

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  04/20/2026
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)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> This citation is related to intake #2973235Based on observation, interview, and record review, the facility failed to treat two of four residents (Resident # 103 and an unidentified resident) with dignity and respect when assisting them with breakfast. Findings:Resident #103 (R103)Review of a Face Sheet revealed R103 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses of traumatic brain injury, quadriplegia, cognitive communication deficit, and need for assistance with personal care which included one staff person required to feed the resident. During an observation on 04/16/26 at 8:50 AM, certified nurse aide (CNA) D stood next to R103's left side of the bed and the breakfast tray and (presumably) CNA's D's cell phone sat on the overbed table. CNA D offered R103 a bite of food and then looked down at the cell phone and scrolled through the screen. At 8:51 AM, CNA D offered R103 another bite of food and then continued to scroll through the cell phone. At no time during the observation did CNA D engage in meaningful conversation with R103. Unidentified ResidentDuring an observation on 04/16/26 at 8:45 AM, a resident sat at a table in the dining room with her back to the doorway and CNA C sat at the same table and was observed assisting the unidentified resident with breakfast. CNA C lifted a utensil with food on it to the residents mouth and then began scrolling on a cell phone that sat on the dinning room table. There was no meaningful conversation or interaction observed between the resident and CNA C. During an interview on 04/16/26 at 8:55 AM, the ADON (assistant director of nursing) was made aware of the above-mentioned observations and stated that staff cell phone use when providing care and assistance to resident's was not an acceptable practice.</p>		

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review, the facility failed to follow contact precautions for one of three resident's (Resident #104) reviewed for infection control practices. Findings: Resident #104 (R104) Review of a Face Sheet revealed R104 was a [AGE] year-old female, admitted to the facility on [DATE], with pertinent diagnoses of adult failure to thrive. During an observation on 04/16/26 at 9:31 AM, a contact precautions sign hung outside R104's room that directed staff .gown and gloves to be worn each time room entry is made. Review of a physician order summary for R104 reflected .contact precautions due to confirmed diagnoses of shingles. During an observation on 04/16/26 at 12:30 PM, certified nurse aide (CNA) C assisted R104 with lunch as the resident laid in bed. CNA C did not have on a gown or gloves nor any PPE (personal protection equipment). During an interview on 04/16/26 at 12:35 PM, Registered Nurse (RN) E indicated that the expectation for all staff was to follow posted contact precautions when entering R104's room for any reason.</p>		