

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235598	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2024
NAME OF PROVIDER OR SUPPLIER Riveridge Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1333 Wells St Niles, MI 49120	

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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>41424</p> <p>Based on observation and interview, the facility failed to provide an environment that promoted a dignified dining experience for 5 residents (R#104, #108, #109, #110, #111, #112) of 13 residents reviewed for dignity, resulting in feelings of disappointment with the dining experiences.</p> <p>Findings include:</p> <p>Resident #104:</p> <p>Review of an Admission Record revealed Resident #104 was a female with pertinent diagnoses which included dementia, anxiety, adult failure to thrive, need for assistance with personal care, diabetes, and sacral pressure ulcer stage 3.</p> <p>Resident #108:</p> <p>Review of an Admission Record revealed Resident #108 was a female with pertinent diagnoses which included cerebral palsy (caused by damage to or abnormalities in the brain that permanently affect body movement, muscle and coordination), epilepsy (disorder nerve cell activity in the brain is disturbed causing seizures), intellectual disabilities, and rett's syndrome (rare genetic brain disorder and development disorder with loss of motor skills, language, causes seizures, unusual hand movements, and slowed growth).</p> <p>Resident #109:</p> <p>Review of an Admission Record revealed Resident #109 was a female with pertinent diagnoses which included diabetes, dysphagia (difficulty swallowing foods and liquids), Alzheimer's disease, anemia, and muscle weakness.</p> <p>Review of Nutrition Initial assessment completed on 11/3/23 .Mechanical soft diet provided to ease chewing/swallowing. HT is pending, requested. CBW is low at 67#. House supplement appropriate and writer is in agreement with this plan. ST in place 10/26. ENN: 1050kcal (35kcal/kg), 42gms protein (minimum requirements), 1500ml fluid (minimum requirements). Resident is dependent on staff for feeding. Continue POC, monitor weights, labs, PO intakes as indicated. Completed by: Registered Dietician FF, RD .</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident #110:</p> <p>Review of an Admission Record revealed Resident #110 was a male with pertinent diagnoses which included cerebral palsy, severe protein-calorie malnutrition, anemia, GERD, autistic disorder, and deformity of musculoskeletal system.</p> <p>Resident #111:</p> <p>Review of an Admission Record revealed Resident #111 was a male with pertinent diagnoses which included down syndrome, weakness, myelopathy (nervous system disorder affects the spinal cord), intellectual disabilities, GERD, and adult failure to thrive.</p> <p>Resident #112:</p> <p>Review of an Admission Record revealed Resident #112 was a male with pertinent diagnoses which included dysphagia, lack of coordination, anxiety, stroke, paralysis left side, and aphasia (language disorder that affects ability to communicate),</p> <p>During an observation on 2/15/24 at 1:00 PM, Resident #109 was observed seated in her wheelchair at a table on the far back left of the dining room. Seated with her at the table was Resident #111. Both residents had received their lunch trays, but no staff were present to assist them with their meals. Resident #108 was seated at a table in the far right back of the dining room and she had her lunch in front of her with no staff present to assist her with her meal. Resident #110 was brought to the table to sit with Resident #108. During an observation at 1:07 PM, Certified Nursing Assistant (CNA) J brought Resident #110 his lunch tray and walked away. Resident #104 and R#112 were seated near the entrance to the dining room with four other residents with three who had already received their lunch trays upon this writer's entry to the dining room at 1:00 PM. CNA J brought a tray to another resident seated at the table and Resident #112 stated I need my plate too; hope you haven't forgotten me. Resident #112 appeared visibly worried about not receiving his lunch tray. And mumbled under his breath about his concern. Resident #104 reported she needed hers too as she hadn't received hers yet either. Resident #104 received her lunch tray at 1:12 PM following her Resident #112 received his tray. Both sat without lunch trays as others at the table had theirs since prior to 1:00 PM as they had their meals when this writer entered the dining room at that time. At 1:13 PM, CNA J went to assist R#108 with eating her lunch meal. Registered Nurse (RN) H proceeded to assist Resident #109 with her meal. At 1:14 PM, CNA I sat with Resident #111 and proceeded to assist him with his meal. Director of Nursing (DON) B sat with Resident #110 and proceeded to assist him with his lunch tray.</p> <p>In an interview on 2/22/24 at 2:11 PM, DON B reported it was a dignity concern for the residents to have their food in front of them and not to be assisted with their meal as well as the food would be getting cold sitting there waiting for staff to assist the resident with their meal. DON B reported all residents who were sitting at the same table should all have their meals at the same time as the others at their table as that was not maintaining their dignity.</p> <p>Review of policy, Promoting/Maintaining Resident Dignity revised on 2/17/23, revealed, .It is the policy of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life .</p>

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</p> <p>This citation pertains to intake: MI00142287</p> <p>Based on interview and record review, the facility failed to facilitate a resident initiated discharge per resident choice, in 1 of 1 residents (Resident #102) reviewed for resident initiated discharge, resulting in the resident's delay in discharge and the accumulation of a bill for services which were no longer required.</p> <p>Findings include:</p> <p>Resident #102:</p> <p>Review of an Admission Record revealed Resident #102 was a male with pertinent diagnoses which included diabetes, diabetic neuropathy (nerve damage which can occur with diabetes), fracture of right tibia (larger lower leg weight bearing bone between knee and foot), wound right great toe, falls, heart disease, muscle weakness, retention of urine (difficulty urinating), acquired absence of left leg below knee, peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), and malignant neoplasm of prostate (cancer in the prostate).</p> <p>Review of Care Management Assessment completed by referring hospital on 11/9/23 at 12:24 PM, revealed, .CM updated Family Member (FM) GG on admission. FM GG informed CM that he and patient have been looking at assisted living, Local AFC) and (Local AFC) in Grayling. FM GG stated that he is going to contact them to see if the (sic) can accommodate patient with his current needs .FM GG stated that he and patient have been discussing having patient move into assisted living .</p> <p>Review of Care Management Assessment completed by referring hospital on 11/9/23 at 10:53 AM, revealed, .Patient states that he is independent with his transfers from bed to WC (wheelchair) and WC to toilet .CM asked patient if he uses the broken leg to walk himself in the WC, patient stated yes .CM explained that patient will not be able to weight bear, per (Orthopedic surgeon) .</p> <p>Review of IDT (Interdisciplinary Team) NOTE dated 11/16/2023 at 10:18 AM, revealed, .IDT met to review for new admit on 11/13/23 with dx on unspecified fx of tibia, PVD, falls at home, BKA left, DM2, Diabetic neuropathy, BPH, prostate CA, heart disease .Wound to right great toe, treatment is in place. Resident and resident POA plan to rehab and transition into ALF (Assisted Living Facility). Will continue to follow in IDT .</p> <p>Review of Care Conference Note dated 12/8/2022 at 10:10 AM, revealed, .Care conference held today with Daughter and resident, therapy looking for resident to discharge soon from therapy as resident has reached his baseline and is able to transfer independently. Family and resident discussing possible transition to Assisted living .</p> <p>Review of record showed Resident #102 was discharged from physical therapy on 12/13/23.</p> <p>(continued on next page)</p>		

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<p>F 0622</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Social Service Progress Note dated 12/21/2023 at 09:56 AM, .Resident and his family request referral be sent to (Local AFC home) ALF. SSD completed today. Will document as needed . No follow up in the medical record with the referral to the local AFC home.</p> <p>Review of Social Services Note dated 1/3/2024 at 3:11 PM, .Resident and his family request referral be sent to (Local AFC home) AFC Home. SSD completed. AFC Home visited res (resident) today and request Healthcare appraisal to be completed. Will document as needed .</p> <p>In an interview on 2/21/24 at 12:59 PM, Social Work Director (SSD) Z reported she was on maternity leave from September 27th to January 1st. SSD Z reported she was not present for Resident #102's care conference and was not sure who was managing his care. SSD Z reported when she came back from maternity leave, she was asked to make a referral to (Local AFC home) which she did complete and let the daughter and Ombudsman know. SSD Z reported she was back one or two days in December and then back out until the first of January. SSD Z reported the facility usually tried to do the referrals right away, if it was noted in the care conference notes than that was what we would do. SSD Z reported As soon as it was requested of me, I had completed it.</p> <p>In an interview on 2/14/24 at 3:05 PM. Family Member (FM) EE reported she had left several messages for them to send a referral to the (Local) AFC home and they wouldn't send it, I left several messages with the facility to send a referral. FM EE reported the AFC needed a referral from the facility in order for Resident #102 to be discharged to the AFC home. FM EE stated, This postponed him leaving the facility and I have to get in contact with the Ombudsman for them to send out referrals to facilities. FM EE reported she contacted the initial AFC home to see if they had received the referral and they reported they had not received a referral from the facility. FM EE stated, This was two weeks before Christmas, we asked them to send a referral to them so we could get him into (Local AFC home) before Christmas. He ended up being private pay as we could not get them to send a referral, and this postponed him leaving there. FM EE reported they finally sent a referral two weeks ago, and we were able to get him discharged on [DATE]. FM EE reported she had left messages with several staff member including the Administrator and never heard back from any of them.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</p> <p>This citation pertains to intake: MI00142287.</p> <p>Based on interview and record review, the facility failed to complete accurate assessments for 1 of 13 residents (Resident #102) reviewed for assessments, resulting in an inaccurate reflection of the resident's status and the potential for impaired medical and functional problems due to unidentified needs.</p> <p>Findings include:</p> <p>.Gerontological nursing provides care that addresses mutually established goals for an older adult, his or her family, and health care team members. A comprehensive assessment, including strengths, limitations, and resources, provides a baseline of the older adult's health and functional status. Nursing diagnoses and interventions are selected to either maintain or enhance physical abilities and activity .and to create environments for psychosocial and spiritual well-being . [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing, Tenth Edition - E-Book (Kindle Location 11794 of 76897). Elsevier Health Sciences.</p> <p>Resident #102:</p> <p>Review of an Admission Record revealed Resident #102 was a male with pertinent diagnoses which included diabetes, diabetic neuropathy (nerve damage which can occur with diabetes), fracture of right tibia (larger lower leg weight bearing bone between knee and foot), wound right great toe, falls, heart disease, muscle weakness, retention of urine (difficulty urinating), acquired absence of left leg below knee, peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), and malignant neoplasm of prostate (cancer in the prostate).</p> <p>Review of Problem List provided by referring hospital it was noted Resident #102 had a non-healing ulcer of foot .peripheral artery disease .debility .</p> <p>Review of AFC/ECF Transfer Hand-Off form dated 11/13/23 at 11:21 AM revealed, .Report called: Given to (LPN W) .Present Illness/Reason for Admission: Rt (right) tibial fracture - knee immobilizer at all times .0 SX (non surgical) .Patient Goals: F/U (follow up) ortho 1-2 weeks .Skin: Blisters inner R (right) knee .R skin red, bruising .R great toe wound .See wound clinic .Last changed on 11/10/23 at 2:30 PM .</p> <p>Review of the Admit/Readmit Nursing UDA Bundle dated 11/15/23 at 7:56 AM , revealed, .A. Head to Toe Skin Check: 1. Skin integrity: a. skin intact .2. Skin Observation Details - For any areas identified, document the site and a thorough description .Site: Other (specify) .Description: No description was provided .9. Additional Notes: Nothing was noted here.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 02/21/24 at 2:08 PM, Director of Nursing (DON) B reviwed the skin assessment in the medical record and reported a skin assessment was completed which did not include the description of what Other meant in the assessment completed on 11/15/23 with no notation of the two blisters, redness to the shin area, or the wound on the right great toe in the assessment. The nurses were educated during initial orientation on the completion of assessments when they were with the nurse on the floor. DON B reported during morning meeting the staff discussed the new admissions and their needs. When queried whether the blisters, redness or the right great toe ulcer were noted on the skin assessment, the DON B reported they were not.</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</p> <p>This citation pertains to intake: MI00142287</p> <p>Based on interview and record review, the facility failed to completely assess and establish a baseline care plan for 1 resident (Resident #102) of 13 residents reviewed for baseline care plans, that included measurable goals, and interventions to address priority risk factors and individual needs resulting in the potential for ineffective care and continuity of care to be provided to the resident.</p> <p>Findings include:</p> <p>Resident #102:</p> <p>Review of an Admission Record revealed Resident #102 was a male admitted on [DATE] with pertinent diagnoses which included diabetes, diabetic neuropathy (nerve damage which can occur with diabetes), fracture of right tibia (larger lower leg weight bearing bone between knee and foot), wound right great toe, falls, heart disease, muscle weakness, retention of urine (difficulty urinating), acquired absence of left leg below knee, peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), and malignant neoplasm of prostate (cancer in the prostate).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 11/20/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated Resident #102 was cognitively intact.</p> <p>Record review revealed there was no plan of care for activities of daily living (ADL) as Resident #102 had an ADL self care performance deficit related to right tibia fracture, urinary foley catheter, left lower leg amputation, vascular disease, gout, right great toe wound, and diabetes. Resident #102's baseline care plan was not in place for nursing staff to provide person centered, resident specific ADL care for R#102 within 48 hours.</p> <p>Review of the Section 3: Baseline Care Plan Summary indicated it was completed on 12/4/23 at 1:28 PM.</p> <p>Review of the record showed no signature by Resident #102 to verify that the summary was provided.</p> <p>Review of the comprehensive care plan indicated a care plan was not initiated for Resident #102's focuses, goals and interventions until 11/16/23.</p> <p>In an interview on 02/21/24 at 2:15 PM, Director of Nursing (DON) B reported he was admitted on [DATE] and the baseline care plan should have been completed prior to 11/16/23 to ensure nursing staff have the care plan focuses and interventions to ensure person centered care.</p> <p>(continued on next page)</p>

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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of policy, Baseline Care Plan revised on 1/2024, revealed, .The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care .1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission .b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: i. Initial goals based on admission orders .ii. Physician orders .iii. Dietary orders .iv. Therapy services .v. Social services .6. The person providing the written summary of the baseline care plan shall: a. Obtain a signature from the resident/representative to verify that the summary was provided .b. Make a copy of the summary for the medical record .</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>41424</p> <p>Based on observation, interview, and record review, the facility failed to implement resident comprehensive care plans for 1 resident (Resident #108) of 9 residents reviewed for care planning, resulting in a lack of service for residents to maintain their highest practicable physical, mental, and psychosocial well-being.</p> <p>Findings include:</p> <p>Resident #108:</p> <p>Review of an Admission Record revealed Resident #108 was a female with pertinent diagnoses which included cerebral palsy (caused by damage to or abnormalities in the brain that permanently affect body movement, muscle and coordination), epilepsy (disorder nerve cell activity in the brain is disturbed causing seizures), intellectual disabilities, and rett's syndrome (rare genetic brain disorder and development disorder with loss of motor skills, language, causes seizures, unusual hand movements, and slowed growth).</p> <p>Review of current Care Plan for Resident #108, revised on 10/27/23, revealed the focus, .(Resident #108) has an ADL self-care performance deficit r/t (related to) cerebral palsy, epilepsy, generalized anxiety disorder, depression, Rett's syndrome, osteoarthritis . with the intervention .Palm protectors to be worn at all times, remove to wash and dry hands .</p> <p>Review of Resident #108's order summary revealed no order written for the use of hand paddles for contractures to both upper extremities.</p> <p>Review of Skilled Nursing Facility History & Physical dated 10/24/23, revealed, .Musculoskeletal: Comments: Contractures and atrophied muscles of all 4 extremities - left > right .Hand splints in place .</p> <p>During an observation on 2/16/24 at 11:31 AM, Resident #108 was seated across from the nurse's station in her wheelchair, observed a paddle pad in her left hand, and her arm was contracted upward at the elbow as well. She was able to move her right arm, but her right hand the last three fingers were tighter closed shut like a fist and her index finger was more relaxed but still contracted. No hand paddle pad was noted in her right hand.</p> <p>In an interview on 2/21/24 at 9:54 AM, Certified Nursing Assistant (CNA) U reported the CNAs can look at the resident's information in the medical record, she reported she uses a paper as she was still new and learning the residents. CNA U reported she likes the paper as she had it right with her.</p> <p>In an interview on 2/21/24 at 09:53 AM, Licensed Practical Nurse (LPN) BB reported the resident assignment sheets for the CNAs were kept in the desk at the nurse's station and they were updated on third shift if there were any new changes to the resident's plan of care.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/21/24 at 2:07 PM, Director of Nursing (DON) B reported an order would be needed, not noted in the order summary as well as when reviewed the therapy notes .Came to us from an AFC and she had them when she was admitted . DON B reported she knew staff were implementing care plan interventions when completing walking rounds through the facility.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</p> <p>This citation pertains to intake MI00142287.</p> <p>Based on observation, interview, and record review, the failed to follow professional standards of nursing practice in 1 (Resident #102) of 13 residents reviewed for standards of practice when the facility 1). failed to ensure orders were in place for catheter care and monitoring 2.) failed to ensure Resident #102's wound was assessed and treated and 3.) failed to ensure Resident #102 received follow up care with an orthopedic surgeon as recommended resulting in the potential for worsening of health conditions.</p> <p>Findings include:</p> <p>Resident #102:</p> <p>Review of an Admission Record revealed Resident #102 was a male with pertinent diagnoses which included diabetes, diabetic neuropathy (nerve damage which can occur with diabetes), fracture of right tibia (larger lower leg weight bearing bone between knee and foot), wound right great toe, falls, heart disease, muscle weakness, retention of urine (difficulty urinating), acquired absence of left leg below knee, peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), and malignant neoplasm of prostate (cancer in the prostate).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 11/20/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated Resident #102 was cognitively intact.</p> <p>Review of Instructions for Standing Orders revised on 5/17/22, .Instructions for Standing Orders .*Order must be in place on that individual residents order list in (EMR) stating the physician has reviewed and approved the routine standing orders in order to implement an order from the standing order sheet without notifying the physician prior to starting the order .Order must then be written for the specific order from the standing orders page that you are implementing so that the physician signs the specific order and we can document the administration on the MAR/TAR (Medication Administration Record/Treatment Administration Record) . Remember to notify the physician and resident/resident representative as needed regarding any change in condition, as required. Document notification of physician and resident/resident representative .</p> <p>Review of Nursing Note dated 11/13/2023 at 7:39 PM, revealed, .Resident arrived about 1830 (6:30) pm accompany with his daughter and son. He uses wheelchair to ambulates. He wear glasses and hearing aids. He is alert, oriented to place and time. He has a fracture on R/tibia and is wearing a splint. He has a hx L/BKA (left below the knee amputation), diabetes, HTN. He requested to be transfer with sliding board. He has a foley catheter due to chronic urinary retention. He is regular diet. He has a wound on R/great toe .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Admission Note dated 11/14/2023 at 09:05 AM, revealed, .Resident is A & O X 3 with some cognitive issues; he is pleasant and co-operative with staff; he wears glasses, 2 hearing aids & has a full set of Dentures .Resident 69 inches and weighs 168 pounds .He is NON WEIGHT BEARING .Resident arrived per day shift nurse at approx. 1830 via ambulance with daughter and 2 other family members following him in. He is a patient of (Medical Director) MD .House medical Director. Allergies include: Cefepine & Cephalexin. Skin is warm and dry with a dark bruise on his RLE (right lower extremity), measuring 18 cm X 12.5 cm. He has a C/D/I (clean, dry, and intact) dressing on his right great toe. He has a Knee immobilizer on his RLE relating to recent tibial fracture. Has Left BKA with no s/sx (signs/symptoms) of breakdown. HRR @ 72/minute; Lungs are clear throughout bilaterally; Bowel sounds are + X 4 quads with last BM stated yesterday, he is incontinent of bowel and wears a brief/pull-up .Resident has a foley catheter which is draining to gravity clear, yellow urine with a scant amount of sediment, no hematuria or foul odor noted. Fluids are encouraged and provided at bedside. Medications have arrived from pharmacy as well as a clarification with Pharmacist about his Lupron 45 mg/6 months IM, which is due on May 1st, 2024 .Resident is requesting Grab Bars for strengthening, repositioning and transfers .Resident demonstrates use of call light and bed controls. Cares rendered Q 2-3 hours and Prn, leaving bed in low position and call light in reach .</p> <p>Review of written Nurse to Nurse report for Resident #102's admission, revealed, .2 blisters knee and bruises .R (right) great toe wound .Foley catheter last changed November 4 .Continent of bowel .Follow up with ortho (Orthopedic) .Slide board .Needs Trapeze .</p> <p>1. Catheter care:</p> <p>In an interview on 2/16/23 at 10:53 AM, Licensed Practical Nurse (LPN) W reported she did not remember Resident #102 at admission. LPN W reported at admission received a report from the referring facility, for example if he had a catheter there would need to be a reason for it, a diagnosis which supported the use of it. LPN W reported that you would inform the doctor of the resident having a catheter and the expectation would be that he would give you orders on care and monitoring of the resident with the catheter and if the doctor does not then it is expected the nurse would follow up with the provider and obtain those orders for care and monitoring.</p> <p>Review of Order Summary for Resident #102 revealed, no orders for catheter care/foley size, catheter secure device, change catheter bag, monitor input/output, catheter bag positioning or any order relevant for the care of Resident #102' urinary foley catheter when he was admitted on [DATE].</p> <p>Review of Standing Physician Orders document revised on 5/17/22, revealed, no orders for the care of urinary foley catheter care.</p> <p>Review of Treatment Administration Record (TAR) for Resident #102 for November 23 and December 23 revealed no treatments/orders for catheter care.</p> <p>Review of Order Summary for Resident #102 revealed order entered on 1/2/24 to start on 1/3/24, revealed, . Indwelling Urinary (Foley) Catheter measure and record output every shift .DC'd on 1/8/24.</p> <p>Review of medical record revealed no indication as to why the order for 1/3/24 was entered.</p> <p>Review of Treatment Administration Record (TAR) for Resident #102 for January 2024, revealed, missing entries for .1/4/24, Night shift .1/5/24, Day shift .</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Skin Assessment/Wound Management:</p> <p>Review of AFC/ECF Transfer Hand-Off form dated 11/13/23 revealed, .Report called: Given to (LPN W) . Present Illness/Reason for Admission: Rt (right) tibial fracture - knee immobilizer at all times .0 SX (non-surgical) .Patient Goals: F/U (follow up) ortho 1-2 weeks .Skin: Blisters inner R (right) knee .R skin read, bruising .R great tow wound .See wound clinic .Last changed on 11/10/23 at 2:30 PM .Genitourinary: Foley k- has changed 1st of the month .Last changed 11/1/23 Dated 11/13/23 at 11:21 AM .</p> <p>Review of Resident #102's Treatment Administration Record (TAR) for November 23, December 23, and January 24 revealed, No dressing changes were completed on the 11/14, 11/18, 11/28, 12/2, 12/12, 12/16, 12/26, and 12/30 with no documentation of dressing change refusals noted in the medical record.</p> <p>Review of the medical record for Resident #102 revealed no skin/wound notes, measurements/depth/volume/stage, documentation of the wound condition, and progress of healing/non-healing.</p> <p>In an interview on 2/21/24 at 11:46 AM, Licensed Practical Nurse (LPN) X reported she did not have Resident #102 on the wound report. LPN X reported she received notification of a resident with a wound when a referral for admission was submitted, and if not, then there would be a note placed in her box by the admitting nurse/nurse. LPN X reported she had been working third shift to assist the facility with nursing coverage and had not been able to participate in any interdisciplinary team meetings or other administration staff meetings where the resident's conditions were discussed. LPN X reported the nurses do the skin assessments and she completed assessments relative to the residents on her wound report. LPN X reported when a resident had a new wound or arrived with a wound, she would verify there was a treatment in place, measure and document the condition of the wound, and if necessary, have the wound provider complete an assessment on the resident. LPN X reported sometimes she hears of a wound during report when taking over for the off going nurse or at times had been informed by the Director of Nursing. LPN X reported she tried to have Monday and Tuesdays off from the floor so she would be able to complete wound rounds with the wound provider.</p> <p>3. Fractured tibia/Referral to orthopedics:</p> <p>Review of CT Lower Extremity W/O (without) Contrast dated 11/8/23 at 10:01 PM, revealed, .Findings: Severe osteopenia (condition when the body doesn't make new bone as quickly as it reabsorbs old bone) . Impression: Depressed medial lateral tibial plateau fracture (break of the larger lower leg bone below the knee that breaks into the knee joint that can involve the bone, meniscus, ligaments, muscles, tendons) with lipohemarthrosis (escape of fat and blood from the bone marrow into the joint) .</p> <p>Review of Follow Up after Discharge from the Hospital document from referring hospital revealed, .Facility to schedule .Follow up with (Name of Orthopedic surgeon) office .Within 1 to 2 weeks .</p> <p>Review of paper Order in Resident #102's medical record revealed, .Right tibia x-ray, multi views. Please send results to ortho office .Ordered on 12/22/23 . The order was not completed, and no results were located in the medical record.</p> <p>Review of Order dated 1/4/24 revealed, .Xray right lower leg (tib/fib) 2 views .Discontinued . Resident discharged on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of paper Order in Resident #102's medical record revealed, .12/19/23 .Ortho referral r/t (related to) R fx of femur . No order for referral to orthopedic surgeon was entered at admission on 11/13/23.</p> <p>Review of facsimile cover paper sent on 12/20/23 revealed, faxed over the need for a follow up appointment with a local orthopedic for cast removal and status of healing.</p> <p>In an interview on 02/16/24 at 11:03 AM, Senior Receptionist II reported Resident #102 did have an appointment scheduled on 12/26/23 but the appointment was cancelled by the facility due to lack of transportation. Resident #102 was not scheduled again to see an orthopedic surgeon until 1/12/24.</p> <p>In an interview on 02/16/24 at 3:24 PM, Medical Records AA reported she was the person who arranged transportation for appointments for the residents. Medical Records AA reported there were two drivers until recently within the last few weeks. Medical Records AA reported if there was a problem where the facility would not be able to transport or it was an urgent need, the facility would use another transportation company to transport the residents. This writer requested the December appointments which required transportation. Medical Records AA reported she did not have it due to it deleting.</p> <p>This writer reviewed the schedule for Medical Records AA and Transporter Y, and both worked on 12/26/23 and requested maintenance logs for the facility bus and there was no maintenance conducted on 12/26/23.</p> <p>In an interview on 2/16/24 at 10:19 AM, Unit Manager - LPN O reported the nurse would call the doctor and verify orders, place orders in computer, initial review of systems, in there would be the bowel and bladder, skin assessment, elopement, wounds had on admission. LPN O reported she would assist with the admission was completed to review the medications and orders, make sure the orders were correct, would review the admission packet and the hospital records to verify order. If the resident had a wound, would have ensured a would referral have bene completed for those new admissions who have a pressure ulcer, anything big and for chronic conditions. Would tell the wound nurse so would determine the need for referral to the wound provider. For catheters, there were standing orders for them such as the order to change the catheter monthly, catheter care every shift, and depending on the needs of the resident would monitor outputs. LPN O reported catheter bag changes were completed when the foley catheter was changed that was the facility process.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/21/24 at 0946 AM, Licensed Practical Nurse (LPN) BB reported the admission checklist/assessment on the computer was separated, done within 24 hours. LPN BB reported when the resident was admitted there would be weights, skin assessment - really a head to toe, full body assessment involving the lungs, heart, abdomen. LPN BB reported if a resident admitted with a brace, she would undo the brace and take a look at the skin underneath. LPN BB reported she would review the orders from the referring facility and review those with the doctor. If the provider wrote no orders for the care of a wound, LPN BB reported she would review the orders from the referring facility as they should specify and suggest the orders to the provider and use those orders until the wound provider was able to complete an assessment on the new resident. LPN BB reported if the mention of a foley catheter was in the discharge paperwork, she would bring the discharge paperwork to the doctor's attention that the resident had a foley catheter and obtain orders for further care. LPN BB reported in the discharge paperwork if the resident had an appointment or one needed to be scheduled, she would contact the transporter as she was the one who would set up transportation for the appointments as well as scheduled appointments. We would get the referral from the doctor that the resident needed to be seen by a provider like the orthopedic surgeon, he would write a referral to one of our orthopedics the facility used.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/21/24 at 1:27 PM, Director of Nursing (DON) B reported with new admissions, the nurse would have reviewed the orders, assessed the residents from head to toe, skin, completed vital signs, completed the whole admission checklist the facility had, reviewed standing orders for the new admissions. Reviewed the admission bundle for Resident #102 and under Skin observation: Other - description for other - no notes or no additional notes we added to determine what other had been. The nurse would make note of the catheter present on admission, for the right great toe wound the nurse would write down the information of the resident and place it in the wound nurse's box on her door. DON B reported the wound nurse had been helping the facility out by working third shift. DON B reported the responsibilities of the wound nurse would have included measurements of the wound, follow up and follow through to ensure treatment was in place, contact the wound doctor if needed and send a referral over to him. DON B reviewed the orders for treatment and the treatment administration record for Resident #102 and reported there were missed dressing changes for November and December as well as no treatment or monitoring for the blisters or the redness on his shin. DON B reported the treatment does automatically pop up when the nurse reviewed the work to be done and the nurse would have to click through or put in the whatever was completed from the order. When queried what the condition of Resident #102's wound was she reported you would not know if you didn't do the dressing changes and assessed the wound. Review of the medical record, DON B was able to determine the resident attended a wound clinic for his right great toe wound prior to his hospitalization for the fracture. DON B reported there were standing orders for catheter care and when to change the foley catheter. DON B also reported if there were any follow up appointments the nurse would inform the provider for an order for a referral. When queried why an order was written on 1/1/24, DON B reviewed the treatment administration record for January and there was no explanation as to why the nurse put in a treatment to monitor the output for Resident #102's catheter. The medical record was reviewed and there was no explanation in the progress notes and no order for the treatment as well. DON B reported the orders and admissions were double checked by herself and the Unit managers. DON B reported we try to check them the next day unless they admit on a Friday then it would be completed on Monday. When queried why there was no completed orders for x-rays or assessments completed by the doctor for the fractured tibia. The doctor was responsible to assess the leg and order the x-rays. When queried why the x-ray ordered on 12/22/23 was not completed and a new order was entered on 1/4/23 she was unsure why and indicated an x-ray should have been completed sooner. DON B reported the facility would not be sure on how the fracture was healing or if there was anything else which happened to the fracture until an x-ray was completed.</p> <p>In an interview on 2/21/24 at 2:03 PM, Director of Nursing (DON) B reported the admitting nurse would go through the list of orders with the MD prior to entering them in the system.</p> <p>In an interview on 2/21/24 at 2:17PM, Administrator A reported she expected good customer services from her staff, expect staff to greet the resident, staff member to show the new resident their room and help to get them settled. Administrator A reported the paperwork was given directly to the nurse, report was called prior to their arrival, complete the admission packet - most of it is now in (EMR), the nurses would do skin assessment, medications, consents to treat, etc.</p> <p>This writer made multiple attempts to contact the admitting nurse LPN CC while on survey even requesting from Administrator A of a possible additional contact number. This writer left multiple messages with LPN CC.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of policy, Physician Visits and Physician Delegation revised on 1/2024, revealed, .To ensure the physician takes an active role in supervising the care of residents . 1. The Licensed Nurse should: a. Track due dates of physician visits .b. Notify the resident when a physician visit is due .c. Gather medical records and other documents for review by the physician during the visit .d. Make rounds with the physician and provide a verbal update on the resident's condition .e. Provide records such as weight and vital sign records, accident reports, risk assessments, etc. for physician review .f. Remind the physician to date and sign all orders and write a progress note .g. When possible, review the medical record for completeness, prior to the physician leaving the facility .h. Write a note to reflect the date and time of the physician visit, an indication as to whether new orders were written or no new orders were received and any special discussions between the resident and/or family and physician during the visit .i. Inform the Director of Nursing when a physician visit does not occur within the required timeframes. (Note: A physician visit is considered timely if it occurs no later than 10 days after the date the visit was required.) .j. Execute a verbal order with the attending physician for approval of any orders for care written by the Medical Director or alternate physician when visiting for the attending physician .</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>41424</p> <p>This citation pertains to intake: MI00142287</p> <p>Based on observation, interview and record review, the facility failed to ensure assistance with Activities for Daily Living (ADL) care was provided for 2 (Resident #102 and #108) of 9 residents reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for residents who are dependent on staff for assistance.</p> <p>Findings include:</p> <p>Resident #102:</p> <p>Review of an Admission Record revealed Resident #102 was a male with pertinent diagnoses which included diabetes, diabetic neuropathy (nerve damage which can occur with diabetes), fracture of right tibia (larger lower leg weight bearing bone between knee and foot), wound right great toe, falls, heart disease, muscle weakness, retention of urine (difficulty urinating), acquired absence of left leg below knee, peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), and malignant neoplasm of prostate (cancer in the prostate).</p> <p>Review of current Care Plan for Resident #102, revised on 7/10/2018, revealed the focus, (Resident #102) has an ADL self-care performance deficit r/t (related to) tibia fx (fracture) right, left BKA (below the knee amputation), PVD (peripheral vascular disease), gout, DM2 (type 2 diabetes) . with the intervention . Bathing/Showering: (Resident #102) requires extensive staff assistance with bathing/showering as needed . Provide sponge bath when a full bath or shower cannot be tolerated .Toilet Use: Requires limited to extensive assist of 1 staff member .(Resident #102) is able to: use slide board with 1 staff assist .</p> <p>Review of Shower sheet document revealed, .If resident refuses, a nurse's note is required, and supervisor need to be notified. Time of refusals are to be documented here and in nurses note (must be offered multiple times throughout shift) .</p> <p>Review of Shower Sheets dated 11/20/23 revealed, .11/20/23: bed bath - nurse approval for bed bath, no items inspected . No nurse signature on sheet reflecting review of document.</p> <p>Review of Shower Sheet dated 12/8/23, revealed, .Bed Bath requested by family . No nurse signature on sheet reflecting review of document.</p> <p>Review of Shower Sheet dated 12/11/23, revealed, .Bed bath per resident request . No nurse signature on sheet reflecting review of document.</p> <p>Review of Shower Sheet dated 12/18/23, revealed .Bed bath . No nurse signature on sheet reflecting review of document.</p> <p>Review of Shower Sheet dated 12/21/23, revealed, .Bed bath . No nurse signature on sheet reflecting review of document.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Shower Sheet dated 12/25/23, revealed, .Refused both below: (Shower and Bed Bath) .Note: Cast he does not want to get wet . No documentation on the sheet of 1st attempt, reason .2nd attempt, reason . Nurse re-approached .Time and Reason. No nurse signature on sheet reflecting review of document.</p> <p>Review of progress notes showed Resident #102 refused a shower/bed bath on 12/25/23. No other progress notes for shower/bed bath refusals noted in the medical record.</p> <p>Review of Shower Sheet dated 12/28/23, revealed, .Bed bath . No nurse signature on sheet reflecting review of document.</p> <p>Review of Resident #102's bathing schedule, he should have been provided with a shower/bed bath on 11/16/23, 11/20/23, 11/23/23, 11/27/23, 11/20/23, 12/4/23, 12/7/23, 12/11/23, 12/14/23, 12/18/23, 12/21/23, 12/25/23, 12/28/23, 1/1/24, 1/4/24, 1/8/23 . Note: 16 opportunities for the resident to receive a shower/bed bath.</p> <p>Review of Bowel and Bladder Review completed on 11/16/23 at 2:11 PM, revealed, .What is this resident's current bowel status? A. Continent of bowel .</p> <p>Review of Care Management Assessment completed by referring hospital on 11/9/23 at 10:53 AM, revealed, .Patient states that he is independent with his transfers from bed to WC (wheelchair) and WC to toilet .CM asked patient if he uses the broken leg to walk himself in the WC, patient stated yes .CM explained that patient will not be able to weight bear, per (Orthopedic surgeon) .</p> <p>In an interview on 2/14/24 at 3:05 PM, Family Member (FM) EE reported Resident #102 reported to her he never received a shower and for two weeks he had laid in his bed, was not assisted to get out of bed to get up in his wheelchair and was not taken to use the toilet. FM EE reported the resident was placed in briefs until his release even though he was continent. FM EE reported when Resident #102 discharged to his new residence, the staff had a commode in his room. FM EE stated he was so happy to be out of the briefs, he was embarrassed to wear the briefs as he was continent, and this really bothered him they didn't maintain his dignity and forced him to wear the briefs. FM EE reported the trapeze would have been very helpful for him to have as he would have been able to get himself out of his bed to his wheelchair as he used a trapeze at home. FM EE reported she did not understand why they would not get him out of bed.</p> <p>Review of the written nurse to nurse report received on 11/13/23 revealed Resident #102 did request a trapeze for over his bed.</p> <p>Resident #108:</p> <p>Review of an Admission Record revealed Resident #108 was a female with pertinent diagnoses which included cerebral palsy (caused by damage to or abnormalities in the brain that permanently affect body movement, muscle and coordination), epilepsy (disorder nerve cell activity in the brain is disturbed causing seizures), intellectual disabilities, and Rett's syndrome (rare genetic brain disorder and development disorder with loss of motor skills, language, causes seizures, unusual hand movements, and slowed growth).</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of current Care Plan for Resident #108, revised on 10/27/23, revealed the focus. .(Resident #108) has an ADL self-care performance deficit r/t (related to) cerebral palsy, epilepsy, generalized anxiety disorder, depression, Rett's syndrome, osteoarthritis . with the intervention .(Resident #108) is totally dependent on staff to provide shower as necessary. 2 person assist for constant supervision during bathing using reclining shower chair .Palm protectors to be worn at all times, remove to wash and dry hands . Personal Hygiene/Oral Care: (Resident #108) is totally dependent on staff for personal hygiene and oral care .Observe for facial hair, grooming as needed and per resident's choice/preferences .</p> <p>During an observation on 2/15/24 at 1:07 PM, Resident #108 was observed in the dining room with her hair matted, uncombed, and facial hairs on her chin approximately 3/4 inch in length.</p> <p>During an observation on 2/16/24 at 11:31 AM, Resident #108 was seated across from the nurse's station in her wheelchair, observed a paddle pad in her left hand, and her arm was contracted at the elbow as well. She was able to move her right arm, but her right hand the last three fingers were tighter closed shut like a fist and her index finger was more relaxed but still contracted. Resident #108's hair was all matted, uncombed, and had knots in her hair. Observed to have a dry mouth and had hairs on her chin approximately 3/4 inch in length.</p> <p>During an observation on 2/16/24 at 1:50 PM, Resident #108 was observed seated across from the nurse's station in her wheelchair with her hair matted and uncombed. Her hand paddles for the contractures to her left and right hands were observed to be soiled with brown/tan substances appearing like dirt. Resident #108 had white liquid running down the corners of her mouth/chin area.</p> <p>During an observation on 2/21/24 at 9:38 AM, Resident #108 was observed seated across from the nurse's station in her wheelchair with her hair matted, uncombed, and facial hairs on her chin approximately 3/4 inch in length.</p> <p>Review of Resident #108's bathing schedule, she should have been provided with a shower/bed bath on 10/27/23, 10/31/23, 11/3/23, 11/6/23, 11/10/23, 11/10/23, 11/14/23, 11/17/23, 11/21/23, 11/24/23, 11/18/23, 12/1/23, 12/5/23, 12/8/23, 12/12/23, 12/25/23, 12/19/23, 12/22/23, 12/26/23, 12/29/23, 1/2/24, 1/5/24, 1/9/24, 1/12/24, 1/16/24, 1/19/24, 1/23/24, 1/26/24, 1/30/24, 2/2/24, 2/5/24, 2/9/24, 2/12/24, 2/16/24 .</p> <p>No shower sheets were completed for the following dates: 10/27/23, 11/21/23, 11/24/23, 12/1/23, 12/5/23, 12/15/23, 1/2/24, 1/5/24, 1/12/24, 1/19/24, 1/23/24, 1/30/24, 2/2/24, and 2/9/24.</p> <p>In an interview on 2/16/24 at 12:00 PM, Certified Nursing Assistant (CNA) U reported the skin sheets were completed with each shower, documented in the task section as well, try two times, third time would be the nurse, and the reason for refusal was documented on the shower sheet.</p> <p>Review of a document posted at the nurse's station on 02/21/24 at 10:03 AM, revealed, .Shower schedule and completed skin sheets are to be given to the unit manager after Charge Nurse reviews, signs and make a progress note if necessary .</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/21/24 at 09:46 AM, Licensed Practical Nurse (LPN) BB reported the staff would reapproach the resident to see if they had changed their mind about the shower/bed bath. Maybe had another staff member approach to see if more willing with them. If the resident continued to refuse, as the nurse she would reapproach and if the resident still refused, it would be documented in a progress note as well as the CNA would document on the shower sheets.</p> <p>In an interview on 2/21/24 at 2:03 PM, Director of Nursing (DON) B reported when a resident refused a shower, the resident would be offered a second time, then a third time we might have offered a bed bath. If the resident refused both, a progress note would be completed to document the refusal as well as the shower sheet would note the attempts and refusal. The nurse would sign off on the shower sheet regardless.</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>This citation pertains to intake MI00142075 and MI00142287.</p> <p>Based on interview and record review, the failed to ensure quality of care for 2 (Resident #101 and #102) of 13 residents reviewed for quality of care when the facility failed to 1.) ensure assessment and treatment were completed for reported pain and elevated blood glucose levels for Resident #101 and 2.) ensure diabetic monitoring was in place for Resident #102 resulting in the lack of assessment, monitoring, and documentation and the potential for the worsening of a medical condition and the delay in treatment.</p> <p>Findings include:</p> <p>Resident #101</p> <p>Review of an Admission Record revealed Resident #101, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and type 2 diabetes.</p> <p>During an interview on 2/15/24 at 11:34 AM, Family Member (FM) P reported that Resident #101 began reporting left foot pain on 12/24/23. FM P reported that Resident #101 had reported her foot pain to staff, but they were not addressing the concern. FM P reported that Resident #101's foot began to swell, was painful to touch, and she was unable to walk. FM P reported that on 12/28/23 an x-ray was ordered for Resident #101's foot which was negative for any fractures. FM P reported that Resident #101 continued to report pain and staff did not assess her foot after the x-ray was completed. FM P reported that on January 6th, 2024, therapy staff observed Resident #101's foot and noted Resident #101's foot and ankle to be swollen and bruised with a possible pressure ulcer on her ankle.</p> <p>Review of Resident #101's Radiology Results Report dated 12/29/24 revealed, Procedure: Foot 2V (2 views). Reason for study: . Pain in left foot . Conclusion: No obvious or acutely displaced fracture. 2. Repeat radiographs recommended if symptoms persist or worsen . Procedure: Ankle 2V. Reason for study Pain in left ankle and joints of left foot . Conclusion: No obvious or acutely displaced fracture. 2. Repeat radiographs recommended if symptoms persist or worsen .</p> <p>Review of Resident #101's Orders for December 2023 and January 2024 did not reveal any orders related to her left foot or ankle.</p> <p>Review of the facility's Physician Log Book revealed a request written on 1/2/24 which noted Comments/concerns to be addressed: Resident #101 left foot edema with discoloration Action taken by provider: This was initialed by Medical Doctor (MD) Q and dated 1/4/24. The log did not indicate what actions were taken.</p> <p>Review of Resident #101's Progress note completed by MD Q on 12/28/23 revealed, Physical Examination . Skin: No rashes. No lesions. No ulcers present Musculo: (Musculoskeletal) No clubbing. No cyanosis. No edema. Normal range of motion noted in extremities . It was noted that the progress note did not address Resident #101's foot pain or elevated blood glucose levels.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #101's Progress note completed by MD Q on 1/4/24 revealed, Discharge Planning. Patient is being seen today by MD Q for face to face discharge visit. Patient was admitted following a recent hospital course. During admission in the facility patient received rehabilitation services involving physical therapy, speech and occupational therapy. Patient has made significant gain in gait, strength and mobility . Patient is stable now and ready of discharge . Physical Examination: SKIN: No rashes. No lesions. No ulcers present. Musculo: No clubbing. No cyanosis. No edema. Normal range of motion noted in extremities . It was noted that the note did not address Resident #101's foot pain or elevated blood glucose levels.</p> <p>Review of Resident #101's Daily skilled note dated 1/3/24 revealed, . Cardiac/Circulation: 2b. Edema present. 2c. Location: left lower leg and foot</p> <p>Review of Resident #101's Daily skilled note dated 1/7/24 revealed, . Cardiac/Circulation: 2b. Edema present. 2c. Location: left lower leg and foot</p> <p>During an interview on 2/21/24 at 10:46 AM, PTA N reported that Resident #101 began reporting pain in her left foot on 12/29/23 and it was noted that swelling was present at Resident #101's left ankle. PTA N reported that Resident #101 was struggling to participate in therapy due to her foot pain, and that therapy did not have an active discharge date for Resident #101.</p> <p>During an interview on 2/21/24 at 12:40 PM, Occupational Therapy Assistant (OTA) R reported that during her session with Resident #101 on 1/6/24, she was complaining of foot and ankle pain. OTA R reported that she had observed what she believed to be a pressure sore on Resident #101's left heel and bruising on her inner and outer ankle. OTA R reported that the pressure sore was dark in color with redness noted around the edge of the pressure sore, and the bruising on her ankle was blue to purple in color. OTA R reported that as soon as she saw the pressure sore, she asked Registered Nurse (RN) S to look at Resident #101's foot and ankle. OTA R reported that RN S assessed Resident #101's foot, took measurements of the sore, and applied a prevlon boot (heel protector device) to Resident #101's foot. OTA R reported that Resident #101 was not able to participate in therapy due to the pain she was experiencing with her foot.</p> <p>During an interview on 2/21/24 at 1:22 PM, RN S reported that she did recall calling MD Q on 12/28/23 to request a foot x-ray because Resident #101 was reporting pain in her foot and she had observed it as swollen. RN S did not know if the MD Q had followed up with Resident #101 after the x-ray results were reviewed. RN S reported that she could not recall what Resident #101's foot looked like on the day that OTA R asked her to assess her foot. RN S reported that she did recall placing a prevlon boot on her foot. RN S reported that she did not recall if she had notified the wound nurse or the doctor regarding the skin condition on Resident #101's foot, or to report that Resident #101 was still experiencing significant pain in her foot.</p> <p>During an interview on 2/21/24 at 10:33 AM, MD Q reported that he did not recall assessing Resident #101's left foot or ankle before or after the x-ray of her foot was completed on 12/29/23. MD Q reported that he would have not followed up with Resident #101 if the result of the foot x-ray was negative. MD Q reported that if his progress notes did not discuss as assessment and there were no new orders placed by him, he would assume he had not assessed Resident #101's foot.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #101's Orders for December 2023 and January 2024 revealed, NovoLIN N Suspension 100 UNIT/ML (Insulin medication for diabetes) Inject 26 unit subcutaneously one time a day for diabetes. Start date 12/23/23.</p> <p>Review of Resident #101's Orders for December 2023 revealed, Finger Stick Blood Sugar two times a day for diabetes for 7 Days notify MD if below 60 or above 400. Start date 12/24/23.</p> <p>Review of the facility's Physician Log Book revealed a request written on 12/29/23 which noted Comments/concerns to be addressed: Resident #101 blood sugar high Action taken by provider: This was initiated by Medical Doctor (MD) Q and dated 1/4/24. The log did not indicate what actions were taken.</p> <p>Review of Resident #101's Blood Sugar Summary revealed elevated blood glucose levels on the following dates: 12/26/23: 239.0, 12/27/23: 210.0, 12/27/23: 388.0, 12/28/23: 185.0, 12/29/23: 205.0, 12/29/23: 370.0, 12/30/23: 296.0, 12/30/23: 274.0, 12/31/23: 182.0, 1/3/24: 243.0, and 1/4/24: 264.0.</p> <p>During an interview at 2/21/24 at 2:05 PM, LPN-UM O reported that Resident #101 had blood glucose monitoring in place starting on her admitted [DATE] and the order was discontinued on 12/31/23. LPN-UM O reported that she was unaware that nursing staff had requested that MD Q assess Resident #101 for high blood glucose levels. LPN-UM O was not able to provide any evidence that MD Q had assessed Resident #101's high blood glucose levels. LPN-UM O reported that she was not able to find any orders in place to continue to assess Resident #101's blood glucose levels after 12/31/23. LPN-UM O reported that she was not able to provide any documentation that MD Q had assessed Resident #101's foot or addressed the reported concerns that Resident #101 was experiencing significant pain in her foot with swelling and a pressure ulcer/skin condition noted on her ankle. LPN-UM O reported that nursing staff had noted edema in two skilled nursing notes on 1/3/24 and 1/7/24. LPN-UM O reported that the facility did not have any staff monitoring the skilled nursing notes to ensure that reported concerns were being addressed. LPN-UM O reported that nurses were expected to call the physician for urgent concerns or write a request in the physician log book if the concern was not urgent. LPN-UM O reported that the facility did not have any staff members monitoring the physician log book to ensure that reported concerns were being addressed by the physician.</p> <p>41424</p> <p>Resident #102:</p> <p>Review of an Admission Record revealed Resident #102 was a male with pertinent diagnoses which included diabetes, diabetic neuropathy (nerve damage which can occur with diabetes), fracture of right tibia (larger lower leg weight bearing bone between knee and foot), wound right great toe, falls, heart disease, muscle weakness, retention of urine (difficulty urinating), acquired absence of left leg below knee, peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), and malignant neoplasm of prostate (cancer in the prostate).</p> <p>Review of current Care Plan for Resident #102, revised on 7/10/2018, revealed the focus, .(Resident #102) has diabetes mellitus . with the intervention .Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness .Fasting serum blood sugar as ordered by doctor .check all of body for breaks in skin and treat promptly as ordered by doctor .dietary consult for nutritional regimen and ongoing monitoring .</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Orders revealed .Regular diet order date 11/13/23 .Gilmepiride Oral tablet 2 mg, Give 1 tablet by mouth one time a day for diabetes .</p> <p>Review of Routine Labs revised on 5/17/22, revealed, .Dx of Diabetes .Lab test: hgA1c .Frequency: Once during first week .</p> <p>Review of Hospital progress notes revealed on 11/10/23 at 8:44 PM, bedside blood sugar resulted 144, insulin Lispro held per parameters. Type 2 Diabetes Mellitus: continue home regimen, start ISS (insulin sliding scale), Accu-Cheks .Lab results: 11/10/23: Glucose Assay: 179 mg/dl High .</p> <p>Review of hospital Glucose results revealed, .11/8/23 at 8:40 PM, Glucose Assay: 179 .11/9/23 at 6:09 PM, Bedside glucose: 189 .11/9/23 at 8:44 PM, Bedside glucose: 144 .11/10/23 at 6:00 AM, Glucose Assay: 92 .11/10/23 at 11:32 AM, Bedside glucose: 192 .</p> <p>Review of Medication Administration Record from discharging hospital revealed, .Administration date: 11/10/23 at 11:45 AM .Insulin lispro .2 units .</p> <p>Review of Progress Note for Initial encounter dated 11/13/23, revealed, .Assessment and Plan: Diabetes Mellitus .Plan: Nursing staff to monitor patient closely .</p> <p>Review of Treatment Admission Records (TAR) for November 2023, December 2023, and January 2024 revealed no monitoring of Resident 102's blood sugar, labs, and side effects/effectiveness.</p> <p>In an interview on 2/21/24 at 2:15 PM, Director of Nursing (DON) B reported there should have been at least monthly labs to test blood glucose levels and an A1C would be completed. DON B reported since Resident #102 was monitoring daily using Accu-Checks she would continue the monitoring at the facility as well.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>This citation pertains to intake MI00138391 and MI00142287.</p> <p>Based on observation, interview, and record review, the facility failed to accurately assess, monitor, treat, and implement interventions for a residents with pressure ulcers for 2 (Resident #100 and Resident #102) of 6 residents reviewed for pressure ulcers resulting in the potential for worsening condition of a pressure ulcer.</p> <p>Findings include:</p> <p>Resident #100</p> <p>Review of an Admission Record revealed Resident #100, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 11/27/23 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #100 was cognitively intact.</p> <p>Review of Resident #100's Orders revealed, Cleanse right buttock with NS (normal saline) pat dry apply xeroform (dressing cover for wounds) to open / excoriated area cover with bordered gauze. Change daily and as needed, document refusals. every day shift for wound care. Start date: 4/19/23.</p> <p>During an interview on 2/15/24 at 1:31 PM, Resident #100 reported that the facility staff were not completing dressing changes for his pressure ulcer as ordered. Resident #100 reported that he was supposed to have his wound dressing changed every day, but staff were typically only completing the dressing change a few days a week.</p> <p>During an interview on 2/16/24 at 1:01 PM, Resident #100 reported that he had not had his wound dressing changed the day before, and he was not sure the last time that facility staff had changed it. Resident #100 reported that staff were frequently missing the daily wound dressing change.</p> <p>During a wound care observation on 12/16/24 at 3:31 PM, Licensed Practical Nurse (LPN) M had all wound care supplies sitting on Resident #100's tray table and she and Physical Therapy Assistant (PTA) N assisted Resident #101 to roll onto his left side. After Resident #100 rolled onto his left side, LPN M reported that she was not aware that Resident #100's wound required two bordered gauze pads, as she thought the wound on Resident #100 was only on one side. LPN M left Resident #100's room to obtain more supplies and returned. It was noted that the dressing on Resident #100 was dated for 2/14/24.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #100s Treatment Administration Record (TAR) revealed that the order Cleanse right buttock with NS (normal saline) pat dry apply xeroform (dressing cover for wounds) to open / excoriated area cover with bordered gauze. Change daily and as needed,document refusals. every day shift for wound care was documented as completed on 2/15/24 by LPN M. It was also noted that there was no documentation completed for 2/17/24.</p> <p>Review of Resident #100s Progress Notes did not reveal any refusals for wound care treatment on 2/15/24 or on 2/17/24 by Resident #100.</p> <p>During an interview on 2/21/24 at 2:05 PM, LPN Unit Manager (LPN-UM) O reported that it was her expectation that nurses would not document completing a wound dressing change until after the treatment was administered. LPN-UM O reported that nurses were expected to document the reason the treatment was missed in the TAR and complete a progress note any time a treatment was missed. LPN-UM O reported that she was not able to explain why the dressing observed on 2/16/24 was dated for 2/14/24, but the dressing change was documented as completed on 2/15/24 for Resident #100's wound. LPN-UM O was not able to report why there was missing documentation for wound care on 2/17/24. LPN -UM O reported that the facility did not have anyone monitoring documentation of care and treatment to ensure that residents were receiving the ordered treatments and care, and following up when staff were not completing treatments and care.</p> <p>41424</p> <p>Resident #102</p> <p>Review of an Admission Record revealed Resident #102 was a male with pertinent diagnoses which included diabetes, diabetic neuropathy (nerve damage which can occur with diabetes), fracture of right tibia (larger lower leg weight bearing bone between knee and foot), wound right great toe, falls, heart disease, muscle weakness, retention of urine (difficulty urinating), acquired absence of left leg below knee, peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), and malignant neoplasm of prostate (cancer in the prostate).</p> <p>Review of current Care Plan for Resident #102, revised on 11/16/23, revealed the focus, .(Resident #102) has potential/actual impairment to skin integrity of the right great toe r/t (related to) DMII (diabetes mellitus) . with the intervention .Follow facility protocols for treatment of injury .Keep skin clean and dry. Use lotion on dry skin .Monitor/document location, size and treatment of skin injury. Report abnormalities, failure to heal, s/sx (signs & symptoms) of infection, maceration, etc. to MD .Weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations .</p> <p>Review of (Referral Hospital) 11/9/23 at 1:05 PM, revealed, .Pt (patient) states being treated for after(sic) toe didn't heal right. Being treated in (Wound Clinic) .</p> <p>Review of (Referral Hospital) Progress Notes dated 11/10/23 at 08:26 AM, revealed, .Skin/Wound .2 blisters noted to inner right knee, closed with fluid filled sac .Color skin./wound .Blue/Purple .</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of AFC/ECF Transfer Hand-Off form dated 11/13/23 revealed, .Report called: Given to (LPN W) . Present Illness/Reason for Admission: Rt (right) tibial fracture - knee immobilizer at all times .0 SX (non-surgical) .Patient Goals: F/U (follow up) ortho 1-2 weeks .Skin: Blisters inner R (right) knee .R skin read, bruising .R great tow wound .See wound clinic .Last changed on 11/10/23 at 2:30 PM .Genitourinary: Foley k- has changed 1st of the month .Last changed 11/1/23 Dated 11/13/23 at 11:21 AM .</p> <p>Review of Admission Checklist document, revealed, .Day of Admission: Physician order sheet. Completed & reviewed with MD .Don't forget O2, CPAP, etc .Second Nurse Verification of Physician Order Entry . Admission Nursing UDA Bundle w/BCP Part 1, including: skin observation, Braden .Assessments-sign and save after you complete each section .Skin Issues measured and reflected on the Height/Weight/Skin Check form .Within 48 hours: List any F/U (follow up) Appointments in (EMR) so transportation can be arranged . Resident Admission reflected in MD book. Resident MUST be seen within 72 hours of admission by MD . Admission UDA Bundle Part 2 .</p> <p>Requested the Admission checklist completed for Resident #102 and did not receive it prior to exit. It was not located in the paper medical chart for the resident.</p> <p>Review of the Order Summary revealed, .R/(Right) great toe: cleanse with NS, pat dry with gauze. Cover with prizma (biodegradable gel has collagen, ORC, and silver designed to kick start healing protecting against bacteria) cut to size and cover with xeroform (nonadherent dressing with antimicrobial properties) . Cover with 2x2 gauze secured with medipore tape. Change two times weekly and needed. Every day shift on Tues, Sat for wound on R/great toe. Start on 11/14/23 DC date 01/08/24 .</p> <p>No order for treatment/monitoring of blisters and shin redness for right leg noted in the medical record.</p> <p>Review of completed weekly skin assessments revealed no documentation on blisters and shin redness.</p> <p>Review of Resident #102's Treatment Administration Record (TAR) for November 23, December 23, and January 24 revealed, No dressing changes were completed on the 11/14, 11/18, 11/28, 12/2, 12/12, 12/16, 12/26, and 12/30 with no documentation of dressing change refusals noted in the medical record.</p> <p>Review of the medical record for Resident #102 revealed no skin/wound notes, measurements/depth/volume/stage, documentation of the wound condition, and progress of healing/non-healing.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Riveridge Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1333 Wells St Niles, MI 49120	

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2/21/24 at 11:46 AM, Licensed Practical Nurse (LPN) X reported she did not have Resident #102 on the wound report. LPN X reported she received notification of a resident with a wound when a referral for admission was submitted, and if not, then there would be a note placed in her box by the admitting nurse/nurse. LPN X reported she had been working third shift to assist the facility with nursing coverage and had not been able to participate in any interdisciplinary team meetings or other administration staff meetings where the resident's conditions were discussed. LPN X reported the nurses do the skin assessments and she completed assessments relative to the residents on her wound report. LPN X reported when a resident had a new wound or arrived with a wound, she would verify there was a treatment in place, measure and document the condition of the wound, and if necessary, have the wound provider complete an assessment on the resident. LPN X reported sometimes she hears of a wound during report when taking over for the off going nurse or at times had been informed by the Director of Nursing. LPN X reported she tried to have Monday and Tuesdays off from the floor so she would be able to complete wound rounds with the wound provider.</p> <p>In an interview on 2/21/24 at 1:27 PM, Director of Nursing (DON) B reported the floor nurse would write a note to the wound nurse informing her of the new wound. DON B reported she had been helping out on the night shift and not participating in IDT team meetings or other meetings where she would be informed of the new wound. DON B reported she would expect the wound nurse to take measurements and follow up and follow through, contact wound doctor if needed and send a referral over to him. When queried on how else the wound nurse would be informed of a new wound, the DON indicated she would have to refer to the policy and did not report another process on notification of the wound nurse.</p> <p>Review of policy, Wound Treatment Management revised on 1/2024, revealed, .To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders .5. Treatment decisions will be based on: a. Etiology of the wound: i. Pressure injuries will be differentiated from non-pressure ulcers, such as arterial, venous, diabetic, moisture or incontinence related skin damage. ii. Surgical. iii. Incidental (i.e. skin tear, medical adhesive related skin injury). iv. Atypical (i.e. dermatological or cancerous lesion, pyoderma, calciphylaxis). b. Characteristics of the wound: i. Pressure injury stage (or level of tissue destruction if not a pressure injury). ii. Size - including shape, depth, and presence of tunneling and/or undermining. iii. Volume and characteristics of exudate. iv. Presence of pain. v. Presence of infection or need to address bacterial bioburden. vi. Condition of the tissue in the wound bed. vii. Condition of peri-wound skin. c. Location of the wound. d. Goals and preferences of the resident/representative .</p>

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>This citation pertains to intake MI00142075.</p> <p>Based on interview and record review, the facility failed to complete a medical evaluation of resident's condition, review the appropriateness of the resident's medical treatment, and implement orders for 1 (Resident #101) of 8 residents reviewed for physician orders and treatment resulting in Resident #101 experiencing unresolved pain and untreated high blood glucose levels.</p> <p>Findings include:</p> <p>Resident #101</p> <p>Review of an Admission Record revealed Resident #101, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness and type 2 diabetes.</p> <p>During an interview on 2/15/24 at 11:34 AM, Family Member (FM) P reported that Resident #101 began reporting left foot pain on 12/24/23. FM P reported that Resident #101 had reported her foot pain to staff, but they were not addressing the concern. FM P reported that Resident #101's foot began to swell, was painful to touch, and she was unable to walk. FM P reported that on 12/28/23 an x-ray was ordered for Resident #101's foot which was negative for any fractures. FM P reported that Resident #101 continued to report pain and staff did not assess her foot after the x-ray was completed. FM P reported that on January 6th, 2024, therapy staff observed Resident #101's foot and noted Resident #101's foot and ankle to be swollen and bruised with a possible pressure ulcer on her ankle. FM P reported that the facility staff did not indicate what they were planning to do to treat Resident #101's foot.</p> <p>Review of Resident #101's Radiology Results Report dated 12/29/24 revealed, Procedure: Foot 2V (2 views). Reason for study: . Pain in left foot . Conclusion: No obvious or acutely displaced fracture. 2. Repeat radiographs recommended if symptoms persist or worsen . Procedure: Ankle 2V. Reason for study Pain in left ankle and joints of left foot . Conclusion: No obvious or acutely displaced fracture. 2. Repeat radiographs recommended if symptoms persist or worsen .</p> <p>Review of Resident #101's Orders for December 2023 and January 2024 did not reveal any orders related to her left foot or ankle.</p> <p>Review of Resident #101's Progress note completed by MD Q on 12/28/23 revealed, Physical Examination . Skin: No rashes. No lesions. No ulcers present Musculo: (Musculoskeletal) No clubbing. No cyanosis. No edema. Normal range of motion noted in extremities . It was noted that the progress note did not address Resident #101's foot pain.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/21/24 at 1:22 PM, RN S reported that she did recall calling MD Q on 12/28/23 to request a foot x-ray because Resident #101 was reporting pain in her foot and she had observed it as swollen. RN S did not know if the MD Q had followed up with Resident #101 after the x-ray results were reviewed. RN S reported that she could not recall what Resident #101's foot looked like on the day that OTA R asked her to assess her foot. RN S reported that she did recall placing a prevlon boot on her foot. RN S reported that she did not recall if she had notified the wound nurse or the doctor regarding the skin condition on Resident #101's foot, or to report that Resident #101 was still experiencing significant pain in her foot.</p> <p>Review of Resident #101's Orders for December 2023 and January 2024 revealed, NovoLIN N Suspension 100 UNIT/ML (Insulin medication for diabetes) Inject 26 unit subcutaneously one time a day for diabetes. Start date 12/23/23.</p> <p>Review of Resident #101's Orders for December 2023 revealed, Finger Stick Blood Sugar two times a day for diabetes for 7 Days notify MD if below 60 or above 400. Start date 12/24/23.</p> <p>Review of the facility's Physician Log Book revealed a request written on 12/29/23 which noted Comments/concerns to be addressed: Resident #101 blood sugar high Action taken by provider: This was initialed by Medical Doctor (MD) Q and dated 1/4/24. The log did not indicate what actions were taken.</p> <p>Review of Resident #101's Blood Sugar Summary revealed elevated blood glucose levels on the following dates: 12/26/23: 239.0, 12/27/23: 210.0, 12/27/23: 388.0, 12/28/23: 185.0, 12/29/23: 205.0, 12/29/23: 370.0, 12/30/23: 296.0, 12/30/23: 274.0, 12/31/23: 182.0, 1/3/24: 243.0, and 1/4/24: 264.0.</p> <p>Review of the facility's Physician Log Book revealed a request written on 1/2/24 which noted Comments/concerns to be addressed: Resident #101 left foot edema with discoloration Action taken by provider: This was initialed by Medical Doctor (MD) Q and dated 1/4/24. The log did not indicate what actions were taken.</p> <p>Review of Resident #101's Daily skilled note dated 1/3/24 revealed, .Cardiac/Circulation: 2b. Edema present. 2c. Location: left lower leg and foot</p> <p>Review of Resident #101's Progress note completed by MD Q on 1/4/24 revealed, Discharge Planning. Patient is being seen today by MD Q for face to face discharge visit. Patient was admitted following a recent hospital course. During admission in the facility patient received rehabilitation services involving physical therapy, speech and occupational therapy. Patient has made significant gain in gait, strength and mobility . Patient is stable now and ready of discharge . Physical Examination: SKIN: No rashes. No lesions. No ulcers present. Musculo: No clubbing. No cyanosis. No edema. Normal range of motion noted in extremities . It was noted that the note did not address Resident #101's foot pain, elevated blood glucose levels, or the lower left leg and foot edema.</p> <p>Review of Resident #101's Daily skilled note dated 1/7/24 revealed, .Cardiac/Circulation: 2b. Edema present. 2c. Location: left lower leg and foot</p> <p>During an interview on 2/21/24 at 10:46 AM, PTA N reported that Resident #101 began reporting pain in her left foot on 12/29/23 and it was noted that swelling was present at Resident #101's left ankle. PTA N reported that Resident #101 was struggling to participate in therapy due to her foot pain, and that therapy did not have an active discharge date for Resident #101.</p> <p>(continued on next page)</p>		

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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/21/24 at 12:40 PM, Occupational Therapy Assistant (OTA) R reported that during her session with Resident #101 on 1/6/24, she was complaining of foot and ankle pain. OTA R reported that she had observed what she believed to be a pressure sore on Resident #101's left heel and bruising on her inner and outer ankle. OTA R reported that the pressure sore was dark in color with redness noted around the edge of the pressure sore, and the bruising on her ankle was blue to purple in color. OTA R reported that as soon as she saw the pressure sore, she asked Registered Nurse (RN) S to look at Resident #101's foot and ankle. OTA R reported that RN S assessed Resident #101's foot, took measurements of the sore, and applied a prevlon boot (heel protector device) to Resident #101's foot. OTA R reported that Resident #101 was not able to participate in therapy due to the pain she was experiencing with her foot.</p> <p>During an interview on 2/21/24 at 10:33 AM, MD Q reported that he did not recall assessing Resident #101's left foot or ankle before or after the x-ray of her foot was completed on 12/29/23. MD Q reported that he would have not followed up with Resident #101 if the result of the foot x-ray was negative. MD Q reported that if his progress notes did not discuss as assessment and there were no new orders placed by him, he would assume he had not assessed Resident #101's foot.</p> <p>During an interview at 2/21/24 at 2:05 PM, LPN-UM O reported that Resident #101 had blood glucose monitoring in place starting on her admitted [DATE] and the order was discontinued on 12/31/23. LPN-UM O reported that the facility pharmacy had recommended discontinuing the blood glucose monitoring if the resident's blood glucose was stable. LPN-UM O reported that she was unaware that nursing staff had requested that MD Q assess Resident #101 for high blood glucose levels. LPN-UM O was not able to provide any evidence that MD Q had assessed Resident #101's high blood glucose levels. LPN-UM O reported that she was not able to find any orders in place to continue to assess Resident #101's blood glucose levels after 12/31/23. LPN-UM O reported that she was not able to provide any documentation that MD Q had assessed Resident #101's foot or addressed the reported concerns that Resident #101 was experiencing significant pain in her foot with swelling and a pressure ulcer/skin condition noted on her ankle. LPN-UM O reported that nursing staff had noted edema in two skilled nursing notes on 1/3/24 and 1/7/24. LPN-UM O reported that the facility did not have any staff monitoring the skilled nursing notes to ensure that reported concerns were being addressed. LPN-UM O reported that nurses were expected to call the physician for urgent concerns or write a request in the physician log book if the concern was not urgent. LPN-UM O reported that the facility did not have any staff members monitoring the physician log book to ensure that reported concerns were being addressed by the physician.</p>

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that the resident and his/her doctor meet face-to-face at all required visits.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424</p> <p>Based on interview and record review, the facility failed to ensure timely physician visits for 1 resident (Resident #102) out of 9 residents reviewed, resulting in the potential for unmet medical needs.</p> <p>Findings include:</p> <p>Resident #102:</p> <p>Review of an Admission Record revealed Resident #102 was a male with pertinent diagnoses which included diabetes, diabetic neuropathy (nerve damage which can occur with diabetes), fracture of right tibia (larger lower leg weight bearing bone between knee and foot), wound right great toe, falls, heart disease, muscle weakness, retention of urine (difficulty urinating), acquired absence of left leg below knee, peripheral vascular disease (narrowed blood vessels reduce blood flow to the limbs), and malignant neoplasm of prostate (cancer in the prostate).</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #102, with a reference date of 11/20/23 revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated Resident #102 was cognitively intact.</p> <p>Review of Admission Checklist document, revealed, .Day of Admission: Physician order sheet. Completed & reviewed with MD .Don't forget O2, CPAP, etc .Second Nurse Verification of Physician Order Entry . Admission Nursing UDA Bundle w/BCP Part 1, including: skin observation, Braden .Assessments-sign and save after you complete each section .Skin Issues measured and reflected on the Height/Weight/Skin Check form .Within 48 hours: List any F/U (follow up) Appointments in (EMR) so transportation can be arranged . Resident Admission reflected in MD book. Resident MUST be seen within 72 hours of admission by MD . Admission UDA Bundle Part 2 .</p> <p>Review of the medical record for Resident #102 revealed, .11/13/23 - MD initial visit, 11/20/23 - acute visit, 11/27/23, acute visit, 1/4/24 follow up visit, 1/8/24 - discharge visit. Note: No visit was conducted for December 2023 per the requirements for frequency of visits for the first 90 days.</p> <p>(continued on next page)</p>		

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<p>F 0712</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Physician Progress Note dated 11/13/23, revealed, .Initial visit The patient is being seen today by (Medical Director) to establish care. This is the initial encounter. A [AGE] year old on management for Unspecified fracture of shaft of right tibia, Fall on same level, Peripheral vascular disease, COVID-19 Malignant neoplasm of prostate Type 2 diabetes mellitus with diabetic neuropathy, Type 2 diabetes mellitus without complications Atherosclerotic heart disease of native coronary artery Gastro-esophageal reflux disease Idiopathic gout, Muscle weakness (generalized) Benign prostatic hyperplasia with lower urinary tract symptoms ,Retention of urine, Bacteriuria, Personal history of other venous thrombosis and embolism, Acquired absence of left leg below knee. Patient was admitted to the facility to get access to skilled nursing care. No new complaints. Denies any nausea, vomiting, fever, chills, chest pain, shortness of breath. Historical vitals reviewed and are WNL. No acute issues noted .SKIN: No rashes. No lesions. No ulcers present .Plan: Nursing staff to monitor patient closely review medications .Address patient concerns . Continue management for other chronic conditions . No mention of catheter present, no mention of right great toe ulcer/wound, no mention of immobilizer present and care for Resident #102, and no mention of a referral for orthopedic appointment.</p> <p>In an interview on 2/16/24 at 3:16 PM, Medical Records AA reported the provider would email her the progress notes. Medical Records AA reported she had a list of residents who need notes, and she would send a request to the provider for the notes. Medical Records AA reported the provider came to the facility twice a week to see residents who needed to be seen.</p> <p>In an interview on 2/16/23 at 3:20 PM, Licensed Practical Nurse (LPN) HH reported the medical doctor was here on Mondays and Thursdays every week.</p> <p>Review of Physician Visit Log for date 11/14/23 revealed, .New admit, requesting grab bars for strengthening repositioning and transfers. Review of the physician visit log for the remained of the year to present showed no other visits in the log for Resident #102.</p> <p>In an interview on 2/21/24 at 1:27 PM, Director of Nursing (DON) B reviewed the medical record for physician visits for Resident #102 and there was no visit for him for December 2023.</p> <p>During an interview on 2/21/24 at 10:33 AM, MD Q reported that if his progress notes did not discuss an assessment and there were no new orders placed by him, he would assume he had not assessed Resident #102 for those conditions.</p> <p>Review of policy, Physician Visits and Physician Delegation revised on 1/2024, revealed, .To ensure the physician takes an active role in supervising the care of residents .2. The Physician should: a. See resident within 30 days of initial admission to the facility .b. The resident must be seen at least once every 30 calendar days for the first 90 calendar days after admission and at least every 60 days thereafter by physician or physician delegate as appropriate by State law. c. Review the resident's total program of care including medications and treatments at each visit. d. Date, write and sign a progress note for each visit. e. Sign and date all orders except for the flu and pneumococcal vaccines, which may be administered per physician-approved policy after an assessment for contraindications .</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47659</p> <p>Based on observation, interview, and record review, the failed to maintain accurate medical records for 1 of (Resident #100) of 12 residents reviewed for comprehensive and accurate medical records, resulting in an inaccurate reflection of the resident's medical treatments administered resulting in the potential for providers to not have an accurate picture of resident status and condition.</p> <p>Findings include:</p> <p>Resident #100</p> <p>Review of an Admission Record revealed Resident #100, was originally admitted to the facility on [DATE] with pertinent diagnoses which included muscle weakness.</p> <p>Review of a Minimum Data Set (MDS) assessment for Resident #100, with a reference date of 11/27/23 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #100 was cognitively intact.</p> <p>Review of Resident #100's Orders revealed, Cleanse right buttock with NS (normal saline) pat dry apply xeroform (dressing cover for wounds) to open / excoriated area cover with bordered gauze. Change daily and as needed,document refusals. every day shift for wound care. Start date: 4/19/23.</p> <p>Review of Resident #100's Orders revealed, Bed bath. Every day shift every Mon, Wed, Fri, Sat for skin care. Start date 12/27/23.</p> <p>During an interview on 2/15/24 at 1:31 PM, Resident #100 reported that the facility staff were not completing dressing changes for his pressure ulcer as ordered. Resident #100 also reported that the facility staff were not completing bed baths for him as often as ordered, and that he would often go several days without receiving a bed bath. It was noted that Resident #100's hair was greasy, and he had pieces of food crumbs throughout his beard. Food crumbs and stains were also noted on Resident #100's hospital gown.</p> <p>During an interview on 2/16/24 at 1:01 PM, Resident #100 reported that he had not had his wound dressing changed the day before, and he was not sure the last time that facility staff had changed it. Resident #100 reported that staff were frequently missing the daily wound dressing change.</p> <p>During a wound care observation on 12/16/24 at 3:31 PM, Licensed Practical Nurse (LPN) M had all wound care supplies sitting on Resident #100's tray table and she and Physical Therapy Assistant (PTA) N assisted Resident #100 to roll onto his left side. After Resident #100 rolled onto his left side, LPN M reported that she was not aware that Resident #100's wound required two bordered gauze pads, as she thought the wound on Resident #100 was only on one side. LPN M left Resident #100's room to obtain more supplies and returned. It was noted that the dressing on Resident #100 was dated for 2/14/24.</p> <p>(continued on next page)</p>		

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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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Resident #100s Treatment Administration Record (TAR) revealed that the order Cleanse right buttock with NS (normal saline) pat dry apply xeroform (dressing cover for wounds) to open / excoriated area cover with bordered gauze. Change daily and as needed,document refusals. every day shift for wound care was documented as completed on 2/15/24 by LPN M. It was also noted that there was no documentation completed for 2/17/24.</p> <p>Review of Resident #100s Progress Notes did not reveal any refusals for wound care treatment on 2/15/24 or on 2/17/24 by Resident #100.</p> <p>Review of Resident #100's Shower Sheets did not reveal shower sheets for the following dates: 1/5/24, 1/6/24, 1/8/24, 1/29/24, 1/31/24, 2/2/24, 2/3/24.</p> <p>Review of Resident #100's Treatment Administration Record revealed that staff had documented the bed bath treatment as administered on the following dates: 1/5/24, 1/6/24, 1/8/24, 1/31/24, 2/2/24, 2/3/24 and there was no documentation completed for 1/29/24.</p> <p>Review of Resident #100's Progress Notes did not reveal and documented refusals for bed baths by Resident #100 on the following dates: 1/5/24, 1/6/24, 1/8/24, 1/29/24, 1/31/24, 2/2/24, 2/3/24.</p> <p>During an interview on 2/21/24 at 2:05 PM, LPN Unit Manager (LPN-UM) O reported that it was her expectation that nurses would not document completing a wound dressing change until after the treatment was administered. LPN-UM O reported that nurses were expected to document the reason the treatment was missed in the TAR and complete a progress note any time a treatment was missed. LPN-UM O reported that she was not able to explain why the dressing observed on 2/16/24 was dated for 2/14/24, but the dressing change was documented as completed on 2/15/24 for Resident #101's wound. LPN-UM O reported that for bed baths, staff were to document the bed bath as completed after the task was done, and complete a shower sheet with each bed bath to turn into LPN-UM O. LPN-UM O reported that if the resident refused, staff were expected to document the refusal on the shower sheet, progress note, and the TAR. LPN-UM O reported that she was not able to provide any shower sheets for the missing dates, and that staff had missed providing bed baths for Resident #100. LPN-UM O was not able to report why there was missing documentation for wound care on 2/17/24. LPN -UM O reported that the facility did not have anyone monitoring documentation of care and treatment to ensure that residents were receiving the ordered treatments and care, and following up when staff were not completing treatments and care.</p>		