

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/08/2026
NAME OF PROVIDER OR SUPPLIER Schnepf 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)		
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to 1) provide adequate supervision/assistance and implement meaningful interventions to prevent falls and injuries for one Resident (R24) of four Residents reviewed for falls, resulting in R24 fractures and R68 having multiple unsupervised falls 2) safely transfer 1 Resident (R76) of 1 Resident reviewed for lift transfers. Findings include: R24 Review of an admission Record revealed R24 initially admitted to the facility on [DATE] with pertinent diagnoses which included anxiety, nondisplaced fracture, and chronic pain. Review of an Incident Report for R24 dated 6/4/2026, revealed R24 was observed on her bedroom floor with her back leaned against her bed. Root cause of the fall was documented as (R24) felt confusion and unsteady on her feet. R24 had complained of pain to the back of her head and facility received a physician order to transfer R24 to the emergency room for evaluation. Further review of this Incident Report revealed the facility initiated a motion sensor in R24's room as a new fall intervention. Review of a current risk for falls Care Plan intervention for R24, initiated 6/5/2026, directed staff that a motion sensor was placed in R24's room. There was no direction in the care plan as to where to direct the motion sensor or when to verify the alarm was functioning appropriately. Review of an Incident Report for R24 dated 6/14/26, revealed staff were called to R24's room due to the resident lying on the ground on her left side with a . very large gouge on her forehead with a pool of blood on the floor. Further review of the Incident Report dated 6/14/26, revealed that .resident (R24) noted with a large skin tear to (her) forehead and bleeding uncontrolled. Review of a current risk for falls Care Plan focus revealed R24 readmitted to the facility on [DATE] following a hospitalization for a fall sustaining a SAH (Subarachnoid hemorrhage), fracture of odontoid process of axis (break in the peg-like bony projection of the C3 vertebra high in the neck), fracture of L3 (third lumbar vertebra in the lower back), facial lacerations, and a Type II DENS fracture (a break at the base of the dens, the peg-like projection on the second cervical vertebra) along with pleural effusion (an abnormal buildup of excess fluid in the pleural space between the lungs and chest wall). (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of an Incident Report Investigation Findings for R24 dated 6/14/2026, revealed the most probable cause of the incident was that R24 fell asleep while seated in her wheelchair and subsequently fell forward onto the floor. Further review of the Root Cause Analysis dated 6/14/26, revealed the investigation found no evidence of equipment failure or failure to implement existing care interventions. Review of a Fall Scene Investigation Report dated 6/14/26, revealed question number 13 asked if alarm was being used at the time of the fall which had been marked yes with an x. A second question stated, if yes, was it working correctly? which had a handwritten note beneath the question revealing that the motion sensor alarm was not pointed at her (R24). Review of facility policy/procedure Alarm Devices, Use Of, origination date 7/1/2008, revealed .the purpose of alarm devices is to alert staff to aid in the prevention and/or reduction of resident accidents and falls.to ensure the proper functioning of alarm systems and devices. charge nurses to ensure proper application of the alarm device, and that the devices with the on/off switch are turned to the on position when applicable.all alarms utilized will be those manufactured for medical use, and manufacturer's recommendations will be followed.frequency and use of device will be part of the medical care and will be identified on resident care plan and resident care guide. Review of (brand name) Wireless Motion Sensor Doorbell Product Detail, revealed the maximum detection distance of this motion sensor is 26 feet. Further review of Installation and Placement, reveal that the motion sensor should be placed 6.5 to 10 feet off of the ground for optimal human detection and positioned so motion cuts across the detection zone and to avoid placing the sensor facing direct sunlight, air conditioning vents, or near large metal objects. In an interview and observation on 7/8/2026 at 7:30 AM, the Nursing Home Administrator (NHA) reported that R24's motion sensor had not functioned for R24's incident on 6/14/26 as R24 had fallen forward from her wheelchair as the motion sensor was pointing above R24's head to sound the alarm if she tried to stand up. The NHA pointed to the wall in room [ROOM NUMBER] where R24's motion sensor alarm had been placed (alarm was pointing toward the window and approximately 4 feet from the floor revealing the location and position of the motion sensor was inconsistent with the manufacturer's directions for effective use of the motion sensor as noted above). The NHA demonstrated in a male resident's room with the same motion sensor alarm that R24 had used revealed that any motion provided the motion sensor sounded loudly at the nursing station. The NHA moved hands up and down and moved side to side with the motion sensor sounding each time. The NHA reported the motion sensor alarms are attached to the wall and scan the entire room. The NHA reported that the motion sensor had been effective for other residents in preventing falls. In an interview on 7/8/2026 at 9:06 AM, Registered Nurse Unit Manager (RN/UM) K reported that she had been at the nurse's station on 6/14/26 when R24's fall with injury occurred. RN/UM reported that she had no memory of hearing R24's alarm sounding during her time at the nurse's station on R24's hall in which she had been working from approximately 8:00 AM to 1:00 PM on 6/14/26. RN/UM K reported that she was not sure of the monitoring for the proper function of R24's motion sensor alarm. In an interview on 7/8/26 at 9:31 AM, Registered Nurse (RN) F reported that R24 had been propelling (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	her wheelchair prior to her fall after breakfast. RN F reported that R24 used the handrails to move her wheelchair and had been propelling toward her (R24) room. RN F reported that R24 was consistently bending down and over her knees to take her shoes off and grabbing things. RN F was the charge nurse for R24 on 6/14/26 and had not heard the motion sensor alarm sound the entirety of the morning. RN F reported that there had not been any monitoring of the function of the motion sensor alarm that she was aware of. In an interview on 7/8/26 at 9:49 AM, Certified Nursing Assistant (CNA) F reported that she was just asked today (7/8/26) for a statement for a fall with injury that occurred to R24 on 6/14/26. CNA F reported that when she left the floor for lunch R24 had been sitting in her wheelchair in her room playing on her phone. CNA F reported that upon her return from her lunch break between 11:30 AM & 12:00 PM she had walked down R24's hall to answer a call light in room [ROOM NUMBER] and observed R24 on the floor. CNA F reported that she had not heard R24's motion sensor alarm sound the entire morning, which had included during care for R24. CNA F reported that she was not aware that R24 even had a motion sensor alarm until R24 fell. CNA F reported that upon her observation after R24 fell, the motion sensor alarm was pointing toward R24's bed and not at R24. R76 lift transfer Review of R76's admission Record dated 7/8/26 revealed he was an [AGE] year old male admitted to the facility on [DATE] and had diagnoses that included: dementia, abnormal posture, muscle weakness, and unsteady on feet. R76 was not his own responsible party. During an observation on 7/6/26 at 11:00 AM, R76 was observed to be transferred from his bed to a wheelchair with an electronic full body lift machine. Certified Nurse Aides (CNA's) Y and X placed a sling under R76 while he was in bed and partially lifted him off his bed. R76's buttock was still in contact with the mattress when they started moving him towards his wheelchair. CNA's did not move the lift machine legs to the fully open position prior to lifting and moving R76. The CNA's did not verify the loops on the sling were secured on the lift prior to moving R76. The Surveyor stopped the transfer before R76 was fully off his bed. Both CNAs said they were not aware of the need to have the body fully off the bed prior to moving him and did not know they needed to ensure the loops of the sling remained fully in place once R76 was fully suspended in the sling. One CNA said he was aware of the requirement of having the machine legs in a fully open position. Both CNAs denied any training on the safety requirements for this brand of lift machine. During an observation on 7/7/26 at 9:22 AM, CNA's AA and N were observed transferring R76 from his bed to his wheelchair. They placed a sling under him in bed and raised him up. Before R76's feet were off the bed they started moving him off the bed. They did not verify that the loops of the sling were still in place and his body was not fully suspended off the bed when they started to move him. The Surveyor asked the CNAs to stop the transfer while R76's buttock was still over the bed (to protect the resident if the sling would not have been secured). CNA N said she started moving R76 off the bed by his feet because she was concerned that his feet would hit the foot cradle at the end of his bed during transfer. When asked if there was another way to ensure R76's feet did not hit the foot cradle and have his body fully suspended before moving him, CNA N said she could have moved the foot (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	cradle. CNA N removed the foot cradle. Then both CNAs verified the loops were fully in place before moving R76 over to his wheelchair. Both CNA's denied knowledge of the need to verify the sling loops were securely in place prior to moving a resident and the need to have the resident fully suspended prior to verifying the loops were in place. During an interview with the Director of Nursing (DON) on 7/8/26 at 1:45 PM, the lift transfer observations were shared with the DON. The DON confirmed the safety concerns. Review of the lift instruction manual provided by the facility page 5 revealed, a triangle with an exclamation point, ! in the center, DANGER! &ndash; Danger indicates an imminently hazardous situation which, if not avoided, will result in in death or serious injury. Page 12 had a triangle with an exclamation point, ! and the statement after it included, When using an adjustable-base lift, the legs MUST be in the maximum Opened/locked position before lifting the patient. -When elevating a few inches off the surface of the stationary object (wheelchair, commode or bed) and before moving the patient, check again to make sure the sling is properly connected to the hooks and the hanger bar. If any attachments are not properly in place, lower the patient back onto the stationary object (wheelchair, commode, or bed) and correct the attachments.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 1) ensure appropriate hand hygiene during perineal care and 2) ensure full implementation of their water management plan. Findings include: R35 Review of an admission Record revealed Resident 35 (R35) originally admitted to the facility on [DATE] with pertinent diagnoses which included diabetes and multiple sclerosis. In an observation and interview on 7/7/2026 at 11:40 AM in R35's room, Certified Nursing Assistant (CNA) A donned gloves and gown prior to assisting R35 off the bedpan and performing perineal care. CNA A used wet wipes to clean stool from R35's anal area after removing the bedpan and a large amount of feces. Without changing gloves or performing hand hygiene, CNA A then performed perineal care. Prior to removing gloves, CNA A proceeded to reposition R35, touching bedding, the bedside table, and the dividing curtain. After cares were complete, CNA A acknowledged he should have performed hand hygiene after removing the bedpan and prior to completing perineal care and removed gloves prior to touching anything in the room. Review of facility policy/procedure Handwashing and Hand Hygiene, revised 4/29/2020, revealed .Purpose. To ensure appropriate hand hygiene which is essential in reducing the risk of transmission of infectious agents. Conditions which may require hand hygiene include but not limited to: Before and After applying gloves, before and after eating, after using the restroom, after contact/potential contact with blood or body fluids, secretions, mucous membranes, open skin or when the procedure requires hand hygiene. On 07/06/2026 at 1:46PM, observed in the housekeeping closet in the Hope Harbor area, the hot water faucet handle at the mop sink was zip tied and not allowing the handle to be turned in either direction. When Maintenance Director (MD) G was asked why the faucet handle was zip-tied, it was stated MD G believed it was zip tied as part of a backflow prevention solution for the chemical dispenser. MD G also stated the hot water was not turned off at the faucet for the mop sink. When asked MD G stated the line was not being flushed. On 07/06/2026 at 1:51PM, observed in the housekeeping closet in the Harmony area, that water faucet handle at mop sink was zip tied. Housekeeping Director (HD) J was asked by MD G if they knew why the handle was be zip tied. HD J said they understood it was because turning on the hot water at the mop sink affected the shower rooms and had been zip tied to keep staff from turning on the hot water. MD G confirmed the hot water line was not being flushed. On 07/06/2026 record review of the facility's water management program as provided OSHA Technical Manual (OTM) Section III: Chapter 7-Legionnaires' Disease section C Domestic Hot-Water Systems, 3. Maintenance, b. Eliminate dead legs when possible or install heat tracing to maintain 50 degrees Celsius(122 degrees Fahrenheit).Frequent flushing of these lines should also reduce growth.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide medication according to professional standards of practice for 1 resident (R30) of 6 residents reviewed. Findings include: Review of an admission Record revealed R30 initially admitted to the facility on [DATE] with pertinent diagnoses which included type II diabetes. Review of R30's Physician Orders on 7/7/2026, revealed active orders for Lantus Insulin 35 units subcutaneously twice a day for diabetes mellitus. During a medication administration observation on 7/7/2026 at 8:33 AM, Registered Nurse (RN) C was observed preparing to administer Lantus Insulin to R30. RN C attached a new pen needle to the insulin pen, dialed the ordered insulin amount to 35 units, and administered the insulin to R30. RN C did not dial a priming dose or expel insulin into the needle to ensure patency of the needle. In an interview on 7/7/2026 at 8:40 AM, RN C reported she does not prime any new insulin needle before use and was told by her nurse manager that it was not a necessary practice to prime a needle prior to administering insulin using an insulin pen. In an interview on 7/7/2026 at 8:50 AM, the Director of Nursing (DON) reported that the standard of practice is to prime an insulin pen needle prior to dialing the ordered amount of insulin during administration. Review of facility policy/procedure Injectable Medication Administration, dated 9/1/2023 revealed .pen devices: dial dose as instructed by pen manufacturer. Review of a Manufactures Guidelines for Insulin Lantus Pen revealed to always perform the safety test before each injection and indicated after a new needle is applied to select a dose of 2 units by turning the dosage selector and tap the reservoir so that any air bubble rise up toward the needle and then to check if insulin comes out of the needle tip. Guidelines indicated that the safety check may have to be performed several times before insulin is seen in the needle.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely treatment of urinary tract infection (UTI) symptoms for one resident (R35) of one resident reviewed for urinary tract infections. Findings include: Review of an admission Record revealed R35 originally admitted to the facility on [DATE] with pertinent diagnoses which included diabetes and multiple sclerosis. Review of R35's Nurse's Note, dated 7/3/2026 at 2:46 PM, revealed COC (change of condition) #1. Resident has (complaint of) burning at urostomy site and lower back pain. Urostomy draining cloudy yellow urine with visible sediment. Noted to be odiferous. PCP (primary care provider) notified. Awaiting response at this time. Further review of the Electronic Medical Record (EMR) revealed no information regarding the response of the medical provider to this change of condition notification or any direction from the provider for treatment. Review of R35's Nurse's Note, dated 7/5/2026 at 2:48 PM, revealed .COC #5. she was noted to have facial grimacing, tense, moaning, and had tears. When asked, has (complaint of) burning sensation to abdomen. Urostomy draining cloudy yellow urine with visible sediment/odor. Further review of the EMR revealed no documentation that the medical provider was contacted regarding these continued urinary symptoms, no documentation that the medical provider had responded to the notification of symptoms by nursing staff on 7/3/2026, and no documentation that R35's urine had been tested for infection. In an interview on 7/7/2026 at 11:40 AM, R35 reported she had symptoms that felt like a UTI, a burning sensation in her lower abdomen that had been going on for a few days. In an interview on 7/7/2026 at 1:50 PM, Registered Nurse Clinical Care Coordinator (RN CCC) D reviewed R35's EMR and could find no indication the medical provider responded to the nursing notification of urinary symptoms. RN CCC D reported change of condition documentation was reviewed every day by nursing management and R35's urinary symptoms should have been followed up on. RN CCC D reported the nursing staff should have received and documented the medical provider recommendation. In an interview on 7/7/2026 at 2:41 PM, the Director of Nursing (DON) produced R35's Physician Communication Form, initiated 7/3/2026 by nursing staff and faxed from the physician to the facility on 7/6/2026, which directed staff to Do UA (urinalysis) if needed. According to the DON at that time, R35's urine had not yet been tested. The DON reported it should not take 3 days to receive a response from the medical provider. If nursing staff need immediate assistance, they should contact the on-call medical provider.		