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	12/04/2024

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

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation, interview, and record review, the facility failed to ensure a call light was within reach for one resident (Resident #133) out of four residents reviewed. Findings: Resident #133 (R133) Review of a Face Sheet revealed R133 was an [AGE] year old male, admitted to the facility on [DATE], with pertinent diagnoses of recent amputation of left leg below the knee, diabetes mellitus, and dementia. During an observation on 12/02/24 at 9:21 AM, R133's call light touch pad sat on the over bed table in the upper right hand corner. The over bed table was partially across the bed below R133's waist. When interviewed, R133 stated that the call light touch pad was in that location when he woke up this morning and has been there since. When asked to try and reach and activate the touch pad call light, R133 could not. During an observation on 12/02/24 at 10:04 AM, staff were seen leaving R133's room. The call light remained out of reach of R133 in the upper right hand corner of the over bed table. During an observation on 12/03/24 at 8:23 AM, R133 laid in bed with his eyes open. The touch pad call light was attached to the blanket which laid on the floor at the foot of the bed, out of sight and out of reach of the resident. R133 stated that he did not know where the call light touch pad was. During an interview on 12/04/24 at 12:30 PM, certified nurse aide (CENA) F indicated that the expectation was that every time staff enter a residents room, they make sure that essentials are within reach, including the call lights.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on interview and record review, the facility failed to notify the Guardian of changes for one (R30) of one resident reviewed for notification of changes. Findings include: R30 Review of a Face Sheet for R30 revealed she admitted to the facility on [DATE] with pertinent diagnoses of fracture, Down syndrome, and adult failure to thrive. Review of the Electronic Medical Record (EMR) for R30 revealed on 10/19/24 she weighed 88.8 pounds, 11/5/24 - 83.8 pounds, 11/8/24 - 82.6 pounds, and on 11/12/24 - 81.4 pounds. No other weights were documented to 12/3/24 as of this survey. This indicates an 8.33% weight loss in less than 30 days. Review of the EMR Food Intake for R30 between 11/4/24 and 12/3/24 revealed she received the following: 12 breakfasts, 9 lunches, and 14 dinners. Several days of the month she received no meals at all. No documentation indicating the Guardian was informed. Review of a Dietary Progress Note for R30 dated 11/8/24 revealed: Wt (weight) review: current wt 83.8#, signif wt (significant weight) loss noted, reviewed dietary note 11/8/24 Med Pass added to ordered, agree with interventions Med Pass 120cc QD (every day), Shakes BID (twice a day) to provide extra calories/protein. No documentation to show the Guardian was informed. Review of a Dietary Progress note for R30 dated 11/12/24 revealed: Chart review/wt (weight) review: current wt 82.6#, down 7% since admission, po (oral) intake varies 0-100%, receives po supplements as ordered, is assisted by staff at meals, last two wts have been stable with further potential for wt loss, no concerns at this time, no recommendations, current diet/po supplements adequate to maintain wt. No documentation to show the Guardian was informed. Review of the Medical Records for R30 revealed no documentation that her Guardian was notified of her significant weight loss. Review of the Orders for R30 revealed on 10/22/24 an order for Fortified foods for malnutrition and Mighty Shakes twice a day with meals. No documentation to show Guardian was informed. Review of the November 2024 Medication Administration Record (MAR) for R30 revealed she did not receive 120 milliliters (ml) of Med Pass as ordered on 11/15, 11/17, 11/21, 11/25 and took 50 mls (milliliters) or less on five other days. No documentation to show the Guardian was informed. In an interview on 12/4/24 at 12:14 PM, the Resident Representative (RR) M reported she was not notified of R30 having any weight loss or receiving any supplements. She was not aware of R30 not eating or missing any meals. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/4/24 at 1:30 PM, Registered Dietician (RD) L reported R30 needs assistance with meals, and it looked like her weights were stable. She is getting supplements and more supplements were added. Weekly weights are to be done weekly upon admission for a month and then if stable they are to be done monthly. A notification is given to the facility if any changes are made. RD L reported she did not notify the physician of her significant weight loss.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation and interview, the facility failed to keep comfortable temperatures and a homelike environment for 5 (R10, R3, R13, R29, R4) of 5 residents reviewed for comfortable temperatures and homelike environment. Findings include R10 During an observation and an interview on 12/2/24 at 10:04 AM, R10 was observed in bed bundled up in a blanket and shaking. She said she was shivering because it is cold. The hallway thermostat was not proving a temperature, and the Director of Nursing (DON) verified there was no reading. The Maintenance Director was outside shoveling snow at this time. In an interview on 12/2/24 at 10:25 AM the Maintenance Director (MD) N reported he just started working at the facility. He verified with his thermometer the temperature in room [ROOM NUMBER] was reading between 65.5 degrees F (Fahrenheit) and 68 degrees F. There is a thermostat in the room that is set at 68 degrees. He reported the facility has a boiler system and the hallways have heating/air-conditioning units called mini splits. The mini splits were not on at this time. At this time, he reported he was going to put in a call to have the heating system looked at. During an observation and an interview on 12/2/24 at 3:49 PM, R10 was still in bed wrapped up in blankets and said she is still cold. Her baseboard in her bathroom was peeling away from the wall and her air vent was dusty. R3 During an observation and an interview on 12/2/24 at 3:34 PM, R3 reported it was cold in her room because it was an old building. She complained she had not had a shower in a while and her hair was getting greasy. She said it is just too cold. Review of a Skin Monitoring shower sheet dated 11/25/24 for R3 revealed she refused a shower because it was too cold and was signed by the charge nurse. Review of the electronic medical record (EMR) for R3 revealed no documentation addressing the cold environment and no showers. During an observation and an interview on 12/3/24 at 8:53 AM, the Maintenance Director (MD) N walked with this surveyor to verify temperatures. room [ROOM NUMBER] temperature was 65.5 degrees F (Fahrenheit), R10's room was 67-68 degrees. The hallway thermostat was set to 74 degrees F but was not up to temperature yet. R13 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and an interview on 12/2/24 at 10:18 AM, R13 was sitting in his room sitting up in his wheelchair wearing a long-sleeved shirt and said his back and his shoulders are cold because of his age. He said it gets pretty cold around 2 PM and will put on his jacket then to keep warm. During an observation on 12/2/24 at 1:03 PM, R13 was observed in his room with his jacket on. Resident #29 During an observation and an interview on 12/02/24 at 12:21 PM, R29 was bundled up in bed with blankets and her sweater on. She stated she was cold. R4 During an observation and an interview on 12/2/24 at 12:18 PM, R4 was in her room and said she was cold. She is in bed and has a large blanket on. She said she is not usually cold, but she is this day.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. 37573 Based on interview and record review, the facility failed to follow policies and procedures to resolve a grievance for missing items for one (R183) of one resident reviewed for missing items. Findings include: Review of a policy titled Grievances/Concerns last reviewed 1/2024 revealed: Purpose: To support each resident's right to voice grievances and to ensure that a policy is in place to process grievance. Providing prompt actions to resolve grievances/concerns and to keep the resident apprised of progress towards resolution. Please note: Should a grievance/concern be a missing item, please complete the missing item report, track and trend accordingly. In an interview on 12/3/24 at 8:14 AM, R183 reported she has lots of clothes missing and was told by staff that her clothes will come up (appear) but never does. She claims she is missing her winter boots, a pair of pants, some shirts and a gown. R183 reported she told the Administrator who told her needed receipts, but she does not have any receipts because they are things she has already worn. Review of Resident Council Minutes dated 7/24/24 revealed R183 was missing items and clothes missing. Two other residents are documented as missing items. Review of the Resident Council Minutes dated 8/16/24 revealed Missing items reported on 7/26/24 were found on 8/16/24 by [staff] and were transferred over from grievance sheets to missing items sheets and turned over to laundry/housekeeping supervisor on 8/19/24. Originals were found in the Resident Council Book and had not been reported until 8/16/24. No resident names were listed. A request for grievance forms was made to the Nursing Home Administrator (NHA) for the last 6 months for R183 revealed no record of concerns for missing items. In an interview on 12/3/24 at 3:08 PM, the Activities Director (AD) C reported she was not here for the Resident Council meeting in July and not aware of missing items for R183. AD C said they will typically do a missing item report and then talk to the resident after the resident council meeting to get more details of what is missing. They will then give copies of the report to the Director of Nursing, Housekeeping, Maintenance, the NHA, and will keep a copy for herself. AD C reported she will follow up with the NHA regarding any missing items. In an interview on 12/4/24 at 1:10 PM, the NHA reported AD C did talk to her the night before about R183 missing items in July. The NHA reported there was not a form filled out to address the concerns of missing items.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan for one (R30) of one resident reviewed for care plans and interventions. Findings include: R30 Review of a Face Sheet for R30 revealed she admitted to the facility on [DATE] with pertinent diagnoses of fracture, Down syndrome, adult failure to thrive, anxiety, depression, dorsalgia (pain in the muscles, nerves, bones, joint or other structures associated with the spinal column) and spondylosis (cervical osteoarthritis). Review of the Care Plan for R30 revealed no focus for anxiety and depression, dorsalgia or spondylosis. Review of the Admission Minimum Data Set (MDS) dated [DATE] for R30 revealed she is moderately cognitively impaired. She likes doing things with groups of people. She is dependent on staff for toileting, transfers, bathing, dressing, and mobility. She is incontinent of bowel and bladder. Review of the Care Plans for R30 revealed there is no activity care plan, no cognitive status with interventions, incomplete ADL (activities of daily living) care plans reflecting her dependence and needs for incontinence, toileting/bowel and bladder, shower/bathing, and dressing. Review of the Electronic Medical Record (EMR) for R30 revealed on 10/19/24 she weighed 88.8 pounds, 11/5/24 - 83.8 pounds, 11/8/24 - 82.6 pounds, and on 11/12/24 - 81.4 pounds. No other weights were documented to 12/3/24 as of this survey. This indicates an 8.33% weight loss in less than 30 days. Review of the EMR Food Intake for R30 between 11/4/24 and 12/3/24 revealed she received the following: 12 breakfasts, 9 lunches, and 14 dinners. Several days of the month she received no meals at all. Review of a Nutritional Status Care Plan initiated 10/22/24 for R30 revealed: (R30) is at Nutritional/ Hydration risk r/t DX: rt femur neck fx (fracture), pelvic fx, depression, anxiety, Down Syndrome. *Upon admission, requires 1:1 assistance with po (oral) intake. *Leaves 25% or more of most meals uneaten. *Low BMI (underweight) upon admission. *Score of 4 on mini nutrition screen indicating malnutrition. *11/5/24: weight loss x17 days - considered significant at this time. Approach: no new interventions since 10/22/24 and included to assist with meals as needed, diet as ordered, monitor meal intake/record, observe tolerance to diet, make adjustments [as needed], supplements as ordered. (sic) (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/4/24 at 12:14 PM, the Resident Representative (RR) M reported she was not notified of R30 having any weight loss or receiving any supplements. RR M reported R30 gets tired easily when feeding herself and needs assistance. R30 may take the first couple bites herself and then will stop eating. RR M reported she informed the facility of this information. RR M reported she has come to the facility in the evenings at times to see R30 sitting at the table in the dining room with no assistance with her meals and was told by staff they just prompt R30 to eat. Staff have been observed running in and out of the dining room but not sitting down and assisting the residents. If R30 is not 1:1 assistance with meals, she will not eat or drink. R30 likes to be in her room because she feels safe in there. She always liked her room when she was at home too. R30 has no history of seizures but has behaviors that can look like a seizure when she gets upset or scared. If she gets really nervous, her hands will shake significantly and can be a little delirious. R30 was sent to the hospital recently because the facility thought she was having a seizure. Review of a Nursing Progress note for R30 dated 11/4/24 revealed she was diagnosed with a UTI at the hospital and her seizure evaluation cleared. Review of a toileting Care Plan for R30 initiated 10/18/24 revealed she is no longer independent with toileting. She experiences incontinence related to her inability to always inform staff, hip fracture with NWB (non-weight bearing) status. No meaningful interventions and no new interventions since diagnoses of a urinary tract infection UTI on 11/4/24. No care plan for seizures or behaviors.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview and record review, the facility failed to provide foot care for 1 (R13) of two residents reviewed for foot care. Findings include: Review of a Face Sheet for R13 revealed admitted to the facility on [DATE] with pertinent diagnoses of chronic diastolic (congestive) heart failure, diabetes, and chronic obstructive pulmonary disease. During an observation and an interview on 12/2/24 at 10:18 AM, R13 was in his room sitting up in his wheelchair with no shoes on, toes observed contracted and his toenails are very long. He reported he is supposed to see a podiatrist but has not seen one yet. He did not like his toenails being that long. The big toenails were obviously extended beyond the baseline of his nailbed. In an interview on 12/3/24 at 3:27 PM, Social Worker (SW) H reported R13 is on the list to see podiatry as of yesterday. They had a consent for R13 to see podiatry in May of 2023 and was unsure when he was last seen by podiatry. SW H then clarified R13 was last seen in February 2023. Podiatry was just at the facility on 11/11/24 and did not see R13 and will not be back at the facility until February 2025. At 4:40 PM, SW H reapproached this surveyor and reported she had more information about R13 not having his insurance renewed timely, which is why he was not able to see the podiatrist. SW H Provided a Nursing Progress Note revealing R13's last podiatry visit was on 11/9/23. In an interview on 12/4/24 at 2:45 PM, the Guardian of R13 reported she would always give permission for R13 to see a podiatrist if needed. Review of the Care Plan for R13 titled has potential for complications related to diabetes mellitis: hypo/hyperglycemia, polyneuropathy initiated 4/20/23 revealed an approach of Inspect foot for bunions, calluses, cracking, and encourage proper foot care; refer to Podiatrist for foot care and trimming of nails.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 37573 Based on observation, interview and record review, the facility failed to safely secure and store an oxygen tank for one (R183) of one resident reviewed for oxygen tank storage. Findings; R183 During an observation and an interview on 12/2/24 at 9:51 AM, R183 was not in her room, and her coat and a bag of belongings sat in a chair. A portable oxygen tank also sat in the chair laying across the arms of the chair. The Director of Nursing (DON) walked by at this time and the placement of the portable oxygen tank was pointed out to her. The DON reported that it should not stored in that manner. Review of an Oxygen Storage policy last reviewed 1/2024 revealed: -[Oxygen] Cylinders must be secured in racks or by chains.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37573 Based on observation, interview and record review, the facility failed to monitor weights, provide appropriate nutrition, meals and supplements as ordered, and provide assistance with meals for two (R30 and R29) of 2 residents reviewed for nutrition. Findings include: R30 Review of a Face Sheet for R30 revealed she admitted to the facility on [DATE] with pertinent diagnoses of fracture, Down syndrome, and adult failure to thrive. Review of an Initial Nutritional Assessment for R30 dated 10/21/24 revealed: Average po (oral) intake is ranging 51-75% of documented meals since admission and noted to require 1:1 assistance with po intake. Score of 4 on mini nutrition screen indicating malnutrition, request fortified foods and mighty shake (220 kcal (kilocalories), 6 grams pro, ea) BID (twice a day). Admission weight on 10/19/24 of 88.8 lbs (pounds), . estimated nutritional needs of 1290-1505 kcal (30-35 kcal/kg r/t (related to) malnutrition) and 43-52 grams protein (1-1.2 gm pro/kg). Continue to monitor weights with po intake and adjust nutritional plan as needed. Continue to offer alternate food choices if po intake is less than 50%, monitor weights and assist as needed. Review of the Electronic Medical Record (EMR) for R30 revealed on 10/19/24 she weighed 88.8 pounds, 11/5/24 - 83.8 pounds, 11/8/24 - 82.6 pounds, and on 11/12/24 - 81.4 pounds. No other weights were documented to 12/3/24 as of this survey. This indicates an 8.33% weight loss in less than 30 days. Review of the EMR Food Intake for R30 between 11/4/24 and 12/3/24 revealed she received the following: 12 breakfasts, 9 lunches, and 14 dinners. Several days of the month she received no meals at all. Review of a Nutritional Status Care Plan initiated 10/22/24 for R30 revealed: (R30) is at Nutritional/ Hydration risk r/t DX: rt femur neck fx (fracture), pelvic fx, depression, anxiety, Down Syndrome. *Upon admission, requires 1:1 assistance with po (oral) intake. *Leaves 25% or more of most meals uneaten. *Low BMI (underweight) upon admission. *Score of 4 on mini nutrition screen indicating malnutrition. *11/5/24: weight loss x17 days - considered significant at this time. Approach: Assist with meals as needed. Monitor meal intake/record. Review of the Activities of Daily Living (ADL) Care Plan initiated 10/18/24 for R30 revealed: Allow (R30) time to help perform and complete any part of her ADLs as able. Staff to help promote independence as she was at home. Give encouragement and praise. Status of eating ability - requires assist although she was independent at home. Encourage and allow self-feeding as tolerated. Review of a Dietary Progress Note for R30 dated 11/8/24 revealed: Wt (weight) review: current wt 83.8#, signif wt (significant weight) loss noted, reviewed dietary note 11/8/24 Med Pass added to ordered, agree with interventions Med Pass 120cc QD (every day), Shakes BID (twice a day) to provide extra calories/protein. No recommendations at this time. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Dietary Progress note for R30 dated 11/12/24 revealed: Chart review/wt (weight) review: current wt 82.6#, down 7% since admission, po (oral) intake varies 0-100%, receives po supplements as ordered, is assisted by staff at meals, last two wts have been stable with further potential for wt loss, no concerns at this time, no recommendations, current diet/po supplements adequate to maintain wt. Review of the Orders for R30 revealed on 10/22/24 an order for Fortified foods for malnutrition and Mighty Shakes twice a day with meals. No documentation to show she is receiving the mighty shakes. Review of the November 2024 Medication Administration Record (MAR) for R30 revealed she did not receive 120 milliliters (ml) of Med Pass as ordered on 11/15, 11/17, 11/21, 11/25 and took 50 mls (milliliters) or less on five other days. No meaningful documentation for reapproaches or root causes to little or no intake is documented. In an interview on 12/4/24 at 12:14 PM, the Resident Representative (RR) M reported she was not notified of R30 having any weight loss or receiving any supplements. RR M reported R30 gets tired easily when feeding herself and needs assistance. R30 may take the first couple bites herself and then will stop eating. RR M reported she informed the facility of this information. RR M reported she has come to the facility in the evenings at times to see R30 sitting at the table in the dining room with no assistance with her meals and was told by staff they just prompt R30 to eat. Staff have been observed running in and out of the dining room but not sitting down and assisting the residents. If R30 is not 1:1 assistance with meals, she will not eat or drink. RR M was not aware of R30 not eating or missing any meals. In an interview on 12/4/24 at 1:30 PM, Registered Dietician (RD) L reported R30 needs assistance with meals, and it looked like her weights were stable. She is getting supplements and more supplements were added. Weekly weights are to be done weekly upon admission for a month and then if stable they are to be done monthly. A notification is given to the facility if any changes are made. RD L reported she did not notify the physician of her significant weight loss. Review of the EMR for R30 revealed no documentation that the physician was notified of her significant weight loss or the guardian. R29 Review of a Face Sheet revealed R29 admitted to the facility on [DATE] with pertinent diagnoses of dementia and osteoporosis. Review of the mealtimes provided by the facility revealed that breakfast is at 8:30 AM. During an observation and an interview on 12/2/24 at 9:15 AM, R29 was in bed wrapped up in a blanket and reported she did not get her breakfast yet. Hall trays were passed out in the hallway and some residents were already eating breakfast in the dining room. She reported she was going to go to the dining room but did not make it there yet. During an observation and an interview on 12/2/24 at 12:21 PM, R29 reported she still did not get her breakfast or her lunch yet. At this time lunch trays were not provided yet. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Electronic Medical Records (EMR) for R29 revealed from 11/4/24 to 12/4/24 the resident received the following meal totals: 7 breakfasts, 2 lunches, and 8 dinners. No meals provided for several days at a time during this time period. Review of the EMR for R29 revealed on 11/14/24 she weighted 97.8 pounds and is the last weight recorded. Review of the Orders for R29 revealed Mighty Shakes (dietary supplement) twice a day for weight loss was ordered on 9/13/24. Another dietary supplement Med Pass ordered 4 times a day on 12/2/24. Review of the Medication Administration Record for R29 revealed that as of 12/4/24 she had not received her Med Pass Dietary supplement and no documentation in the EMR that she received her Mighty Shakes as ordered. Review of the Nutritional Status Care Plan for R29 initiated 4/9/24 revealed: (R29) is at Nutritional/Hydration risk r/t DX (diagnoses): fall with fracture, HTN (hypertension), unspecified dementia, osteoporosis, glaucoma. *Need for a therapeutic diet *Need for a mechanically altered texture *9/13/24: Sig wt (significant weight) loss x 30 days - resolved *11/14/24: Weight concern while under 100 (pounds). Approach: 4/9/24, Assist with meals as needed. Monitor meal intake/record. Weigh per orders. (sic) Review of the Dietary Progress notes dated 12/2/24 for R29 revealed: [oral] intake varies while ranging 76-100% of documented meals over the past 30 days. Mighty shakes (220 kcal, 6 grams pro, ea) restarted BID (twice a day) 9/13/24 secondary to weight trending down without significance. Current weight on 11/14/24 of 97.8 lbs (pounds) continues to trend down without significance and is concerning r/t (related to) weight now under 100 lbs. Continue to offer alternate food choices if po intake is less than 50%, monitor weights and adjust nutritional POC as needed. (sic) In an interview on 12/4/24 at 1:30 PM, Registered Dietician (RD) L reported she is not aware of R29 not receiving her meals and did not acknowledge her meals were not being documented. RD L reported if there are any changes to a resident's dietary orders or needs, she communicates that with the nursing staff. Review of a Policy titled Residents at Nutritional Risk last revised 8/23 revealed: 1. Once a problem has been identified and the Dietitian has been consulted, the primary nurse should work with the Dietitian and resident in setting realistic goals and identify approaches to be used. These goals should be shared with the SOC team members on a monthly basis. 3. Nursing notes should reflect progress made on a weekly basis. Essential Points: Timely assessment and implementation of a plan is crucial in proper care of the resident at risk. Elderly residents are quick to experience a change in condition with negative outcome, but very slow to recover. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a policy titled Weight Monitoring last reviewed 1/2024 revealed: 4. Procedure: Those residents that trigger for a significant weight loss (>5%) from the previous month will be placed on weekly weights. Each resident will be reviewed by the IDT committee and appropriate interventions will be put into place. Monthly and Weekly Weights -Monthly weights: conducted on residents whose weight has been stable from the time of admission to current. - Weekly weights conducted on residents that: a. Have experienced a significant weight loss\gain as indicated by the weight variance report b. Are newly admitted to the facility regardless of payer c. Are readmitted to facility d. Have a gradual weight loss over a period of time -Weekly weights will be monitored for 30 days or more. The IDT determines if the resident is at high risk for further weight loss -Re-weighs: conducted on residents that: a. Have experienced a 5% weight gain or loss from the previous month if current weight is over 100 lbs. b. Have experienced a 3 lb. weight loss or gain from previous month if current weight is under 100 lbs. -The DTR/RD will be responsible for reviewing the weight variance report, making additional nutritional recommendations, documenting in the medical record and discussing the weight changes with the weight committee.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 37577 Based on observation, interview, and record review, the facility failed to store and label medications with currently accepted professional standards for 1 of 1 medication carts reviewed. Findings: During an observation on 12/03/24 at 8:00 AM, the medication cart contained 18 loose pills of various shapes and colors. Each of the pills represented a medication that was prescribed by a physician to a resident. The assistant director of nursing (ADON) indicated that the loose pills should not be there. During the same observation a Basaglar insulin kwik pen prescribed to the resident in bed 12-2, did not have a date written on it indicating when the pen was first opened and used. Review of the facility policy Storage and Expiration dating of Medications (5) Once any medication is opened, facility should follow manufacturer guidelines with respect to expiration dates for opened medications Facility staff should record the date opened on the primary medication container when the medication has a shortened expiration date once opened.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation, interview, and record review, the facility failed to provide food at a palatable temperature to 3 of 16 residents and all residents who consume food resulting in the potential for decreased food consumption and potential nutritional decline. During a tour of lunch service, at 12:08 PM on 12/2/24, an interview with Dietary Manager (DM) D found that the plate warmer has not been working that good since he started a month ago. At this time the plates were found to be 88F. DM D stated that he's only been here a month and has had the plate warmer looked at a couple times. When asked if there was a way to turn it up, DM D stated it only has an on and off switch. Outside of thermal covers, the facility does not use any other equipment to ensure hot food to residents. During an interview with DM D at 12:13 PM on 12/2/24, found that he likes to see 180F from hot food on the steam table in order to keep it hot for residents. When asked to see the temperature sheet for today's lunch, in order to check the temperatures, DM D checked the log and found that [NAME] O didn't take pre-service temperatures for meal service and was not sure what the temperatures of the hot food was before service started. At 12:28 PM on 12/2/24, a test tray was plated and put on a cart to be delivered with hall trays. At 12:33 PM the cart was delivered to the hall and after a few minutes staff started to deliver meal trays to residents. At 12:46 PM on 12/2/24, all trays on the cart were delivered and the surveyor took the test tray to the conference room and found the following temperatures: chicken 119F, vegetables 116F and rice was 111F. The flavor and appeal of the vegetables were bland and lukewarm in the mouth. The rice was lukewarm and found to be dry and hard in spots. No salt or pepper was placed on the test tray. 37577 During an interview on 12/02/24 at 9:28 AM, the resident in room [ROOM NUMBER]-1 stated that the food was repulsive, had no flavor except if it was heavy on pepper, and was delivered cold. We are the last to get served. During an interview on 12/02/24 at 11:50 AM, the resident residing in room [ROOM NUMBER]-2 stated that the food is mostly disgusting, usually has no flavor and is not hot, and would call it awful. 37573 During an interview on 12/2/24 at 12:11 PM, the resident in room [ROOM NUMBER]-A reported his vegetables were cold and not seasoned. He reported he does not get to choose what he wants for meals ahead of time. He has to receive whatever they serve, then if he does not like it, he can choose something else. If he chooses something else, he will have to wait until everyone else is served, then the kitchen can make him something else to eat.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on interview and record review, the facility failed to consistently provide bedtime snacks to four of four residents (Resident #17, Resident #5, Resident #12, and Resident #133) reviewed. Findings: Resident #17 (R17) Review of a Face Sheet revealed R17 was a [AGE] year old male with pertinent diagnoses of diabetes mellitus, weight loss, and weakness. During an interview on 12/02/24 at 11:50 AM, R17 reported that he does not get offered a bedtime snack consistently. Review of a bedtime snack log for R17 reflected from 11/02/24 to 12/02/24, the resident was offered a bedtime snack on four evenings. Resident #5 (R5) Review of a Face Sheet revealed R5 was a [AGE] year old female with a pertinent diagnosis of insulin dependent diabetes. During an interview on 12/04/24 at 9:40 AM, R5 indicated that sometimes she was offered a snack at bedtime. Review of a bedtime snack log for R5 reflected that from 11/04/24 to 12/04/24, the resident was offered a bedtime snack on eight evenings. Review of a Care Plan for R5 showed that the resident had the potential for low and high blood sugars related to diabetes and one intervention to prevent this was for staff to provide/offer a bedtime snack. Resident #12 (R12) Review of a Face Sheet revealed R12 was a [AGE] year old female with a pertinent diagnoses of insulin dependent diabetes. During an interview on 12/04/24 at 9:01 AM, R12 responded I don't know when asked if she was consistently offered a snack at bedtime. Review of a bedtime snack log for R12 reflected that from 11/02/24 to 12/02/24, the resident was offered a bedtime snack on three evenings. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #133 (R133) Review of a Face Sheet revealed R133 was an [AGE] year old male, admitted to the facility on [DATE], with pertinent diagnoses of diabetes mellitus and dementia. During an interview on 12/04/24 at 11:25 AM, R133 indicated that he does not get snacks consistently at bedtime and went onto say that he would like to get them because he is often hungry before bed. Review of a bedtime snack log for R133 reflected that from 11/12/24 to 12/02/24, the resident was offered a bedtime snack on one evening. During an interview on 12/04/24 at 11:40 AM, the Administrator (ADM) stated that dietary staff prepare substantial snacks at bedtime for residents that need them, like diabetics. This was partially because the scheduled time frames between dinner and breakfast exceeds 14 hours. The ADM also stated that the nursing staff know which residents are diabetics and ensure that they receive a substantial bedtime snack. During an interview on 12/04/24 at 9:10 AM, Dietary Manager (DM) D reported that dietary staff do not have a list of the residents who are diabetic. Instead, dietary staff make sure there are at least 5 peanut butter and jelly sandwiches on the bedtime snack cart. DM D did not know how many current residents were diabetics. Review of the facility policy Nourishment, HS (bedtime) Snacks and Med Cart Supplies, last reviewed 01/2024, revealed .Residents will be provided nourishing HS snack and other nourishments as needed .the nursing department is responsible for the delivery of nourishments .Nursing should document the intake of all nourishments.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38905 Based on observation, interview, and record review, the facility failed to prepare food in accordance with professional standards for food service safety. This deficient practice has the potential to result in food borne illness among all residents that consume food from the kitchen. Findings include: During a tour of the kitchen, starting at 9:45 AM on 12/2/24, observation of the two door True cooler found that the left and right doors each had a section of gasket that was ripped and torn. During an interview with Dietary Manager (DM) D, at 10:01 AM on 12/2/24, it was found that he has only been at the facility for a month. When asked if there was any plumbing issues in the kitchen, DM D stated that the faucet and water line leading to the one compartment sink on the dish line leaks when it's in use. When asked if Maintenance is aware of the issue, DM D stated he's been informed, but he's only been here less than a week. During a tour of the lunch service, at 12:10 PM on 12/2/24, it was observed that the plate warmer was only holding plates at 88F. When asked if there was an issue with the plate warmer, DM D stated that it hasn't been working that good and that they have had it looked at a couple times in the past few weeks. DM D stated that it doesn't seem to get hot and takes a long time to warm the plates to 88F. According to the 2017 FDA Food Code section 4-501.11 Good Repair and Proper Adjustment. (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight, and adjusted in accordance with manufacturer's specifications. According to the 2017 FDA Food According to the 2017 FDA Food Code section 5-205.15 System Maintained in Good Repair. A PLUMBING SYSTEM shall be: (A) Repaired according to LAW; and (B) Maintained in good repair. During a tour of the kitchen, at 10:10 AM on 12/2/24, it was observed that a bottle of less sodium soy sauce was found on a shelf above the three-compartment sink. The bottle was dated for 10/13/24 with about 20% of its contents left. A review of the manufacture label found that the directions state to Refrigerate After Opening. According to the 2017 FDA Food Code section 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. (A) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under S3-501.19, and except as specified under (B) and in (C) of this section, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD shall be maintained: (1) At 57C (135F) or above, except that roasts cooked to a temperature and for a time specified in 3-401.11(B) or reheated as specified in 3-403.11(E) may be held at a temperature of 54C (130F) or above; or (2) At 5C (41F) or less. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the utensil drawers, at 10:25 AM on 12/2/24, an interview with DM D found that this is where clean utensils are stored. Observation of the clean utensil drawers found two mechanical scoops, one metal spoon, and one potato masher, all with excess dried food debris on their surfaces. During a tour of the ice machine, at 10:39 AM on 12/2/24, it was observed that an accumulation of pink and brown slimy debris was evident around the bottom perimeter of the dispensing shield of the machine. Further observation found that the dump drain portion of the ice machine was covered in sticky red staining with visible accumulation on the grate and bottom drain portion of the machine. When asked who cleans the machine, DM D stated that maintenance does cleanings of the machine. Further observation found that the ice machine was leaking onto the floor in the back left corner. Large amounts of black accumulation under the ice machine and on the floor were observed. During a tour of the juice machine area, at 10:40 AM on 12/2/24, it was observed that the underside of the juice spouts were found with dried orange accumulation of sticky debris. During a tour of the dining room refrigerator, at 10:45 AM on 12/2/24, it was observed that red juice staining and spillage had occurred in the unit. a red sticky splash was found on the left wall and the main bottom storage area. Observation of the drawers found that each drawer contained red juice in the bottom. During a tour of the dry storage area, at 10:35 AM on 12/2/24, it was observed that the bulk containers of flour and sugar were found with three scoops stored in the containers with their handles in the product. According to the 2017 FDA Food Code section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. During a tour of the dining room refrigerator, at 10:43 AM on 12/2/24, the following items were found with no date to indicate when the item should be discarded: a bag with a peanut butter and jelly sandwich, a plastic bag with three hot dogs, a container of tuna salad, a container of mac and cheese, two banquet pot pies (stated keep frozen), a breakfast sandwich (stated keep frozen), two unopened packs of soft cheese with a use by date of [DATE], a small container of mashed potatoes, a grocery bag with two plates of thanksgiving leftovers, and a grocery bag of thanksgiving leftovers dated 11/28/24. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the 2017 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . According to the 2017 FDA Food Code section 3-501.18 Ready-to-Eat, Time/Temperature Control for Safety Food, Disposition. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination as specified in 3501.17(A) . During an observation of lunch service, at 12:20 PM on 12/2/24, it was observed that another cart was be needed to help deliver trays to the floor. [NAME] O stepped away from plating meals on the serving line to wash down and clean a cart that had dirty equipment on it. After cleaning and sanitizing the cart, [NAME] O put gloves back on and went back to plating meals without using the hand sink and washing his hands. According to the 2017 FDA Food Code section 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified under S 2-301. 12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES and:(A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; (B) After using the toilet room; (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in 2-403.11(B); (D) Except as specified in 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; (E) After handling soiled EQUIPMENT or UTENSILS; (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; (H) Before donning gloves to initiate a task that involves working with FOOD; and (I) After engaging in other activities that contaminate the hands.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37577 Based on observation the facility failed to maintain a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. This resulted in an increased potential for contamination and a possible decrease in the satisfaction of living, affecting residents in following areas: During an observation on 12/02/24 at 9:21 AM, the following were noted in the living area of bed 14-2: (a) the window blinds had multiple broken slats, (b) the foot board of the bed had fall off and laid on the floor at the end of the bed on top of the machine that controlled the APM (alternating pressure mattress), and (c) at the foot of the bed a strip of molding that secured and protected a cord had been pulled off the wall and laid on the floor. During an observation on 12/02/24 at 9:59 AM, the following was noted in the east hall dining room: (a) a television was on for residents to sit and watch, (b) there was a hoyer lift stored in the room, (c) four wheelchairs were stored in the room, and (d) two vitals machines were stored in the room. The dining room was congested and did not provide for easy and safe movement throughout the room. During an observation on 12/02/24 at 11:38 AM, the following was noted in the bathroom of room [ROOM NUMBER]: (a) no heat could be detected coming from the floor register, (b) the temperature in the bathroom at the ceiling was 59.1 degrees and 62.9 degrees on the floor (obtained with an infrared thermometer), (c) peeling paint was noted on the wall near the light switch, (d) the toilet paper holder had two metal rings that were bent out of place and the toilet paper could not roll, (e) the paint at the base of the outside wall near the heat register was cracked and peeling, (f) the ventilation cover was layered with dust, and (g) more than six small dark objects were noted inside the light fixture. During an observation on 12/03/24 at 8:21 AM, the following were still noted in the east hall dining room: (a) the hoyer lift was stored in the room, (b) three wheelchairs were stored in the room, (c) 4 vitals machines were stored in the room, and (d) three large totes sat on the floor that contained Christmas decorations. During an observation in the living area of bed 14-2 and completed on 12/03/24 at 8:51 AM, the foot board remained on the floor at the foot of the bed on top of the APM machine. During an observation on 12/04/24 at 8:36 AM, the following was noted in the bathroom used by the residents in room [ROOM NUMBER]: (a) the toilet paper dispenser was covered with brownish/rust colored stains, (b) there was no light fixture cover on the fluorescent lamps, (C) the ventilation cover was layered with dust, and (d) the floor in front of the toilet had very large dark gray stains. 38905 (continued on next page)

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	12/04/2024

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 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a tour of the facility, starting at 11:22 AM on 12/2/24, with Maintenance Director (MD) N, observation of the clean linen closets by (resident room [ROOM NUMBER]) were found with excess accumulation and floor storage. The floor of the closets had clean socks, a bag of briefs, wash cloths, and dust. Observation of the utility closet, at 11:30 AM on 12/2/24, found that there was no vinyl base cove molding around the bottom perimeter of the floor. Parts of the wall near the floor juncture were found deteriorating. During a tour of utility closets, at 11:34 AM on 12/2/24, near resident room [ROOM NUMBER], it was observed that the closets had items on the floor, including disposable silverware. The bottoms of the closets were found with an accumulation of dust debris and cobwebs. During a tour of the linen closets near resident room three, at 11:37 AM on 12/2/24, it was observed that the bottoms of the closets were found with socks, cobwebs, and dust accumulation.