STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235549	A. BUILDING _____ B. WING _____	**06/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROOSEVELT PARK NURSING AND REHABILITATION COMMUNIT	**1300 W BROADWAY AVE MUSKEGON, MI 49441**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0835 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Administer the facility in a manner that enables it to use its resources effectively and efficiently.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake # MI- 0762 Based on interview and record review, the previous facility administration failed to provide a safe resident environment and protect residents from abuse, when the previous administrator (PADM) and previous Director of Nursing (PDON) (A) were informed by staff that one resident (Resident #3) had allegedly been involved in a case of abuse through the use of a staff cell phone, (B) did not report the allegation to the state or to their corporate office, and (C) instructed staff not to speak of the incident or tell anyone about the incident, resulting in an incident of inappropriate staff conduct towards a resident with cognitive deficits to go unreported and kept hidden putting all vulnerable residents at risk for continued and/or further abuse. Findings: Review of facility policy Abuse Prevention Program Policy & Procedure, last revised 11/2018, indicated that staff were to prevent residents from abuse that included abuse facilitated or enabled through the use of technology. Resident #3 Review of a Face Sheet revealed R3 was a [AGE] year old female, admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. During an interview on 06/24/20 at 11:25 A.M., Certified Nurse Aid (CNA) B indicated being aware of the video that had been posted to snapchat, did not see the video, but was aware that R3 had been on the video. CNA B also stated that when speaking to the PADM and PDON about the matter, was advised to keep quiet and not talk about it with anyone. During an interview on 06/24/20 at 12:40 P.M., R3 stated that she did not recall the incident in question where she was allegedly on a video that was seen on snapchat. During an interview on 06/25/20 at 9:40 A.M., CNA E indicated knowing about the video, saw the video on snapchat and was told by the PADM and PDON to not talk about it with anyone. Review of a Personnel Action Form dated 2/19/20 and an Employee Memorandum also dated 2/19/20 revealed that CNA C had been terminated from employment due to inappropriate behavior in a resident room-violation of social media policy. During an interview on 06/25/20 at 1:10 P.M., Regional Clinical Coordinator-Registered Nurse (RCC-RN) A reported that the PADM had not notified the corporate office of the alleged incident and that corporate was not aware that a staff member had been fired as a result of the twerking incident. RCC-RN A also indicated that a facility investigation regarding the incident could not be located. Record review of the complaint intake received revealed that in February 2020, Two aides were reported to have posted a snap chat video of themselves twerking one employee was fired and the other was suspended for 3 days the aides names were {name and name) dont know her last name. When it was brought up staff was told to keep quiet. The administration said it could effect their job if it got but whatabout the residents whose rights was violated she was looking very uncomfortable and offended as they danced in her room right in her face total disrespect to her.

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

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.