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	01/23/2026

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2709637, 2718464Based on interview and record review, the facility licensed staff failed to follow professional standards of practice, communicate effectively with a provider for an acute change in condition for 1 (Resident #100) of 3 residents reviewed for change in condition, resulting in delay in care for blood in the stool, increased confusion, and leading to the potential of a decline in overall physical, mental, and psychosocial well-being.Findings include: Review of an admission Record revealed Resident #100 was a female with pertinent diagnoses which included dementia, sleep disorders, mild cognitive impairment, muscle weakness, lack of coordination, dysphagia (damage to the brain responsible for production and comprehension of speech), cognitive communication deficit (progressive degenerative brain disorder resulting in difficulty with thinking and how someone uses language), and need for assistance with personal care. Review of Nurses Note dated [DATE] at 02:15 AM, revealed, .Patient looked confused and restless, Checked temp and was 97.8 , checked Oxygen it was 88% . I gave patient Oxygen at 2L (liters), and the Oxygen went up to 93%. There was blood in her stool. Put a note in the Physician book. Review of Resident #100's medical record revealed no documentation in progress notes or vitals section of blood pressure results, temperature results, or pulse results for the concern documented dated [DATE]. Review of Physician's Binder dated [DATE] revealed, .She was confused and when time to change her there was blood in the stool. Need to be checked . In an interview on [DATE] at 11:47 AM, Licensed Practical Nurse (LPN) F confirmed when the provider placed the initial swirl it was noting the resident was seen. In an interview on [DATE] at 3:37 PM, Director of Nursing (DON) B reported she was off the week of [DATE]th, 2025. DON B reported the previous provider group's contract expired on [DATE]. This writer requested the provider notes for Resident #100 to determine if she had been seen by a provider for those concerns. Review of the facility provided Provider Notes for Resident #100 revealed no follow up note by a provider which indicated Resident #100 had not been seen for the concern with low oxygen saturation, confusion, and blood in her stool. In an interview on [DATE] at 12:11 PM, LPN C reported the facility had standing orders for oxygen for any levels below 90%. LPN C reported she would contact the provider to obtain an order for the placement of oxygen and obtain further directives on how the provider wanted to proceed. LPN C reported if the resident's mental status was altered, she would obtain a full set of vitals as the resident may have an infection or something else had happened to the resident. LPN C reported with the altered mental status, oxygen level low and blood in the stool could indicate a GI (gastrointestinal) bleed. LPN C reported she would contact the provider whenever there was a new issue, and/or a change with the resident beyond their norm/baseline. In an interview on [DATE] at 1:46 PM, Unit Manager (UM) D reported she would contact the provider to obtain orders for oxygen and any other directive the provider wanted for Resident #100. In an interview on [DATE] at 11:48 AM, DON B reported the nurse who noted the blood in the stool and low oxygen level should have called the doctor right then due (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to a change in condition and not place a notation in the doctor's book especially as it was a holiday week and the weekend was near. DON B reported the physician should have been called. Review of policy, Acute Change in Condition (ACOC) provided on [DATE], revealed, .Changes (symptoms) in a resident's condition are communicated by any staff member to nurses via (see warning signs): Stop and Watch/Interact; Intershift rounds findings; Clinical Rounds findings; Verbal reports; Huddle reports .4. Utilize care paths, Document findings, assessments and interventions on the CHANGE OF CONDITION. Tip: If CHANGE OF CONDITION is complete with all components than it can be used as your progress note. Changes (symptoms) are communicated to the physician via: Phone call (urgent); Physician Log (non-urgent); Physician rounds; .6. If a plausible cause was not found readily in someone with an ACOC assess whether delirium, fluid and electrolyte imbalance, infection, and medication related effects is the cause for the ACOC .7. A change in a resident's status that affect the problem(s)/goal(s) or approach (es) on his/her care plan are documented as revisions and communicated to the interdisciplinary caregivers .8. Communicate changes of condition at the stand-up meeting to the interdisciplinary team .9. Review resident with an acute change of condition daily in Stand Up .Cognitive Symptoms: a Abrupt onset of, or increase in, confusion Onset of hallucinations, delusions or paranoia .Significant fluctuations in level of confusion during the day or over several days .Sensory: a New onset of impaired balance, *Dizziness, * Worsening vision impairment .Bleeding from any orifice: *Appearance of frank blood in stool, urine or vomit . According to [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 20717-20719). Elsevier Health Sciences. Kindle Edition.The health care provider (physician or advanced practice nurse) is responsible for directing medical treatment. Nurses follow health care providers' orders unless they believe that the orders are in error, violate agency policy, or are harmful to the patient .