STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235516	A. BUILDING _____ B. WING _____	**07/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIVERGATE TERRACE	**14141 PENNSYLVANIA 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0842 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to MI 170. Based on interview and record review, the facility failed to safeguard against loss of medical information for one (R602) resident reviewed for medical records, resulting in the unavailability of written information regarding care provided, and the potential for errors in care to occur due to lack of proper record maintenance. Findings include: It was reported to the State Agency that facility staff failed to properly monitor the resident. A review of the clinical record for Resident #602 (R602) documented an original admission date of [DATE] and readmission date of [DATE]. R602's medical [DIAGNOSES REDACTED]. A Minimum (MDS) data set [DATE] documented intact cognition. A further review of R602's electronic health record (EHR) did not revealed any [MEDICAL TREATMENT] communication forms were available in the EHR. On 7/7/2020 at 1:48 PM, the Director of Nursing (DON) was requested to provide all of R602's [MEDICAL TREATMENT] communication forms for May 2020. On 7/7/2020 at 2:30 PM, the facility Administrator and DON indicated that R602 had been moved to a different unit and the former ADON (Assistant Director of Nursing) was going to help the current ADON locate R602's [MEDICAL TREATMENT] communication forms. When the Administrator was queried about the purpose of the [MEDICAL TREATMENT] communication forms, she said, They are used for communication between the patient's PCP (Primary Care Provider), the [MEDICAL TREATMENT] (HD) center, and the facility. (The resident) is a shared patient and the [MEDICAL TREATMENT] center and PCP needs to be communicated with. On 7/8/2020 at 8:25 AM, Unit Manager, Nurse D provided May 2020 [MEDICAL TREATMENT] communication forms dated 5/9/2020, 5/16/2020, 5/28/2020, and 5/30/2020. Nurse D said, We did education for our nurses on the use of and importance of ([MEDICAL TREATMENT]) communication form documentation. Our role (here at the facility) is to review it, follow up as necessary, and file it in the chart. May 2020 HD communication forms were not provided for 5/2/2020, 5/5/2020, 5/7/2020, 5/12/2020, 5/14/2020, 5/19/2020, and 5/21/2020. R602 was sent to the hospital on [DATE] and returned from the hospital on [DATE]. Nurse D said, Since we had some missing ([MEDICAL TREATMENT]) communication forms, we contacted the [MEDICAL TREATMENT] center where he was seen. Nurse D provided a chart containing pre/post HD vital signs and thrill/bruit information. A HD trending report provided did not contain May 2020 clinical information. Nurse D stated the information on the trending report and post treatment information from the [MEDICAL TREATMENT] centers was not available for review by facility nurses until today. Nurse D agreed that other pertinent information, such as medications given or if the resident experienced nausea/vomiting, documented on the HD communication forms was not available. On 7/8/2020 at 1:45 PM, when the facility Administrator was queried about her expectations for the completion of the HD communication forms, she said, We should have received the communication forms back from the [MEDICAL TREATMENT] center. When the Administrator was queried if the HD communication forms are part of the resident's medical record, she said, Yes. When queried if missing HD communication forms are an indication of an incomplete medical record, the facility Administrator said, Yes. The facility policy titled, [MEDICAL TREATMENT], dated 5/12/2020, was reviewed and revealed in part the following: Purpose: To provide care guidelines for the resident who receives [MEDICAL TREATMENT] at another facility. Policy: This facility assures that each resident receives care and services for the provision of [MEDICAL TREATMENT] and/or peritoneal [MEDICAL TREATMENT] consistent with professional standards of practice including the ongoing communication and collaboration with the [MEDICAL TREATMENT] facility regarding [MEDICAL TREATMENT] care and services. Procedures: Day of [MEDICAL TREATMENT]: initiate the pre/post [MEDICAL TREATMENT] communication form to be sent to the [MEDICAL TREATMENT] clinic with the resident. Post [MEDICAL TREATMENT]: obtain vital signs of resident upon return from [MEDICAL TREATMENT] and complete the pre/post [MEDICAL TREATMENT] communication form. Follow routine [MEDICAL TREATMENT] instructions on [MEDICAL TREATMENT] transfer form.

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.