STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235297	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERGATE HEALTH CARE CENTER	14041 PENNSYLVANIA RD RIVERVIEW, MI 48193

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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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** This citation pertains to MI 731. Based on observation, interview, and record review, the facility failed to ensure timely and consistent monitoring and assessments for two (#602, #604) residents reviewed for physician's orders [REDACTED]. Findings include: It was reported to the State Agency that the facility failed to monitor resident's health status. Resident #602- A review of the clinical record for Resident #602 (R602) revealed an admission date of [DATE]. R602 was discharged from the facility on 9/28/19. His [DIAGNOSES REDACTED]. A Minimum Data Set ((MDS) dated [DATE] documented severe cognitive impairment. On 3/10/2020 at 12:12 PM, when Nurse A was queried about what interventions are implemented for a resident that demonstrated an elevated temperature, he said, Use one cotton (bed) sheet, give liquids, call the physician, put an ice pack under their arms and behind the neck, give Tylenol. When Nurse A was queried if he would chart these interventions, he said, Yes. On 3/10/2020, at 3:16 PM, when Assistant Director of Nursing (ADON B) was queried about the frequency of monitoring a resident's temperature when Tylenol or [MEDICATION NAME] has been given, she said, It should be every 30 minutes to an hour. We need to know if what we're doing is effective and to notify the physician if it is not. On 3/10/2020 at 4:12 PM, when the Director of Nursing (DON) was queried about the frequency of monitoring a resident's temperature when Tylenol or [MEDICATION NAME] has been administered for a fever, she said, You should check their temperature again one hour after. The DON added that monitoring of the resident's temperature should occur every shift if something is going on with the resident. The DON said, You need to check to see if the medication was effective. When queried if the resident's temperature should be documented, the DON said, Yes. When a review of R602's clinical record was conducted with the DON, the following was noted: --September 2019 Medication Administration Record [REDACTED]. A review of R602's clinical progress notes documented in part the following: --9/27/19 at 2:28 AM: Resident received in bed resting quietly. X-ray (chest) received as clear and within normal limits. Labs received slightly elevated white blood cell count (11.2), slightly low monocytes (18.4) .Will continue to monitor throughout remaining shift. --9/27/19 at 7:38 PM: .Labs and chest x-ray results reviewed, order for ([MEDICATION NAME] an antibiotic) 1 gm intramuscular injection x 1 now .And, [MEDICATION NAME] (an antibiotic) 100 mg every 12 hours; Diagnoses: [REDACTED].Tylenol was given for elevated temp. Will continue to monitor. --9/27/19 at 9:27 PM: Writer assisting residents assigned nurse with the care of the resident. Writer contacted on call Nurse Practitioner (NP C) regarding resident's temperature of 101.9. Writer made aware by assigned Nurse that resident's temperature was rising from 101.4 at 7:25 PM when given Tylenol by day shift nurse to 101.9. NP C advised writer to adjust scheduled time for Tylenol 325 mg from every six hours to every eight hours and to also alternate Tylenol with [MEDICATION NAME] 600 mg for fever every eight hours. NP C advised Nurse to place an IV (intravenous) of 0.9 normal saline 100 ml/hr time one liter. NP C advised if IV is unable to be placed, to administer fluids via hypodermoclysis (subcutaneous administration of fluids to the body) . --9/28/19 at 2:33 AM: Resident observed resting in bed, IV is running with patent line, resident is tolerating. Cough and congestion minimal. Monitor increasing temps .Will continue to monitor throughout shift. --9/28/19 at 5:04 PM: .Writer obtained new vitals 99.7 temperature .Resident did leave (to go to the hospital) at 12:20 PM. Additional temperatures documented in R602's clinical record included: 98.0 on 9/24/19 at 8:30 PM 99.1 on 9/27/19 at 2:15 PM The clinical record review revealed a reference to monitor increasing temps in the progress note of 9/28/19 at 2:33 AM. The next reference to the monitoring of R602's temperature occurred on 9/28/19 prior to 12:20 PM. When the DON was queried if the frequency of R602's temperature monitoring was adequate, she said, No. Not in this case, because I would have done a more thorough assessment. There was no follow up of the temperature. Did it (the Tylenol) work or did it not? Resident #604- On 3/10/2020 at 10:45 AM, when Nurse D was queried about her assigned residents, she included Resident #604 (R604). Nurse D indicated she was working on obtaining STAT labs (laboratory testing required in order to immediately treat a patient) for this resident. On 3/10/2020 at 10:48 AM, R604 was observed lying in her bed and did not respond when greeted. A Concern Family Member (CFM) was observed sitting at her bedside and indicated that R604 was her mother. When queried about the current condition of her mother, the CFM said, She has had a steady decline since this past Saturday. Her nutrition has been worse. They plan to start an IV. She can't drink on her own. Someone has to offer her fluids. A review of the clinical record for R604 documented an admission date of [DATE]. Her [DIAGNOSES REDACTED]. A MDS dated [DATE] documented severe cognitive impairment and extensive one person physical assistance for eating and drinking. On 3/5/2020, at 3:20 PM, when a review of R604's clinical record and Unit Lab Order book was performed with ADON B the following was revealed: --R604's pulse was to be monitored every shift per the monitor hydrational clinical indicators order. When ADON B was queried about the last time R604's pulse rate was monitored, she said, The last one documented was on [DATE]. It was 64 bpm (beats per minute). --R604 had a physician's orders [REDACTED]. ADON B confirmed that this lab was not drawn. --R604 had a physician's orders [REDACTED]. A notation in the lab order book documented the CBC w/ diff and BMP were not drawn because resident was resistant. ADON B was interviewed about the monitoring of hydrational clinical indicators. When queried if and why the resident's pulse should be taken, ADON B said, Yes, in order to do the assessment. The ADON was queried about what should be done when there is a physician's orders [REDACTED]. She said, We can redirect them; calm them; and, try again later. We should let the physician know and document. On 3/10/2020 at 4:46 PM, when R604's clinical record was reviewed with the DON, she confirmed that according to physician's orders [REDACTED]. When queried about why this was ordered, the DON said, Because when you're dehydrated it will affect this vital sign. This is one way of getting a red flag and acting. The DON confirmed that the last pulse obtained on R604 was on [DATE]. The DON said, That's too long. When the DON was queried about what should happen if a resident resists a lab draw, she said, We have to attempt; educate. You have to come back later and try again. When queried if it was a concern that R604's lab ordered on [DATE] was not drawn, she said, Yes because we're not poking people for no reason. We should notify the doctor and let him know we can't get this lab for you. R604's clinical record did not document additional attempts to obtain the labs ordered on [DATE]. Per the DON, There is no documentation of follow-up with the physician regarding missed lab draw. A review of the referenced facility documents revealed the following: --Vital Signs, dated 4/22/19: Policy: Vital signs will be checked as needed and as ordered by the physician to aid in the [DIAGNOSES REDACTED]. Abnormal vital signs will be reported to the licensed nurse. --Obtaining a Blood Sample for Laboratory Analysis, dated 3/5/2020: It is the responsibility of the licensed nurse to assure that all orders for diagnostic services are promptly carried out.
F 0692 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough food/fluids to maintain a resident's health.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 629. Based on observation, interview, and record review the facility failed to provide an adequate fluid intake for one (#604) resident reviewed for hydration, resulting in dehydration requiring the infusion of intravenous (IV) fluids to resolve dehydration. Findings include: It was reported to the State Agency that a resident was

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

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.

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F 0692 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) receiving poor care. On 3/10/2020 at 10:45 AM, when Nurse D was queried about her assigned residents, she included Resident #604 (R604). Nurse D indicated she was working on obtaining STAT labs (laboratory testing required in order to immediately treat a patient) for this resident. On 3/10/2020 at 10:48 AM, R604 was observed lying in her bed and did not respond when greeted. A Concern Family Member (CFM) was observed sitting at her bedside and indicated that R604 was her mother. When queried about the current condition of her mother, the CFM said, She has had a steady decline since this past Saturday. Her nutrition has been worse. They plan to start an IV. She can't drink on her own. Someone has to offer her fluids. On 3/10/2020 at 12:49 PM, R604 was observed in her room with the CFM. The CFM stated that nursing staff tried but were unable to obtain a urine specimen. The CFM added they are trying to rehydrate her so they can do a lab draw and obtain urine. An IV was observed infusing into the Resident. A review of the clinical record for R604 documented an admission date of [DATE]. Her [DIAGNOSES REDACTED]. A Minimum (MDS) data set [DATE] documented severe cognitive impairment and extensive one person physical assistance for eating and drinking. Further review of R604's clinical record documented in part the following progress note dated 3/10/2020: .Family in at bedside during breakfast time. Family (R.P.) voiced concern to Nurse about resident having a decline and poor appetite. Nurse assessed resident vital signs stable .Nurse spoke with N.P. (nurse practitioner). Suggested STAT labs and to start an IV for fluids .New order for STAT labs, STAT CXR (chest x-ray), STAT UA (urinalysis) and to get an IV started of 0.45% NS (normal saline) at 75ml/hr X 2 liters. IV started by RN .Nurse attempted to obtain UA, unable to obtain, will attempt again .Report passed to oncoming nurse. Will continue to monitor. On 3/5/2020, at 3:20 PM, when a review of R604's clinical record was performed with Assistant Director of Nursing (ADON B) the following was revealed: R604's pulse was to be monitored every shift per the monitor hydrational clinical indicators physician order. When ADON B was queried about the last time R604's pulse rate was monitored, she said, The last one documented was on [DATE]. It was 64 bpm (beats per minute). When queried if and why the resident's pulse should be taken, ADON B said, Yes, in order to do the assessment. On 3/10/2020 at 4:46 PM, when the R604's clinical record was reviewed with the DON, she confirmed that according to physician's orders [REDACTED]. When queried about why this was ordered, the DON said, Because when you're dehydrated it will affect this vital sign. This is one way of getting a red flag and acting. The DON confirmed that the last pulse obtained on R604 was on [DATE]. The DON said, That's too long. When the DON was queried, Why was (R604) given normal saline via IV today?, she said, (R604) is having a decline and instead of sending her out to the hospital, we're trying to investigate here. We started an IV to push fluids, ordered stat labs, x-ray, and UA. When queried about the purpose of pushing fluids, the DON said, Two of the most common reasons would be to push fluids (into the body) or get the BP (blood pressure) up. A review of the following facility documents revealed the following: --Vital Signs, dated 4/22/19: Policy: Vital signs will be checked as needed and as ordered by the physician to aid in the [DIAGNOSES REDACTED]. Abnormal vital signs will be reported to the licensed nurse. --Hydration and Nutrition, dated 4/29/19: Adequate nutrition and hydration are essential for overall functioning. Each resident receives a sufficient amount of food and fluids to maintain acceptable parameters of nutritional and hydration status.