

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235297	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/17/2025
NAME OF PROVIDER OR SUPPLIER Rivergate Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41423</p> <p>This citation pertains to Intake: MI00151131</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision and monitoring to prevent an elopement for one resident (R600) who had severe cognitive impairment and was assessed and care planned as an elopement risk. R600 left a secured unit on the second floor and exited the front door during the time a staff member left the lobby unsecured. R600 exited the building while following an unknown visitor on 03/01/2025 at approximately 6:37 PM, unbeknownst to facility staff.</p> <p>Immediate Jeopardy:</p> <p>The Immediate Jeopardy (IJ) started on 03/01/2025 and the immediacy was removed 04/04/2025 per review of the facility's responding interventions as verified on 4/17/2025.</p> <p>The IJ was identified on 04/17/2025 during an abbreviated survey. The facility was notified of the IJ on 04/17/2025 at 3:20 PM and was asked for a removal plan.</p> <p>The IJ was removed on 04/04/2025, based on the facility's implementation of the removal plan as verified onsite on 04/17/2025.</p> <p>Findings Include:</p> <p>On 4/16/2025 at 11:30 AM, R600 was observed in their room. R600 was lying in their bed, positioned on their right-side, and watching TV. R600 was wearing a sweatshirt, sweatpants, and was well groomed. R600 asked if they remembered leaving the building without staff. R600 said, Sorry I don't. R600 gave a smile and said, Is there anything else you would like to talk about?</p> <p>On 03/01/2025 the State Agency received a Facility Reported Incident that on 03/01/2025 R600 exited the building unsupervised while following a visitor on 03/01/2025 at approximately 6:37 PM.</p> <p>A review of R600's electronic medical record revealed an admission to the facility on [DATE] with the diagnoses of Alzheimer's Disease, Difficulty Walking, Muscle Weakness, Dementia, Anxiety, and Major Depression. R600 was under the legal care of a guardianship.</p> <p>(continued on next page)</p>

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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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of R600's Brief Interview for Mental Status (BIMS) dated 02/06/2025 revealed a score of 7/15 (severe cognitive impairment).</p> <p>A review of R600's Elopement Risk Evaluation dated 02/05/2025 revealed that R600 was at risk for elopement.</p> <p>A review of R600's care plan revealed the following:</p> <p>Focus: ELOPEMENT: At risk for elopement. Resident states he needs to leave for work, drive his car. Following visitors onto elevators, seeking exit doors. Date Initiated: 2/05/2025. Revision on: 03/06/2025 .</p> <p>Interventions/Task: Monitor for exit-seeking behaviors including pacing around the elevator and doors, following family members/visitors, voicing desire to leave for work/to drive. Date Initiated: 02/05/2025 . Revision on: 03/06/2025 .</p> <p>Focus: (R600) impaired cognitive ability /impaired thought processes r/t (related to) Dementia/Anxiety Date Initiated: 02/05/2025 .Revision on: 02/06/2025 .</p> <p>Interventions/Task: Cue, reorient and supervise as needed. Date Initiated: 02/06/2025 .</p> <p>Focus: (R600) impaired cognitive ability/impaired thought processes r/t Dementia/Anxiety. Date Initiated: 02/05/2025 .Revision on: 02/06/2025 .</p> <p>Focus: (R600) is at risk for communication problem r/t impaired cognitive processes.</p> <p>Date Initiated: 02/13/2025 .</p> <p>Interventions/Task: Observe for residents (R600) ability to express and comprehend language, memory, reasoning ability, problem solving ability and ability to attend. Date Initiated: 02/13/2025 .</p> <p>Focus: (R600) is at risk for falls. Date Initiated: 02/06/2025 .</p> <p>A review of R600's progress note written by Licensed Practical Nurse (LPN)B, dated 03/01/2025 revealed the following:</p> <p>Note Text: At approximately 6:30pm resident (R600) was going to (the) dining room to eat dinner. Aides (Certified Nurse Aide/CNA) exchanged directions on how resident (R600) likes his coffee. At approximately 6:50pm an aide (CNA A) from a different unit brought resident (R600) to med cart and stated (CNA A) found (R600) walking in the back parking lot. Resident (R600) stated (they) didn't know how (they) got outside but (R600) was looking for (R600's) car. Writer assessed resident and took (R600's) vitals. Writer ordered lab work and contacted Guardian and Physician Assistant .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/16/2025 at 3:10 PM, a request was made to the Director of Nursing (DON) to view the outdoor cameras. However, the DON stated that they couldn't adjust the camera's date to 03/01/2025. The DON was asked about their observation of R600 walking towards the back of the facility upon viewing of the outdoor cameras. The DON said that R600 walked out of the facility behind a visitor on 3/01/2025. R600 turned left and started walking toward the back of the facility. The DON said that R600 was walking on the driveway, when they reached the back of the facility they turned left towards the back parking lot. The DON said that R600 walked toward the shed behind the facility.</p> <p>On 4/17/2025 at 09:08 AM, an observation was made of the outside of the facility while attempting to follow the steps that the DON discussed as observed on their outside cameras. This writer walked out of the front door of the facility. A major busy street in front of the facility with two lanes going right, two lanes going left, and a middle turning lane was observed. This surveyor walked out the front door and turned left. At the end of the walkway and parking lot, a left turn was made toward a long driveway. To the right side of the driveway was another long-term care facility. To the left were about nine tall trees next to the facility. In addition, the long driveway had several cracks at the side and back of the facility. At the back and left corner of the facility was a diesel fuel container, a generator, and electrical metal boxes, sitting on a block of concrete. There was also a step up to a door with signage that noted Oxygen Room. To the right of the Oxygen Room was a shed.</p> <p>On 4/17/2025 at 10:35 AM, an interview was conducted with CNA A related to R600 being found behind the facility. CNA A said, I picked up a double that day and took a later lunch break around 6:50-6:59pm .I came out of the employee entrance back door .It was dusk, but I could still see. I was parked in the second row of the parking lot. I did not notice anyone outside at that time. I got into my car and the headlights automatically came on. They usually come on at dusk . that's when I saw (R600). CNA A said that R600 was standing near the supply shed (behind the facility and next to the Oxygen Room door).</p> <p>CNA A continued to state that (they) were surprised to see R600 outside in the back of the building. CNA A stated they approached R600 in a calm manner because CNA A did not want to startle R600. CNA A said that it looked as if R600 was looking for something. CNA A continued and asked (R600) what they were doing outside and (R600) said they were looking for their car. CNA A stated to R600, Let's go inside to get your keys. R600 then followed CNA A inside the facility, utilizing the back employee door entrance, and ushered R600 back to the second floor using the elevator.</p> <p>On 4/17/25 at 10:58 AM an interview was conducted with the Lead Receptionist C. Receptionist C explained that receptionist should never leave the desk without having someone cover. Receptionist C stated that during day shift, the receptionist should asked staff that work up front to cover the desk if the receptionist needed to leave the lobby. Receptionist C said, If it's during the afternoon (shift), the receptionist should ask staff at Nurse Station One to cover .the receptionist should not leave the desk uncovered (unattended).</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 4/17/25 at 11:34 AM, an interview was conducted via phone with Receptionist D. Receptionist D was asked if they worked the lobby desk as the receptionist on 3/01/2025 around 6:30 PM. Receptionist D said, Yes. Receptionist D was queried if they left the front desk during that time and Receptionist D said, I stepped away from the desk around 6:30pm to get a message from the resident in room (redacted), that's a few doors away from the receptionist desk .The resident started talking about their life and then I told them that I had to leave. I was gone for about 5-10 minutes. Receptionist D was asked if it was within their policies/procedures to leave the desk uncovered and Receptionist D said it was ok if it was less than 15-30 minutes.</p> <p>On 4/17/25 at 11:42 AM, an interview was conducted with the Director of Human Resources (also manager of the receptionists). The Director of Human Resources was queried and asked if it was their policy for Receptionist D to leave the lobby front desk unattended during their shift. The Director of Human Resources stated, When the receptionist needs to leave the desk, they should always have someone to cover .they (Receptionist) should never leave the front desk uncovered.</p> <p>A record review of the facility's investigation, interviews, and statements revealed the following:</p> <p>Facility Executive Director was notified that resident (R600) was observed by the back door of the facility by (CNA A) at approximately 6:45pm. Resident (R600) was escorted back into facility .Resident stated (they) was looking for (their) car. Resident responsible party, physician notified of event .</p> <p>A record review of the facility's interview and statements of CNA A revealed the following:</p> <p>On 3/1/25 at approximately 6:50 pm, (CNA A) exited the facility using the employee entrance to take (their) break. As (CNA A) got to (their) car, which was located in the parking lot behind the building, (CNA A) saw (R600) walking by the exit door near the oxygen supply shed .(CNA A) then redirected (R600) and assisted (R600) back into the facility via the employee entrance and escorted (R600) back to (their) unit and nurse .</p> <p>A record review of the facility's witness statement of LPN B revealed the following:</p> <p>(LPN B) was the nurse assigned to (R600) on the afternoon shift on 3/1/25. At approximately 6:30 pm, (LPN B) observed (R600) come out of (their) room walking towards the dining room. (LPN B) overheard two aides talking about (R600) liking a large cup of coffee. Approximately 20 minutes later, (CNA A) brought (R600) to (LPN B) and informed (LPN B) where (R600) was observed and assisted back into the facility .</p> <p>An attempt was made to contact LPN B via phone on 4/17/2025 at 09:40 AM. A voice message was left with contact number.</p> <p>A record review of the facility's witness statement of Receptionist D revealed the following:</p> <p>Receptionist D was the receptionist on duty the afternoon of 3/1/25. Receptionist D states that around 6:30 pm he had stepped away from the desk to assist a resident. This resident was in 106 whom had called the front desk for assistance and clarification on (their) discharge information. Receptionist D was away from the desk for 5-10 minutes assisting the resident. Receptionist C states that during that time there was no other employee at the reception desk.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The facility report of the external cameras documented the following:</p> <p>Review of the external facility cameras indicated that (R600) exited the facility via front door at 6:37 pm, following close behind a visitor. (R600) proceeded around the facility, via the parking lot and was observed by a staff member and assisted back into the facility at 6:45 pm via the back door employee entrance .</p> <p>A review of the facility's interview with Visitor F (R600 followed this visitor out of the front door) documented the following:</p> <p>(Visitor F) remembered being at the facility on 3/1/25 and leaving sometime between 6:30pm and 7:00pm. When asked if (Visitor F) had reached over the high-top counter of the front desk to push the button of security release for the front doors to exit the facility, (Visitor F) did not remember if anyone was at the desk to (get out) or if anyone followed (Visitor F) out of the front door .(Visitor F stated) I do not remember what I did earlier in the day, let alone on the weekend.</p> <p>On 04/17/2025 at 11:56 AM, the DON was interviewed and asked how R600 left the second floor via the elevator (the 2nd floor elevator required a passcode). The DON stated R600 must have followed visitors into the elevator. The DON was asked how R600 exited the front door. The DON stated, (R600) was viewed on the front camera following (Visitor F) out the front door.</p> <p>On 4/17/2025 at 12:28 PM, an interview was conducted with the Nursing Home Administrator (NHA). When queried regarding R600 exiting the facility on 3/01/2025 without staff knowledge, the Administrator explained that (R600) exited the facility behind Visitor F. The NHA stated, We investigated and concluded that (R600) followed a visitor onto the elevator and then followed (Visitor F) out of the front door. The NHA was asked if the second floor was a locked unit. The NHA stated that it was not a locked unit, it was a secured unit that required a passcode to open the elevator on the second floor. The Administrator was asked if residents were given the passcode and the NHA said, No. Residents are not given the passcode. The NHA stated that R600 was let out of the facility by a visitor. The NHA was queried if it was within their policy to maintain staff at the front desk during business hours. The NHA said that receptionists were not used as security. The NHA continued to explain that R600 had been outside for about 10 minutes. The DON stated, (R600) was not in danger because he did not leave the grounds.</p> <p>A review of the facility's policy Area of Focus: Elopement dated 11/19/2024 revealed the following:</p> <p>Elopement occurs when a resident leaves the premises or a safe area without authorization .and/or any necessary supervision to do so. A resident who leaves a safe area may be a risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle.</p> <p>During the onsite survey, past noncompliance (PNC) was cited after the facility implemented actions to correct the noncompliance which included the following:</p> <p>1. Corrective Action for Affected Individual(s).</p> <p>-A Schedule has been established to monitor the involved R600 15 minutes.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>-R600 elopement care plan was reviewed and updated to reflect activities of interest including model care that he can design, music, bingo, purposeful wandering.</p> <p>-Notification sent to families/representatives on not letting self out of the building, which is a breach of our security systems.</p> <p>2. Identification of Residents Affected or Likely to be Affected:</p> <p>-Residents identified at risk for exit seeking, assessment to reduce opportunity to exit facility their care plans will be reviewed, photos updated, if necessary, Medical Director and responsible parties will be notified to be aware of surroundings when on elevator.</p> <p>3. Identification of Residents Affected or Likely to be Affected:</p> <p>-An ad hoc QAPI meeting was held on 3/7/25 review systematic process enhancements and no further occurrences have been noted. Committee will continue to monitor and perform analysis for any potential root cause to variation in updated systematic process.</p> <p>-Signage has been placed by and in the elevator to remind visitors to be aware of anyone on the elevator without a badge/nametag may be an indication of an unaccompanied resident and to notify a staff member immediately.</p> <p>-All current resident's elopement risk evaluations were reviewed and updated with care plans reviewed and updated as needed.</p> <p>-Front door push button relocated and a protective cover placed over it so visitors cannot reach over the counter and push the button.</p> <p>3. Systemic Changes to Prevent Recurrence:</p> <p>-Staff educated on elopement, front desk to be attended during business hours.</p> <p>-Education on proper visitor sign in/out process.</p> <p>-Elopement policies were reviewed on 3/05/25. No revisions made to the current policies.</p> <p>-Elopement risk list updated.</p> <p>-Elopement investigation procedure and documentation process were reviewed on 3/05/25. No revisions made to the current procedures and processes.</p> <p>-Elopement drill was from 3/5/25-3/8/25 completed multiple shifts.</p> <p>-Elopement audits last date 4/4/25.</p> <p>The facility was able to demonstrate monitoring of the corrective action and maintained compliance.</p>		