STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235297	A. Building B. Wing	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivergate Health Care Center	14041 Pennsylvania Rd Riverview, MI 48193

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 This citation pertains to intake MI00142899. Based on interview and record review the facility failed to prevent the use of inappropriate language during care to one resident (R916) out of three residents reviewed for abuse. Findings include: Record review of Incident Report dated 2/11/2023 (actual date 2/11/2024) documented, On 2/12/24 at approximately 2:56 pm C.N.A. (Certified Nursing Assistant) (E) notified the Executive Director that on the prior shift, while she was working with (CNA F), (CNA E) indicated that she witnessed (CNA F) on last rounds enter into room (XXX) to check on (R916) and see if she was clean and dry. (CNA E) indicated that she witnessed (R916) became combative during care and scratched (CNA F). (CNA F) stated I am tired of you fucking scratching me. I am not doing this shit; I am trying to go home. Further review of the same document noted, . Conclusion: Based on interviews and statements, the facility can conclude that (CNA F) used profane language in front of R916 . Record review revealed R916 was admitted into the facility on [DATE] with pertinent diagnoses of unspecified dementia. According to Minimum Data Set (MDS) dated [DATE], R916 had impaired cognition and required assistance with Activities of Daily Living (ADLS). During an interview on 3/22/24 at 12:30 PM with Director of Nursing (DON), it was reported that it is not appropriate for staff to speak to residents as reported. During an interview on 3/22/24 at 1:15 PM with Executive Director, it was reported that CNA F was terminated related to swearing in front of R916. Record review Termination Form dated 2/22/24 documented, .Reason for Termination -Violation of company policies and procedures.

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

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38208 This citation has two deficient practice statements. Deficient Practice Statement #1. This citation pertains to intake MI00142978. Based on interview and record review the facility failed to develop/implement a care plan for one resident (R917) out of three residents reviewed for care interventions for psychotropic medications. Findings Include: Record review of R917's electronic medical records revealed admission into the facility on [DATE] with a pertinent diagnosis of dementia. According to the Minimum Data Set (MDS) dated [DATE], R917 had impaired cognition and required assistance with Activities of Daily Living (ADLS). Record review of Physician orders documented, Seroquel Oral Tablet 25 MG (antipsychotic) Give 0.5 tablet by mouth at bedtime for mood disorder. Start date 8/16/23. Record review of R917's care plans revealed no documentation or implementation of interventions to assess or monitor resident's progress or side effects of taking a psychotropic medication. Further review of Medication Administration Record (MAR) for the month of September 2023 had no documentation of assessment/ monitoring of possible side effects of Seroquel. During an interview on 3/22/24 at 1:45 PM with Director of Nursing (DON), it was reported that facility should have developed and implemented a care plan for R917 when Seroquel was ordered by physician. It was further reported that residents should be monitored when receiving anti-psychotic medications. Record review of policy Comprehensive Care Plans and Revisions reviewed 8/22/23, documented the following: The facility will ensure the timeliness of each resident's person-centered, comprehensive care plan, and to ensure that the comprehensive care plan is reviewed and revised by an interdisciplinary team composed of individuals who have knowledge of the resident and his/her needs, and that each resident and resident representative, if applicable, is involved in developing the care plan and making decisions about his or her care. Deficient Practice Statement #2: This citation pertains to intake MI00142978. Based on interview and record review the facility failed to obtain a consent for the use of a psychotropic drug for one resident (R917) out of three residents reviewed for unnecessary medications. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings Include: Record review of R917's electronic medical records revealed admission into the facility on [DATE] with a pertinent diagnosis of dementia. According to the Minimum Data Set (MDS) dated [DATE], R917 had impaired cognition and required assistance with Activities of Daily Living (ADLS). Record review of Physician orders documented, Seroquel Oral Tablet 25 MG (antipsychotic) Give 0.5 tablet by mouth at bedtime for mood disorder. Start date 8/16/23. Record review of R917's Medication Informed Consent form it was documented with an X for anti- anxiety medication and was signed by daughter of R917. There was no information documented related to the anti-anxiety medication. No other choices for other medications. Form was not completed, and consent or refusal was not marked. Document was not dated. Record review of 917's electronic medical records revealed no evidence that responsible party was informed before receiving Seroquel medication. During an interview on 3/22/24 at 1:45 PM with Director of Nursing (DON), it was reported that facility should obtain consent before administering an antipsychotic medication. It was further reported that R917's electronic medical record had no indication that R917's responsible party was informed or consented to the use of Seroquel. Record review of policy Psychotropic Mediation Informed Consent Policy" reviewed 8/29/23, documented the following: .The facility will obtain consent or refusal to the use of Psychotropic Medications. This documentation will reflect the intended or actual benefit is understood by the resident and, if appropriate, his/her family and/or representative(s) and is sufficient to justify the potential risk(s) or adverse consequences associated with the selected medication, dose, and duration.

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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** 47964 Based on interview and record review the facility failed to ensure complete and accurate documentation was maintained in an Electronic Health Record (EHR) for one resident (R916) of three residents reviewed for accurate medical records resulting in inaccurate and incomplete medical records with inadequate care delivery. Findings include: Record review of R916's Electronic Medical Record (EMR) revealed admission into the facility on [DATE] with most recent readmission on 3/16/24 with pertinent diagnosis of paraplegia. According to the Minimum Data Set (MDS) dated [DATE] R916 had severe impaired cognition and required substantial assistance with Activities of Daily Living (ADLS). Record review of the May 2024 Treatment Administration Record (TAR) with ADON A revealed documentation that Registered Nurse (RN) B performed wound care on 5/13/24 and 5/14/24. On 5/15/24 at 11:50 AM RN B was interviewed about R916's wound care and stated, I didn't perform wound care on 5/14/24 but documented that I did. RN B said that wound care was not performed on 5/14/24 and that the TAR was incorrect. On 5/15/24 at 2:50 PM the Nursing Home Administrator (NHA) was interviewed and said documentation should be accurate and timely. Review of the facility policy titled Skin Integrity & Pressure Ulcer/Injury Prevention and Management addendum Documentation, long term care undated revealed in part .accurate, detailed documentation shows the extent and quality of care that nurses provide, the outcomes of that care and the treatment and education that the resident still needs. Record must be complete, accurate, and must provide documentation of the resident's assessments and the care plan and services provided.