STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235535	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing Centre	415 Friant Street Grand Haven, MI 49417

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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 1275500. Based on interview and record review, the facility failed to 1.) ensure care conferences were completed and 2.) ensure residents/their representatives participated in their cares at the facility for 3 residents (R2, R4, and R8) of 4 residents reviewed for care conferences. This deficient practice affects all 33 residents who reside in the facility.Findings include: Resident #2 (R2)Review of a Face Sheet for R2 revealed she originally admitted to the facility on [DATE]. In an interview on 7/8/25 at 9:03 AM, Family Member (FM) I reported concerns about R2 needing to see the eye doctor for a few months and as of last month R2 needed new glasses. FM I reported he had talked to the Social Worker (SW) B several times in the past few months about getting R2 an appointment with the in-house optician and had yet to hear anything. FM I reported he finally gave up and came to the facility and took R2 himself to the eye doctor with no assistance from the facility. FM I had concerns about the care R2 was receiving including medication changes and falls. FM I reported he is not notified timely of changes or concerns regarding R2. Review of the Electronic Medical Records (EMR) for R2 revealed no documentation indicating R2 had any care conferences. In an interview on 7/9/25 at 9:05 AM, SW B reported care conferences were to be done upon admission and quarterly and had recognized they were not meeting the requirements for all staff of the Interdisciplinary Team (IDT) to be in attendance. SW B confirmed R2 had not had one care conference in the last year. SW B confirmed that R4 admitted to the facility in 10/18/2024 and did not have an admission care conference. R4 had a care conference in January and February of 2025, but none since then. SW B confirmed that R8 was admitted to the facility on [DATE] and did not have an admission care conference. The electronic medical records (EMR) on 7/8/25 revealed an April 2025 care conference is in progress. SW B reported the responsibility of the care conferences had toggled back and forth between her and the Minimum Data Set (MDS) staff and acknowledged that all the residents in the building had not had care conferences as required. SW B acknowledged that the care conferences would benefit residents and family members to be informed of their care and services. In an interview on 7/11/25 at 8:09 AM, the Director of Nursing (DON) reported that care conferences were not held on a regular basis. The DON acknowledged the benefits of care conferences for ideas and information to be shared, to address any concerns, and to provide a more person-centered approach to care. In an interview on 7/11/25 at 10:13 AM, the Nursing Home Administrator (NHA) reported that she was aware that care conferences had not been held for a while and/or attended by all IDT members at each conference. The NHA reported she did not know until recently that there had not been any documentation for the residents who did have a care conference.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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	This citation pertains to intake 1275499 and 1275500. Based on interview and record review, the facility failed to follow policies and procedures and report allegations of neglect for 1 resident (R8) of 2 residents who complained of not receiving afternoon medications during resident council.Findings Include:Review of an Abuse Prevention Program Policy & Procedure last reviewed 1/2025 revealed: Each resident has the right to be free from abuse, neglect, and corporal punishment of any type by staff or anyone. Neglect, is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. REPORTING/RESPONSE: All alleged or suspected violations are to be reported immediately to the Administrator or Director of Nursing, which are responsible to notify required officials, including to the State Survey Agency, Adult Protective Services, Local Public Safety, Licensure Boards, Regional Director of Operations or Regional Clinical Directors (representative of governing board) and any other agencies in accordance with State law through established procedures. All alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Reporting results of all investigations to required officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Review of the Resident Council Meeting minutes on 6/18/25 revealed three residents complained of not getting medications on time or when needed, two residents (R8 and another unknown resident) complained of not receiving afternoon medications at all, and all complaints are when the agency nurses are here.Resident Council Department Plan of Action revealed the DON documented Agency Nurse [Licensed Practical Nurse (LPN) M] working on day of concern. Has not worked in facility since. Has no further shifts. Residents state have (sic) not had any concerns since, signed 6/30/25. In an interview on 7/9/25 at 11:35 AM, the Nursing Home Administrator (NHA) reported she was unaware of the grievance from Resident Council when R8 and another unknown resident had concerns of not receiving their medications on the afternoon of 6/18/25. The NHA reported she would ask the Director of Nursing (DON) about that. At this time there was no follow-up to the allegations, and it was not reported to the State Agency. In an interview on 7/9/25 at 3:04 PM, the DON reported she received the grievances for the two residents who stated they did not receive their afternoon medications from the Resident Council meeting on 6/18/25. One of those residents was R8, and at this time the DON was not sure who the other resident was. The DON reported the Agency LPN M will work this weekend and will talk to her before her shift starts. The DON then reported R8 did not have any afternoon medications and needed to check on who the other resident who complained of not getting her afternoon medications on 6/18/25 was. In a follow up interview on 7/11/25 at 10:13 AM, the NHA was asked about the resident council meeting minutes on 6/18/25 when R8 and another resident complained of not getting their afternoon medications. The NHA reported the residents who attended the resident council meeting were to be anonymous because they may fear retaliation and therefore did not discuss or question the allegations of neglect (not receiving medication) with R8 or the other 5 residents who attended the resident council meeting. There was no documentation that the residents had a full medication review at this time. The NHA speculated there may have been some confusion where the residents got ramped up during the meeting. When asked about the Agency Nurse (LPN M) who worked the day of the resident council meeting potentially being the perpetrator, the NHA reported they have not talked to that nurse yet but before she starts her next shift, LPN M will need to be spoken to about the facility's expectation. The NHA could not elaborate any more on this incident and reported she was convinced there were no concerns of neglect.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation pertains to intake 1275498, and 1275497. Based on interview and record review, the facility failed to: 1) operationalize policies and procedures, to 2) investigate and address allegations of neglect for two residents (R8 and another unknown resident from resident council) who alleged they did not receive afternoon medications, 3) ensure the alleged staff had current abuse/neglect training, and 4) continue to monitor, correct, and prevent further neglect of dressing changes and wound care not being provided, for three residents (R5, R6, and R9) of 4 residents reviewed for wound care after a Facility Reported Incident (FRI) was reported to the State Agency on 5/10/25. Findings include: Review of an Abuse Prevention Program Policy & Procedure last reviewed 1/2025 revealed: Neglect, is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Neglect/Deprivation of Goods and Services by Staff. Abuse also includes the deprivation by staff of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Caregiver have been determined to have the knowledge and ability to provide care and services, but choose not, or acknowledge the request for assistance from a resident(s) and intentional or willfully fail to provide goods or services, that result in care deficits to a resident(s). Possible Indicators of Neglect The failure to provide necessary care and services resulting in neglect may not only result in a negative physical outcome, but may also affect the psychosocial well-being of the resident. This includes but is not limited to: Failure to provide sufficient, qualified, competent staff, to meet resident's needs; Failure to provide orientation and/or training to staff; Failure to provide training on new equipment or new procedures or medications Failure to oversee the implementation of resident care policies; Failure to provide supervision and/or monitoring of the delivery of care; Failure of staff to implement resident interventions, when residents have beenassessed and interventions are care planned Failure to identify, assess, and/or contact a physician for an acute change incondition, and/or a change in condition that requires the plan of care to be revisedto meet the residents needs in a timely manner; Failure of the Quality Assurance and Assessment committee to develop andimplement appropriation action plans to correct identified quality deficiencies; Failure of administration to use its resources and oversight of medical services toattain or maintain the highest practicable physical, mental, and psychosocial wellbeing Training: The facility will ensure that all staff, new and existing are trained and knowledgeable of the facility's Abuse Prevention Program, with additional in-service training for nursingassistants. Shift report and access to resident information to ensure staff assigned haveknowledge of the individual residents' care needs and behavioralsymptoms Investigation: The Administrator and or Director of Nursing are to initiate and coordinatecompletion of a thorough investigation. Investigations must be initiatedimmediately and concluded as soon as possible not to exceed (5) days. Forms areavailable to assist the investigator and may utilized. Resident #5 (R5) Review of a Facility Reported Incident (FRI) dated 5/10/25 regarding an allegation of R5 not receiving a pressure ulcer dressing change in 5 days. The facility reported Registered Nurse (RN) G provided a dressing change on 5/1/25 for R5 and initialed and dated the dressing that day. RN G also provided care on 5/7/25 and noticed the same dressing with her initials was in place and dated 5/1/25. The facility reported the pressure ulcer dressing changes were ordered to be done every day and acknowledged 2 different nurses documented the dressing changes were done 5/4/25 and 5/5/25 but did not actually provide the services. The Nursing Home Administrator (NHA) reported they identified like residents, reviewed dressing change orders and skin assessments to ensure dressing changes aligned with treatment documentation and did not find any concerns or discrepancies. The NHA concluded she could not substantiate the allegation and R5's basic needs were met and continued to be met. In an interview on 7/11/25 at 10:13 AM, the NHA was asked about the FRI that was reported to the State Agency on 5/10/25 when the facility identified R5's dressing changes were being documented as completed when they were not and how the facility was auditing/monitoring to ensure compliance with physician orders, assessments, care and services, the NHA reported that it was not being done. The NHA reported she recognized these concerns for a while now but has not had a game plan put together yet. Resident #8 Review of a Grievance/Complaint Form for R8 dated 6/18/25 revealed: reported not receiving afternoon medication on 6/18/25. Summary of Findings/Conclusion: agency nurse (LPN M) working on day of concern. Has not worked in facility since. No further shifts. Signed by the Director of Nursing on 6/30/25.Review of the Resident Council Meeting minutes on 6/18/25 at 2:10 PM revealed three residents complained of not getting

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. (continued on next page)

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F 0685 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 1275500. Based on interview and record review, the facility failed to accommodate and provide vision services for 1 resident (Resident #2) of 3 residents reviewed for ancillary services.Findings include: Resident #2 (R2)Review of a Face Sheet for R2 revealed she originally admitted to the facility on [DATE]. In an interview on 7/8/25 at 9:03 AM, Family Member (FM) I reported concerns about R2 needing to see the eye doctor for a few months and as of last month R2 needed new glasses. FM I reported he had talked to the Social Worker (SW) B several times in the past few months about getting R2 an appointment with the in-house optician and had yet to hear anything. On 6/10/25 he came to the facility and R2's glasses were missing, and she was wearing some random pair of black glasses that were not hers. FM I reported the Social Worker did not know where R2 got those glasses. FM I reported he talked to SW B many times about getting an eye doctor appointment that he finally gave up and came to the facility on 6/28/25 and took R2 himself to the eye doctor with no assistance from the facility to get her new eyeglasses. FM I reported he also had text messages between him and SW B regarding concerns of R2 needing to see the eye doctor. Review of an Invoice dated 6/28/25 revealed R2 had left the facility to visit the eye doctor for an ophthalmology appointment. Review of a communication text dated 4/21/25 at 8:30 AM revealed FM I communicated with the facility's Social Worker about R2's vision and questioned when the eye doctor would make their rounds at the facility. The Social Worker responded they did not have a date yet. Review of the Electronic Medical Records (EMR) for R2 revealed no documentation indicating R2 had any care conferences in the last year. Review of the EMR for R2 revealed no documentation she left the building to see the eye doctor on 6/28/25. Review of the Care Plan for R2 revealed she did not have a Care Plan for eyeglasses or vision services. Review of the EMR for R2 revealed no progress notes from social services regarding R2's representative wanting R2 to see the eye doctor at the facility or any concerns or conversations with R2's representative. In an interview on 7/8/25 at 3:30 PM, SW B reported R2 was missing a red pair of glasses and was wearing a black pair of glasses that were broken. SW B reported she had tried to fix them for her, but they were beyond repair. SW B reported she was aware FM I wanted R2 to visit with the in-house optician but could not secure a date when they could come to the facility. SW B reported she talked to FM I about taking a transport van to see the eye doctor, but he did not want to do that. SW B reported the in-house optician was at the facility around the beginning of the year but since R2 was private pay, she must go to a private provider. SW B reported that ancillary services were offered at care conferences. SW B reported that R2 was on the list to be seen when the in-house optician comes to the facility. SW B reported she could not secure a date and time for them to come to the facility after she has tried several times. SW B said reported it was in the contract that they would only come out to the facility if there was more than a couple of residents. Then SW B reported the optician could only give her a period of time they may be able to come to the facility. A request for the contract for ancillary services was requested at the time of the interview. SW B did not have a clear answer why there was very little documentation of communication and concerns in the EMR for R2. SW B reported R2 did not leave the facility with FM I to go to the eye doctor. At the time of the interview, SW B was not aware R2 left the facility for an ophthalmology appointment. During a follow up interview and record review on 7/9/25 at 8:00 AM, SW B verified that the last time the optician was actually at the facility was on 9/11/24 and had secured a date of 8/12/25 for them to return. SW B reported R2 would be on the list. Review of the contract revealed no minimum resident criteria for them to come to the facility to provide services. SW B reported she was aware R2 had a missing pair of red glasses back in beginning of June.Review of the admissions packet shows they offer ancillary services for optometry at the facility with no restrictions documented.In an interview on 7/9/25 at 11:35 AM, the Nursing Home Administrator (NHA) reported FM I had reached out to her because he felt his concerns were not getting addressed by the other staff. The NHA reported she found out R2 did not sign out on the LOA (leave of absence) form or the clipboard to go to the eye doctor on 6/28/25 with FM I. At the time of this survey, the NHA was not aware R2 had left the building to see the eye doctor. The NHA reported that because they have a smaller building, they cannot get other ancillaries to come to the facility. The NHA reported she was aware that R2 had missing glasses and as of yesterday she connected with FM I to discuss reimbursement of R2's eyeglasses. In an interview on 7/11/25 at 8:09 AM, the Director of Nursing (DON) reported that care conferences were not held on a regular basis. The DON acknowledged the benefits

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 1275497 and 1275498. Based on observation, interview, and record review, the facility failed to: 1) operationalize policies and procedures, 2) provide services as documented, 3) notify physician of wounds with oversight, 3) timely interventions of wounds, and 4) implement care plan interventions of wounds for 3 residents (R5, R6, and R9) of 4 residents reviewed for pressure ulcers, resulting in the development and worsening of pressure ulcers. Findings include: Review of a policy titled Pressure Injury Prevention and Care, last reviewed 1/2025 revealed: 1. Nurses will complete the Skin Body Assessment Observation upon admission/readmission, then weekly and as needed. 2. Nurses will complete Braden Scale for residents on admission/readmission, weekly for 4 weeks, quarterly, at time of new pressure injury identification, and as needed. 5. Interventions will be implemented, and care planned to prevent pressure injury development or to promote pressure injury resolution. 6. Pressure injuries will be assessed and documented upon admission, readmission, upon discovery, and weekly thereafter. Assessment may include the size, location, category/stage, odor (if any), drainage (if any), peri-wound condition, wound edges, undermining, tunneling, exudate, pain, and current treatment order. 7. Physicians and responsible parties will be notified of pressure injury upon identification and with change in status of pressure injury. 8. Physician/provider will be notified if pressure injury shows signs of deterioration, infection, or no improvement for further evaluation and recommendations regarding treatment and interventions. Resident #5 (R5) Review of a Face Sheet revealed R5 originally admitted to the facility on [DATE]. No diagnoses of pressure ulcers. Review of the Progress Notes for R5 revealed she died in the facility on [DATE]. Review of a Facility Reported Incident (FRI) dated [DATE] regarding an allegation of R5 not receiving a pressure ulcer dressing change in 5 days. The facility reported Registered Nurse (RN) G provided a dressing change on [DATE] for R5 and initialed and dated the dressing that day. RN G also provided care on [DATE] and noticed the same dressing with her initials was in place and dated [DATE]. The facility reported the pressure ulcer dressing changes were ordered to be done every day and acknowledged two different nurses documented the dressing changes were done [DATE] and [DATE] but did not actually provide the services. The Nursing Home Administrator (NHA) reported they identified like residents, reviewed dressing change orders and skin assessments to ensure dressing changes aligned with treatment documentation and did not find any concerns or discrepancies. The NHA concluded she could not substantiate the allegation. Review of the Electronic Medical Records (EMR) for R5 revealed some notes were in the nursing progress notes, some notes were in the Wound Summary, some notes were in the observations tab, and some were under the skin assessments. However, they did not correlate with one another. Review of an order dated [DATE] and discontinued on [DATE] for R5 revealed: Cleanse wound site with wound cleanser, apply triad wound dressing, cover with foam dressing, twice a day. This was documented as done on [DATE] between 7:00 AM and 11:00 PM, then the order changed. The exact wound is not identified. Review of the Nursing Progress notes for R5 revealed she went to the hospital on [DATE] at 8:00 PM and returned to the facility on [DATE] at 10:04 AM. Hospice admission was in progress upon her return. Review of a Nursing Progress Note for R5 dated [DATE] revealed: wound care provided to buttock (exact location not identified), wound bed 100% granulated tissue. Peri wound intact with discoloration from noted scar tissue. resident denies pain with wound cares. consulted with provider [Name] regarding ordered wound cares. new orders received. wound measuring 1.7cm x 3cm x 0.1 cm. DON (Director of Nursing) informed of findings. An order for R5 dated [DATE] and discontinued on [DATE] to be done at bedtime revealed: left upper buttock stage 2 pressure injury: 1. cleanse with normal saline 2. apply skin prep to intact peri wound. 3. allow skin prep to dry fully to air. 4. apply small amount of medihoney to wound bed. 5. place foam dressing over wound bed as secondary dressing 6. nursing to change daily and PRN (as needed). This is documented as done on 5/1 by RN G, 5/4 by LPN H, 5/5 by LPN F, and 5/6 by RN G. (Out to the hospital on 5/2 and 5/3). It was documented the dressing changes were done on [DATE] and on [DATE]; but not done per the facility's investigation. Review of an order dated [DATE] and discontinued on [DATE] for R5, once every 3 days, revealed: Left upper buttock: 1. Cleanse with soap and water. 2. Apply skin prep to area. 3. Cover with foam dressing. 4. Change every 3 days or prn (as needed) if soiled/dislodged. This is documented as done on [DATE].Review of a Nursing Progress Note for R5 dated [DATE] revealed: Coccyx wound resolved. Will continue to use foam dressing for protection. Change every 3 days or prn if soiled/dislodged. This progress note did not correlate

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 1275500, 1275498, and 1275497. Based on interview and record review, the facility failed to 1.) follow physician orders to obtain labs and change medication orders for 1 resident (R2) and 2.) ensure physician supervision of wounds for three residents (R5, R6, and R9), of 5 residents reviewed for physician supervision and the effectiveness of treatments. Findings include:Resident #2 (R2)Review of a Face Sheet for R2 revealed she originally admitted to the facility on [DATE].Review of a Nurse Practitioner Progress note dated [DATE] for R2 revealed: increase lisinopril from 30 mg (milligrams)/d (daily). Will repeat BMP (basic metabolic panel lab) next lab day.Review of a Physician Progress note dated [DATE] for R2 revealed: Lisinopril recently increased from 30mg/d to 40mg/d however not changed in chart. BMP ordered however no results, will re-order.Review of the Medication Administration Record (MAR) for R2 revealed the changed dose of lisinopril 40 mg originally ordered on [DATE] was changed and administered on [DATE]. Review of a list of blood pressure values for R2 revealed as follows:[DATE] at 12:18 PM- [DATE]/25 at 1:25 AM-[DATE]/25 at 11:49 AM-[DATE]/25 at 10:50 PM- [DATE]/25 at 11:00 AM- 178/80Review of a Nursing Progress note dated [DATE] for R2 revealed: T.O. (telephone order) from [Practitioner] to give a one-time dose of hydralazine 25 mg for elevated BP (blood pressure) now.Review of a Nursing Progress note dated [DATE] for R2 revealed: Phone call placed to RP (representative) to make aware of elevated BP with one time does of hydralazine.Review of the July MAR for R2 revealed no hydralazine orders and no documentation indicating it was administered to R2. During an interview and record review on [DATE] at 3:25 PM, Licensed Practical Nurse (LPN) A reported the BMP lab was collected on [DATE] for R2 and could not elaborate on why the lisinopril order took approximately a month to be changed in the EMR. When asked about the one-time order for hydralazine on [DATE] and on [DATE], LPN A confirmed there were not orders in the Electronic Medical Record (EMR) for that and could not confirm it was given and reported if it was not documented on the MAR, then it was not done. During an interview and a record review on [DATE] at approximately 8:30 AM, the Director of Nursing (DON) was questioned about R2's orders for hydralazine. The DON reported it was an Agency Nurse who did not put the order in the EMR and told the DON she did not know she needed to do that. The DON reported that the Agency Nurse said she did give R2 the hydralazine on [DATE] but did not enter it into the EMR or document that it was given. The DON reported she notified R2's representative on [DATE] regarding the hydralazine that was given on [DATE]. The DON could not elaborate about the elevated blood pressure on [DATE] of 198/104 and if it was followed up by the nurse. The DON at this time did not know if it was taken out of the backup medication supply and later provided a document to show that 25 mg of hydralazine was removed from the backup box on [DATE] at 2:30 AM. There was no document to show any hydralazine was taken out for the elevated blood pressure on [DATE] or if the physician was notified. Resident #5 (R5)Review of a Face Sheet revealed R5 originally admitted to the facility on [DATE].Review of the Progress Notes for R5 revealed she died in the facility on [DATE].Review of a Wound Management Detail Report for R5 revealed the following wounds:1. Scab-Right 2nd toe scab: 0.2 cm (centimeters x 0.2 cm- identified [DATE].2. Unspecified Ulcer on coccyx: 3.2 cm x 4.5 cm - identified [DATE] (10 days after order is in the MAR. The MAR has 2 different orders for the left upper buttock; one is documented as stage II with orders that started on [DATE] and discontinued on [DATE]. The other order is for the left upper buttock that started on [DATE] and discontinued on [DATE].)3. Unspecified Ulcer- Right big toe pressure area: 0.7 x 1.4 cm- identified [DATE].4. Pressure Ulcer- Right heel: 3.5 cm x 2. 5 cm- identified on [DATE].5. Unspecified Ulcer- Right ankle inner ankle: 2.5 cm x 2 cm- identified [DATE]. Review of the EMR for R5 revealed no documentation from any of the practitioners indicating they were overseeing the wounds of this resident. Review of the Facility Reported Incident (FRI) reported to the State Agency on [DATE] for R5 revealed the facility identified an incident where R5 was documented as receiving an ordered daily wound dressing change on [DATE] and the nurse initialed the dressing. The resident was in the hospital from [DATE] to [DATE]. On [DATE], the same nurse who provided the dressing change on [DATE] noticed R5 had the same dressing in place dated [DATE] with her initials. The MAR revealed R5 was documented she received dressing changes on [DATE] and [DATE] but did not actually provide the services. Review of the MAR revealed an order dated [DATE] and discontinued on [DATE] for R5 revealed: Stage 2 coccyx pressure injury: cleanse with N/S (normal saline), pay (sic) dry. Apply sacral comfort foam to area, once a day every other day. This is documented as done on 5/18, 5/20/ and 5/22. (No dressing changes

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Riverside Nursing Centre	415 Friant Street Grand Haven, MI 49417

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 - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	This citation pertains to intakes 1275500, 1275498, and 1275497. Based on interview and record review, the facility failed to administer the facility and use its resources effectively and efficiently to ensure resident cares and services met the residents needs to attain or maintain the highest practicable physical, mental and psychosocial well-being. This deficient practice affects all 33 residents who reside at the facility. Findings include: Review of the Administrator/Administration Job Description revealed: GENERAL PURPOSE: Direct the day-to-day functions of the facility in accordance with current federal, state and local standards, guidelines and regulations that govern long term care facilities, as well as all company policies to assure that the highest degree of quality care can be provided to the residents at all times. ESSENTIAL JOB FUNCTIONS: A. Administrative and Supervisory Functions, . C. Personnel Functions, . D. Resident's Rights Functions, . E. Continuous Quality Improvement Functions, . OTHER FUNCTIONS: A. Committee Functions, . C. Staff Development Functions, . In an interview on 7/11/25 at 10:13 AM, the Nursing Home Administrator (NHA) questioned about the lack of quarterly resident care conferences. The NHA reported she was aware they had not been done for a while or at least attended to by all IDT (Interdisciplinary Team) members. The NHA did not know until recently that there was no documentation of care conferences being done. When asked about skin assessments and wound care not being overseen by a practitioner, the NHA reported they used to have a wound care company come to the facility, but they are no longer able to provide services there. No input was provided regarding the wound care oversight moving forward or when the wound care company's contract was cancelled. The NHA reported she reached out to the Regional Clinical Director and made them aware. When asked about the nonsensical documentation of skin assessments and pressure ulcer care and services, the NHA reported these were things they have recognized for a while and identified it needs improvement. She started working with the Director of Nursing (DON) about 1 1/2 months ago after the DON started working there but has not come up with a game plan yet. When asked about the Facility Reported Incident (FRI) that was reported to the State Agency on 5/10/25 regarding R5 not receiving dressing changes but the nursing staff documented it as done. The NHA reported they were not doing any audits or monitoring of cares and services for the residents at the facility to ensure ongoing compliance. The NHA acknowledged there was a one time audit where some resident wounds were identified and had orders placed or changed as needed. Now that they have a new DON, they started wound care rounds on Fridays just after the FRI was filed in May. When asked about the Agency Staff not getting oriented and not reviewing policies/education prior to starting their shift at the facility, the NHA reported they have a binder with policies and procedures and information they need to review but reported it had not been happening consistently. The NHA could not provide one Agency Staff who was provided with orientation or policy reviews. When asked about the Certified Nursing Assistants (CNA) not receiving their annual trainings, the NHA reported they do not have a Human Resources staff as of a couple of weeks ago and they were the ones who would provide the training when the aides were due for their annual reviews. When asked about the 5 residents who attended resident council in June and 3 complained of receiving their medications late and 2 residents complained of not receiving their afternoon medications, the NHA reported she did not investigate or report to the State Agency any allegations of neglect and did not talk to the nurse who worked the day the allegations were made. The NHA reported she is certain there is no concern of neglect. The NHA reported they do have daily IDT meetings that include her, the DON, the Activities Director, the Regional Dietary Consultant and the Social Worker. Review of a policy titled Physician Services last reviewed 1/2025 revealed: The Administrator shall be responsible for assuring or promptly arranging for continuing medical care under the direction of a licensed physician. Arrangement of services from additional Ancillary services will also be arranged based on resident needs, including but not limited to Dentists, Podiatry, Audiology, and Vision Services.Primary Care Physician Procedure:1. A physician approves in writing the resident's admission2. Each resident is under the care of a qualified physician.3. The Physician should:a. See the resident within 30 days of initial admission to the facility.b. The resident must be seen at least once every 30 calendar days for the first 90calendar days after admission and at least every 60 days after that by a physician orphysician delegate as appropriate by State law.c. Review the resident's total care program, including medications and treatments ateach visit.d. Date, write, and sign a progress note for each visit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 1275500, 1275498, and 1275497. Based on observation, interview and record review, the facility failed to ensure the Medical Director's involvement in the collaboration, coordination, and oversight of cares and services for 6 residents (R2, R4, R5, R6, R8, and R9), of 6 residents reviewed for physician involvement. This deficient practice affects all 33 residents who reside at the facility. Ancillary Services for Vision CareResident #2 (R2)Review of a Face Sheet for R2 revealed she originally admitted to the facility on [DATE].In an interview on 7/8/25 at 9:03 AM, Family Member (FM) I reported concerns about R2 needing to see the eye doctor for a few months and as of last month R2 needed new glasses. FM I reported he had talked to the Social Worker (SW) B several times in the past few months about getting R2 an appointment with the in-house optician and had yet to hear anything. On 6/10/25 he came to the facility and R2's glasses were missing, and she was wearing some random pair of black glasses that were not hers. FM I reported the Social Worker did not know where R2 got those glasses. FM I reported he talked to SW B many times about getting an eye doctor appointment that he finally gave up and came to the facility on 6/28/25 and took R2 himself to the eye doctor with no assistance from the facility to get her new eyeglasses. FM I reported he also had text messages between him and SW B regarding concerns of R2 needing to see the eye doctor. Review of the EMR for R2 revealed no indication the physician was aware of R2 needing to see the eye doctor or difficulty of access to an eye doctor. No documentation in the Electronic Medical Record (EMR) acknowledging a request to see the eye doctor even after her glasses were missing. During an interview and a record review, SW B verified that the last time the Optician was at the facility was on 9/11/24 and now secured a date of 8/12/25 for them to come back to the facility and reported R2 will be on the list. SW B reported she was aware R2 had a missing pair of red glasses back in beginning of June.Review of the Ancillary Services contract revealed no minimum resident criteria for the mobile optician to come to the facility to provide services. In an interview on 7/9/25 at 11:35 AM, the Nursing Home Administrator (NHA) reported FM I had reached out to her because he felt his concerns were not getting addressed by the other staff. The NHA reported she found out R2 did not sign out on the LOA (leave of absence) form or the clipboard to go to the eye doctor on 6/28/25 with FM I. At the time of this survey, the NHA was not aware R2 left the building to see the eye doctor. The NHA reported that because they have a smaller building, they cannot get other ancillaries to come to the facility. The NHA reported she was aware that R2 had missing glasses and as of yesterday she connected with FM I to discuss reimbursement of R2's eyeglasses. Care ConferencesReview of the EMR for R2 revealed she was admitted to the facility on [DATE] and had no care conferences with physician oversight documented from 7/1/24 to 7/9/25. Review of the EMR for R8 revealed she was admitted to the facility on [DATE] and had no admission care conference with physician oversight. R8's April 2025 care conference showed in progress as of 7/8/25. Review of the EMR for R4 revealed a care conference was held in February 2025 and January 2025 after she was admitted on [DATE] with no other care conference since then.In an interview on 7/11/25 at 8:09 AM, the Director of Nursing (DON) reported that care conferences are not held on a regular basis. The DON acknowledged the benefits of care conferences for ideas and information to be shared, to address any concerns, and to provide a more person-centered approach to care. Wound CareReview of the EMR for R5, R6, and R9 revealed no physician oversight and assessments of their pressure ulcers documented in the EMR, no notification that the medical director was aware/notified of the FRI (Facility Reported Incident) regarding R5's dressing changes documented as completed when they were not, and no ongoing monitoring to ensure services were provided. There was no documentation showing all 3 residents' wounds which changed in condition were seen and monitored by a practitioner. Review of a policy titled Physician Services last reviewed 1/2025 revealed: The Administrator shall be responsible for assuring or promptly arranging for continuing medical care under the direction of a licensed physician. Arrangement of services from additional Ancillary services will also be arranged based on resident needs, including but not limited to Dentists, Podiatry, Audiology, and Vision Services.Primary Care Physician Procedure:1. A physician approves in writing the resident's admission2. Each resident is under the care of a qualified physician.3. The Physician should:a. See the resident within 30 days of initial admission to the facility.b. The resident must be seen at least once every 30 calendar days for the first 90calendar days after admission and at least every 60 days after that by a physician orphysician delegate as appropriate by State law.c. Review the resident's total care program

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes 1275500, 1275498, and 1275497. Based on interview and record review, the facility failed to 1.) implement systematic documentation and accurate reflection of 2 residents (R2, R5 and R6) of 4 residents reviewed for complete and accurate medical records and 2.) ensure wound dressing changes were not falsified for 1 resident (R5) of 4 residents reviewed for treatment administration. Findings include:Resident #2 (R2)Review of a Face Sheet for R2 revealed she originally admitted to the facility on [DATE].Review of a Physician Progress note dated 7/1/25 for R2 revealed: Lisinopril recently increased from 30mg/d to 40mg/d however not changed in chart. BMP ordered however no results, will re-order.Review of a Nursing Progress note dated 7/6/25 for R2 revealed: T.O. (telephone order) from [Practitioner] to give a one-time dose of hydralazine 25 mg for elevated BP (blood pressure) now.Review of the July MAR for R2 revealed no hydralazine orders and no documentation indicating it was administered to R2. During an interview and record review on 7/8/25 at 3:25 PM, Licensed Practical Nurse (LPN) A reported the BMP lab was collected on 7/7/25 for R2 and could not elaborate on why the lisinopril order took approximately a month to be changed in the Electronic Medical Record (EMR). When asked about the one-time order for hydralazine on 7/6/25 and on 7/7/25, LPN A confirmed there were no orders in the EMR for that and could not confirm it was given and reported if it was not documented on the MAR, then it was not done. During an interview and a record review on 7/9/25 at approximately 8:30 AM, the Director of Nursing (DON) was questioned about R2's orders for hydralazine. The DON reported it was an Agency Nurse who did not put the order in the EMR and told the DON she did not know she needed to do that. The DON reported that the Agency Nurse said she did give R2 the hydralazine on 7/6/25 but did not enter it into the EMR or document that it was given. The DON reported she notified R2's representative on 7/7/25 regarding the hydralazine that was given on 7/6/25. The DON could not elaborate about the elevated blood pressure on 7/7/25 of 198/104 and if it was followed up by the nurse. The DON at this time did not know if it was taken out of the backup medication supply and later provided a document to show that 25 mg of hydralazine was removed from the backup box on 7/6/25 at 2:30 AM. There was no document to show any hydralazine was taken out for the elevated blood pressure on 7/7/25 or if the physician was notified. In an interview on 7/8/25 at 9:03 AM, Family Member (FM) I reported he took R2 to the eye doctor on 6/28/25 because the facility would not accommodate the in-house optician to see R2 after several months of expressing his concerns to the facility. Review of the EMR for R2 revealed no documentation of R2 wanting to see the in-house optician or any attempt to assist R2 in meeting her vision needs. Review of an invoice for R2 dated 6/28/25 revealed she had left the facility to visit an offsite eye doctor. Review of the Electronic Medical Records (EMR) revealed R2 did not leave the building on 6/28/25 and went to the eye doctor. In an interview on 7/8/25 at 3:30 PM, Social Worker (SW) B reported she was aware R2 needing to see the eye doctor and it was a struggle to get the inhouse optician to the facility. SW B also reported she was aware of R2 needing new glasses but did not follow up with assisting R2 with this process. SW B reported she informed FM I she could arrange transportation to an offsite eye doctor, but no documentation in the EMR supported there was any effort or discussion made. In an interview on 7/9/25 at 9:05 AM, SW B was questioned about R2 having a care conference in the last year and the lack of documentation for social services. SW B reported care conferences were done sometimes but not always documented.Resident #5 (R5)Review of the Facility Reported Incident (FRI) reported to the State Agency on 5/10/25 for R5 revealed the facility identified an incident where R5 was documented as receiving an ordered daily wound dressing change on 5/1/25 and the nurse initialed the dressing. The resident was in the hospital from [DATE] to 5/4/25. On 5/7/25, the same nurse who provided the dressing change on 5/1/25 noticed R5 had the same dressing in place dated 5/1/25 with her initials. The MAR revealed R5 was documented she received dressing changes on 5/4/25 and 5/5/25 but did not actually provide the services. Review of a Wound Management Detail Report for R5 revealed the following wounds:1. Scab-Right 2nd toe scab: 0.2 cm (centimeters x 0.2 cm- identified 5/20/25. 2. Unspecified Ulcer on coccyx: 3.2 cm x 4.5 cm - identified 5/16/25 (10 days after order is in the MAR. The MAR has 2 different orders for the left upper buttock; one is documented as stage II with orders that started on 5/1/25 and discontinued on 5/7/25. The other order is for the left upper buttock that started on 5/7/25 and discontinued on 5/10/25.)3. Unspecified Ulcer- Right big toe pressure area: 0.7 x 1.4 cm- identified 5/16/25.4. Pressure Ulcer- Right heel: 3.5 cm x 2.5 cm- identified on 6/13/25.5. Unspecified Ulcer- Right ankle inner

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 1275499, 1275500, 1275498, and 1275497. Based on interview and record review, the facility failed to operationalize policies and procedures for an effective Quality Assurance and Performance Improvement (QAPI) program by not monitoring, identifying, developing and promptly implementing corrective actions. This deficient practice affects all 33 residents who reside in the facility. Findings include: Review of a policy titled Quality Assurance and Performance Improvement (QAPI) dated 11/2022 (which does not show it is annually reviewed/revised) revealed: It is the policy of this facility to develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life and addresses all the care and unique services the facility provides. 3. The QAPI plan will address the following elements:a. Design and scope of the facility's QAPI program and QAA Committee responsibilities and actions.b. Policies and procedures for feedback, data collection systems, and monitoring.c. Process addressing how the committee will conduct activities necessary to identify and correctquality deficiencies. Key components of this process include, but are not limited to, the following:i. Tracking and measuring performance.ii. Establishing goals and thresholds for performance improvements.iii. Identifying and prioritizing quality deficiencies.iv. Systematically analyzing underlying causes of systemic quality deficiencies.v. Developing and implementing corrective action or performance improvement activities.vi. Monitoring and evaluating the effectiveness of corrective action/performance improvementactivities and revising as needed.d. A prioritization of program activities that focus on resident safety, health outcomes, autonomy,choice and quality of care, as well as, high-risk, high-volume, or problem-prone areas as identifiedin the facility assessment that reflects the specific units, programs, departments and uniquepopulation the facility serves. The facility must also consider the incidence, prevalence, andseverity of problems or potential problems identified.e. A commitment to quality assessment and performance improvement by the governing body and/orexecutive leaders.f. Process to ensure care and services delivered meet accepted standards of quality.1. Program Design and Scope -a. The QAPI program will be ongoing, comprehensive, and will address the full range of care andservices provided by the facility.b. At a minimum, the QAPI program will:i. Address all systems of care and management practices.ii. Include clinical care, quality of life, and resident choice.iii. Utilize the best available evidence to define and measure indicators of quality and facilitygoals that reflect processes of care and facility operations that have been shown to bepredictive of desired outcomes for residents of a Skilled Nursing Facility (SNF) or NursingFacility (NF).iv. Reflect the complexities, unique care, and services the facility provides.3. Program Feedback, Data Systems, and Monitoring -The facility maintains procedures for feedback, data collection systems, and monitoring, includingadverse event monitoring.b. The facility draws data from multiple sources, including input from all staff, residents, families,and others as appropriate. Data sources may include, but are not limited to: .4. Program Activities -a. All identified problems will be addressed and prioritized, whether by frequency of datacollection/monitoring or by the establishment of sub-committees. Considerations include, but arenot limited to: .b. Medical errors and adverse events are routinely tracked.c. The facility conducts at least one distinct performance improvement project (PIP) annually thatfocuses on high risk or problem prone areas. Additional projects may be conducted as needed, andmay be clinical or non-clinical in nature.5. Program Systematic Analysis and Systemic Action - . Care ConferencesReview of the EMR for R2 revealed she admitted to the facility on [DATE] and had no care conferences documented from 7/1/24 to 7/9/25. Review of the EMR for R8 revealed she admitted in 12/2024 and had no admission care conference. R8's April 2025 care conference showed in progress as of 7/8/25. Review of the EMR for R4 revealed a care conference was held in February 2025 and January 2025 after she was admitted on [DATE] with no other care conference since then. In an interview on 7/8/25 at 3:30 PM, Social Worker (SW) B reported ancillary services were provided during care conferences and acknowledged R2 had not had a care conference in last year. In an interview on 7/9/25 at 9:05 AM, SW B reported care conference notes are not always documented in the system if the residents had one. SW B reported she had recognized a few weeks ago that they were not meeting the requirements for all staff in the IDT (Interdisciplinary Team) attending and the responsibility had been shifting between Social Services and the MDS (Minimum Data Set) Coordinators to arrange them. In an interview on 7/11/25 at 8:09 AM, the Director of Nursing (DON) reported that care conferences were not held on a regular basis. The DON acknowledged the benefits of care conferences for

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. This citation pertains to intake 1275498, 1275500, and 1275497. Based on interview and record review, the facility failed to provide agency staff training/orientation to the facility prior to starting their shift for 2 of 2 agency nurses reviewed for training and one agency Certified Nursing Assistant (CNA). This deficient practice has the potential to affect all 33 residents who reside at the facility.Findings include: In an interview on 7/9/25 at approximately 11:00 AM, Agency CNA L was questioned if a certain resident wore hearing aids. CNA L reported she did not get that information during the shift change report but should be able to find it in the care plan. At this time, she accessed the Electronic Medical Records (EMR) and could not find the resident on the computer. CNA L reported she did not get a training or an orientation to the facility prior to starting and that was her first day. CNA L reported she would provide that information after she found out. Review of two agency nurse employee files revealed Licensed Practical Nurses (LPN) F and LPN M did not have any trainings/orientations documented by the facility. The Nursing Home Administrator (NHA) provided a binder and reported that it contained the training/orientation the agency staff received prior to starting their shift. The binder consisted of information from a past education provided to some staff for a survey from another department. In an interview on 7/10/25 at 3:50 PM, the Regional Nurse (RN) C confirmed that the agency staff at this facility were not getting the training/orientation to the facility and understood the concern with CNA L trying to get by the day before without appropriate training/orientation to the facility. RN C reported the company did have a more formal education staff were to have before starting on the floor. During an interview on 7/11/25 at 10:13 AM, the NHA reported they use a lot of agency staff and acknowledged the agency staff were not getting any training or orientation to the facility prior to starting their shift. The NHA reported they do have a binder that has all the policies laid out and when the agency staff come to the building, they were to review it. The NHA reported that it appeared it had not been happening consistently. The NHA reported she was ultimately responsible to make sure it was being done. Review of a policy titled Standards of Nursing Practices last reviewed 1/2025 revealed: New Hired Nurses1. All newly hired licensed nurses and direct care givers will be provided ameaningful job specific orientation according to company guidelines prior tofilling an open position.2. All newly hired licensed nurses and direct care givers will be competency tested.3. Competencies will be performed by the employee in the presence of asupervising nurse. Competencies are valid only when witnessed for correct procedureby the supervising nurse. Competency testing is also completed annually. (Michigan- skills checks will be completed on all newly hired nursing assistants prior to themaccepting an independent assignment).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235535	A. Building B. Wing	07/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Nursing Centre	415 Friant Street Grand Haven, MI 49417

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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. This citation pertains to intake 1275498, 1275500, and 1275497.Based on interview and record review, the facility failed to ensure 2 Certified Nursing Assistants (CNA's) received their annual competencies out of 2 CNAs reviewed for sufficient training and continuing competencies. This deficient practice has the potential to affect all 33 residents who reside at the facility.Findings include: Review of the employee files for Certified Nursing Assistants (CNA) J and CNA K revealed they had not received their in-service training that included their continuing annual competencies. In an interview on 7/11/25 at 10:13 AM, the Nursing Home Administrator (NHA) reported that one of the duties of the Human Resource (HR) staff was to complete the annual skills checks. The facility did not have an HR staff at the time of this survey.