

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 Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 427 E Washington Saint 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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410</p> <p>Based on interview and record review, the facility failed to provide personal care in a dignified manner for one Resident (R46) and failed to provide timely personal care and assistance for eight Residents (R40, R29, R55, R191, R32, R38, R13, & R43) of nine residents reviewed for dignity.</p> <p>R46</p> <p>Review of an Admission Record revealed R46 admitted to the facility on [DATE] with pertinent diagnoses which included Parkinson's disease (a disorder of the central nervous system that affects movement) and heart failure.</p> <p>Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R46, with a reference date of 4/9/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 14, out of a total possible score of 15, which indicated R46 was cognitively intact. Further review of same MDS assessment revealed R46 required substantial assistance from staff with toileting and hygiene.</p> <p>In an interview on 6/3/2025 at 11:10 AM, R46 reported a female staff was rough and hurried when caring for him. R46 reported he felt like he was thrown around in bed during care. R46 reported he thought the staff member was rough because she was hurried and not because she was trying to hurt him.</p> <p>In an interview on 6/5/2025 at 8:54 AM, R46 reported he experienced rough care about once a week.</p> <p>Review of R46's Assistance Form, dated 6/3/2025, revealed R46 complained that a second shift nurse was rough when she changed him, pushing and shoving.</p> <p>In an interview on 6/5/2025 at 10:03 AM, the Director of Nursing (DON) reporting she was still investigating R46's concern form regarding rough care and trying to identify which staff was responsible.</p> <p>In an interview on 6/5/2025 at 11:11 AM, R46 stated receiving hurried and rough care made him feel like I don't matter.</p> <p>31771</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
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Resident Council Minutes dated 1/21/25 reflected Old Business- Review of Previous Meeting, Outstanding issues and Resident Council Departmental Response Forms. Handwritten in the section of the Resident Council Minutes reflected Call lights can be long at times but residents state it is usually at busy times.</p> <p>Review of the Resident Council Minutes dated 3/5/25 reflected a complaint of having to wait a long time for help.</p> <p>Review of the Resident Council Minutes dated 4/1/25 reflected the Old Business review from 3/5/25 that the waiting for help was going better. However, New Business revealed a complaint of the call light being placed in inaccessible location and Call lights can be (on) long at times and included but they know staff is busy.</p> <p>Review of the Resident Council Minutes dated 5/6/25 reflected that the Old Business from the 4/1/25 meeting of the inaccessible call light had not been resolved and that Call lights can still be an issue. The New Business section revealed some staff state they will be right back when answering call lights and then don't come back.</p> <p>Review of the Resident Council Minutes dated 6/3/25 reflected the Old Business of Call lights being turned off and staff not returning was much better. However, the Resident Council New Business minutes documentation continued with complaints that call lights can be long at times, that staff .forget that she is here, and that the afternoon shift . call lights are longer.</p> <p>The policy provided by the facility titled Call light Policy last revised 5/1/2017 was reviewed. The policy reflected Procedure . 3. Call lights will remain on until staff is available to meet the resident needs/request.</p> <p>During an interview and record review conducted 6/4/25 at 3:13 PM, the Director of Nursing (DON) reported the facility had been made aware of the resident's call light concern. The DON reported that on 5/13/25 staff training was initiated to address this concern. The DON provided documentation with staff signatures that education had been provided to leave the (call) lights on as a reminder to return.</p> <p>R40</p> <p>Review of the medical record reflected R40 admitted to the facility 2/5/25, was cognitively intact, and was his own responsible party. Review of the Minimum Data Set (MDS) dated [DATE] reflected R40 required staff assistance with toileting and transfers.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview conducted 6/3/25 at 1:44 PM, R40 reported he had a concern with call lights and the call light system. R40 explained how the call light worked by him initiating the light and staff were notified by a pager and it also appeared on the wall (wall mounted monitor). R40 reported a couple of weeks ago he waited 28 minutes to get water. R40 reported he had timed the wait on his clock. R40 also reported staff would turn of the light often without meeting his need indicating they would return but do not. R40 reported if the light was turned off and then he turned it back on it puts him at the end of the list because staff go to the light that has been on the longest and they don't know that someone had responded and turned off his light. R40 reported he had complained to the nurse manager who put on a sheet in his closet that staff were not to turn off the light until the need was met. R40 reported he has had to show that sheet to staff several times. R40 strongly conveyed frustration stating that . it still happens often enough.</p> <p>Review of the inside closet door of R40 reflected a document titled (R40)'s Schedule and Preferences. The document reflected bullet points of topics that included showers and shoes. Near the bottom of the document in bold type read Leave my call light on until my needs are met.</p> <p>R29</p> <p>Review of the medical record reflected R29 originally admitted to the facility 3/30/23, was cognitively intact and was his own responsible party. Review of the Care Plan for R29 reflected the Resident was at risk for falls and required two staff member and a lift for transfers.</p> <p>In an interview on 6/3/25 at 11:30 AM, R29 was sitting in a Geri Chair and reported long call light waits several times a week. R29 reported often after eating he needed to have a bowel movement but must wait as long as an hour. R29 reported that staff would respond but turned off the call light, leave, then forget to come back. R29 reported he had a history of hemorrhoid surgery and that it hurt to hold on to the (stool). R29 reported he had talked with a nursing manager about this but indicated the issue had continued. When asked how this made him feel R29 looked away and shook his head. R29 then reported they just need more people (staff).</p> <p>R55</p> <p>Review of the medical record reflected R55 originally admitted to the facility 1/14/23 and was listed as a responsible party. Review of the MDS dated [DATE] reflected a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated mild cognitive impairment. Review of the Care Plan for R55 reflected the Resident required the use of a mechanical lift for transfers.</p> <p>In an interview conducted 6/3/25 at 11:42 AM, R55 reported delayed call light response was not associated with a certain time of the day. R55 reported staff had responded but turned off the light and indicated they would return later. R55 reported that this happened at least once a day. When asked how this made him feel R55 was initially quiet then stated, I try to not get wrapped up in my feelings.</p> <p>R191</p> <p>Review of the medical record reflected R191 admitted to the facility 5/24/25 and was her own responsible party.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45410</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper Personal Protective Equipment (PPE) and hand hygiene for 1 resident (R294) of 1 resident reviewed for Transmission Based Precautions (TBP).</p> <p>Findings include:</p> <p>Review of an Admission Record revealed R294 admitted to the facility on [DATE] with pertinent diagnoses which included enterocolitis (inflammation in the lining of the small intestine and colon) due to clostridium difficile (C. diff, a bacterium that causes diarrhea and colitis) and end stage renal disease.</p> <p>Review of R294's Physician's Orders, active 6/4/2025, revealed an order for Contact Precautions started 6/2/2025 for C. diff.</p> <p>In an observation on 6/4/2025 at 10:17 AM outside R294's room, Physical Therapy Assistant (PTA) G exited the room after removing his gown and gloves and performed hand hygiene using hand sanitizer. A sign on the door directed staff R294 was in Contact Precautions and that gown and gloves were required when in contact with resident.</p> <p>In an interview on 6/4/2025 at 2:32 PM, PTA G reported he was aware R294 was in contact precautions for C. diff and forgot to wash his hands with soap and water upon exiting the room after completing therapy with him earlier. PTA G stated, I should have washed my hands instead of using hand sanitizer, I forgot about that.</p> <p>In an observation on 6/4/2025 at 10:33 AM outside R294's room, Certified Nursing Assistant (CNA) L entered R294's room with Contact Precaution signage on the door without performing hand hygiene or donning gloves or a gown. CNA L assisted resident with his wheelchair, touching his legs, without PPE. CNA Ls clothing made contact with R294's body and wheelchair. CNA L did not perform hand hygiene after she finished assisting R294.</p> <p>In an interview on 6/4/2025 at 2:10 PM, CNA L reported she had been educated that she must use gown and gloves any time she was in contact with R294 and wash hands with soap and water as this is required with residents being treated for C. diff.</p> <p>In an interview on 6/4/2025 at 2:08 PM, Registered Nurse (RN) H reported hand sanitizer was not effective for C. diff and staff must wash hands with soap and water instead.</p> <p>In an interview on 6/4/2024 at 2:40 PM, Infection Preventionist (IP) A reported staff were required to wash hands with soap and water for C. diff precautions instead of using hand sanitizer as hand sanitizer is not effective with C. diff. IP A reported staff were required to use gown and gloves when in contact with R294 because he was in Contact Precautions for treatment of C. diff.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>These organisms may be readily transmitted unless removed using hand hygiene. If hands are visibly soiled with proteinaceous material or care is being provided to a patient with a spore-borne infection such as anthrax (<i>Bacillus anthracis</i>) or <i>Clostridium difficile</i> (<i>C. difficile</i>), washing with soap and water is the preferred practice (CDC, 2021c).</p> <p>[NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 453). Elsevier Health Sciences. Kindle Edition.</p> <p>Review of facility policy/procedure Handwashing and Hand Hygiene, revised 4/2020, revealed . (alcohol-based hand rub) is appropriate for hand hygiene as first choice however when hands are visibly soiled, after using the restroom, before and after eating, or when caring for residents in precautions for C-diff, Norovirus, or COVID-19 soap and water is preferred .</p> <p>Review of facility policy/procedure Transmission-Based Precautions, dated 5/10/2023, revealed .It is our policy to take appropriate precautions to prevent transmission of infectious agent, based on the agents' modes of transmission . Contact Precautions . Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment . Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. VRE, <i>C. difficile</i>, noroviruses and other intestinal tract pathogens) .</p>		