

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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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 07/09/2026
NAME OF PROVIDER OR SUPPLIER Royalton Manor, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1.) have an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), 2.) maintain hydration carts' ice scoop holders in good repair and a sanitary manner, 3.) ensure facility staff use appropriate personal protective equipment (PPE) and enhanced barrier orders were in place in 2 of 2 residents (Resident #69 and Resident #1), reviewed for infection control practices, resulting in increased risk of transmission of multidrug-resistant organisms (MDROs), increased risk of infection among all residents in the facility or consumption of contaminated water. Findings include: On 7/7/26 at 10:13 AM, observation in the kitchen found a water line coming down from the ceiling and heading towards the back of the cookline for equipment, running about 10 feet. At this time, nothing was hooked up to or was using this water line, indicating an area where water would stagnate. On 7/7/26 at 2:01 PM, with Maintenance QQ, observation of the South janitors' closet found discolored water discharge momentarily before running clear from the hot water fixture when turned on. When asked if he saw the discolored water come out initially, Maintenance QQ stated yes. On 7/7/26 at 2:08 PM, an interview with Maintenance QQ, while observing the South Spa, found that staff and residents do not use this spa room often. When asked why, Maintenance QQ stated each room in the South has their own private shower, but he wasn't sure how often they were used either in comparison to residents getting bed baths. When asked if the spa or South personal showers were regularly flushed, Maintenance QQ stated they were not part of the fixtures that are on the flushing schedule. On 7/7/26 at 2:34 PM, observation of the central soiled utility found the hopper with the spray turned off, indicating a stagnant and unused water line. On 7/7/26 at 2:37 PM, observation of the central soiled linen room with a mop sink, found the cold water was turned off to the fixture, indicating a stagnant water line. On 7/7/26 at 2:42 PM, an interview with Maintenance QQ, found that he was unaware of the unused water line on the cookline and stated it's not something that gets flushed currently. When asked what areas are regularly flushed, Maintenance QQ stated that hoppers and water heaters get flushed, as well as purging water in different sections of the building. (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
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A record review of the facility document entitled Water Management Team Meeting Minutes dated, 6/11/26, found a section where staff should evaluate the waters cloudiness or turbidity and it was left blank. A further review of the document shows that flushing was complete and is done weekly, but no list or map of fixtures that are flushed. Unsanitary Ice Scoop Storage on Hydration Carts: During an observation on 07/07/2026 at 2:52 PM, a hydration cart (a mobile cart that held water pitchers, ice, an ice scoop, and an ice scoop holder), on the central unit of the 200s hallway, had a cracked plastic ice scoop holder with white and brown debris inside. During an observation on 07/08/2026 at 8:35 AM, a hydration cart, across from nurses' station on the 200s hall, had a cracked plastic ice scoop holder with white and brown debris inside. During an observation on 07/08/2026 at 2:48 PM, a hydration cart, outside of room [ROOM NUMBER] in the hallway, had an ice scoop holder that was cracked in several places, and pink material was present on the interior. During an observation on 07/09/2026 at 8:33 AM, the hydration cart, in the hallway outside of room [ROOM NUMBER], had a cracked ice scoop holder, and pink material was present on the interior. During an interview on 07/09/2026 at 10:07 AM, Infection Preventionist (IP) K reported if an ice scoop's holder was cracked it should be thrown out. IP K reported the staff in the kitchen should clean the carts and scoops after nurse aides bring the carts back to the kitchen and this should be done every shift/every 8 hours. IP K reported the cracked ice scoop holders could harbor bacteria and the kitchen should monitor the condition of the ice scoop holder for cracks and/or being soiled. Resident #69 (R69) Review of a Care Plan for R69 with a reference date of 4/27/26 revealed: (R69) .straight cath (catheterization {inserting tube into the bladder to facilitate urine drainage}) Q (every) 6 hours.Interventions: Enhanced barrier precautions during high contact care. In an interview on 7/7/26 at 10:57am, Durable Power of Attorney (DPOA)/Family Member (FM) ZZ reported she visited R69 throughout most of the day and witnessed staff members not wearing proper PPE during cares. During an observation on 7/7/26 at 11:20am, a PPE cart sat outside R69's room and signage on his door stated, Enhanced Barrier Precautions (EBP).wear gown and gloves for.device care or use: .urinary catheter. During an observation and interview on 7/7/26 at 11:31am, Registered Nurse (RN) P entered R69's room as the resident laid on his bed. RN P donned gloves as she entered the room. RN P reported she was going to complete a scan on R69's bladder and if need be, catheterize R69 to drain the urine from his bladder. RN P scanned R69's bladder but did not put on additional PPE prior to providing care. RN P reported the resident needed to be catheterized. The surveyor left the room and stood outside the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	closed room door. RN P remained in the room with R69. In an interview outside R69's room on 7/7/26 at 11:56am, Certified Nursing Assistant (CNA) V reported all PPE was kept in the bins outside each resident's room. CNA V reported no PPE was kept in resident rooms. During an observation and interview on 7/7/26 at 12:14pm, RN P emerged from R69's room and entered the hallway. Of note, this was the first time RN P left R69's room since reporting she was going to catheterize his bladder. When queried, RN P confirmed she did not wear a gown while catheterizing R69. RN P stated I should have but I forgot. In an interview on 7/9/26 at 10:07am, Infection Preventionist (IP) K reported it was the expectation that staff wear a gown and gloves when catheterizing a resident and not doing so was a breach of enhanced barrier precautions. Resident #1 (R1) Review of an admission Record revealed R1 had pertinent diagnosis that included: methicillin resistant staphylococcus aureus (MRSA) (type of bacterial infection that is resistant to several types of antibiotics). Review of a Care Plan for R1 with a reference date of 6/8/26 revealed: Focus: (R1) has potential for complications related to.hx (history) of MRSA.Interventions: Enhanced Barrier Precautions. During an observation on 7/7/26 at 11:39am an unknown Certified Nursing Assistants (CNA) entered R1's room as he sat in his wheelchair and approached the restroom. The CNA stated to R1, You need a brief change. The CNA then closed the door. No PPE was outside R1's room and no signage for infection control precautions was present on or near R1's door. During an observation and interview on 7/7/26 at 11:42am, CNA V reported R1 recently moved from another room. CNA V then entered R1's room and pushed R1 into his bathroom before the unknown CNA closed the room door. Neither CNA was wearing a gown. During an observation on 7/7/26 at 11:47am, CNA V and the unknown CNA exited R1's room. CNA V carried a clear bag with a used incontinence brief inside it. In an interview on 7/9/26 at 10:07am, IP K reported any resident who had a previous multi-drug-resistant (MDRO) infection, should remain in EBP precautions while in the facility. When queried, IP K confirmed R1 had been treated for an MDRO and should be on EBP. IP K reported it was her responsibility to ensure physician orders for EBP were in place and precautions were implemented. IP K reported R1 completed treatment for an MDRO infection on 6/8/26 and should have received new isolation orders for EBP on that date but it was overlooked and had not been implemented.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility to ensure urinary catheter equipment (internal urine drainage system) was maintained in a sanitary manner for 2 of 5 residents (R6 and R109) reviewed for urinary catheter care resulting in urinary catheter bags and tubing touching the floor resulting the potential for urinary tract infection (UTI). Findings include: R6 According to R6's Minimum Data Set (MDS) dated [DATE], the resident was cognitively intact as evidenced by a score of 13/15 on his BIMS (Brief Interview Mental Status). Diagnoses included obstructive uropathy (a structural or functional blockage in the urinary tract that prevents urine from flowing freely). Required substantial/maximal assist with toileting. Section H-Bladder and Bowel indicated R6 had an indwelling catheter (urinary catheter/foley). Observed on 07/07/26 at 8 AM, R6's urinary catheter bag (holding bag for urine) was resting on the floor of his room. Observed on 07/07/2026 at 12:51 PM, R6 was sitting in a high-backed wheelchair at a table in the common dining room. R6's urinary catheter bag attached to bottom of chair and resting on the floor. Observed on 07/07/2026 at 2:22 PM, R6 sitting crossways in his bed. His catheter tubing was strung taunt from point of entry to urinary catheter bag. The urinary catheter bag was hanging from the bed frame with a blue privacy cover. The urinary catheter bag sitting on the floor with 400 ml light yellow clear urine. Observed on 07/07/2026 at 3:03 PM, R6 was participating in a religious music program in the main dining room. R6's urinary catheter bag was attached to his wheelchair and dragging on the floor. During an interview on 07/08/2026 at 1:09 PM, Unit Manager (UM) C stated, The urinary catheter bag or urinary tubing should not be dragging or resting on the floor for infection control purposes. Observed on 07/08/26 at 1:55 PM R6 outside of the south dining room hall sitting in his wheelchair. R6's urinary catheter bag was in his wheelchair, noted urine in the tubing. Observed on 7/8/26 at 4:45 PM, R6 in hall slowly self-ambulating in hall. R6's urinary catheter bag was in the seat next to him with urine filling the tubing that was kinked and coiled. Observed on 7/9/26 at 8:30 AM, R6 was in bed with eyes closed. Urinary catheter bag was attached to the frame of bed and resting on the floor under the bed. On the floor under the bed where the catheter bag was touching was dust and debris. Resident #109 (R#109): (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R#109's urinary catheter care plan, dated 1/21/2026, stated, .(R#109) is at risk for urinary tract infection (an infection of the urinary system which can result in painful burning, pressure, and frequent urge to urinate) and catheter-related trauma (injury to the body's tissues caused by insertion, removal, or pulling/tugging): has Suprapubic Catheter (a tube surgically placed directly into the urinary bladder through the abdomen just above the pubic bone).to gravity drainage (urine flows downward into a collection bag) r/t (related to) Neurogenic (sic) bladder/ Urinary Retention (urine doesn't empty from the bladder as it should).Date Initiated: 01/21/2026.Interventions.Ensure the drainage bag (urine collection bag) is secured properly.Date Initiated: 02/20/2026. During observations on 07/07/2026 at 10:43 AM and 07/07/2026 at 12:19 PM, R#109 was seated in his wheelchair in his room. R#109's urinary catheter bag was attached to the wheelchair's frame below the seat, and the catheter bag, privacy cover, and tubing were all resting directly on the floor. During an observation on 07/08/2026 at 2:56 PM, R#109 was seated in his wheelchair in his room. R#109's urinary catheter bag was attached to the wheelchair's frame below the seat, and the catheter bag and privacy cover were resting directly on the floor. During an observation on 07/09/2026 at 8:52 AM, R#109 was seated in his wheelchair in his room. R#109's urinary catheter bag was resting directly on the front right wheelchair wheel. During an interview on 07/09/2026 at 10:07 AM, Licensed Practical Nurse S reported a urinary catheter bag should be not on the floor. Review of the facility's Urinary Catheter policy, dated 12/17/2025, stated, .don't place the drainage bag on the floor to reduce the risk of contamination and subsequent CAUTI (catheter-associated urinary tract infection).		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. This citation pertains to intake 3028987. Based on interview and record review the facility failed to ensure facility staff obtained a resident's consent before searching through their personal property for 1 (Resident #5) of 7 residents reviewed for dignity resulting in feelings of anger and frustration. Findings include: Review of R#5's functional ability care plan, dated 8/4/2025, stated, "(R#5) has a functional ability deficit and requires assistance with self-care/mobility R/T (related to): debility (weakness), immobility. Bed Mobility: Resident is dependent with two helpers. This is including rolling side to side, lying to sitting on side of bed and sitting to lying. The care plan included pertinent diagnoses which included insomnia (sleep disorder that can cause difficulty falling asleep, staying asleep, or waking too early), depression, anxiety, lack of coordination (broad category covering various coordination impairments not specified elsewhere). Review of Resident #5 (R#5)'s brief interview for mental status, dated 6/24/26, was scored 15 which reflected R#5 was cognitively intact. Review of the facility's Disciplinary Action Record Work Rules document, which pertained to Resident #5 (R#5), dated 3/11/26, stated, Employee Name: (Registered Nurse (RN) M). Written Warning #1 issued on: 3/11/26. Disciplinary action to be taken. Written Warning #1. Date of Infraction: 3/9/26. Describe the reason(s) for disciplinary action, including date, time and supporting documentation: Follow policy and procedure for personal property. Specific Plan for Improvement, Ask permission from resident. Employee Comments: I reviewed the policy, my intention was the patient's (R#5) safety. I do not agree with it. During an interview on 07/07/2026 at 11:11 AM, R#5 reported she was frustrated and upset that RN M, on 3/9/26, had searched her purse and removed [Name brand of medication omitted; the reported medication's active ingredients were acetaminophen (a pain reliever) and diphenhydramine Hydrochloride (sleep aid)] without explanation, her knowing about it, or getting her consent to search. R#5 reported after this event happened, she understood she couldn't have medications in her room, but reported it made her feel bad to have her personal property looked through by RN M without her consent. During a follow up interview on 07/09/2026 at 8:06 AM, R#5 reported the medication RN M removed was not out in plain view and confirmed it was in her closed purse in a closed dresser drawer that night. R#5 reported when she woke up, she had asked a worker, unknown, to hand her purse, as she was not physically able to get it herself, and became aware the medication wasn't in her purse at that time. R#5 reported when RN M came to her room next, he initially denied going into her purse but then he admitted to her that he had. R#5 reported she was initially worried because she was uncertain if other items had been taken from her purse. R#5 stated, made me feel like garbage regarding her property being searched without prior consent. During a phone interview on 07/08/2026 at 4:39 PM, Registered Nurse (RN) M could not recall what medication he removed from R#5's room on 3/9/26, but reported it was two bottles of medication that were not provided by the facility. RN M was unable to recall where he found the medication in R#5's room and reported different locations including on her table (bedside table) or an open bedside drawer but was unable to recall how the dresser was opened. RN M confirmed R#5 was asleep when he searched and removed the items from her room. During an interview on 07/08/2026 at 5:00 pm, Nursing Home Administrator (NHA) A confirmed the disciplinary action form, dated 3/9/26, was issued to RN M because RN M had gone into R#5's room to check to make sure she didn't have any medications, not provided by the facility, in her purse. NHA A reported it was his understanding that RN M had found medications that were out in view on R#5's table or in an open drawer, but that RN M was given the disciplinary action because RN M went into R#5's purse. NHA A confirmed RN M did not get R#5's (continued on next page)		

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consent to search her purse and he should have before going into her purse. During an interview on 07/09/2026 at 12:32 PM, Director of Nursing (DON) B reported he remembered talking to RN M that night but couldn't remember what RN M had told him other than he had found medication in R#5's room and RN M took it away. DON B confirmed the way in which RN M searched for medications was done improperly. DON B confirmed there was no documentation, other than the disciplinary action form dated 3/9/26, that addressed what happened on 3/9/26 with RN M and R#5's personal property. Review of the facility's Resident Rights policy, dated 5/14/2024, stated, .The facility protects and promotes the rights of each resident. The resident has a right to a dignified existence, self-determination .These rights include the resident's right to .Exercise his or her rights .Privacy .		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3027977. Based on observation, interview, and record review the facility failed to ensure the appropriate head of bed angle was maintained during tube feeding (delivers liquid nutrition through a flexible tube into the body) and as ordered between meals for 1 (Resident #14) of 1 resident reviewed for tube feeding resulting in the potential for aspiration (inhalation of substances into the airway), aspiration pneumonia (lung infection caused by inhaling foreign material), and/or discomfort. Findings include: Review of Resident #14 (R#14)'s admission Record, dated 7/9/26, indicated she was a [AGE] year old female, was admitted to the facility on [DATE], and pertinent diagnoses included Dementia (decline in mental abilities), Other symptoms and signs concerning food and fluid intake, and Dysphagia (difficulty swallowing) following unspecified cerebrovascular disease (condition affecting the blood vessels and blood supply to the brain). Review of R#14's Order Summary Report, dated 7/9/26, included physician orders:- Nothing By Mouth diet, start date, 5/28/26.- [Name brand of tube feeding formula omitted] 1.5 Cal (calories; 1.5 calories for each milliliter of formula)/Fiber Enteral (tube feeding) Liquid (Nutritional Supplements) Give 55 ml/hr (milliliters per hour) via G-Tube (Gastrostomy (medical procedure that creates a small opening through the abdomen directly into the stomach in which a feeding tube (G-Tube) is inserted to provide liquid nutrition/hydration) one time a day for feeding off at 0900 (9:00 AM) back on at 1300 (1:00 PM), start date, 5/28/26.- keep head of bed elevated 45 degrees to prevent aspiration every day and evening shift for aspiration precautions, start date, 5/28/26. Review of R#14's hospital notes, dated 5/21-5/28/2026, stated, .Hospital Problems .Acute aspiration pneumonia .Date Noted 05/22/2026 .Aspiration pneumonia. Date Noted 05/20/2023 .Review of R#14's hospital note, dated 6/20/26, stated, .XR (x-ray; medical imaging test) Chest.Possible asp (aspiration) PNA (pneumonia).Impression.Lingular infiltrate (abnormal substance in the upper area of the left lung) or atelectasis (lung sacs have collapsed or deflated). Review of R#14's nutrition care plan, revised 4/28/26, stated, (R#14) is unable to tolerate nutritionally adequate food and/or fluids by mouth requiring the use of a feeding tube/PEG (Percutaneous Endoscopic Gastrostomy; a type of gastrostomy) Tube r/t (related to): CVA (cerebrovascular accident; term for a stroke), dysphagia, dementia.Goal.will be free of aspiration.Interventions.Elevate the HOB (head of bed) for (R#14) to semi-Fowlers (sic) position during and thirty minutes after tube feed.During an observation on 07/08/2026 at 8:56 AM, R#14 was nonverbal and lying in bed on her back, the head of bed angle was measured to be 22 degrees, and her tube feeding was running (tube feeding pump (medical device that delivers liquid nutrition/hydration) was on and infusing the tube feeding formula into the stomach). On the right side of the bed frame, where the angle of the head of the bed adjusts up or down, had black markings that indicated the position required for the head of the bed to be at a 45 degree angle.During an interview on 07/08/2026 at 11:48 AM, Director of Nursing (DON) B reported R#14 went to the hospital recently, 6/20/26, and a swallow study indicated it was possible that she was aspirating her secretions (oral secretions; natural fluids, saliva, produced in the mouth). DON B reported the facility marked R#14's bed frame to indicate the correct setting to keep the head of the bed at a 45 degree angle. DON B confirmed the usual head of the bed angle recommendation for tube feeding administration was 30-45 degrees during tube feeding and maintained at that level for 1 hour after. DON B confirmed because of her aspiration risk they were to have her positioned all day at a 45 degree head of bed angle.During an observation on 07/09/2026 at 7:43 AM, R#14 was asleep, lying in (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed on her back, tube feeding was running, and the head of bed angle was measured to be 28 degrees. Review of the facility's Enteral Nutrition policy, dated 9/22/2023, stated, .A resident who is fed by .gastrostomy. receives the appropriate treatment and services to reduce the risk of aspiration pneumonia, diarrhea, vomiting. The resident should be in a semi-Fowler's position (a medical posture where a patient lies on their back with the head and upper body elevated at an angle of 30 to 45 degrees) during administration and for 30 minutes to one hour afterward to prevent aspiration.		