

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235709	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER The Rivers Health & Rehabilitation Center of Gross		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake:1359931Based on observation, interview, and record review, the facility failed to prevent a fall for one resident (R14) of three residents reviewed for falls. Findings include:A review of information submitted to the State Agency (SA) revealed R14 sustained a fall due to their assigned Certified Nursing Assistant (CNA) providing care alone resulting in a transfer to the hospital for an evaluation.On 8/18/25 at 9:25 AM, R14 was observed lying in bed with two fall mats observed on both sides of their bed. Attempts to interview the resident were to no avail due to their cognition.A review of R14's medical record revealed they were admitted into the facility on [DATE] with diagnoses that included Dementia, Chronic Obstructive Pulmonary Disease, Heart Failure, and Diabetes. Further review revealed the resident was cognitively impaired and required extensive assistance of two staff for bed mobility.Further review of the medical record revealed the following care plan: Problem Start Date: 02/13/2024 Category: ADLs (activities of daily living) Functional Status/Rehabilitation Potential. [R14] requires assistance with ADL's due impaired mobility, B/L AKA (bilateral above knee amputation), and dx (diagnosis) of dementia .Approach Start Date: 11/18/2024. Assist me with two-person bed mobility .On 8/19/25 at 10:38 AM, an attempt to contact R14's assigned nurse, Licensed Practical Nurse (LPN) L the date of the fall was to no avail. On 8/19/25 at 12:04 PM, CNA M was interviewed via phone regarding R14's fall and explained while attempting to change the resident when they became agitated and combative. CNA M further explained the resident let go of their grab bar and fell to the floor. A review of the medical record revealed the following progress note authored by LPN L: 6/12/25 at 7:05am. Resident experience a fall during care. Writer had previously informed the CNA that resident might refuse care due to [their] combative behavior. The CNA was well aware of this, as she witnessed the resident slap the writer during an earlier interaction. I told the CNA that it was in best interest to leave the resident alone. Res and CNA exited the room. Writer notified everyone on the 2nd floor that she was going on break. Writer went to her car. 20 minutes later the CNA was knocking on my window. Stating that [R14] fell on her. The CNA reported that the resident was holding onto the bed rails and actively resisting being turned. During this struggle, the resident fell on top of her. Upon assessment, the resident was found with blood actively gushing from area just above the right amputation swite (site). All surgical staples remained intact; however, tissue was noted hanging from the tip of knee. (An old slightly opened sore was noted on the top surface of knee as well). The wound care specialist was immediately contacted. After an evaluation, the specialist was determined it was in the resident best interest to be sent out for further medical care A review of one-on-one in-service documentation dated and signed by CNA M noted the following, Topic of Inservice: ADL Care. DON (Director of Nursing) met with employee to discuss the concerns with the care provided to [R14]. Per the nurse on duty pt (patient) was combative .the CNAs did the care which resulted in a fall out of bed during positioning. Outcome of in-service: Moving forward employee will attempt to redirect resident or allow then to calm down before providing care.On 8/20/25 at 10:58 AM, the DON was interviewed regarding the fall of R14 and acknowledged that there was one CNA providing care to the resident, and the resident required two. A review of the facility's Fall Management Guidelines revealed the following, 2. Residents identified at risk for falls will have a care plan developed and implement fall prevention interventions as needed based on their assessment .</p>		