STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235384	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Schnepp Senior Care and Rehabilitation Center	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)
F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Citation related to intake #2575541Based on interview and record review, the facility failed to prevent physical abuse and neglect for two residents (R4, R6) of three residents reviewed for abuse, resulting in emergency hospitalization, injury and fearfulness. Findings include: Resident #4 (R4)Review of an admission Record revealed R4 was a [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses of dementia, Parkinson's disease, and type 2 diabetes. Review of a Brief Interview for Mental Status (BIMS) dated 7-25-25, reflected a score of 0 out of 15 which indicated severe cognitive impairment. Review of a VA (veteran's administration) admission report, faxed to the facility and stamped as received on 7-09-25, revealed the following information regarding R4: (a) veteran (R4) with recent noted appetite and oral intake decrease, (b) wife/caregiver had been offering and feeding R4 with nutritional supplements but there had been a 10-15 pound weight loss in past 6 months, (c) type 2 diabetes assessment-blood sugars are well controlled .VA pharmacy discontinued his insulin in March 2025 and will continue on Metformin 1000 mg (milligrams) twice daily .if blood sugars are consistently elevated above 200, pharmacy has recommended restarting insulin.Review of a Blood Sugar Summary for R4 revealed that blood sugars were not checked by the facility from time of admission on [DATE] to the time of hospitalization on 7-27-25.Review of a Nursing Note for R4 dated 7-18-25 revealed .(R4) arrived at facility via car from home accompanied by wife, walked onto unit using a walker, unsteady gait, no skin concerns noted, and able to handle hot liquids.Review of a Nursing Note for R4 dated 7-19-25 at 8:34 AM reflected .(R4) alert to self, accepts meds crushed, respirations even/unlabored, breath sounds diminished, no edema noted, vital signs stable, ambulates with one person assist and four wheeled-walker, allows staff to assist him.Review of a 'Nursing Note for R4 dated 7-19-25 at 10:23 AM reflected .alert and oriented to self, has difficulty making needs known, no signs or symptoms of pain, lung sounds clear on room air, ambulates with one assist and four wheeled-walker with shuffling gait, able to feed self finger foods.Review of a Nursing Note for R4 dated 7-19-25 at 7:00 PM reflected .alert and oriented to self with confusion, lung sounds clear, no edema (swelling) noted, skin warm and dry, maximum assist needed with ADL's (activities of daily living), requires assist with meals, ambulates with walker and assist, requires assist with meal, is pocketing food and not swallowing well.Review of a Nursing Note for R4 dated 7-19-25 at midnight revealed .alert and oriented to self, respirations even and unlabored, no edema, ambulates with walker and assist.Review of a Nursing Note for R4 dated 7-20-25 at 9:50 AM reflected .alert and oriented to self, confusion, lung sounds clear on room air, no edema, transfers and ambulates with four-wheel walker and one assist, pocketing food and putting too much in his mouth. During an interview on 8-11-25 at 2:00 PM, Family Member W stated that she spoke to R4 on the phone the evening of 7-20-25 and he sounded pretty good and like himself.Review of a Nursing Note for R4 dated 7-21-25 at 6:04 PM revealed .resident noted to be pocketing food, cognition is poor and not following simple directions, Speech Therapy screen placed. This was the only nursing progress note documented on 7-21-25. Review of a Physician Note for R4 dated 7-22-25 revealed the following: (a) required long term care due to dementia, Parkinson's disease, heart disease, and diabetes, (b) currently ambulatory with assist, (c) exam is positive for trouble swallowing, weakness, and confusion.Review of the EHR (electronic health record) for R4 reflected that no Nursing Note (s) were documented for a face-to-face nursing assessment on 7-22-25. Review of the EHR for R4 reflected that no Nursing Note (s) were documented for a face-to-face nursing assessment on 7-23-25. Review of a Nursing Note for R4 dated 7-24-25 at 3:04 AM reflected .resident is alert to self, accepts meds crushed in pudding, poor appetite, resting in bed at this time. This was the only nursing progress note documented on 7-24-25 regarding the overall well-being and assessment of R4. Review of the EHR for R4 reflected that no Nursing Note (s) were documented for a face-to-face nursing assessment on 7-25-25.Review of an Occupational Therapy (OT) Evaluation for R4 dated 7-25-25 indicated the reason for the referral was staff reported that on 7-23-25 and 7-24-25 the resident had difficulty holding up his head and/or was bent over in half forward or leaning position. During an interview on 8-11-25 at 2:25 PM, Family Member V stated that the Wednesday before (R4) went to the hospital (7-23-25) something was wrong, and I told staff that he wasn't himself and that something was different. FM V indicated that nursing staff told her that he (R4) is giving up and this is how the end of life looks. FM wife stated that this was very upsetting to her and that it felt like staff were making excuses, so they didn't have to figure out what happened and why he (R4) was so much worse. Review of a Nursing Note for R4 dated 7-26-25 at 12:30 AM

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2581979 and #2585133Based on interview and record review, the facility failed to report an allegation of sexual abuse that involved two of two resident's (Resident #1 and Resident #2). Findings:Resident #1 (R1)Review of an admission Record revealed R1 was an [AGE] year-old female, admitted to the facility on [DATE] with pertinent diagnosis of severe dementia. Resident #2 (R2)Review of an admission Record revealed R2 was an [AGE] year-old-male, last admitted to the facility on [DATE] with pertinent diagnosis of dementia. Review of a Brief Interview for Mental Status (BIMS), dated 6-05-25, revealed a score of 3 out of 15 for R2, that indicated severe cognitive impairment. Review of a Nursing Progress Note for R1, dated 8-05-25, reflected the following: Resident (R1) was found in her room with male resident by CNA (certified nurse aide). When CNA walked in the resident (R1) was pulling her pants up and the male resident (R2) was laying in the roommate's bed completely naked and with feces .CNA then reported that the male resident (R2) was fully erect (penile erection) when found in the roommate's bed. Floor nurse manager (Clinical Care Coordinator/Registered Nurse B) came into the facility to do skin assessments and documentation on both female (R1) and male (R2) resident. Floor nurse manager (CCC/RN B) reported no skin issues were found, and no signs of sexual intercourse were found. During an interview on 8-13-25 at 11:00 AM, CNA D reported the following information regarding the above incident between R1 and R2 on 8-05-25: CNA D walked into R1's room and found R1 at the foot of the bed pulling her pants up and R2 laying in a bed naked, under a sheet, and R2 had an erection. CNA D separated R1 and R2. CNA D asked R2 what had happened. R2 did not seem like his usual self, looked flustered and upset, and just kept saying I don't know when asked about the details of the interaction with R1. CNA D reported the information to the floor nurse. During an interview on 8-13-25 at 11:50 AM, CCC/RN B conveyed the following information regarding the above incident between R1 and R2 on 8-05-25: (a) received a telephone call from the floor nurse about the matter and went to the facility to assess the situation, (b) stated that neither resident had any skin issues identified (no bruising, no blood, no discharge (vaginal or penile) and no signs of sexual intercourse were found, and (c) stated that she could not tell if there had been oral sex or fondling involved. CCC/RN B also indicated that she did not report the incident to the abuse coordinator. During an interview on 8-13-25 at 12:10 PM, the Nursing Home Administrator/Abuse Coordinator (NHA/AC) indicated that she was not made aware of the incident between R1 and R2 the evening of 8-05-25 until the next morning (8-06-25) at stand up (a daily morning meeting where team heads meet to discuss any concerns and new changes). The NHA/AC became aware by reading the progress note submitted by CCC/RB B and stated that there was nothing in the progress note that lead her to believe there was a possible sexual interaction between R1 and R2. The NHA/AC stated that she had received a phone call later in the afternoon of 8-06-25, from a concerned staff person, Registered Nurse (RN) S who reported hearing that something had occurred between R1 and R2 the evening before (8-05-25) that included (a) a male resident was found naked in a female room, (b) the male resident had an erection and his foreskin was pulled back, and (c) that families had not been notified. The NHA/AC stated that the alleged incident was not reported to the State Agency. During an interview on 8-13-25 at 12:46 PM, RN S stated that she contacted the NHA/AC on the afternoon of 8-06-15 just after hearing some of the information about the interaction between R1 and R2 the evening of 8-05-25. RN S indicated that the information she heard made her very uneasy, was concerned that a sexual encounter may have occurred, knew that neither resident could consent due to significant cognitive impairment, and wanted to make sure that the NHA/AC had been given all available information. Review of the State Operations Manual SOM reflected the following definition of an Alleged Violation: a situation or occurrence that is observed or reported by staff .but has not yet been investigated and, if verified, could be noncompliance with Federal requirements related to abuse.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to assess for physician ordered parameters during medication administration for one of three residents (Resident #7), reviewed for professional standards. Findings:Resident #7 (R7)Review of an admission Record revealed R7 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses of dementia, high blood pressure, type 2 diabetes, and chronic kidney disease stage 3. A Brief Interview for Mental Status (BIMS) completed 7-29-25 revealed a score of 11 out of 15 that reflected moderate cognitive impairment. Review of a physician order summary for R7 revealed an order for Metoprolol 25 MG (milligrams) 1/2 tab in the morning for high blood pressure. HOLD if SBP (systolic blood pressure) if less than 110 and pulse is less than 60. Review of an Electronic Medication Administration Record (Emar) for R7, dated July 2025, revealed R7 received the blood pressure medication Metoprolol, from 7-23-25 to 7-31-25, six times without blood pressure monitoring before administration of the medication. On 7-30-25, R7's blood pressure was assessed in the morning, was found to be 97/61, below the parameters to administer the medication, and R7 was still administered the Metoprolol.Review of an Emar for R7, dated August 2025, revealed R7 received Metoprolol, from 8-1-25 to 8-13-25, twelve times without blood pressure monitoring before the administration of the medication. During an interview on 8-13-25 at 9:45 AM, the Director of Nursing (DON) could not locate blood pressures for R7 on every morning that the medication Metoprolol was administered to the resident. The DON indicated that nurses were expected to follow physician orders with each medication administration. Review of the facility policy General Procedures for All Medications reflected .Nursing will administer medications in a safe and effective manner .(J) obtain and record any vital signs as necessary prior to medication administration.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation is related to intake #2585133Based on observation, interview, and record review, the facility failed to accurately assess, document, and initiate treatment for one of three residents (Resident #7) reviewed for pressure ulcers, resulting in the worsening of a coccyx wound. Findings:Resident #7 (R7)Review of an admission Record revealed R7 was an [AGE] year-old male, originally admitted to the facility on [DATE], with pertinent diagnoses of dementia, high blood pressure, type 2 diabetes, and chronic kidney disease stage 3. A Brief Interview for Mental Status (BIMS) completed 7-29-25 revealed a score of 11 out of 15 that reflected moderate cognitive impairment. Review of a Nx-admission Assess (nursing admission assessment) section C. skin integrity, for R7 and dated 7-22-25, reflected the following: R7 had four documented skin wounds at the time of admission (a) a stage 1 pressure injury to the coccyx, (b) bruising to the left elbow, (c) pressure injuries to the left toes, and (d) pressure injuries to the right toes. Per the assessment tool in the document, a stage 1 pressure wound involves intact skin with non-blanchable redness of an area. The nursing admission assessment did not indicate the stage of the pressure injuries to either the right or the left toes, nor were any measurements documented regarding the skin impairments. Review of an Electronic Treatment Administration Record (Etar) for R7, dated July 2025, revealed the facility did not have a treatment order in place for the stage 1 pressure injury to the coccyx. Review of a Physician Progress Note for R7, dated 7-24-25, reflected the purpose of the exam was for admission and H&P (history and physical). The physician documented .Skin: negative for rash and wound. The physician progress note did not contain any information about the stage 1 coccyx pressure injury noted at admission, nor any of the pressure injuries to the toes on both feet. Review of Nursing Progress Notes and Skin/Wound Assessments for R7, dated 7-22-23 to 7-31-25, revealed no skin documentation that demonstrated assessment and monitoring of the stage 1 coccyx pressure wound that was identified at admission. Review of a Nursing Progress Note for R7, dated 8-01-25 reflected .resident with history of skin breakdown on buttocks/coccyx in past with scarring noted . MASD (moisture associated skin damage) to coccyx and bilateral buttocks. Order to apply Desitin every shift and monitor weekly for effectiveness. Review of a Skin/Wound assessment for R7, dated 8-06-25, reflected that one new wound was identified by nursing on that day. Review of Nursing Progress Notes revealed that no additional information regarding the new wound was documented in the residents' health record, (location, size, drainage, color of wound and surrounding areas, odor, etc).During an observation on 8-13-25 at 10:10 AM, Registered Nurse (RN) T provided skin/wound care to R7. An open area and probable stage 2 pressure injury was identified just to the right of the anus. RN T did not take any measurements of the identified open wound. During an interview on 8-13-25 at 10:22 AM, R7 was asked if staff provide wound/skin care every shift as ordered on 08-01-25 and R7 responded, not to me they don't.