STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235598	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riveridge Rehabilitation and Healthcare Center	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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 47955 This citation pertains to intake #MI00142839 Based on observation, interview, and record review, the facility failed to develop, implement, and update person centered care plans in 3 (Resident #101, Resident #104, and Resident #109) of 4 residents reviewed for care planning, resulting in the potential for unmet care needs and a potential for injury to resident. Findings include: Resident #101 Review of an Admission Record revealed Resident #101 had pertinent diagnoses which included: dependence on renal dialysis (treatment to remove waste and excess water from the body when the kidneys are no longer able to do it), muscle weakness, and urinary tract infection. Review of Care Plan for Resident #101 revealed no care plan related to allergies and Resident #101 was listed as having no known allergies. Review of Transfer Care Record from (Name Omitted) acute care hospital, printed on 12/29/24 at 5:24 PM., revealed .Allergies Not on File. Review of Discharge Service Communication dated 2/23/24 at 13:49 PM., revealed .Allergies . allergen-penicillin reaction-anaphylaxis, allergen-morphine reaction-itching, allergen-fluoxetine reaction-hallucinations, allergen-meperidine reaction-unknown, allergen-tramadol reaction-nausea . During an interview on 3/7/24 at 1:55 PM., Unit Manager/Licensed Practical Nurse (UM/LPN) X reported that allergies should be verified on admission and a care plan should be created for any allergies. Resident #104 Review of an Admission Record revealed Resident #104 had pertinent diagnoses which included: End stage renal disease (decreased function of the kidneys), sepsis (full system infection), and hypotension (low blood pressure). (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 2/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #104 was cognitively intact. Review of Care Plan for Resident #104 revealed . Focus: resident limited physical mobility r/t (related to) Interventions: Ambulation: The resident requires (SPECIFY: assistance) by (X) staff to walk (SPECIFY FREQ) the resident uses (SPECIFY assistive devices) for walking. Clean (SPECIFY FREQ) initiated on 2/1/2024 . Focus: the resident has impaired visual function r/t Interventions: ensure appropriate visual aids (SPECIFY) are available .initiated 2/1/2024. It was noted that there was no resident specific information provided when (SPECIFY) was indicated in Resident #104's care plan and there was no related information listed for either focus area. During an observation and interview on 3/6/24 at 11:00 AM., Resident #104 was in his room lying in his bed, and it was noted that Resident #104 had bilateral BKA (both sides of the body, and below the knee) amputation. Resident #104 reported he does not have prosthesis (artificial legs) legs and does not ambulate (walk). Resident #104 reported he requires the use of a mechanical lift for transfers. R#104 reported he was legally blind, and his vision was very bad. Review of CVW - Admit/readmit Nursing UDA bundle w/BCP dated 2/15/24 at 19:59 revealed admitting diagnosis to include unspecified complications of amputation stump (the part of the limb left attached to the body), and surgical procedures of BKA . Vision and Hearing . check boxed was vision adequate. During an interview on 3/7/24 at 9:15 AM., Licensed Practical Nurse (LPN) S reported that Resident #104 is a two-person hoyer (mechanical) lift transfer because he was a double amputee (both right and left legs were removed below the knee). LPN S reported Resident #104 does not have a prosthesis for either leg. During an interview on 3/7/24 at 1:55 PM., UM/LPN X reported care plans were triggered with the admission assessment in the electronic medical record. UM/LPN X reported that she was responsible to look over initial care plans, personalize them, and create the comprehensive care plan. UM/LPN X reported that the expectation was that a nurse manager would complete and update a care plan. UM/LPN X reported that care plans should be updated quarterly, when changes occurred for a resident, and as needed. Resident #109 Review of an Admission Record revealed Resident #109 had pertinent diagnoses which included: Cerebral Infarction, unspecified (stroke), Parkinson' disease (disease that causes muscle weakness and a loss of coordination), and seizures. Review of a Minimum Data Set (MDS) assessment for Resident #109, with a reference date of 12/8/23 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #109 was mildly cognitively impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation and interview on 3/5/24 at 3:33 PM., Certified Nurse Assistant (CNA) I and CNA M transferred Resident #109 in his room from his reclining chair to his wheelchair using a sit to stand mechanical lift. CNA I reported that Resident #109 has been using the sit to stand lift for months. Review of Care Plan for Resident #109 revealed .Focus: has an ADL (activities of daily living) self-care deficit r/t impaired balance, stroke, history of seizures . interventions: Transfer: is able to transfer with 2 assist and gait belt, rolling walker . initiated on 10/29/21 with a revision on 7/6/23. Review of Lift Assessment for Resident #109 dated 2/3/24 revealed . what can the resident do to assist with transfer? Full lift transfer .Lift recommendation sit-to-stand lift. During an interview on 3/7/24 at 2:13 PM., CNA J reported that Resident #109 has been a sit to stand lift transfer since she started employment in early December 2023. During an interview on 3/7/24 at 3:17 PM., RN U reported that Resident #109 was a sit to stand transfer. During an interview on 3/7/24 at 2:23 PM., Physical Therapist Assistant (PTA) EE reported Resident #109 was a two-person transfer. During an interview on 3/7/24 at 2:24 PM., Director of Therapy (DOT) D reported that on the last quarterly screening on 12/12/23. Resident #109 was a two person transfer with a gait belt. DOT D reported she was not aware of any request for evaluation for a change in transfer status for Resident #109.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 47955 This citation pertains to intake #MI00142839 Based on observation, interview, and record review, the facility failed to ensure safe transfers of residents with gait belt use during transfer and two staff members during mechanical lift transfer in two (Resident #102 and Resident #109) of four residents reviewed for transfers, resulting in the potential for injury during transfer. Findings include: Resident #102 Review of an Admission Record revealed Resident #102 had pertinent diagnoses which included: Alzheimer's disease with late onset, lack of coordination, and unsteadiness of feet. During an observation and interview on 3/5/24 at 10:13 AM., Certified Nurse Assistant (CNA) G placed her hands/arms into Resident #102's armpits, with the palm of her hand against Resident #102's back near his shoulder blades and lifted Resident #102 from a seated position in his wheelchair (parked parallel to his bed) and transferred Resident #102 onto his bed. CNA G did not use a gait belt during the transfer. CNA G reported that she can find transfer status information for a resident in their care plan. CNA G stated I know Resident #102 is a one-person transfer. During an interview on 3/5/24 at 10:23 AM., CNA I reported that all resident transfers not using a mechanical lift required the use of a gait belt. CNA I reported that she did not have a gait belt with her at that time. During an interview on 3/5/24 at 10:30 AM., Unit Manager/Licensed Practical Nurse (UM/LPN) X reported that all transfers of resident without a mechanical lift required the use of a gait belt. UM/LPN X reported that all mechanical lift transfers required two staff members be present. Review of Care Plan for Resident #102 revealed has an ADL (activities of daily living) self-care performance . will maintain current level .transfers require limited to extensive assistance of 1 staff member initiated on 8/26/21 with a revision on 12/30/22 . During an interview on 3/5/24 at 11:36 AM., CNA L reported that all mechanical lift transfers required two people and all non-mechanical lift transfers required the use of a gait belt. During an interview on 3/5/24 at 1:24 PM., Registered Nurse (RN) T reported that a transfer without a mechanical lift required the use of a gait belt. During an observation and interview on 3/5/24 at 1:30 PM., CNA G was standing at the nurse's station wearing a bright green gait belt over her uniform top. When asked CNA G provided a description of a one person transfer that included the use of a gait belt. When asked CNA G reported that she did not use a gait belt when she transferred Resident #102, and she should have. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/5/24 at 2:22 PM., Director of Therapy (DOT) DD reported that the use of a gait belts was not always specified in a resident's care plan or communication form from therapy department to nursing department. DOT DD reported that no transfer should be completed without a gait belt unless the transfer was a mechanical lift. Resident #109 Review of an Admission Record revealed Resident #109 had pertinent diagnoses which included: Cerebral Infarction, unspecified (stroke), Parkinson' disease (disease that causes muscle weakness and a loss of coordination), and seizures. Review of a Minimum Data Set (MDS) assessment for Resident #109, with a reference date of 12/8/23 revealed a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated Resident #109 was mildly cognitively impaired. During an observation and interview on 3/6/24 at 12:17 PM., CNA O exited Resident #109's room with a sit to stand lift. When asked, CNA O reported she was the only staff member in the room. During an interview on 3/6/24 at 12:17 PM., Resident #109 reported that CNA O transferred him from the bathroom commode into his recliner chair with the sit to stand lift by herself. Resident #109 reported she was the only staff member who was in the room. During an interview on 3/6/24 at 12:24 PM., CNA O reported that one staff member can transfer a resident by themselves with a mechanical lift and she did transfer Resident #109 by herself. Review of facility policy Safe Resident Handling/Transfers reviewed 1/2024, revealed .or other approved transferring aids will be used based on the resident's needs to prevent manual lifting except in medical emergencies .handling aids may include gait belts .two staff members must be utilized when transferring residents with a mechanical lift .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 47955 This citation pertains to intake #MI00142839. Based on interview and record review the facility failed to ensure that (1) pre and post dialysis treatment assessment and monitoring communication between themselves (the facility) and the dialysis provider (Name Omitted) was maintained and (2) a physician order was in place for dialysis treatments in 2 (Resident #101 and Resident #104) of 2 residents reviewed for dialysis services, resulting in the potential for unrecognized adverse reactions or resident decline related to dialysis treatments and the disruption in the continuity of care. Findings include: Resident #101 Review of an Admission Record revealed Resident #101 had pertinent diagnoses which included: dependence on renal dialysis (treatment to remove waste and excess water from the body when the kidneys are no longer able to do it), muscle weakness, and urinary tract infection. Resident #104 Review of an Admission Record revealed Resident #104 had pertinent diagnoses which included: End stage renal disease (decreased function of the kidneys), sepsis (full system infection), and hypotension (low blood pressure). Review of a Minimum Data Set (MDS) assessment for Resident #104, with a reference date of 2/18/24 revealed a Brief Interview for Mental Status (BIMS) score of 15/15 which indicated Resident #104 was cognitively intact. Review of Physician Orders for Resident #101 revealed no order for dialysis treatments. Review of Physician Orders for Resident #104 revealed no order for dialysis treatments. During an interview on 3/6/24 at 10:55 AM., Unit Manager/Licensed Practical Nurse (UM/LPN) X reported that a resident going to dialysis needed to have a dialysis sheet printed from the electronic medical record and sent with the resident to treatment. Requested dialysis communication sheets for Resident #101 and Resident #104 for the month of January and February 2024. During an interview on 3/6/24 at 2:32 PM., Licensed Practical Nurse (LPN) S reported that a dialysis communication sheet was to be sent out with the resident every time they went to dialysis. LPN S reported that the dialysis communication sheet included vital signs, medications given, and other assessment information the dialysis center needed to know about the resident. LPN S reported that the dialysis center nurse would complete the bottom half of the dialysis communication form and sent it back to the facility with information regarding the resident's treatment tolerance and medications given. LPN S reported that the dialysis communication forms were given to medical records to be placed into the resident's medical record. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a telephone interview on 3/7/24 at 12:15 PM., Registered Nurse (RN) CC reported that the facility should send a communication form with Resident #101 to the dialysis center appointment. RN CC reported that after Resident #101's treatment is complete the dialysis center nurse completed the other half of the communication form and return the form to the facility with the resident. RN CC reported the dialysis center does not keep a copy of the communication form. During an interview on 3/7/24 at 12:43 PM., RN W reported that she would complete the dialysis communication form for Resident #101, place it into a binder that went with Resident #101 to the dialysis center. RN W reported that she would check the communication log in the binder when Resident #101 returned from dialysis for notes following Resident #101's treatment. RN W was unable to locate any dialysis communication forms for Resident #101. During an interview on 3/7/24 at 1:26 PM., UM/LPN X reported a physician order is required for dialysis treatments. No dialysis communication forms for Resident #101 and Resident #104 were provided by the time of exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47955 This citation pertains to intake #MI00142839 Based on interview and record review, the facility failed to maintain ensure accurate medical records for 1 resident (Resident #101) of 9 sampled residents reviewed for accurate medical records, resulting in inaccurate documentation of allergies. Findings include: Resident #101 Review of an Admission Record revealed Resident #101 had pertinent diagnoses which included: dependence on renal dialysis (treatment to remove waste and excess water from the body when the kidneys are no longer able to do it), muscle weakness, and urinary tract infection. Review of Allergies for Resident #101 revealed No Known Allergies. Review of Census for Resident #101 revealed 12/29/23 In house, 1/2/24 in house, 1/20/24 in house, and 2/16/24 stop billing. Indicating Resident #101 resided in the facility from [DATE] until discharge on [DATE]. Review of Transfer Care Record from (Name Omitted) acute care hospital, printed on 12/29/24 at 5:24 PM., revealed .Allergies Not on File. Review of Care Plan for Resident #101 revealed Allergies No Known Allergies. Review of Discharge Service Communication dated 2/23/24 at 13:49 PM., revealed .Allergies . allergen-penicillin reaction-anaphylaxis, allergen-morphine reaction-itching, allergen-fluoxetine reaction-hallucinations, allergen-meperidine reaction-unknown, allergen-tramadol reaction-nausea . During an interview on 3/6/24 at 10:51 AM., Licensed Practical Nurse (LPN) S reported that allergies listed on acute care hospital discharge paperwork as not on file does not indicate no known allergies. LPN S reported a resident's allergies could be verified by calling the discharging hospital, asking the resident themselves, or asking a family member. During an interview on 3/6/24 at 10:55 AM., Registered Nurse (RN) W reported that allergies listed on acute care hospital discharge paperwork as not on file indicates the hospital did not know the resident's allergies. RN W reported that a resident's allergies should be verified by the resident or a family member at admission. During an interview on 3/6/24 at 11:11 AM., Unit Manager/Licensed Practical Nurse (UM/LPN) X reported that allergies should be verified on admission with the resident or a family member. UM/LPN X reported that allergies listed on acute care hospital discharge paperwork as not on file indicated no known allergies. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/6/24 at 11:18 PM., [NAME] President of Clinical Operations (VPoCO) reported that if there were no allergies documented on the discharge papers the expectation was to document no known allergies. During a telephone interview on 3/6/24 at 12:15 PM., RN CC reported that Resident #101 has been a patient at (Name Omitted) dialysis care center since 2019. RN CC reported that patient allergies are obtained at admission and updated as needed. RN CC reported that Resident #101's listed allergies were morphine, penicillin, Prozac (Fluoxetine), meperidine, and tramadol.