STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235384	A. BUILDING _____ B. WING _____	03/04/2020

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

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F 0551 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Give the resident's representative the ability to exercise the resident's rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to promptly address the need for a durable power of attorney for one resident (Resident #86) out of 4 residents reviewed for advance directives and competency, resulting in the lack of resident representation for a resident no longer able to make health care decisions. Findings include: Review of face sheet and electronic medical record (EMR) for Resident #86 revealed he initially admitted to the facility on [DATE] and most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #86's most recent Minimum Data Set (MDS) Assessment on [DATE] revealed a Brief Interview for Mental Status (BIMS) score of ,[DATE], indicating severe cognitive impairment. Resident #86 was listed as a DNR (do not resuscitate), for his code status. Further review of Resident #86's EMR revealed a document from his initial admission titled Code Status Form. Per this document, Resident #86 had indicated a desire to be a Full Code and receive Cardiopulmonary Resuscitation in the event my heart stops or I stop breathing. This was signed by Resident #86 on [DATE]. Another Code Status Form was signed and dated on [DATE] from his subsequent admission and Resident #86 indicated a desire for a Do-Not-Resuscitate Order. The form reads Being of sound mind, I voluntarily execute this order, and I understand its full import. Review of Resident #86's initial BIMS assessment on [DATE] revealed a score of ,[DATE], indicating severe cognitive impairment. Continued review of Resident #86's EMR documents revealed a competency determination, Decision Making Determination Form signed by one physician on [DATE] and an additional physician on [DATE] indicating the undersigned have determined that the patient/resident is unable to participate in medical or mental health treatment decisions. This determination is supported by the facts and circumstances noted in the patient's medical record. An additional document titled Petition for Appointment of Guardian of Incapacitated Individual revealed the SW J as the petitioner and the request was filed on [DATE]. The attached documentation revealed: (Resident #86 suffers from unspecified dementia, major [MEDICAL CONDITIONS], gout, and repeated falls, among other medical conditions .Because of his mental and physical impairments, (Resident #86) is unable to make or communicate informed decisions regarding his care, custody, and control and requires a guardian .Due to his mental and physical condition, (Resident #86) is reliant upon the medically-trained staff .to complete all his activities of daily living .(Resident #86) scored a 5 on his most recent Brief Interview for Mental Status assessment, which indicates severe cognitive impairment .(Resident #86) needs a guardian to participate in care conferences and coordinate with medical professionals to develop and implement appropriate treatment plans. (Resident #86) requires a guardian who can be easily communicated with in the event of an emergency and make medical decisions on his behalf . The section completed by Resident #86's physician indicated that he is not capable of determining where to live, consenting to supportive services, handling personal financial affairs, or authorizing or refusing medical treatment. The attached notice of hearing revealed the matter was scheduled to be reviewed by the court on [DATE]. Review of Resident #86's progress notes revealed social services notes on [DATE] at 10:25 AM and [DATE] at 1:53 PM that code status was reviewed and not changed. The [DATE] note reveals: He completed the BIMS with a score of 5 . During an interview with Social Worker (SW) J on [DATE] at approximately 10:05 AM, Resident #86's code status and competency was discussed. SW J stated that when Resident #86 readmitted to the facility, he signed a DNR order and then I realized he had some cognitive issues. SW J stated the facility started the guardianship process with Resident #86's wife since he had no Durable Power of Attorney paperwork in place. SW J stated the process took a while because the process went through the facility's corporate attorneys. SW J stated Resident #86 would have been making his own medical decisions in the interim or possibly his wife, depending on the situation. SW J agreed that he should not be making his own medical or financial decisions if he was deemed incompetent and his wife was not legally able to make the decisions either. SW J agreed that Resident #86's code status should have been reviewed since he was deemed incompetent shortly after signing the document. On [DATE] at 11:15 AM, the NHA (Nursing Home Administrator) confirmed there was no specific policy or procedure that addresses what to do when an individual is incapacitated other than code policy. Review of facility provided policy Resident Code Policy with a most recently revised date of [DATE] revealed a purpose: To respect each resident's individual, informed decision regarding code status. The section Procedure includes: 3. If DNR is requested: A. The admission nurse, social worker or designee will assure appropriate assessments have been completed and the appropriate legal representative has been identified (if applicable) .5. If CPR is indicated by default (resident not able to make decision with no legal representative) .
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement their abuse policy and procedure for 2 residents (Resident #6 and #86) out of 3 residents reviewed for abuse, resulting in the potential for abuse going undetected, causes of abuse going undetected, and residents not being protected from incidents of abuse. Findings include: Review of face sheet and electronic medical record for Resident #86 revealed he most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #86's most recent Minimum Data Set (MDS) Assessment on [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7/15, indicating severe cognitive impairment. Review of face sheet and electronic medical record for Resident #6 revealed he most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #6's most recent Minimum Data Set (MDS) Assessment on 12/01/2019 revealed a Brief Interview for Mental Status (BIMS) score of 12/15, indicating moderate cognitive impairment. Review of Resident #6's progress notes revealed a note from 2/29/2020 at 1:57 PM: Resident c/o that his roommate is pushing his wheelchair into my table and into my bed. I asked him to stop and he said I 'll punch you in the nose. No physical action, only words. Res also states res. goes into the bathroom and leaves it a mess (sic) Res only question if may have a room change. Will cont. to monitor at this time. Review of facility provided Resident Assistance Form involving Resident #6 with an incident date of 2/29/2020 revealed a concern: Res. (resident) rmmate (roommate) in room pushing wheelchair into other res table & into my bed. Making threats to punch me in the nose. Leaves the bathroom a mess. The facility response was Offered room move- res agreed. On 03/02/2020 at approximately 11:18 AM, Resident #6 and Resident #86 were seen passing each other in the hallway, Resident #6 was viewed to have an annoyed look on his face and said something to Resident #86 that could not be heard. On 03/02/2020 at 11:22 AM an interview was completed with Resident #6 in his room. Resident #6 asked if this surveyor observed Resident #86 stopping in the hall and making a face at him. Resident #6 stated Resident #86 is cornering him and making faces at him often and he just wants me to whack him. Resident #6 stated they used to be roommates and now still have to share a bathroom and they are still around each other often. Resident #6 is annoyed that Resident #86 makes such a mess in the bathroom, so is not sure the room change will end their conflicts. Resident #6 stated in the past Resident #86 had pinned me against the table in the dining room and has run his mouth, he said he was going to punch me out. Resident #6 stated that this was within the last week. Resident #6 stated his son was there visiting last week and Resident #86 told them to shut up and shut our damn mouth. Resident #6 reiterated that Resident #86 had just a made face at him in the hall and came to close. About a week ago, Resident #86 had got right next to me and said if you ain't careful I'm going to punch you. Resident #6 stated that

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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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) while they shared a room, Resident #86 had took his wheelchair and pushed it into his bedside table across the room and it bumped into him and he felt trapped on his bed. Resident #6 said his son in brought a piece of wood in and put it on his bed so that his former roommate could not move the table into his bed anymore. Resident #6 has felt threatened in the dining room, and other times by Resident #86 and is concerned this will continue. He stated he is not sure if the facility or his son knew about all the times it has happened. Resident #86 stated I'm so embarrassed, I don't even want to leave my room or eat in the dining room. I came here because didn't want to be alone. It's been pretty stressful. During lunch in the main dining room on 03/02/2020 Resident #86 and #6 were viewed sitting at tables that were next to each other, Resident #6 had his back to Resident #86. As Resident #6 was leaving the dining room after eating at approximately 12:21 PM, he stopped to speak with the surveyor. Resident #6 presented as agitated and said did you see that? He was making faces at me when I left! Resident #6 clarified that he was referring to Resident #86. An interview was completed with LPN (Licensed Practical Nurse) D on 03/03/2020 at 01:43 PM regarding the incident between Resident #86 and #6 on 2/29/2020. LPN D said the conflict was mostly words and said Resident #86 had threatened to punch Resident #6 in the nose. LPN D stated she contacted her supervisor to see what they could do because (Resident #6) felt threatened. LPN D stated she called her unit manager and thinks her supervisor contacted the Director of Nursing (DON). LPN D stated that Resident #6 did not seem to be fearful but did want to move out of the room. LPN D stated they are right next to each other now and still share a bathroom so is not sure if it will still spark something. LPN D did not see or hear any of the interaction, and was not previously aware of any conflicts, but do not think (Resident #86) would be abusive. LPN D stated she did write up a complaint form and the Resident #6 was moved to a different room. LPN D was asked if she was concerned this situation was abuse and she replied if he was making statements, it would be concerning for a potential for abuse, he did make a threat. This was why went to supervision for guidance. LPN D stated that Resident #6 also reported he was having problems with Resident #86 because he was pushing his wheelchair into a table and the table pushed into his bed. LPN D stated there was a board on his bed bolted to frame and Resident #6 said it was to prevent Resident #86 pushing on his bed. Resident #6 said his son had put the board on the bed but was not sure when. LPN D stated she had just noticed the board during the room move and maintenance then removed it. An interview was completed with Resident #6's son on 03/03/2020 at 2:08 PM. He stated he was visiting Resident #6 sometime last week, he thought Thursday or Friday, and his father and his roommate were talking about punching each other. He stated that Resident #86 had told Resident #6 to shut up and he responded make me, then they were arguing about taking it outside to fight. Resident #6's son stated his father had also told him that Resident #86 was pushing his wheelchair into his table and if he was lying in bed, it was hitting him in the head. Resident #6's son stated he never observed the incidents happen, but about 3 weeks ago he brought a board in to try to prevent the table from knocking into Resident #6. Resident #6's son stated he does not believe his dad is fearful but does say it has been hard to deal with the behavior. He stated, knowing my dad, it could turn physical and if he gets frustrated enough he could take matters into his own hands. On 03/03/2020 at 02:37 PM an interview was completed with the NHA (Nursing Home Administrator) and the DON regarding the complaint form filed by Resident #6 and why it was not submitted to the State Agency as an abuse allegation. The NHA stated: we talked about that, but in following up with him, there was no mental anguish and he admitted it could have been taken out of context. Resident #6 was irritated and annoyed by it, but not afraid. The NHA admitted that the interaction could be considered verbal threat, whether or not he was fearful. Review of facility provided policy Abuse, Neglect and/or Misappropriation of Resident Funds or Property with a last revised date of 12/10/18 revealed a purpose: To assure each resident in the center is free from abuse, neglect and exploitation. Definitions included: Mental Abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation . Physical Abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment, which is physical including, but not limited to, spanking, slapping of hands, flicking, or hitting with an object . and Verbal abuse refers to any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents. Verbal abuse includes but is not limited to using spoken, written or gestured language that includes insulting, offensive or disapproving terms to any resident (or within his or her hearing distance), regardless of age, disability, or ability to comprehend. Included under the section Protection & Identification, the procedure revealed: the facility administrator or DON will 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 . and (Facility) will take all action necessary to prevent the abuse, neglect, or misappropriation of the resident's funds or property from occurring while it is conducting its investigation of the incident, and will also take appropriate action to attempt to prevent similar incidents in the future. Included in the section Investigation, the procedure revealed: The investigation shall be initiated immediately .as part of the investigation, the Administrator, or his/her designee, shall take the following action: (a) Interview the resident, the accused .and all witnesses. Witnesses shall include anyone who (1) witnessed or heard the incident; (2) came in close contact with either the resident the day of the incident (including other residents, family members, etc.); (3) employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. To the extent possible, all interviews should be summarized into a written statement, which is signed and dated.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report allegations of abuse to the state survey agency for 2 of 3 residents (Resident #6 and #86) reviewed for abuse, resulting in allegations of abuse not being reported to the state survey agency and the potential for residents to not be protected from abusive individuals. Findings include: Review of face sheet and electronic medical record for Resident #86 revealed he most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #86's most recent Minimum Data Set (MDS) Assessment on [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7/15, indicating severe cognitive impairment. Review of face sheet and electronic medical record for Resident #6 revealed he most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #6's most recent Minimum Data Set (MDS) Assessment on 12/01/2019 revealed a Brief Interview for Mental Status (BIMS) score of 12/15, indicating moderate cognitive impairment. Review of Resident #6's progress notes revealed a note from 2/29/2020 at 1:57 PM: Resident c/o that his roommate is pushing his wheelchair into my table and into my bed. I asked him to stop and he said I 'll punch you in the nose. No physical action, only words. Res also states res. goes into the bathroom and leaves it a mess (sic) Res only question if may have a room change. Will cont. to monitor at this time. Review of facility provided Resident Assistance Form involving Resident #6 with an incident date of 2/29/2020 revealed a concern: Res. (resident) rmmate (roommate) in room pushing wheelchair into other res table & into my bed. Making threats to punch me in the nose. Leaves the bathroom a mess. The facility response was Offered room move- res agreed. On 03/02/2020 at approximately 11:18 AM, Resident #6 and Resident #86 were seen passing each other in the hallway, Resident #6 was viewed to have an annoyed look on his face and said something to Resident #86 that could not be heard. On 03/02/2020 at 11:22 AM an interview was completed with Resident #6 in his room. Resident #6 asked if this surveyor observed Resident #86 stopping in the hall and making a face at him. Resident #6 stated Resident #86 is cornering him and making faces at him often and he just wants me to whack him. Resident #6 stated they used to be roommates and now still have to share a bathroom and they are still around each other often. Resident #6 is annoyed that Resident #86 makes such a mess in the bathroom, so is not sure the room change will end their conflicts. Resident #6 stated in the past Resident #86 had pinned me against the table in the dining room and has run his mouth, he said he was going to punch me out. Resident #6 stated that this was within the last week. Resident #6 stated his son was there visiting last week and Resident #86 told them to shut up and shut our damn mouth. Resident #6 reiterated that Resident #86 had just a made face at him in the hall and came to close. About a week ago, Resident #86 had got right next to me and said if you ain't careful I'm going to punch you. Resident #6 stated that while they shared a room, Resident #86 had took his wheelchair and pushed it into his bedside table across the room and it bumped into him and he felt trapped on his bed. Resident #6 said his son in brought a piece of wood in and put it on his bed so that his former roommate could not move the table into his bed anymore. Resident #6 has felt threatened in the dining room, and other times by Resident #86 and is concerned this will continue. He stated he is not sure if the facility or his son knew about all the times it has happened. Resident #86 stated I'm so embarrassed, I don't even want to leave my room or eat in the dining room. I came here because didn't want to be alone. It's been pretty stressful. During lunch in

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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to thoroughly investigate allegations of abuse for 2 residents (Residents #86 and #6) of 3 residents reviewed for abuse, resulting in the potential for abuse going undetected, causes of abuse going undetected, and residents not being protected from incidents of abuse. Findings include: Review of face sheet and electronic medical record for Resident #86 revealed he most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #86's most recent Minimum Data Set (MDS) Assessment on [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7/15, indicating severe cognitive impairment. 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F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) so is not sure if it will still spark something. LPN D did not see or hear any of the interaction, and was not previously aware of any conflicts, but do not think (Resident #86) would be abusive. LPN D stated she did write up a complaint form and the Resident #6 was moved to a different room. LPN D was asked if she was concerned this situation was abuse and she replied if he was making statements, it would be concerning for a potential for abuse, he did make a threat. This was why went to supervision for guidance. LPN D stated that Resident #6 also reported he was having problems with Resident #86 because he was pushing his wheelchair into a table and the table pushed into his bed. LPN D stated there was a board on his bed bolted to frame and Resident #6 said it was to prevent Resident #86 pushing on his bed. Resident #6 said his son had put the board on the bed but was not sure when. LPN D stated she had just noticed the board during the room move and maintenance then removed it. An interview was completed with Resident #6's son on 03/03/2020 at 2:08 PM. He stated he was visiting Resident #6 sometime last week, he thought Thursday or Friday, and his father and his roommate were talking about punching each other. He stated that Resident #86 had told Resident #6 to shut up and he responded make me, then they were arguing about taking it outside to fight. Resident #6's son stated his father had also told him that Resident #86 was pushing his wheelchair into his table and if he was lying in bed, it was hitting him in the head. Resident #6's son stated he never observed the incidents happen, but about 3 weeks ago he brought a board in to try to prevent the table from knocking into Resident #6. Resident #6's son stated he does not believe his dad is fearful but does say it has been hard to deal with the behavior. He stated, knowing my dad, it could turn physical and if he gets frustrated enough he could take matters into his own hands. On 03/03/2020 at 02:37 PM an interview was completed with the NHA (Nursing Home Administrator) and the DON regarding the complaint form filed by Resident #6 and why it was not submitted to the State Agency as an abuse allegation. The NHA stated: we talked about that, but in following up with him, there was no mental anguish and he admitted it could have been taken out of context. Resident #6 was irritated and annoyed by it, but not afraid. The NHA admitted that the interaction could be considered verbal threat, whether or not he was fearful. Review of facility provided policy Abuse, Neglect and/or Misappropriation of Resident Funds or Property with a last revised date of 12/10/18 revealed a purpose: To assure each resident in the center is free from abuse, neglect and exploitation. Definitions included: Mental Abuse includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation . Physical Abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment, which is physical including, but not limited to, spanking, slapping of hands, flicking, or hitting with an object . and Verbal abuse refers to any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents. Verbal abuse includes but is not limited to using spoken, written or gestured language that includes insulting, offensive or disapproving terms to any resident (or within his or her hearing distance), regardless of age, disability, or ability to comprehend. Included under the section Protection & Identification, the procedure revealed: the facility administrator or DON will 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 . and (Facility) will take all action necessary to prevent the abuse, neglect, or misappropriation of the resident's funds or property from occurring while it is conducting its investigation of the incident, and will also take appropriate action to attempt to prevent similar incidents in the future. Included in the section Investigation, the procedure revealed: The investigation shall be initiated immediately .as part of the investigation, the Administrator, or his/her designee, shall take the following action: (a) Interview the resident, the accused .and all witnesses. Witnesses shall include anyone who (1) witnessed or heard the incident; (2) came in close contact with either the resident the day of the incident (including other residents, family members, etc.); (3) employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident. To the extent possible, all interviews should be summarized into a written statement, which is signed and dated.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for 3 of 19 residents (Resident #86, Resident #59, and Resident #20) reviewed, resulting in inaccurate and incomplete medical records and the potential for providers not having an accurate picture of the residents condition for Resident #86 and for code status documentation for Residents #59 and Resident #20 not being legally sound. Findings include: Resident #86 Review of face sheet and electronic medical record for Resident #86 revealed he most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #86's most recent Minimum Data Set (MDS) Assessment on [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 7/15, indicating severe cognitive impairment. Review of facility provided Resident Assistance Form involving Resident #6 with an incident date of 2/29/2020 revealed a concern: Res. (resident) rmmate (roommate) in room pushing wheelchair into other res table & into my bed. Making threats to punch me in the nose. Leaves the bathroom a mess. The facility response was Offered room move- res agreed. Further review of Resident #86's progress notes revealed no entry related to him making verbal threats or pushing items into another resident. On 2/29/2020 at 2:45 PM there is only a nurses note that reflects: Res notified of getting a new room mate. Resident #59 Review of face sheet and electronic medical record for Resident #59 revealed she most recently admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #59 was listed as her own responsible party. Review of a facility document for Resident #59 titled, Code Status Form revealed the resident elected a do not resuscitate order and this document was signed and dated on 1/21/2020 by the resident, physician and witnessed in signature by two people. Resident #59 had signed on the incorrect line on the form (on the line Type or Print Signer's Name), the physician did not date his signature and one of the witnesses did not print their name and date their signature. On 03/04/2020 at approximately 10:05 AM during an interview with Social Worker Designee (SW) J, Resident #59's advanced directive was reviewed. SW J agreed that the form did have some blanks and therefore was not complete. Resident #20 According to a facility face sheet dated [DATE], Resident #20 was a [AGE] year old admitted into the facility on [DATE] with [DIAGNOSES REDACTED]. Review of a facility document for Resident #20 titled, Code Status Form, this form revealed that the guardian wished a do not resuscitate order and this document was signed and dated on 4/6/19 by the guardian and witnessed in signature by one person. The second person witness signature line was observed to be blank. On 3/04/20 at 10:03 AM during an interview with Social Worker Designee (SW) J, she revealed that there should have been two signatures of witnesses on the Code Status Form. She revealed the health care team had noticed some holes in documentation. She stated she was now responsible to make sure all blanks were all filled in. She revealed at the first part of the year they started the new process of checking for missing signatures/documentation. SW J stated she was reviewing and noticed missing items on uploaded documents.
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** Based on observation, interview, and record review, the facility failed to utilize infection control practices with 2 sampled residents (Resident #50 & Resident #71), resulting in the potential for the transmission of pathogens (illness causing agents). Findings: Resident #50 Review of an Admission Record revealed Resident #50 (R50) was a [AGE] year old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. A Minimum Data Set assessment, completed on 01/21/20, revealed R50 required total assistance from 2 staff persons for all cares and had severe cognitive impairment. During an observation on 03/03/20 at 10:44 A.M., staff provided care for R50. Certified Nurse Aid (CNA) E cleaned R50's perineum and buttocks, and did not perform hand hygiene and change gloves when the task was completed. CNA E then placed a new brief under R50, while touching the inside of the crotch area of the brief, with contaminated gloves. During an interview on 03/04/20 at 10:10 A.M., CNA E indicated that the correct practice would have been to change gloves and perform hand hygiene, before handling and placing the clean brief under R50. Resident #71 Review of an Admission Record revealed Resident #71 (R71) was an [AGE] year old female, originally admitted to the facility on [DATE], with pertinent [DIAGNOSES REDACTED]. A Minimum Data Set assessment, completed on 02/04/20, revealed R71 required extensive assistance from 2 staff persons for all cares and had severe cognitive impairment. During an observation on 03/02/20 at 10:59 A.M., CNA F and Clinical Care Coordinator (CCC) *** performed pericare for R71. The following concerns were noted: (a) CNA F used a gait belt to transfer R71 to bed, placed the gait belt in a pant pocket, and then, later used the gait

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235384	A. BUILDING _____ B. WING _____	**03/04/2020**

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) belt on another resident, (b) CNA F washed R71's perineum by wiping the folds between the pubic region and the thighs and then, while using the same portion of the wash cloth, wiped R71's outer labia. CNA F did not spread R71's labia to ensure that the entire perineum was free of urine or stool, (c) CNA F, with dirty gloves, touched her forehead, (d) CNA F, with dirty gloves, touched R71's privacy curtain 3 times (e) CNA Fs gown came loose at the neck line and fell down, CNA F, with dirty gloves, reached up to pull the gown back up, touching the scrub shirt under the gown, (f) CNA Fs employee badge, which hung on the front of the scrub top, came in contact with R71's skin, and the contact went unnoticed, and (g) CNA F placed a contaminated bottle of periwash in R71's drawer with other personal hygiene supplies. During an interview on 03/02/19 at 11:49 A.M., Infection Control Nurse H stated that the facility did not have a specific policy for glove use, rather, the facility followed CDC guidelines.