STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235535	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/12/2026
NAME OF PROVIDER OR SUPPLIER Riverside Nursing Centre		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #s 2655849 and 2663547.Based on interview and record review, the facility failed to ensure residents were treated with dignity and respect for 2 of 12 residents (Resident #10 and #17), and residents in attendance at the resident group meeting, reviewed for resident rights, dignity and respect.Findings: Resident #10 (R10) Review of an admission Record revealed R10 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: diabetes and hypertension Review of a Minimum Data Set (MDS) assessment for R10, with a reference date of 12/24/25 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated R15 was cognitively intact. Review of a Facility Incident Report received via online submission on 10/24/25 revealed, (R10) made an allegation that a staff member took a long time to assist her to the bathroom and that the staff member said, I'm not doing this and left the resident there. The resident then stated that the staff member came back to assist her to the bathroom and after that she put her in bed, then stated, Don't ring that bell again for the rest of the night. The resident alleges that this took place around 1:30 am on the 10/24/25.There was a staff member fitting that description working during that time period named (Certified Nursing Assistant [CNA] C).When asked to give more clarification the event that took place, (R10) stated: (I) needed to get up and go to the bathroom and was having a hard time getting up. Rang the call light and she (CNA C) came and she (CNA C) said, I'm not doing that because you (R10) were having a hard time getting up. She (CNA C) left and came back in a short time and took me (R10) to the bathroom. She (CNA C) told me (R10) to put the call light on when I was done, so I did. She (CNA C) put me back in bed and said, Don't push the call light for the rest of the night . Review of a Complaint/Incident Investigation Report received by the State on 10/27/25 revealed, .On 10/24/2025, (R10) pressed her call light for assistance to use the bathroom. (CNA C) came in and told her that she couldn't assist her at the moment. (CNA C) did return to get her to the bathroom and put her back into bed again. Afterwards, (CNA C) told (R10) not to press the call light again. Review of CNA C's Personnel Action Form with an effective date of 11/4/25 revealed, .Investigation completed. Resident states employee told her not to push her call light the rest of the night. Employee says untrue. Resident alert + oriented. No reason to not believe resident.Termination of (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	employment. During a confidential group meeting with 8 residents in attendance on 02/11/2026 at 10:30 AM until 02/11/2026 at 11:37 AM, the residents were queried on the staff attitudes and their right to be treated with dignity and respect. The residents unanimously agreed that the agency staff did not perform their work duties as they should reporting that they would often stand at the (nurses) station and talk, get real loud and goof around, don't know their a** from a hole in the ground, don't follow protocol at the facility. One resident reported that upon answering their call light an agency staff member impolitely stated, your lights on, what do you want. Another resident reported they would shut off their call light and would not return. They unanimously agreed that on nights with primarily agency staff, there were extensive call light wait times (up to an hour) and medications were administered later than their preferred time. The residents in the group meeting unanimously reported that the agency staff members were overall rude and disrespectful and need to be trained. Further discussion revealed dissatisfaction with the environment and the sound level. 5 of the 8 residents reported that at night the facility staff members were not careful about doors shutting and would allow them to slam which was terrifying at night. Review of the facility policy Resident Rights last reviewed 01/2025 revealed, It is the policy of this facility to ensure residents have the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. Resident #17 (R17) Review of an Face Sheet revealed R17 admitted to the facility on [DATE] with pertinent diagnoses which included acute respiratory failure, chronic kidney disease, type II diabetes mellitus, morbid obesity, chronic obstructive pulmonary disease, difficulty in walking, and need for assistance with personal care. Review of a Minimum Data Set (MDS) (a tool used for assessing a resident's care needs) assessment for R17, with a reference date of 12/02/2025 revealed a Brief Interview for Mental Status (BIMS) (a scale used to determine a resident's cognitive status) score of 15, out of a total possible score of 15, which indicated R17 was cognitively intact. Review of a current (Activities of Daily Living) ADL Care Plan intervention for R17, initiated 06/14/2023, revealed R17 required the assistance of two staff to go to the bathroom. Further review of ADL Care Plan indicated: to keep R17 clean and dry as possible and to minimize skin exposure to moisture. In an interview on 02/09/2026 at 11:11 AM, R17 reported she had been incontinent of bowel the previous night after waiting for her call light to be answered. R17 reported when staff answered her call light the Certified Nursing Assistant (CNA) stated you stink. R17 reported when the staff treat her like that she feels like I don't mean anything.

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2741552Based on interview and record review, the facility failed to 1.) ensure that pain management was provided to residents who required such services, consistent with professional standards of practice, and 2.) ensure that controlled pain medications were administered following provider orders and the residents' goals and preferences for 4 of 12 residents (Resident #24, R6, R1, and R20) and residents in attendance at the resident group meeting, reviewed for pain management.Findings:Resident #24 (R24)Review of an admission Record revealed R24 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: acute and chronic respiratory failure with hypoxia, spinal stenosis, low back pain, and asthma.Review of a Minimum Data Set (MDS) assessment for R24, with a reference date of 1/21/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated R24 was cognitively intact. Review of R24's Order Summary dated 12/4/25 revealed, hydromorphone (dilaudid) tablet; 2 mg; Amount to Administer: 2mg; oral Every 6 Hours Take with methocarbamol. AND methocarbamol (muscle relaxer) tablet; 750 mg; Amount to Administer: 750mg; oral Four Times A Day Take with hydromorphone.During an interview on 02/11/2026 at 11:40 AM, R24 reported that a few weeks prior she had not received her scheduled pain medication when an agency nurse was working. R24 confirmed the nurse was Licensed Practical Nurse (LPN) F. R24 stated, Supposedly he came in at midnight and at 6AM to give me my medicine. He did not! R24 reported LPN F brought medications to her room (around 9:30 PM) but her dilaudid was missing. When she confronted LPN F about the missing dilaudid, he kept saying it was in there (in the medication cup). LPN F did not go through and identify each medication he provided in the medication cup with R24 to refute the allegation. R24 stated, I know my pills. I know what they look like and I know if they're there. R24 reported that she had filed a complaint with the Director of Nursing (DON) after speaking with Registered Nurse (RN) G about not receiving her scheduled midnight or 6:30 AM pain medication and the agency nurse was terminated.Review of the Social Services Note dated 01/15/2026 at 4:20 PM revealed, Social Work met with (R24) for a supportive visit, specifically regarding concerns reported on 1/15/2026. Inquiry was made as to what occurred that prompted her concerns. (R24) reports that the nurse last night did not provide her with her prescribed pain medication or muscle relaxer. She reports the nurse gave her other medications, but her pain medication and muscle relaxer were not included. She states, I hate to second guess what the nurse gives me, but I know what I am taking and what my medications look like. She further stated, I can't have my pain medication and muscle relaxer until 11:00pm and the nurse was in between 9:30pm-9:45pm, that is too early. (R24) reports the only effect from the reported concern was that she is experiencing increased pain. Indicating her dilaudid ordered for pain control had not been administered.Review of the Social Services Note dated 01/16/2026 revealed, Social Work met with (R24) for a supportive visit, specifically regarding concerns reported on 1/15/2026.She reports she still has lingering pain, from not getting her meds the night prior, but she said, it will be better once it builds up in my system again.Review of a Facility Incident Report received via online submission on 1/15/26 revealed, Resident reported to the DON that she (R24) strongly believes that she did not receive her pain medication last night or this morning form (sic) (LPN F). It is reported in the medication administration record that the medication was given at 0000 on 1/15/26 and at 0600 on 1/15/26 and proof of use sheets coincide with medication being given. There was no discrepancy in medication count. Resident states that she did not receive her pain medication at those times.Audit of other residents receiving pain medications and no discrepancies identified.A statement written by (DON) stated: At 3:28pm on January 15th, 2026, (R24) came (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	into my office stating, I need to talk to you. Something's been on my mind all day. (R24) explained how she strongly believes she did not receive her pain medication (Dilaudid) last night or this morning from (LPN F) (agency LPN). DON informed (R24) that (LPN F) had charted that he gave her Dilaudid at (midnight) on 1/15/26 and (6:00AM on 1/15/26. (R24) shook her head no and said, THAT DID NOT HAPPEN. I know what my Dilaudid looks like. He was last in my room around 9:30pm last night and I never saw him again. She explained how she shook the med cup around after he gave her meds at 9:30pm and stated, There was no medicine in there, when referring to her Dilaudid.The dictated statement from (R24) stated: At 945pm last night, he (LPN F) brought me medicine. He told me my pain pill and muscle relaxer were and (in) it. I looked and no matter what I did, I could not find them. And I did look to the bottom of it looking for the little pill because the pain pill, it's very small and I couldn't see it, so I shook it around, looked in the top, shook it around some more, looked in the bottom: there was nothing there. He (LPN F) told me he was giving me my 12am pain medication and muscle relaxer because he didn't want to have to wake me up to give it to me, which is very unusual. And then he said he gave me my medicine at 6:00 this morning. There was no medicine in there. He never came in and I think I was reading between 4:00 and 6:00 this morning and I mean I was reading pretty early. But yeah. I just don't know what he did with my medication, but I know I wasn't given them. I'm worried he took them for himself. I know what my meds look like. And those weren't it.A statement by (RN G) who was the off-going nurse at the time of the alleged incident. She stated that she was nervous following him and that he was not a good communicator, possibly a language barrier. Truly I think he is a sloppy nurse. He told me that morning conflicting times when he locked his (med cart) keys in the med room. Once it was 1:00, then 3:30 am. He did tell me he prepped all his narcs. He did want everyone to know that. I think that he has poor practices. If you are thinking he's diverting, I don't think he is, I don't ever see any signs. He tried to leave that morning without counting, he signed out before I got him to count with me.A statement from (Regional Clinical Nurse [RCN] H) who spoke with (LPN F) the morning in question prior to his departure. The writer (RCN H) arrived at the facility on January 15, 2026, at 7:00 AM to conduct an in-service training for nurses regarding controlled substance policies, including record-keeping, shift to shift counts, and verification procedures for items such as fentanyl patches. Upon arrival, (RNC H) noticed confusion at the medication cart. (RNC H) approached two nurses identified as (LPN F and RN G) regarding the required controlled substance count. (LPN F) stated he had already completed and signed off on the count, while (RN G) indicated she had not participated and that he needed to complete the count with her before leaving, in accordance with policy. (RNC H) expressed concern that (LPN F) appeared not to understand or follow the policy, as he insisted he already completed the count but did not perform it with another nurse as required. (RNC H) instructed (LPN F) to complete an additional medication count, in which he did so. Also, (RNC H) also observed that (LPN F) did not complete the medication refrigerator count as required and admitted to not doing so, but ultimately completed the medication count as required and instructed.On January 15, 2026, (LPN F) notified the Director of Nursing at 4:53 AM that he had accidentally locked the narcotic and med-cart keys inside the medication room, preventing access to controlled medication. Access was restored at 6:40 AM when incoming nurse (RN G) obtained spare keys. After arriving around 6:45 AM, the DON spoke with (LPN F) who explained he mistakenly locked the keys in the med room while receiving an early morning medication delivery. As a result, some narcotics were not administered until 7:00 AM, after the narcotic box was opened and a proper nurse-to-nurse narcotic count was completed. After his shift, (LPN F) called the DON at 8:58 AM and made several unsolicited statements about medication administration, including giving medications overnight and (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that morning without proper documentation. He appeared distressed, repeatedly using profanity and speaking nervously. When asked for clarification he avoided the question. (LPN F) called again at 9:10 AM, but the DON informed him she was in a meeting. Later that day, at 6:12 PM, (LPN F) texted the DON asking for help correcting what he said (staffing agency) believed was a no-call/no-show for 1/14/2026. He made additional attempts to call the DON that evening and again the following morning (January 16) at 8:41 AM, but she did not answer. At 12:02 PM on January 16, (LPN F) arrived at the facility in person with several bottles that appeared to contain home medications. He attempted to discuss the prior events, but the DON and (RNC H) instructed him that he was not permitted on the property. He was escorted out and seen leaving at 12:03 PM.Conclusion Based on the information obtained, the investigation into the alleged incident involving (R24) and (LPN F) has yielded inconclusive results. (R24) alleges that she did not receive her pain medications on the night of 1/15/26 but an in-depth narcotic reconciliation of facility narcotic records showed that there was no diversion or missing medications.(LPN F) denies any diversion and states that he gave the medications to the resident. Given the lack of corroborating evidence and the conflicting accounts, the investigation cannot definitively substantiate a drug diversion. (The statements above were dated and signed by the referenced nurses).Although it was reported in the medication administration record that the medication was given at 0000 on 1/15/26 and at 0600 on 1/15/26 and proof of use sheets coincide with medication being given, LPN F reported to both the oncoming nurse (RN G) and the DON that he did not have access to the narcotic key during the 6:00 AM dilaudid administration. Additionally, he reported to RN G that he had prepped all his narcs (narcotics). Indicating LPN F removed 2 doses of R24's dilaudid and documented the administration on her Controlled Substance Proof of Use form at the beginning of his shift and not at the actual time the dilaudid was dispensed (for R24 and all other residents that were to receive controlled drugs throughout the entirety of his shift). Prepping R24's dilaudid would account for the correct count (number of remaining dilaudid tablets) on R24's Controlled Substance Proof of Use form. Prepping/presetting controlled drugs can lead to medication errors (wrong resident, wrong dose, wrong time, wrong medication), count discrepancies, and/or missed doses.LPN F confessed to the DON that he did not properly document medications that he administered throughout his shift and that narcotics were administered late (when he obtained access to the narcotic keys). He openly admitted to RNC H that he did not complete or follow the required controlled substance count procedures and RNC H expressed concerns of LPN F's inability to understand or follow controlled drug policies. LPN F was described as a sloppy nurse with poor (nursing) practices by a colleague. Resident Group MeetingDuring a confidential group meeting with 8 residents in attendance on 02/11/2026 at 10:30 AM until 02/11/2026 at 11:37 AM, the residents were queried about medication administration. 1 resident reported (with 5 other residents in agreement) that medications were not always administered and that staff were always confrontational if the concern was addressed. 1 resident reported that pain medications that are scheduled are passed late and as needed pain medications are not promptly administered when requested (greater than an hour).3 residents reported that they have not received pain medications in the past which they reported to management. 1 resident reported because they did not receive their as needed pain medication timely, they had to receive therapy services unmedicated, further reporting how difficult it was to participate in therapy when experiencing pain. The resident reported that he had had a problem with a male nurse they brought in not administering pain medication on time and sometimes not at all (3 other residents reported the same concerns with the male nurse). The residents reported resolution of the concerns with that nurse as he was no longer working at the facility.Resident #6 (R6)Review of an admission Record revealed R6 was an [AGE] year-old (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	male, admitted to the facility on [DATE], with pertinent diagnoses which included: Hypertensive heart and chronic kidney disease with heart failure.Review of R6's Order Summary dated 9/225 revealed, hydrocodone-acetaminophen (Norco)- tablet; 7.5-325 mg; amt 1 tab Three Times A Day. To be administered between 07:00 AM-11:00 AM, 01:00 PM-02:30 PM, and 07:00 PM-11:00 PM. Review of R6's Controlled Substance Proof of Use form revealed that on 2/6/26 the afternoon dose (1:00 PM-2:30 PM) was not dispensed. (Indicating the medication was not removed from the blister pack for administration).Review of R6's Medication Administration Record revealed that on 2/6/26 the afternoon dose of Norco was not administered (area left blank).Review of R6's Electronic Medical Record revealed no documentation for the withholding of the Norco.Resident #1 (R1)Review of an admission Record revealed R1 was a [AGE] year-old male, admitted to the facility on [DATE], with pertinent diagnoses which included: lumbar inflammatory spondylopathy (inflammatory disease that typically causes lower back pain and stiffness).Review of R1's Order Summary dated 6/20/25 revealed, hydrocodone-acetaminophen (Norco) tablet; 10-325 mg; amt: 1 tab; oral Three Times A Day. To be administered between 07:00 AM-11:00 AM, 01:00 PM-02:30 PM, and 07:00 PM-11:00 PM.Review of R1's Controlled Substance Proof of Use form revealed that on 2/8/26 R1's morning dose of Norco was not dispensed.Review of R1's Medication Administration Record revealed that on 2/8/26 all 3 doses of R1's Norco was documented as administered.Review of R1's Electronic Medical Record revealed no documentation for the withholding of the Norco.Resident #20 (R20)Review of an admission Record revealed R20 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses which included: neuropathy.Review of R20's Order Summary dated 1/23/26 revealed, pregabalin (Lyrica-used for nerve pain) capsule; 50 mg; amt: one capsule; oral Three Times A Day. To be administered between 07:00 AM-11:00 AM, 01:00 PM-02:30 PM, and 07:00 PM-11:00 PM.Review of R20's Controlled Substance Proof of Use form revealed that on 2/6/26 the afternoon dose of lyrica was not administered.Review of R20's Medication Administration Record revealed that on 2/6/26 R20's afternoon dose of Lyrica was not administered (area left blank).Review of R20's Electronic Medical Record revealed no documentation for the withholding of the Lyrica.Review of the facility policy, General Dose Preparation and Medication Administration last revised 1/1/13 revealed, .Facility staff should only prepare medications for one resident at a time.Review of the facility policy Controlled Substances Standards of Practice last reviewed 01/2025 revealed, Policy: In order to accurately account for all control substances through the process of ordering, receiving, storage, administration and destruction, the following procedures have been provided.Distribution and Record Keeping in FacilityNurses removing controlled substance from the narcotic storage require documentation on the Proof-of-Use Sheet the amount removed using a full last name signature. Nurse documentation of inventory balance on Proof-of Use sheet MUST be made as soon as the controlled substance is removed from the package/cart. Avoid waiting until the end of med pass or end of shift.Once the nurse completes the administration, then the nurse is to document on the MAR paper record or E-Mar electronic record. If PRN medication is administered, additional documentation regarding reason, result, time and initials are required. Note: If documentation is not provided on MAR or E-Mar, medication will be considered not given. MAR or E-Mar is record of administration NOT the proof-of-use sheet.Both on-going and off-going Nurses will count the number of containers and narcotic Proof-of-Use sheets to ensure accuracy reconciliation and provide signatures on the Narcotic Page and Card Count sheet.Both on-going and off-going nurses reconcile the Narcotic EDK and Narcotic Refrigerator EDK by checking and signing that the tag numbers on the boxes to ensure accuracy of safekeeping. Counts will occur with each change in ownership of narcotic keys, at shift change and change in assigned.Review of Fundamentals of Nursing ([NAME] and [NAME]) 11th edition revealed, Never document that you have given a (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication until you have actually given it. Document the name of the medication, the dose, the time of administration, and the route on the MAR. [NAME], [NAME] A.; [NAME], [NAME] G.; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 644). Elsevier Health Sciences. Kindle Edition.