STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235476	A. BUILDING _____ B. WING _____	08/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERVIEW HEALTH AND REHAB CENTER NORTH	**18300 E WARREN DETROIT, MI 48224**

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** This citation pertains to intake MI 276, and MI 64. Based on interviews and record reviews the facility failed to notify family members of a change in condition for two of six residents (R#2, R#3), resulting in the family members being unaware that R#2 had difficulty swallowing, failed a swallow test and had a subsequent order for a downgraded diet, and that R#3 was transferred to the hospital for signs and symptoms of Covid-19 (elevated temperature and decreased pulse oximeter readings). Findings include: Resident #2: During a phone conversation with R#2's family member on [DATE] at 9:00 AM, she said that she was never told the resident had suffered 'stroke like symptoms' in early April. She was only made aware of the changes in the resident's condition in late April when the resident had an 'emesis 'and 'bowel obstruction symptoms'. At that time the family became aware that R#2 had earlier signs of a decline in health. According to the closed medical record review, R#2 resided at the facility since 2015 with multiple [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] indicated the resident had a BIMS score (brief interview for mental status) of ,[DATE] and did not have any difficulty eating her meals. The resident was prescribed a regular diet at this time. A progress note dated [DATE] indicated that R#2 was having difficulty swallowing. On [DATE], the physician was notified that R#2 had delayed swallowing. The physician ordered a 'swallow test' for the resident, downgraded the resident's diet to 'soft mechanical', and consulted a SLP (Speech Language Pathologist, a health care professional trained to evaluate and treat people who have voice, speech, language, swallowing, or hearing disorders, especially those that affect their ability to consume food and communicate). On [DATE], the Registered Dietitian (RD) documented that she had received a call from the SLP, downgraded R#2's diet to 'mechanical soft with NTL (nectar thickened liquids)', and recommended a 'one-to-one' staff assist with meals because of increased coughing and requiring cueing. There is no documentation to support the family members were notified of the change in R#2's swallowing ability, SLP consult, or the downgraded diet order during the time of [DATE] through [DATE]. During an interview with the Administrator and the Director of Nursing (DON) on [DATE], at approximately 12:00 PM, they confirmed it was the facility's policy to notify family members/legal guardian (LG) about changes in a resident's condition. The Administrator said the notification of a family member or LG would be documented in the resident's progress notes. At this time, the Administrator and DON reviewed R#2's medical record. They could not locate any documentation to support that R#2's family member was notified of the resident's difficulty in swallowing resulting in a downgraded diet on [DATE]. During a phone interview with the RD on [DATE] at 11:00 AM she said she reviewed the medical record and did not see any documentation to indicate the family was notified on [DATE] or [DATE] regarding the SLP consultation or change in diet or feeding assistance. The RD said did not notify the family of the change in diet because that was a nursing order. Resident #3: According to the complaint intake the family members were not made aware the resident had a change in condition and was sent out to the hospital on [DATE]. According to the closed medical record, the resident had resided at the facility since [DATE] with multiple [DIAGNOSES REDACTED]. The resident's face sheet listed five family members with their phone numbers as 'emergency contacts'. The MDS dated [DATE] indicated that R#3 had a BIMS score of ,[DATE], with no cognition impairment. A progress noted dated [DATE] at 9:00 AM indicated that R#3 had an elevated temperature and deceased oxygenation level and complained of a 'sore throat and cough'. R#3 was transferred to the hospital in accordance with the physician's orders [REDACTED]. There is no additional documentation to support that another attempt to contact that family member or any other family member listed in the resident's medical record was made. During an interview with the Administrator on [DATE], she said the staff member should have attempted to contact another family member listed on the medical record to notify them the resident was transferred to the hospital.
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 intake MI 785. Based on interviews and record review, the facility failed to provide a timely evaluation in the form of a 'STAT x-ray' (immediate) after a fall with injury for one of four residents (R#4) reviewed for quality of care after a fall, resulting in a delay of treatment for [REDACTED]. Findings include: According to the facility's reported incident (FRI) and investigation, on 4/3/2020 at approximately 5:30 PM R#4 was found on the floor, in her room with her right leg underneath her. The resident was assisted back to bed and during the nurse assessment was observed to have swelling and pain at the right knee area. The physician was notified and prescribed a STAT x-ray, along with ice to the area, and pain medication as needed. The resident was sent out to [MEDICAL TREATMENT] on 4/4/20 at approximately 5:00 AM. On 4/4/20 the facility was notified by the [MEDICAL TREATMENT] center that the resident was sent to the hospital and diagnosed with [REDACTED]. A review of the closed medical record revealed that R#4 had resided at the facility since 3/22/2017 with multiple [DIAGNOSES REDACTED]. The Minimum Data Set ((MDS) dated [DATE] indicated that R#4 had a BIMS (brief interview for mental status) score of 6/15 and had severe cognition impairment. Resident #4 was identified to be at 'risk for falls', but had none prior to the 4/3/2020 incident. A progress note dated 4/3/20 at 6:33 PM, documented that R#4 had swelling to the right shin area. The physician was notified, ice was applied, and a STAT X-ray to the right tibia fibula area was ordered. A progress note dated 4/4/20 at 2:31 AM, written by staff G indicated that R#4 complained of pain to the right leg, ice was applied and a pain medication given. Awaiting X-ray. On 8/13/20 at 1:17 PM, staff G said, R#4 did not get her STAT X-ray before the end of her shift because, this was during the height of Covid-19, and the radiology service said they were running slow. Staff G said she reported off to the midnight shift nurse before the resident got her X-ray. Staff G said she didn't know why they did not send the resident to the hospital for the X-ray at this time. A progress note dated 4/4/20 at 6:39 AM, written by staff F indicated that R#4 was out to [MEDICAL TREATMENT]. There is no documentation regarding the X-ray. A progress note dated 4/5/20 at 11:40 PM, that was a late entry for 4/4/20 at approximately 11:00 AM, documented that R#4 was sent to the emergency room from the [MEDICAL TREATMENT] center for increased discomfort and abnormal blood levels. R#4 was diagnosed with [REDACTED]. On 8/13/20 at 3:35 PM, Staff F said that she could not recall if the resident got the X-ray before she left the facility for [MEDICAL TREATMENT]. Staff F then said she thought the resident had already had the X-ray and it was negative, but could not recall how she came to that conclusion. According to the radiology report dated 4/7/2020, R#4 was diagnosed with [REDACTED]. During an interview on 8/13/20 at 11:00 AM the Administrator confirmed that the facility staff had sent R#4 to [MEDICAL TREATMENT] prior to getting an X-ray on her right knee and shin area. The Administrator could not explain why the physician or nursing staff did not send the resident to the hospital for evaluation and treatment. The Administrator said she reported it to the State

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Agency as soon as the X-ray was determined to be positive for a fracture on 4/4/20.