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SCHNEPP SENIOR CARE AND REHAB CENTER	427 E WASHINGTON SAINT LOUIS, MI 48880

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F0000 SS=	INITIAL COMMENTS Schnepp Senior Care And Rehab Center was surveyed for a Recertification survey on 6/5/2025. Intakes: MI00149260, MI00152195, MI00153088, MI00153208 Census: 92	F0000		
F0550 SS= E	Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and	F0550		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide personal care in a dignified manner for one Resident (R46) and failed to provide timely personal care and assistance for eight Residents (R40, R29, R55, R191, R32, R38, R13, & R43) of nine residents reviewed for dignity. R46 Review of an "Admission Record" revealed R46 admitted to the facility on 9/26/2024 with pertinent diagnoses which included Parkinson's disease (a disorder of the central nervous system that affects movement) and heart failure. Review of a "Minimum Data Set" (MDS) (a tool used for assessing a resident's care needs) assessment for R46, with a reference date of 4/9/2025 revealed a "Brief Interview for Mental Status" (BIMS) (a scale used to determine a resident's cognitive status) score of 14, out of a total possible score of 15, which indicated R46 was cognitively intact. Further review of same MDS assessment revealed R46 required substantial assistance from staff with toileting and hygiene. In an interview on 6/3/2025 at 11:10 AM, R46 reported a female staff was rough and hurried when caring for him. R46 reported he felt like he was thrown around in bed during care. R46 reported he thought the staff member was rough because she was hurried and not because she was			

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	trying to hurt him. In an interview on 6/5/2025 at 8:54 AM, R46 reported he experienced rough care about once a week. Review of R46's "Assistance Form", dated 6/3/2025, revealed R46 complained that a second shift nurse was rough when she changed him, pushing and shoving. In an interview on 6/5/2025 at 10:03 AM, the Director of Nursing (DON) reporting she was still investigating R46's concern form regarding rough care and trying to identify which staff was responsible. In an interview on 6/5/2025 at 11:11 AM, R46 stated receiving hurried and rough care made him feel "like I don't matter." Review of the Resident Council Minutes dated 1/21/25 reflected "Old Business- Review of Previous Meeting, Outstanding issues and Resident Council Departmental Response Forms". Handwritten in the section of the Resident Council Minutes reflected "Call lights can be long at times but residents state it is usually at busy times". Review of the Resident Council Minutes dated 3/5/25 reflected a complaint of having to wait "a long time for help". Review of the Resident Council Minutes dated 4/1/25 reflected the "Old Business" review from 3/5/25 that the "waiting for help" was "going better". However, "New Business" revealed a complaint of the call light being placed in inaccessible location and "Call lights can be (on) long at times" and included "but they know staff is busy".			

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	Review of the Resident Council Minutes dated 5/6/25 reflected that the "Old Business" from the 4/1/25 meeting of the inaccessible call light had not been resolved and that "Call lights can still be an issue". The "New Business" section revealed "some staff state they will be right back when answering call lights and then don't come back". Review of the Resident Council Minutes dated 6/3/25 reflected the "Old Business" of "Call lights being turned off and staff not returning" was "much better". However, the Resident Council "New Business" minutes documentation continued with complaints that "call lights can be long at times", that "staff ...forget that she is here", and that the afternoon shift " ... call lights are longer". The policy provided by the facility titled "Call light Policy" last revised 5/1/2017 was reviewed. The policy reflected "Procedure ... 3. Call lights will remain on until staff is available to meet the resident needs/request". During an interview and record review conducted 6/4/25 at 3:13 PM, the Director of Nursing (DON) reported the facility had been made aware of the resident's call light concern. The DON reported that on 5/13/25 staff training was initiated to address this concern. The DON provided documentation with staff signatures that education had been provided to "leave the (call) lights on as a reminder to return". R40 Review of the medical record reflected R40 admitted to the facility 2/5/25, was cognitively intact, and was his own responsible party. Review of the Minimum Data Set (MDS) dated 5/1/25 reflected R40 required staff assistance with toileting and transfers.			

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	During an interview conducted 6/3/25 at 1:44 PM, R40 reported he had a concern with call lights and the call light system. R40 explained how the call light worked by him initiating the light and staff were notified by a pager and it also appeared on the wall (wall mounted monitor). R40 reported "a couple of weeks ago" he "waited 28 minutes to get water". R40 reported he had timed the wait on his clock. R40 also reported staff would turn of the light often without meeting his need indicating they would return but do not. R40 reported if the light was turned off and then he turned it back on it puts him at the end of the list because staff go to the light that has been on the longest and they don't know that someone had responded and turned off his light. R40 reported he had complained to the nurse manager who put on a sheet in his closet that staff were not to turn off the light until the need was met. R40 reported he has had to show that sheet to staff several times. R40 strongly conveyed frustration stating that " ... it still happens often enough". Review of the inside closet door of R40 reflected a document titled "(R40)'s Schedule and Preferences". The document reflected bullet points of topics that included showers and shoes. Near the bottom of the document in bold type read "Leave my call light on until my needs are met". R29 Review of the medical record reflected R29 originally admitted to the facility 3/30/23, was cognitively intact and was his own responsible party. Review of the Care Plan for R29 reflected the Resident was at risk for falls and required two staff member and a lift for transfers.			

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	In an interview on 6/3/25 at 11:30 AM, R29 was sitting in a Geri Chair and reported long call light waits several times a week. R29 reported often after eating he needed to have a bowel movement but must wait as long as an hour. R29 reported that staff would respond but turned off the call light, leave, then "forget to come back". R29 reported he had a history of hemorrhoid surgery and that it "hurt" to "hold on to the (stool)". R29 reported he had talked with a nursing manager about this but indicated the issue had continued. When asked how this made him feel R29 looked away and shook his head. R29 then reported "they just need more people" (staff). R55 Review of the medical record reflected R55 originally admitted to the facility 1/14/23 and was listed as a responsible party. Review of the MDS dated 3/26/25 reflected a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated mild cognitive impairment. Review of the Care Plan for R55 reflected the Resident required the use of a mechanical lift for transfers. In an interview conducted 6/3/25 at 11:42 AM, R55 reported delayed call light response was not associated with a certain time of the day. R55 reported staff had responded but turned off the light and indicated they would return later. R55 reported that this happened "at least once a day". When asked how this made him feel R55 was initially quiet then stated, "I try to not get wrapped up in my feelings". R191 Review of the medical record reflected R191 admitted to the facility 5/24/25 and was her own responsible party.			

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	Review of the Care Plan for R191 reflected the Resident was at risk for falls and required staff assistance with transfers. In an interview on 6/5/25 at 9:21 AM, R191 reported she had recently admitted to the facility. R191 reported she has had to "wait awhile" for a response to her call light. R191 reported that staff "frequently" would respond, turn off the light and tell her they would be back. R191 reported that this had happened "a couple of times" in the previous two days. R32 Review of the medical record reflected R32 admitted to the facility 2/1/21. Review of the MDS dated 4/2/25 reflected the Resident had a BIMS score of 12 which indicated mild cognitive impairment. Review of the Care Plan for R32 reflected the Resident was at risk for falls and required staff assistance with toileting and transfers. During an interview on 6/5/25 at 9:30 AM, R32 stated when she initiated a call light, she knew she "must be patient and wait your turn". R32 reported that staff would come to the room, turn off the light and state they would be back. R32 reported "you may have to call again ...". R38 Review of the medical record reflected R38 admitted to the facility 11/26/24 and was her own responsible party. During an interview on 6/5/25 at 9:34 AM, R38 reported sometimes the person responding to her call light was not regular care staff. R38 reported this person would turn off the light and say they would send someone in.			

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	R13 Review of the medical record reflected R13 originally admitted to the facility 3/12/21 and was her own responsible party. Review of the MDS dated 5/13/25 reflected a BIMS score of 15 which indicated the Resident is cognitively intact. During an interview conducted 6/5/25 at 9:45 AM, R13 reported she was the Resident Council Vice President. R13 reported that the call light issue comes up often at Resident Council and, despite ongoing complaints, the concern " ... is staying the same". R43 Review of the MDS dated 3/26/25 reflected R43 admitted to the facility 4/16/24 and had a BIMS score of 15 which indicated the Resident was cognitively intact. This MDS reflected R43 required supervision with toileting and transfers. During an interview on 6/5/25 at 9:51 AM, R43 reported that she needed help getting out of bed to go to the bathroom. R43 indicated she got anxious when the response to her request for assistance was delayed because "I don't want to wet myself, I'm wearing slacks". R43 acknowledged that she did wear a brief but preferred to use the bathroom. During an interview on 6/5/25 at 10:28 AM, Certified Nurse Aide (CNA) "R" reported that if a second staff member was needed to assist a resident, she would turn off the call light and return when the second staff member was available.			
F0580	Notify of Changes (Injury/Decline/Room, etc.)	F0580		

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SS= D	§483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its			

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	different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00153208 Based on observation, interview, and record review, the facility failed to notify the responsible party of an event that may have mental or psychological disturbance for two Residents (R36 and R293) of two Residents reviewed for abuse. Findings included: Review of the facility policy, "Change of Condition - Resident Family/Responsible Party Notification" dated 4/12/16 revealed, "Purpose: To notify family and/or responsible party any time there is a: 3. Change in mental, psychosocial or behavioral management." Review of the facility "Abuse Policy" dated, 3/15/2023 revealed, "viii) Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault and includes non-consensual sexual contact of any type with a resident." D) The Administrator and/or Director of Nursing ("DON") must me notified of all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown origin and misappropriation of resident property immediately. If the events that cause the allegation involve abuse or result in serious bodily injury, the facility administrator or DON with report to appropriate licensing agencies and local officials immediately but not later than 2 hours and not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and did not result in serious bodily injury. e) INVESTIGATION i) Time Frame for Investigation. (1) The investigation shall be			

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	initiated immediately, after the Administrator has knowledge of the incident, but in no event shall the investigation take longer than five (5) working days. " R36 Review of R36's "Admission Record "dated 6/3/2025 revealed she was 84 years old and admitted on 2/23/22. Her diagnoses included: Dementia, heart failure, depression, and anxiety disorder. She was not her own responsible party. Review of R36's "Behavior note" dated 5/18/25 at 4:33 PM revealed, "Activity aid observed a male resident grab (R36) to back of head and kiss her. The nurse asked R36 about the incident and she is unable to recall incident. No S/S (signs or symptoms) of distress noted, Registered Nurse (RN) "A "notified. " (no indication that R36's responsible party was notified of this event). R36 and R293 were both observed in the activity room on 6/3/25 at 9:41 AM. There were a total of 12 residents in the room and all residents were very close to each other. One staff member was in the room most of the time. For a few minutes at a time staff would leave the room and all 12 residents were left unsupervised. On 6/3/25 at 9:54 AM, a Certified Nurse Aide (CNA) was in the activity room supervising 12 residents as the activity aid left the room for a break. CNA "P" said the only resident that needs close supervision was R293 because he gets "Handsy" (someone who is prone to touch other people, often in an inappropriate or unwanted way). Within a minute of this interview R293 was observed reaching out to a female resident. CNA "P" went over to R293 and said we need to keep our hands to ourselves and R293 pulled his hand back.			

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	During an interview with RN "A" on 6/5/25 at 10:10 AM, RN "A" confirmed that Licensed Practical Nurse (LPN) "J" notified her on 5/18/25 about R293 kissing R36. RN "A" confirmed that she notified the Director of Nursing (DON) and Nursing Home Administrator (NHA) that R293 kissed R36. RN "A" reviewed all text messages, and no one was instructed to notify R36's or R293's responsible parties of the event. During an interview with LPN "J" on 6/5/25 at 10:10 AM, LPN "J" reviewed her text messages and confirmed that she notified RN "A" about the report of R293 kissing R36 on 5/18/25. LPN "J" texted RN "A" twice about notifying R36's responsible party and she was instructed not to notify them by RN "A". During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 6/5/25 at 12:20 PM, the DON and NHA confirmed they received a text message from RN "A" on 5/18/25 at 12:08 PM that informed them R293 kissed R36. They said they did not notify the responsible parties or instruct anyone to notify the responsible parties. They were not able to locate any documentation the R36's or R293's responsible parties were notified of the event. During an interview with Activity Aide (AA) "Q" on 6/4/25 at 11:55 AM, AA "Q" recalled working on 5/18/25 and being in the activity room with several residents when R293 kissed R36. She recalled a resident yelled "hey" and when she turned to see what was going on R293 was sitting in front of R36. R293 had R36's head in his lap (R36 was sitting in a chair and R293 was in a wheelchair). R293 kissed R36 on the lips. "It was a romantic kiss like a Hallmark Movie". After the kiss R36 looked wide eyed and dazed. AA "Q" said she walked over to them and pulled R293 away from R36 and that was the end of it. AA			

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	"Q" could not recall the time of day or anyone else working at the time. She said she could not report it immediately as she was in the room by herself. She said when it was safe she reported it to the nurse in charge. She was not sure who the nurse in charge was but believed it might have been LPN "J". R293 Review of R293's "Admission Record " dated 6/5/25 revealed he was 83 years old and was admitted on 5/14/25. His diagnoses included: Alzheimer's disease, dementia, and alcoholic cirrhosis of the liver. He was not his own responsible party. Review of R293's "Behavior note" dated 5/18/25 at 1:30 PM revealed, "(11:30) Activity Aid (sic) observed R293 grab a hold of another resident's head and pull her into his face and kiss other resident. Activity asked him to stop and R293 did not let go. As Activity aid approached R293. He released her. This nurse was informed of. Specific behavior: above asked R293 what happened states. "I wanna kiss" Educated R293 not to touch others. Removed from dining room. Later on, this afternoon did not recall incident. Continues to make sexual comments to staff and other residents. Attempting to grab other residents and staff as they are passing by him. Making sexual gestures." (no indication that R293's responsible party was notified of this event)			
F0609 SS= D	Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are	F0609		

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	reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c) (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00153208 Based on observations, interviews, and record review, the facility failed to report to the State Agency an allegation of abuse for two resident (R36 and R293) of two residents reviewed for abuse. Findings included: Review of the facility "Abuse Policy" dated, 3/15/2023 revealed, "viii) Sexual abuse includes, but is not limited to, sexual harassment, sexual coercion or sexual assault and includes non-consensual sexual contact of any type with a resident." D) The Administrator and/or Director of Nursing ("DON") must me notified of all			

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	alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown origin and misappropriation of resident property immediately. If the events that cause the allegation involve abuse or result in serious bodily injury, the facility administrator or DON with report to appropriate licensing agencies and local officials immediately but not later than 2 hours and not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and did not result in serious bodily injury. e) INVESTIGATION i) Time Frame for Investigation. (1) The investigation shall be initiated immediately, after the Administrator has knowledge of the incident, but in no event shall the investigation take longer than five (5) working days. " R36 Review of R36's "Admission Record "dated 6/3/2025 revealed she was 84 years old and admitted on 2/23/22. Her diagnoses included: Dementia, heart failure, depression, and anxiety disorder. She was not her own responsible party. Review of R36's "Behavior note" dated 5/18/25 at 4:33 PM revealed, "Activity aid observed a male resident grab (R36) to back of head and kiss her. The nurse asked R36 about the incident and she is unable to recall incident. No S/S (signs or symptoms) of distress noted, Registered Nurse (RN) "A "notified. " R36 and R293 were both observed in the activity room on 6/3/25 at 9:41 AM. There were a total of 12 residents in the room and all residents were very close to each other. One staff member was in the room most of the time. For a few minutes at a time staff would leave the room and all 12 residents were left unsupervised.			

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	On 6/3/25 at 9:54 AM, Certified Nurse Aide (CNA) was in the activity room supervising 12 residents as the activity aid left the room for a break. CNA "P" said the only resident that needs close supervision was R293 because he gets "Handsy" (someone who is prone to touch other people, often in an inappropriate or unwanted way). Within a minute of this interview R293 was observed reaching out to a female resident. CNA "P" went over to R293 and said we need to keep our hands to ourselves and R293 pulled his hand back. During an interview with RN "A" on 6/5/25 at 10:10 AM, RN "A" confirmed that Licensed Practical Nurse (LPN) "J" notified her on 5/18/25 about R293 kissing R36. RN "A" confirmed that she notified the Director of Nursing (DON) and Nursing Home Administrator (NHA) that R293 kissed R36. RN "A" reviewed all text messages, and no one was instructed to report this allegation of abuse to the State Agency. RN "A" was not able to recall any particulars about the event. RN "A" did not report this allegation to the State Agency she just checked on R36 and she had no recall of the event or injury. During an interview with LPN "J" on 6/5/25 at 10:10 AM, LPN "J" reviewed her text messages and confirmed that she notified RN "A" about the report of R293 kissing R36 on 5/18/25. RN "A" did not instruct her to report this event to anyone. During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 6/5/25 at 12:20 PM, the DON and NHA confirmed they received a text message from RN "A" on 5/18/25 at 12:08 PM that informed them R293 kissed R36. They said there was only one witness Activity Aid AA "Q". They spoke to AA "Q" on the phone and because there was no intent, injury or recall of the event they did not			

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	investigate or report this event to the State Agency. They did not document any interviews or conversations about the event. During an interview with Activity Aide (AA) "Q" on 6/4/25 at 11:55 AM, AA "Q" recalled working on 5/18/25 and being in the activity room with several residents when R293 kissed R36. She recalled a resident yelled "hey" and when she turned to see what was going on R293 was sitting in front of R36. R293 had R36's head in his lap (R36 was sitting in a chair and R293 was in a wheelchair). R293 kissed R36 on the lips. "It was a romantic kiss like a Hallmark Movie". After the kiss R36 looked wide eyed and dazed. AA "Q" said she walked over to them and pulled R293 away from R36 and that was the end of it. AA "Q" could not recall the time of day or anyone else working at the time. She said she could not report it immediately as she was in the room by herself. She said when it was safe she reported it to the nurse in charge. She was not sure who the nurse in charge was but believed it might have been LPN "J". R293 Review of R293's "Admission Record " dated 6/5/25 revealed he was 83 years old and was admitted on 5/14/25. His diagnoses included: Alzheimer's disease, dementia, and alcoholic cirrhosis of the liver. He was not his own responsible party. Review of R293's "Behavior note" dated 5/18/25 at 1:30 PM revealed, "(11:30) Activity Aid (sic) observed R293 grab a hold of another resident's head and pull her into his face and kiss other resident. Activity asked him to stop and R293 did not let go. As Activity aid approached R293. He released her. This nurse was informed of. Specific behavior: above asked R293 what happened			

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	states. "I wanna kiss" Educated R293 not to touch others. Removed from dining room. Later on, this afternoon did not recall incident. Continues to make sexual comments to staff and other residents. Attempting to grab other residents and staff as they are passing by him. Making sexual gestures."			
F0610 SS= D	Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: This citation pertains to intake MI00153208 Based on observations, interviews, and record review, the facility failed to thoroughly investigate an allegation of abuse for two Residents (R36 and R293) of two Residents reviewed for abuse. Findings included: Review of the facility "Abuse Policy" dated, 3/15/2023 revealed, "viii) Sexual abuse includes,	F0610		

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	but is not limited to, sexual harassment, sexual coercion or sexual assault and includes non-consensual sexual contact of any type with a resident." D) The Administrator and/or Director of Nursing ("DON") must me notified of all alleged violations involving abuse, neglect, exploitation or mistreatment including injuries of unknown origin and misappropriation of resident property immediately. I he events that cause the allegation involve abuse or result in serious bodily injury, the facility administrator or DON with report to appropriate licensing agencies and local officials immediately but not later than 2 hours and not later than twenty-four (24) hours if the events that cause the allegation does not involve abuse and did not result in serious bodily injury. e) INVESTIGATION i) Time Frame for Investigation. (1) The investigation shall be initiated immediately, after the Administrator has knowledge of the incident, but in no event shall the investigation take longer than five (5) working days. " R36 Review of R36's "Admission Record "dated 6/3/2025 revealed she was 84 years old and admitted on 2/23/22. Her diagnoses included: Dementia, heart failure, depression, and anxiety disorder. She was not her own responsible party. Review of R36's "Behavior note" dated 5/18/25 at 4:33 PM revealed, "Activity aid observed a male resident grab (R36) to back of head and kiss her. The nurse asked R36 about the incident and she is unable to recall incident. No S/S (signs or symptoms) of distress noted, Registered Nurse (RN) "A "notified. " R36 and R293 were both observed in the activity room on 6/3/25 at 9:41 AM. There were a total of 12 residents in the room and all residents were			

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	very close to each other. One staff member was in the room most of the time. For a few minutes at a time staff would leave the room and all 12 residents were left unsupervised. On 6/3/25 at 9:54 AM, Certified Nurse Aide (CNA) was in the activity room supervising 12 residents as the activity aid left the room for a break. CNA "P" said the only resident that needs close supervision was R293 because he gets "Handsy" (someone who is prone to touch other people, often in an inappropriate or unwanted way). Within a minute of this interview R293 was observed reaching out to a female resident. CNA "P" went over to R293 and said we need to keep our hands to ourselves and R293 pulled his hand back. During an interview with RN "A" on 6/5/25 at 10:10 AM, RN "A" confirmed that Licensed Practical Nurse (LPN) "J" notified her on 5/18/25 about R293 kissing R36. RN "A" confirmed that she notified the Director of Nursing (DON) and Nursing Home Administrator (NHA) that R293 kissed R36. RN "A" reviewed all text messages, and no one was instructed to start an investigation. RN "A" was not able to recall any particulars about the event. RN "A" did not do an investigation she just checked on R36 and she had no recall of the event or injury. During an interview with LPN "J" on 6/5/25 at 10:10 AM, LPN "J" reviewed her text messages and confirmed that she notified RN "A" about the report of R293 kissing R36 on 5/18/25. RN "A did not instruct her to investigate the event or notify anyone of the event. LPN "J" was only aware the Activity Aide "Q" witnessed the event, she was not aware of any investigation and did not recall who was working. She was unaware of any other witnesses to the event. She did recall R36 had no recall of the event or any injury.			

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	During an interview with the Director of Nursing (DON) and Nursing Home Administrator (NHA) on 6/5/25 at 12:20 PM, the DON and NHA confirmed they received a text message from RN "A" on 5/18/25 at 12:08 PM that informed them R293 kissed R36. They said there was only one witness Activity Aid "Q". They spoke to AA "Q" on the phone and because there was no intent, injury or recall of the event they did not investigate or report this event to the State Agency. They did not document any interviews or conversations about the event. During an interview with Activity Aide (AA) "Q" on 6/4/25 at 11:55 AM, AA "Q" recalled working on 5/18/25 and being in the activity room with several residents when R293 kissed R36. She recalled a resident yelled "hey" and when she turned to see what was going on R293 was sitting in front of R36. R293 had R36's head in his lap (R36 was sitting in a chair and R293 was in a wheelchair). R293 kissed R36 on the lips. "It was a romantic kiss like a Hallmark Movie". After the kiss R36 looked wide eyed and dazed. AA "Q" said she walked over to them and pulled R293 away from R36 and that was the end of it. AA "Q" could not recall the time of day or anyone else working at the time. She said she could not report it immediately as she was in the room by herself. She said when it was safe she reported it to the nurse in charge. She was not sure who the nurse in charge was but believed it might have been LPN "J". R293 Review of R293's "Admission Record " dated 6/5/25 revealed he was 83 years old and was admitted on 5/14/25. His diagnoses included: Alzheimer's disease, dementia, and alcoholic cirrhosis of the liver. He was not his own responsible party.			

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	Review of R293's "Behavior note" dated 5/18/25 at 1:30 PM revealed, "(11:30) Activity Aid (sic) observed R293 grab a hold of another resident's head and pull her into his face and kiss other resident. Activity asked him to stop and R293 did not let go. As Activity aid approached R293. He released her. This nurse was informed of. Specific behavior: above asked R293 what happened states. "I wanna kiss" Educated R293 not to touch others. Removed from dining room. Later on, this afternoon did not recall incident. Continues to make sexual comments to staff and other residents. Attempting to grab other residents and staff as they are passing by him. Making sexual gestures."			
F0880 SS= D	Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F0880		

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	persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure proper Personal Protective Equipment (PPE) and hand hygiene for 1 resident (R294) of 1 resident reviewed for Transmission Based Precautions (TBP). Findings include:			

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	Review of an "Admission Record" revealed R294 admitted to the facility on 5/31/2025 with pertinent diagnoses which included enterocolitis (inflammation in the lining of the small intestine and colon) due to clostridium difficile (C. diff, a bacterium that causes diarrhea and colitis) and end stage renal disease. Review of R294's "Physician's Orders", active 6/4/2025, revealed an order for Contact Precautions started 6/2/2025 for C. diff. In an observation on 6/4/2025 at 10:17 AM outside R294's room, Physical Therapy Assistant (PTA) "G" exited the room after removing his gown and gloves and performed hand hygiene using hand sanitizer. A sign on the door directed staff R294 was in Contact Precautions and that gown and gloves were required when in contact with resident. In an interview on 6/4/2025 at 2:32 PM, PTA "G" reported he was aware R294 was in contact precautions for C. diff and forgot to wash his hands with soap and water upon exiting the room after completing therapy with him earlier. PTA "G" stated, "I should have washed my hands instead of using hand sanitizer, I forgot about that." In an observation on 6/4/2025 at 10:33 AM outside R294's room, Certified Nursing Assistant (CNA) "L" entered R294's room with Contact Precaution signage on the door without performing hand hygiene or donning gloves or a gown. CNA "L" assisted resident with his wheelchair, touching his legs, without PPE. CNA "L"s clothing made contact with R294's body and wheelchair. CNA "L" did not perform hand hygiene after she finished assisting R294. In an interview on 6/4/2025 at 2:10 PM, CNA "L"			

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SCHNEPP SENIOR CARE AND REHAB CENTER	427 E WASHINGTON SAINT LOUIS, MI 48880

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	reported she had been educated that she must use gown and gloves any time she was in contact with R294 and wash hands with soap and water as this is required with residents being treated for C. diff. In an interview on 6/4/2025 at 2:08 PM, Registered Nurse (RN) "H" reported hand sanitizer was not effective for C. diff and staff must wash hands with soap and water instead. In an interview on 6/4/2024 at 2:40 PM, Infection Preventionist (IP) "A" reported staff were required to wash hands with soap and water for C. diff precautions instead of using hand sanitizer as hand sanitizer is not effective with C. diff. IP "A" reported staff were required to use gown and gloves when in contact with R294 because he was in Contact Precautions for treatment of C. diff. These organisms may be readily transmitted unless removed using hand hygiene. If hands are visibly soiled with proteinaceous material or care is being provided to a patient with a spore-borne infection such as anthrax (Bacillus anthracis) or Clostridium difficile (C. difficile), washing with soap and water is the preferred practice (CDC, 2021c)." Potter, Patricia A.; Perry, Anne G.; Stockert, Patricia A.; Hall, Amy. Fundamentals of Nursing - E-Book (p. 453). Elsevier Health Sciences. Kindle Edition. Review of facility policy/procedure "Handwashing and Hand Hygiene", revised 4/2020, revealed " ... (alcohol-based hand rub) is appropriate for hand hygiene as first choice however when hands are visibly soiled, after using the restroom, before and after eating, or when caring for residents in precautions for C-diff, Norovirus, or COVID-19 soap and water is preferred ..."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	294050	A. BUILDING _____ B. WING _____	**6/5/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCHNEPP SENIOR CARE AND REHAB CENTER	**427 E WASHINGTON SAINT LOUIS, MI 48880**

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	Review of facility policy/procedure "Transmission-Based Precautions", dated 5/10/2023, revealed " ...It is our policy to take appropriate precautions to prevent transmission of infectious agent, based on the agents' modes of transmission ... Contact Precautions ... Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment ... Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. VRE, C. difficile, noroviruses and other intestinal tract pathogens) ..."			