 2053 S SHERIDAN DRIVE MUSKEGON, MI 49442			
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE	
	tasks including se to admit here. Thi me as I don't need what to do. I am v which makes com this makes me any and endurance ovv not safe to walk al recent fall. I have UTI's (urinary trac Review of R22's of revised on 4/12/22 related to injuries and lack of safety impaired perfusion branch block), Aft of TIA (transient i like attack), impai w/ frequency, pote neuropathy and po medication w/ occ Review of interve indicate how the f when she was awa anticipate her care Review of the fact revealed she fell of 5:00 AM, 4/12/22 5/2/22 at 7:50 PM timeline showed F one) care after the 5/2/22 at 7:50 PM timeline did not ir stopped or how th supervise R22 ond discontinued.	are plan dated 3/23/22 and 2 revealed, "I am at risk for falls due to my impaired cognition awareness, potential for n due to RBBB (right bundle ib w/pacemaker and hx (history) ischemic attack) (brief stroke- red vision, overactive bladder ential effects of Paget's disease, stential effects of cardiac easional postural hypotension. ntions for this concern did not acility was going to supervise ake and how they planned to						

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER: 614010	À. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 5/12/2022	
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE NURSING CENTER				STREET ADDRESS, 2053 S SHERIDAI MUSKEGON, MI 4		DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO CORRECTIVE ACTION SH REFERENCED TO THE DEFICIENC	IOULD BE CROSS- APPROPRIATE	(X5) COMPLETION DATE	
F0689 SS= D	that R22 had faller on 1:1 the rest of h On 5/11/22 at 9:37 sleeping in a reclin staff were within e During an intervier Registered Nurse ( 05/12/22 at 01:47 I for R22 was review admission and all f "S" and RN "T" co had no fall interver R22 was awake an supervising R22 to "S" and RN "T" co in place did not giv R22 before she cou able to notify staff Free of Accident Hazards/Supervia Accidents. The fa §483.25(d)(1) Th remains as free co possible; and §48 receives adequat assistance device This REQUIREM evidenced by: Based on observ review, the faciliti assistance and s for 1 Resident (R for falls, resulting	AM R 22 was observed her style chair in her room. No yesight of R22. w with the Unit Manager, RN) "T", and RN "S" on PM the facility timeline of falls wed. R22 had 6 falls since falls were unsupervised. RN onfirmed the facility currently ntions in place to ensure when d needed care staff were o provide the needed care. RN onfirmed the current equipment ve staff enough notice to get to ald self-transfer. R22 was not when she needed assistance. sion/Devices §483.25(d) acility must ensure that - ie resident environment of accident hazards as is 83.25(d)(2)Each resident te supervision and es to prevent accidents. IENT is not met as ation, interview and record y failed to provide adequate upervision to prevent falls i.22) of 1 Resident reviewed in R22 having 6 ee admission and the	F0689				

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 614010		À. BUILDIN	G	STRUCTION	. COMF	(X3) DATE SURVEY COMPLETED 5/12/2022	
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE NURSING CENTER			STREET ADDRESS, CITY, S 2053 S SHERIDAN DRIVE MUSKEGON, MI 49442				DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	L /IDER'S PLAN OF CORREC' RECTIVE ACTION SHOULD :FERENCED TO THE APPR( DEFICIENCY)	BE CROSS-	(X5) COMPLETION DATE	
	revealed she wa admitted to the f diagnoses that in anxiety disorder overactive bladc abnormalities of traumatic brain i Review of R22's nursing assessm revealed she rec one person for th use. Review of R22's concern dated 3 4/12/22, "I admit where I had bee several years. A during the last s memory and cog difficulty with ma self-care made i here. This chang don't need help what to do. I am which makes co All this makes m strength and end months, so I am have back pain 1 history of breast tract infections). Review of R22's revised on 4/12/ falls related to in cognition and law	face sheet dated 5/12/22 s a 96-year-old female acility on 3/23/22 and had ncluded: Atrial fibrillation, irritable bowel syndrome, ler, unsteady on feet, other gait and mobility, history of a njury, and weakness. Minimum Data Set (MDS) nent tool, dated 3/30/22, quired limited assistance of ransfers, walking and toilet care plan revealed a focus /23/22 and revised on ted here from my home n living independently for lthough my family helped me averal months, my impaired gnition, confusion and unaging daily tasks including t necessary for me to admit ge is very difficulty for me as I or want others telling me very HOH (hard of hearing) mmunication more difficult. le anxious. I have lost some durance over the last few not safe to walk alone. I from a recent fall. I have a cancer and UTI's (urinary "						

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 614010	À. BUILDIN	G	STRUCTION	COMF	(X3) DATE SURVEY COMPLETED _ <b>5/12/2022</b>	
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE NURSING CENTER				STREET ADDRESS, CITY, S 2053 S SHERIDAN DRIV MUSKEGON, MI 49442			DDE	
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	hx (history) of TI (brief stroke-like overactive bladd effects of Paget' potential effects occasional postu interventions for how the facility v she was awake anticipate her ca Review of the fa revealed she fell 4/12/22 at 9:00 PI 5/10/22 at 9:45 F R22 was placed 4/12/22 at 5:00 / 5/10/22 at 9:45 F indicate what tim how the facility v once the 1:1 car During shift nerse nurse that R22 F had been put on On 5/11/22 at 9: Sleeping in a rec No staff were wi During an intervi Registered Nurs 05/12/22 at 01:4 falls for R22 was since admission unsupervised. R the facility curret in place to ensur	ck), Afib w/ pacemaker and A (transient ischemic attack) attack), impaired vision, ler w/ frequency, potential s disease, neuropathy and of cardiac medication w/ ural hypotension. Review of this concern did not indicate vas going to supervise when and how they planned to are needs. cility timeline for R22's falls I on 4/3/22 at 8:15 pm, AM, 4/12/22 at 6:15 AM, M, 5/2/22 at 7:50 PM, and PM. The timeline showed on 1:1 care after the falls on am, 5/2/22 at 7:50 PM, and PM. The timeline did not ne the 1:1 was stopped or vas going to supervise R22 e was discontinued. ort on 5/11/22 at 6:15 AM the reported to the day shift nad fallen at 4:00 AM and 1:1 the rest of her shift. 37 AM R 22 was observed cliner style chair in her room. thin eyesight of R22. iew with the Unit Manager, ie (RN) "T" and RN "S" on 7 PM the facility timeline of s reviewed. R22 had 6 falls and all falls were N "S" and RN "T" confirmed ntly had no fall interventions re when R22 was awake and ff were supervising R22 to						

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 614010	À. BUILDIN	G	ISTRUCTION	_ COM	(X3) DATE SURVEY COMPLETED <b>5/12/2022</b>	
IAME OF PRO	VIDER OR SUPPLIE	ER		STREET ADDRESS, CITY, ST			ATE, ZIP CODE	
HRISTIAN	CENTER			2053 S SHERIDAN DRI MUSKEGON, MI 49442				
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	confirmed the cu not give staff end before she could	ded care. RN "S" and RN "T" irrent equipment in place did ough notice to get to R22 I self-transfer. R22 was not ff when she needed						
F0756 SS= E	On §483.45(c) ID §483.45(c)(1) The resident must be month by a licen (2) This review re- resident's medic pharmacist must the attending phe- medical director these reports mul- litregularities incl any drug that me- paragraph (d) of unnecessary dru- noted by the pha- must be docume- report that is ser and the facility's of nursing and lis- resident's name, irregularity the p- attending physic resident's medic irregularity thas b- any, action has I there is to be no the attending ph- or her rationale i record. §483.45i develop and ma procedures for the review that inclu- time frames for the time frames for the second content of the	Review, Report Irregular, Act orug Regimen Review. the drug regimen of each a reviewed at least once a used pharmacist. §483.45(c) must include a review of the al chart. §483.45(c)(4) The t report any irregularities to ysician and the facility's and director of nursing, and ust be acted upon. (i) lude, but are not limited to, bets the criteria set forth in t this section for an ug. (ii) Any irregularities armacist during this review ented on a separate, written the the attending physician medical director and director sts, at a minimum, the therelevant drug, and the harmacist identified. (iii) The tain must document in the al record that the identified been taken to address it. If change in the medication, ysician should document his in the resident's medical (c)(5) The facility must intain policies and he monthly drug regimen de, but are not limited to, the different steps in the ps the pharmacist must take	F0756					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI. ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 614010		À. BUILDIN	G	STRUCTION	(X3) DATE SURVEY COMPLETED _ <b>5/12/2022</b>	
	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, 2053 S SHERIDAN DRI MUSKEGON, MI 49442			DDE
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	requires urgent	identifies an irregularity that action to protect the resident. //ENT is not met as					
	facility failed to or reviews and door recommendation R23, and R24) or medication usage	ew and record review, the conduct monthly pharmacy sument pharmacy ns for 4 Residents (R3, R4, of 5 residents reviewed for ge, resulting in the potential egularities to be missed.					
	Findings include	:					
	R3						
	revealed he was admitted to the f diagnoses that in with delusions d condition, major	ace sheet dated 5/12/22 s an 84-year-old male acility on 11/2/17 and had ncluded: Psychotic disorder ue to know physiological depressive disorder, iabetes Mellitus. R3 was not ibility party.					
	review for R3 on Worker (SW) "R information on a (GDR) of the and Geodon for R3. a GDR of Geodo	sychotropic medication 1 5/12/22 at 11:50 AM, Social " was not able to locate gradual dose reduction tipsychotic medication SW "R" said R3 did not have on in the last year. SW "R" locate any pharmacy n for R3.					
	pharmacist supe Pharmacist "U" (	one interview with the facility rvisor (PHS) "V" said does monthly reviews on all was not sure where he					

-	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 614010		À. BUILDIN	G	STRUCTION	ĊOMF	(X3) DATE SURVEY COMPLETED 5/12/2022		
NAME OF PROVIDER OR SUPPLIER CHRISTIAN CARE NURSING CENTER				STREET ADDRESS, CITY, S 2053 S SHERIDAN DRIV MUSKEGON, MI 49442					
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	paper charts and for all residents. locate a pharma of the medication Pharmacist "U" a meetings over th locate any docur recommendation meeting. PHS "\ should track yea medications. On 5/12/22 at 2: Administrator (N the pharmacy re residents. R4 Review of R4's f revealed she wa was admitted to diagnoses that in disease, Demen classified elsewid disturbance, psy disorder. R4 was party. During the antiper review with Soci 5/12/22 at 11:33 Seroquel were re able to locate an recommendation SW "R" said pha the behavior car "R" was not able	eview as the facility has d electronic medical records PHS "V" was not able to cist recommended for a GDR n Geodon. PHS "V" said attends the behavioral care he phone and could not mentation of pharmacy ns during the behavior /" confirmed pharmacy try GDR of psychotropic 46 PM, the Nursing Home HA) said she just received views for the facility face sheet dated 5/12/22 hs an 80-year-old female that the facility on 1/3/22 and had ncluded: Alzheimer's tia in other diseases here with behavioral vchotic disorder, and anxiety s not her own responsibility sychotropic medication al Worker (SW) "R" on AM, R4's use of Zoloft and eviewed. SW "R" was not hy pharmacy ns in R4's medical records. armacy does participate in e conferences however SW to locate any information led during the behavior care							

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		614010	B. WING _			5/12/2	2022
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NAME OF PROV	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CO	DE
CHRISTIAN C	ARE NURSING C	ENTER			2053 S SHERIDAN DRIVE MUSKEGON, MI 49442	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE
	Administrator (NI	16 PM, the Nursing Home HA) said she just received views for the facility					
	pharmacist supe Pharmacist "U" d residents but he documents the re paper charts and for all residents. I locate a pharmad R4 was on Seroor medication) on a was increased in not able to find a and confirmed th	ne interview with the facility rvisor (PHS) "V" said loes monthly reviews on all was not sure where he aview as the facility has electronic medical records PHS "V" was not able to cist recommended for R4. Juel (antipsychotic dmission. R4's Seroquel April 2022. PHS "V" was ny pharmacy reviews for R4 at the Pharmacist should be hitoring the use of Seroquel.					
	5/12/22, revealed I resident admitted t addition, R23's Ad multiple diagnoses diabetes, and depre A review of R23's paper), dated 7/9/2 any evidence that R23's medications 2021, December 2 2022, and April 20 During an intervie NHA was notified locate any evidence pharmacist had rev during the months	medical record (electronic and 1 to 5/11/22, failed to reveal the pharmacist had reviewed during the months of October 021, February 2022, March					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI IND PLAN OF CORRECTION IDENTIFICATION NUMBER: 614010		À. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			ATE SURVEY LETED
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STAT	E, ZIP CO	DE
CHRISTIAN C	ARE NURSING C	ENTER			2053 S SHERIDAN DRIVE MUSKEGON, MI 49442		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTION ( RECTIVE ACTION SHOULD BE CI FERENCED TO THE APPROPRIA DEFICIENCY)	ROSS-	(X5) COMPLETION DATE
	2022. The surveyo that would prove R been reviewed dur	r requested any documentation 23's medication regimen had ing these months.					
	AM, the NHA was not have any documedications had be during the months 2021, February 202 2022. The surveyo documentation that	terview on 5/12/22 at 10:00 notified the surveyor still did nentation that R23's een reviewed by a pharmacist of October 2021, December 22, March 2022, and April r again requested any t would prove R23's n had been reviewed during					
	DON stated she un requested documer had been reviewed months of October February 2022, Ma	w on 5/12/22 at 11:45 AM, the derstood that the surveyor had tation that R23's medications by a pharmacist during the 2021, December 2021, urch 2022, and April 2022. The are still working on getting					
	record, dated 7/9/2 Pharmacist (Pharm	f R23's electronic medical 1 to 5/12/22, revealed ) "U" made the following cist Monthly Review late					
	- 10/30/21- No Red 1:57 PM.	commendation on 5/12/22 at					
	- 12/22/21- No Red 1:57 PM.	commendation on 5/12/22 at					
	- 2/27/22- No Reco 1:59 PM.	ommendation on 5/12/22 at					
	- 3/27/22- No Reco 1:59 PM.	ommendation on 5/12/22 at					

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CHRISTIAN C	CARE NURSING C	CENTER			2053 S SHERIDAN DRIVE MUSKEGON, MI 49442		
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	- 4/21/22- No Reco 1:58 PM.	ommendation on 5/12/22 at					
	NHA stated she ha documentation that the facility did not documentation. Th entering the above R23's electronic m not have any docu conducted monthly for the months of G February 2022, Ma R24 A review of R24's 5/12/22, revealed 1 admitted to the fac R24's Admission H diagnoses that incl depression. A review of R24's paper), dated 5/1/2 any evidence that f R24's medications During an intervie NHA was notified locate any evidence pharmacist had rev May 2021 to April any documentation medication regime by the pharmacist During a second in AM, the NHA was not have any docu	w on 5/12/22 at 04:00 PM, the dd provided all of the t the surveyor requested and have any other additional neerfore, prior to the pharmacist mentioned late entries into tedical record, the facility did mentation the pharmacist had y medication regimen reviews October 2021, December 2021, arch 2022, and April 2022. Admission Record, dated R24 was a 97-year-old resident fility on 11/6/19. In addition, Record revealed multiple luded dementia, anxiety, and medical record (electronic and 21 to 5/11/22, failed to reveal the pharmacist had reviewed from May 2021 to April 2022. w on 5/11/22 at 2:50 PM, the that the surveyor could not the in the medical record that the viewed R24's medications from 1 2022. The surveyor requested an that would prove R24's en had been reviewed monthly over the last 12 months. hterview on 5/12/22 at 10:00 s notified the surveyor still did mentation that R24's een reviewed by a pharmacist					

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NAME OF PROVIDER OR SUPPLIE			STREET ADDRESS, CITY,		
			MUSKEGON, MI 49442	-	
PRÉFIX (EACH DEFICIEN TAG FULL REGULA	NTEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC CORRECTIVE ACTION SHOULD REFERENCED TO THE APPRO DEFICIENCY)	BE CROSS- COMPLÉTION	
again requested ar prove R24's medic reviewed monthly 12 months. During an intervie DON stated she un requested docume had been reviewed 2021 to April 2022 still working on ge A second review of record, dated 5/1/2 "U" made the follo Monthly Review I - 5/11/21- No Rec 9:29 AM. - 6/9/21- No Rec 9:29 AM. - 7/26/21- No Rec 9:29 AM. - 8/30/21- No Rec 9:29 AM. - 9/14/21- No Rec 9:30 AM. - 11/26/21- No Rec 9:30 AM.	April 2022. The surveyor by documentation that would action regimen had been by the pharmacist over the last w on 5/12/22 at 11:45 AM, the nderstood that the surveyor had ntation that R24's medications 1 by a pharmacist from May 2. The DON stated, "they are etting that for you." of R24's electronic medical 21 to 5/12/22, revealed Pharm owing Consultant Pharmacist ate entries: ommendation on 5/12/22 at mmendation on 5/12/22 at ommendation on 5/12/22 at commendation on 5/12/22 at commendation on 5/12/22 at commendation on 5/12/22 at commendation on 5/12/22 at				

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NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, STATE,	ZIP CO	DE
CHRISTIAN C	ARE NURSING C	ENTER			2053 S SHERIDAN DRIVE MUSKEGON, MI 49442		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	IDER'S PLAN OF CORRECTION (E RECTIVE ACTION SHOULD BE CR FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	- 1/31/22- No Reco 9:31 AM.	ommendation on 5/12/22 at					
	- 2/27/22- No Reco 9:30 AM.	ommendation on 5/12/22 at					
	- 3/27/22- No Reco 9:31 AM.	ommendation on 5/12/22 at					
	- 4/21/22- No Reco 9:30 AM.	ommendation on 5/12/22 at					
	NHA stated she ha documentation tha the facility did not documentation. Th entering the above R24's electronic m not have any docum	w on 5/12/22 at 04:00 PM, the d provided all of the t the surveyor requested and have any other additional terefore, prior to the pharmacist mentioned late entries into edical record, the facility did mentation the pharmacist had y medication regimen reviews April 2022.					
F0888 SS= F	§483.80(i) COVII staff. The facility implement policie that all staff are f COVID-19. For p are considered ft 2 weeks or more primary vaccinati The completion of series for COVID administration of the administration multi-dose vaccir of clinical respon the policies and p the following faci	nation of Facility Staff D-19 Vaccination of facility must develop and es and procedures to ensure ully vaccinated for surposes of this section, staff ully vaccinated if it has been since they completed a ton series for COVID-19. of a primary vaccination D-19 is defined here as the a single-dose vaccine, or n of all required doses of a ne. §483.80(i)(1) Regardless sibility or resident contact, procedures must apply to lity staff, who provide any or other services for the	F0888				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CON G		(X3) DATE SURVEY COMPLETED		
	614010		B. WING			5/12/2	5/12/2022	
AME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	TATE, ZIP CC	DDE	
CHRISTIAN (	CARE NURSING (	CENTER			2053 S SHERIDAN DRIVI MUSKEGON, MI 49442	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B EFERENCED TO THE APPRO DEFICIENCY)	E CROSS-	(X5) COMPLETIC DATE	
	employees; (ii) L Students, trained Individuals who other services for residents, under arrangement. §4 procedures of th following facility exclusively provi- telemedicine ser setting and who contact with resi- specified in para and (ii) Staff who the facility that a outside of the fa- have any direct of other staff speci- section. §483.80 procedures mus- following compo- ensuring all staff of this section (e have pending re granted, exempt requirements of whom COVID-19 temporarily delar CDC, due to clin considerations) I minimum, a sing or the first dose series for a multi- prior to staff prov- other services for residents; (iii) A implementation d intended to mitig spread of COVII fully vaccinated	residents: (i) Facility icensed practitioners; (iii) es, and volunteers; and (iv) provide care, treatment, or r the facility and/or its contract or by other 83.80(i)(2) The policies and is section do not apply to the staff: (i) Staff who de telehealth or vices outside of the facility do not have any direct dents and other staff graph (i)(1) of this section; provide support services for re performed exclusively cility setting and who do not contact with residents and ied in paragraph (i)(1) of this (i)(3) The policies and it include, at a minimum, the nents: (i) A process for specified in paragraph (i)(1) xcept for those staff who quests for, or who have been ions to the vaccination this section, or those staff for 9 vaccination must be yed, as recommended by the ical precautions and nave received, at a le-dose COVID-19 vaccine, of the primary vaccination- dose COVID-19 vaccine, of the primary vaccination- dose COVID-19 vaccine, of the primary vaccination- dose COVID-19 vaccine, of the transmission and 0-19, for all staff who are not for COVID-19; (iv) A process securely documenting the						

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER: 614010			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WING _			5/12/2	5/12/2022	
NAME OF PRO	VIDER OR SUPPLIE	ĒR			STREET ADDRESS, CITY,	STATE, ZIP CO	DDE	
CHRISTIAN	CARE NURSING	CENTER			2053 S SHERIDAN DRIV MUSKEGON, MI 49442	VE		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	/IDER'S PLAN OF CORREC RECTIVE ACTION SHOULD FERENCED TO THE APPR DEFICIENCY)	BE CROSS-	(X5) COMPLETIO DATE	
	specified in para (v) A process for documenting the status of any sta booster doses a (vi) A process by exemption from vaccination requ applicable Fedel tracking and sec information prov requested, and f granted, an exer COVID-19 vacci process for ensu which confirms r contraindications which supports a exemptions from signed and date who is not the in exemption, and respective scope and in accordan and local laws, a such documenta information spec authorized COV contraindicated t receive and the for the contraind by the authentic recommending t exempted from t vaccination requ the recognized oc A process for en- secure document status of staff for vaccination mus	nation status of all staff graph (i)(1) of this section; r tracking and securely a COVID-19 vaccination off who have obtained any s recommended by the CDC; y which staff may request an the staff COVID-19 irrements based on an ral law; (vii) A process for curely documenting ided by those staff who have or whom the facility has mption from the staff nation requirements; (viii) A uring that all documentation, recognized clinical s to COVID-19 vaccines and staff requests for medical n vaccination, has been d by a licensed practitioner, dividual requesting the who is acting within their e of practice as defined by, ce with, all applicable State and for further ensuring that ation contains: (A) All citying which of the ID-19 vaccines are clinically for the staff member to recognized clinical reasons lications; and (B) A statement ating practitioner hat the staff member be the facilitys COVID-19 irrements for staff based on clinical contraindications; (ix) issuring the tracking and thation of the vaccination r whom COVID-19 t be temporarily delayed, as y the CDC, due to clinical						

STATEMENT OF DEFICIENCIES         (X1) PROVIDER/SUPPLIER/CLIA           AND PLAN OF CORRECTION         IDENTIFICATION NUMBER:			A (X2) MULTII A. BUILDING	PLE CONSTRUCT		(X3) DATE SURVEY COMPLETED	
		614010	B. WING _	B. WING			022
NAME OF PRO	VIDER OR SUPPLIE	R		STREET	T ADDRESS, CITY, STATE,	ZIP CO	DE
CHRISTIAN (	CARE NURSING C	ENTER			SHERIDAN DRIVE EGON, MI 49442		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	CORRECTIVE	PLAN OF CORRECTION (E E ACTION SHOULD BE CRO CED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE
	but not limited to illness secondary individuals who r antibodies or cor COVID-19 treatm plans for staff wh COVID-19. Effec Publication: §483 ensuring that all (i)(1) of this secti COVID-19, excep been granted exc requirements of t whom COVID-19 temporarily delay CDC, due to clini considerations; This REQUIREM evidenced by: Based on observati review, the facility records of staff CC failed to operationa affecting all facility facility not being a of ten staff member residents. Findings include: A review of the faa and Vaccination pp defined "Staff" as volunteer at (the fa responsibility or re	considerations, including, , individuals with acute / to COVID-19, and eceived monoclonal avalescent plasma for hent; and (x) Contingency to are not fully vaccinated for tive 60 Days After 8.80(i)(3)(ii) A process for staff specified in paragraph on are fully vaccinated for pt for those staff who have emptions to the vaccination this section, or those staff for 0 vaccination must be red, as recommended by the ical precautions and IENT is not met as ion, interview, and record failed to maintain accurate DVID 19 vaccination status and alize their COVID 19 Staff nation policy, potentially y residents, resulting in the tware of the vaccination status ers who provide care to twe contact with residents and e spread of illness to facility cility's Covid 19 Staff Testing policy, last revised 2/16/22, "Any individuals who work or ticility) regardless of clinical stident contact. Thus, staff , licensed practitioners,					

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CHRISTIAN	CENTER							
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	provide care, treat facility) and/or its	volunteers, and others who ment, or other services for (the residents 14. The Infection be responsible for tracking		1				
	Nursing Home Ac that Maintenance	roximately 8:50 AM the Iministrator (NHA) reported Supervisor (MS) "K" had sitive for COVID-19.						
	Matrix provided b (DON) and the St provided by the D (DHR) "L" soon a facility did not rev status of MS "K" positive for COVID facility COVID 19 provided by the fa vaccination status Additionally, revi and staff schedule revealed an additi were not listed on list the facility pro Aide (AA) "M", C "N", Dietary Aide Practical Nurse (I Nurse Aide "Y", a	OVID 19 Staff Vaccination by the Director of Nursing aff Covid 19 Exemption Roster irrector of Human Resources there he survey team entered the veal the vaccination/exemption (who had recently tested ID 19). Further review of the 9 Staff Vaccination Matrix acility did not reveal the of Medical Director (MD) "A". ew of the facility staff roster provided by the facility onal eight staff members (who the Matrix, or the Exemption ovided), and included: Activity Certified Nurse Aide (CNA) (DA) "O", CNA "P", Licensed .PN) "W", Med Tech "X", und Physical Therapist and Manager (PTPM) "H".						
	Therapy Program she is a contract s facility usually the reported that she l submitted and acc was observed to b Protection Equipm	43 AM, Physical Therapist and Manager (PTPM) "H" reported taff member and is in the ree days a week. PTPM "H" has an exemption that was repted by the facility. PTPM "H" e wearing the Personal nent (PPE) required to be worn semption. Review of the facility						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A (X2) MULTI A. BUILDIN	PLE CON G	ISTRUCTION	(X3) DATE SURVEY COMPLETED	
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	COVID 19 Staff V Covid 19 Exemptive vaccination/exemptive on 5/10/22 at 2:50 verified as a Certif provided an update Vaccination Matrix MD "A" received 1 12/8/20 and the CC However, the upda about the status of members listed on but not on the Mat On 5/11/22 at 2:43 NHA requesting the staff members from but not on the Mat On 5/11/22 at 4:41 from DHR "L" that of the nine staff ide but not on the facil Vaccination Matrix email revealed that members were cur and Nurse Aide "Y facility). On 5/11/22 at 4:44 about the Exemptive that reflected six ref "voluntary" exemptions of the second work of the second the second	<ul> <li>'accination Matrix and Staff on Roster did not reveal the otion status of PTPM "H".</li> <li>PM the DON, who was led Infection Preventionist, ed facility COVID 19 Staff x that included the data that the initial vaccination on DVID 19 booster on 10/18/21.</li> <li>ted Matrix did not reflect data MS "K" or the other eight staff the staff roster and schedule rix or Exemption Roster.</li> <li>PM, an email was sent to the ee employee status of the nine n the staff roster and schedule rix or Exemption list.</li> <li>PM, an email was received t clarified the employee status entified from the staff roster lity COVID 19 Staff x or Exemption Roster. The t seven of the nine staff rent employees (Med Tech "X" " no longer worked at the</li> <li>PM, the DON was asked on list provided by the facility eligious exemptions and one tion. The DON reported she at a "voluntary" exemption is.</li> </ul>			DEFICIENCY)		
	This was later clar voluntary terminat of why the former Exemption Roster. A review of the CO	ified by DHR "L" as a ion but without an explanation staff member remained on the					

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER: 614010		À. BUILDIN	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 5/12/2022	
NAME OF PROVIDEF				TATE, ZIP CODE				
PRÉFIX (EA	CH DEFICIEN	TEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY 'ORY OR LSC IDENTIFYING IFORMATION)	ID PREFIX TAG	COR	I /IDER'S PLAN OF CORRECTI RECTIVE ACTION SHOULD B FERENCED TO THE APPROF DEFICIENCY)	E CROSS-	(X5) COMPLETION DATE	
repo Netw data This beca PTP men were Vacc Exer after betw and high In ar the N of st conc any On 5 copy vacc lister Matti infor COV did r be p PTP	rted to the Nai vork (NHSN) the survey tea was a discrep use there were M "H", MS "F ibers) whose v e not listed on cination Matri nption Roster the entrance of een what was what the facilitier. In interview con VHA was info aff COVID 19 ern. The NHA clarifying que i/12/22 at 9:49 documentatic ination status d on the facilities in or the Exer med that the t VID 19 vaccin- tot indicate the rovided. S/12/22 at 1:56 lucted with the lity Assurance The NHA was taff Vaccination used during ( this was an idued forward. T	the 84.2% that the facility ional Healthcare Safety the week of 4/24/22 (the latest m had prior to the survey). ancy of 7.1%. However, then staff members (MD "A", C", and seven other listed staff accination/exemption status the COVID 19 Staff x and the Staff Covid 19 the survey team received soon conference, the discrepancy reported to the NHSN database ty has in their records could be inducted 5/12/22 at 9:45 AM, rmed the tracking and reporting vaccination status was a a made no comment or asked stions. AM, the DON provided hard- on of the Seven staff members not y COVID 19 Vaccination nption list. The DON was racking and reporting of staff ation was a concern. The DON at additional information will PM, an interview was the NHA in her office during the Quality Improved (QAPI) s asked if the facility COVID on tracking, and reporting was API meetings. It was reiterated entified concern that is being the NHA reported that there was Human Resource staff and the						

		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONST IDENTIFICATION NUMBER: A. BUILDING			(X3) D/ COMP	ATE SURVEY LETED		
		614010		B. WING _			5/12/2022	
NAME OF PROV	VIDER OR SUPPLIE	R				STREET ADDRESS, CITY, STATE,	ZIP CO	DE
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	DON. The NHA re no issues with the employee COVID "very meticulous".	e not sharing data with the eported she feels that there are tracking and reporting of 19 status and that the DON is rmation was provided by						