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	08/22/2024

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** 32220 This citation pertains to Intake MI00146468. Based on interview and record review, the facility failed to notify the responsible party and obtain x-ray results timely for one resident (R123) of one resident reviewed for a change in condition, resulting in the responsible uninformed about a fall until hours later and a delay in treatment. Findings include: A review of the record for R123 revealed a progress note dated 06/10/24 at 10:30 AM by Unit Manager D which documented, Writer was reported to by oncoming staff that resident was lowered to the floor by CENA (Certified Nursing Assistant, CNA) on midnight shift while doing peri care, resident was reaching and grabbing onto CENA and CENA had to lower resident to floor for safety. Resident has abrasion on left shoulder and left side of torso, x-ray ordered to rule out any injury, (Director of Nursing) DON notified, spouse notified. investigation process and complete. Patient is resting well, no s/s of distress or discomfort. family at bedside. The previous progress note identified in the electronic medical record was dated 06/09/24 at 12:58 PM. No notification of the responsible party was documented until 06/10/24 at 10:30 AM. A review of the Nurse Practitioner (NP) note dated 06/10/24 at 6:07 PM documented, .Chief Complaint: fall at facility on 6/10 .Assessments/Plans: Unspecified fall .resident was lowered to floor by staff on 6/10 x-ray ordered to (rule out) r/o injury . A review of the Nurse Practitioner (NP) note dated 06/12/24 documented, . x-ray positive for left clavicle (fracture) FX spouse notified and desires transfer to the hospital for evaluation .resident was lowered to floor by staff on 6/10/24 . On 08/21/24 at 2:27 PM, Licensed Practical Nurse (LPN) E reported R123 was total care, non verbal, and two person for care. LPN E was asked what indicates the need to send a resident to the hospital and reported if the resident was on a blood thinner, if there was a fall with acute pain, a change in vital signs or the resident was not at baseline. LPN E was also queried about any issue with x-ray when ordered stat and reported x-rays were not truly stat and could take four hours or even the next day to result or get a technician out to the facility. (continued on next page)

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
	235709	A. Building B. Wing	08/22/2024

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	On 08/21/24 at 2:46 PM, [NAME] Clerk G reviewed the order for the X-Ray for R123. It was noted the order was sent early afternoon on 06/10/24. Clerk G noted x-rays are usually ordered at the time of the fall and R123's fall actually happened on midnights (11PM - 7AM). Clerk G reported the x-ray was ordered stat and generally the technician will come in two hours or at least the same day. On 08/21/24 at 4:57 PM, LPN H reported that R123 had been sent out prior to their afternoon shift on 06/12/24. On 08/21/24 at 5:00 PM, Unit Manager (UM) D and Wound Nurse I were asked about R123's fall. UM D reported they found about the fall when they came into to work on 06/10/24. UM D was asked about the x-ray company and timeliness and reported there was a delay and the report did not arrive until the 06/12/24. UM D reported they had contacted the responsible party about the fall once they found out about it and the night nurse assigned had not called the family or notified the Director of Nursing as should have been done. UM D further reported the responsible party was called when the result of the x-ray was received on 06/12/24. A progress note dated 06/11/24 at 2:44 PM, by LPN E documented, .localized swelling (left) Lt shoulder clavicle region, also noted mild swelling and bruising around Lt eye .x-ray results pending . On 08/22/24 at 8:57 AM, LPN E confirmed they did see increased swelling to the face on 06/12/24. A progress noted dated 06/12/24 at 3:56 PM, by LPN H documented, 3:40 PM sent to (hospital name) for evaluation of left clavicle, due to abnormal x-ray report. On 08/22/24 at 9:17 AM, NP F reported they felt it was safe for R123 to stay at the facility until the x-ray results were reviewed. NP F reported R123 was stable from a clinical standpoint and once the x-ray result was received on 06/12/24, R123 was sent out to the hospital. The decision for R123 to remain was based on clinical presentation and R123 lacked any a change in vital signs, obvious pain, or deformity from the clavicle fracture. NP F reported a stat x-ray can take 24 hours and the expectation is the result is called to the faciity if acute like a fracture and also faxed to the facility. On 08/22/24 at 10:26 AM, R123's fall was reviewed with the Director of Nursing (DON). The DON reported they heard about the fall when notified by the management team later in the morning. The DON confirmed they were not called by the midnight nurse or CNA and the expectation is that all falls, injury or not, are reported to the DON when they occur. The DON was asked about the timing of the call to the responsible party and reported the midnight nurse should also have called the responsible party (like they documented they did). The DON was also asked about the timing of the x-ray and result received. A review of the x-ray result documented it resulted on 06/10/24 at 9:52 PM and documented a mild displaced fracture of the mid to distal left clavicle. The DON was asked why the result had not been reported until 06/12/24. It was noted the result was not received until 06/12/24 at 10:45 AM and the x-ray company should have called and faxed the result to the facility prior to that time. The DON further reported that staff should have called on 06/11/24 when no result had been received. On 08/22/24 at 3:01 PM, CNA K confirmed they worked the midnight shift with two nurses and another CNA on 06/09/24 into the morning of 06/10/24. CNA K reported they had to put R123 on the floor and had to do it by themselves as no one came when they called out for help. CNA K reported they and another aide helped to get R123 back into bed. (continued on next page)

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	08/22/2024

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	A review of the record for R123 revealed R123 was admitted into the facility on [DATE]. Diagnoses included Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side, Heart Disease and Muscle Spasm. A review of the Minimum Data Set (MDS) assessment dated [DATE] indicated moderately impaired cognition, a range of motion impairment on both upper and lower extremities, total dependence to roll left and right, and total dependence all for all activities of daily living (ADLs). The .require assist with ADLs care plan dated 12/04/23 documented assist me with bed mobility and two person total assist with hoyer lift transfers as needed .follow therapy recommendations . A review of the Continuity of Care Document revealed no vitals signs were documented as completed from 06/09/24 at 6:39 PM until 7:03 AM on 06/10/24. The weight documented on 06/05/24 was 212.9 pounds. A review of the facility contract with the x-ray company documented, .(company name) will promptly transcribe the full written report and electronically send and or fax a copy to the facility . The contract did not specifically address orders for stat x-rays or provide designated time frames for delivery of the report. A review of the facility policy titled, Fall Management Guidelines revised April 2023 revealed, .After each fall the nurse will assess for pain and document the findings .The licensed nurse will document the incident on . nurse's notes .as soon as practicable communicate the fall to the attending physician and the responsible party/legal representative and document in the medical record .any fall with injury that is significant, fractures needing sutures hospitalization , must be called to the Director of Nursing as soon as practicable . A review of the facility policy titled, Change of Condition revised April 2023, revealed, An acute change in condition is a sudden, clinically important deviation from a resident's baseline in physical, cognitive, behavioral or functional domains. Clinically important means a deviation that without intervention, may result in complications or death .Document in the medical record all interventions to address the change in condition .x-ray: new or unsuspected finding (such as) fracture .

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	08/22/2024

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38207 Based on observation, interview, and record review, the facility failed to facilitate and assist in obtaining eye glasses in a timely manner for one resident (R2) of one reviewed for ancillary services, resulting in R2 experiencing impaired vision. Findings include: On 8/20/24 at 10:35 AM, R2 was interviewed regarding their care and services at the facility and indicated that they had provided the facility with a prescription for eye glasses over a month ago and had not heard anything since then about obtaining new eye glasses. R2 stated, I don't know what's going on. It was observed that R2 was not wearing eye glasses. On 8/21/24 at 11:22 AM, a follow up visit was conducted with R2 and they were further interviewed about their eye glasses. R2 stated, I can't see well. R2 was observed to not be wearing eye glasses. On 8/21/24 at 11:30 AM, R2's responsible party (RP) A was interviewed by phone regarding R2's eye glasses and indicated that a prescription was provided to the facility following R2's eye appointment in July 2024. RP A stated, I haven't heard anything about [R2's] eye glasses since then. A review of R2's electronic medical record (EMR) revealed the following document from [Outpatient Vision Clinic Provider], Report of consultation: Report: New Eyeglasses: Glasses RX (Prescription) .7/11/24. Further review of R2's EMR revealed that R2 was originally admitted to the facility on [DATE] with diagnoses that included, Chronic obstructive pulmonary disease (COPD) (Lung disease) and Congestive heart failure. R2's most recent quarterly minimum data set assessment (MDS) dated [DATE] revealed that R2 had impaired vision, an intact cognition, and was independent to requiring partial assistance for all activities of daily living (ADLs). On 8/21/24 at 12:14 PM, Social Services Director (SSD) B was interviewed regarding assistance provided to R2 with obtaining their eye glasses. SSD B indicated they sent R2's eye glass prescription to the [Facility eye glass provider] on 8/14/24. SSD B stated, I told them to put a rush on it. SSD B was further interviewed and asked if facilitation of obtaining eye glasses for R2 should have been done more timely. SSD B stated, Yes, to be honest with you I forgot about it. On 8/21/24 at 12:21 PM, the Administrator (NHA) was interviewed regarding their expectations regarding assisting residents with ancillary services such as obtaining eye glasses. The NHA stated, I would expect it to be done within a week or two. A facility policy titled, Ancillary Services with no date, was reviewed and stated the following, Policy: The Facility will take such steps as necessary to ensure that the residents will be provided with .vision .to have meaningful access, adequate and effective care. Ancillary services are medical services provided in the facility to ensure that the residents will continue to have [services] during their stay in long term care setting. Procedure: 2) The IDT (Interdisciplinary Team) will coordinate any resident needs to obtain and schedule ancillary services needed. 5) Follow-up as needed .

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	08/22/2024

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 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** 32220 This citation pertains to Intake MI00146468. Based on interview and record review, the facility failed to implement interventions to prevent a fall from the bed for one resident (R123) of two reviewed for falls, resulting in a fracture, facial trauma, skin abrasions and bruising. Findings include: A review of the record for R123 revealed a progress note dated 06/10/24 at 10:30 AM by Unit Manager D which documented, Writer was reported to by oncoming staff that resident was lowered to the floor by CENA (Certified Nursing Assistant, CNA) on midnight shift while doing peri care, resident was reaching and grabbing onto CENA and CENA had to lower resident to floor for safety. Resident has abrasion on left shoulder and left side of torso, x-ray ordered to rule out any injury, (Director of Nursing) DON notified, spouse notified. investigation process and complete. patient is resting well, no s/s of distress or discomfort. family at bedside. The previous progress note identified in the electronic medical record was dated 06/09/24 at 12:58 PM. No documentation of the fall by the midnight shift was found in the progress notes. A progress note dated 06/10/24 at 3:24 PM, by Wound Care Nurse I documented, .Resident suffered a fall from previous shift and was assessed for any injuries as follows. (right) RT back abrasion, buttocks and hip abrasions, (left) LT clavicle bruise, LT eye swollen and slightly bruised . A review of the Nurse Practitioner note dated 06/10/24 at 6:07 PM documented, .Chief Complaint: fall at facility on 6-10 .resident was lowered to floor by staff on 6-10, x-ray ordered to (rule out) r/o injury . A review of the Nurse Practitioner (NP) note dated 06/12/24 documented, .Review Of Systems: Musculoskeletal: Positive for: Joint Pain-Shoulders .Assessments/Plans: Pain in left shoulder, x-ray positive for left clavicle (fracture) FX spouse notified and desires transfer to the hospital for evaluation discuss in detail with (interdisciplinary team) IDT we will transfer to hospital for evaluation and ortho consult .(vital signs stable) VSS .Patient with (paralysis of one side) Hemiplegia and Hemiparesis following (stroke) cerebral infarction, has developed non fixed contracture of ankle bilaterally, patient is non ambulatory .phone call placed to spouse at 11 am- message left spouse was called again at 1320 . On 08/21/24 at 2:27 PM, Licensed Practical Nurse (LPN) E reported R123 was total care, non verbal, and two person for care. LPN E reported they had heard the midnight CNA had turned the resident by themselves and the resident fell out of the bed. LPN E was asked what indicates the need to send a resident to the hospital after a fall and reported if the resident was on a blood thinner, if there was a fall with acute pain, a change in vital signs or the resident was not at baseline. On 08/21/24 at 2:46 PM, [NAME] Clerk G noted R123's fall actually happened on midnights (11PM - 7AM). On 08/21/24 at 4:57 PM, LPN H reported that R123 did not usually exhibit signs of pain. (continued on next page)

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	08/22/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/21/24 at 5:00 PM, Unit Manager (UM) D and Wound Nurse I were asked about R123's fall. The nurses reported R123 did not exhibit outward signs of pain other the skin abrasions and bruising on assessment. UM D reported they found about the fall when they came into to work on 06/10/24 and that an agency CNA did provide care with one person instead of required two. UM D reported the normal two nurses and two CNAs were present. UM D and Wound Nurse I confirmed all agency staff received orientation to the floor and a binder is available for care plan needs and questions. This binder was observed with Wound Nurse I and present at the nurse station with care sheets filed by room number. Wound Nurse I further reported the book is not difficult to find and staff are oriented to where the information can be found. UM D was asked about the x-ray company and timeliness and reported that there was a delay and the report did not arrive until the 06/12/24. UM D reported they had contacted the responsible party about the fall once they found out about it and the the night nurse assigned had not called the family or notified the Director of Nursing as should have been done. UM D further reported the responsible party was called when the result of the x-ray was received on 06/12/24. On 08/22/24 at 8:57 AM, LPN E reported they did see R123 the morning after the fall and recalled as surprised by the fall and injuries and it was not well communicated in report. The next day LPN E noted no acute change in behavior or vitals except for the obvious injuries. LPN E confirmed they did see increased swelling to the face on 06/12/24. A progress note dated 06/11/24 at 2:44 PM, by LPN E documented, .localized swelling (left) Lt shoulder clavicle region, also noted mild swelling and bruising around Lt eye . A progress noted dated 06/12/24 at 3:56 PM, by LPN H documented, 3:40 PM sent to (hospital name) for evaluation of left clavicle, due to abnormal x-ray report. On 08/22/24 at 9:17 AM, NP F reported they felt it was safe for R123 to stay at the facility until the x-ray results were reviewed. NP F reported R123 was stable from a clinical standpoint and once the x-ray result was received on 06/12/24, R123 was sent out to the hospital. The decision for R123 to remain was based on clinical presentation and R123 lacked any a change in vital signs, obvious pain, or deformity from the clavicle fracture. On 08/22/24 at 10:26 AM, R123's fall was reviewed with Director of Nursing (DON). The DON they heard about the fall when notified by the management team later in the morning on 06/10/24. The DON reported it was a normal night with two CNAs and two nurses per floor and root cause of the fall was that the agency CNA did not follow the plan of care. The CNA was alone for incontinence care. The DON confirmed they were not called by the midnight nurse or CNA and the expectation is the all falls injury or not are reported to the DON when they occur. On 08/22/24 at 2:51 PM and 2:52 PM, phones call were made to the midnight nurses for R123. The calls were not returned. 08/22/24 02:54 PM CNA J was asked about the night R123 fell out of bed. CNA J reported it was busy and it was them and another aide. CNA J reported the only time the other aide asked for assistance was when she came and asked for help to get R123 off the floor. CNA J reported they were not the assigned aide for R123 that night but had said to the other aide to ask if help was needed. CNA J reported they believed R123 was a two person because of their size and and that they shook when moved. (continued on next page)

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	08/22/2024

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/22/24 at 3:01 PM, CNA K confirmed they worked the midnight shift with two nurses and another CNA on 06/09/24 into the morning of 06/10/24. CNA K reported they had to put R123 on the floor and had to do it by themselves as no one came when they called out for help. CNA K reported that the nurse assigned to R123 never came. CNA K reported they had asked the assigned nurse, who was in the day room on a computer, to come and assess R123 after the fall but they did not and it was the other nurse and aide who helped to get R123 back into bed. CNA K further noted they had not seen the assigned nurse enter the room of R123 all night. CNA K reported on query that R123 was a two person for incontinence care and that they had not requested an assist. CNA K also reported they had many years of experience as an aide and were not given a login to document on residents. CNA K further reported that a care guide was not given and only had what another aide wrote out for them about the residents. A review of the record for R123 revealed R123 was admitted into the facility on [DATE]. Diagnoses included Hemiplegia and Hemiparesis following cerebral infarction affecting right dominant side, Heart Disease and Muscle Spasm. A review of the Minimum Data Set (MDS) assessment dated [DATE] indicated moderately impaired cognition, a range of motion impairment on both upper and lower extremities, total dependence to roll left and right, and total dependence all for all activities of daily living (ADLs). The .require assist with ADLs care plan dated 12/04/23 documented assist me with bed mobility and two person total assist with hoyer lift transfers as needed .follow therapy recommendations . A review of the Continuity of Care Document revealed no vitals signs were documented as completed from 06/09/24 at 6:39 PM until 7:03 AM on 06/10/24. The weight documented on 06/05/24 was 212.9 pounds. A review of the undated Resident's Care Guide revealed under the heading # of person assistance the lines for one person and two person were not checked. A review of the facility policy titled, Fall Management Guidelines revised April 2023 revealed, Each resident is assisted in attaining/maintaining his or her highest practicable level of function by providing the resident adequate supervision, assistive devices, and or functional programs as appropriate to minimize the risk for falls. Residents will be evaluated by the interdisciplinary team for their risk of falls. A care plan is developed and implemented based on this evaluation with ongoing review .When a fall occurs the nurse should assess the patient for injury .After each fall the nurse will assess for pain and document the findings .The licensed nurse will document the incident on .nurse's notes .as soon as practicable communicate the fall to the attending physician and the responsible party/legal representative and document in the medical record .any fall with injury that is significant, fractures needing sutures hospitalization , must be called to the Director of Nursing as soon as practicable .

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	08/22/2024

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28776 Based on observation, interview and record review, the facility failed to ensure the dressing for a Peripherally Inserted Central Catheter (PICC) intravenous (IV) was changed timely for one resident (R27) of one whose line was reviewed. Findings include: On 08/21/24 at 9:06 AM, the PICC line dressing on the left upper arm of R27 was observed with Licensed Practical Nurse (LPN) L. An antibiotic medication was infusing. The dressing was dated 8/12/24. LPN L reported the dressing would need to be changed. On 08/21/24 at 11:02 AM, the Infection Control Nurse was asked about the PICC line dressing and reported R27 had been out to the hospital and the dressing did not get changed when R27 came back and it should have been changed Monday. On 08/22/24 at 10:26 AM, the Director of Nursing (DON) reported the dressing should have been changed every seven days per protocol. A review of the record for R27 revealed R27 was admitted into the facility 08/12/24 and readmitted [DATE]. Diagnoses included Osteomyelitis (bone infection) of the left ankle and foot. A review of the physician order dated 08/16/24 documented, .PICC dressing change every 7 days. Maintain sterile technique. Frequency: Once A Day on Mon 1: 03:00 PM - 11:00 PM. Special Instructions: Change upon admit and every 7 days thereafter . A review of the facility policy titled, IV Therapy Central Lines PICC Lines revised March 2024 revealed, . Manage Central Venous Catheters as follows: Use sterile transparent or gauze dressing over all central lines; [NAME] the dressing with date and initials when site care is performed; Visually assess the site every day for signs of complications or infection; Perform site care per physician order or as necessary. Change the dressing, Luer lock caps {for multi-lumen catheters}, and IV tubing down to the cannula hub .

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	08/22/2024

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 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** 32220 Based on observation, interview, and record review, the facility failed to label medications when opened in two of three medications carts reviewed. Findings include: On [DATE] at 4:45 PM, the second floor cart one front medication cart was observed with Licensed Practical Nurse (LPN) H. An Incruse inhaler did not a have a date opened on the box not the actua inhaler. An identifier was not included on the inhaler; A Breo Ellipta had no identifier on the actual inhaler; and a Latanoprost eyed dropper was not dated when opened on the vial. On [DATE] at 8:37 AM, the first floor back cart was observed with LPN M. A Fluticasone propionate/salmeterol ,d+[DATE] inhaler did not have an identifier on the actual inhaler; A Trelegy inhaler , d+[DATE].5 was not dated when opened on the acutal inhaler and did not have an identifier on the actual inhaler; A second Trelegy Inhaler was not dated on the actual inhaler and did not have an identifier on the actual inhaler; A Fluticasone/Salmeterol inhaler ,d+[DATE] and an Incruse inhaler was not dated when opened on the actual inhaler and did not have an identifier on the actual inhaler. On [DATE] at 8:53 AM, the first floor cart two medication cart was observed with LPN N. A Trelegy inhaler did not have a resident identifier on the actual inhaler. On [DATE] at 10:51 AM, the Director of Nursing was asked about label and dating of inhalers and reported the open date should be applied to the actual container when opened and ensure returned to the original box from the pharmacy so the name will be known. A review of the undated facility policy titled, Medication Administration revealed, .Before giving medication to a resident check to be sure it is not expired. Medication containers for insulin, eye, nasal, ear and topical medications will be dated when opened . The policy did not indicate to label an inhaler when opened. A review of the facility policy titled, Medication Ordering and Receipt dated [DATE] did not specifically address the labeling and dating of inhalers or eyedroppers. A review of the information at Drugs.com revealed: for the Incruse, Store at room temperature away from moisture, heat, and light. Keep the inhaler device in the sealed foil tray until ready to start using it. Throw the inhaler away 6 weeks after opening, or when the dose indicator shows a zero whichever comes first; for the Trelegy, Trelegy Ellipta should be discarded in the trash 6 weeks after first use OR when the counter reads 0 which means you are out of medicine, whichever occurs first; For Fluticasone/salmeterol, Discard Fluticasone Propionate/Salmeterol 1 month after opening the foil pouch or when the counter reads 0 (after all blisters have been used), whichever comes first; for the Lantanoprost, Once a bottle is opened for use, it may be stored at room temperature up to 25 C (77 F) for 6 weeks.

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	08/22/2024

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 22960 Based on observation, interview, and record review, the facility failed to maintain the dish machine to ensure dishware was sanitized. This deficient practice had the potential to affect all residents that consume food from the kitchen. Findings include: On 8/20/24 at 8:55 AM, dietary staff was observed cleaning soiled dishware in the facility's dish machine. At that time, a plate simulating dishwasher tester was sent through the dish machine to check the sanitizing properties of the facility's high temperature dish machine. The maximum temperature recorded on the plate simulator was noted to be 124 degrees Fahrenheit. The plate simulating dishwasher tester was sent through the dish machine a second time, and the maximum temperature was noted to be 125 degrees Fahrenheit. Dietary Staff continued to use the dish machine. On 8/20/24 at 9:10 AM, Dietary Manager (DM) O was queried about the dish machine, and stated that he was aware of the issue and had put in a work order for maintenance last week. No explanation was given as to why staff continued to use the dish machine, when it was not properly sanitizing. On 8/20/24 at 9:35 AM, Maintenance Supervisor P was queried about the dish machine, and stated that DM O had contacted him about the dish machine temperatures. Maintenance Supervisor P stated that because they rent the dish machine, that he told DM O he would have to call the company for service. Review of a work order dated 8/14/24 noted: Description: Dish machine not getting hot. According to the 2017 FDA Food Code section 4-703.11 Hot Water and Chemical, After being cleaned, EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be SANITIZED in: (B) Hot water mechanical operations by being cycled through EQUIPMENT that is set up as specified under SS 4-501.15, 4-501.112, and 4-501.113 and achieving a UTENSIL surface temperature of 71 C (160 F) as measured by an irreversible registering temperature indicator; P According to the 2017 FDA Food Code section 4-501.112 Mechanical Warewashing Equipment, Hot Water Sanitization Temperatures, (A) Except as specified in (B) of this section, in a mechanical operation, the temperature of the fresh hot water SANITIZING rinse as it enters the manifold may not be more than 90 C (194 F), or less than: Pf (1) For a stationary rack, single temperature machine, 74 C (165 F); Pf or (2) For all other machines, 82 C (180 F). Pf.