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	06/26/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41424 This citation pertains to intakes: MI00145073, MI00144852, MI00145032. Based on observation, interview, and record review, the facility failed to provide an environment that promoted and enhanced resident dignity in 2 (Resident #111 and #101) of 17 residents reviewed for dignity, resulting in the potential of feelings of humiliation and embarrassment. Findings include: Resident #111: Review of an Admission Record revealed Resident #111 was a female with pertinent diagnoses which included muscle weakness, muscle wasting, need for assistance with personal care, abnormal weight loss, and severe protein calorie malnutrition. Review of current Care Plan for Resident #111, revised on 12/29/2022 revealed the focus, .(Resident #111) is at risk for nutritional problem or potential nutritional problem r/t (related to) dx (diagnosis) of Malnutrition, hx of weight loss and Anorexia. I have a terminal illness. Anticipate decline in nutritional status with continued decline in overall health status . with the intervention .Offer hydration qshift (every shift) and with cares. Assist (Resident #111) as needed with hydration and keep hydration within reach of resident . During an observation on 6/21/24 at 2:45 PM, R#111 was observed lying in her bed, with her head leaning to the right side towards her right shoulder area. It was observed on her right side near the neck and shoulder area were multiple chunks of baked potatoe from the lunch today on her blanket. In an interview on 6/26/24 at 11:54 AM, Licensed Pratical Nurse (LPN) HH reported when the staff were finished assisting a resident with a meal, the staff would ensure the resident's face, clothes, and surfaces were clean and free of food and debris. LPN HH reported if the resident was being fed in their bed, the staff would ensure there was no foot or crumbs in the bed with the resident. In an interview on 6/26/24 at 11:26 AM, Unit Manager (UM) O reported prior to leaving the resident, staff would ensure the resident's face was clean, there was no food on the bed at all and would have sueveyed the area to make sure. UM O reported this would be done for the dignity of the resident and she would not want food left in the bed with her. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Using the reasonable person concept, though Resident #111 had decreased ability to verbally express her own thoughts due to her medical diagnoses, any reasonable person would likely feel a decreased sense of self-worth, frustration, and humiliation in the situations observed. Resident #101: Review of an Admission Record revealed Resident #101 was a female with pertinent diagnoses which included heart failure, fall, pain in left knee, restless leg syndrome, high blood pressure, low back pain, asthma, epilepsy (seizures), embolism of deep veins of lower extremity, dependence on oxygen and kidney disease. Review of Kardex received on 6/21/24, revealed, .Safety: Be sure (Resident #101)'s call light is within reach . (Resident #101) needs prompt response to all requests for assistance .Toileting: Provide pericare after each incontinent episode . In an interview on 6/25/24 at 10:27 AM, Family Member (FM) JJ reported Resident #101 had expressed to her the way the night CNAs had treated her. FM JJ reported the resident had told her the CNAs had said to her she did not need to be changed but every 2 hours, and one stated she was only obligated to only change her every two hours, and if the resident turned on her call light before the two hours was up, she would tell her she doesn't have to t have to change her and had stated to the resident, This is f*$@&#% ridiculous. Review of Concern & Comment Form dated 5/18/24, revealed, .Complaint Acknowledged: Nursing customer service- long call light wait, being rude, and making rude statements .Person Designated to Investigate and Follow-Up: (Director of Nursing B) .Date/Time/Findings/Action Plan Share wtih Concerned Party: Spoke with CNAs, staff to go in 2 at a time .Lights to be answered timely . Review of Concern & Comment Form dated 5/29/24, revealed, .Complaint Acknowledged: Waited a long time to be cleaned up called at 10 PM at night .Were the FOUR STEPS TO GREAT SERVICE RECOVERY Followed? .Yes .1. Apoligized and asked for forgiveness due to state of dissatification of service .2. Reviewed the complaint, listened and asked how we can fix it .3. Fixed the problem within 20 minutes or followed-up within 20 minutes with progress to resolve .4. Documented with your Admininstrator, including the FORM, with intention for discussing at next business day's Morning Meeting .Date/Time/Findings/Action Plan Share wtih Concerned Party: Staff reminded to answer call light in a timely manner. Will go in 2 at a time, to continue . In an interview on 6/26/24 at 11:26 AM, Unit Manager (UM) O reported Resident #101 had complained about numerous staff members but she never reported anything about verbal abuse to her. If she had, UM O reported she would speak to the staff members about the concerns. In an interview on In an interview on 6/26/24 at 10:44 AM, Anonymous interviewee OO reported Resident #101 reported the night shift staff would be mean and rude to her but she never indicated if there was a specific staff member. In an interview on 6/26/24 at 12:04 PM, Director of Nursing (DON) B reported she had not received a complaint of verbal abuse by a staff member towards Resident #101 but there were the concern forms submitted by the resident and she would go to speak to the resident to find out what the issue was and then would follow up with the staff on the issue.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 This citation pertains to intake: MI00145073. Based on observation, interview, and record review the facility failed to maintain a safe and comfortable temperature in resident rooms in 2 of 17 residents (Resident #111, #114) reviewed for homelike environment, resulting in the potential for hyperthermia and dehydration. Findings include: Review of Portable A/C Unit Placement received on 6/26/24, revealed, .6/12/13- portable that we have in house placed in room [ROOM NUMBER] .6/13/24-four units purchased and placed in rooms 18, 29, 34, and 36 .6/18 24 - Unit purchased and placed in room [ROOM NUMBER] .6/20/24- units purchased and placed in Rooms 10, 16, 20, 28, and 42 . During an observation on 6/20/24 at 10:58 AM, Resident #111's room was located at the end of the hallway and it was noted for the temperature to increase as you approached the end of the hallway were the room was located. The sun was shining through the exit doors. The room was very stuffy and hot even with fans running in the room. No AC unit was noted in the room. Resident #111: Review of an Admission Record revealed Resident #111 was a female with pertinent diagnoses which included muscle weakness, muscle wasting, need for assistance with personal care, abnormal weight loss, and severe protein calorie malnutrition. Review of current Care Plan for Resident #111, revised on 12/29/2022 revealed the focus, .(Resident #111) is at risk for nutritional problem or potential nutritional problem r/t (related to) dx (diagnosis) of Malnutrition, hx of weight loss and Anorexia. I have a terminal illness. Anticipate decline in nutritional status with continued decline in overall health status . with the intervention .Offer hydration qshift (every shift) and with cares. Assist (Resident #111) as needed with hydration and keep hydration within reach of resident . In an interview on 6/20/24 at 11:06 AM, Maintenance Director (MD) H reported the temperatures for the rooms should be between 71-81 degrees to be incompliance. The temperature for Resident #110's room was noted to be 80 degrees. In an interview on 6/21/24 at 1:00 PM, Maintenance Director (MD) H reported she had obtained a quote for a split unit, the ac was not making it into the rooms, the ones the facility had were for big box stores and didn't make it into the rooms like it should. MD D reported she had noticed at the end of the hallways on the square, the rooms were too warm and the facility had to do something that was why the portable air conditioners were purchased. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview and observation on 6/20/24 at 1:28 PM, Assistant Director of Nursing (ADON) P was performing temperature checks of the rooms on the memory care unit. ADON P reported they were completing temperature checks every hour. She reported she was handed the infrared temperature gun today and instructed to go do it. She reported she was not provided any direction on how to complete the task. She reported usually the facilities staff did it when the temperatures rise. ADON P reported they took the temperature for the resident's safety and would move them out of their rooms to cool spaces like the dining room. Note: For the duration of the survey, residents were not removed from their rooms and taken to the dining room or areas which were cooler. The residents who were typically up by the nurse's station for supervision were the residents located there. This writer did not note any offer of ice cream or popsicles to the residents to help cool them as well as no fans in the hallways to help ciculate the air in the hallways. Review of Temperature Logs dated 6/20/24 revealed, 10:00 AM, room [ROOM NUMBER] - 82 degrees, room [ROOM NUMBER] - 82 degrees, room [ROOM NUMBER] - 81 degrees, room [ROOM NUMBER]- 81 degrees, room [ROOM NUMBER] - 81 degrees, room [ROOM NUMBER] - 83 degrees, room [ROOM NUMBER] -81 degrees. On 6/21/24 at 10:53 AM, the door to room [ROOM NUMBER] was closed and this writer entered the room and was overcome with the temperature of the room and the density of the heat with no fans circulating the air. There was no air conditioning unit in the room. No fan noted in the hallway to circulate air. During an observation on 6/21/24 at 12:36 PM, noted no AC unit in room [ROOM NUMBER]. Only fan in the room was in the far left corner faced at the resident in bed 3. No fan noted in the hallway to circulate air. During an observation on 6/21/24 at 4:05 PM, a temperature log was located at the nurse's station and it was documented room [ROOM NUMBER] had a temperature of 81.5 degrees and room [ROOM NUMBER] was 82 degrees at 4:00 PM today. room [ROOM NUMBER] was located midway down the hallway on the unit and the door was shut to the room due to isolation. Per the Portable A/C Unit Placement documentd received on 6/26/24, revealed, .6/20/24- units purchased and placed in Rooms 10, 16, 20, 28, and 42 . Review of Temperature Logs dated 6/21/24 revealed, .6/21/24 at 4:00 PM, room [ROOM NUMBER] - 82 degrees, room [ROOM NUMBER] - 81.5 degrees, 6/21/24 at 5:00 PM, room [ROOM NUMBER] - 82.9 degrees, room [ROOM NUMBER] - 82.2 degrees (located midway down the hallway). Resident #114: Review of an Admission Record revealed Resident #114 was a male with pertinent diagnoses which included diabetes, edema, and need for assistance with personal care. In an interview on 6/21/24 at 2:46 PM, Resident #114 reported his room did not have an air conditioner in the room and the room was designated to have an AC unit assigned to it on 6/20/24. Noted there was no fan in the room as well. The lights in the room were dimmed. Resident #114 reported the room had been so hot in there and it was very uncomfortable for him. Resident #114 reported he did not feel like doing much because of the heat. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Temperature Logs dated 6/22/24 revealed, .2:00 PM, room [ROOM NUMBER] - 81.5 degrees, 7:00 PM, room [ROOM NUMBER] - 83 degrees. Review of Temperature Logs dated 6/24/24, revealed, .room [ROOM NUMBER] - 81 degrees, room [ROOM NUMBER] - 81 degrees, room [ROOM NUMBER] - 88 degrees, room [ROOM NUMBER] - 81 degrees, room [ROOM NUMBER] - 82 degrees, room [ROOM NUMBER] - 81 degrees, room [ROOM NUMBER] - 83 degrees, room [ROOM NUMBER] - 82 degrees. Note: no times of checks were documented. In an interview on 6/25/24 at 11:17 AM, Maintenance Director (MD) H reported the facility began checking temperatures of the rooms which were noted to be the hottest in the facility and had purchased portable AC units for those rooms. MD H reported one of the facility roof top units had frozen over as it had been working overtime to cool everything and getting the AC into the rooms. The rooms do not have individual AC units so when the door was closed, the rooms were not getting the AC from the hallways. During an observation on 6/25/24 at 11:24 AM, Certified Nursing Assistant (CNA) X was observed standing in the hallway outside of a resident's doorway and pointed the infrared thermometer into the room. MD H intervened and informed the CNA she was completing the temperature check incorrectly and demonstrated the proper process to take the temperature of the room by entering the resident's room and point the infrared thermometer towards the center of the room. In an interview on 6/25/24 at 11:25 AM, CNA X reported she was educated on how to take the temperature of the room from another CNA and she had completed the taking room temperatures for the previous two days. In an interview on 6/25/24 at 2:00 PM, Anonymous interviewee OO reported the residents in room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] had complained to them about the heat and the temperature of the rooms. Review of the temperatures for June 2024 for [NAME] Michigan revealed, 6/20/24 was 93 degrees, 6/21/24: 93 degrees, and 6/22/24: 92 degrees. Review of Safe and Homelike Environment provided on 6/26/24, revealed, .7. The facility will maintain comfortable and safe temperature levels .Comfortable and safe temperature levels means that the ambient temperature should be in a relatively narrow range that minimizes residents ' susceptibility to loss of body heat and risk of hypothermia/ hyperthermia and is comfortable for the residents .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 41424 Based on observation, interview, and record review, the facility failed to implement resident comprehensive care plans for 1 resident of 17 (Resident #113) reviewed for care planning resulting in a lack of service for residents to maintain their highest practicable physical, mental, and psychosocial well-being. Findings include: Resident #113: Review of an Admission Record revealed Resident #113 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). Review of current Care Plan for Resident #113, revised on 10/30/23, revealed the focus, .(Resident #113) has an ADL self-care performance deficit r/t cerebral palsy, epilepsy, generalized anxiety disorder, depression, Rett's syndrome, osteoarthritis . with the intervention .Palm protectors to be worn at all times as (Resident #113) allows, remove to wash and dry hands . Review of current Care Plan for Resident #113, revised on 6/7/24, revealed the focus, .(Resident #113) has an actual impairment to skin integrity of the left and right posterior ankles . with the intervention . Identify/document potential causative factors and eliminate/resolve where possible .Therapy department to assess wheelchair for proper positioning, alignment and pressure reduction . Review of Nutrition Note dated 6/8/2024 at 1:53 PM, revealed, .Resident seen for wound review. scabs/unstageable to heels r/t (related to) rubbing on wheelchair. Interventions in place, puree diet with fortified foods. Recommend Zn/Vit C x 28d (days) to promote healing, wheelchair is pending replacement, if areas do not resolve, will recommend additional interventions . Review of Nursing Note dated 4/23/2024 at 3:20 PM, revealed, .Left foot 2nd digit noted slight redness, no swelling. Podiatrist here today seen resident N.O. Left 2nd toenail bed, cleanse with WC/NS apply antibiotic ointment and cover with Band-Aid change daily x14days for cellulitis . Review of Nursing Progress Note dated 6/7/2024 at 10:56 AM, .This writer was asked by staff nurse to assess bil posterior ankles abrasions remain from patient spastic movements and scrapping of her ankles on the footplate of her wheelchair. Spoke with (Medical Director) new order to continue with skin prep but cover with duoderm and change q (every) 3 days and PRN. Therapy to assess wheelchair for proper positioning placement with feet ankles to prevent injury. Guardian made aware of above . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Nursing Progress Note dated 6/7/2024 at 11:07 AM, revealed, .This writer spoke with (Rehab Director) PT director who states that he is working with social work and OT to coordinate the wheelchair vendor and therapist on time to evaluate patient and be fitted for possible wheelchair adjustments and or replacement wheelchair all together. Therapist (Rehab Director) states that he will look at the footplate today to see if he can add padding or make adjustments to help prevent resident from rubbing her posterior ankles on the foot plate. Soft fleece lap blanket used at this time with long fluffy socks to assist in positioning and protecting the posterior ankles. Staff aware and updated on above . Review of Social Service Progress Note dated 6/12/2024 at 2:54 PM, revealed, .Referral for new customized wheelchair made to (Durable equipment company). Will cont to follow-up and document as needed . During an observation on 6/21/24 at 12:40 PM. Resident #113 was observed in the dining room with ankle socks on with the fleece blanket dragging on the floor. She did not have on long fluffy socks. During an observation on 6/25/24 at 11:53 AM, Resident #113 was observed in the tv room area without her sheepskin braces for her hands. She had on socks which came to her ankles, no fleece blanket for protector of her legs and feet, she had nothing in the foot cradle area except for the rubber lining pad which were splitting at the middle on the ends. On the left foot side, the metal plate was exposed. She had her left foot under the foot rubber lining and it was curled back behind her heel. Her right foot was hanging over the edge of the foot rest and the back of her heel was rubbing on the edge of the foot cradle. During an observation and interview on 6/25/24 at 12:00 PM, Unit Manager (UM) O requested Rehab Director RR come to adjust the foot cradle for Resident #113's chair. CNA J was sent into Resident #113's room to look for the pad to help protect Resident #113's feet on the foot cradle but she was unable to locate it. UM O reported at 12:03 PM, therapy had put foam padding on her foot cradle until we get the new wheelchair for her. CNA J was observed to retrieve Resident #113's hand sheepskin braces for UM O to place on the resident's hands as well as a maroon fleece blanket to place under her feet in the foot cradle. UM O reported it was better than having nothing, and reported the resident had rubbed the back of her heels on the foot cradle and it was causing breakdown. UM O reported the facility had ordered a new foot cradle for the chair but it had not arrived yet and the pad was supposed to be in there to protect her feet until the foot cradle comes in. UM O reported the hand braces were to be in place to help prevent further contractures of her hands. She reported if the resident had refused them, the staff were able to place hand rolls in there. In an interview on 6/26/24 at 09:43 PM, Registered Nurse (RN) C reported for a resident who had an order for monitoring the administration of a device like a brace or boots there was an option in the medical record to document the refusal of the resident to wear the device. In an interview on 6/26/24 at 11:26 AM, UM O reported she was able to determine if care plan interventions were being implemented by observations of the residents, staff, and would conduct on the spot questions of staff about the resident. UM O reported if a resident refused to wear a device, it would be document in the medical record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 Based on observation, interview, and record review, the facility failed to ensure a resident was provided daily personal hygiene care in 3 (Resident #110, #111, #113) of 17 residents reviewed for activities of daily living resulting in unmet personal hygiene needs. Findings include: According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 50742-50744). Elsevier Health Sciences. Kindle Edition.Personal hygiene affects patient's comfort, safety, and well-being. Hygiene care included cleaning and grooming activities that maintain personal body cleanliness and appearance. Personal hygiene activities which as taking a bath or shower and brushing and flossing the teeth also promote comfort and relaxation foster a positive self-image, promote healthy skin, and help prevent infection and disease . Resident # 110: Review of current Care Plan for Resident #110, revised on 5/2/24, revealed the focus, .(Resident #110) has an ADL self-care performance deficit r/t (related to) Alzheimer's, glaucoma, confusion, impaired balance, limited mobility, limited ROM (range of motion) . with the intervention .Personal Hygiene: Requires limited to extensive assist of 1 staff member . During an observation on 6/21/24 at 12:29 PM, Resident #110 was observed in the TV room and observed the resident's teeth had plaque buildup on them and had not been brushed. Resident #110 had rotten and decaying teeth upper and lower jaw. Review of Shower Schedule located in the shower book, Resident #110 was to have a shower on Mondays and Thursdays. Showers were missed on 4/2/24, 4/6/24, 5/23/24, and 5/27/24. Resident #111: Review of current Care Plan for Resident #111, revised on 12/29/2022 revealed the focus, .(Resident #111) has an ADL self-care performance deficit r/t (related to) limited mobility . with the intervention .Persona Hygiene: Requires limited to extensive assist of 1 staff . During an observation on 6/21/24 at 10:50 AM, Resident #111 was observed lying in her bed. Observed Resident #111 had plaque buildup on her teeth as her teeth had not been brushed. Her hair had not been combed and had a braid in the back which was in disarray. During an observation on 6/21/24 at 12:38 PM, Resident #111 was observed lying in her bed and her teeth had still not been brushed and her hair was still disheveled. Resident #113: (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an Admission Record revealed Resident #113 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). Review of current Care Plan for Resident #113, revised on 10/30/23, revealed the focus, .(Resident #113) has an ADL self-care performance deficit r/t cerebral palsy, epilepsy, generalized anxiety disorder, depression, Rett's syndrome, osteoarthritis . with the intervention .Personal Hygiene/Oral Care: (Resident #113) is totally dependent on staff for personal hygiene and oral care .Requires extensive assist of 1 staff member . During an observation on 06/20/24 at 10:12 AM, Resident #113 was observed in the tv room across the hall from her room. Her hair was disheveled and greasy appearing like it had not been washed. Resident #113 had plaque built up on her teeth as they had not been brushed. During an observation on 6/25/24 at 11:53 AM, Resident #113 was observed in the tv room area, and she had greasy hair which was uncombed. Her harness had dried liquid material on it and was covered with dried white flaky material which appeared to be hair dander. During an observation on 6/26/24 at 10:07 AM, Resident #113 was observed seated in her heelchair, she had on her hand braces, but she had a sling under her, and it went to her feet, she had on ankle socks and her left foot was hanging over the edge of the foot rest for her chair. The right was placed on the bottom of the footrest area. She had a blanket there, but it was behind the rubber protective cover for the metal foot board, and she had it behind her heel of her right foot. Her hair was greasy . and uncombed. Review of Shower Sheets for Resident #113 revealed, her last shower was conducted on 6/14/24. Review of Shower Schedule located in the shower book, Resident #113 was to have a shower on Mondays and Fridays. Showers were missed on 4/22/24, 5/6/24, 5/24/24, 6/4/24, 6/17/24 and 6/21/24. In an interview on 6/26/24 at 09:27 AM, CNA CC reported when she gets a resident up and ready for the day, she would ensure their face was washed, teeth were brushed, hair was combed, and dressed. CNA CC reported this would not be considered a partial bed bath as that would entail more areas of the body being cleaned like arms and underarms. In an interview on 6/26/24 at 09:41 AM, Registered Nurse (RN) C reported if a resident a shower/bath, the CNA would then come to her after they had attempted a couple of times, then she would go in and talk to the resident to determine why they were refusing, as maybe they wanted a different time of the day or another day. If the resident still refused, the CNA would make a notation on the shower sheet, she would review it and sign off on it. RN C reported she would then complete a progress note which would indicate the resident still refused after multiple attempts. In an interview on 6/26/24 at 10;17 AM, CNA J reported when she gets a ready up and ready for the day, she would get them dressed, shave them if they needed shaved, clean their face, brush their teeth, clean brief and comb their hair. (continued on next page)

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Riveridge Rehabilitation and Healthcare Center	1333 Wells St Niles, MI 49120

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 6/26/24 at 10:18 AM, CNA J reported if a resident refused a shower/bed bath, she would reapproach twice, and the second time let the nurse and nurse know. The refusal would be documented on the shower sheet and the medical record. CNA J reported a partial bed bath would not be documented in the record as a bed bath as it was not a full bed bath. In an interview on 6/26/24 at 11:26 AM, Unit Manager (UM) O reported a resident's teeth should be brushed every day and if a resident refused cares the CNAs can document the refusals in the medical record. In an interview on 6/26/24 at 12:04 PM, Director of Nursing (DON) B reported a resident's teeth should be brushed daily when they get up in the morning. DON B reported if a resident refused the shower/bath, the CNA would let the nurse know and she can go back and ask them if the resident wanted one, if they still refused the refusal would be noted on the shower sheet, and the nurse would put in a note.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. 41424 Based on observation, interview and record review the facility failed to maintain sufficient hydration in 1 (Resident #111) of 17 residents reviewed for hydration resulting in the potential for dehydration, unmet resident needs, and unnecessary negative physical, mental and psychosocial outcomes. Findings include: Resident #111: Review of an Admission Record revealed Resident #111 was a female with pertinent diagnoses which included muscle weakness, muscle wasting, need for assistance with personal care, abnormal weight loss, and severe protein calorie malnutrition. Review of current Care Plan for Resident #111, revised on 12/29/2022 revealed the focus, .(Resident #111) is at risk for nutritional problem or potential nutritional problem r/t (related to) dx (diagnosis) of Malnutrition, hx of weight loss and Anorexia. I have a terminal illness. Anticipate decline in nutritional status with continued decline in overall health status . with the intervention .Offer hydration qshift (every shift) and with cares. Assist (Resident #111) as needed with hydration and keep hydration within reach of resident . Review of Order dated 3/8/2022 at 1:19 PM, revealed, .Regular diet, Regular texture, Thin Liquids consistency fortified foods . Review of Nutrition Note dated 6/13/2024 at 12:58 PM, revealed, .Resident seen for Q nutritional ARD . Regular diet with fortified foods. Est needs: 1100-1400kcal (MSJ x 1.3), 1100-1400ml fluid (1ml/kcal) . Review of Task-Nutrition- Fluid Intake for the last 30 days, revealed, .5/28/24: 500 cc's; 5/31/24: 400 cc's; 6/1/24: 420 cc's; 6/2/24: nothing documented; 6/3/24: nothing documented; 6/4/24: 400 cc's; 6/5/24: 400 cc's; 6/6/24: 1040 cc's documented; 6/7/24: 720 cc's; 6/8/24: nothing documented, 6/9/24: nothing documented; 6/10/24: 1200 cc's; 6/11/24: nothing documented; 6/12/24: 240 cc's; 6/13/24: 1200 cc's; 6/14/24: nothing documented; 6/15/24: nothing documented; 6/16/24: 215 cc's; 6/17/24: 380 cc's; 6/18/24: 140 cc's; 6/19/24: 400 cc's; 6/20/24: 730 cc's; 6/21/24: nothing documented; 6/22/24: 320 cc's; 6/23/24: 400 cc's; 6/25/24: 500 cc's . During an observation on 6/20/24 at 11:03 AM, Resident #111 was observed lying in her bed, her water was on the night stand next to her bed. It was noted to be full. During an observation on 6/20/24 at 1:00 PM, Resident #111 was observed lying in her bed, her ice in her water had melted and she had not drank any water from the sytrofoam cup. It had sweat running down the side of the cup and had not been touched. During an observation on 6/21/24 at 09:11 AM, Resident #111 was lying in her bed and her water was placed on the night stand out of her reach and had not been drank. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 6/21/24 at 10:50 AM, Resident #111 was still in the same position she was earlier. Her water was at the same level and had not been touched. During an observation on 6/21/24 at 12:38 PM, Resident #111's water was at the same leave as it was earlier. During an observation on 6/21/24 at 2:45 PM, Resident #111's water was down approximately a 1/4 inch from the previous level. In an interview on 6/21/24 at 4:13 PM, Licensed Practical Nurse (LPN) V reported Resident #111 did not get out of bed, she ate between 25-50% of meals. LPN V reported she will call out when she wants a drink. She reported she tried to have her medication cart stay on the wall by her room. Note: Residents two rooms down on the left had the TV so loud it was very difficult to hear in the location of the cart as well as other TVs in rooms close to the cart. Resident #113 was in a 3 person room and she was at the far left in the room far away from the doorway. During an observation on 6/25/24 at 11:28 AM, Resident #111 was lying in her bed, same position. Her water was full. During an observation on 6/25/24 at 2:19 PM, Resident #111 had a medium glass of milk and nothing else on her tray to drink. Resident #113 had drank approximately 2/3 of her cup of milk. Staff had pulled the straw from her water to use for her milk and did not replace it, her water had not been touched, it was still full. In an interview on 6/26/24 at 9:55 AM, Dietary Aide Y reported the medium cup was 8 oz and the smaller slender cup was 6 oz. During an observation on 6/25/24 at 4:14 PM, Resident #111 was lying in her bed, her styrofoam cup for water did have a new straw in it but it was marked as AM and there was approximately 1/4 inch drank from the cup. In an interview on 6/26/24 at 09:27 AM, Certified Nursing Assistant (CNA) CC reported she would go in a resident's room every two-three hours to check on the resident, make sure to rotate them in the bed, or place them chair and can keep an eye on them, do the rounds, especially for the more dependent residents. CNA CC reported if a resident was unable to drink much or at all the facility had green sponges to get the water in there for them. During an observation on 6/26/24 at 10:00 AM, Resident #111 was lying in her bed, she had an 8oz cup of milk on her night stand with a lid on it, but no straw. She had drank approximately 20z of the milk. Her water on the night stand was full, had a lid but did not have a straw. In an interview on 6/26/24 at 10:35 AM,, LPN V reported she expected the CNAs to round regularly and offer drinks to the residents especially with the heat lately. In an interview on 6/26/24 at 12:04 PM, Director of Nursing (DON) B reported she expected the staff to go and offer the residents water or a drink at least every 2-3 hours. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of policy, Hydration provided on 6/25/24, revealed, .The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health .b. Interventions will be individualized to address the specific needs of the resident. Examples include, but are not limited to: i. Offer the resident a variety of fluids during and between meals .ii. Provide assistance with drinking .iii. Ensure beverages are available and within reach .e. The resident will be monitored for conditions that may increase fluid needs: i. hot or humid weather . According to Bunn (2019), .Older people are more at risk of developing low-intake dehydration because, with age, kidney function decreases and muscle mass drops, reducing water stores in muscle. Older people may also develop difficulties remembering to drink, accessing drinks, and swallowing. If an older person is concerned about continence or needs help to get to the toilet, they often choose to drink less, thereby increasing their risk of low-intake dehydration. The risk of dehydration is increased in care homes residents because they are more likely to experience these problems, relying on staff to help with drinking .Residents rarely helped themselves to, or asked for, drinks, which puts the onus on nursing and care staff .Tips for improving hydration in care homes: Offer more drinks more frequently .Do not rely on residents asking for, or helping themselves to, drinks, but proactively offer them .If drinks are not finished, offer more frequent drinks . Improve continence support and access to toilets .Involve all care home staff in promoting residents' hydration . https://cdn.ps.emap.com/wp-content/uploads/sites/3/2019/09/054-058_RevDehydration-CT1.pdf

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 41424 This citation pertains to intake: MI00143691 Based on observation, interview, and record review the facility failed to ensure proper infection control protocols and practices including enhanced barrier precautions (EBP) for 2 residents (#110, #114) of 5 residents, resulting in the increased potential for the spread of infection, bacterial harborage, cross contamination, and disease transmission for residents residing in the facility. Findings include: Review of Centers for Disease Control and Prevention (CDC) dated March 20,2024, revealed, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .EBP are indicated for residents with any of the following: o Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO . Effective Date: April 1, 2024 . Resident #110: Review of an Admission Record revealed Resident #110 was a female with pertinent diagnoses which included diabetes, heart failure, dementia, pressure ulcer of sacral region, stage 3, and muscle weakness. Review of current Care Plan for Resident #110, revised on 5/2/24, revealed the focus, .(Resident #110) has the potential for skin breakdown r/t (relate to) fragile skin, immobility and incontinence, dementia, DMII (diabetes), depression, arthritis, hx (history) of pressure ulcer . with the intervention .Staff to use enhanced barrier precautions to prevent infections . Review of Orders dated 5/8/24, revealed, .Enhanced barrier precautions due wounds. every shift for wounds/ prevent infection . During an observation on 6/20/24 at 10:16 AM, Hospice RN L was observed to have no gown on in the room with Resident #110. There was an enhanced barrier precautions sign outside of entrance to room on the wall as well as a personal protective equipment (PPE) cart. RN L reported the resident had a bed sore and she needed a staff member to come and assist her with rolling the resident so she can take a look at the sore on her bottom. RN L had adjusted the height of the bed and came out and was looking in the hallway to see if someone was coming to assist her. When she went back in to the room, RN L told Resident #110 to not touch herself down there. Certified Nursing Assistant (CNA) J entered the room without donning PPE to assist the nurse with the rolling/transferring of Resident #110 so the nurse could assess the wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of IDT NOTE dated 6/6/2024 at 10:40 AM, revealed, .IDT met to review for stage 2 pressure ulcer to coccyx, being followed by wound care physician, area noted to be improving, treatment in place . In an interview on 6/20/24 at 10:29 AM, Certified Nursing Assistant (CNA) J entered the room to assist Hospice Registered Nurse (RN) L with rolling Resident #110 so RN L could assess her wound. CNA J reported while she was in there, she also performed a brief change and pericare for Resident #110. CNA J reported as the resident was on enhanced barrier precautions she should have donned a gown and gloves prior to direct care for Resident #110. In an interview on 6/20/24 at 10:51 AM, Hospice RN L reported she was not aware of the changes in the requirements implemented a few months ago for to enhanced barrier precautions to be in place for residents who had wounds. RN L indicated it was her first time here and she should have asked the nurse if she was unsure who was in bed b as noted on the enhanced barrier precautions sign on the wall outside of Resident #110's door. When queried if Resident #110 had a wound, RN L reported she did. During an observation on 6/21/24 at 2:36 PM, Resident #110 was calling out from the TV room asking to be taken back to her room. Certified Nursing Assistant (CNA) T and CNA U responded and wheeled her back into her room as she was asking to lie down, go back to bed, and indicated her back hurt. CNA T and CNA U entered the room and placed Resident #110 into her bed without donning personal protective equipment (PPE) prior to entry. Resident #114 Review of an Admission Record revealed Resident #114 was a male with pertinent diagnoses which included diabetes, edema, chronic ulcer of other part of left foot, and need for assistance with personal care. Review of current Care Plan for Resident #114, revised on 6/4/24, revealed the focus, .Diabetic Ulcer to skin integrity of the Left great toe . with the intervention .Enhanced barrier precautions due to wound . Review of Nursing note dated 6/7/2024 at 7:34 PM, revealed, .Resident continues on ABT for infection of the legs. No adverse reaction noted. Bilateral legs noted to have non-pitting edema . During an observation on 6/21/24 at 2:49 PM, sign on wall outside of Resident #114's door indicated he was under enhanced barrier precautions. Sign indicated for transfers, staff would have to don a gown and gloves. This writer observed Certified Nursing Assistant (CNA) T and CNA U enter the resident's room without donning a gown. CNA U did not have on gloves when she entered the room as they were pushing a hoyer lift into the room. Resident #114 was observed to be seated in his wheelchair prior to entry. In an interview on 6/21/24 at 2:57 PM, CNA U reported they placed the resident in the bed and CNA T was positioning him, removing the sling from under him, and was unsure what else he was doing. She was pushing the hoyer out of the room and did not have gloves or did not perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 6/21/24 at 2:59 PM, CNA T reported he did not think the enhanced barrier precautions was for Resident #114, he thought it was for his roommate. This writer and CNA T reviewed the enhanced barrier precautions sign on the wall and it indicated Bed A & Bed B on the top of the document. CNA T reported whenever direct care like transferring happened the staff were to wear a gown and gloves. In an interview on 6/26/24 at 11:24 AM, CNA DD reported when a resident was on enhanced barrier precautions a gown and gloves should be donned prior to providing care to the resident, like feeding a resident who was dependent for care, pericare, transfers, had a catheter, infections, wounds, or fluids. In an interview on 6/26/24 at 12:04 PM, Director of Nursing (DON) B reported when a resident was placed on enhanced barrier precautions, the staff were to don gloves and gown anytime direct care was provided to the resident. This was put in placed for residents with MDROs or infections so it was not passed on to staff and to other residents. Review of policy, Enhanced Barrier Precautions reviewed/revised on 9/203, revealed, .It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms .Definitions: Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters) even if the resident is not known to be infected or colonized with a MDRO. (Peripheral IVs, continuous glucose monitors, insulin pumps, or ostomies without an associated indwelling medical device are not an indication for EBP.) .ii. Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply .3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. c. Ensure access to alcohol-based hand rub in every resident room (ideally both inside and outside of the room) .4. High-contact resident care activities include: a. Dressing .b. Bathing. C. Transferring .d. Providing hygiene .e. Changing linens .f. Changing briefs or assisting with toileting .g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes, hemodialysis catheters, PICC lines, midline catheters .h. Wound care: any skin opening requiring a dressing .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41424 This citation pertains to intake: MI00145073, MI00143691 Based on observation, interview, and record review, the facility failed to ensure clean and sanitary environment, resulting in the potential for cross contamination, infections, and bacterial harborage. Findings include: During an observation on 6/20/24 at 10:58 AM, room [ROOM NUMBER] had dried material spilled on the floor midway through the room. During an observation on 6/20/24 at 12:54 PM, outside of room [ROOM NUMBER] on the wall there was dried liquid material running down the wall. There were chunks of dirt, like dried mud in a boot tread and scattered dirt/paper/debris on the floor outside of room [ROOM NUMBER]. During an observation on 6/20/24 at 12:57 PM on the floor outside of room [ROOM NUMBER] there were pieces of straw paperand scattered dirt/debris. In front of the nurse's station, there was various dirt and debris scattered on the floor in front of it. The hallway had scattered locations of dirt/debris/pieces of straw paper scattered from one end to the other, espcially in the outer part of the hallway closer to the walls. During an observation on 6/20/24 at 1:07 PM, outside of the clean linen room.storage by the double doors there was dried material on the floor, outside of room [ROOM NUMBER] there were chunks of dirt and debris on the floor. During an observation on 6/21/24 at 12:37 PM, Outside of Resident #113's room, the housekeeper was mopping just outside the doorway but not across the whole hallway. Housekeeper E reported she mopped outside of the room as the mop was excessively wet and to get the excess water out of it. In an interview on 6/21/24 at 1:54 PM, Family Member S pointed towards the window in her family member's room to the big mess of cob webs in the upper left corner of the window and reported those had been there since her family member had moved into this room. In an interview on 6/21/24 at 4:08 PM, Housekeeper W reported the housekeepers were responsible for mopping the hallways, half the hallway at a time. In an interview on 6/26/24 at 11:42 AM, Maintenance Director (MD) H reported she does not have a housekeeping supervisor she was the supervisor. During the duration of the survey, this writer noticed various dried liquid spots on the hallway floors throughout the building, scrapes on the walls, dried liquid/dirt spots on the hallway walls. The main hallway upon entry had dirt and debris and various spots of dried liquid scarttered across the hallway all the way down the hallway to the nurse's station. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 6/26/24 at 11:44 AM, Maintenance Director (MD) H reported the floors for the hallway would be cleaned as the housekeepers do the rooms, and then they would mop one hall of the hallway and then the other half so the entire hallway was mopped. They do this so as to let one side dry and then mop the other. MD H reported the wall get cleaned as needed and the deep cleans were done once a month, this was when every room, every space would be cleaned. Observed dirt and dried liquid on the wall where the laundry shoot was which is just below the crown molding running down the bottom 1/3 of the wall and MD H reported it was dirty as they were placing soiled laundry down the shoot.