STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	414090	B. WIN	B. WING		11/7/2	11/7/2023		
VIDER OR SUPPLIE	I.:R	<u> </u>		STREET ADDRESS, CITY,	STATE, ZIP CO	DE		
COREWELL HEALTH REHAB & NURSING CENTER - KEN			GE 4118 KALAMAZOO AV			ESE		
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE			
INITIAL COMME	NTS	F0000						
Corewell Health R Kentridge was sur survey from 11/6/2	tehab & Nursing Center - veyed for an Abbreviated 2023 to 11/7/2023.							
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The promote the right (2) The facility m quality care rega of condition, or p must establish ar and practices reg and the provisior plan for all reside source. §483.10 resident has the rights as a reside citizen or resider §483.10(b)(1) Th the resident can without interfere or reprisal from t resident has the resident has the	VIDER OR SUPPLIER  HEALTH REHAB & NURSING CENTER - KENT  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  Corewell Health Rehab & Nursing Center - Kentridge was surveyed for an Abbreviated survey from 11/6/2023 to 11/7/2023.  Intakes: MI00138935 and MI00139889.	VIDER OR SUPPLIER  ### HEALTH REHAB & NURSING CENTER - KENTRIDGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  Corewell Health Rehab & Nursing Center - Kentridge was surveyed for an Abbreviated survey from 11/6/2023 to 11/7/2023.  Intakes: MI00138935 and MI00139889.  Census=135  Resident Rights/Exercise of Rights §483.10(a) (2) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section, \$483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a) (2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) (Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of	VIDER OR SUPPLIER  HEALTH REHAB & NURSING CENTER - KENTRIDGE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  INITIAL COMMENTS  Corewell Health Rehab & Nursing Center - Kentridge was surveyed for an Abbreviated survey from 11/6/2023 to 11/7/2023.  Intakes: MI00138935 and MI00139889.  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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 11/15/2023

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.

		(X1) PROVIDER/SUPPLIER/CLI/IDENTIFICATION NUMBER:	A (X2) MULTIPLE CO A. BUILDING					3) DATE SURVEY OMPLETED	
		414090	B. WING					11/7/2023	
NAME OF PRO	VIDER OR SUPPLIE	R				STREET ADDRESS, CITY, STAT	E, ZIP CO	DE	
COREWELL I	HEALTH REHAB	& NURSING CENTER - KENT	TRIDG	BE		4118 KALAMAZOO AVE S E GRAND RAPIDS, MI 49508	<u>.</u>		
(X4) ID PREFIX TAG	(EACH DEFICIEN FULL REGULAT	ICY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING		ID PREFIX TAG	COR		ROSS-	(X5) COMPLETION DATE	
	her rights and to in the exercise of under this subpa This REQUIREM evidenced by:  This citation pertain Based on interview failed to promote refull of 3 resident resulting in feeling the potential for rehighest practicable psychosocial well by Findings include:  Review of an "Adra Resident #101 adra 8/16/2021 with per included depression Review of a "Miniassessment for Resident #101 was cognitive same MDS assess required assistance In an interview on Resident #101 desertook place between Assistant (CNA) ". approximately 9:20 while CNA "N" with commode with the	This citation pertains to intake MI00138935.  Based on interview and record review, the facility failed to promote resident dignity in 1 (Resident #101) of 3 residents reviewed for dignity, resulting in feelings of diminished self worth and the potential for residents to not meet their highest practicable physical, mental, and psychosocial well being.		PREFIX CORRECTIVE ACTION SHOULD BE ( TAG REFERENCED TO THE APPROPRI		nd rsing lursing.  ng lated on ment orth, and cticable ell-being.  if the or omotes sing ality-the hly lidents			

		(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:			ISTRUCTION	(X3) DATE SURVEY COMPLETED		
		414090	B. WING			_ 11/7/	11/7/2023	
NAME OF PRO	VIDER OR SUPPLIE	R			STREET ADDRESS, CITY, S	STATE, ZIP CO	DDE	
COREWELL	HEALTH REHAB	& NURSING CENTER - KENT	TRIDGE		4118 KALAMAZOO AVE GRAND RAPIDS, MI 495	-		
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	floor and picked it told CNA "N" not "N" acted as if she wipe to clean her. "N" stated, "you de #101 reported CN. brief without wipin on to her pants wit attempted to pull to reported she asked multiple times before request. Reside her feel "like I was that I had no rights. In an interview on Team Lead "C" re evening of 8/4/202 between Resident Team Lead "C" re Resident #101 con Resident #101 was with CNA "N". CR Resident #101 was left on by CNA "N commode when sh CNA Team Lead "C" re between Resident who paid CNA "N" reported CNA "N" facility paid her, a: "N" that she paid creported she notifi Administrator "A"	11/7/2023 at 8:10 PM, CNA ported she was team lead the 3 when the event took place #101 and CNA "N". CNA ported the nurse caring for tacted her to inform her that a upset about an interaction NA Team Lead "C" reported upset that her old brief was "while she was on the e wanted it to be removed. "C" reported CNA "N" dropped ripes on the floor and Resident them to be used on her. CNA ported there was a discussion #101 and CNA "N" regarding ". CNA Team Lead "C" told Resident #101 told CNA CNA "N". CNA Team Lead "C" ed Nursing Home of the situation.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ISTRUCTION	(X3) D	(X3) DATE SURVEY COMPLETED	
		414090	B. WING _			11/7/3	2023	
NAME OF PRO	OVIDER OR SUPPLIE	<u> </u> Er			STREET ADDRESS, CITY	, STATE, ZIP CO	DDE	
COREWELL	HEALTH REHAB	& NURSING CENTER - KENTR	IDGE		4118 KALAMAZOO AV GRAND RAPIDS, MI 49			
(X4) ID PREFIX TAG	(EACH DEFICIENT FULL REGULA	ATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY TORY OR LSC IDENTIFYING NFORMATION)	ID PREFIX TAG	COR	VIDER'S PLAN OF CORREC RECTIVE ACTION SHOULI EFERENCED TO THE APPF DEFICIENCY)	D BE CROSS-	(X5) COMPLETION DATE	
	Investigation Wordated 8/4/2023 at (Resident #101) a in a verbal disagrewere being provide salary resulting in disrespected in the incident, the CNA coaching from her of: provision of by (including to direct and recommendat staff support where residents become investigation did any education on conduct after the information of the cocurred. On 11/7 confirmed by NH.  Review of CNA "Documented Coacaltercation between dated 8/7/2023, refor resident during care, team member request while provider Team unprofessional copolicy and/or Profexpectations Refor Improvement resident to direct oprovider as reside adhere to Professi communicating wpatients as a represent the control of the communicating wpatients as a reference of the control of the communicating wpatients as a reference of the control of the c	ility "Event Summary and rksheet" regarding incident 9:20 PM, revealed " and (CNA "N") became involved between tregarding how the cares led and who pays the aide's at the resident feeling emoment As a result of this a did receive performance rupline which included review athroom cares, residents' rights et their own individual care), ion to always bring in additional in conversations/situations with challenging "The not show all staff had received resident rights and professional indicent with Resident #101 1/23 at 12:13 PM, this was A "A".  N"'s Performance Correction ching regarding the verbal en Resident #101 and CNA "N", exceled " Team member caring got oileting. Resident directing er did not honor residents widing care. Including timing of val and seeking alternative care member engaged in niversation, related to salary cedure Violated Professional esident Rights Expectations Team member will allow care, seek alternative care in requests Team member to onal expectation policy when with team members, residents and issentative of (facility)"						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		414090		B. WING			11/7/2023		
NAME OF PROV	IDER OR SUPPLIE	R				STREET ADDRESS, CITY, STATE,	, ZIP CODE		
COREWELL HEALTH REHAB & NURSING CENTER - KEN			TRID	GE		4118 KALAMAZOO AVE S E GRAND RAPIDS, MI 49508			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	COR	/IDER'S PLAN OF CORRECTION (E. RECTIVE ACTION SHOULD BE CRO FERENCED TO THE APPROPRIAT DEFICIENCY)	DSS-	(X5) COMPLETION DATE	
	Resident self-deter	with dignity and respect mination through support of ould be promoted by the facility							