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	02/20/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 This citation pertains to MI00148844. Based on interview and record review, the facility failed to protect the resident's right to dignity and respect in 1 resident (Resident #5) of 4 residents reviewed for dignity, resulting in the potential for feelings of diminished self-worth, sadness, and frustration. Findings include: Resident #5 (R5) Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R5's initial admitted to the facility was 3/10/2024 with diagnoses including Alzheimer's disease, dementia, depression and anxiety. Brief Interview for Mental Status (BIMS) reflected a score of 15 out of 15 which indicated R5 was cognitively intact (13 to 15 cognitively intact). During an interview on 2/19/2025 at 2:37 PM, Licensed Practical Nurse (LPN) MM stated that back in December 2024 (thought it was around 12/9/2024), she was working the floor and she heard Nursing Home Administrator (NHA) A in R5's room. LPN MM reported that NHA A was being rude and mean to R5 and called her a liar. LPN MM said that R5 was crying after the interaction and she tried to console her. LPN MM stated when she was consoling R5, R5 asked her if she heard NHA A correctly when he called her a liar and LPN MM told her that was what she heard. R5 told LPN MM that she saw a resident (R9) hit another resident (R1) and she told NHA A and he said she was lying and that it didn't happen. LPN MM then told Social Services (SS) S what happened. During an interview on 2/19/2025 at 11:05 AM, SS S stated that LPN MM told her that NHA A was verbally abusive to R5 and he told R5 that what she saw didn't occur and NHA A called R5 a liar and made her cry. SS S wasn't sure if this was reported to the State Agency. SS S stated during the morning meeting that all department heads attend, it was discussed that R5 told R1's daughter that she saw R9 hit R1. NHA A stated in the meeting that he was going to talk to R5 about this since he didn't think it happened. When further queried, SS S reported that R5 doesn't fabricate or make things up for as long as she had known her. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/18/2025 at 10:57 AM, R5 was asked about the incident that occurred in December and she stated that she saw something and said something and NHA A got mad at her and told her she wasn't being truthful about what she saw. R5 said he hurt her feelings. During an interview on 2/19/2025 at 1:34 PM, Certified Nursing Assistant (CNA) E stated that she worked with R5 when she first got to the facility and she had no recollection of her making up stories. During an interview on 2/19/2025 at 1:36 PM, Certified Nursing Assistant (CNA) K stated that she worked with R5 for the last 6 months, and she does not recall any behaviors and she doesn't believe that she makes anything up. During an interview on 2/19/2025 at 1:51 PM, Certified Nursing Assistant (CNA) L stated that R5 was nice and she had no issues with her or noted any behaviors that she knows of. During an interview on 2/19/2025 at 1:55 PM, Certified Nursing Assistant (CNA) NN stated that she had no recollection of R5 making up stories of any kind or exaggerating. During an interview on 2/19/2025 at 2:07 PM, Certified Nursing Assistant (CNA) GG stated that she didn't hear her make up any stories. Review of R5's care plan with a creation date of 12/9/2024 and put in by Minimum Data Set nurse (MDS) T revealed Focus: (R5) has an actual behavior problem R/T: making false accusations about (R9) and vocalizing anger about this resident. During an interview on 2/19/2025 at 1:32 PM, MDS T stated that additions to care plans are done in morning clinical meetings and that's where they make updates and she puts in what she is told to put in. She stated she put the new care plan in R5's chart regarding false accusations of R9 during the clinical meeting on 12/9/2024 but didn't listen to the reason why. During an interview on 2/20/2025 at 10:30 PM, Business Office Manager (BOM) Q reported that in morning meeting in December (couldn't remember the date) it was brought up that R5 witnessed R9 hit R1 and NHA A was going to talk to R5 about it. BOM Q stated that R5 likes to gossip and talk about everybody and she tells a lot of lies. During an interview on 2/19/2025 at 1:55 PM, NHA A was unaware of an allegation of verbal abuse towards him since it wasn't reported to him or corporate and he couldn't recall something of that nature. NHA A stated that R5 told him R9 hit R1 and he spoke to a nurse who said she didn't see it. NHA A reported that R5 had a history of making things up. He said when he talked to R5 about the incident, she said it didn't happen. Further review of R5's chart didn't reveal any other documentation of R5 making false accusations about residents or staff before or after 12/9/2024. Review of R5's behavioral consulting group documentation for visits completed on 12/21/2024, 1/20/2025 and 2/2/2025 did not reveal any concerns regarding fabrication or made-up stories.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 This citation pertains to Intake #MI00146234 Based on interview and record review the facility failed to adhere to professional standards related to ensuring physician orders were in place, monitoring nephrostomy tubes, and providing timely nephrostomy tube care for 1 (Resident #3) of 8 residents reviewed for professional standards resulting in delayed order placement, monitoring, and care of nephrostomy tubes. Findings include: Resident #3 Review of an Admission Record revealed Resident #3 was a male, who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: malignant neoplasm of the posterior wall of the bladder (cancer of the bladder that had spread to other areas of the body), severe sepsis (systemic infection of the blood), and infection and inflammatory reaction due to nephrostomy catheter (infection resulting from nephrostomy catheters (tubes placed through the skin in the back directly into the kidneys to drain urine). Review of Nurse's Note for Resident #3 dated 7/26/24 at 17:44 pm, (5:44 pm) revealed . Bilateral (on both sides of the body) nephrostomy sites covered with split gauze (a piece of gauzed that cut on one side and able to surround a tube) and transparent film (clear sticky plastic) dressing, no shadowing (discoloring on the gauze) noted on dressings, urine bags have yellow and clear urine . Review of Order Summary for Resident #3 revealed Record output of each nephrostomy tube each shift; with a start date of 7/30/24; and Nephrostomy tube care bilateral- check bilateral tubes to ensure each suture is still in place and that tubes are still secured to resident. Clean bilateral tubes and around insertion site with NS (normal saline) then pat dry completely before applying a thin layer of TAO (triple antibiotic ointment) to insertion site. Apply new split sponge gauze that is secure to resident around the tube at the insertion site every shift; with a start date of 8/1/2024. In an interview on 2/18/25 at 1:18 pm, Licensed Practical Nurse (LPN) P reported admission orders, including wound care or other special device orders should be entered by the admitting nurse. In an interview on 2/18/25 at 1:35 pm, LPN M reported the admission nurse was responsible for entering a resident's orders, and when a resident did not have orders at admission, the nurse should call the facility on-call provider and obtain orders. In an interview on 2/18/25 at 1:42 pm, Registered Nurse (RN) N reported a resident's discharge papers were the facilities admission orders and the admitting nurse should enter the orders. RN N reported if a resident admitted on a Friday, they should not go all weekend without orders. (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 2/18/25 at 11:14 am, Wound Nurse (WN) V reported she did not enter any orders regarding nephrostomy tube care or monitoring. WN V reported the admitting nurse should have entered in the orders regarding Resident #3's nephrostomy tubes. WN V confirmed Resident #3 did not have orders in place to monitor or provide care to his nephrostomy tubes until 8/1/24, 5 days after he admitted to the facility on [DATE]. In an interview on 2/18/25 at 11:45 AM., Director of Nursing (DON) B reported the admitting nurse was responsible for entering resident orders, including wound care or special devices at admission. DON B reported if a resident did not arrive with orders the admitting nurse should reach out to the on-call provider to obtain orders. DON B reported Resident #3 should have had orders for monitoring and care of his nephrostomy tubes at admission. Review of How to Care for your Nephrostomy Tube from Resident #3's medical record revealed .Your nephrostomy tube will be on your back or side. You will need help when taking care of your skin .Keep the open area where the tube comes out of your skin dry .clean the site each day or every other day. Cleaning your nephrostomy tube site: you will need .soap or other cleaner, split gauze dressings, antibacterial ointment .Place a new dressing: apply one sterile 4 x 4 split gauze pad around the tube .your drainage system .empty your bag when it is half full . In an interview on 2/19/25 at 12:20 pm, this surveyor and DON B reviewed the How to Care for your Nephrostomy Tube document located in Resident #3's medical record and DON B confirmed that Resident #3 should have had an order in place upon admission related to nephrostomy tube care and monitoring. Review of Resident #3's medical record revealed no noted documentation regarding the monitoring of, providing care to, or completed dressing changes to bilateral nephrostomy tubes between the dates of 7/26/24 and 7/31/24.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 This citation pertains to Intake #MI00146234 Based on interview and record review the facility failed to ensure proper care for nephrostomy catheter (tubes placed through the skin in the back directly into the kidneys to drain urine) in 1 (Resident #3) of 1 resident reviewed for nephrostomy catheter care resulting in the potential for decreased effectiveness, catheter dislodgement, and/or infection. Findings include: Resident #3 Review of an Admission Record revealed Resident #3 was a male, who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: malignant neoplasm of the posterior wall of the bladder (cancer of the bladder that had spread to other areas of the body), severe sepsis (systemic infection of the blood), and infection and inflammatory reaction (systemic infection) due to nephrostomy catheter (tube). Review of Nurse's Note for Resident #3 dated 7/26/24 at 17:29 pm, (5:29 pm) revealed Resident#3 arrived about 4pm .alert and oriented to place and time .is able to verbalize needs . Review of Nurse's Note for Resident #3 dated 7/26/24 at 17:44 pm, (5:44 pm) revealed . Bilateral (on both sides of the body) nephrostomy sites covered with split gauze (a piece of gauzed that cut on one side and able to surround a tube) and transparent film (clear sticky plastic) dressing, no shadowing (discoloring on the gauze) noted on dressings, urine bags have yellow and clear urine . Review of Skilled Care Note for Resident #3 dated 7/27/24 at 14:18 pm, (2:18 pm) revealed no noted documentation regarding resident #3's bilateral nephrostomy tubes. Review of How to Care for your Nephrostomy Tube from Resident #3's medical record revealed .Your nephrostomy tube will be on your back or side. You will need help when taking care of your skin .Keep the open area where the tube comes out of your skin dry .clean the site each day or every other day. Cleaning your nephrostomy tube site: you will need .soap or other cleaner, split gauze dressings, antibacterial ointment .Place a new dressing: apply one sterile 4 x 4 split gauze pad around the tube .your drainage system .empty your bag when it is half full . Review of ED Provider Note (Emergency Department) dated 8/7/24 for Resident #3 dated 8/7/24 revealed . history of stage IV (4) bladder cancer .requiring placement of bilateral nephrostomy tubes . He (Resident #3) currently has no complaints other than his dissatisfaction regarding his current situation at (Name Omitted) facility, He (Resident #3) stated that he does not want to return to that facility as the staff does not regularly change his nephrostomy tube dressings . (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Order Summary for Resident #3 revealed Record output of each nephrostomy tube each shift; with a start date of 7/30/24; and Nephrostomy tube care bilateral- check bilateral tubes to ensure each suture is still in place and that tubes are still secured to resident. Clean bilateral tubes and around insertion site with NS (normal saline) then pat dry completely before applying a thin layer of TAO (triple antibiotic ointment) to insertion site. Apply new split sponge gauze that is secure to resident around the tube at the insertion site every shift; with a start date of 8/1/2024. In an interview on 2/18/25 at 1:18 pm, Licensed Practical Nurse (LPN) P reported admission orders, including wound care or other special device orders should be entered by the admitting nurse. LPN P reported admission orders came with the resident when they arrived at the facility. LPN P reported if information was missing the nurse should contact the discharge location for clarification and follow up. LPN P reported a resident with nephrostomy tubes should have orders in place for care of the nephrostomy tubes. In an interview on 2/18/25 at 1:35 pm, LPN M reported orders come with the resident when they admit to the facility. LPN M reported when a resident did not have orders at admission, the nurse should call the discharge location or the facility on-call provider and obtain orders. LPN M reported physician orders are needed for the care of nephrostomy tubes. In an interview on 2/18/25 at 1:42 pm, Registered Nurse (RN) N reported a resident's discharge papers were the facilities admission orders. RN N reported if the resident did not have orders when they arrived at the facility, the nurse should call the discharging nurse for clarification. RN N reported if a resident admitted on a Friday, they should not go all weekend without orders. RN N reported nephrostomy tubes should have orders for care and monitoring. In an interview on 2/18/25 at 11:14 am, Wound Nurse (WN) V reported she would assess a resident when the admission paperwork or the admission nurse indicated a resident had a wound, a dressing, or a special device. WN V reported she recalled she had to call the discharging facility regarding Resident #3's nephrostomy tube care. WN V reviewed Resident #3's medical record and reported she had entered documentation on 8/1/24 as a late entry, regarding Resident #3's admission on 7/26/24 indicating the presence of Resident #3's nephrostomy tubes and dressings, WN V reported she did not enter any orders regarding the care or monitoring of Resident #3's nephrostomy tubes. WN V reported the admitting nurse should have entered in the orders regarding Resident #3's nephrostomy tubes. WN V confirmed Resident #3 did not have orders in place to monitor or provide care to his nephrostomy tubes until 8/1/24, 5 days after he admitted to the facility on [DATE]. In an interview on 2/18/25 at 11:45 am, Director of Nursing (DON) B reported the admitting nurse was responsible for entering resident orders, including wound care or special devices at admission. DON B reported if a resident did not arrive with orders the admitting nurse should reach out to the on-call provider to obtain orders. DON B reported Resident #3 should have had orders for monitoring and care of his nephrostomy tubes at admission. In an interview on 2/19/25 at 12:20 pm., DON B provided reference material from [NAME] that revealed nephrostomy tube dressing should be changed every 2 to 7 days. This surveyor reviewed the How to Care for your Nephrostomy Tube document located in Resident #3's medical record with DON B that revealed clean the site each day or every other day and DON B confirmed that Resident #3 should have had an order in place upon admission for dressing changes to his bilateral nephrostomy tubes for every day or every other day. (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #3's medical record revealed no noted documentation regarding the monitoring of, providing care to, or completed dressing changes to bilateral nephrostomy tubes between the dates of 7/26/24 and 7/31/24.