STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235516	A. Building B. Wing	06/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rivergate Terrace	14141 Pennsylvania 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38230 This citation pertains to Intake MI144703 Based on observation, interview, and record review the facility failed to provide adequate supervision for one resident (R701) or two residents reviewed for elopements, resulting in a cognitively impaired resident with risk for elopementr exiting the facility unsupervised and the potential for injury. Findings include: Review of the facility investigation and other pertinent documentation regarding a facility reported incident (FRI) that occurred on 5/15/24, revealed that it was reported R701 exited the facility to the outside through the main entrance following an activities aide at approximately 2:56 p.m. Resident #701 was brought back into the facility at approximately 2:58 p.m. by the Director of Rehab with no injury. Review of the clinical record documented R701 was admitted into the facility on [DATE] with diagnoses that included dementia, history of falling, anxiety, and psychotic disorder with hallucinations. According to the admission Minimum Data Set assessment dated [DATE], R701 had severe cognitive impairment, required supervision with walking, and had wandering behavior that occurred 1-3 days. Review of the Elopement care plan date initiated 5/10/24 documented: Focus: At risk for elopement. (Resident's name) wonders without purpose through the building and is often seen exit seeking. Family reports this is a reoccurring behavior regarding to dementia. Goal: The Resident will not leave facility unattended through the next review date (8/7/24). Review of the following progress notes documented: 5/10/24- Psychosocial Note: Resident was added to facility elopement list r/t new admission, independent ambulation, and wandering. 5/12/24- Behavior Note: Resident noted exit seeking this pm shift. Noted door alarm sounding. Resident did NOT exit building and nurse on duty had in visual sight. Resident pushed door open in vestibule and maintained in between doors. Returned to green unit and placed with 1:1hospitality. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/24 at 9:45 a.m. upon entry into the main entrance of the facility, the first set of doors opened automatically. The second set of doors had to be activated by the receptionist from behind the receptionist desk for everyone to enter the facility. A keypad was located next to the doors. The third set of doors that lead unto the units (pass the receptionist desk and through the lobby) were not locked and can be easily pushed or pulled open. On 6/5/24 at 11:10 a.m. the Maintenance Director A was interviewed and said prior to the incident on 5/15/24, staff had access to open the doors using a pass code. Staff no longer have the pass code for the keypad to get out. On 6/5/24 at 12:01 p.m. the Nursing Home Administrator (NHA) submitted a Past Non-Compliance plan to be reviewed and considered. The NHA was interviewed and said employees were terminated following the investigation of the incident. The nurse aide providing one to one supervision was supposed to provide supervision for the resident and their whereabouts were unknown at the time of the incident; the receptionist received an in-service on Elopement due to a previous incident in April. All doors are to be monitored by everyone and the front door is the receptionist's responsibility; and the activity's aide the resident followed out of the building who went to their car while not on break. The resident and activity aide were walking side by side (outside) while the aide looked down the entire time at a cell phone. She never looked up. On 6/5/24 at 2:59 p.m. the video surveillance was reviewed with the NHA and Maintenance Director A present. The video revealed at 2:56 p.m. Activity's Aide B was observed exiting the main entrance of the facility walking towards the parking lot, looking down at a cell phone. R701 was walking slightly behind the aide then next to the aide. Activity's Aide B never looked up from the phone. R701 was then observed walking towards the west side of the building as the aide proceeded to the parking lot. On 6/5/24 at 3:17 p.m. an attempt to interview Activity's Aide B via telephone was made. A message was left on the voicemail for a return call. Activity's Aide B witness statement was reviewed and read, I made a mistake. I didn't realize it was a resident. Had I realized it was resident, I would have stopped them. On 6/5/24 at 3:41 p.m. an attempt to interview Receptionist C via telephone was made. A message as left on the voicemail for a return call. Receptionist C witness statement was reviewed and read in part, Unfortunately I was not able to see the resident come pass me while I was talking to 2 staff as they were signing out and 2 guest were signing in. I missed her . On 6/5/24 at 4:30 p.m. R701 was observed on the Village (dementia) Unit of the facility. R701 was unable to recall the incident. Review of the facility's policy titled Unsafe Wandering and Elopement Prevention dated 9/14/23 documented in part the following: 1. Accurate and thorough assessment of the resident is fundamental in determining indicators for unsafe wandering and elopement. Not all residents exhibit unsafe wandering behaviors or verbalize the desire to leave facility unplanned. A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After review of the facility reported incident, the facility provided evidence of Past Non-Compliance on 6/5/24. The Past-Non-Compliance was reviewed and accepted by the reviewing surveyor. The facility was found to be in substantial compliance with F-tag 689 on 5/17/24 when the following interventions were noted to be put into place by the surveyor on 6/5/24. The facility's past non-compliance indicated the following: Immediate Actions: Policy Review & Staff Education A. The Executive Director and DON reviewed the facility's policies related to elopement and supervision on 5/15/24. There was no revision necessary. The policy meets the standards of best practice. B. The Reception desk staff was provided with training by the Director of H.R. related to the policy with emphasis on redirecting wandering or exit seeking residents and to consult the nurse or social services for resident's care plan or notify the DON/Administrator/MDS Nurse/Social Worker of any new or worsening wandering or exit-seeking behaviors. The training also includes but is not limited to the Front desk staff's responsibility to provide adequate supervision to prevent elopement for a resident with a history of wandering, exit seeking, and assessed to be at risk for elopement. C. The same training was provided to all staff in the non-clinical departments. The training was done by the Department Heads, DON, Asst. Administrator, MDS, Social Worker or Designee. All Receptionists were educated by Human Resource Director. Actions to Prevent Occurrence/Recurrence A. An RCA (root cause analysis) using the Fishbone diagram was done on 5/20/24. It was identified that Resident #18546 N.D. had been at risk for elopement. The error that led to the incident was related to being a 'Human error' verses a 'system failure'. B. Based on the RCA, the following interventions are implemented to address the alleged deficiency: INTERVENTIONS BELOW . a. 1:1 supervision, room change, labs, Happy Feet-activities. b. The At Risk residents' elopement assessments were reviewed on 5/20/24 by the DON (Director of Nursing), Social Worker and Nurses. c. To ensure any subtle resident's changes are identified, the DON/Care Plan Nurse & the Social worker will review all elopement assessments monthly for the next three (3) months, and quarterly and PRN, thereafter. d. Care Plans will also be reviewed monthly for the next three (3) months. (continued on next page)

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