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	11/14/2024

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 41982 Based on observations, interviews, and record review, the facility failed to ensure a positioning device (a left resting hand splint) was applied per therapy recommendations for 1 (Resident #201) of 3 residents reviewed for therapy services, resulting in the potential for contracture progression (hardening of the muscles, tendons, and other tissues), pain, and decline in range of motion. Findings include: Resident #201 Review of an Admission Record revealed Resident #201 was a female, with pertinent diagnoses which included: vascular dementia, unspecified severity; and stiffness of unspecified hand. Review of a current Care Plan for Resident #201 revealed a focus of (Resident #201) has an ADL (activities of daily living) self-care performance deficit r/t (related to) dementia, HTN (high blood pressure), lack of coordination, balance issues . last revised on 10/18/24 with care planned interventions which included (Resident #201) is to wear left resting hand splint (a positioning device) when out of bed with a date initiated of 10/22/24. A review of Resident #201's current Order Summary Report on 11/14/24 at 10:50 AM, revealed no physician order for Resident #201 for a left resting hand splint. During an observation on 11/13/24 at 12:28 PM, Resident #201 was seated at a table in the dining room waiting for her lunch meal. Resident #201 was not wearing a left resting hand splint. During an observation on 11/13/24 at 1:49 PM, Resident #201 was seated in her wheelchair across from the nurses' station on the unit where she resided. Resident #201 was not wearing a left resting hand splint. During an observation on 11/14/24 at 10:26 AM, Resident #201 was seated at a table in the dining room observing other residents who were engaged in a kickball activity. Resident #201 was not wearing a left resting hand splint. (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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 11/14/24 at 12:41 PM, Resident #201 was seated at a table in the dining room waiting for her lunch meal to be served to her. Resident #201 was not wearing a left resting hand splint. In an interview on 11/13/24 at 3:14 PM, Certified Nurse Aide (CNA) G was queried by this surveyor about Resident #201's left resting hand splint. CNA G reported thought Resident #201 had something for her wrist at some point, but haven't seen that in a while and that therapy usually handled that. In an interview on 11/14/24 at 10:34 AM, Physical Therapist (PT) P reported therapy had recommended the left resting hand splint for Resident #201 because of hand pain. PT P reported Resident #201 had previously had a different hand splint but that she would remove it, so therapy recommended the current left resting hand splint in hopes that Resident #201wear it without trying to remove it. PT P reported the purpose of the splint was to prevent/manage contracture progression and pain of Resident #201's left hand. PT P reported therapy had given nursing staff training on applying the splint and instructed on the splint wearing schedule. Review of Resident #201's Occupational Therapy Treatment Encounter Note dated 10/23/24 revealed, . Manual tx (treatment): provided joint mobilization techniques and stretching of shortened connective tissue left hand .pt (patient) indicated no pain with movement this date; resting hand splint applied following manual tx .Skilled interventions focused on caregiver education for resting hand splint application and wearing schedule, instruction provided to unit nurse and CNAs (certified nurse aides) . In an interview on 11/14/24 at 1:32 PM, Licensed Practical Nurse (LPN) K reported she regularly worked with Resident #201. LPN K reported hadn't seen a splint for Resident #201 for quite some time. LPN K reported knew Resident #201 had a splint at one point and thought maybe it had been discontinued. LPN K reported if a CNA attempted to apply the splint to Resident #201's hand and she refused to wear it, the refusal should be documented in the medical record. LPN K reported there should be a physician order if a resident was to wear a splint or other positioning device. In an interview on 11/14/24 at 12:50 PM, Director of Nursing (DON) B reported there was no physician order entered for Resident #201's left resting hand splint but there should have been. DON B reported if staff attempted to apply the splint and Resident #201 refused, there would be documentation in Resident #201's medical record. DON B reported there was no documentation in Resident #201's medical record to show that she was offered or refused to wear the left resting hand splint that was recommended by therapy.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41027 This citation pertains to intake #MI00147923. Based on interview and record review, the facility failed to ensure adequate monitoring, assessment and care for 1 resident (Resident #202) of 3 residents, with an indwelling catheter, reviewed for urinary catheter/UTI (urinary tract infection) care, resulting in hospitalization due to severe UTI and Sepsis. Findings include: Review of an Admission Record revealed Resident #202 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: urinary retention. In an interview on 11/13/24 at 1:51 PM, Licensed Practical Nurse (LPN) K reported that she had noticed on 11/10/24 that Resident #202 was not himself, was pale in color, not eating and drinking, had a large amount of sediment and blood in his urine, and was not using his typical sign language to communicate. LPN K reported that she had come across UA results that clearly indicated an infection, but were incomplete, so she called for the final results. LPN K reported that the results were from several days prior, but did not appear to have been addressed. LPN K reported that she called DON B and MD C to get permission to send Resident #202 to the hospital. In an interview on 11/14/24 at 2:56 PM, LPN M reported that she was concerned about Resident #202's UA results on 11/8/24 and had sent MD C an email, but did not hear anything back prior to finishing her shift on 11/9/24. LPN M reported that Resident #202's urine was cloudy and bloody, and based on the UA result, he had a UTI. LPN M reported that UA results are available in 48 hours or less and C&S takes at least 48 hours. LPN M reported that Resident #202's urine color and clarity should have been documented in his progress notes, the CNA's are expected to document color and amount of output, and the nurses should have orders to ensure catheter care is being provided. Review of Resident #202's Urology Visit Notes dated 10/31/24 revealed, .Hospital follow up .Exam: .foley draining cloudy urine .Assessment/Plan: 1. Urolithiasis (stone in urinary system) .Discussed with caregiver that we need permission from (guardian) to proceed with cystoscopy (procedure to see the inside of the bladder and urethra), litholapaxy (procedure to break up bladder stones), bilateral ureteroscopy (procedure to examine and treat the upper urinary tract), laser lithotripsy (procedure to break up kidney stones) and bilateral stent exchange once his infection is cleared .plan for this 11/6. In the meantime, we will have (facility) change foley and submit urine for C&S in the next 24 hours .4. UTI and suspect upper tract involvement - last urine culture with morganella (bacteria), pseudomonas (bacteria) and proteus (bacteria), he completed tx (treatment) with Cefepime (antibiotic) on 10/18 .(facility) change foley and submit urine for C&S (culture and sensitivity test to determine which antibiotic will be needed to treat the bacteria) in the next 24 hours . The visit note was printed by facility staff on 11/5/24. There were no nurse's notes, and/or physician visits recorded between 10/23/24 and 11/3/24. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #202's Progress Note dated 11/3/24 at 7:20 PM revealed, at 7:30 PM urine specimen collected and sent to (lab name). The urine test was obtained 36 hours after Resident #202's urology appointment, and not 24 hours as ordered. There were no nurse's notes, and/or physician visits recorded between the above note on 11/3/24 and 11/8/24. Review of Resident #202's Progress Note dated 11/8/24 at 10:02 PM revealed, sent a message to Dr. to review resident's UA (urinalysis: urine test) results. There were no nurse's notes, and/or physician visits recorded between the above note on 11/8/24 and 11/10/24. Review of Resident #202's Progress Note dated 11/10/24 at 2:16 PM revealed, observed UA results at nurse's station today with no susceptibility results. Called for results to be faxed. Called (Medical Director (MD) C) who says to send to ER (emergency room). Resident's V/S (vital signs): 92/70 (blood pressure) 113 (heart rate) 97.3 (temperature) 93% (blood oxygen level) .Resident is not eating and drinking as per his normal and appears weak. Called DON (Director of Nursing) with update . Review of Resident #202's UA Results were collected on 11/3/24 at 8:08 PM, and resulted on 11/3/24 at 8:49 PM. The results indicated the urine was turbid (cloudy), contained a moderate amount of blood, a large amount of Leukocyte esterase (indicates a UTI or inflammation), greater than 100 WBC (white blood cells: indicates infection), 48 RBC (red blood cell count: indicates issues such as infection), and a moderate amount of bacteria (indicates an infection). The report had a print stamp by facility staff on 11/4/24 at 10:52 AM. Based on the abnormal results, a Urine C&S was automatically added to the UA test. The C&S results were final on 11/8/24 at 9:10 AM. The results indicated greater than 100,000 CFU/ml Pseudomonas Aeruginosa (indicating a serious bacterial infection), and the recommended antibiotics to treat the infection. The C&S report was received via fax by facility staff on 11/10/24 at 1:54 PM. Review of Resident #202's Ambulance Report dated 11/10/24 revealed, .On scene 2:28 PM .Patient was found laying in bed .Patient skin was pale, extremely warm and dry. Patient had a urinary catheter and it was cloudy and thick sediment in the tubing and blood was noted as well. Staff on scene advised that the patient got a UA done on November 3rd and got the results on November 4th that he had a UTI and was septic. Nurse advised that since she last worked there has been no new notes in the system and no vital signs charted on the patient. Nurse also advised that the facility doctor was made aware of the UA results on November 8th .Nurse stated that when she called the facility doctor today to get permission to send the patient out and the doctor stated on the phone that she had zero idea of the results . (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #202's Hospital Records course of stay 11/10/24 to present (11/14/24) revealed, . significant medical history of recurrent urinary tract infections with a chronic indwelling Foley catheter . presented to the emergency department for altered mental status .Review of previous microbiology (urine test) showed susceptibility to Zosyn (antibiotic) and this was started in the ED (emergency department). Vancomycin (antibiotic) also started. Labs were remarkable for elevated WBC and creatinine. Due to most recent history, obtained a CT (detailed x-ray image) of the abdomen and pelvis without contrast. Imaging was remarkable for misplaced Foley catheter and severely distended urinary bladder. Likely contributing to AKI (acute kidney injury). Replaced catheter in the ED with good output .Attempted to call (facility) however unable to reach RN (registered nurse). Patient is also unable to give history. He has a significant medical history of a chronic indwelling Foley catheter, bilateral deafness, learning delay. Of note, patient was recently in the hospital on October 2, 2024 for septic shock secondary to urosepsis .Clinical impression/plan: .Septic shock due to Pseudomonas .secondary to urologic infection as noted by CT scan with hydronephrosis (back up of urine into the kidney), Foley catheter balloon inflation in urethra, both urine and blood cultures showing both Pseudomonas and Proteus . Review of Resident #202's documentation of Vital Signs indicated that the resident had normal vital signs, including temperatures on 11/3/24 and 11/7/24, but there were no vital signs recorded after that until 11/10/24 when the resident was sent to the hospital. Review of Resident #202's Treatment Administration Record (TAR) revealed no orders for catheter care and/or monitoring. Review of Resident #202's documentation of CNA (Certified Nursing Assistant) Tasks from the past 30 days revealed, Catheter Care was recorded as performed 0/30 days, and Catheter Output (urine) Amount was recorded as performed 0/30 days. In an interview on 11/14/24 at 1:38 PM, DON/Infection Preventionist B reported that she was not made aware that Resident #202's urologist had wanted Resident #202's catheter changed and a urine C&S obtained immediately after his appointment on 10/31/24. DON/IP B reported that the facility did not send a communication sheet along with residents and/or have a process in place to receive information such as visit notes and test results, timely and efficiently. DON/IP B reported that due to Resident #202's upcoming surgery, they changed his catheter and obtained a urine specimen for testing. DON/IP B reported that Resident #202 was lethargic (drowsy) and suspected to have a UTI on 11/3/24, but that was not the reason that the UA was obtained. DON/IP B reported that Resident #202 did not have any documentation of his signs or symptoms related to a UTI, and was not being regularly monitored for a UTI. DON/IP B reported that with Resident #202 being lethargic, and considering his history of repeated UTI's, he should have had regular monitoring of vital signs, and prompt follow up of his urine test results. In an interview on 11/14/24 at 2:47 PM, CNA I reported that Resident #202 had decrease appetite, and his urine was cloudy a couple days prior to his hospitalization . CNA I reported that the CNA's are expected to report catheter output to the nurse and then the nurse documents it in the record. In an interview on 11/14/24 at 2:25 PM, CNA J reported that catheter output amounts are reported to the nurse. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 11/14/24 at 2:30 PM, LPN K reported that the CNA's should be documenting catheter output amounts.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. 41982 Based on observation, interview, and record review, the facility failed to ensure adaptive dining equipment was provided per physician's order for 1 (Resident #201) of 3 residents reviewed for food, resulting in the potential for difficulty with self-feeding and weight loss. Findings include: Resident #201 Review of an Admission Record revealed Resident #201 was a female, with pertinent diagnoses which included: vascular dementia, unspecified severity; unspecified lack of coordination; and stiffness of unspecified hand. Review of a current Physician's Order for Resident #201 revealed, Regular diet Mechanical Soft texture, Thin Liquids consistency, Divided plates for all meals .Order Status Active Order Date 5/12/2023 Start Date 5/12/2023 . Review of a current Care Plan for Resident #201 revealed a focus of (Resident #201) is at risk for nutritional problem or potential nutritional problem r/t (related to) Dementia secondary HTN (high blood pressure), hyperlipidemia (elevated levels of fat in the blood), vascular dementia with behavioral disturbance, mild cognitive impairment, obesity, wt (weight) fluctuations with diuretics in place, dysphagia (swallowing difficulty) with mech (mechanical) soft diet in place last revised 7/18/24 with pertinent interventions which included Provide divided plate for all meals with a date initiated of 8/9/24. During an observation on 11/13/24 at 12:53 PM in the dining room, noted Resident #201 was seated at a table with her lunch meal in front of her. The entree, which appeared to be chicken casserole, was served on a regular flat plate, and not in a divided dish as specified on Resident #201's Tray Ticket. Review of a Tray Ticket for Resident #201 revealed .INSTRUCTIONS: Real Silverware, NO Styrofoam, Divided Plate In an interview on 11/14/24 at 11:31 AM, Registered Dietitian (RD) Q reported sometimes Resident #201 needed help to eat and sometimes she was able to eat on her own. RD Q reported Resident #201 used a divided dish to help with self-feeding ability because it made it a little easier for her to see what food she had and helped her to get food onto her utensils because of the edges in each of the wells of the plate. RD Q reported Resident #201 should have a divided plate for all meals.

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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** 41027 This citation pertains to intake #MI00147923. Based on interview and record review, the facility failed to maintain complete and accurate medical records for 1 of 4 residents (Resident #202) reviewed for medical records, resulting in the lack of documentation pertaining to catheter care, test results, vital signs, and resident status, as it related to an impending UTI (urinary tract infection). Findings include: Review of an Admission Record revealed Resident #202 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: urinary retention. In an interview on 11/13/24 at 1:51 PM, Licensed Practical Nurse (LPN) K reported that she had noticed on 11/10/24 that Resident #202 was not himself, was pale in color, not eating and drinking, had a large amount of sediment and blood in his urine, and was not using his typical sign language to communicate. LPN K reported that she had come across UA (Urinalysis:urine test) results that clearly indicated an infection, but were incomplete, so she called for the final results. LPN K reported that the results were from several days prior, but did not appear to have been addressed. In an interview on 11/14/24 at 2:56 PM, LPN M reported that she was concerned about Resident #202's UA results on 11/8/24 and had sent MD (Medical Director) C an email, but did not hear anything back prior to finishing her shift on 11/9/24. LPN M reported that Resident #202's urine was cloudy and bloody, and based on the UA result, he had a UTI. LPN M reported that typically UA results were available in 48 hours or less, and C&S takes at least 48 hours. LPN M reported that Resident #202's urine color and clarity should have been documented in progress notes, the CNA's (Certified Nursing Assistants) are expected to document color and amount of output, and the nurses should have orders in place to ensure catheter care was being provided. Review of Resident #202's Progress Note dated 11/3/24 at 7:20 PM revealed, at 7:30 PM urine specimen collected and sent to (lab name). There were no nurse's notes, and/or physician visits recorded between the above note on 11/3/24 and 11/8/24. Review of Resident #202's Progress Note dated 11/8/24 at 10:02 PM revealed, sent a message to Dr. to review resident's UA (urinalysis: urine test) results. There were no nurse's notes, and/or physician visits recorded between the above note on 11/8/24 and 11/10/24. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #202's Progress Note dated 11/10/24 at 2:16 PM revealed, observed UA results at nurse's station today with no susceptibility results. Called for results to be faxed. Called (Medical Director (MD) C) who says to send to ER (emergency room). Resident's V/S (vital signs): 92/70 (blood pressure) 113 (heart rate) 97.3 (temperature) 93% (blood oxygen level) .Resident is not eating and drinking as per his normal and appears weak. Called DON (Director of Nursing) with update . Review of Resident #202's UA Results were collected on 11/3/24 at 8:08 PM, and resulted on 11/3/24 at 8:49 PM. The results indicated the urine was turbid (cloudy), contained a moderate amount of blood, a large amount of Leukocyte esterase (indicates a UTI or inflammation), greater than 100 WBC (white blood cells: indicates infection), 48 RBC (red blood cell count: indicates issues such as infection), and a moderate amount of bacteria (indicates an infection). The report had a print stamp by facility staff on 11/4/24 at 10:52 AM. Based on the abnormal results, a Urine C&S was automatically added to the UA test. The C&S results were final on 11/8/24 at 9:10 AM. The results indicated greater than 100,000 CFU/ml Pseudomonas Aeruginosa (indicating a serious bacterial infection), and the recommended antibiotics to treat the infection. The C&S report was received via fax by facility staff on 11/10/24 at 1:54 PM. Review of Resident #202's documentation of Vital Signs indicated that the resident had normal vital signs, including temperatures on 11/3/24 and 11/7/24, but there were no vital signs recorded after that until 11/10/24 when the resident was sent to the hospital. Review of Resident #202's Treatment Administration Record (TAR) revealed no orders for catheter care and/or monitoring. Review of Resident #202's documentation of CNA (Certified Nursing Assistant) Tasks from the past 30 days revealed, Catheter Care was recorded as performed 0/30 days, and Catheter Output (urine) Amount was recorded as performed 0/30 days. In an interview on 11/14/24 at 1:38 PM, DON/Infection Preventionist B reported that Resident #202 did not have any documentation of his signs or symptoms related to a UTI, and was not being regularly monitored for a UTI. DON/IP B reported that with Resident #202 being lethargic, and considering his history of repeated UTI's, he should have had regular monitoring of vital signs, and prompt follow up of his urine test results. In an interview on 11/14/24 at 2:47 PM, CNA I reported that Resident #202 had decrease appetite, and his urine was cloudy a couple days prior to his hospitalization . CNA I reported that the CNA's are expected to report catheter output to the nurse and then the nurse documents it in the record. In an interview on 11/14/24 at 2:25 PM, CNA J reported that catheter output amounts are reported to the nurse. In an interview on 11/14/24 at 2:30 PM, LPN K reported that the CNA's should be documenting catheter output amounts.