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	03/19/2026

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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** Based on observation, interview, and record review the facility failed to ensure dignity with dining for 1 (Resident #110) of 3 residents reviewed for dignity with dining resulting in Resident #110 taking another resident's meal and consuming it.Findings include:Resident #110 Review of an admission Record revealed Resident #110 was a male who was originally admitted to the facility on [DATE] and had pertinent diagnoses which included: alzheimer's disease (a progressive neurodegenerative disorder that primarily affects memory, thinking, and behavior), type 2 diabetes (a chronic condition characterized by insulin resistance and high blood sugar levels), and anxiety.Review of a Minimum Data Set (MDS) assessment for Resident #110, with a reference date of 2/18/26 revealed Functional Abilities as dependent for eating, indicating a helper does all of the effort, Resident does none.Review of Kardex (a concise patient information system used by nurses to quickly reference and organized key details about resident needs) for Resident #110 revealed CNA (certified nurse assistant) will assist Resident #110 with meals as needed.provide diet as ordered, regular diet mechanical soft texture, thin liquids.Review of Order Summary for Resident #110 revealed Regular diet, Level 3 Advanced (Mechanical Soft) texture, Thin consistency, Enriched foods, TID (three times a day) for diet with a start date of 12/17/2025.On 3/17/26 at 1:11 PM, Resident #110 was sitting alone at a table in the dining room. Resident #110 was the last resident served and received his meal tray at 1:25 PM.On 3/18/26 at 1:30 PM, Resident #110 was observed sitting at a table in the dining room with two other male residents. Both other residents had plates of food in front of them. Resident #110 did not have any food.On 3/18/26 at 1:40 PM, an unknown resident was observed pushing an open carton of milk across the tabletop to Resident #110. Resident #110 was then observed picking up the carton of milk given to him by the unknown resident seated across the table from him and drinking from it.On 3/18/26 at 1:43 PM, Resident #110 was observed reaching to his right, into the place setting area set for an unknown male resident seated next to him at the table. Resident #110 retrieved a bowl and a spoon and began to eat the dessert from the bowl with the unknown resident's spoon.On 3/18/26 at 1:45 PM, Resident #110 was observed reaching to his right into the place setting area for an unknown male resident seated next to him at the table and retrieving the plate and began to eat the food still present on the plate. The unknown male resident was observed reaching for his plate, speaking out loud single words of protest Hey! and Mine!, and Resident #110 was observed moving his arm to keep the plate out of the reach of the unknown resident. During this observation Certified Nurse Assistant (CNA) U, CNA Z, CNA GG were present in the dining room and Social Worker (SW) D was seated at the nurse's station directly across from the table the three residents were sitting at. No staff observed or intervened when Resident #110 took and consumed the food of two unknown male residents.In an interview and observation on 3/18/26 at 1:47 PM, CNA U reported Resident #110 was a mechanical soft diet with thin liquids and what he was eating was a pureed. CNA U stated I have no words for what is happening right now, I don't know what to say. CNA U disposed of the plate of food Resident #110 was eating, moved him to a different table, and then sent CNA GG to the kitchen to retrieve a replacement meal for the unknown male resident.In an interview on 3/18/26 at 1:49 PM, SW D (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	reported she was there if they needed assistance with residents, but she did not assist with meal service.In an interview on 3/18/26 at 1:50 PM, Licensed Practical Nurse (LPN) NN reported her responsibility on the unit was to supervise and over see the unit.In an interview on 3/18/26 at 2:24 PM, Director of Nursing (DON) B reported his expectations were that each resident at the table be served at the same time and to get all resident meal trays served timely.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intakes #2628754 and #2727216.Based on observation, interview, and record review, the facility failed to monitor the effectiveness of post elopement interventions for 1 resident (Resident #100) of 3 residents reviewed for accidents/hazards, resulting in Resident #100 who was assessed as an elopement risk and liked to have his door closed to potentially elope again.Findings include: Resident # 100 (R100)Review of the admission Record and Minimum Data Set (MDS) dated [DATE] revealed R100's initial admission date was on 9/2/2025 with pertinent diagnoses including dementia with psychotic disturbance (hallucinations or delusions which often causes severe distress and safety concerns) and anxiety. Brief Interview for Mental Status (BIMS) reflected a score of 4 out of 15 which indicated R100 was severely cognitively impaired. Review of the Facility Reported Incident (FRI) Report dated 9/17/2025 revealed . Incident Summary: It was reported to the writer at 8:48p (PM) that resident (R100) a resident of memory care unit of the facility, broke his room window and eloped. Search protocol initiated, resident was found at 9:01 PM 300 yards off the property, unharmed. Daughter/POA (power of attorney), police and physician notified, one on one initiated for safety.Further review of the FRI Report revealed .Immediate Facility Response.Corrective Measures and Follow-Up Actions.One-on-one supervision initiated on 9/16/2025. One on one terminated as window secured per CMS (Centers for Medicare and Medicaid Services) and NFPA (National Fire Protection Association) guidelines on 9/17/2025.Order date: 9/16/2025.Order Summary: One on one until window amended.Review of R100's Risk for Elopement admission assessment completed on 9/4/2025 revealed a score of 13 which indicated he was at risk for elopement and that he was ambulatory and had attempts to elope in the last 3 months. It also revealed .Wandering: behavior of this type occurred 1 to 3 days. does the wandering place the resident at significant risk of getting to a potentially dangerous place (e.g. stairs, outside of the facility)? Yes. Review of R100's last completed Risk for Elopement assessment dated [DATE] revealed a score of 13 which indicated he was still at risk for elopement and that he was ambulatory and had attempts to elope in the last 3 months. It also revealed .Wandering: behavior of this type occurred 1 to 3 days . Review of R100's MDS dated [DATE] revealed .Section E0900. Wandering-Presence and Frequency: 1. Behavior of this type occurred 1 to 3 days.Review of R100's Care Plan revealed .Focus: (R100) is at risk for wandering r/t (related to): new environment and new dx (diagnosis) of altered mental status. Date initiated: 9/2/2025.Review of R100's Care Plan revealed .Focus: (R100) has history of elopement out of window and risk for elopement r/t dx dementia. New Custom Goal: resident will remain safe and in building until follow-up. New Custom Intervention.1:1 care initiated until window repaired from elopement. Review of R100's Care Plan revealed .Focus: (R100) is at risk for exit seeking and wandering. Hx (history) of elopement .Date initiated: 10/27/2025.Review of R100's progress notes dated 9/30/2025 at 0800 (8:00 AM) . Notified by nursing that patient is aggressive and suicidal and saying things like he is going to break and jump out window.Review of R100's progress notes dated 9/30/2025 at 0800 (8:00 AM) revealed .Patient was heard by nursing staff saying that he is going to break and jump out window and shoot himself. Patient was sent to ER for further evaluations.Review of R100's progress notes dated 9/30/2025 at 17:49 (5:49 PM) revealed .Resident reported to me he is going to kick out the window and leave so maybe then he will get shot and die.Review of R100's progress notes dated 10/2/2025 at 0455 (4:55 AM) revealed .Resident is on 15min check (checks) he was wandering and exit seeking earlier in the shift.Review of R100's progress notes dated 10/13/2025 at 0800 (8:00 AM) revealed . Patient was heard by nursing staff saying that he is going to break and jump out window.Review of R100's progress notes dated 10/27/2025 at 2200 (10:00 AM) revealed .he (R100) got up and started wandering up and down the hall going from doors and he kept standing by the door in the tv room.Review of R100's progress notes dated 10/30/2025 revealed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Wandering hall, went SW (to southwest) exit door and is pushing door, trying to get it open, this writer went to try to redirect res (resident).Review of R100's progress notes dated 2/7/2026 revealed Resident was packing his belongings last night he said he have to leave and was exit seeking all night going from door to door asking do we have his keys so he can go.During an interview on 3/17/2026 at 3:00 PM Certified Nursing Assistant (CNA) DD stated that R100 liked to have his door closed even when his daughter wasn't visiting. CNA DD said R100 stated that he wanted to get out of the facility and break the walls and his daughter should come and get him. During an interview on 3/17/2026 at 12:57 PM, Licensed Practical Nurse (LPN) JJ stated that R100 liked his door shut. LPN JJ said management assessed the window after R100 eloped but she didn't know what interventions they put in place. During an interview and observation on 3/17/2026 at 1:24 PM, Family Member (FM) II stated that after R100 eloped on 9/16/2025, management put another screw in the windowsill so the window could only open 3-4 inches. The screw was observed to be almost flat against the windowsill and the screen on the window was busted at the bottom. FM II said she was able to pull the window up the other day even though the screw was on the windowsill. FM II was observed unlocking the window and demonstrated using little force and pulled the window all the way up over the screw. FM II stated she was going to bring her screwdriver in and pull the screw out more so R100 doesn't try to get out of the window again. During an interview on 3/17/2026 at 1:34 PM, Maintenance Director (MD) O stated after R100 eloped on 9/16/2025, he came to work on 9/17/2025 and put a new screw in R100's window since the screw was flush from opening and closing the window and he checked all the windows in the facility to make sure they had a screw to prevent further elopements. During an observation in R100's room on 3/17/2026 at 1:50 PM, MD O unlocked his window, and couldn't open the window because of the screw in place and proceeded to lock the window. Then, this surveyor unlocked the window, noticed the screw was barely out from the windowsill and pulled the window all the way up over the screw. During an interview on 3/17/2026 at 2:02 PM, MD O reported after the elopement on 9/16/2025 he didn't document any follow-up on R100's window or other resident windows since that day to make sure the intervention was working. MD O said I visualize that screws are on the windowsill, but I don't physically try to open the windows to see if it works, and I wasn't told that I should do that. I would lie if I told you I do that. MD O stated that he went back to R100's room and pulled the screw out more on R100's windowsill after this surveyor was able to pull the window up over the screw so the window wouldn't be able to open all the way.During an interview on 3/18/2026 at 8:52 PM, Director of Nursing (DON) B stated that MD O checked on all resident windows the next day after the elopement but they didn't have documentation on it. When discussing that this surveyor was able to open R100's window and pull it up over the screw, DON B said that he thought all the windows were repaired. DON B also stated that R100 and his daughter like the door closed. During an interview on 3/18/2026 at 9:05 AM, when discussing this surveyor being able to open R100's window and pull it up over the screw, Nursing Home Administrator (NHA) A stated that R100 was below the threshold so he can't open the window now. NHA A said there wasn't a regulation to have documentation on checking resident windows after an elopement occurred and the window should be able to be opened in case of a fire. During an interview on 3/18/2026 at 9:50 AM, Activity Aide (AA) OO stated that R100 used to say he wanted to go home all the time and he would wait for his daughter to pick him up. During an interview on 3/18/2026 at 10:10 AM, LPN V stated that R100 was exit seeking for a while even after the elopement on 9/16/2025. During an interview on 3/18/2026 at 10:14 AM, Registered Nurse (RN) NN stated that R100 would talk about leaving the facility a lot for the first few months after admission. During another interview on 3/19/2026 at 11:38 AM, MD O restated that all he did after the elopement was put the screw on R100's windowsill and then he made sure all other resident windowsills had a screw but he didn't test them to see if he could open them all the way. MD O reported that all resident windows had a screw except the memory care unit which included 15 resident rooms so he put them in on 9/17/2026. During another interview on 3/19/2026 at 10:25 AM, when discussing post elopement interventions and this surveyor being (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	able to open the window, NHA A stated that any force can open the window whether there was a screw on the windowsill or not and the facility did a good job keeping R100 safe.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure 1.) the published menu was served as planned, 2.) residents were informed of the menu change in advance and 3.) the Registered Dietitian (RD) was notified about these menu changes resulting in the potential for all residents that consume food from the kitchen to be dissatisfied with their meal service and for meals to not be nutritionally adequate.Findings include:Review of the menu posted outside the main dining room on 3/18/2026 revealed Lunch: BBQ Chicken, Macaroni and Cheese, Collards, Corn Bread, Sweet Potato Pie.Review of the menu spreadsheet provided by the facility revealed Lunch: BBQ Chicken, Macaroni and Cheese, Collards, Corn Bread, Sweet Potato Pie.During an observation in the kitchen on 3/18/2026 at 1:30 PM, the test lunch tray was noted to have green beans and no collard greens. During an interview on 3/18/2026 at 1:35 PM, Dietary Manager (DM) M stated that she didn't have collard greens to serve at lunch so she substituted green beans. When asked if this substitution was approved by the facility RD, DM M said No. DM M stated that she usually ran changes to the published menu by the RD and made changes on the board outside the dining room, but she didn't get a chance to do that. When asked if she keeps a log of substitution changes and whether the RD approved it, she said no.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure palatable and appetizing food was served to 2 (Resident #108 and Resident #109) of 2 residents reviewed for receiving palatable and appetizing food, resulting in potential for decreased oral intake.Findings include:Resident #108Review of an admission Record revealed Resident #108 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: bipolar disorder (a mental health condition characterized by significant mood swings), anxiety, and depression.Review of Order Summary for Resident #108 revealed Regular diet, regular texture, Thin consistency for Diet Order with a start date of 11/3/2025.In an interview on 3/17/26 at 3:25 PM, Resident #108 reported the food was yucky and sometimes cold. She reported the staff did not reheat it when she asked them to.In an interview on 3/18/26 at 7:50 AM, Resident #108 reported breakfast today should be french toast sticks. Resident #108 stated I will get the french toast sticks and I will eat them, but they will probably be cold.In an observation and interview on 3/18/26 at 9:35 AM, Resident #108's breakfast tray was on her over the bed table, beside her bed, with the lid on the plate. Resident #108 reported the temperature of her food was ok, but the sausage was under cooked and the french toast sticks were hard as a rock. Resident #108 reported she was unable to cut them with a fork and only one was soft enough for her to bite into. Resident #108 reported she only ate one of the four french toast sticks she was served. Resident #108 reported she had to eat the french toast stick with her fingers after it had been covered in syrup. Resident #108 then removed the lid from her plate on the tray to show two sausage links and three French toast sticks still on the plate, covered in syrup. Resident #108 picked up a French toast stick from the plate and tapped it on the plate to demonstrate that it was hard as a rock. Resident #108 picked up the fork off the tray and demonstrated her inability to cut through the french toast stick. It was noted in the sound and visualization that the French toast stick was hard.Resident #109Review of an admission Record revealed Resident #109 was a female who originally admitted to the facility on [DATE] and had pertinent diagnoses which included: unspecified dementia, weakness, and history of falling.Review of Order Summary for Resident #109 revealed Regular diet, regular texture, Thin consistency for Diet Order with a start date of 11/3/2025.In an observation and interview on 3/18/26 at 9:30 AM, Resident #109 was asked how was breakfast? Resident #109's reply was It sucked. When further queried, Resident #109 reported the food was cold, the sausage could have been cooked longer, and the french toast sticks were rock hard. Resident #109 reported she could not eat any of it. Resident #109 was noted to have two bowls of oatmeal on her tray that was on the over the bed table in her room and two cups of fruit. Resident #109 reported she had no idea why she got two bowls of oatmeal; she wouldn't even eat one, much less two, but the fruit was ok. Resident #109 reported that the food was not great.In an interview on 3/18/26 at 2:45 PM, Resident #109 reported lunch was terrible and it did not taste good. Resident #109 reported she did not even get served what was on the menu. Resident #109 reported the menu said ?collards' but she got green beans. Resident #109 stated they are not the same thing. In an observation and interview on 3/19/26 at 9:01 AM, Resident #109 was in her wheelchair in the hallway. She reported she was headed to the kitchen to get come fruit because whatever they served her this morning needed some help. Resident #109 reported .no idea what breakfast was, but she couldn't eat it. Resident #109 reported I don't know who was cooking, but it isn't good. Resident #109 reported she had called the kitchen to order some fruit and was on her way to get it. Resident #109 was observed at the kitchen doorway speaking with the kitchen staff about a bowl of fruit.Review of Menu revealed Wednesday 3/18 breakfast sausage link, cereal of choice, French toast sticks, juice of choice.Lunch.chicken BBQ, Macaroni & Cheese, Collards, Cornbread, Sweet Potato Pie.In an interview on 3/18/26 at 2:55 PM, Dietary Manager (DM) N reported residents can ask for alterative choices if they do not like something. DM N reported there is a list of always ready foods that a resident could request as an alternative meal.

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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. Based on observation, interview, and record review, the facility failed to ensure 1.) hairnets were worn in the kitchen and 2.) desserts from the kitchen were covered that were transported across the facility, resulting in the potential for increased risk of foodborne illness and contamination of food. Findings include: During an observation on 3/18/2026 at 1:25 PM in the memory care unit, a dietary aide brought a black cart from the kitchen carrying 6 resident trays. All 6 resident trays had dessert (sweet potato pie) on the tray and they were not covered and were exposed to air. Then, at 1:30 PM, another black cart was brought in from the kitchen and 3 resident trays had desserts and they were not covered and were exposed to air. During an observation on 3/19/2026 at 12:30 PM, Dietary Manager (DM) M walked across the kitchen without a hairnet on and to the door to help a staff member that requested orange juice and milk for a resident. DM M went back to the kitchen without a hairnet on, didn't wash her hands and retrieved orange juice and milk for the staff. During an interview on 3/19/2026 at 12:35 PM, DM M stated that she had a hairnet and forgot to put it on but she doesn't touch the food. DM M said since she was in and out of the kitchen a lot she didn't put it on. When discussing washing hands every time she or other dietary staff enters the kitchen, DM M said she forgot to wash her hands but she didn't touch any food. Also discussed dietary staff taking resident trays from the kitchen to the memory care unit and the desserts not being covered and DM M stated that the staff knew to cover food during transport and they shouldn't have done that. According to the 2022 FDA Food Code section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation. (A) FOOD shall be protected from cross contamination by. (4) Except as specified under Subparagraph 3-501.15(B)(2) and in (B) of this section, storing the FOOD in packages, covered containers, or wrappings. Review of the Nutritional Services Department Dress Code with a revision date of 3/11/2026 revealed . Nutritional services staff must wear hair restraints (e.g. hairnet, hat and beard restraint) to prevent their hair from contacting exposed food (according to the 2009 FDA food code Food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, and linens; and unwrapped single service and single use articles). On 3/18/26 at 9:14 AM, Dietary Manager (DM) N was observed entering the kitchen, approaching the steam table, speaking to Dietary [NAME] (DC) FF, accepting a plate of food from DC FF and placing the plate of food onto a tray. DM N was not wearing a hair net.