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	11/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rivers Health & Rehabilitation Center of Gross	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake 2674204. Based on observation, interview, and record review the facility failed to provide adequate supervision to prevent elopement of one cognitively impaired resident (R901) of three residents reviewed for elopement risk. Findings include: A Facility Reported Incident documented, On 11/12/2025, (R901) had exited the building at 10:14 PM and was returned to their room at 10:26 PM. This data was from camera review. R901 had been located by a laundry associate at 10:20 PM who had just punched out for the end of their shift. R901 stated (R901) was going to visit (their) friend but was agreeable to return to the building. A review of the facility Safety Event-Elopement report dated 11/13/25 documented nursing discovered the resident was off the unit at 10:07 PM.On 11/24/25 at 7:40 AM and 8:01 AM, Security Desk Staff A reported someone was to be seated at the desk 24 hours a day and if a break is needed a substitute staff person needs to be in place. Staff A was asked about cameras which revealed the exits of the facility were visible with a camera view. A camera was observed mounted to the ceiling at the entry to the hallway to the first-floor nursing unit. Staff A was asked about a list of residents with known wandering or elopement risk and revealed a bulletin board behind the security desk on which pictures of known elopement risk residents. On review it was noted two of the pictured residents on the board had been discharged months earlier. A picture of R901 was not on the bulletin board. Staff A was unsure of who kept the bulletin board up to date.At 9:15 AM, Certified Nursing Assistants (CNA) F and G reported they were aware of R901's tendency to wander and end up down the hall around the elevator. Both CNAs worked on the floor where R901 resided.At 9:30 AM, Licensed Practical Nurse (LPN) H reported R901 easily moved around by walking fast but would sometimes use their wheelchair. LPN H reported R901 was adamant about getting out and in the last couple of months was more apt to walk to the elevator, get on and go downstairs, but was easily redirected once located. LPN H reported security staff along with nursing staff were aware of R901's wanderings. LPN H further reported R901 would play like they were relaxing on the couch in lobby area by the elevator but would actually be looking for staff in the hallway and wound say, you caught me then redirected to return to the floor or move away from the elevator. When asked about R901's cognition, LPN H reported R901 knew their name, what type of place they were in. At 9:50 AM, the unit clerk reported R901 had been more actively wandering to the elevator and downstairs in the last thirty days or so prior to the elopement and knew staff were watching them.At 10:30 AM, the Director of Nursing (DON) was asked about their knowledge of the elopement and staff present at the security desk and confirmed security staff had stepped away, leaving the security desk unattended, at the time R901 exited the facility. The DON also confirmed the front door was not alarmed and R901 pushed it open when it did not open automatically.At 2:33 PM, Security Staff N reported, when you go on break, you have to make sure someone watches the desk. Staff N further noted residents do walk into the lobby about once a week and ask to go out or just look out the window or sit on one of the couches. At 3:46 PM, LPN R acknowledged they were the assigned nurse for R901 on the night shift 11/12/25. LPN R reported R901 was mostly in the lounge and did a lot of singing and watching TV. LPN R reported they had not (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	witnessed R901 walk down the hall to the elevator. LPN R reported they thought it was around ten minutes after the elopement code was called that R901 was back on the floor.At 4:13 PM, CNA V reported they were aware R901 liked to roam around and had last seen R901 in the activity room between 9:30 PM and 10 PM on 11/12/25. CNA V noted they were giving another resident a bath around 10 PM which was about the timeframe LPN R was passing meds to the same resident. At 4:29 PM, the Administrator reported their knowledge of the elopement was from viewing the cameras. The Administrator reported R901 exited at 10:14 PM, while security was in the restroom. The Administrator reported the timing of the elopement code and the location of R901 by the laundry aide were about the same time. It was further noted the cameras for the second-floor hallway were not in operation and it looked like R901 had arrived in the lobby around 10:12 PM. R901 stopped looked out the front doors and then pushed them out of the way and walked out. On 11/25/25 at 10:11 AM, a phone message was returned by Security Staff O. Staff O reported it was about 9:45 PM to 10 PM when they went to the bathroom after being unable to reach any staff via the phone. When they returned to the lobby a female staff alerted them a resident was missing. LPN R came down shortly after so Staff O went to the office and reviewed the camera footage. Staff O reported they saw R901 come around the furniture in lobby and stood before the front doors and when they did not open R901 pushed the door open. Staff O noted R901 had come down from the second floor at two different times during the same evening R901 had eloped. A review of the record for R901 revealed R901 was admitted into the facility on [DATE]. diagnoses included Schizophrenia, Dementia and Insomnia. A review of the Minimum Data Set (MDS) assessment dated [DATE] documented a 5/15 Brief Interview for Mental Status (BIMS) score which indicated severe cognitive impairment. The MDS further documented that R901 had wandering behavior. A review of the most recent care plans documented, I have a variety of interests that include spending time with others, going outside, watching movies and listening to music. Wandering halls and into other rooms, usually easily redirectable. Attempting to leave facility unattended. Placed in Elopement Books throughout facility and at security. Category: Behavioral Symptoms: Start Date: 06/17/2025. Last Reviewed/Revised 09/09/2025 08:44 AM; Problem: I scored 12 or greater on elopement assessment. Category. Behavioral Symptoms. Start Date 06/17/2025. Last Reviewed/Revised 06/17/2025. Approach: Observe for whereabouts and redirect as needed. Start Date 09/21/2025; Problem: I display poor short- and long-term memory deficits. I am alert and oriented x 1-2, with periods of increased confusion. Able to make simple needs known. Category Cognitive Loss / Dementia Start Date 06/17/2025 Last Reviewed/Revised 06/17/2025 04:02 PM; MDS date 09/09/25. A review of the Elopement Risk assessment dated [DATE] documented a score of 22. This indicated high risk and that greater than 12 was considered at high risk. A review of the progress notes indicated some increase in elevator use activity since 04/15/25. A note dated August 8th, noted redirected several times from the area around the elevator. Additional dates noted were: 10/27/25, 09/30/25, and 09/12/25. Social work documented similar concerns on review in notes dated 09/11/25 and 09/09/25, with frequent attempts and redirection noted, these single notes included Wandering halls and into other rooms, usually easily redirectable. Attempting to leave facility unattended. Placed in Elopement Books throughout facility and at security. Approach: Attempt distraction with an activity, snack, conversation, etc. Start Date; 09/09/2025, Approach: Placed picture in Elopement Books throughout facility and at security. Start Date 09/09/2025, Approach: Observe whereabouts and redirect as needed. Start Date 09/09/2025.A review of the undated facility policy titled, Resident Elopement revealed, It is the facility's policy to provide residents with a safe and secure environment and identify residents at risk for unplanned exit from the facility. Residents who enter the facility may display behaviors that are unsafe particularly since they are entering an environment that is unfamiliar. Residents with cognitive loss or impaired judgement may attempt to leave the premises, known as exit seeking behavior. Residents are most vulnerable in the early admission period; however, residents with progressive cognitive disorders can begin displaying exit seeking behaviors at any time . Monitoring doors: All exit doors on each unit will (continued on next page)

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