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	04/16/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation and interview, the facility failed to maintain resident rooms (227, 216, 225, 222, 213) with clean floors, floors and dining chairs in the memory unit, and 2 of 2 residents (R6 and R87) with clean wheelchairs reviewed for environment resulting in decreased satisfaction of living conditions. Findings include: Observed on 4/14/25 at 9:49 AM, in room [ROOM NUMBER] along the wall/floor perimeter of room was dust, dirt, food, and paper debris Observed on 4/14/25 at 10:27 AM, in room [ROOM NUMBER] along the wall/floor perimeter of room was dust, food, and paper debris. Observed on 4/14/25 at 9:54 AM, in room [ROOM NUMBER] along the wall/floor perimeter of room was dust, food, and paper debris Observed on 4/14/25 at 12:11 PM, behind the handrail next to room [ROOM NUMBER], was a plastic drink lid with a red liquid on it. On the wall next to the lid was a dried red substance that had ran down the wall to the floor. Observed on 4/14/25 at 12:30 PM, the alcove floor on 200 hall, to have paper and food debris. Observed on 04/16/25 at 7:44 AM, room [ROOM NUMBER] along the wall/floor perimeter of room was dust, food, and paper debris Observed on 4/16/25 at 8:01 AM room [ROOM NUMBER] along the wall/floor perimeter of room was dust, food, straws, and debris. Under bed-2 was an accumulation of personal items, dust, debris, and pieces of paper. During an interview on 4/16/25 at 10:52 AM, Housekeeping II stated, Housekeeping daily duties are first to always respect the residents. This is their home. I sweep and mop floors. Floors should be swept every day all the way around the room if possible and behind the doors. 48637 (continued on next page)

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235623	A. Building B. Wing	04/16/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #6 (R6) Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R6's initial admitted was 4/12/2022 with diagnoses including depression and anxiety. Brief Interview for Mental Status (BIMS) reflected a score of 13 out of 15 which indicated R6 was cognitively intact (13 to 15 cognitively intact). During an observation and interview on 4/14/2025 at 10:25 AM, R6 stated that her wheelchair was dirty and she doesn't remember if it had been cleaned and it was probably never cleaned as far as she knows. It was observed that her wheelchair was dirty with crumbs on the handles and dried up food and crumbs were underneath her wheelchair pad. R6 stated that she picks at the dirt and crumbs on her wheelchair to get it off. Further observations on 4/15/2025 at 8:28 AM and 4/16/2025 at 8:15 AM revealed that R6's wheelchair was still dirty and crumbs and dried up food was still underneath the wheelchair cushion. During an interview on 4/15/2025 at 8:42 AM, Certified Nursing Assistant (CNA) O stated that third shift CNAs clean the wheelchairs and if any CNA notices the wheelchair are dirty after meals, they should clean it at that time instead of waiting for third shift to clean it. CNA O said a resident shouldn't be put in a dirty wheelchair. During an interview on 4/15/2025 at 8:44 AM, Licensed Practical Nurse (LPN) J stated that third shift deep cleans the wheelchairs according to a schedule and if any CNA notices a dirty wheelchair after meals, they should clean it right then. During an interview on 4/15/2025 at 8:53 A, CNA Q who was also the CNA Preceptor stated that third shift cleans the wheelchairs. CNA Q said that the book at the nurses' station had the CNA night shift duties and one of them was cleaning the wheelchairs. CNA Q stated that there wasn't a list of rooms and the wheelchairs that need to be cleaned but they are supposed to clean the wheelchairs in their group after the resident goes to bed. During an interview on 4/16/2025 at 8:34 AM, CNA S and CNA P stated that the expectation was for the night shift CNAs to clean the wheelchairs unless they notice it was dirty after a meal then they should clean it. Review of the sheet Night Shift Duties revealed CNA Duties: clean wheelchairs There was no specific schedule posted for the CNAs to follow. Review of R6's Task: Wheelchair Cleaning/Audit Room was created and revised by Director of Nursing (DON) B on 12/7/2023. Review of the task for the last 30 days revealed Resident's wheelchair/gerichair has been cleaned No data found. (continued on next page)

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	04/16/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/16/2025 at 8:48 AM, DON B stated that wheelchairs are cleaned by the night shift team and it correlates with the resident's shower days. DON B said the night shift used to clean the wheelchairs in their specific group but now it was correlated with resident shower days. DON B stated that the CNAs have a scrub brush and the wheelchair should be hosed down in the shower room and wheelchair pads and underneath them should be cleaned at that time. He stated that R6 refuses showers at times but this surveyor pointed out that it shouldn't matter since the night shift CNAs clean the wheelchairs on shower days when the resident was in bed and DON B said you are correct. DON B said cleaning the equipment/wheelchairs was a challenge. 46999 Resident #87 Review of an Admission Record revealed Resident #87 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: adjustment disorder with mixed disturbance of emotions and conduct (short-term mental and behavioral condition that occurs when someone has an unhealthy reaction to a stressful life change). Review of a Minimum Data Set (MDS) assessment for Resident #87 with a reference date of 1/10/25, revealed a Brief Interview for Mental Status (BIMS) score of 12/15 which indicated Resident #87 was moderately cognitively impaired. In an interview on 4/16/25, at 10:39am, Resident #87 reported the chairs in the dining area needed to be cleaned more often. Resident #87 then ran her right thumb across the frame of the dining chair in which she sat, turned her thumb over, looked at the dust and debris that had transferred to her thumb from the frame of the chair, and stated Yuck!. Resident #87 also voiced that she had noticed several brown stains on the carpet and stated, I don't have to shampoo the floors anymore, but someone needs to do it here. During an observation on 4/16/25 at 10:46am, the frames and legs of 17 of 19 dining chairs were soiled with dried white and brown liquid as well as dust and debris. 7 of the 10 dining table bases were soiled with dried white and brown liquid, crumbs, dust, and debris. During an observation on 4/15/25 at 10:16am multiple dried brown stains were noted on the carpet in the entryway area of the memory care unit. During an observation on 4/15/25 at 10:18am, 7 dried brown stains were noted on the carpet in the common area of the memory care unit, where residents were seated. During an observation on 4/15/25 at 10:22am, the emergency exit door, in the common area of the memory care unit, was heavily soiled with dried yellow liquid that covered the width of the door. During an observation on 4/15/25 at 10:24am, a large dried yellow stain, approximately 2x3' was noted on the carpet, near the center of the entryway area of the memory care unit.

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	04/16/2025

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 0604 Level of Harm - Actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46999 Based on observation, interview, and record review, the facility failed to ensure a resident was free from physical restraints imposed for the purpose of convenience in 1 of 1 resident (Resident #11) reviewed for restraints, resulting in the restriction of mobility, episodes of anxiety and frustration, a potential for decline in physical functioning, and an increased risk of injury. Findings include: Review of Physical restraint in older people: an opinion from the Early Career Network of the International Psychogeriatric Association, October 2023, www.researchgate.net , revealed: .The fundamental rationale for employing physical restraints is ostensibly to ensure the safety of the patient .common justi?cations for resorting to physical restraints include: . To reduce the risk of falls or accidents in ambulant patients with safety concerns .These well-intended motives, however, are not supported by the evidence. On the contrary, many studies show that restraints do not prevent falls and can instead increase the likelihood of injury from falls ([NAME], et al., 2011). Review of Restraint Definition and Examples, [NAME] D [NAME], OTR/L, 2015, phsyicaltherapy.com revealed: .examples of restraints: .A reclining geri-chair (a specialized reclining chair which cannot be propelled by the user, and restricts movement in a resident that is able to propel in a manual wheelchair) would be considered an example of a restraint .An upright geri-chair with a lap tray .that prevents the resident from rising from the seat .they are not able to stand up. Review of an Admission Record revealed Resident #11 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: alzheimer's disease (disease causing progressive deterioration of cognitive skills), anxiety disorder (excessive worry and fear that are persistent, intense, and often out of proportion to the situation), major depressive disorder (persistent depressed mood or loss of interest in activities causing significant impairment in daily life) and edema (buildup of fluid in the body's tissue, most commonly in the legs and feet). Review of a Minimum Data Set (MDS) assessment for Resident #11 with a reference date of 1/7/25, revealed a Brief Interview for Mental Status (BIMS) score of 99 which indicated Resident #11 was unable to complete the evaluation. Section E revealed Resident #11 did not exhibit behavioral symptoms of verbal/vocal screaming or making disruptive sounds during the 14-day assessment period. Section GG revealed Resident #11 could ambulate 10' with supervision or light touching assistance and could propel a standard wheelchair up to 150' with moderate assistance. Section M revealed Resident #11 was at risk for developing pressure ulcers. Section P revealed no physical restraints were used on Resident #11. Review of a Care Plan for Resident # 11 with a reference date of 1/30/25, revealed a focus/goal/interventions of: (Resident #11) is at risk for complications due to they (sic) require use of a Gerichair (sic) w/tray (with tray) to enable her up related to multiple falls. Goal: (Resident #11) will be free from complications related to the use of Gerichair w/tray through next review. interventions: Apply Gerichair w/tray when up and release tray after meals or when in bed .Release and reposition q2 hours, with supervised meals, supervised activities and with toileting. (continued on next page)

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	04/16/2025

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 0604 Level of Harm - Actual harm Residents Affected - Few	During an observation on 4/15/25 at 9:21 am, Resident #11 sat in a geri-chair in the common area of the memory care unit. The arms of the geri-chair pushed against a table and the brakes locked. Resident #11 sat upright, supported her torso with her trunk muscles with her back unsupported. Resident #11 rocked her trunk back and forth as a staff member passed by and said to her (Resident #11's name) what's wrong? We're going to do a history activity in twenty minutes. Resident #11's feet hung unsupported above the floor with her feet extended, causing her toes to point toward the floor. Resident #11's feet appeared swollen. During an observation on 4/15/25 at 9:58 am, Resident #11 sat unsupported at the edge of her bed with the geri-chair parked against the wall across from the foot of her bed. A lap tray for the geri-chair was propped against the wall. No staff were in her room and the call light was activated. In an interview on 4/15/25 at 12:15pm, Certified Nursing Assistant (CNA) U reported the nursing and hospice staff decided to use a geri-chair with a table across it for Resident #11 after the resident had multiple falls. When asked if the resident seemed upset about using the geri-chair with the lap tray, CNA U reported Resident #11 hates it. CNA U reported Resident #11 was not able to get out of the chair with the lap tray in place and frequently made statements such as get me out of here while in the chair. CNA U reported Resident #11 was less frustrated if the geri-chair did not have the tray on it but was pushed up against a table, although the resident still could not stand when she was in this position. In an interview on 4/15/25 at 1:49pm, Social Services Director (SSD) T reported Resident #11 started using the geri-chair after she had been hospitalized and returned too weak to maintain good trunk control. SSD T reported Resident #11's strength had improved, and she could now sit unsupported. When queried regarding the use of the lap tray across the chair, SSD T confirmed the lap tray was affixed across Resident #11's lap at times and to her knowledge, was used so Resident #11 could pursue tabletop leisure interests. SSD T reported the geri-chair and tray were not used to reduce Resident #11's fall risk and she was not aware of any negative response the resident had to it. In an interview on 4/16/25 at 9:27am Activity Aide (AA) E reported Resident #11 had become more anxious and agitated in recent months. When further queried, AA E reported in the past Resident #11 was very proud of her independence and felt the resident was experiencing more distress now due to her loss of independence and the inability to move around as much. In an interview on 4/16/25 at 9:32am, CNA HH reported Resident #11 was screaming out, calling staff names and hitting at them more frequently than she had a few months ago. CNA HH described Resident #11 as irritated with the lap tray when it was on her chair. In an interview on 4/16/25 at 9:51am, CNA U reported Resident #11 frequently pounded on the lap tray of the geri-chair and stated, get me out of this thing. CNA U reported Resident #11 had regained the strength she lost during a recent hospitalization , could walk short distances again and had been found with one leg over the lap tray of the geri-chair as she tried to get out of it unassisted. CNA U reported the use of the geri-chair and lap tray had been detrimental to Resident #11's mood and described it as agitating to the resident. CNA U reported Resident #11 had difficulty expressing her thoughts but the resident commonly, clapped her hands and said yay! when CNA U removed the lap tray in preparation to transfer the resident out of the geri-chair. (continued on next page)

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	04/16/2025

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 0604 Level of Harm - Actual harm Residents Affected - Few	During an observation on 4/16/25 at 10:16am, Resident #11 sat in a geri-chair with a hard plastic lap tray affixed across her lap in the common area of the memory care unit. 2 staff members sat next to Resident #11. In an interview on 4/16/25 at 10:20am, Resident #11 was asked about the geri-chair and although she did not verbally respond, she grabbed the lap tray of the chair and rattled it side to side several times. During an observation on 4/16/25 at 10:46am, Director of Nursing (DON) B walked past Resident #11 as she sat in the common area of the memory care unit, in the geri-chair with the lap tray affixed across her lap, as she engaged in a supervised activity. DON B waved to Resident #11. In an interview on 4/16/25 at 10:51am, Registered Nurse/Hospice Care Coordinator (RNCC) GG reported Resident #11 was provided with the geri-chair in February 2025 after a hospitalization . RNCC GG reported Resident #11 needed the geri-chair for trunk support and to maintain proper positioning while eating but she did not recommend the use of the tray table. RNCC GG reported it was her expectation that the facility would communicate to her if Resident #11 regained her strength and could sit unsupported or if the resident began to express any distress related to using the geri-chair. RNCC GG reported it was important that the facility share this type of information because the resident would need to be reassessed to see if another type of wheelchair would better meet her needs. RNCC GG stated we want her to be more mobile and more independent if she can be because that will maintain her best quality of life. RNCC GG reported she was not aware the facility was using the lap-tray on Resident #11's geri-chair, that doing so would be considered a restraint and could be detrimental to the resident's overall psychosocial well-being. RNCC GG stated She (Resident #11) is already behavior prone, and we should not do anything that makes her more anxious. When further queried, RNCC GG reported that Resident #11 being found with her leg over the lap-tray indicated she felt anxious and trapped and increased her risk of falling. In an interview on 4/16/25 at 11:19am, RN Unit Manager (UM) X reported she did not know why a geri-chair and lap-tray had been implemented for Resident #11. UM X reported the lap tray should be removed anytime the resident voices that she wants it off, and that Resident #11 cannot remove the tray herself. UM X reported she had heard Resident #11 multiple times as she banged on the lap-tray and said repeatedly that she wanted to lay down. UM X reported the staff usually assisted Resident #11 to bed at that time. UM X reported she was not aware Resident #11 had been found with one of her legs over the lap-tray as she tried to climb out of the geri-chair, which put her at greater risk for injury, and that staff were expected to report this type of information to her. (continued on next page)

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	04/16/2025

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 0604 Level of Harm - Actual harm Residents Affected - Few	In an interview on 4/16/25 at 12:05pm, DON B reported the facility implemented the use of a geri-chair with a lap tray for Resident #11 in effort to reduce the number of falls the resident had. DON B reported Resident #11 had become very restless, at times wanted to lay down or get up every 15 minutes and the staff did not have time to assist her with doing that, so the geri-chair was implemented. DON B reported the intent for use of the geri-chair and lap-tray was to keep Resident #11 comfortable but out of her room and in one place. DON B reported the only other way to keep Resident #11 safe would have been to assign 1 staff member to her and that was not feasible. When asked about Resident #11's current ability to sit unsupported, DON B reported he believed her core isn't strong and he was unsure if the resident was able to stand up. DON B reported Resident #11's most recent Physical Restraint Reduction assessment was 1/29/25. When asked if staff members had reported Resident #11 having any behaviors related to the geri-chair and the lap tray, DON B did not respond. When further queried about any anxiety the resident had exhibited because of the use of the geri-chair and lap tray, DON B stated she was banging on the tray this morning, saying she wanted to go to bed when I tried to talk to her. DON B reported when Resident #11 banged on the lap tray and asked to go to bed during his interaction with her on this date, he responded by consoling her. In an interview on 4/16/25 at 2:26pm, AA Z reported she had seen Resident #11 trying to get out of the geri-chair at times and that the resident could not remove the lap-tray on her own. Review of a Physical Restraint Reduction Assessment for Resident #11 with a reference date of 1/29/25 revealed 2. Is the resident a candidate for restraint reduction? Yes. 2a. If yes, what actions are going to be taken (include less restrictive measure to be used and start date for when reduction is going to begin) . 1/29/25 remove tray table q (every) 2 hours and prn (as the situation demands) and when in supervised activity. Review of a Nursing Progress Notes for Resident #11 revealed: 4/11/25 at 6:59pm, Banging hands on tray and yelling. 4/10/25 at 4:14am, resident .trying to get up out of her chair this shift .we found a chair just like hers because she (sic) getting out of this one . 4/9/25 at 5:35pm, clamp that hold tray onto geri-chair broke off . 3/30/25 at 2:15am, Resident have(sic) been yelling and beating on her table . 3/28/25 at 2:00pm, Res started yelling and banging the board on her chair, hard to be redirected. 3/25/25 at 9:00pm, Resident was very agitated beating on table and yelling out. 3/25/25 at 9:40am, Yelling out nonsensical statements, hitting lap tray with her hand, unable to redirect. 3/25/24 at 1:48am, she have (sic) been hitting on the table and getting out of her recliner chair yelling out to get up we have taken her to the bathroom and laid her down when she asked and she would get up from bed in 5-10min after we put her in because she asked to go to bed, she is up in recliner chair at this time because we caught her getting out of bed . (continued on next page)

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	04/16/2025

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 0604 Level of Harm - Actual harm Residents Affected - Few	3/16/25 at 3:35am resident .was yelling to get up and hitting the table she got out of her chair . Review of a Behavior Monitoring Log with a reference date of 1/1-1/31/25 revealed Resident #11 demonstrated behavioral symptoms (frequent crying, repeated movements, yelling, wandering, grabbing, hitting) 38 times during the 31-day period. Review of Physician Orders for Resident #11 with a reference date of 1/29/25 revealed Geri chair with lap tray to enable her to be up with reduction in falls. Review of a Behavior Log for Resident #11 with a reference date range of 3/18/25-4/15/25 revealed the resident displayed behavioral symptoms (frequent crying, repeated movements, yelling, wandering, grabbing, hitting) 97 times during the 30-day period. Review of a facility Restraint Management policy with a reference date of 3/7/23 revealed Policy: Restraints are not used unless the resident has medical symptoms that warrant the use of the restraint. Overview: Physical restraints are not used for the purpose of .convenience .physical restraints include .lap trays the resident cannot easily remove .placing a resident in a chair .that prevents a resident from rising .Guidelines . 8. Residents using physical restraints will have a Physical Restraint Reduction Evaluation completed .with any significant change of condition for the use and appropriateness of physical restraints. Attempts to contact Resident #11's legal guardian were unsuccessful at the time of the completion of the survey. Using the reasonable person concept, though Resident #11 could not recall and verbalize the degree of emotional distress she experienced because of being physically restrained, she clearly demonstrated a desire to be free from the chair and lap tray that limited her movement, and experienced increased anxiety from the confinement.

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	04/16/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review the facility failed to follow professional standards of practice during medication administration for 2 (Resident #101 & #207) residents of 2 reviewed for medication administration, resulting in inaccurate documentation of medications, late/missed medications, and the potential for the worsening of medical conditions and residents not meeting their highest practicable level of wellbeing. Findings include: Resident #101 In an interview on 04/15/25 at 09:36 AM, Infection Preventionist-Unit Manager (IP-UM) KK reported that Resident #101 had a blood infection and was on an IV (medication administered directly into a vein) antibiotic for 32 days. IP-UM KK reported that the resident was supposed to have the IV medication at 9:00 AM, but that she was not sure if it had been administered yet that day. In an interview on 04/15/25 at 09:51 AM, Resident #101 reported that she had eaten her breakfast earlier, and had not taken her morning medications yet. During an observation of IV medication administration on 04/15/25 at 09:56 AM for Resident #101. Registered Nurse (RN) JJ was at the medication cart gathering supplies to administer an IV medication. RN JJ had a bag of Daptomycin-Sodium Chloride (antibiotic mixed with normal saline) IV solution 700-0. 9mg/100ml with tubing attachments and a syringe of normal saline in one hand, and retrieved a cup containing 6 pills from the medication cart. The resident's medication administration record (MAR) was observed on the computer screen and revealed that several medications were already signed out as administered. RN JJ entered Resident #101's room and asked the resident where her IV pole was and asked When did you get back from the hospital? Resident #101 did not understand and stated, I just got back last night .I will need applesauce for my pills . RN JJ then exited the room to obtain an IV pole and applesauce. At 10:10 RN JJ was back in the resident's room, handed the resident the cup of pills, hung the IV medication on the pole, flushed the resident's PICC line (a long tube inserted into a vein in the upper arm that is threaded into a larger vein leading to the heart, used to administer medications) and then attached the IV medication tubing to the PICC line. In an interview on 04/15/25 at 10:12 AM, RN JJ reported that Resident #101 received the following 6 medications during the morning medication pass at 10:10 AM: Buspirone (antidepressant), Cetirizine (allergy), Eliquis (blood thinner), Lactobacillus (probiotic), Oxybutynin (bladder control) , and Celebrex (anti-inflammatory). RN JJ reported that the only medication that was not given as scheduled was Tramadol (controlled medication for pain), because it was not in the cart, and she would have to go pull it from back up. RN JJ reported that she had signed out the medications as administered when she pulled them from the drawer earlier that day. Review of Resident #101's Physician Orders for current date of 4/15/25 revealed: Daptomycin-Sodium Chloride IV solution 700-0.9mg/100ml once a day at 9:00 AM, to be administered over 1 hour. (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 04/16/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Normal Saline IV flush 10 ml prior to and after infusion of Daptomycin. Buspirone 7.5 mg upon (upon rising: when the resident wakes up in the morning) Cetirizine 10 mg upon. Eliquis 5 mg upon. Lactobacillus upon. Oxybutynin 10 mg upon. Celebrex 10 mg upon. Senna (stool softener) 8.6-50 mg upon. Miralax (for constipation) 17 gram by mouth upon. Metformin (to manage blood sugar) 500mg 2 pills upon. Duloxetine (antidepressant) 60 mg upon. Amiodarone (abnormal heart rate) 200 mg upon. Torsemide (edema) 100 mg upon. Tramadol (narcotic pain medication) 50 mg upon. Review of Resident #101's Medication Administration Record (MAR) for 4/15/25 revealed the following medications and times they were administered by RN JJ: Daptomycin-Sodium Chloride IV solution 700-0.9mg/100ml at 9:50 AM Normal Saline IV flush at 9:50 AM and 9:51 AM Buspirone at 9:51 AM Cetirizine at 9:51 AM Eliquis at 9:51 AM Lactobacillus at 9:51 AM Oxybutynin at 9:51 AM Celebrex at 9:51 AM with a pain level of 5. Senna at 9:51 AM (continued on next page)

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	04/16/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Miralax at 9:51 AM Metformin at 9:51 AM Duloxetine at 10:56 AM Amiodarone at 10:57 AM Torsemide documented as 5 (not given, see nurse notes) at 10:56 AM and there was no follow up explanation recorded. Tramadol documented as 5 (not given, see nurse notes) at 9:53 AM and there was no follow up explanation recorded. This surveyor noted that Senna, Metformin, and Miralax were not administered during the observation at 9:51 AM or during the observation at 10:10 AM. Duloxetine and Amiodarone were documented as administered late, but not observed. Torsemide and Tramadol were documented as not given, with no explanation. During an observation on 04/15/25 at 01:30 PM Resident #101 was lying in bed and her IV medication was still attached to her PICC line. The bag of solution appeared empty, but the tubing still had solution in it. The medication was ordered to run for a total of 1 hour (11:10 AM), which was approximately 2 hours earlier. In an interview on 04/15/25 at 1:45 PM, RN JJ reported that she had just returned from her break, but that Resident #101's IV medication was still running when she left the unit for her break. RN JJ was observed disconnecting the IV tubing, flushing the line with normal saline. RN JJ reported that this was her first time with this type of IV and she could not explain how long it was supposed to run or how the system works. Additionally, RN JJ reported that she had administered Tramadol to Resident #101 at approximately 12:00 PM after retrieving it from the backup supply. RN JJ could not verify this and then reported that she had not gotten an order for the late medication, so she was not able to document it as administered. In an interview on 04/15/25 at 02:01 PM, IP-UM KK reported that UPON RISING is defined as when the resident wakes up, or between 4 AM and 10 AM for medication administration. IP-UM KK reported that all medications should first be pulled from the medication cart, administered to the resident, and then signed out on the MAR. IP-UM KK reported that sometimes residents refuse medications, so it's important to only document them as administered AFTER they have been accepted by the resident. IP-UM KK reported that she had not been notified that Resident #101 had medications that were not available, and/or that she had any missed medications for that day. IP-UM KK reported that any time a medication is late, the physician should be notified and a progress note should be written in the record. (continued on next page)

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	04/16/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/15/25 at 02:10 PM, Director of Nursing (DON) B reported that IV antibiotics should be flushed as soon as possible after the medication finishes running so that it doesn't irritate the vein. DON B reported that if Tramadol was not available in the resident's supply of medications, the nurse could get an order to pull it from the backup box. Observation of the medication back up boxes did not reveal any orders for Tramadol, or any indication that RN JJ had pulled any medications for Resident #101. DON B approached RN JJ to ask about the Tramadol for Resident #101, and could not get a clear answer from RN JJ. DON B asked for a moment to talk to NHA A and figure out what happened. A few moments later, DON B reported that RN JJ apparently took Tramadol from Resident #207's medication supply, and administered it to Resident #101. DON B reported that this would be reported to the state agency and a full investigation would be started. Resident #207 During an observation of medication administration on 04/15/25 at 10:20 AM, RN JJ opened the top drawer of the medication cart and grabbed a handful of medications that were wrapped in foil, but not labeled with a resident name. RN JJ reported that she had pulled the medications from Resident #207's supply earlier that morning, but then had to do Resident #101's IV antibiotic, so she had put the pills in the drawer. Observation of RN JJ placing the following medications in a cup: Metoprolol (blood pressure medication) 50 mg, Eliquis (anticoagulant) 5 mg, Bupropion (antidepressant) ER (extended release) 300mg, Lisinopril (blood pressure) 10 mg, Oxybutynin (urinary retention) ER 10 mg, Stool softener 100mg and Aspirin 81 mg. Then prepared Lantus (insulin) 10 units to administer by injection. RN JJ entered Resident #207's room and stated, Where would you like your insulin? Your hand or abdomen? Resident #207 answered that she would like it in her arm. RN JJ administered the Lantus insulin in Resident #207's right upper arm, and handed the resident the cup of pills. This surveyor noted that RN JJ mispoke and said hand, when she should have said arm. Review of Resident #207's current Physician Orders for 4/15/25 revealed: Aspirin 81 mg at 9:00 AM Bupropion ER 300mg at 9:00 AM Lantus Insulin 10 units at 9:00 AM Lisinopril 10 mg at 9:00 AM Med Pass 120 ml (nutritional supplement drink) at 9:00 AM Oxybutynin ER 10mg at 9:00 AM Eliquis 5 mg at 9:00 AM Stool Softener at 9:00 AM Metoprolol 50 mg at 9:00 AM Miralax (for constipation) upon rising (continued on next page)

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	04/16/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Senna (for constipation) at 9:00 AM. This surveyor noted that Senna, Miralax, and Med Pass were not observed given during the observation at 10:20 AM, and the remainder of the medications were administered greater than 1 hour following the ordered administration time of 9:00 AM. Review of the facility policy Medication Administration dated 10/17/2023 revealed, .4. Follow safe preparation practices. a. Prepare medications immediately prior to administration. b. Never administer medications supplied for one resident to another resident .6. Administer medications within 60 minutes of the scheduled time. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. For example, if the medication is ordered for 8:00 a.m., it must be given between 7:00 a.m. and 9:00 a.m. in order to be considered timely . Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, .After administering a medication, immediately document which medication was given on a patient's MAR per agency policy to verify that it was given as ordered. Inaccurate documentation, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about patient care. For example, errors in documentation about insulin often result in negative patient outcomes .Never document that you have given a medication until you have actually given it. Document the name of the medication, the dose, the time of administration, and the route on the MAR . [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 609-610). Elsevier Health Sciences. Kindle Edition.

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	04/16/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48637 Based on interview and record review, the facility failed to ensure timely and consistent weight monitoring and complete and accurate documentation for 2 residents (Resident #100, Resident #31) of 5 residents reviewed for nutritional status resulting in undetected weight changes and potential for nutritional status decline and unmet nutritional needs. Findings include: Resident #100 (R100) Review of the Admission Record and Minimum Data Set (MDS) dated [DATE] revealed R100 admitted to the facility on [DATE] with diagnoses including weakness and dysphagia (difficulty swallowing). Brief Interview for Mental Status (BIMS) reflected a score of 99 which indicated it could not be complete due to R100's severe cognitive impairment. On 4/14/2025 at 2:36 PM, R100 was observed to be lying in bed and was unable to respond to questions. An empty can of Jevity 1.5 (nutritional supplement) and a syringe was inside a plastic cup on the bedside table. Review of physician orders revealed Enteral feed (method delivering nutrition directly into the gastrointestinal tract via a tube) four times a day for Tube Feed Jevity 1.5 via PEG (percutaneous endoscopic gastronomy tube, a feeding tube inserted directly into the stomach through the abdominal wall which allows liquid nutrition , fluids and medications to be delivered directly to the stomach by passing the mouth and esophagus used for feeding liquid nutrition directly into tube) bolus of 235 mL (milliters)/1 can to provide 940 mL/4 cans total volume {1420 kcal (calories)}. Nothing By Mouth diet, Nothing By Mouth texture, Nothing By Mouth consistency. Review of R100's weight records: 4/1/2025 08:34 142.9 Lbs (pounds) 3/25/2025 14:34 143.0 Lbs 3/24/2025 12:51 142.8 Lbs 3/21/2025 17:48 150.2 Lbs 3/18/2025 09:57 151.0 Lbs 3/11/2025 14:01 151.0 Lbs 3/7/2025 20:24 152.8 Lbs (continued on next page)

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	04/16/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The weight record revealed on 3/7/2025 R100 weighed 152.8 pounds and on 4/1/2025 R100 weighed 142.9 pounds which was a 6.48 % (percent) significant weight loss. There were no other weights obtained since 4/1/2025. Resident at Risk progress note on 4/4/2025 documented by Dietary Manager (DM) MM revealed Reviewed Clinical Indicator: Resident (R100) triggered for weight loss. Action Taken: RD (Registered Dietitian) referred to review enteral feedings. Response to Previous Actions Taken: In attendance, dietary, social work, and nursing. There was no additional documentation in R100's chart after 4/4/2025 from the RD or DM MM regarding the weight loss and that the physician was aware/notified of the weight loss. Review of R100's Care Plan revealed there was no documentation regarding her weight loss. There was no RD documentation in R100's chart since the Admission Nutrition Evaluation that was completed 3/18/2025. During an interview on 4/15/2025 at 11:56 AM, Dietary Manager (DM) MM stated that he isn't a Certified Dietary Manager (CDM) and isn't taking classes to become certified. DMMM stated when a resident is triggered for weight loss, he will put any interventions in, document the best he can, refer the resident to the RD and he will attend the Resident at Risk meetings. DMMM stated that he put a note in regarding R100's weight loss and let the RD know about it. He said there should be a note in the chart and he looked for any documentation in R100's chart and could not find anything. DM LL stated that the RDs work remotely and RD EE was the main corporate RD and there are several float RDs. During an interview on 4/15/2025 at 1:01 PM, Corporate RD EE acknowledged that DM MM wasn't a CDM. She said that she tries to get to the facility 1-2 times a year and that there are 2 other RDs that assist remotely with charting and clinical documentation but they are full time RDs in other buildings and are stretched thin. RD EE stated that they are having trouble finding a RD to cover the building and can't find an agency RD. She stated that DM MM attends the clinical meetings and consults the RDs if needed. RD EE stated that the other RD did R100's admission assessment. She also said that the expectation was to address weight loss timely and before additional weight loss happens. RD EE stated that enteral feeding documentation was completed monthly by the RD but if weight loss was found in between it should be addressed and documented right away. RD EE stated that she couldn't say R100's weight loss wasn't addressed but it was not documented in her chart. During an interview on 4/16/2025 at 9:23 AM, Director of Nursing (DON) B stated that weekly weights should be done when a resident has significant weight loss and the RD should document this weight loss in the resident's chart. When discussing R100's weight loss, DON B agreed that there wasn't a note by the RD regarding her weight loss in her chart. DON B' also agreed that there was no documentation that the physician was notified about the weight loss. (continued on next page)

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	04/16/2025

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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Weight Management Policy with a revision date of 9/22/2023 revealed .5. Residents determined to be at risk or have significant weight changes will be weighed on a weekly basis. Residents at risk are .c. Residents receiving a tube feeding with significant weight changes f. residents with insidious weight loss- 5% in one month .8. Once an insidious weight loss is identified, the RD. further assesses the guest/resident and makes recommendations as indicated to prevent/treat unintended weight loss. 11. A 'Resident at Risk' meeting will be conducted at least monthly by the Interdisciplinary Team and any changes documented in the care plan at the meeting. 41027 Resident #31 In an interview on 04/14/25 at 11:42 AM, Resident #31 reported that he thought he had been losing weight and complained about the food being cold. Resident #31 reported that he was recently admitted to the facility following two surgeries, and that he may have lost the weight because of the surgeries. Review of Resident #31's Weight Record revealed a significant weight loss indicated by 164.3# (pounds) recorded on 4/11/2025, 185# on 4/10/2025, and 195# on 3/19/2025 (admitted). The record indicated 3 weeks lapsed between the first and second time that the resident was weighed. In an interview on 04/16/25 at 10:40 AM, Licensed Practical Nurse (LPN) OO reported that the nurse enters the weight in the record as reported by staff, but that Certified Nursing Assistant (CNA) NN and the dietician manage and address any concerns. In an interview on 04/16/25 at 10:43 AM, CNA NN reported that Resident #31 was still on a weekly weight list, but that she was not sure about his weight loss. CNA NN reported that Dietary Manager (DM) MM followed up with weight concerns. In an interview on 04/16/25 at 10:52 AM, DM MM reported that Resident #31's weight loss should have been addressed immediately, but that he had not been aware of it and had not spoken to the resident. In a subsequent interview on 04/16/25 at 10:58 AM, DM MM reported that they would be re-weighting Resident #31 to establish an accurate baseline weight. DM MM reported that when residents admit to the facility they should be weighed weekly for the first 4 weeks, then monthly and as needed. DM MM reported that this policy was not followed for Resident #31.

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	04/16/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on observation, interview, and record review, the facility failed to ensure that all licensed nursing staff remained competent and possessed the technical and communication skill sets necessary to provide nursing and related services to meet the residents' needs in 2 of 2 resident (Resident #207 and Resident #101) resulting in mismanagement of controlled substances, and the potential for all residents residing in the facility to not attain or maintain their highest practicable level of physical, mental, functional and psychosocial well-being. Findings include: Resident #207 During an observation of medication administration on 04/15/25 at 10:20 AM, RN JJ opened the top drawer of the medication cart and grabbed a handful of medications that were wrapped in foil, but not labeled with a resident name. RN JJ reported that she had pulled the medications from Resident #207's supply earlier that morning. RN JJ placed the pills in a cup, then prepared Lantus (insulin) 10 units to administer by injection. RN JJ entered Resident #207's room and stated, Where would you like your insulin? Your hand or abdomen? Resident #207 answered that she would like it in her arm. It was noted that RN JJ referred to the arm as hand. Resident #101 During an observation on 04/15/25 at 01:30 PM Resident #101 was lying in bed and her IV medication (Daptomycin-Sodium Chloride IV solution 700-0.9mg/100ml) was attached to her PICC line (tube inserted into a vein in the upper arm that is threaded into a larger vein leading to the heart, used to administer medications). The bag of solution was empty, but the tubing still had solution in it. The medication was ordered to run for a total of 1 hour, then flushed with normal saline. Review of Resident #101's Physician Orders for current date of 4/15/25 revealed: Daptomycin-Sodium Chloride IV solution 700-0.9mg/100ml once a day at 9:00 AM, to be administered over 1 hour, and Tramadol 50mg upon rising. In an interview on 04/15/25 at 1:45 PM, RN JJ reported that this was her first time with this type of IV and she could not explain how long it was supposed to run or how the system works. Additionally, RN JJ reported that she had administered Tramadol late to Resident #101 at approximately 12:00 PM after retrieving it from the back up supply. RN JJ could not verify this and then reported that she had not gotten an order for the late medication, so she was not able to document it as administered. (continued on next page)

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	04/16/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/15/25 at 02:10 PM, Director of Nursing (DON) B reported that IV antibiotics should be flushed as soon as possible after the medication finishes running so that it doesn't irritate the vein. In addition to that DON B reported that if Tramadol was not available in the resident's supply of medications, the nurse could have gotten an order to pull it from the backup box. Observation of the medication back up boxes did not reveal any orders for Tramadol, or any indication that RN JJ had pulled any medications for Resident #101. DON B approached RN JJ to ask about the Tramadol for Resident #101, and could not get a clear answer from RN JJ. DON B asked for a moment to talk to Nursing Home Administrator (NHA) A and to figure out what happened. A few moments later, DON B reported that RN JJ apparently took Tramadol from another resident's (Resident #207) medication supply, and administered it to Resident #101. DON B reported that this would be reported to the state agency and an investigation would be started. This surveyor requested to inspect medication carts and review controlled substance inventory sheets for the entire facility. In an interview on 04/15/25 at 03:03 PM, RN JJ reported that she had not documented any of the controlled substances that she had administered that day on the corresponding controlled substance inventory sheets; she had written them all down on a piece of paper and was going to do it before she left that day. In an interview on 04/16/25 at 09:43 AM, DON B reported that he had investigated and determined that RN JJ had made multiple errors in documentation of controlled substance administration, and did not follow professional standards and/or facility policy related to controlled substance administration and documentation for several residents. DON B reported at that time he had also determined that RN JJ had used Tramadol 50 mg from Resident #207, and administered it to Resident #101, and had not documented it as administered to Resident #101. DON B continued to explain what he had concluded; RN JJ pulled Tramadol 50 mg from the back up supply and attempted to put it back into Resident #207's medication card, RN JJ had pulled Tramadol 100 mg from Resident #102 and administered it to a resident with orders for Tramadol 50 mg. DON B concluded that there were actual medication errors in addition to not following professional standards and facility policy. DON B reiterated that attempts were being made to verify what actually happened but it was inconsistent and not clear at that time. This surveyor requested to further review Resident #207's Tramadol inventory. During inspection and review of Resident #207's Controlled Substance Inventory on 04/16/25 at 10:00 AM along with DON B revealed that RN JJ had signed out ONE Tramadol 50mg tablet, but the resident's MAR indicated that RN JJ had administered THREE separate doses of Tramadol 50 mg to Resident #207 that day. Review of RN JJ's employee file revealed a hire date of 3/13/24 and a completed orientation checklist of job responsibilities. The file did not include any competency evaluations after orientation. In an email on 04/16/25 at 10:37 AM, Nursing Home Administrator (NHA) A reported that RN JJ did not have an annual competency evaluation on record. In an interview on 04/16/25 at 12:30 PM, Staff Development/Educator (SD-E) LL reported that he, along with DON B had been working to start the licensed nurse annual competency evaluations, but had not gotten to them yet. Then in a subsequent interview with SD-E LL on 4/16/25 at 1:00 PM, reported that the facility policy did not complete licensed nurse competency evaluations, only certified nursing assistant evaluations. SD-E LL could not answer how the facility ensured that licensed nursing staff remained competent to provide resident care. (continued on next page)

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	04/16/2025

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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy Medication Administration dated 10/17/2023 revealed, .4. Follow safe preparation practices. a. Prepare medications immediately prior to administration. b. Never administer medications supplied for one resident to another resident .6. Administer medications within 60 minutes of the scheduled time. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility. For example, if the medication is ordered for 8:00 a.m., it must be given between 7:00 a.m. and 9:00 a.m. in order to be considered timely . Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, .After administering a medication, immediately document which medication was given on a patient's MAR per agency policy to verify that it was given as ordered. Inaccurate documentation, such as failing to document giving a medication or documenting an incorrect dose, leads to errors in subsequent decisions about patient care. For example, errors in documentation about insulin often result in negative patient outcomes .Never document that you have given a medication until you have actually given it. Document the name of the medication, the dose, the time of administration, and the route on the MAR . [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 609-610). Elsevier Health Sciences. Kindle Edition. Review of the Fundamentals of Nursing revealed, Maintain a running count of narcotics by counting them whenever dispensing them. If you find a discrepancy, correct and report it immediately. Use a special inventory record each time a narcotic is dispensed. Records are often kept electronically and provide an accurate ongoing count of narcotics used, wasted, and remaining. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 38278-38281). Elsevier Health Sciences. Kindle Edition.

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	04/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 Based on interview and record review, the facility failed to maintain clear and concise controlled substance count and failed to accurately document administration of controlled substances impacting 9 residents (Resident #101, #207, #102, #36, #206, #86, #62, #43, #18) in 2 of 6 medication carts reviewed, resulting in the potential for overdose and/or ineffective management of pain, and the potential for drug diversion of controlled substances. Findings include: In an interview on 04/15/25 at 10:12 AM, Registered Nurse (RN) JJ reported that Resident #101 had not received her Tramadol (controlled medication for pain) with her other morning medications because it was not in the medication cart, and she would have to go pull it from back up. RN JJ reported that she had signed out the Tramadol as not available in the resident's chart. Review of Resident #101's Physician Orders for current date of 4/15/25 revealed: Tramadol (narcotic pain medication) 50 mg upon rising. Review of Resident #101's Medication Administration Record (MAR) for 4/15/25 indicated that Tramadol 50 mg was documented as 5 (not given, see nurse notes) at 9:53 AM and there was no follow up explanation recorded. During an observation on 04/15/25 at 01:30 PM Resident #101 was lying in bed and reported that she was not sure if she had gotten her Tramadol yet. In an interview on 04/15/25 at 1:45 PM, RN JJ reported that she had administered Tramadol to Resident #101 at approximately 12:00 PM, after retrieving it from the backup supply. RN JJ could not verify with the MAR and then reported that she had not gotten an order for the late medication, so she was not able to document it as administered. In an interview on 04/15/25 at 02:01 PM, Infection Preventionist-Unit Manager (IP-UM) KK reported that UPON RISING is defined as when the resident wakes up, or between 4 AM and 10 AM for medication administration. IP-UM KK reported that she had not been notified that Resident #101 had medications that were not available, and/or that she had any missed medications for that day. IP-UM KK reported that any time a medication is late, the physician should be notified and a progress note should be written in the record. IP-UM KK reported that medications should be documented on the MAR immediately following the resident receiving the medication. (continued on next page)

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	04/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/15/25 at 02:10 PM, Director of Nursing (DON) B reported that if Tramadol was not available in the resident's supply of medications, the nurse could have gotten an order to pull it from the backup box. Observation of the medication back up boxes did not reveal any orders for Tramadol, or any indication that RN JJ had pulled any medications for Resident #101. DON B approached RN JJ to ask about the Tramadol for Resident #101, and could not get a clear answer from RN JJ. DON B asked for a moment to talk to Nursing Home Administrator (NHA) A and to figure out what happened. A few moments later, DON B reported that RN JJ apparently took Tramadol from another resident's (Resident #207) medication supply, and administered it to Resident #101. DON B reported that this would be reported to the state agency and an investigation would be started. This surveyor requested to inspect medication carts and review controlled substance inventory sheets for the entire facility. In an interview on 04/15/25 at 03:03 PM, RN JJ reported that she had not document any of the controlled substances that she had administered that day on the corresponding controlled substance inventory sheets; she had written them all down on a piece of paper and was going to do it before she left for the day. During an observation on 04/15/25 at 3:03 PM on 100 hall of RN JJ's medication cart/narcotic box to verify controlled substance medication counts, revealed the following discrepancies: 1. Resident # 207: Tramadol 50 mg 7 pills in card, and the corresponding controlled substance sheet indicated 9 pills left in the card. Two pills were unaccounted for. 2. Resident # 102: Tramadol 100 mg had 27 pills in the card and 28 indicated on the sheet. One pill was unaccounted for. 3. Resident # 206: Clonazepam (antianxiety controlled medication) had 26 pills in the card and 27 indicated on the sheet. One pill was unaccounted for. 4. Resident # 86: Oxycodone (controlled pain medication) 5 mg had 11 pills in the card and 13 indicated on the sheet. Two pills were unaccounted for. 5. Resident # 36: Morphine 30 mg ER had 25 pills in the card and 26 indicated on the sheet. In addition for Resident #36: Hydrocodone/Acetaminophen (controlled medication for pain) 5-325 mg had 19 pills in the card and 20 pills indicated on the sheet. Two pills were unaccounted for. 6. Resident # 62: Hydromorphone (controlled pain medication) 8 mg had 14 pills in the card and 16 indicated on the sheet. Two pills were unaccounted for. During an observation on 04/15/25 at 3:23 PM on 200 hall, of Licensed Practical Nurse (LPN) J's medication cart/narcotic box to verify controlled substance medication counts, revealed the following discrepancies: 1. Resident # 43: Oxycodone 10 mg had 23 pills in the card and 22 pills indicated on the sheet. LPN J reported that she had signed out the medication, but then the resident refused it. Subsequent review of Resident #43's MAR indicated that he received the medication and that LPN J documented that it was effective. LPN J's explanation and the documentation on the controlled substance log were conflicting. (continued on next page)

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	04/16/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #18: Tramadol 50 mg had 5 pills in the card and 4 pills indicated on the sheet, and Lorazepam (controlled medication for antianxiety) 1 mg had 29 pills in card and 30 pills indicated on the sheet. LPN J's explanation was that she may have accidentally given the medication to a different resident with the same order. In an interview on 04/16/25 at 09:43 AM, DON B reported that he had investigated and determined that RN JJ and LPN J had made multiple errors in their documentation of controlled substance administration, and did not follow professional standards and/or facility policy related to controlled substance administration and documentation for several residents. DON B reported at that time he had also determined that RN JJ had used Tramadol 50 mg from Resident #207, and administered it to Resident #101, but had not documented it as administered to Resident #101. DON B continued to explain what he had concluded; RN JJ pulled Tramadol 50 mg from the back up supply and attempted to put it back into Resident #207's medication card, RN JJ had pulled Tramadol 100 mg from Resident #102 and administered it to a resident with orders for Tramadol 50 mg. DON B concluded that there were actual medication errors in addition to not following professional standards and facility policy. DON B reiterated that attempts were being made to verify what actually happened but it was inconsistent and not clear at that time. This surveyor requested to further review Resident #207's Tramadol inventory. During inspection and review of Resident #207's Controlled Substance Inventory on 04/16/25 at 10:00 AM along with DON B revealed a sheet for Tramadol 50mg tablets (the same one from the day before) that there were 5 pills remaining in the card. The Tramadol card also contained 5 pills. The sheet indicated that Resident #207 had received a total of FOUR Tramadol 50 mg pills on 4/15/25, but the resident's MAR indicated that she had received a total of SIX Tramadol 50 mg pills on 4/15/25. There was only one entry on the sheet from RN JJ on 4/15/25 at 1:00 PM, but the MAR indicated that RN JJ had administered Tramadol on 4/15/25 at 10:59 AM, 12:32 PM and 4:56 PM. DON B reported that his understanding was that RN JJ documented a couple of the Tramadol doses on other resident's inventory sheets. Review of the Fundamentals of Nursing revealed, Maintain a running count of narcotics by counting them whenever dispensing them. If you find a discrepancy, correct and report it immediately. Use a special inventory record each time a narcotic is dispensed. Records are often kept electronically and provide an accurate ongoing count of narcotics used, wasted, and remaining. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 38278-38281). Elsevier Health Sciences. Kindle Edition. Review of Fundamentals of Nursing ([NAME] and [NAME]) 10th edition revealed, After administering a medication, immediately document which medication was given on a patient's MAR per agency policy to verify that it was given as ordered .Never document that you have given a medication until you have actually given it. Document the name of the medication, the dose, the time of administration, and the route on the MAR. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME] A.; Hall, [NAME]. Fundamentals of Nursing - E-Book (p. 609-610). Elsevier Health Sciences. Kindle Edition.

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	04/16/2025

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 48637 Based on interview and record review, the facility failed to employ a staff with appropriate credentials to supervise and manage the dietary department resulting in the potential for food service sanitation failures, food borne illness and for clinical areas of dietary needs of all residents being compromised and unmet. Findings include: During a tour of the kitchen on 4/15/2025 at 11:56 AM, Dietary Manager (DM) MM stated that he wasn't a Certified Dietary Manager (CDM) and wasn't taking classes to become certified. He said he had experience working in long term care but doesn't have the national certification for a food service manager or associates degree or higher in food service management. DM MM said he was only ServSafe certified right now. DM MM stated that the facility does not have a full-time Registered Dietitian (RD) but a RD was available by phone when questions arise. DM MM said he had only seen a RD a few times in the last 2 years he worked at the facility. Review of DM MM's ServSafe credentials revealed he completed the ServSafe Food Handler online course on 7/10/2023 and did not complete a course of study in management. During an interview on 4/15/2025 at 1:01 PM, Corporate RD EE acknowledged stated that DM MM wasn't a CDM. She said that she tries to get to the facility 1-2 times a year and that there are 2 other RDs that assist remotely with charting and clinical documentation but they are full time RDs in other buildings and are stretched thin. RD EE stated that they are having trouble finding a RD to cover the building and can't find an agency RD. She stated that DM EE attends the clinical meetings even though he wasn't a certified dietary manager and consults the RDs if he had questions.

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	04/16/2025

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 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. 48637 Based on observation, interview and record review, the facility failed to ensure proper label and dating of foods in the kitchen resulting in the potential to spread food borne illness to all residents that consume food from the kitchen. Findings include: During the initial tour of the kitchen and nourishment areas on 4/14/2025 at 9:39 AM, the following was observed: The food pantry by the kitchen which contains resident food items contained the following: A small plastic container of chicken salad, open with a date of 4/7/2025 and no use by date. A small plastic container of deviled eggs, open with a date of 4/7/2025 and no use by date. A galloon of 2% milk, open with no label and date. During a full kitchen tour on 4/15/2025 at 10:23 AM, the following was observed in the walk-in refrigerator: Cheddar cheese slices in plastic gallon bag with a use by date of 4/7/2025. Sausage in a metal pan partially covered with aluminum foil. According to the 2022 FDA Food Code section 3-501.17 Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking. (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TOEAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (B) Except as specified in (E) -(G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety . Review of the Food Purchasing and Storage Policy with a revision date of 12/10/2024 revealed 5. Perishable Food Storage: . All food items in refrigerators will be properly dated, labeled, and placed in containers with lids, will be wrapped, or stored in sealed food storage bags.

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	04/16/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38384 Based on observation, interview, and record review, the facility failed to: 1.) ensure adequate hand hygiene with Enhanced Barrier Precautions for 1 (R54) of 12 residents reviewed, 2.) ensure proper transportation of clean linen, 3.) maintain cleanliness of resident-shared equipment, and 4.) maintain an effective water management program to prevent Legionella, resulting in the potential for harborage and cross-contamination of infectious pathogens to a vulnerable population. Findings include: According to R54's Minimum Data Set (MDS) dated [DATE], the resident was cognitively intact with a score of 15/15 on the BIMS (Brief Interview Mental Status). Review of R54's Skin and Wound Evaluation dated 4/2/25, indicated the resident had a stage 2 pressure wound to her sacrum. During an observation and interview on 4/14/25 at 9:58 AM, Resident #54's room had Enhanced Barrier Precautions (EBP) signage on the door with a 3-drawer isolation cart outside of room. On the top of the cart was a bottle of hand sanitizer. Activities Aide (AA) N entered R54's room, went to the roommate, picked up a water cup, shook it, set it down, and walked out of the room. AA N did not perform hand hygiene going in or out of room and was wearing artificial nails that extended 1/4 inch beyond fingertips. AA N reported she did not know there was an EBP sign posted on R54's door, what the signage was for, or which resident in the room was on EBP or why. During an observation and interview on 4/14/25 at 10:01 AM, Certified Nursing Assistant (CNA) S, was carrying clean towels and wash cloths under her left upper arm, touching both her shirt and exposed skin. CNA S entered R54's room without performing hand hygiene, went to the resident's bed area, left a towel and wash cloth on the resident's dresser and exited the room without performing hand hygiene. CNA S was wearing artificial nails that extended 1/4 inch past the fingertips. CNA S reported she thought R54 and roommate had to be retested because there was some kind of virus going around. On 4/14/25 at 10:10 AM, AA N reported she had gone to another staff and inquired what the EBP signage meant, stating The signage on the door means that only the aides and nurses that are doing direct patient care need to gown up and put gloves on. I do not do direct care, so I do not need to gown up. When asked about performing hand hygiene entering and exiting R54's, and after touching R54's roommate's water cup, AA N did not have a response. According to https://www.cdc.gov/, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms .The CDC (Centers for Disease Control) recommends hand hygiene as a crucial component of Enhanced Barrier Precautions (EBP), a targeted approach to preventing the spread of multidrug-resistant organisms (MDROs) in nursing homes .Never carry soiled linen against the body. Resident-Shared Equipment (continued on next page)

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	04/16/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observed on 4/14/25 at 12:30 PM, the alcove on 200 hall, four resident-shared mechanical lifts, one straight chair, bed pan, blanket riser, air purifier, and a clean linen cart. Mechanical life #4 had dirt, dust, and various colored debris on the foot stand. The black plastic knee rest has splatters of a light-colored dried substance. A container of Clorox Bleach Germicidal Wipes was in a clear plastic bag attached to the mechanical lift. Observed on 4/14/25 at 12:47 PM, Mechanical Lift #10 had a dried, brown-colored substance on the hydraulic and base. On the left leg of the lift was exposed glue covered with dirt and debris. On the left leg was a rubber cover. During an interview on 4/16/25 at 9:46 AM, Infection Preventionist (IP) KK stated, Resident-shared equipment including mechanical lifts are to be cleaned after each use to prevent cross-contamination of infection. All staff regardless of what they do here at the facility, should be aware of Precaution signs on resident doors. All staff when entering and exiting rooms should perform hand hygiene especially since we have an outbreak of Covid and have a few residents that have recently had loose stools and Norovirus. Towels and linens should not be carried next to the staff's body, it should not be carried that way because of infection control reasons. Legionella During an interview on 4/16/25 at 11:55 AM, Maintenance Director, I stated, I have been here at the facility for 6-weeks and I do not know where any of the logs are about running water for Legionella's disease. I do not know anything about taking water samples for the free chlorine testing or do I know where the facility's process is for Legionella's. I know (Maintenance Assistant)C) says he runs water in the nine off-line rooms but there are no logs for that. Review of facility policy Legionnaire's Disease revised 2/1/2024, revealed, 'The facility will utilize sound engineering and housekeeping practices to minimize growth of and exposure to the Legionella bacteria and other water-borne pathogens. Legionellosis is a respiratory disease caused by Legionella bacteria .To minimize the potential for growth of and exposure to the legionella bacteria, facilities will adhere to the following standards: Utilize an approved contractor to perform water chemistry sampling for whirlpools/tubs and cooling towers according to manufacturer recommendation .CLEANING FREQUENCIES AND PROCEDURES: Remove shower heads and sink aerators in all bathing areas and resident rooms every other month and replace with spare devices or cleaned and disinfected devices. For cleaning fully submerse and soak removed items in a solution of an EPA registered product for Legionella pneumophila for the appropriate contact time per manufacturer's instructions. Repeat process every other month and document in TELs (communication service for work orders). In accordance with manufacturer's operations and maintenance protocols, periodically discharge or blow down water from boilers, hot water heaters, heat exchangers, and other domestic water tanks. This will facilitate the removal of suspended solids and sludge which may harbor the legionella bacteria .Domestic water boilers, heat exchangers, and tanks will be inspected and cleaned annually by a qualified technician in accordance with manufacturer's recommendations .MINIMIZING STAGNATION IN THE DOMESTIC WATER SYSTEM: Remove dead legs in the system whenever possible by removing piping to abandoned .showers and other fixtures .For resident rooms with beds off-line .flush toilets and run faucets and shower heads for a minimum of 3 minutes monthly . (continued on next page)

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	04/16/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Chlorine Residual Testing Fact Sheet, CDC SWS Project, Chlorine Residual Testing, .the presence of chlorine residual in drinking water indicates that: 1) a sufficient amount of chlorine was added initially to the water to inactivate the bacteria and some viruses that cause diarrheal disease; and, 2) the water is protected from recontamination during storage. The presence of free residual chlorine in drinking water is correlated with the absence of disease-causing organisms, and thus is a measure of the potability of water.

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	04/16/2025

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. 41027 Based on interview and record review, the facility failed to ensure residents who were eligible for recommended vaccines were offered vaccinations in a timely manner for 2 residents (Resident #101& #206) out of 5 residents reviewed for immunizations resulting in lack of documentation and the potential for developing vaccine preventable disease. Findings include: Resident #101 Review of Resident #101's Immunizations revealed, no record of Influenza or Pneumococcal historical records, education, and or consents offered. In an interview on 04/16/25 at 01:45 PM, Infection Preventionist (IP) KK reported that she had not gotten to Resident #101. IP KK reported that immunizations should have been discussed upon admission on 3/20/25, but there was no record of it. Resident #206 Review of Resident #206's Immunizations revealed, that the resident received 2 doses of pneumococcal historically as follows: PPSV23 on 06/17/2019, and Prevnar 13 on 11/03/2016. There was no record of Influenza, and no record of education and/or consents offered. In an interview on 04/16/25 at 01:45 PM, Infection Preventionist (IP) KK reported that she had not gotten to Resident #206. IP KK reported that immunizations should have been discussed upon admission on 3/26/25, but there was no record of it.

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	04/16/2025

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 41027 Based on interview and record review, the facility failed to ensure COVID-19 immunization were offered to 2 (Resident #101 & #206) of 5 residents, reviewed for COVID-19 immunizations, resulting in lack of documentation and the increased likelihood of severe infection and complications/death related to COVID-19. Findings include: Resident #101 Review of Resident #101's Immunizations revealed, no record of Covid-19 vaccine received, education provided, and/or consents on record. In an interview on 04/16/25 at 01:45 PM, Infection Preventionist (IP) KK reported that she had not gotten to Resident #101. IP KK reported that immunizations should have been discussed upon admission on 3/20/25, but there was no record of it. Resident #206 Review of Resident #206's Immunizations revealed, that the resident received 4 doses of Covid-19 vaccination historically prior to admission. The record did not include any documentation related to further Covid-19 booster education, declinations, or consents. In an interview on 04/16/25 at 01:45 PM, Infection Preventionist (IP) KK reported that she had not gotten to Resident #206. IP KK reported that immunizations should have been discussed upon admission on 3/26/25, but there was no record of it.