STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235502	A. Building B. Wing	06/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Commons Rehab and Nursing Center, LLC	16391 Rotunda Dr Dearborn, MI 48120

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. This citation pertains to intake 3034793.Based on interview and record review, the facility failed to perform a post-fall assessment in a timely manner and failed to ensure a radiology exam was completed for one (R504) of four residents reviewed for a change in condition resulting in the delay of medical care/treatment.Findings include:Review of an intake submitted to the State Agency revealed the following: Complainant (Family Member A) states that (R504) fell about two weeks ago, maybe longer. (Family Member A) states the aide (Certified Nurse Aide), (CNA D) was changing (R504) brief, rolled (R504) over, the bed wasn't locked so (R504) rolled to the floor. (Family Member A) states (R504) hit the floor hard and hit (their) head and there was no follow up to examine for injury. (Family Member A) states (R504) been complaining of a lot of pain since the fall, migraine, pain in her back, shoulder and lower legs. (Family Member A) states requested facility to send (R504) to the emergency, resident was sent to (the hospital on) 6/4/26.On 6/23/26 at 9:45 AM, Family Member A was interviewed via telephone about R504's fall on 5/23/26. Family Member A said R504 fell off the bed during care. Family Member A said the facility did not send R504 to the hospital until (Family Member A) insisted they (the facility) send R504 to the hospital. Family Member A said R504 did not return to this facility after hospitalization. R504 was admitted to another long-term care facility after hospital discharged .A review of R504's electronic medical record (EMR) revealed an admission to the facility on 3/11/25 with the diagnosis of Intracerebral Hemorrhage (bleeding inside the brain), Muscle Weakness, Falls, Cerebral Infarction (an ischemic stroke, is the pathologic process that results in an area of necrotic tissue in the brain) Hemiplegia and Hemiparesis affecting left dominant side (mean the non-dominant brain hemisphere (typically the right) has sustained damage), Progressive Vascular Leukoencephalopathy refers to the slow, progressive damage to the brain's white matter caused by the deterioration or blockage of small blood vessels), Morbid Obesity, Glaucoma, Implantable Loop Recorder (ILR) (a heart monitor) and Neuropathy. R504's has a Brief Interview for Mental Status score of 15/15 (cognitively intact with normal thinking, learning, and memory skills) dated 5/15/26.A record review of R504 progress note created Registered Nurse C (RN C) on 5/23/2026 at 09:29 AM revealed the following: Informed by (CNA D) that while (CNA D) was changing (R504's) brief and turning (R504) to the other side (of the bed), resident slid out of bed. Writer and supv(supervisor) enter rm (room)and observed resident sitting on floor between bed and wall. Resident denies any discomfort and striking head. ROM to all 4 extremities without difficult.Staff used Hoyer lift to transfer resident from floor back into bed.A review of R504's progress note dated 5/26/2026 at 5:13 PM, revealed the following: Resident c/o (complain of) pain on right side of head due to a fall over the weekend. Writer reached out to resident attending NP (Nurse Practitioner) and order for x-ray to right side of face and C-spine (the neck region of the backbone) .Resident agreed.Review of R504's EMR order dated, 5/27/2026 at 10:15 PM (four days after the fall), and placed by Physician G, revealed the following: X-ray right side of face and C-spine.STAT (medical directive meaning immediately and without delay.)A review of R504's progress note dated 6/04/2026 at 10:57 PM revealed the following: .Resident sustained a fall approximately two weeks ago. MD ordered transfer today for further evaluation related to previous fall. Resident transferred via EMS (emergency Medical Services) accompanied by two EMS personnel at 8:00PM resident departed facility in stable condition.Prior to R504's transfer to the hospital on (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/4/2026 at 8 PM, the radiology exam had not been completed.A review of R504 hospital note, dated June 5, 2026, revealed the following: Admitting Diagnoses: Compression Fracture of the Body of Thoracic Vertebra.On 6/24/26 at 2:25 PM, an interview was conducted with the Nursing Home Administrator (NHA) and the DON (Director of Nursing) concerning R504's fall on 5/23/26, the absence of the post-fall assessment, and the radiology order that was not completed. The DON stated, During this transition (facility change in ownership and new EMR) we had trouble with our records and keeping track, we found out that the X-Ray was canceled by the radiology people. The DON did not respond to the absence of the post fall report. The NHA was present for the interview but had nothing to add to the discussion.A review of the facility's policy Change in a Resident's Condition or Status dated 07/11/2018, revealed the following: A significant change of condition is a major decline or improvement in the resident's status that:Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting);Impacts more than one area of the resident's health status;Requires interdisciplinary review and/or revision to the care plan; andUltimately is based on the judgment of the clinical staff and the guidelines outlined in the Resident Assessment Instrument.A review of the facility's policy Care and Treatment: Fall dated 07/11/2018, revealed the following: It is the policy of this facility to evaluate extent of injury after fall, prevent complications and to provide emergency care.6. Evaluate cause of fall.10. Document all appropriate information in the medical record.11. Note on 24- Hour Report.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 3034793.Based on observation, interview and record review, the facility failed to lock one resident's bed and failed to stop repositioning a resident at their request during a brief change for one (R504) of three residents reviewed for falls, resulting in R504 falling from the bed, injuring their head and knee with subsequent hospitalization related to a fracture.Findings include:A review of an intake submitted to the State Agency revealed the following: Complainant (Family Member A) states that (R504) fell about two weeks ago, maybe longer. (Family Member A) states the aide (Certified Nurse Aide), (CNA D) was changing (R504) brief, rolled (R504) over, the bed wasn't locked so (R504) rolled to the floor. (Family Member A) states (R504) hit the floor hard and hit (their) head and there was no follow up to examine for injury. (Family Member A) states (R504) been complaining of a lot of pain since the fall, migraine, pain in her back, shoulder and lower legs. (Family Member A) states requested facility to send (R504) to the emergency, resident was sent to (the hospital on) 6/4/26. On 6/23/26 at 9:45AM, Family Member A was interviewed by telephone about R504's fall. Family Member A said R504 fell off the bed during care. Family Member A said R504 did not return to this facility after hospitalization. R504 was admitted to another long-term care facility after hospital discharged .A review of R504's electronic medical record revealed an admission to the facility on 3/11/25 with the diagnosis of Intracerebral Hemorrhage (bleeding inside the brain), Muscle Weakness, Falls, Cerebral Infarction (an ischemic stroke, is the pathologic process that results in an area of necrotic tissue in the brain) Hemiplegia and Hemiparesis affecting left dominant side (mean the non-dominant brain hemisphere (typically the right) has sustained damage), Progressive Vascular Leukoencephalopathy refers to the slow, progressive damage to the brain's white matter caused by the deterioration or blockage of small blood vessels), Morbid Obesity, Glaucoma, Implantable Loop Recorder (ILR) (a heart monitor) and Neuropathy. R504's has a Brief Interview for Mental Status score of 15/15 (cognitively intact with normal thinking, learning, and memory skills) dated 5/15/26.A review of R504's care plan revealed the following:Problem (R504) is at risk for falls due to generalized muscle weakness with impaired/unsteady gait with history of falls Dated 3/12/2025.A review of R504's MDS (Minimum Data Set) section GG (measures a patient's functional abilities) dated 5/15/26 revealed the following:Roll left and right: The ability to roll from lying on back to left and right side and return to lying on back on the bed. (R504 scored Substantial/Maximal Assistance: Substantial/Maximal Assistance-Helper (staff) does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort).A record review of R504 progress note created Registered Nurse C (RN C) on 5/23/2026 at 09:29 am revealed the following: Informed by (CNA D) that while (CNA D) was changing (R504's) brief and turning (R504) to the other side (of the bed), resident slid out of bed. Writer and supv(supervisor) enter rm (room)and observed resident sitting on floor between bed and wall. Resident denies any discomfort and striking head. ROM (range of motion) to all 4 extremities without difficult.Staff used Hoyer lift to transfer resident from floor back into bed.A review of R504's progress note dated 5/26/2026 at 5:13 PM, revealed the following: Resident c/o (complain of) pain on right side of head due to a fall over the weekend. Writer reached out to resident attending NP (Nurse Practitioner) and order for x-ray to right side of face and C-spine (the neck region of the backbone) .Resident agreed.A review of R504's progress note dated 6/04/2026 at 10:57PM revealed the following: .Resident sustained a fall approximately two weeks ago. MD ordered transfer today for further evaluation related to previous fall. Resident transferred via EMS (emergency Medical Services) accompanied by two EMS personnel at 8:00 PM .A review of R504's inpatient hospitalization note, dated June 5, 2025, revealed the following: Admitting Diagnoses: Compression Fracture of the Body of Thoracic Vertebra.R504 was discharged from the hospital on 6/9/2026 and admitted to another facility.A review of the facility's CNA D investigation, signed on 6/14/2026, (continued on next page)

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	235502	A. Building B. Wing	06/24/2026

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	revealed the following: Stated at approximately 4:45 AM CNA D went into (R504's) room to give peri-care. (CNA D) notes that (R504) was close to the edge of bed to the resident's right side. (CNA D) asked (R504) to roll to left side which was toward (CNA D). The resident grabbed the mobility bar with (R504's) right hand and proceeded to roll over. The resident crossed (their) right led over the left leg to help roll over. While (R504) was rolling over, (R504) was slowly sliding out of the bed and landed on (their) bottom. (CNA D) stated that the resident did not hit (their) head. (CNA D) also stated that the bed was locked.Attempts to contact CNA D were made on 6/23 at 2:20 pm and at 4:18 pm. A third attempt was made on 6/24/26 at 1:05 pm. All attempts to contact CNA D were unsuccessful.On 6/24/26 at 8:33 AM, CNA E was interviewed about the care provided to R504, post fall on 5/23/26. CNA E stated, (R504 asked me to be careful because their head and leg hurt from falling out of bed last shift (on 5/23/26, midnight shift). (R504's) roommate (R505) said (R504) hit (their) head on the wall too. I asked (R504) why they did not tell the nurse about their pain. (R504) said they didn't want to be a problem. At that time CNA E said she told the nurse about R504's pain.On 6/24/26 at 8:42 AM R505 (R504's roommate during the time of the fall) was observed sitting on the side of their bed, wearing a hospital gown, and watching TV. R505 was asked about R504's fall from the bed. R505 stated, The Aide (CNA D) came to the room to change (R504's) brief.(R504's) bed was up against the wall (on R504's right side) .the Aide (CNA D) started rolling (R504) toward the wall (on the R504's) right side and the Aide was on the other side (R504's left side) . R504) started yelling 'I'm falling, I'm falling.that girl kept saying 'roll over, roll over, grab the bar'. R505 asked how (R505) was able to visualize that event. R505 stated, I'm nosy.I was looking at them because the curtain was open and I was at the bottom of the bed.I was looking with my own eyes the whole time.the bed was rolling because it didn't look to be locked.I saw the Aide (CNA D) kept trying to roll (R504) over and (R504) said 'stop, stop I'm falling'. R505 said R504 ended up falling on the floor. R505 said CNA D asked R504, why did you do that? R505 stated, (R504) said my leg, my leg.the bed was moved out some. R505 continued, saying R504 was yelling. R505 said, I was concerned because (R504) fell hard and I knew (R504) was hurt.they might get mad at me because I'm talking to you.but I look after people here. R505 said CNA D went to get the nurse, and they got R504 back in bed. R505 said R504 said their head and leg hit on the floor. A review of R505's EMR revealed an admission to the facility on [DATE] with the diagnosis of Atherosclerosis (blood vessels that carry oxygen and nutrients from the heart to the rest of the body become thick and stiff), Falls, Difficulty walking, and Congestive Heart Failure. A review of R505 has a Brief Interview for Mental Status score of 15/15 (cognitively intact with normal thinking, learning, and memory skills) dated 6/12/2026.On 6/24/26 at 11:03 am, R504 was interviewed via telephone to discuss their fall. R504 said, (CNA D) was changing my brief, then (CNA D) unlocked the bed and moved my bed away from the wall. R504 said the bed was against the wall because she asked staff to position it that way, thinking it would help with positioning in bed. R504 continued, (CNA D) moved the bed out and started rolling me towards the wall. (CNA D) was on the other side at my backside. (CNA D) asked me to roll over and started pushing me over.I told (CNA D) that I felt like I was falling because the bed was moving.then (CNA D) kept saying 'roll over', I kept saying 'I'm going to fall'.(CNA D) kept pushing me over and told me to hold the bar.then I fell out of the bed. I felt like (CNA D) kept pushing me and did not stop when I said stop. (CNA D) said to me, 'now why did you do that?' .I told (CNA D) I was falling but (CNA D) didn't say nothing. R504 said they did not feel the pain for a few hours, and added, My head and leg were hurting so badly. R504 explained their pain had gotten worse since the fall.On 6/24/26 at 2:25 pm, a follow-up interview was conducted with the Nursing Home Administrator (NHA) and the DON concerning R504's fall from bed during care. The DON stated that when staff are performing care, they should always consider safety first. The NHA was present for the interview but had nothing to add to the discussion.A review of the facility's policy Care and Treatment: Fall dated 07/11/2018, revealed the following: It is the policy of this facility to evaluate extent of injury after fall, prevent complications and to provide emergency care.6. Evaluate cause of fall.Document all appropriate information in the medical record.11. Note on 24- Hour Report.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. This citation pertains to intake 3034793.Based on interview and record review the facility failed to ensure an X-Ray was completed in a timely manner for one resident (R504) of three residents reviewed for physician orders, resulting in radiology orders not being executed for R504 after a fall. Findings include:On 5/23/26 at 9:45AM, Family Member A was asked about R504's fall. Family Member A said R504 fell off the bed during care. Family Member A said the facility did not send R504 to the hospital until (Family Member A) insisted they (the facility) send R504 to the hospital. Family Member A said R504 did not return to this facility after hospitalization. R504 was admitted to another long-term care facility.A review of R504's electronic medical record (EMR) revealed an admission to the facility on 3/11/26 with the diagnosis of Intracerebral Hemorrhage (bleeding inside the brain), Muscle Weakness, Falls, Cerebral Infarction (an ischemic stroke, is the pathologic process that results in an area of necrotic tissue in the brain) Hemiplegia and Hemiparesis affecting left dominant side (mean the non-dominant brain hemisphere (typically the right) has sustained damage), Progressive Vascular Leukoencephalopathy refers to the slow, progressive damage to the brain's white matter caused by the deterioration or blockage of small blood vessels), Morbid Obesity, Glaucoma, Implantable Loop Recorder (ILR) (a heart monitor) and Neuropathy. R504's has a Brief Interview for Mental Status score of 15/15 (cognitively intact with normal thinking, learning, and memory skills) dated 5/15/26.A record review of R504 progress note created Registered Nurse C (RN C) on 5/23/2026 at 09:29 AM revealed the following: Informed by (CNA D) that while (CNA D) was changing (R504's) brief and turning (R504) to the other side (of the bed), resident slid out of bed. Writer and supv (supervisor) enter rm (room)and observed resident sitting on floor between bed and wall.A review of R504's EMR order dated 5/26/2026 at 4:47 PM, ordered by Physician G revealed the following: X-ray right side of face.R504's EMR order dated 5/26/2026 at 5:26 PM, ordered by Physician G revealed the following: X-ray right side of face and C-spine.A review of R504's Order dated 5/27/2026 at 10:15 PM, ordered by Physician G revealed the following: X-ray right side of face and C-spine.STAT (medical directive meaning immediately and without delay.Prior to R504's transfer to the hospital on 6/4/2026 at 8 PM, the ordered radiology tests were not done.On 6/24/2026 at 2:25 PM, an interview was conducted with the Nursing Home Administrator (NHA) and the DON concerning R504's fall from bed during care, ordered radiology not completed, and R504's change in condition. The DON stated, During this transition (facility's change in ownership and new EMR) we had trouble with our records and keeping track, we found out that the X-Ray was canceled by the radiology people. The DON was asked who was responsible for residents' orders and the DON said the nurse manager should keep up with all orders. The DON was asked if there was documentation of when and why the X-Rays were discontinued. The DON did not respond.A review of the facility's policy Physician Orders, updated 04/09/2021, revealed the following: It is the policy of this facility to ensure that all resident/patient medications, treatment and plan of care must be in accordance to the licensed physician's orders. The facility shall ensure to follow physician orders as input into the medical chart.