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	11/21/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately identify incidents of physical harm as abuse by a Resident Representative (RR), for one resident (R501) of three residents reviewed for abuse, resulting in the potential for continued physical harm.Findings include:It was reported to the State Agency that the facility failed to protect a resident from abuse. The complaint revealed the following: Anonymous complainant states on 9/26, last Friday, a. resident (R501) on Station 4 of the facility. was being fed by the (RR), (R501) wouldn't eat (their) food so the (RR) became frustrated and smacked (R501) and grabbed (R501's) jaw . Complainant states the DON and Administrator instructed the nurse to not put a note in the system because it would alert the state. Complainant states the next day, 9/27, the (RR) was observed grabbing (R501's) arm by a dietary aide. On 10/8/25 at 11:35 AM, Licensed Practical Nurse (LPN) A was queried regarding the incident on 9/26/25. LPN A reported she observed LPN C running down the hall. LPN C was screaming, (RR) hit (R501)! According to LPN A, LPN C was typically unhurried, but after this incident moved swiftly down the hall yelling, What should I do? What should I do?. LPN A said that (LPN C) called the Nursing Home Administrator (NHA) and was told not to document in the electronic medical record (EMR) that RR hit R501 because it could alert the state. A review of the clinical record did not reveal documentation of this incident.On 10/8/25 at 12:22 PM, RN D was interviewed and stated, Staff had noticed that (the RR) was getting frustrated with (R501) because (R501) would not eat. RN D said we pulled the RR aside and talked to the RR because the RR was observed grabbing R501's chin while inside of R501's room. On 10/8/25 at 2:47 PM, LPN C was interviewed by telephone and reported witnessing the RR grab R501's jaw to force R501 to eat. LPN C stated to RR, You can't do that! LPN C reported the incident by telephone to the NHA shortly after witnessing RR grab R501's face with force. LPN C stated, The (NHA) determined that it was not abuse and that's why I didn't document it. The clinical record did not reveal that LPN C assessed the R501 for bruising/injury immediately after the incident. On 10/9/25 at 12:30 PM, Social Worker (SW) I was interviewed and reported on 10/7/25 that SW I was informed by LPN A that The (RR) cannot go into (R501's) room because (the RR) slapped (R501). LPN A informed SW I that the NHA was notified of the incident. SW I stated, The (NHA) is the abuse coordinator and did not initiate an investigation. SW I confirmed not being informed of an investigation for this incident as of this date. On 10/9/25 at 12:45 PM, LPN A was interviewed again and confirmed witnessing LPN C being visibly upset after seeing the RR slap and grab R501's face.Physical harm continued to occur as referenced in the complaint. On 9/27/25, the (RR) was observed grabbing (R501's) arm by a dietary aide.On 10/8/25 at 2:15 PM, Dietary Aide (DA) F was interviewed and stated, The (RR) is controlling. When asked to elaborate on controlling, DA F stated, (The RR's) actions are aggressive, even the way (the RR) pushes drinks towards (R501). DA F demonstrated a powerful and aggressive pushing motion with their hand. On 10/8/25 at 2:35 PM, DA B was interviewed and said that approximately two weeks ago they witnessed RR grab R501's arm with force and snatched R501 away from the table where R501 was socializing with other residents. RR then took R501 to another table in the dining room. According to DA B, This made me feel uncomfortable. DA B said with her experience and (continued on next page)

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

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	11/21/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	training, she knows what abuse looks like. DA B said this incident was immediately reported to a group of staff persons at the nurse's desk. Interviews revealed incomplete instructions and rationale were given to staff regarding RR's visitation with R501. 1. On 10/8/25 at 11:43 AM, LPN G who was currently assigned to R501, was asked about supervised intervention. LPN G stated, I was not aware of supervised visitation for (R501).2. On 10/8/25 at 11:50 AM, Certified Nursing Assistant (CNA) H who was currently assigned to R501, was asked about supervised visitation. In response, CNA H stated, I was not aware of any incident.3. On 10/8/25 at 11:55 AM, Registered Nurse (RN) D was interviewed and stated, The (RR) was flustered with (R501), so the (NHA) suggested that the (RR) meet with (R501) in the dining room. RN D was unable to state the purpose of the change. 4. On 10/8/25 at 12:00 PM, CNA's M, N and O were interviewed and reported they did not witness an incident but were told that the RR and R501 were to sit in the dining room during meals. CNA's M, N, and O were unable to state the purpose of the change. A record review of the electronic medical record revealed R501 was admitted to the facility on [DATE] with a diagnosis of Atrial Fibrillation, Alzheimer's with late onset, Hypertension, Obstructive Pulmonary Disease, Anemia, Dementia and Adjustment Disorder. Further review of the clinical record revealed a Brief Interview for Mental Status (BIMS) score of 0/15 denoting a severe cognitive impairment. A review of R501's care plans documented:- resident plans to discharge home- dated 9/15/25-resident has impaired cognitive ability related to dementia- dated 9/15/25-resident is alert with confusion- dated 9/19/25-resident requires set-up assistance for meals- dated 9/12/25-resident has a potential for a nutritional problem - intervention included: provide verbal encouragement/assistance with meals as needed to ensure adequate intake- dated 9/25/25A review of R501's care plans documented the following intervention initiated on 9/28/25- Provide meals to RR when in the facility during mealtime so that RR can eat meals with R501 in the dining room to help promote visual cuing to increase oral intake. Staff to provide assistance when indicated. However, the facility failed to provide care plan interventions for R501 related to the prevention of further physical harm. On 10/8/25 at approximately 1:30 PM, the NHA was requested to provide a complete investigation regarding the alleged abuse of R501. On 10/8/25 at 3:30 PM, the NHA was queried about the incident between the RR and R501. The NHA reported not doing an investigation or reporting this incident due to It not being abuse. The NHA acknowledged being out of the office when they received a telephone call from staff regarding the RR grabbing R501's jaw in an attempt to make R501 eat. When asked, why would they call you for this incident if this was not suspected abuse? NHA stated, They call me for everything. According to the NHA, after receiving the telephone call from the nurse regarding RR grabbing the jaw of R501, the NHA spoke directly to the RR by telephone and educated the RR about dementia. The NHA admitted telling LPN C, (RR) is not trying to hurt (R501). Even though there was not a skin assessment completed on R501, the NHA indicated that it was not abuse.A review of the document titled, Abuse-Inservice Training, dated 5/6/25, revealed the following:- The facility must develop and implement written policies and procedures that prohibit and prevent abuse. -Procedures include staff orientation and training to identify and prevent behaviors constituting abuse.No further documentation related to abuse identification was provided by the facility.

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	11/21/2025

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 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 interview and record review, the facility failed to thoroughly implement an abuse policy for incidents of physical harm of one resident (R501) by a Resident Representative (RR), for one of three residents reviewed for abuse, resulting in the potential for continued physical and/or psychosocial harm.Findings include:It was alleged that Resident Representative (RR) to resident abuse occurred. The complaint revealed the following: Anonymous complainant states on 9/26, last Friday, a. resident (R501) on Station 4 of the facility. was being fed by the (RR), (R501) wouldn't eat (their) food so the (RR) became frustrated and smacked (R501) and grabbed (R501's) jaw . Complainant states the next day, 9/27, the (RR) was observed grabbing (R501's) arm by a dietary aide. On 10/8/25 at 11:35 AM, Licensed Practical Nurse (LPN) A was queried regarding an incident on 9/26/25. LPN A reported she observed LPN C running down the hall. LPN C was screaming, (RR) hit (R501)! According to LPN A, LPN C was typically unhurried, but after this incident moved swiftly down the hall yelling, What should I do? What should I do?. LPN A said that (LPN C) called the Nursing Home Administrator (NHA) and was told not to document in the electronic medical record (EMR) that RR hit R501 because it could alert the state. A review of the clinical record did not reveal documentation of this incident.On 10/8/25 at 12:22 PM, RN D was interviewed and stated, Staff had noticed that (the RR) was getting frustrated with (R501) because (R501) would not eat. RN D said we pulled the RR aside and talked to the RR because the RR was observed grabbing R501's chin while inside of R501's room.On 10/8/25 at 2:47 PM, LPN C was interviewed by telephone and reported witnessing the RR grab R501's jaw to force R501 to eat. LPN C stated to RR, You can't do that! LPN C reported the incident by telephone to the NHA shortly after witnessing RR grab R501's face with force. LPN C stated, The (NHA) determined that it was not abuse and that's why I didn't document it. The clinical record did not reveal that LPN C assessed R501 for bruising/injury immediately after the incident.On 10/9/25 at 12:30 PM, Social Worker (SW) I was interviewed and reported on 10/7/25 that SW I was informed by LPN A that The (RR) cannot go into (R501's) room because (the RR) slapped (R501). LPN A informed SW I that the NHA was notified of the incident. SW I stated, The (NHA) is the abuse coordinator and did not initiate an investigation. SW I confirmed not being informed of an investigation for this incident as of this date. On 10/9/25 at 12:45 PM, LPN A was interviewed again and confirmed witnessing LPN C being visibly upset after seeing the RR slap and grab R501's face.Physical harm continued to occur as referenced in the complaint. On 9/27/25, the (RR) was observed grabbing (R501's) arm by a dietary aide.On 10/8/25 at 2:15 PM, Dietary Aide (DA) F was interviewed and stated, The (RR) is controlling. When asked to elaborate on controlling, DA F stated, (The RR's) actions are aggressive, even the way (the RR) pushes drinks towards (R501). DA F demonstrated a powerful and aggressive pushing motion with their hand.On 10/8/25 at 2:35 PM, DA B was interviewed and said that approximately two weeks ago they witnessed RR grab R501's arm with force and snatched R501 away from the table where R501 was socializing with other residents. RR then took R501 to another table in the dining room. According to DA B, This made me feel uncomfortable. DA B said with her experience and training, she knows what abuse looks like. DA B said this incident was immediately reported to a group of staff persons at the nurse's desk.A record review of the electronic medical record revealed R501 was admitted to the facility on [DATE] with a diagnosis of Atrial Fibrillation, Alzheimer's with late onset, Hypertension, Obstructive Pulmonary Disease, Anemia, Dementia and Adjustment Disorder. Further review of the clinical record revealed a Brief Interview for Mental Status (BIMS) score of 0/15 denoting a severe cognitive impairment. On 10/8/25 at approximately 1:30 PM, the NHA was requested to provide a complete investigation regarding the alleged abuse of R501. On 10/8/25 at 3:30 PM, the NHA was queried about the incident between the RR and R501. The NHA reported not doing an investigation or reporting this incident due to It not being abuse! The NHA acknowledged that she was out of the office when she received a telephone call from staff regarding the RR grabbing R501's jaw (continued on next page)

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	11/21/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in an attempt to make R501 eat. When asked, why would they call you for this incident if this was not suspected abuse? NHA stated, They call me for everything. The NHA admitted telling LPN C, (RR) is not trying to hurt (R501).No further documentation related to abuse identification was provided by the facility.

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	11/21/2025

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 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 interview and record review, the facility failed to report to the State Agency incidents of physical harm for one resident (R501) by a Resident Representative (RR), for one of three residents reviewed for abuse, resulting in unreported incidents of physical harm.Findings include:The State Agency received an anonymous complaint that a resident was abused at the facility and that it was not reported.The complaint revealed the following: Anonymous complainant states on 9/26, last Friday, a. resident (R501) on Station 4 of the facility. was being fed by the (RR), (R501) wouldn't eat (their) food so the (RR) became frustrated and smacked (R501) and grabbed (R501's) jaw . Complainant states the next day, 9/27, the (RR) was observed grabbing (R501's) arm by a dietary aide. On 10/8/25 at 11:35 AM, Licensed Practical Nurse (LPN) A was queried regarding the incident on 9/26/25. LPN A reported she observed LPN C running down the hall. LPN C was screaming, (RR) hit (R501)! According to LPN A, LPN C was typically unhurried, but after this incident moved swiftly down the hall yelling, What should I do? What should I do?. LPN A said that (LPN C) called the Nursing Home Administrator (NHA) and was told not to document in the electronic medical record (EMR) that RR hit R501 because it could alert the state. A review of the clinical record did not reveal documentation of this incident.On 10/8/25 at 12:22 PM, RN D was interviewed and stated, Staff had noticed that (the RR) was getting frustrated with (R501) because (R501) would not eat. RN D said we pulled the RR aside and talked to the RR because the RR was observed grabbing R501's chin while inside of R501's room.On 10/8/25 at 2:47 PM, LPN C was interviewed by telephone and reported witnessing the RR grab R501's jaw to force R501 to eat. LPN C stated to RR, You can't do that! LPN C reported the incident by telephone to the NHA shortly after witnessing RR grab R501's face with force. LPN C stated, The (NHA) determined that it was not abuse and that's why I didn't document it. The clinical record did not reveal that LPN C assessed the R501 for bruising/injury immediately after the incident.On 10/9/25 at 12:30 PM, Social Worker (SW) I was interviewed and reported on 10/7/25 that SW I was informed by LPN A that The (RR) cannot go into (R501's) room because (the RR) slapped (R501). LPN A informed SW I that the NHA was notified of the incident. SW I stated, The (NHA) is the abuse coordinator and did not initiate an investigation. SW I confirmed not being informed of an investigation for this incident as of this date. On 10/9/25 at 12:45 PM, LPN A was interviewed again and confirmed witnessing LPN C being visibly upset after seeing the RR slap and grab R501's face.Physical harm continued to occur as referenced in the complaint. On 9/27/25, the (RR) was observed grabbing (R501's) arm by a dietary aide.On 10/8/25 at 2:15 PM, Dietary Aide (DA) F was interviewed and stated, The (RR) is controlling. When asked to elaborate on controlling, DA F stated, (The RR's) actions are aggressive, even the way (the RR) pushes drinks towards (R501). DA F demonstrated a powerful and aggressive pushing motion with their hand.On 10/8/25 at 2:35 PM, DA B was interviewed and said that approximately two weeks ago they witnessed RR grab R501's arm with force and snatched R501 away from the table where R501 was socializing with other residents. RR then took R501 to another table in the dining room. According to DA B, This made me feel uncomfortable. DA B said with her experience and training, she knows what abuse looks like. DA B said this incident was immediately reported to a group of staff persons at the nurse's desk.A record review of the electronic medical record revealed R501 was admitted to the facility on [DATE] with a diagnosis of Atrial Fibrillation, Alzheimer's with late onset, Hypertension, Obstructive Pulmonary Disease, Anemia, Dementia and Adjustment Disorder. Further review of the clinical record revealed a Brief Interview for Mental Status (BIMS) score of 0/15 denoting a severe cognitive impairment. On 10/8/25 at approximately 1:30 PM, the NHA was requested to provide a complete investigation regarding the alleged abuse of R501. On 10/8/25 at 3:30 PM, the NHA was queried about the incident between the RR and R501. The NHA reported not doing an investigation or reporting this incident due to It not being abuse! The NHA acknowledged that she was (continued on next page)

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	11/21/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	out of the office when she received a telephone call from staff regarding the RR grabbing R501's jaw in an attempt to make R501 eat. When asked, why would they call you for this incident if this was not suspected abuse? NHA stated, They call me for everything. The NHA admitted telling LPN C, (RR) is not trying to hurt (R501). The NHA indicated that it was not abuse.A review of Form Centers for Medicare & Medicaid Services (CMS) 20059 Abuse Critical Element Pathway dated 10/2022 revealed the following: 6) For alleged violations of abuse, did the facility:-Report the results of all investigations within five working days to the administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency)?No further documentation related to abuse identification was provided by the facility.

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	11/21/2025

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 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 interview and record review, the facility failed to thoroughly conduct and document an investigation of incidents of physical harm of one resident (R501) by a Resident Representative (RR), for one of three residents reviewed for abuse, resulting in the potential for continued physical harm.Findings include:It was alleged that RR to resident abuse occurred. The complaint revealed the following: Anonymous complainant states on 9/26, last Friday, a. resident (R501) on Station 4 of the facility. was being fed by the (RR), (R501) wouldn't eat (their) food so the (RR) became frustrated and smacked (R501) and grabbed (R501's) jaw . Complainant states the next day, 9/27, the (RR) was observed grabbing (R501's) arm by a dietary aide. On 10/8/25 at 11:35 AM, Licensed Practical Nurse (LPN) A was queried regarding the incident on 9/26/25. LPN A reported she observed LPN C running down the hall. LPN C was screaming, (RR) hit (R501)! According to LPN A, LPN C was typically unhurried, but after this incident moved swiftly down the hall yelling, What should I do? What should I do?. LPN A said that (LPN C) called the Nursing Home Administrator (NHA) and was told not to document in the electronic medical record (EMR) that RR hit R501 because it could alert the state. A review of the clinical record did not reveal documentation of this incident.On 10/8/25 at 12:22 PM, RN D was interviewed and stated, Staff had noticed that (the RR) was getting frustrated with (R501) because (R501) would not eat. RN D said we pulled the RR aside and talked to the RR because the RR was observed grabbing R501's chin while inside of R501's room.On 10/8/25 at 2:47 PM, LPN C was interviewed by telephone and reported witnessing the RR grab R501's jaw to force R501 to eat. LPN C stated to RR, You can't do that! LPN C reported the incident by telephone to the NHA shortly after witnessing RR grab R501's face with force. LPN C stated, The (NHA) determined that it was not abuse and that's why I didn't document it. The clinical record did not reveal that LPN C assessed the R501 for bruising/injury immediately after the incident.On 10/9/25 at 12:30 PM, Social Worker (SW) I was interviewed and reported on 10/7/25 that SW I was informed by LPN A that The (RR) cannot go into (R501's) room because (the RR) slapped (R501). LPN A informed SW I that the NHA was notified of the incident. SW I stated, The (NHA) is the abuse coordinator and did not initiate an investigation. SW I confirmed not being informed of an investigation for this incident as of this date. On 10/9/25 at 12:45 PM, LPN A was interviewed again and confirmed witnessing LPN C being visibly upset after seeing the RR slap and grab R501's face.Physical harm continued to occur as referenced in the complaint. On 9/27/25, the (RR) was observed grabbing (R501's) arm by a dietary aide.On 10/8/25 at 2:15 PM, Dietary Aide (DA) F was interviewed and stated, The (RR) is controlling. When asked to elaborate on controlling, DA F stated, (The RR's) actions are aggressive, even the way (the RR) pushes drinks towards (R501). DA F demonstrated a powerful and aggressive pushing motion with their hand.On 10/8/25 at 2:35 PM, DA B was interviewed and said that approximately two weeks ago they witnessed RR grab R501's arm with force and snatched R501 away from the table where R501 was socializing with other residents. RR then took R501 to another table in the dining room. According to DA B, This made me feel uncomfortable. DA B said with her experience and training, she knows what abuse looks like. DA B said this incident was immediately reported to a group of staff persons at the nurse's desk.A record review of the electronic medical record revealed R501 was admitted to the facility on [DATE] with a diagnosis of Atrial Fibrillation, Alzheimer's with late onset, Hypertension, Obstructive Pulmonary Disease, Anemia, Dementia and Adjustment Disorder. Further review of the clinical record revealed a Brief Interview for Mental Status (BIMS) score of 0/15 denoting a severe cognitive impairment. On 10/8/25 at approximately 1:30 PM, the NHA was requested to provide a complete investigation regarding the alleged abuse of R501. On 10/8/25 at 3:30 PM, the NHA was queried about the incident between the RR and R501. The NHA reported not doing an investigation or reporting this incident due to It not being abuse! The NHA acknowledged that she was out of the office when she received a telephone call from staff regarding the RR grabbing R501's jaw in an (continued on next page)

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	11/21/2025

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	attempt to make R501 eat. When asked, why would they call you for this incident if this was not suspected abuse? NHA stated, They call me for everything. The NHA admitted telling LPN C, (RR) is not trying to hurt (R501).A review of Form Centers for Medicare & Medicaid Services (CMS) 20059 Abuse Critical Element Pathway dated 10/2022 revealed the following: 6) For alleged violations of abuse, did the facility:-Report the results of all investigations within five working days to the administrator or his/her designated representative and to other officials in accordance with State law (including to the State survey and certification agency)?- Develop policies and procedures related to ensuring the reporting of suspected crimes, within mandated timeframes (i.e., immediately but not later than two hours if the suspected crime resulted in serious bodily injury, within 24 hours for all other cases) and notifying covered individuals annually of their reporting obligations. No further documentation related to abuse identification was provided by the facility.