STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235476	A. Building B. Wing	08/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverview Health and Rehab Center North	18300 E Warren Detroit, MI 48224

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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 22349 Based on observation, interview, and record review, the facility failed to notify and discuss a room change with a resident and their responsible party for one resident (R801) of one residents reviewed for room changes, resulting in R801 being moved to a new room without approval of the responsible party and the increased potential for transfer trauma (physical, behavioral, and emotional reaction to a sudden change in ones surroundings). Findings include: On 8/20/24 at 10:40 AM R801 was observed seated in a wheelchair in a private room on the 1st floor. During interview the resident said the private room was nice but missed being on the 3rd floor with friends. R801 said, They moved me because I was hanging around some girls. Nobody told me I couldn't have girlfriends. I didn't do anything, just hanging around them in their room. I won't hang around them anymore if I can go back upstairs. They didn't tell me nothing before, just moved me down here. According to R801's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with multiple diagnoses that included Parkinson's disease and major depressive disorder. The Minimum Data Set (MDS) quarterly assessment on 5/23/24 indicated the resident had moderately impaired cognition and no behaviors. R801 had no care plans for behaviors or wandering. On 7/10/24, Social Worker (SW) E documented that R801's family member was in the process of becoming the resident's Legal Guardian and paperwork was in progress. On 8/6/24 at 2:34 PM, a progress note written by the unit manager, Licensed Practical Nurse (LPN) A documented R801 was transferred to another room and the doctor was made aware. There is no documentation to support the resident (R801) or the resident's family member was made aware of R801's room change. On 8/20/24 at 12:15 PM, LPN A was asked about R801's room change. LPN A said that R801 was moved to the first floor because the resident was wandering into other resident's room without their permission. LPN A could not provide any documentation to support that R801 had wandered into other resident's rooms or had ever been redirected by staff from other resident's room. There was no care plan or interventions implemented to prevent wandering. LPN A acknowledged that she did not notify R801's family member of the resident's room change. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/20/24 at 2:20 PM, the Nursing Home Administrator was asked about room changes and said, It is our facility's policy to inform resident's family members when a resident's room is changes. On 8/20/24 at 6:10 PM, R801's family member said that he was unaware the facility had moved the resident to the first floor. The family member said he feels he should have been notified of this. They call me with other things that go on with him (R801). Nobody said anything about this to me. The resident's family member said he had paperwork that made him the resident's LG and was delivering them to the facility shortly. According to the facility's undated Room Change Policy in part; It is the policy of this facility to promote a resident's right to make choices and to promptly receive written notice of a room change or change in an assigned roommate. The facility supports the resident's right to refuse a room change made for the purpose of moving the resident into or out of a SNF or NF certified distinct part of the facility, solely for the staff's convenience Moving to a new room or changing roommates is challenging for residents. A resident's preferences should be taken into account when considering such changes. When a resident is being moved at the request of facility staff, the resident, family, and/or resident representative must receive an explanation in writing of why the move is required. The resident should be provided the opportunity to see the new location, meet the new roommate, and ask questions about the move. OBJECTIVE OF THE ROOM CHANGE POLICY The objective of the room change policy is to ensure that the resident is informed of an impending room change or assigned roommate. The intent of the room change policy supports each resident ' s right to refuse a room change in specific circumstances. The policy provides guidance to facility practices for room and roommate management and notification to residents and the resident representative. CENTERS FOR MEDICAID AND MEDICARE SERVICES (CMS) - DEFINITIONS The following are CMS definitions or clarifications from the Draft State Operations Manual Appendix PP effective November 28, 2016 Resident representative The term resident representative means any of the following: An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; Legal representative, as used in section 712 of the Older Americans Act; or. The court-appointed guardian or conservator of a resident. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction.

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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** 22349 Based on observation, interview, and record review the facility failed to develop or implement a person-centered behavior care plan for one (R801) of three residents reviewed for care planning resulting in R801 not having a care plan for behaviors of wandering and the potential for psychosocial needs to go unmet. Findings include: On 8/20/24 at 10:40 AM R801 was observed seated in a wheelchair in a private room on the 1st floor. During interview the resident said the private room was nice but missed being on the 3rd floor with friends. R801 said, They moved me because I was hanging around some girls. Nobody told me I couldn't have girlfriends. I didn't do anything, just hanging around them in their room. I won't hang around them anymore if I can go back upstairs. They didn't tell me nothing before, just moved me down here. According to R801's Electronic Health Record (EHR) the resident admitted to the facility on [DATE] with multiple diagnoses that included Parkinson's disease, Paranoid Schizophrenia, and major depressive disorder. The Minimum Data Set (MDS) quarterly assessment on 5/23/24 indicated the resident had moderately impaired cognition and no behaviors. R801 had no care plans for behaviors or wandering. On 6/25/24 a Behavioral Care progress note written by Nurse Practitioner (NP) F in part reads: Social Work requesting evaluation for behaviors. Nursing reports resident is sexually inappropriate and steals from the nursing station and the snack room. On 8/6/24 at 2:34 PM, a progress note written by the unit manager, Licensed Practical Nurse (LPN) A documented R801 was transferred to another room on a different floor. A review of R801's progress notes, assessments, and care plans did not reveal any documentation of R801's behaviors or that interventions were implemented. On 8/20/24 at 12:15 PM, LPN A was asked about R801's room change. LPN A said that R801 was moved to the first floor because the resident was wandering into other resident's room without their permission. LPN A had no knowledge of the resident stealing snacks from the nurse's station or snack room. LPN A could not provide any documentation to support that R801 had wandered into other resident's rooms or had ever been redirected by staff from other resident's room. There was no care plan or interventions implemented to prevent wandering. LPN A acknowledged that a care plan should have been implemented for the resident's behaviors. On 8/20/24 at 2:00 PM Social Worker (SW) E was asked about R801's behaviors. SW E said the resident had started to wander into other resident's rooms and that it needed to be care planned. SW E was not aware that R801 did not have a care plan for behaviors and said, It should have been in there. I will look into that. SW E said she was new to the building and had no knowledge of the resident stealing from the nurses station or snack room. On 8/20/24 at 2:10 PM, the Director of Nursing (DON) was asked about developing and implementing care plans for residents. The DON reviewed R801's EHR and said, Yes, the resident should have had a care plan for the behavior of wandering. I don't know why it wasn't done. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	According to the facility's RAI and Care Planning policy dated 8/20/23, in part reads; As required at 42 CFR 483.25, the comprehensive care plan is an interdisciplinary communication tool. It must include measurable objectives and time frames and must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and physical well- being. The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care. 3. The overall care plan should be oriented towards: -Using an appropriate interdisciplinary approach to care plan development to improve the resident's functional abilities. -Involving resident resident's family and other resident representatives as appropriate. -Assessing and planning for care to meet the resident's medical, nursing, mental and psychosocial needs. -Involving the direct care staff with the care planning process relating to the resident's expected outcomes. -Addressing additional care planning areas that are relevant to meeting the resident's needs in the long-term care setting.