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	08/20/2025

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

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(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** Based on observation, interview, and record review, the facility failed to assess and treat a wound for one resident (R68) of one reviewed for wound care and failed to ensure appropriate positioning while in bed for one resident (R11) of one reviewed for positioning. Findings include: R68 On 8/18/25 at 10:55 AM, R68 was observed to have a pink foam dressing between the elbow and wrist that had leaked dried blood on the upper border of the dressing. The dressing was not dated. R68 was dressed in a short-sleeve shirt. A review of the medical record revealed R68 was admitted on [DATE] with the following relevant diagnoses: Non-ST elevation myocardial infarction (heart attack), atrial fibrillation (rapid heart rate), and diabetes, type 2. Their [NAME] Data Set assessment revealed an intact cognition. On 8/19/25 at 9:00 AM and 12:27 PM, the pink foam dressing remained in the same condition as the previous observation. R68 was wearing a short-sleeved shirt. On 8/19/25 at 3:31 PM, R68 was interviewed regarding the dressing, they revealed it occurred when an unknown staff member had touched a large blood blister on their arm, and it began to bleed. The unknown staff member applied a pink foam dressing to their arm that has not been changed since initially applied. On 8/20/25 a review of the R68's shower sheets revealed on 8/12/25, a shower was given by Certified Nurse Assistant (CNA) H and they had indicated a change in skin condition R68's right forearm corresponding with the location of the dressing. A review of the Electronic Medical Record (EMR) revealed no documentation regarding the wound by nursing or medical staff. Further review revealed a progress note by the Rehabilitation Nurse Practitioner (NP) dated 8/12/25 which indicated the following: SKIN – No skin lesions or rashes noted in exposed upper/lower limbs. A progress note dated 8/19/25 by the NP revealed the following: SKIN – No skin lesions or rashes noted in exposed upper/lower limbs. On 8/20/25 at 3:55 PM, an interview with Wound Care Nurse (WCN) C revealed they were unaware of any skin issues with R68. They further revealed that when any caregiver notes a change in a resident skin condition, they are to be notified, and staff are to initiate treatment (cover/protect with appropriate dressing) and notify them. Staff are then to document their findings in the nursing (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	progress notes, if a CNA notices the change, they are to notify their nurse. On 8/20/25 at 4:10 PM, the Director of Nursing (DON) confirmed that when a staff member notices a change in skin condition, the nurse for the resident should be notified. The nurse then puts a treatment in place and notifies the wound care nurse. A review of the policy titled, Skin Management Facility Guidelines revised April 2023, revealed the following: . 10. A weekly meeting will be conducted by the Interdisciplinary Team as necessary. Residents reviewed for skin alterations .3. The presence of any pressure ulcer, wound, or other skin condition is documented weekly on the pressure ulcer or skin report forms. R11 On 8/18/25 at 12:31 PM, an observation was made of R11 being in bed and positioned a quarter to a third of the way down from the top of the mattress. Mats were observed on both sides of the bed. On 8/19/25 at 11:35 AM and 12:11 PM, R11 was in bed and was observed positioned a quarter to a third of the way down from the top of the mattress and close to the edge of the bed nearest the door with their right elbow being very close to being off of their bed. Mats were observed on the floor on both sides of the bed. On 8/19/25 at 12:43 PM, R11 was observed in bed with the head of the bed elevated approximately thirty degrees and their tray table in front of them eating their lunch. R11 was interviewed and asked if they would like to be repositioned in bed and sitting up straighter. R11 stated, sure. On 8/19/25 at 12:48 PM, Certified Nursing Assistant (CNA) A who was walking by R11's room, was interviewed about R11's current positioning in bed. CNA A stated, I'll get another Aide (CNA) and we will reposition [R11]. On 8/20/25 at 10:39 AM, Unit Nurse Manager/LPN (Licensed Practical Nurse) B was interviewed regarding positioning expectations for R11. LPN B indicated R11 tends to slide down from the top to the middle of their bed and lay close to the side of their bed. LPN B said R11 was a fall risk and had a history of falls and their expectation was for staff to be checking on the resident regularly to ensure they were appropriately positioned. On 8/20/25 at 11:30 AM, the Director of Nursing (DON) was interviewed regarding their expectations for positioning of dependent residents in bed and during meals while in their bed eating. The DON confirmed during a meal the resident should be in a seated position with the tray table positioned directly in front of them. The DON further indicated R11 was a fall risk and should be positioned appropriately in bed as needed. A review of R11's care plan revealed an intervention which documented R11 should be assisted with turning and repositioning as needed to avoid pressure ulcers and falls. A review of R11's electronic medical record (EMR) revealed R11 was originally admitted to the facility on [DATE] with diagnoses that included Dementia and COPD (Chronic Obstructive Pulmonary Disease-lung disease). R11's most recent minimum data set assessment (MDS) dated [DATE], revealed that R11 had a severely impaired cognition and required partial to moderate assistance for bed mobility and all other activities of daily living (ADLs) other than eating. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/19/25 at 2:14 PM a policy regarding positioning was requested from the facility and not received by survey exit.

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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: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 .

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide staff with education regarding (R68's) Wearable Cardioverter Defibrillator (WCD- a device that continuously monitors the heart and can automatically deliver a shock to restore normal rhythm if it detects life-threatening arrhythmias) for 3 of 3 direct care nursing staff. Findings include:On 8/18/25 at 9:34 AM R68 was sitting in their wheelchair. Upon inquiry R68 revealed they had a WCD vest due to recently having a heart attack. They further revealed that it had not been activated (no shock given) since they first began to wear it. R68 revealed there are two batteries one is always charging the other is on the device and the vest is only removed for showers.A review of the Electronic Medical Record (EMR) revealed R68 was admitted on [DATE] with the following relevant diagnoses: Non-ST elevation myocardial infarction (heart attack), atrial fibrillation (rapid heart rate), and diabetes, type 2. R68's Minimum Data Set assessment revealed an intact cognition. A review of the EMR revealed a physician order as follows: Monitor function of WCD every shift. Confirm battery is fully charged on vest as well as the spare on the charger. Notify MD with concerns. Twice A Day 07:30 - 11:30 AM, 07:30 PM - 11:30 PM.On 8/19/25 at 9:30 AM an inquiry regarding the function of the WCD vest was made to Licensed Practical Nurse (LPN) F. LPN F revealed the device alerts them and staff if the heart rate drops too low. LPN F further revealed the resident will get a message when battery is low and it can be heard when near the resident room, not at the nursing desk. LPN F did not know the device would deliver a shock if R68's rhythm became dangerously irregular or what the risks were for the resident. On 8/19/25at 9:45 AM, LPN J was queried and did not know what the device was or what it was used for.On 8/20/25 at 9:27 AM, an inquiry with LPN E revealed they did not know how to monitor the function of the device but knew they had to push a button on the front of the device and a message indicating battery was charged and resident name would appear. LPN E was unaware a shock would be delivered if the device was activated. On 8/20/25 at 2:30 PM, Staff Educator (SE) K was interviewed and revealed they was not invited to an in-service meeting with the company providing the device. SE K further revealed they were familiar with the device, had extensive conversation with R68 and knew there was paperwork with instructions in the resident's room. On 8/20/25 at 10:50 AM the Director of Nursing (DON) was queried about how the staff were educated on the WCD vest and/or other equipment that staff may be unfamiliar with. The DON indicated that the company providing the vest, came to the facility and gave about an hour in-service. The DON further indicated that a sign-in sheet was not provided so there is no documentation of who was educated and if those staff members were care givers for R68.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than five percent for one (R2) of three residents reviewed during medication pass. Findings include:A review of the electronic medical record (EMR) revealed R2 was admitted on [DATE] with the following relevant diagnoses: Traumatic Subdural Hemorrhage (stroke), Diabetes, Convulsions (Seizures), Atrial Fibrillation, and Schizoaffective Disorder. The Minimum Data Set assessment revealed severe cognitive impairment. R2 also requires maximum to substantial assistance for all activities of daily living and mobility. On 8/19/25 at 9:19 AM, during a medication observation for R2, it was noted the resident was on two extended-release medication, Depakote and Keppra which should not be crushed. An inquiry as to how those medications would be delivered, Licensed Practical Nurse (LPN) F revealed if a capsule, they would crush the other tablets, then empty capsule contents into the medicine cup and then mix with applesauce per resident preference. Further inquiry regarding if extended-release medications should be crushed or capsule opened, LPN F hesitated and after several minutes stated no. LPN F then identified the Depakote and Keppra and removed them from the dispensing cup with their ungloved finger/hand. The tablets were then laid on the cart top near the opened packages and LPN F crushed the remaining medications, mixed with applesauce and dispensed to resident leaving the extended-release medication unattended on the medication cart outside the room and proceeded to enter the resident's room. LPN F return to the medication cart, gather the packages and two medications and place them in the cart trash bag.Further inquiry regarding what is done with discarded medications, LPN F indicated she would take the two meds out of the trash after medication pass was completed and put them in the drug buster container in the medication room. On 8/19/25 at 10:00 an interview with Unit Manager (UM) G indicated extended-release medications should not be opened or crushed and the order should indicate the same. A review of the Electronic Medical Record (EMR) revealed an order for levetiracetam (Keppra) 500 milligrams (mg) one tab that should not be crushed. Further review of the EMR revealed an order for valproex (Depakote) 500 mg 1 tab that should not be crushed. The container indicated the drug name and dose with a notation do not crush.An interview with the Infection Control Nurse (ICN) K revealed, when a nurse is required to remove a medication that either the resident does not want, does not fall within parameters outlined by the physician or was put in the medication cup in error, the nurse should have a glove on or use a clean spoon to retrieve it.On 10/20/25 at 12:00 PM an interview with the Director of Nursing (DON) indicated when R2's dietary downgraded on 4/14/25 was implemented, the pharmacy should have been notified to change any non-crushable medication to another form, i.e., liquid. Prior to the dietary downgrade, R2 took their medications whole in applesauce, after the downgrade medications were crushed in applesauce. The DON further revealed that nurses should be aware that extended-release medication capsules/tablets should not be opened or crushed and that there is a DO NOT CRUSH list of medication available to them. They further revealed if a nurse comes upon an order for a non-crushable medication for a resident who requires crushing, the physician should be notified. A Medication Administration Policy was requested on 8/19/25 at 12:24 and was not received by survey exit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to properly label medication in one of two medication carts. Findings include:On [DATE] at 10:00 AM, Licensed Practical Nurse (LPN) L was observed administering medication from the second floor medication cart and the following medications were observed to be without an open date; Lispro Insulin Pen, Tobramycin Eye Drops, and a bottle of Enulose liquid. Also observed was vial of Novolog without a resident label or an open date and a bottle of Latanoprost Eye Drops with an expired date of 5/31. Under the dated label was a sticker indicating it should be discarded 42 days after opening. On [DATE] at 10:13 AM, an interview with LPN L revealed all multi-use prescription medications should have a resident identifier as well as an open date.On [DATE] at 10:15 AM, an interview with Unit Manager (UM) B revealed that the medication carts are reviewed each week for unlabeled, undated medication and those that are found are discarded in the sharps container or a drug busting solution to prevent use. UM B further revealed all multi-use prescription medications should have a resident label and be dated when opened.On [DATE] at 10:50 AM, an interview with the Director of Nursing (DON) revealed all medication in the medication carts should be dated when opened and should have a resident identifier. Any prescription item without a resident identifier or open date should be discarded.A policy for Medication Storage was requested on [DATE] at 12:34 PM and was not received by survey exit.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that call lights were in reach for one dependent resident (R11) of five reviewed for call light accessibility. Findings include: On 8/18/25 at 12:25 PM, R11 was observed lying in their bed with no call light anywhere in sight. R11 was interviewed regarding the location of their call light and was unaware of its location. On 8/19/25 at 11:42 AM, 12:11 PM, 1:15 PM, and 2:16 PM, R11's call light was observed to be on the floor by the side of the bed farthest from the door. R11 indicated that they were unaware of the location of their call light. On 8/20/25 at 10:45 AM, Unit Nurse Manager (UNM)/LPN (Licensed Practical Nurse) B was interviewed regarding their expectations for call light placement when residents were in their rooms in bed. UNM B indicated that the call light should be accessible to the resident and clipped to the resident when in bed. On 8/20/25 at 11:50 AM, the Director of Nursing (DON) was interviewed regarding their expectations for call light placement when residents were in their rooms in bed. The DON indicated that the call light should be clipped to the resident and within their reach. A review of R11's electronic medical record (EMR) revealed that R11 was originally admitted to the facility on [DATE] with diagnoses that included Dementia and COPD (Chronic Obstructive Pulmonary Disease) (lung disease). R11's most recent minimum data set assessment (MDS) dated [DATE], revealed that R11 had a severely impaired cognition and required partial to moderate assistance for all activities of daily living (ADLs) other than eating. A facility policy titled Accommodation of Needs with no date, was reviewed and stated the following, Procedures 4. Ensure that the resident has the call system within reach and can use it if desired.