STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235623	A. Building B. Wing	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royalton Manor, L L C	288 Peace Blvd St Joseph, MI 49085

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 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 This citation pertains to intake MI00145692 Based on interview and record review the facility failed to ensure proper procedure for a facility-initiated discharge for 1 (Resident #106) of 1 resident reviewed for facility-initiated discharge resulting in the untimely and unapproved discharge of the resident from the facility. Findings include: Review of an Admission Record revealed Resident #106 had pertinent diagnoses which included: alzheimer's disease with last onset, dementia with mood disturbances, and generalized anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 7/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 2/15 which indicated Resident #106 was severely cognitively impaired. Review of Notice of involuntary transfer or discharge and facility-initiated discharge for nursing homes for Resident #106 dated 6/10/2024 revealed facility completed sections to include .date of notice was 6/10/2024 . proposed discharge date was 7/15/2024 .reason for discharge was nonpayment of resident stay . Review of Notice of involuntary transfer or discharge and facility-initiated discharge for nursing homes for Resident #106 dated 6/10/2024 revealed Transfer or Discharge Timeline, Discharge Plan .If Michigan Department of Licensing and Regulatory Affairs ([NAME]) determines that a transfer or discharge is authorized, the resident should not be required to transfer or discharge from the facility before the 34th day following receipt of the notice . prior to any involuntary transfer or discharge, a transfer or discharge plan must be prepared by the nursing home and approved by [NAME] . Review of Facility involuntary transfer/discharge plan for Resident #106 revealed date of counseling provided to resident prior to transfer was 6/29/24 and the form was signed by facility representative Social Worker (SW) G on 6/10/24. On 7/26/24 review of Social Services Note for Resident #106 dated 6/26/24 at 11:09 AM., authored by SW G revealed .reached out to family regarding the discharge that will happen on 7/15/2024. Family did not answer .left a voicemail requesting call back . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
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F 0622 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/26/24 review of Social Services Note for Resident #106 dated 7/15/24 at 16:14 PM., authored by SW G revealed .spoke with residents guardian and he stated he has arranged (Name Omitted) transport for her discharge . In an interview on 7/26/24 at 2:23 PM., SW G reported that the discharge papers for Resident #106 were submitted to the state, they were denied a couple of times, and then it was accepted. SW G reported the facility had the approval from [NAME] for Resident #106's discharge. When asked for the approval letter, SW G reported that she did not have the approval letter. In an interview on 7/26/24 at 3:08 PM., Accounts Receivable Coordinator (ARC) LL reported that the facility did receive approval from the [NAME] for the involuntary discharge of Resident #106. ARC LL was asked the approval letter form [NAME] and ARC LL produced the Notice of involuntary transfer or discharge and facility-initiated discharge for nursing homes for Resident #106. ARC LL reported that she believed this form was the approval for discharge and that she had not received any other letter regarding Resident #106's discharge. On 7/26/24 at 4:15 PM., when this surveyor left the building for the day, the facility was unable to provide this surveyor with a copy of an approval letter from [NAME] that indicated Resident #106's discharge plan had been accepted and Resident #106 could be discharged from the facility. On 7/30/24 at 08:00 AM., NHA A provided to this surveyor a letter from [NAME] that revealed .this letter approves the involuntary transfer discharge plan for Resident #106 .the resident may be transferred or discharged according to the approved plan on 7/30/2024 . In an interview on 7/30/24 at 8:05 AM., NHA A reported that Resident #106 was discharged from the facility on 7/15/2024. Review of Census in Resident #106's medical record indicated Resident #106 discharged from the facility on 7/15/24. Review of Licensing and Regulatory Affairs/Involuntary Transfer/Discharge Overview website at the following link, Involuntary Transfer/Discharge Overview (michigan.gov), on 8/1/24 revealed .[NAME] will provide written approval of the acceptance of the proposed transfer or discharge plan . the approval of the proposed transfer or discharge plan shall be placed into the Resident's medical record . Review of electronic communications (emails) from [NAME]-BHCS-Involuntary Transfer dated 7/30/2024 revealed .the discharge plan (for Resident #106) was submitted 7/29/2024 .sent an approval letter yesterday (7/29/2024) .they (the facility) discharged Resident #106 on 7/15/2024 without a plan in place .that would be noncompliance .

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. 47955 Based on interview and record review the facility failed to provide written notice of transfer for 1 (Resident #101) of 2 resident reviewed for hospital transfers, resulting in the potential for the resident and/or the resident's representative to be unaware of the resident's transfer out of the facility, the reason for the resident's transfer out of the facility, and/or the resident's rights. Findings include: Resident #101 Review of an Admission Record revealed Resident #101 had pertinent diagnoses which included: repeated falls, altered mental status, and adult failure to thrive. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 6/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #101 was severely cognitively impaired. Review of eINTERACT SBAR Summary for Providers for Resident #101 dated 6/22/24 at 12:33 PM., revealed ' . the change in condition .abnormal vital signs .tired, weak, confused or drowsy . recommendations: Send to the ER for further evaluation . In an electronic communication (email) on 7/31/24 at 1:01 PM., to Nursing Home Administrator (NHA) A this surveyor requested the notice of transfer forms that were provided to Resident #101 for the transfers to the hospital. In an interview on 7/31/24 at 1:53 PM., Regional Clinical Coordinator (RCC) II reported that the transfer notices were in a folder at each of the nurse's stations and the nurses were not giving them to residents or resident representatives prior to any transfer or discharge from the building. Review of facility policy Transfer and Discharge with a revision date of 3/26/2024 revealed .notice must be made as soon as practicable before transfer or discharge when: .his or her needs cannot be met in the facility (i.e., emergency transfer to an acute care facility) .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47955 Based on interview and record review the facility failed to ensure professional nursing standards of documentation were maintained in 1 (Resident #101) of 12 reviewed for professional nursing standards resulting in the potential for inaccurate assessment, lack of monitoring a condition, and incomplete communication of care needs. Findings include: Resident #101 Review of an Admission Record revealed Resident #101 had pertinent diagnoses which included: repeated falls, altered mental status, and adult failure to thrive. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 6/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #101 was severely cognitively impaired. Review of eINTERACT SBAR summary for Providers for Resident #101 dated 6/22/2024 at 12:33 PM., revealed .Nursing observations, evaluation, and recommendations are, Resident has had 500 ml viqa (via) hyoerdermaclesis (hypodermoclysis - infusion of fluids into the subcutaneous (under the skin) tissue.) and then an additional 500ml running currently . Review of Physician Orders for Resident #101 revealed .initiate hypodermoclysis access and administer 500 ml normal saline at 100ml/hr .Verbal .6/21/24 . In an interview on 7/31/24 at 11:25 AM., Director of Nursing (DON) B reported that hypodermoclysis was something they used in the building to help rehydrate a resident. DON B reported that there was recent education provided by Staff Development Coordinator (SDC) KK regarding the procedure. DON B reported that hypodermoclysis requires a physician order and needs to be documented in the resident's medical records. DON B stated if wasn't charted it wasn't done. In an interview on 8/1/24 at 9:16 AM., Registered Nurse (RN) T reported that documenting a resident's condition in a progress note was the only way you can document the things you did for the resident, and so the staff that comes after you knows what you did for the resident. In an interview on 8/1/24 at 9:25 AM., Nurse Practitioner (NP) FF reported that hypodermoclysis requires a physician order to be administered, and she recalled that only one resident in the building had the procedure completed. This surveyor asked NP FF if Resident #101 was the resident that received hypodermoclysis and NP FF stated No, Resident #101 did not. In an interview on 8/1/24 at 9:27 AM., Licensed Practical Nurse (LPN) L reported that one resident did receive hypodermoclysis, and Resident #101 was not the resident that received hypodermoclysis. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/1/24 at 9:32 AM., Infection Prevention/Assistant Director of Nursing (IP/ADON) N reported that Resident #101 did not have the procedure of hypodermoclysis. IP/ADON N reported that when the procedure of hypodermoclysis was performed it should be documented in a resident's record. IP/ADON N stated if it wasn't documented, it didn't happen. IP/ADON N reported that her expectation was that all procedures and monitoring of resident's conditions were documented in the resident's record. In a telephone interview on 8/1/24 at 9:52 AM., DON B reported that Resident #101 would have been a candidate to receive hypodermoclysis, but he was unsure if Resident #101 had the procedure. DON B stated I would have to differ to what the record says, if Resident #101's records says he had hypodermoclysis, then he had it. DON B reported that SDC KK was the staff member that would have performed the procedure and would have provided the education to staff about hypodermoclysis. In a telephone interview on 8/1/24 at 10:00 AM., LPN K reported that Resident #101 did receive hypodermoclysis for 1or 2 days before he was transferred to the emergency room . LPN K reported that DON B or SDC KK obtained the physician order and performed the procedure to start hypodermoclysis. In an interview on 8/1/24 at 10:35 AM., LPN Y reported that he observed SDC KK start and administer hypodermoclysis on Resident #101. LPN Y reported that the procedure demonstration was an educational training and in-service about the procedure. In an interview on 8/1/24 at 10:59 AM., NHA A reported that he recalled the education and demonstration that was provided to nurses by the SDC KK and that there was a sign in sheet and education material regarding hypodermoclysis. Review of Medication Administration Record for Resident #101 for June of 2024 revealed no noted documentation regarding initiating hypodermoclysis access or the administration of 500ml of normal saline. Review of Progress Notes for Resident #101 revealed no noted documentation regarding the procedure of initiating hypodermoclysis. Review of Employee In-Service/Education Attendance Record dated 6/21 presented by SCD KK for the topic of Hypodermoclysis, revealed 7 nurses attended, including LPN K' and LPN Y and the last point of the education was .document the procedure .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 41982 This citation pertains to Intake MI00145627. Based on interview and record review, the facility failed to ensure a resident received timely treatment for an infection in 1 (Resident #103) of 4 residents reviewed for quality of care, resulting in Resident #103 not receiving antibiotic treatment for a urinary tract infection for 10 days after the infection was confirmed. Findings include: Review of an Admission Record revealed Resident #103 was a female, with pertinent diagnoses which included: Paroxysmal Atrial Fibrillation (irregular heartbeat), Heart Failure (a condition in which the heart doesn't pump blood as well as it should), and Chronic Kidney Disease Stage 3 (a disease in which the kidneys don't filter excess waste and fluid from the blood effectively). Review of a Nurses Note for Resident #103 dated 6/29/24 at 7:06 PM revealed, Note Text: Patient has positive urine culture result. Awaiting plan for treatment. [A positive urine culture indicated the resident had a UTI (urinary tract infection)]. Review of a Communication Log to provider (physician, nurse practitioner) revealed an entry on 6/29/24 regarding Resident #103 that read, + (positive) urine culture w/ (with) symptoms that was initialed and dated by Nurse Practitioner (NP) FF on 6/29. Review of a Physician Order dated 7/10/24 revealed, a Prescriber Entered order for Resident #103 for Nitrofurantoin Macrocrystal (an antibiotic) Oral Capsule 100 MG (milligrams) (Nitrofurantoin Macrocrystal) Give 100 mg (milligrams) by mouth every 6 hours for UTI until 7/16/2024 23:59 (11:59 PM). Review of Resident #103's Order Summary Report Order Status: Active, Completed, Discontinued revealed no other physician ordered treatments for Resident #103's UTI. There was an active order dated 2/13/24 for the antibiotic Bactrim Tablet 400-80 (Sulfamethoxazole-Trimethroprim) Give 1 tablet by mouth two times a day for lifetime use for osteomyelitis (a bone infection) suppression which was not for the treatment of Resident #103's UTI. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 7/31/24 at 10:47 AM, Licensed Practical Nurse (LPN) Y reported when a resident had test result that required attention, the lab would call the facility and notify the nurse and then send the report. LPN Y reported the process for notifying the provider of a positive urine culture called in by the lab was that if the provider was in house (meaning at the facility), the nurse would verbally notify the provider, but if the provider was not available or if it was after hours, the provider on-call would be notified by the nurse via telephone. LPN Y reported if the provider did not respond back to the notification, there was also a binder on each unit that had a Communication Log for the nurse to document notes about residents for the physician. LPN Y reported the provider would typically wait for the infection sensitivity report to also come back from the lab to know what antibiotic the infection was susceptible to in order to make sure correct antibiotic was prescribed. LPN Y reported the provider would then notify the nurse of the new order for treatment which would then be entered into the computer. LPN Y reported the nurse would also put a note in the resident's electronic medical record under progress notes. Review of Resident #103's Urinalysis / Urine Culture report revealed the culture was received by (lab name omitted) on 6/27/24 and results were reported on 6/29/24. Review of Resident #103's electronic medical record Results tab revealed the Urinalysis / Urine Culture report was uploaded on 6/30/2024 at 12:22 PM. In an interview on 7/31/24 at 11:58 AM, Nurse Practitioner (NP) FF reported nursing staff was supposed to call her or verbally notify her (when in the building) with any resident test results, at which point an order for treatment would be initiated. NP FF reported after hours, the nurses would notify the physician on-call of the results. NP FF reported each nursing unit also had a binder where nurses could write a communication about a resident issue that needed to be addressed, including test results. NP FF reviewed the Communication Log entry on 6/29/24 for Resident #103 and reported she had acknowledged that the resident had a positive result on 6/29/24 but that she had to wait for the paper copy of the report with the sensitivity. NP FF reported she had been instructed by the facility not to order an antibiotic for a UTI until she got the paper copy. NP FF reported when the facility received the paper copy of the test results, they uploaded the paper copy into the electronic medical record at which point she would check the results and order the proper antibiotic. NP FF reported Resident #103's antibiotic treatment for her UTI should have been started before 10 days after the result. In an interview on 7/31/24 at 1:30 PM, Regional Clinical Coordinator (RCC) II reported resident laboratory tests results, including urinalysis reports, got uploaded to the facility's electronic medical record directly from (lab name omitted). RCC II reviewed Resident #103's electronic medical record with this surveyor and confirmed the urinalysis and culture sensitivity were uploaded on 6/30/24. RCC II reported had discovered that NP FF hadn't ordered the urinalysis for Resident #103; rather, an on-call provider for the group had ordered it and that since NP FF hadn't ordered the urinalysis herself, she didn't know that it needed to be followed up on. In an interview on 7/31/24 at 3:26 PM, Infection Preventionist (IP) N reported NP FF didn't have to wait until she got the printed copy of results because she had access to the results in the electronic medical record. IP N reported treatment for Resident #103's UTI should have been initiated sooner.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 41982 Based on interview and record review, the facility failed to consistently and timely monitor for antibiotic medication efficacy and adverse reaction in 1 (Resident #103) of 1 resident reviewed for medication monitoring, resulting in the potential for unrecognized side effects or ineffective treatment. Findings include: Review of an Admission Record revealed Resident #103 was a female, with pertinent diagnoses which included: Paroxysmal Atrial Fibrillation (irregular heartbeat), Heart Failure (a condition in which the heart doesn't pump blood as well as it should), and Chronic Kidney Disease Stage 3 (a disease in which the kidneys don't filter excess waste and fluid from the blood effectively). Review of a Nurses Note for Resident #103 dated 6/29/24 at 7:06 PM revealed, Note Text: Patient has positive urine culture result. Awaiting plan for treatment. (A positive urine culture indicated the resident had a UTI (urinary tract infection)). Review of a Physician Order dated 7/10/24 revealed, a Prescriber Entered order for Resident #103 for Nitrofurantoin Macrocrystal (an antibiotic) Oral Capsule 100 MG (milligrams) (Nitrofurantoin Macrocrystal) Give 100 mg (milligrams) by mouth every 6 hours for UTI until 7/16/2024 23:59 (11:59 PM). Review of a Nurses Note for Resident #103 dated 7/12/24 at 6:42 PM revealed, Note Text: Antibiotic continued for UTI with no adverse reaction denies pain upon urination no urgency or burning. Will continue to monitor and assist the resident. Review of Resident #103's Progress Notes from 7/10/24 through 7/16/24 (antibiotic treatment period) revealed no subsequent documentation related to antibiotic adverse reaction or efficacy was found. A physician Progress Note dated 7/15/24, .Patient seen in for follow-up visit .Patient being seen for low diastolic ranges in B/p (blood pressure) . was noted with no assessment of Resident #103's UTI treatment efficacy. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #103's current Care Plan revealed a focus of (Resident #103) is at risk for complications r/t (related to) has Urinary Tract Infection (UTI) Abnormal Labs (specify), Urine changes (specify: cloudy, concentrated, odor, sediment, hematuria) with dates initiated and revised of 7/15/2024, goal of Will be free from signs and symptoms of UTI without complications by the review date with dates initiated and revised of 7/15/2024, and interventions, all of which were initiated on 7/15/24, included Administer antibiotic therapy as ordered. Observe/document for side effects and effectiveness; Encourage adequate fluid intake as tolerated; Observe/document/report to physician PRN (as needed) for s/sx (signs and symptoms) of UTI: Frequency, Urgency, Malaise, foul smelling urine, dysuria, Fever, nausea and vomiting, flank pain, Supra-pubic pain, Hematuria, Cloudy urine, Altered mental status, Loss of appetite, Behavioral changes; Obtain labs/diagnostics as ordered. Report abnormal results to to (sic) the physician; Obtain vital as ordered/facility protocol; Resident requires (Specify: reminders with hand washing after being toileted and before and after meals). It should be noted the care plan was developed and implemented 5 days after Resident #103's antibiotic treatment for UTI began. Further, a review of Resident #103's Care Plan revision history revealed no previous care planned focus, goals, or interventions related to Resident #103's UTI and antibiotic treatment. In an interview on 8/1/24 at 10:17 AM, Infection Preventionist (IP) N reported a resident who was prescribed an antibiotic should be monitored daily to ensure their condition was improving and to make sure they didn't have any side effects from the medication. IP N reported it was important to know if the resident was not improving because the provider would need to be notified in case the antibiotic needed to be changed or if further testing should be done. When queried as to how daily monitoring was documented, IP N reported every resident on an antibiotic should have a Sepsis Screening Evaluation completed by the nurse every day for 21 days. IP N reported said evaluations showed up in the electronic medical record under the Evaluations tab. IP N reported the monitoring was to be continued beyond the course of the antibiotic to make sure the infection had resolved. A review of Resident #103's electronic medical record on 8/1/24 at 10:44 AM revealed no Sepsis Screening Evaluation had been completed for Resident #103 since 4/11/2022.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 Based on interview and record review the facility failed to maintain clear, concise, and accurate medical records in 3 (Resident #101, Resident #106, and Resident #104) of 12 residents reviewed for clear, concise, and accurate medical records resulting in an incomplete record of care needs, and the potential for a diminished medical outcome. Findings include: Resident #101 Review of an Admission Record revealed Resident #101 had pertinent diagnoses which included: repeated falls, altered mental status, and adult failure to thrive. Review of a Minimum Data Set (MDS) assessment for Resident #101, with a reference date of 6/17/24 revealed a Brief Interview for Mental Status (BIMS) score of 3/15 which indicated Resident #101 was severely cognitively impaired. Review of eINTERACT SBAR summary for Providers for Resident #101 dated 6/22/2024 at 12:33 PM., revealed .Nursing observations, evaluation, and recommendations are, Resident has had 500 ml viqa (via) hyoerdermaclesis (hypodermoclysis - infusion of fluids into the subcutaneous (under the skin) tissue.) and then an additional 500ml running currently . Review of Physician Orders for Resident #101 revealed .initiate hypodermoclysis access and administer 500 ml normal saline at 100ml/hr .Verbal .6/21/24 . In a telephone interview on 8/1/24 at 10:00 AM., Licensed Practical Nurse (LPN) K reported that Resident #101 did receive hypodermoclysis for 1or 2 days before he was transferred to the emergency room . LPN K reported that Director of Nursing (DON) B or Staff Development Coordinator (SDC) KK obtained the physician order and performed the procedure to start hypodermoclysis. In an interview on 8/1/24 at 10:35 AM., LPN Y reported that he observed SDC KK start and administer hypodermoclysis on Resident #101. LPN Y reported that the procedure demonstration was an educational training and in-service about the procedure. Review of Medication Administration Record for Resident #101 for June of 2024 revealed no noted documentation regarding initiating hypodermoclysis access or the administration of 500ml of normal saline. Review of Progress Notes for Resident #101 revealed no noted documentation regarding the procedure of initiating hypodermoclysis. Review of Employee In-Service/Education Attendance Record dated 6/21 presented by SCD KK for the topic of Hypodermoclysis, revealed 7 nurses attended, including LPN K' and LPN Y and the last point of the education was .document the procedure . (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #106 Review of an Admission Record revealed Resident #106 had pertinent diagnoses which included: alzheimer's disease with last onset, dementia with mood disturbances, and generalized anxiety disorder. Review of a Minimum Data Set (MDS) assessment for Resident #106, with a reference date of 7/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 2/15 which indicated Resident #106 was severely cognitively impaired. In an interview on 7/26/24 at 2:23 PM., Social Worker (SW) G reported that she sent referrals for Resident #106's potential transfer to other facilities. SW G reported that she spoke with Resident #106's guardian about upcoming discharge, equipment that Resident #106 needed for discharge, and home care needs. SW G reported that she offered home care services to be set up for the resident and the guardian denied needing these things for Resident #106's discharge. SW G reported that she offered to set up transportation for Resident #106 at discharge and those needs were denied by the guardian. On 7/26/24 review of Social Services Note for Resident #106 dated 6/26/24 at 11:09 AM., authored by SW G revealed .reached out to family regarding the discharge that will happen on 7/15/2024. Family did not answer .left a voicemail requesting call back . On 7/26/24 review of Social Services Note for Resident #106 dated 7/15/24 at 16:14 PM., authored by SW G revealed .spoke with residents guardian and he stated he has arranged (Name Omitted) transport for her discharge . On 7/26/24 review of Resident #106's medical record revealed no other documentation noted regarding the resident's discharge from the facility. On 7/26/24 review of Nurses Notes for Resident #106 dated 7/15/24 at 20:03 PM., revealed .Day shift RN (Name Omitted) reported patient sent to (name omitted) hospital from facility . On 7/26/24 review of Nurses Notes for Resident #106 dated 7/15/24 at 22:58 PM., revealed .patient being admitted to (Name Omitted) hospital from facility . In an interview on 7/26/24 at 12:18 PM., Registered Nurse (RN) W reported that he was working the day Resident #106 discharged from the facility. RN W reported that he did not transfer her to the hospital as she had no reason to go to the hospital and he did not have discharge instructions for Resident #106. RN W reported that (Name Omitted) ambulance picked Resident #106 up at the facility on 7/15/24, and that he did not document anything regarding Resident #106 leaving the building. In an interview on 7/30/24 at 8:05 AM., NHA A reported that Resident #106 was discharged from the facility on 7/15/2024. In an interview on 7/30/24 at 4:35 PM., DON B reported the Resident #106's discharge was smooth, and her discharge packet was sent with the (Name Omitted) ambulance that transported her home. DON B reported that his expectation was that any resident discharge from the building should be documented in the resident records. In an interview on 7/31/24 at 11:25 AM., DON B stated .if it wasn't charted it wasn't done . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024
NAME OF PROVIDER OR SUPPLIER Royalton Manor, L L C		STREET ADDRESS, CITY, STATE, ZIP CODE 288 Peace Blvd St Joseph, MI 49085	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/1/24 review of Resident #106's medical record revealed . Late Entry . social services note .effective date 7/12/24 10:34AM . created date 7/29/24 10:38:28 . created by SW G . called (Name Omitted) regarding discharge the is set for Monday 7/15 . called (Name Omitted) and he stated that she (Resident #106) is unable to come home and that a referral for DME and homecare is not necessary because she (Resident #106) will not be coming to their home . In an interview on 8/1/24 at 9:32 AM., Infection Preventionist/Assistant Director of Nursing (IP/ADON) N stated .if it wasn't documented then it didn't happen. IP/ADON N reported that her expectation was that resident conditions were documented in thier medical records. 41982 Resident #104 Review of an Admission Record revealed Resident #104 was a female, readmitted to the facility on [DATE] with pertinent diagnoses which included: urinary tract infection and pulmonary embolism (blood clot in an artery in the lung). Review of Resident #104's electronic medical record revealed Resident #104 was present in the facility on 6/16/24 to 7/3/24 and was hospitalized from 7/4/24 to 7/8/24. Review of a Blood Pressure Summary Report for Resident #104 revealed no blood pressure values entries between 6/16/24 to 7/3/24. Entry on 6/16/24 revealed a value of 126/78. Review of an O2 Sats (oxygen saturation) Summary Report for Resident #104 revealed no O2 sats values entries between 6/16/24 to 7/3/24. Entry on 6/16/24 revealed a value of 96% (percent). Review of a Pulse Summary Report for Resident #104 revealed no pulse values entries between 6/16/24 to 7/3/24. Entry on 6/16/24 revealed a value of 66 bpm (beats per minute). Review of a Respirations Summary Report for Resident #104 revealed no respiration values entries between 6/16/24 to 7/3/24. Entry on 6/16/24 revealed a value of 16 Breaths/min (breaths per minute). Review of a Temperature Summary Report for Resident #104 revealed no temperature readings entries between 6/16/24 and 7/3/24. Entry on 6/16/24 revealed a temperature reading of 97.4 degrees Fahrenheit. Review of Resident #104's Progress Note titled eINTERACT SBAR Summary for Providers note dated 6/24/24 at 5:17 AM revealed, Situation: The Change in Condition/s (CIC) reported on this CIC Evaluation are/were Food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts) Functional decline (worsening function and/or mobility) Weight Loss At the time of evaluation resident/patient vital signs, weight and blood sugar were: - Blood Pressure: BP 126/78 6/16/24 .-Pulse: P 76 6/16/24 .-RR (Respiration Rate) R 16.0 6/16/24 .-Temp: T 97.4 6/16/24 .Puise Oximetry: O2 96% (percent) 6/16/24 .Nursing observations, evaluation, and recommendations are: patient has had a significant decrease in PO (by mouth) intake. At the writing of this note patient has had a 30 LB (pound) weight loss since October. Increasedlethargy (sic) and decline in mobility . It should be noted that vital signs readings in note were from 6/16/24. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235623	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Royalton Manor, L L C	288 Peace Blvd St Joseph, MI 49085

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 8/1/24 at 9:24 AM, Licensed Practical Nurse (LPN) Y reported a resident Change of Condition (CIC) was created based on nursing judgement and gave examples of abnormal vital signs, altered mental status, and weight loss. LPN Y reported the nurse generated the CIC in the computer and part of the form automatically populated with the resident's most current vital signs entries from the electronic medical record. LPN Y reported the computer form allowed for editing of the vital signs and when completing the form, if the vital signs information was not current, the nurse should take a new set of vital sign measurements and enter it into the form. In an interview on 8/1/24 at 9:33 AM, Registered Nurse (RN) O reported a Change of Condition form would be generated when a resident reported something was wrong that was outside of their normal disease processes or when the nurse identified something out of the ordinary for that resident. RN O reported as part of the change of condition assessment, the nurse would complete a symptom assessment, obtain a current set of vital signs readings, check blood pressure, etc. and then contact the Director of Nursing, the Nursing Home Administrator, and the physician. Review of a facility-provided document titled Change in status, identifying and communicating, long-term care revealed In a long-term care setting, any change from baseline in a resident's status must be identified and addressed. A resident is more likely to return to baseline status and avoid complications when a condition is recognized early so that it can be treated .A change in status may happen quickly in just minutes or slowly over hours or days .A focused, thorough assessment of the resident's condition can help identify a recurring fluctuation in symptoms-such as a change in blood pressure or increased confusion-that happens at the same intervals daily. At a minimum, assessment should include: .obtaining vital signs .