

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  235384	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  06/05/2025
NAME OF PROVIDER OR SUPPLIER  Schnepp Senior Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE  427 East Washington St. Louis, MI 48880	
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake MI00153208</p> <p>Based on observation, interview, and record review, the facility failed to notify the responsible party of an event that may have mental or psychological disturbance for two Residents (R36 and R293) of two Residents reviewed for abuse.</p> <p>Findings included:</p> <p>Review of the facility policy, Change of Condition - Resident Family/Responsible Party Notification dated 4/12/16 revealed, Purpose: To notify family and/or responsible party any time there is a: 3. Change in mental, psychosocial or behavioral management.</p> <p>Review of the facility Abuse Policy dated, 3/15/2023 revealed, viii) Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault and includes non-consensual sexual contact of any type with a resident. D) The Administrator and/or Director of Nursing (DON) must be notified of all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown origin and misappropriation of resident property immediately. If the events that cause the allegation involve abuse or result in serious bodily injury, the facility administrator or DON with report to appropriate licensing agencies and local officials immediately but not later than 2 hours and not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and did not result in serious bodily injury. e) INVESTIGATION i) Time Frame for Investigation. (1) The investigation shall be initiated immediately, after the Administrator has knowledge of the incident, but in no event shall the investigation take longer than five (5) working days.</p> <p>R36</p> <p>Review of R36's admission Record dated 6/3/2025 revealed she was [AGE] years old and admitted on [DATE]. Her diagnoses included: Dementia, heart failure, depression, and anxiety disorder. She was not her own responsible party.</p> <p>Review of R36's Behavior note dated 5/18/25 at 4:33 PM revealed, Activity aid observed a male resident grab (R36) to back of head and kiss her. The nurse asked R36 about the incident and she is unable to recall incident. No S/S (signs or symptoms) of distress noted, Registered Nurse (RN) A notified. (no indication that R36's responsible party was notified of this event).</p> <p>(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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:  Facility ID: 235384	If continuation sheet Page 1 of 7

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R36 and R293 were both observed in the activity room on 6/3/25 at 9:41 AM. There were a total of 12 residents in the room and all residents were very close to each other. One staff member was in the room most of the time. For a few minutes at a time staff would leave the room and all 12 residents were left unsupervised.</p> <p>On 6/3/25 at 9:54 AM, a Certified Nurse Aide (CNA) was in the activity room supervising 12 residents as the activity aid left the room for a break. CNA P said the only resident that needs close supervision was R293 because he gets Handsy (someone who is prone to touch other people, often in an inappropriate or unwanted way). Within a minute of this interview R293 was observed reaching out to a female resident. CNA P went over to R293 and said we need to keep our hands to ourselves and R293 pulled his hand back.</p> <p>During an interview with RN A on 6/5/25 at 10:10 AM, RN A confirmed that Licensed Practical Nurse (LPN) J notified her on 5/18/25 about R293 kissing R36. RN A confirmed that she notified the Director of Nursing (DON) and Nursing Home Administrator (NHA) that R293 kissed R36. RN A reviewed all text messages, and no one was instructed to notify R36's or R293's responsible parties of the event.</p> <p>During an interview with LPN J on 6/5/25 at 10:10 AM, LPN J reviewed her text messages and confirmed that she notified RN A about the report of R293 kissing R36 on 5/18/25. LPN J texted RN A twice about notifying R36's responsible party and she was instructed not to notify them by RN A.</p> <p>During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 6/5/25 at 12:20 PM, the DON and NHA confirmed they received a text message from RN A on 5/18/25 at 12:08 PM that informed them R293 kissed R36. They said they did not notify the responsible parties or instruct anyone to notify the responsible parties. They were not able to locate any documentation the R36's or R293's responsible parties were notified of the event.</p> <p>During an interview with Activity Aide (AA) Q on 6/4/25 at 11:55 AM, AA Q recalled working on 5/18/25 and being in the activity room with several residents when R293 kissed R36. She recalled a resident yelled hey and when she turned to see what was going on R293 was sitting in front of R36. R293 had R36's head in his lap (R36 was sitting in a chair and R293 was in a wheelchair). R293 kissed R36 on the lips. It was a romantic kiss like a Hallmark Movie. After the kiss R36 looked wide eyed and dazed. AA Q said she walked over to them and pulled R293 away from R36 and that was the end of it. AA Q could not recall the time of day or anyone else working at the time. She said she could not report it immediately as she was in the room by herself. She said when it was safe she reported it to the nurse in charge. She was not sure who the nurse in charge was but believed it might have been LPN J.</p> <p>R293</p> <p>Review of R293's admission Record dated 6/5/25 revealed he was [AGE] years old and was admitted on [DATE]. His diagnoses included: Alzheimer's disease, dementia, and alcoholic cirrhosis of the liver. He was not his own responsible party.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of R293's Behavior note dated 5/18/25 at 1:30 PM revealed, (11:30) Activity Aid (sic) observed R293 grab a hold of another resident's head and pull her into his face and kiss other resident. Activity asked him to stop and R293 did not let go. As Activity aid approached R293. He released her. This nurse was informed of. Specific behavior: above asked R293 what happened states. I wanna kiss Educated R293 not to touch others. Removed from dining room. Later on, this afternoon did not recall incident. Continues to make sexual comments to staff and other residents. Attempting to grab other residents and staff as they are passing by him. Making sexual gestures. (no indication that R293's responsible party was notified of this event)</p>

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake MI00153208</p> <p>Based on observations, interviews, and record review, the facility failed to report to the State Agency an allegation of abuse for two resident (R36 and R293) of two residents reviewed for abuse.</p> <p>Findings included:</p> <p>Review of the facility Abuse Policy dated, 3/15/2023 revealed, viii) Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault and includes non-consensual sexual contact of any type with a resident. D) The Administrator and/or Director of Nursing (DON) must be notified of all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown origin and misappropriation of resident property immediately. If the events that cause the allegation involve abuse or result in serious bodily injury, the facility administrator or DON with report to appropriate licensing agencies and local officials immediately but not later than 2 hours and not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and did not result in serious bodily injury. e) INVESTIGATION i) Time Frame for Investigation. (1) The investigation shall be initiated immediately, after the Administrator has knowledge of the incident, but in no event shall the investigation take longer than five (5) working days.</p> <p>R36</p> <p>Review of R36's admission Record dated 6/3/2025 revealed she was [AGE] years old and admitted on [DATE]. Her diagnoses included: Dementia, heart failure, depression, and anxiety disorder. She was not her own responsible party.</p> <p>Review of R36's Behavior note dated 5/18/25 at 4:33 PM revealed, Activity aid observed a male resident grab (R36) to back of head and kiss her. The nurse asked R36 about the incident and she is unable to recall incident. No S/S (signs or symptoms) of distress noted, Registered Nurse (RN) A notified.</p> <p>R36 and R293 were both observed in the activity room on 6/3/25 at 9:41 AM. There were a total of 12 residents in the room and all residents were very close to each other. One staff member was in the room most of the time. For a few minutes at a time staff would leave the room and all 12 residents were left unsupervised.</p> <p>On 6/3/25 at 9:54 AM, Certified Nurse Aide (CNA) was in the activity room supervising 12 residents as the activity aid left the room for a break. CNA P said the only resident that needs close supervision was R293 because he gets Handsy (someone who is prone to touch other people, often in an inappropriate or unwanted way). Within a minute of this interview R293 was observed reaching out to a female resident. CNA P went over to R293 and said we need to keep our hands to ourselves and R293 pulled his hand back.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with RN A on 6/5/25 at 10:10 AM, RN A confirmed that Licensed Practical Nurse (LPN) J notified her on 5/18/25 about R293 kissing R36. RN A confirmed that she notified the Director of Nursing (DON) and Nursing Home Administrator (NHA) that R293 kissed R36. RN A reviewed all text messages, and no one was instructed to report this allegation of abuse to the State Agency. RN A was not able to recall any particulars about the event. RN A did not report this allegation to the State Agency she just checked on R36 and she had no recall of the event or injury.</p> <p>During an interview with LPN J on 6/5/25 at 10:10 AM, LPN J reviewed her text messages and confirmed that she notified RN A about the report of R293 kissing R36 on 5/18/25. RN A did not instruct her to report this event to anyone.</p> <p>During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 6/5/25 at 12:20 PM, the DON and NHA confirmed they received a text message from RN A on 5/18/25 at 12:08 PM that informed them R293 kissed R36. They said there was only one witness Activity Aid AA Q. They spoke to AA Q on the phone and because there was no intent, injury or recall of the event they did not investigate or report this event to the State Agency. They did not document any interviews or conversations about the event.</p> <p>During an interview with Activity Aide (AA) Q on 6/4/25 at 11:55 AM, AA Q recalled working on 5/18/25 and being in the activity room with several residents when R293 kissed R36. She recalled a resident yelled hey and when she turned to see what was going on R293 was sitting in front of R36. R293 had R36's head in his lap (R36 was sitting in a chair and R293 was in a wheelchair). R293 kissed R36 on the lips. It was a romantic kiss like a Hallmark Movie. After the kiss R36 looked wide eyed and dazed. AA Q said she walked over to them and pulled R293 away from R36 and that was the end of it. AA Q could not recall the time of day or anyone else working at the time. She said she could not report it immediately as she was in the room by herself. She said when it was safe she reported it to the nurse in charge. She was not sure who the nurse in charge was but believed it might have been LPN J.</p> <p>R293</p> <p>Review of R293's admission Record dated 6/5/25 revealed he was [AGE] years old and was admitted on [DATE]. His diagnoses included: Alzheimer's disease, dementia, and alcoholic cirrhosis of the liver. He was not his own responsible party.</p> <p>Review of R293's Behavior note dated 5/18/25 at 1:30 PM revealed, (11:30) Activity Aid (sic) observed R293 grab a hold of another resident's head and pull her into his face and kiss other resident. Activity asked him to stop and R293 did not let go. As Activity aid approached R293. He released her. This nurse was informed of. Specific behavior: above asked R293 what happened states. I wanna kiss Educated R293 not to touch others. Removed from dining room. Later on, this afternoon did not recall incident. Continues to make sexual comments to staff and other residents. Attempting to grab other residents and staff as they are passing by him. Making sexual gestures.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation pertains to intake MI00153208</p> <p>Based on observations, interviews, and record review, the facility failed to thoroughly investigate an allegation of abuse for two Residents (R36 and R293) of two Residents reviewed for abuse.</p> <p>Findings included:</p> <p>Review of the facility Abuse Policy dated, 3/15/2023 revealed, viii) Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault and includes non-consensual sexual contact of any type with a resident. D) The Administrator and/or Director of Nursing (DON) must be notified of all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown origin and misappropriation of resident property immediately. The events that cause the allegation involve abuse or result in serious bodily injury, the facility administrator or DON with report to appropriate licensing agencies and local officials immediately but not later than 2 hours and not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and did not result in serious bodily injury. e) INVESTIGATION i) Time Frame for Investigation. (1) The investigation shall be initiated immediately, after the Administrator has knowledge of the incident, but in no event shall the investigation take longer than five (5) working days.</p> <p>R36</p> <p>Review of R36's admission Record dated 6/3/2025 revealed she was [AGE] years old and admitted on [DATE]. Her diagnoses included: Dementia, heart failure, depression, and anxiety disorder. She was not her own responsible party.</p> <p>Review of R36's Behavior note dated 5/18/25 at 4:33 PM revealed, Activity aid observed a male resident grab (R36) to back of head and kiss her. The nurse asked R36 about the incident and she is unable to recall incident. No S/S (signs or symptoms) of distress noted, Registered Nurse (RN) A notified.</p> <p>R36 and R293 were both observed in the activity room on 6/3/25 at 9:41 AM. There were a total of 12 residents in the room and all residents were very close to each other. One staff member was in the room most of the time. For a few minutes at a time staff would leave the room and all 12 residents were left unsupervised.</p> <p>On 6/3/25 at 9:54 AM, Certified Nurse Aide (CNA) was in the activity room supervising 12 residents as the activity aid left the room for a break. CNA P said the only resident that needs close supervision was R293 because he gets Handsy (someone who is prone to touch other people, often in an inappropriate or unwanted way). Within a minute of this interview R293 was observed reaching out to a female resident. CNA P went over to R293 and said we need to keep our hands to ourselves and R293 pulled his hand back.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with RN A on 6/5/25 at 10:10 AM, RN A confirmed that Licensed Practical Nurse (LPN) J notified her on 5/18/25 about R293 kissing R36. RN A confirmed that she notified the Director of Nursing (DON) and Nursing Home Administrator (NHA) that R293 kissed R36. RN A reviewed all text messages, and no one was instructed to start an investigation. RN A was not able to recall any particulars about the event. RN A did not do an investigation she just checked on R36 and she had no recall of the event or injury.</p> <p>During an interview with LPN J on 6/5/25 at 10:10 AM, LPN J reviewed her text messages and confirmed that she notified RN A about the report of R293 kissing R36 on 5/18/25. RN A did not instruct her to investigate the event or notify anyone of the event. LPN J was only aware the Activity Aide Q witnessed the event, she was not aware of any investigation and did not recall who was working. She was unaware of any other witnesses to the event. She did recall R36 had no recall of the event or any injury.</p> <p>During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 6/5/25 at 12:20 PM, the DON and NHA confirmed they received a text message from RN A on 5/18/25 at 12:08 PM that informed them R293 kissed R36. They said there was only one witness Activity Aid Q. They spoke to AA Q on the phone and because there was no intent, injury or recall of the event they did not investigate or report this event to the State Agency. They did not document any interviews or conversations about the event.</p> <p>During an interview with Activity Aide (AA) Q on 6/4/25 at 11:55 AM, AA Q recalled working on 5/18/25 and being in the activity room with several residents when R293 kissed R36. She recalled a resident yelled hey and when she turned to see what was going on R293 was sitting in front of R36. R293 had R36's head in his lap (R36 was sitting in a chair and R293 was in a wheelchair). R293 kissed R36 on the lips. It was a romantic kiss like a Hallmark Movie. After the kiss R36 looked wide eyed and dazed. AA Q said she walked over to them and pulled R293 away from R36 and that was the end of it. AA Q could not recall the time of day or anyone else working at the time. She said she could not report it immediately as she was in the room by herself. She said when it was safe she reported it to the nurse in charge. She was not sure who the nurse in charge was but believed it might have been LPN J.</p> <p>R293</p> <p>Review of R293's admission Record dated 6/5/25 revealed he was [AGE] years old and was admitted on [DATE]. His diagnoses included: Alzheimer's disease, dementia, and alcoholic cirrhosis of the liver. He was not his own responsible party.</p> <p>Review of R293's Behavior note dated 5/18/25 at 1:30 PM revealed, (11:30) Activity Aid (sic) observed R293 grab a hold of another resident's head and pull her into his face and kiss other resident. Activity asked him to stop and R293 did not let go. As Activity aid approached R293. He released her. This nurse was informed of. Specific behavior: above asked R293 what happened states. I wanna kiss Educated R293 not to touch others. Removed from dining room. Later on, this afternoon did not recall incident. Continues to make sexual comments to staff and other residents. Attempting to grab other residents and staff as they are passing by him. Making sexual gestures.</p>		