STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235709	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rivers Health & Rehab Center of Grosse Pointe	900 Cook Road Grosse Pointe Woods, MI 48236

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40330 This citation relates to Intake # MI00148495. Based on interview and record review, the facility failed to notify the responsible party and physician of x-ray findings timely for one Resident (R901) of three residents reviewed for change of condition. Findings include: On 12/04/24 at 11:08 a.m, R901's Family Member, FM B, reported they were concerned R901 received a diagnosis of a new left knee fracture which occurred during their stay at the facility, from 11/04/24 to 11/22/24. FM B stated they learned about the new knee fracture when they accompanied R901 to their orthopedic surgical follow-up visit on 11/22/24, which was for a left hip fracture that occurred on 10/30/24 from a fall FM B reported the orthopedic surgeon found the new left knee fracture during the visit, showed them the x-ray with the new fracture, and asked if R901 had fallen, or how the second fracture had occurred. FM B reported R901 was emergently transferred to an acute care hospital directly from the orthopedic surgeon's office on 11/22/24, where they underwent a second surgery to stabilize the new left knee fracture. FM B reported they noticed R901's left knee began swelling on 11/14/24 and 11/15/24 at the facility, which they reported to nursing management, including the Unit Manager, Registered Nurse (RN) A. FM B stated they knew something was not right. FM B learned R901 had a blood clot on 11/18/24 at the facility, although their leg remained swollen until 11/22/24, when they had the orthopedic surgery follow-up appointment. FM B reported they asked the facility nursing staff what had occurred after the appointment on 11/22/24, when they went to pick up R901's belongings, and no one explained the cause or the injury to them. Review of R901's Minimum Data Set (MDS) assessment, dated 11/10/24, revealed R901 was admitted to the facility on [DATE], with diagnoses including hip replacement, anemia, diabetes, and dementia. R901 required maximal assistance with toileting, bed mobility, and transfers. The Brief Interview for Mental Status (BIMS) assessment revealed a score of 15/15, which showed R901 was cognitively intact upon admission to the facility. Further review of R901's Electronic Medical Record (EMR) on 12/04/24 revealed no documentation of any falls, accidents, or incidents during R901's stay, which was confirmed was from 11/04/24 to 11/22/24. Surveyor requested any accident and incident reports including falls related to this resident, and none were provided. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R901's hospital discharge record history and physical, beginning 10/31/24, revealed R901 was admitted on [DATE], with a fracture of the left intertrochanteric (hip) fracture, which was surgically fixated (stabilized) by nailing on 11/01/24. R901 was discharged from the hospital to the facility for care and rehabilitation on 11/04/24. The report further revealed R901 was WBAT (Weight Bearing as Tolerated) on their left lower extremity upon discharge, with physical and occupational therapy ordered. Review of Electronic Medical Record (EMR) revealed R901's left knee X-ray report, dated 11/19/2024 at 10:29 a.m, revealed R901 had a new distal (lower) displaced fracture of the left femur (long upper leg bone). The report described the fracture as Knee .left. Results: There is a displaced obliquely oriented (diagonal fracture often from a direct blow or forceful twisting motion) fracture of the distal left femoral metadiaphysis (the part of the femur located near the knee joint) . Further review revealed the X-ray report was faxed to the facility on [DATE] at 10:34 a.m., and initialed by the ordering provider, Nurse Practitioner, (NP) E, and undated. Review of R901's facility census revealed R901 was discharged to the hospital on 11/22/24 following the orthopedic appointment. Review of R901's orthopedic consult, dated 11/22/24, revealed, On post-op (operation) appointment, patient (R901) found to have a new (underlined) left femoral shaft fracture with left leg pain and inability to bear weight. Has been hurting for over one week, does not remember mechanism (cause of injury). Review of R901's progress note, dated 11/20/24 at 8:46 a.m., by Licensed Practical Nurse (LPN) C, revealed R901 complained of left leg pain of 7/10 (with 10 the highest pain), requiring as needed pain medication (not scheduled), with pain relief. Review of R901's progress note, dated 11/20/24 at 11:48 p.m., by LPN C, revealed R901 continued to keep their left leg externally rotated inward due to pain (level unspecified) whenever their leg was moved. There was no documentation of physician communication. Review of R901's progress note, dated 11/22/24 at 7:49 a.m., by LPN C revealed R901 continued to keep their left leg internally rotated due to pain (level unspecified) whenever their leg was moved. There was no documentation of physician communication. Review of R901's progress notes, dated 11/18/24, revealed R901 was diagnosed with a blood clot in their left leg, and Eliquis (an anticoagulant) was started. Review of R901's EMR from 11/19/24 to 11/22/24 revealed no documentation or interventions related to R901's distal femur (knee) fracture, including physician or resident/representative notification, a referral to an orthopedic physician, or an emergent hospital transfer. Review of R901's provider progress note, dated 11/18/24 at 6:37 p.m., by NP E revealed they visited R901 with a chief complaint of left knee edema (swelling). There was no mention of an x-ray being ordered in the progress note. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R901's EMR including physician orders with the daytime unit manager, Registered Nurse (RN) A, the Acting Director of Nursing (DON), revealed there was no x-ray order found. There was a referral found in the facility documents for the x-ray to R901's left knee after NP E's visit on 11/18/24. On 12/04/24 at approximately 1:45 p.m., RN A was asked about R901's x-ray report dated 11/19/24, showing the new distal femur (knee) fracture. RN A reported they or any nursing management had not been made aware R901 had a new knee fracture on 11/19/24, and they were not aware an x-ray had been requested by NP E. RN A reviewed the medical record and found no evidence of the physician or nursing documentation regarding the x-ray results. Further review of R901's nursing progress notes from 11/18/24 through 11/22/24 with RN A showed R901 reporting increased pain and staff noted rotation of their left leg. RN A explained if they had known about the fracture, they would have sent R901 out emergently for orthopedic follow-up and acute pain management. RN A confirmed there was no physician or provider documentation showing any awareness of the 11/19/24 x-ray results for a new distal femur (knee) fracture. On 12/04/24 at 2:15 p.m., R901's x-ray report was reviewed with Physical Therapist (PT) D, who confirmed R901's left distal femur (knee) fracture was a new fracture, after review of initial hospital documentation and their records. PT D clarified R901 made limited progress in therapy, and required maximal assistance with two people to transfer during their rehab stay and upon discharge. On 12/04/24 at 3:01 p.m., LPN C was asked about their documentation showing R901 had increased pain and their left leg being rotated inward on 11/20/24 and 11/22/24. LPN C reported they had not been made aware of any acute fracture on 11/19/24, and only knew R901 had new blood clot, and was being treated with Eliquis, so they believed their pain and condition was from the blood clot. When asked if they reported this to the physician, as no physician communication was documented respective to R901's increased pain and leg rotation, LPN C stated they had communicated with NP E on 11/22/24. On 12/04/24 at 3:57 p.m., NP E was asked during a phone interview about R901's 11/19/24 x-ray report which they ordered, showing a new knee (distal femur) fracture, NP E confirmed they initialed the x-ray however could not recall when they reviewed the x-ray report dated 11/19/24, as their initials were not dated. NP E recalled they were focused more on R901 having a blood clot, due to the swelling in their left leg. Review of R901's MAR (Medication Administration Record) report from 11/19/24 through 11/22/24, reviewed with the Nursing Home Administrator (NHA) and RN A, showed R901 received prn (as needed) Hydrocodone-acetaminophen (opioid pain medication). The medication was administered on 11/14/24 for pain of 7/10 in their left hip, on 11/15/24 for 7/10 pain in their left leg, on 11/16/24 for pain of 6/10 in their back, on 11/18/24 for 4/10 pain in their knee, on 11/19/24 for 7/10 pain in their left leg, and on 11/22/24 for pain in their left leg. On 12/04/24 at 4:20 p.m., the concerns were reviewed with the NHA and RN A, including R901 or their representative not being notified of an acute knee fracture on 11/19/24, increased pain and discomfort, lack of timely orthopedic consultation and/or emergent hospital transfer, and process concerns related to the x-ray not being made available to NP E timely, and nursing management not being made aware. Both reported they understood the concerns and confirmed they had already begun working on corrections during the survey to prevent a recurrence. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the policy, (Facility) Notification of Changes Policy, undated, revealed, It is the policy of this facility that changes in a resident's condition or treatment are immediately shared with the resident representative, according to their authority, and reported to the attending physician or delegate (hereafter designated as the physician). The resident and/or representative will be educated about treatment options and supported to make an informed choice about care preferences when there are multiple care options available. All pertinent information will be made available to the provider by the facility staff. Nursing and other care staff are educated to identify changes in a resident's status and define changes that require notifications of the resident and/or their representative, and the resident's physician, to ensure the best outcomes of care for the resident .A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences .or commencing a new form of treatment to deal with a problem (for example, the use of any medical procedure . The objective of the notification policy is to ensure that the facility staff makes appropriate notification to the physician and delegated non-physician practitioner and immediate notification to the resident and/or the resident representative when there is a change in the resident's condition, or an accident that may require physician intervention. The intent of the policy is to provide appropriate and timely information about changes relevant to a resident's condition .The nurse will immediately notify the resident, resident's physician, and the resident representative for the following .: A need to alter treatment significantly .